St Patrick's
Mental Health Services

Outcomes Report 2022

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 twelfth 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 2022, despite the challenges posed by a third 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 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 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. Technology-enabled care has not replaced inpatient admission or other onsite care delivery where needed. SPMHS continued to deliver the Homecare service in 2022, 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, delivered remotely through daily or more frequent contact over videocall and other technological channels.

The 2022 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 2022. SPMHS provides community care through its Dean Clinic community mental health 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 2022, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

SPMHS considers service user participation and consultation to be an essential and integral aspect of clinical service development. Section 5 summarises the outcomes from a number of service user experience surveys which assist the organisation in continually improving services so that more people have a positive experience of care, treatment and support at SPMHS. In addition, these service user evaluations provide a method of involving and empowering service users to improve mental health service standards.

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

Section 7 provides a reference list.

SECTION TWO

Service accessibility

2. St Patrick's Mental Health Services

SPMHS is the largest independent, not-for-profit mental health service provider in Ireland. Our services are accessed in a number of ways including community care accessed through our Dean Clinic network, day programme care accessed through our Wellness and Recovery Centre and our inpatient care accessed through three approved centres. In addition, a free-of-charge Prompt Assessment of Needs (PAON) was introduced in December 2017 through the Referral and Assessment service (R&A) and aims to improve access for service users. The PAON service is delivered through technology eg. telephone/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 2022.

2.1. Prompt Assessment of Needs (PAON)

Referrals received for Dean Clinic assessment are transferred into SPMHS's Referral and Assessment service (R&A) and, where approparite, receive a free-of-charge assessment by an experienced mental health nurse. This allows for more prompt and efficient mental health assessments and onward referral to the most appropriate service.

Service users can access this assessment from their own home, without the need to travel to a clinic. A range of communications technologies including telephone and audio-visual technologies are used to provide the assessment. The choice of communication with the 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 2021 and 2022. These results identify the immediate outcome of the PAON assessment. The reduction in monthly adult PAONs since September 2022, is due to a change in the process for managing referrals that was implemented in August 2022. This change provides more precise screening of referrals and this in turn more clearly informs the decisions of clinicians in relation to the treatment options for service users.

	2021 number	%	2022 number	%
Dean Clinic referral	1038	78%	949	77%
Discharge*	56	4%	52	4%
Admission referral	244	18%	237	19%
Total	**1338**	**100%**	**1238**	**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 multi-disciplinary community mental health services, known as Dean Clinics, has been established by the organisation. SPMHS operates a total of four adult Dean Clinics and two adolescent Dean 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 four adult Dean Clinics provide multi-disciplinary mental health assessments and treatment for those who can best be supported and helped within a community-based setting and provision of continued care for those leaving the hospital's 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 2022, there was a total of 1,421 adult Dean Clinic referrals received from the centralised Referral and Assessment service (R&A). This presents a decrease of 12.2% comparing with 1,618 referrals received in 2021. This decrease is probably due to the centralised R&A service assessing and forwarding referrals to the most suitable service.

2.2.2. Dean Clinic referral source by province

The following table illustrates the geographical spread of Dean Clinic referrals by province from 2020 to 2022. The highest referral volumes continued to be from Leinster in 2022 with 1,021 referrals.

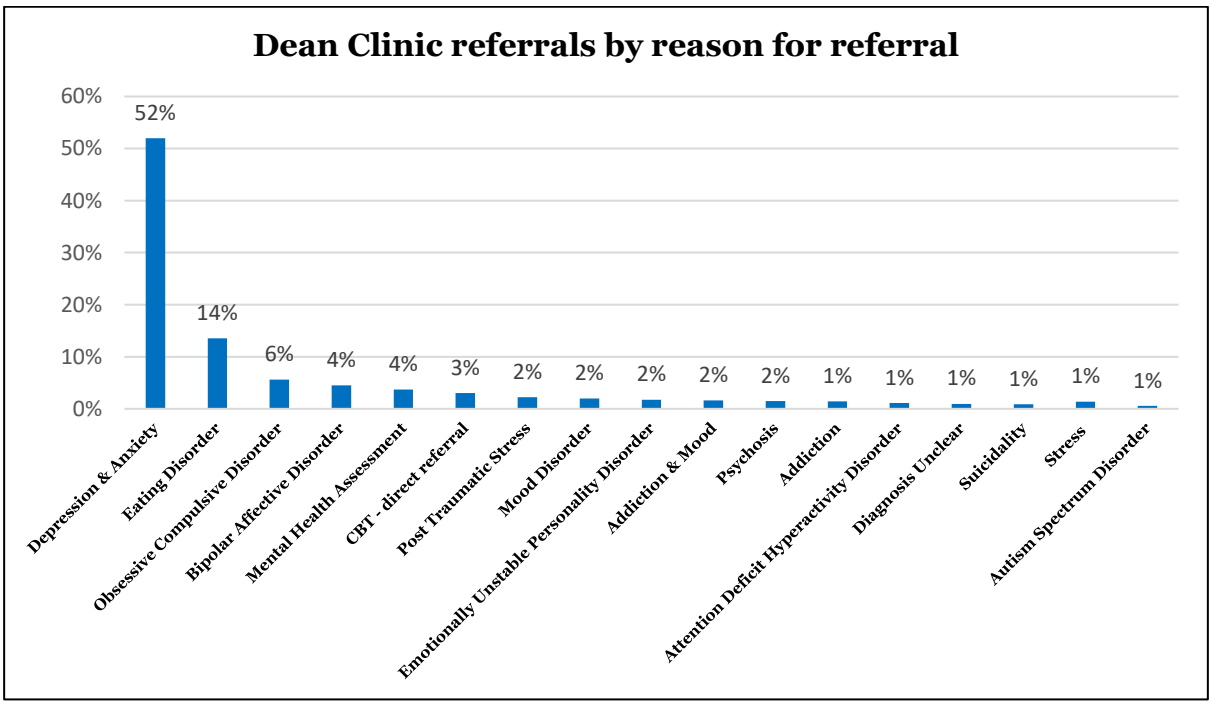
Year	Leinster	Munster	Connaught	Ulster	Other
2020	1,212	241	177	26	0
2021	1,160	230	182	45	1
2022	1,021	217	143	40	0

2.2.3. Dean Clinic referrals by gender

The gender ratio of Dean Clinic adult referrals for 2022 was 60/40, with the majority female. Male referrals increased in comparison to male referrals in 2021 – potentially indicating that more men are looking for support.

2.2.4. Dean Clinic referrals by reason for referral

The chart below documents the most common mental health difficulties referred to the Dean Clinics throughout 2022. It shows depression and dnxiety, eating disorders and OCD 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 2020. In 2022 18.4% of referrals went on to have a mental health assessment in comparison to 19.2% in 2021. Not all referrals resulted in an assessment. 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 some service users have a more immediate need and are assessed for possible urgent admission to inpatient care. Additionally, a large volume of referrals suitable for assessment had to be declined as there was no capacity to assess them.

Year	No. of referrals	No. of assessments
2020	1,656	**457**
2021	1,618	**310**
2022	1,421	**262**

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 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 2020 to 2022. 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 1.3% decrease

in adult Dean Clinic appointments attended in 2022. This was due to unplanned reduction of clinical resources during 2022.

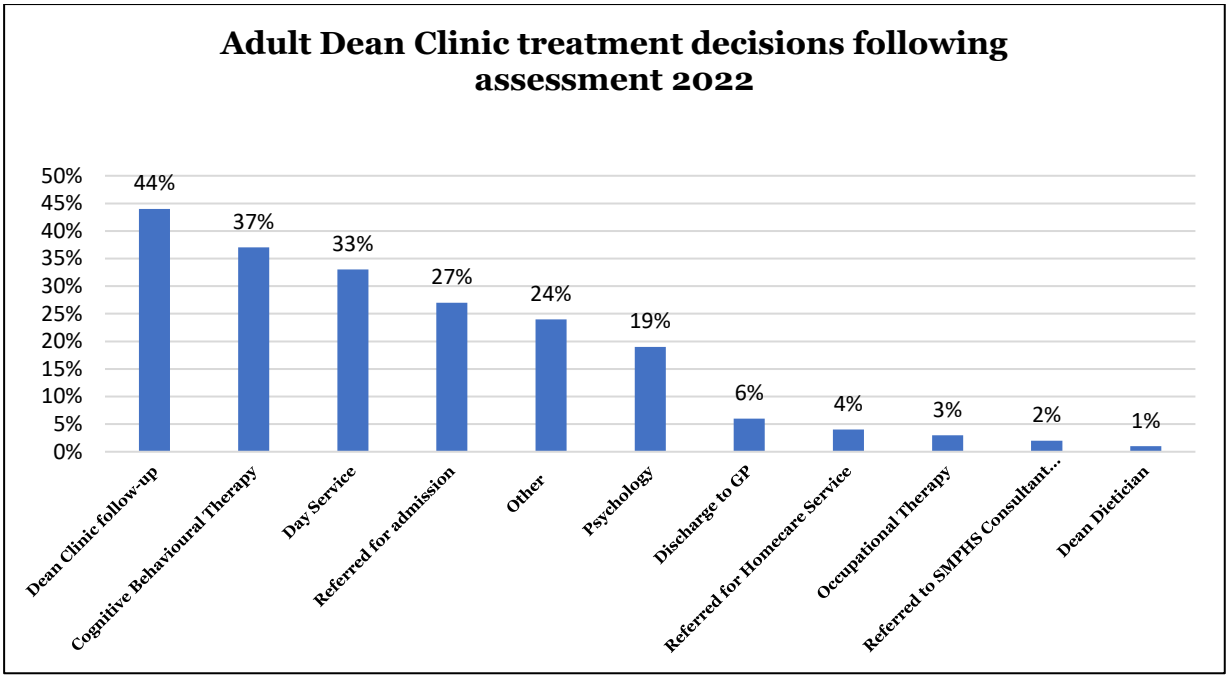
Year	Total No. of adult Dean Clinic appointments
2020	15,730
2021	14,057
2022	13,876

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 2020 to 2022. There was an increase of 23% in first time admissions from the Dean Clinics in 2022, potentially due to robust triaging of referrals and increased access to nurse reviews. The ability to transition to a Homecare admission provided an attractive solution for service users who otherwise may have declined admission.

Year	First admission
2020	195
2021	152
2022	187

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 2022.



2.2.7. Adolescent Dean Clinics

The adolescent Dean Clinics are based in Dublin and Cork. In 2022, there were a total of 1,045 referrals received for the adolescent service – a decrease of 5.4% from 2021. 283 adolescent Prompt Assessment of Needs (PAON's) were performed in 2022. This presented an increase of 7.6% in comparison with 2021's 263 PAON's.

All referrals to the adolescent service are centrally received and reviewed by the Willow Grove Adolescent Unit clinical team. There are a number of outcomes from the review process, namely referral for admission or referrals forwarded to the Dean Clinic teams for review of suitability for community-based care. The referrals to the Dean Clinics are reviewed by the adolescent Dean Clinic team in SPUH and the adolescent Dean Clinic team in Cork. 384 referrals were forwarded to the Dean Clinics for review, the detail of the Dean Clinic referrals is discussed from paragraph 2.2.9.

Another outcome is that referrals can also be declined or discharged prior to assessment. In 2022, 785 (75.1%) of the 1,045 referrals received by the adolescent service were declined or discharged prior to admission or Dean Clinic assessment. The main reason for declining the referrals was due to complex needs or that a specialist service was required at 196 (18.8%). In addition, 171 (16.4%) of the

referrals were declined because the young person referred needed more urgent care than could be provided by SPMHS at that time. A further 125 (12%) were declined due to the young person either being underage or almost 18. Additionally, 112 (10.7%) referrals were declined by young people and parents and 102 (9.8%) referrals were declined due to exclusion criteria. A total of 79 (7.6%) were declined due to unsuitable milieu, young people being admitted elsewhere, the crisis abated or the lack of parental consent.

2.2.8. Adolescent referral source by province

The following table illustrates the geographical spread of adolescent referrals by province from 2020. The highest referral volume is from Leinster.

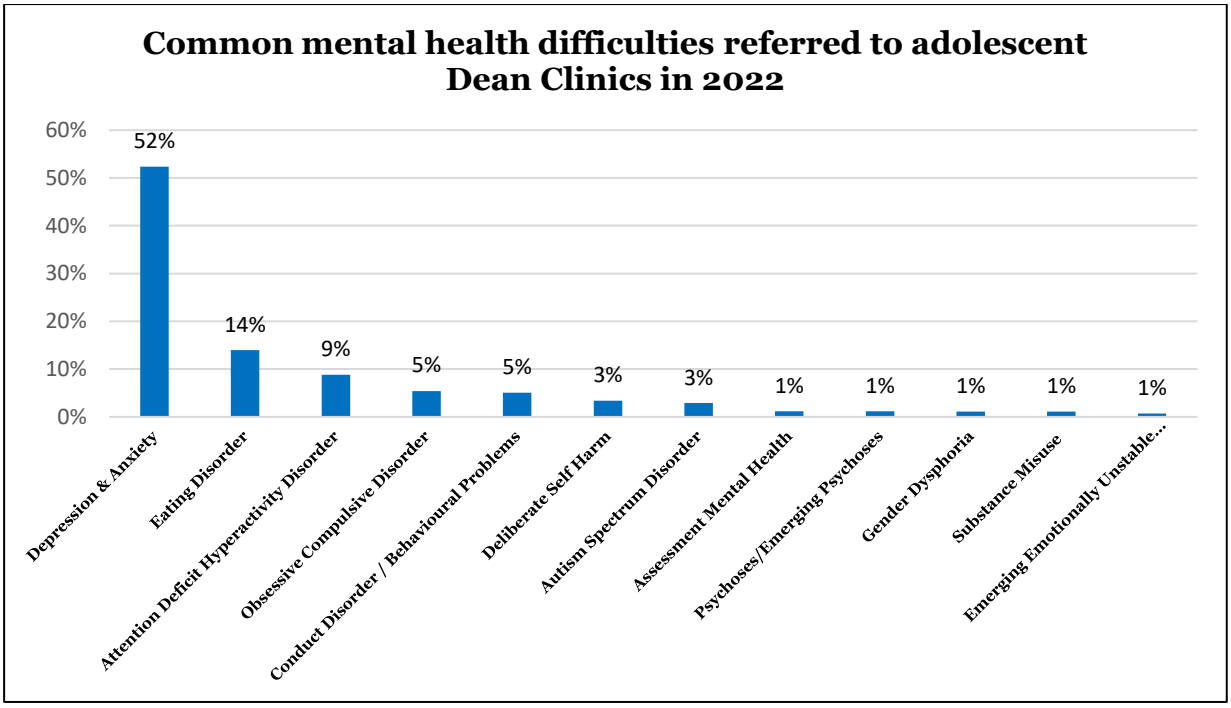
Year	Leinster	Munster	Connaught	Ulster	Other
2020	509	162	25	14	0
2021	746	294	45	20	0
2022	695	291	44	15	0

2.2.9. Dean Clinic referrals by gender

The gender ratio of Dean Clinic adolescent referrals for 2022 was 64/36 with the majority being female. There was an increase of 6% in male referrals in comparison to male referrals in 2021 – potentially indicating that young men are increasingly looking for support.

2.2.10. Common mental health difficulties referred to adolescent Dean Clinics

The chart below documents a sample of the common mental health difficulties referred to the adolescent Dean Clinics throughout 2022 by GP's, HSE CAMH services, private consultants, HSE adult mental health inpatient services and independent mental health services. The primary reasons for referral were depression and anxiety, eating disorders and ADHD.



2.2.11. Dean Clinic activities

The table below summarises the total number of referrals received by the adolescent service, the number of referrals sent to the adolescent Dean Clinics and the number of adolescent mental health assessments provided across the Dean Clinics since 2020. 384 referrals were forwarded to the adolescent Dean Clinics in 2022, presenting a decrease of 10.5% in comparison to the number of referrals in 2021. The increased capacity of Homecare admissions increased accessibility to the service by creating an attractive alternative to physical admissions for young people and their parents; and negated the waiting times for a Dean Clinic assessment.

As mentioned in paragraph 2.2.7., not all referrals result in an assessment due to service users already being under the care of another service; non-attendance of assessment appointments; declining the assessment offered and / or may be referred for an admission assessment. In addition, service users may have been referred to several services and opted to take a local service. Parental consent is required prior to adolescent assessments taking place.

Year	Total no. of referrals to adolescent service	No. of referrals to adolescent Dean clinics	No. of assessments in the Dean clinics
2020	710	305	113
2021	1,105	440	123
2022	1045	394	109

There was an 11.4% decrease in the adolescent Dean Clinic assessments in 2022. This could be due to the reduction in referrals and the increased number of admissions at the central Referral and Assessment triage stage.

The mental health assessment involves a comprehensive evaluation of the young persons' mental state carried out by members of the multidisciplinary team. An individual care plan is agreed with the referred young person and family following assessment. This may involve follow-on community-based therapy, a referral to a day 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 psychoeducation to assist families in supporting the adolescents' recovery.

The total number of adolescent Dean Clinic appointments provided in 2022 by the adolescent Dean Clinics nationwide reflects an increase of 8.4% as summarised in the table below.

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

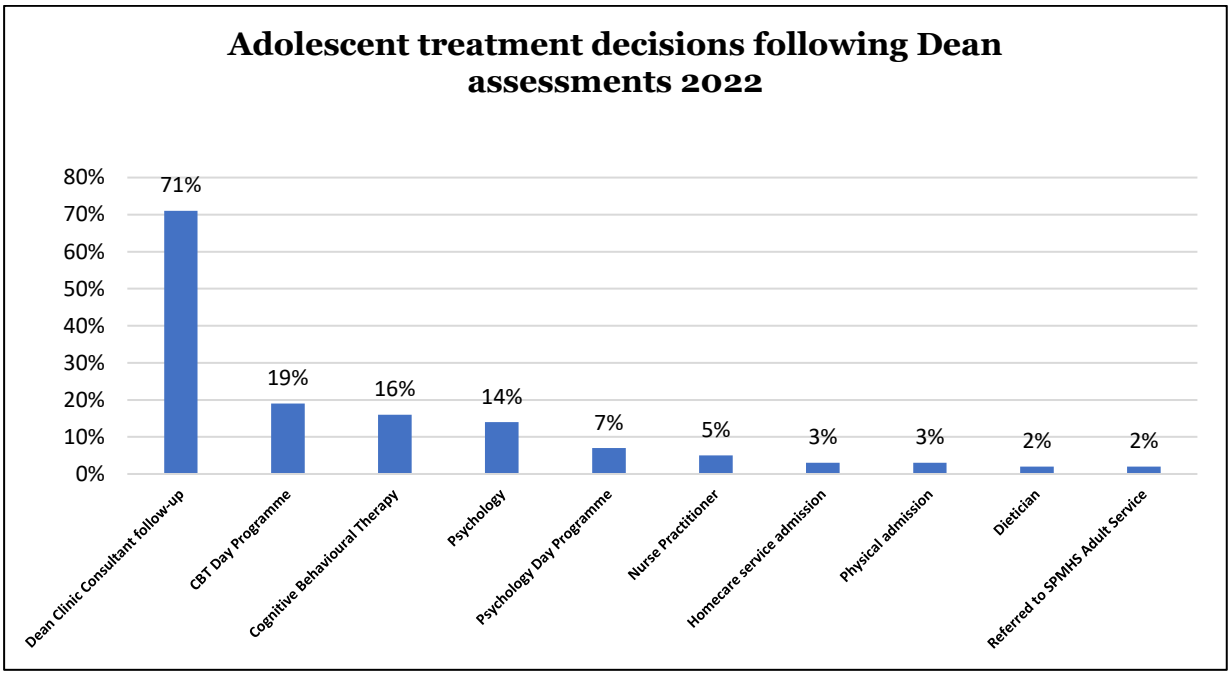
Year	Total no. of Dean Clinic adolescent appointments
2020	2,156
2021	2,089
2022	2,264

The total number of admissions to Willow Grove Adolescent Unit in 2022 was 169; with the total number of first-time admissions at 92, increasing by 4.5%. The table below summarises the number of first-time inpatient admissions to Willow Grove Adolescent Unit from 2020.

Year	First admission
2020	88
2021	88
2022	92

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 2022.



2.3. SPMHS' inpatient care and Homecare service

During 2022, SPMHS continued its Homecare service first introduced in March 2020. 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 frequent contact daily 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 three 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 two virtual beds (ie. 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 2022, there were a total of 4,064 inpatient admissions across the organisation's three approved centres compared to 3,813 for 2021.

2.3.1. SPMHS inpatient admission rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the three SPMHS approved centres; SPUH, SPL and WGAU for 2022.

The table below shows inpatient admission numbers and the percentage rates for male and female admissions. In 2022, 61.1% of admissions across all three approved centres were female, this compared to 61.1% also in 2021 and 64.2% in 2020

No. of admissions (% of admissions) 2022				
	SPL	**SPUH**	**WGAU**	**Total**
Female	547 (60.0%)	1,831 (61.4%)	128 (75.7%)	2,506 (61.7%)
Male	364 (40.0%)	1,150 (38.5%)	41 (24.3%)	1,555 (38.3%)
Not specified		3 (0.1%)		3 (0.1%)
Total	**911 (100%)**	**2,984 (100%)**	**169 (100%)**	**4,064 (100%)**

The table below shows the numbers and percentages of admission care/treatment days delivered in 2022, providing a synopsis of the inpatient care days and the Homecare days.

No. (%) of inpatient admission days and Homecare admissions days 2022			
	Total Adult	**WGAU**	**Total**
Homecare admission days	23,440 (23.5%)	3,297 (59.1%)	26,737 (25.4%)
Inpatient admission days	76,349 (76.5%)	2,279 (40.9%)	78,628 (74.6%)
Total admission days	**99,789**	**5,576**	**105,365**

The table below shows the average age of service users admitted across the three approved centres was 47.82 in 2022 (2021 - 46.39 years). The average age of adolescents admitted to WGAU was 15.69 years in 2022 and was 15.56 years in 2021. The average age of adults admitted to SPL was 49.63 years in 2022 and was 48.57

years in 2021. Finally, the average age of adults admitted to SPUH was 49.81 years in 2022 and was 48.06 years in 2021.

Average age at admission (ALL) 2022					
	SPL	**SPUH**	**Total Adult**	**WGAU**	**Total**
Female	50.30	49.94	49.98	15.60	47.61
Male	48.56	49.68	49.57	15.90	48.20
Not specified		26.00	26.00		26.00
Grand total	49.63	49.81	49.79	15.69	47.82

2.3.2. SPMHS inpatient length of stay 2022

The following tables present the 2022 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 one week up to five years.

SPMHS length of stay (LOS) for adults

2022 adults	**Number of discharges**	**Percentage**
Under 1 week	991	25.4%
1 -<2 weeks	667	17.1%
2-<4 weeks	781	20.0%
4-<5 weeks	331	8.5%
5-<6 weeks	333	8.5%
6-<7 weeks	219	5.6%
7-<8 weeks	159	4.1%
8-<9 weeks	101	2.6%
9-<10 weeks	86	2.2%
10-<11 weeks	64	1.6%
11 weeks -< 3 months	82	2.1%
3-<6 months	81	2.1%
6 + months	13	0.3%
Total number of adult discharges 2022	3,908	100.00%

SPMHS length of stay (LOS) for adolescents (WGAU)

2022WG	Number of discharges	Percentage
Under 1 week	17	10.1%
1 -<2 weeks	26	15.4%
2-<4 weeks	41	24.3%
4-<5 weeks	14	8.3%
5-<6 weeks	20	11.8%
6-<7 weeks	11	6.5%
7-<8 weeks	13	7.7%
8-<9 weeks	6	3.6%
9-<10 weeks	6	3.6%
10-<11 weeks	3	1.8%
11 weeks -< 3 months	4	2.4%
3-<6 months	8	4.7%
Total number of adolescent discharges 2022	169	100%

2.3.3. SPMHS analysis of inpatient Primary ICD Diagnoses (for all inpatients discharged in 2022)

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 2022)

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 2022**	SPUH Admissions		SPUH Discharges		SEH Admissions		SEH Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	55	1.8	65	2.2	0	0	0	0	55	1.4	65	1.7	0	0	0	0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	398	13.3	431	14.4	77	8.4	79	8.6	475	12.2	510	13.1	0	0	0	0
F20-F29 Schizophrenia, schizotypal and delusional disorders	155	5.2	156	5.2	44	4.8	44	4.8	199	5.1	200	5.1	0	0	0	0
F30-F39 Mood [affective] disorders	1302	43.5	1245	41.6	363	39.7	355	38.8	1665	42.6	1600	40.9	27	16	19	11.2
F40-F48 Neurotic, stress-related and somatoform disorders	725	24.2	684	22.9	318	34.8	306	33.4	1043	26.7	990	25.3	55	32.5	50	29.6
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	104	3.5	97	3.2	15	1.6	14	1.5	119	3	111	2.8	31	18.3	29	17.2
F60-F69 Disorders of adult personality and behaviour	249	8.3	311	10.4	96	10.5	115	12.6	345	8.8	426	10.9	3.0	1.8	14	8.3
F70-F79 Mental retardation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
F80-F89 Disorders of psychological development	3	0.1	2	0.1	1	0.1	2	0.2	4	0.1	4	0.1	7	4.1	8	4.7
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1	0	1	0	1	0.1	0	0	2	0.1	1	0	46	27.2	49	29
F99-F99 Unspecified	1	0	1	0	0	0	0	0	1	0	1	0	0	0	0	0
Totals	2993	100	2993	100	915	100.0	915	100	3908	100	3908	100	169	100	169	100

2.5. SPMHS' Day Programme: Wellness and Recovery Centre

The Wellness and Recovery Centre (WRC), as well as providing a number of recovery-oriented programmes, provides service users with access to a range of specialist clinical programmes which are available as a step-down service following inpatient treatment or as a step-up service accessed from the Dean Clinics. Throughout 2022, many day programmes continued to be delivered entirely or in part via technology-enabled care. Clinical programmes are delivered by specialist multi-disciplinary teams and focus primarily on disorder-specific interventions, psychoeducation and supports, and include the following:

1. Access to Recovery	14. Family Therapy for Anorexia
2. Acceptance Commitment Therapy (ACT)	15. Formulation Group Therapy
3. Addictions Programmes	16. Group Radical Openness
4. Anxiety Programme	17. Group Schema Therapy
5. Bipolar Programme	18. Living Through Psychosis
6. Building Strength & Resilience (BSR)	19. Mindfulness (MBSR)
7. CBT for Adolescents	20. Pathways to Wellness
8. Compassion-Focused Therapy	21. Psychology Skills for Adolescents
9. CFT Eating Disorders	22. SABE Adolescents & families (new)
10. DBT	23. SAGE
11. Depression Programme (incl BHSE)	24. SCEG (new)
12. Eating Disorders Programme	25. Recovery Programme
13. EFT Young Adults	26. Trauma Group Therapy

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 2021 and 2022. Referrals come from a number of sources, including SPMHS multidisciplinary teams, Dean Clinics, GPs, and external mental health services. In 2022, the WRC received a total of 2,543 referrals compared to a total of 2,787 for 2021, a year-on-year decrease of 9%. Despite this decrease actual attendances increased in 2022. This is indicative of more appropriate referrals and a greater understanding of the programme criteria and content, by referrers.

Of the day programme referrals for 2022; 665 (26%) were received from Dean Clinics. This compares to a total of 604 (22%) referrals received from Dean Clinics in 2021.

SPMHS day programmes	Total day programme referrals 2021	Total day programme referrals 2022
Access to Recovery	299	217
Acceptance Commitment Therapy	271	279
Addictions Programmes	222	259
Anxiety Programme	340	202
Bipolar Programme	112	74
Building Strength and Resilience	40	77
CBT for Adolescents	29	45
Compassion-Focused Therapy	208	221
CFT Eating Disorders	33	23
DBT	266	147
Depression Programme (incl BHSE)	237	167
Eating Disorders Programme	96	88
EFT YA (new)	0	50
Family Therapy for Anorexia	6	9
Formulation Group Therapy	101	85
Group Radical Openness	85	93
Living Through Psychosis	36	28
Mindfulness (MBSR)	69	76
Pathways to Wellness	57	92
Psychology Skills for Adolescents	18	24
SABE Adolescents & Families (new)	0	49
SAGE	31	29
SCEG (new)	0	23
Recovery Programme	195	120
Schema Group Therapy	9	33
Trauma Group Therapy	26	33
Total	**2,786**	**2,543**

2.5.2. Day programme referrals by gender

Of all referrals to day services in 2022, 1,814 (68.42%) were female, 837 (31.57%) were male and one (0.037%) was non specified. This is reflective of previous years.

2.5.3. Day programme attendances for clinical programmes 2021-2022

In 2022, of the 2,651 referrals to a day programme, 1,670 commenced day programmes. This compares to 1,618 referrals and 1,533 commencing a programme in 2021. These registrations represented a total of 18,260 (2021) and 19,797 (2022) half day attendances respectively. Therefore, in 2021 each registered day service user attended on average 10.25 half days while in 2022 each registered day service user attended on average 11.85 half days, indicating a lower attrition rate and a higher level of service user engagement and satisfaction.

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 mental health difficulties, inpatient admission, personal circumstances (work, family, travel) or not feeling the programme meets their needs or expectations.

Day programme attendances at clinical programmes

SPMHS day programmes	Total day programme registrations 2021	Total day programme registrations 2022	Total day programme attendances 2021	Total day programme attendances 2022
Access to Recovery	152	133	1451	1292
ACT	221	206	1894	1827
Addictions Programmes	166	264	1779	2622

Anxiety Programme	176	132	1298	1405
Bipolar Programme	77	38	421	473
Building Strength & Resilience	25	35	44	187
CBT for Adolescents	23	25	166	155
Compassion-Focused Therapy	72	134	1060	1281
CFT Eating Disorders	22	19	304	221
DBT	163	84	1757	1697
Depression Prog (incl BHSE)	149	102	1365	884
EFT YA (New)	0	20	0	219
Eating Disorders Prog	71	57	922	1988
Family Therapy for Anorexia	5	8	60	78
Formulation Group Therapy	60	61	392	400
Group Radical Openness	38	53	1036	1233
Living Through Psychosis	17	19	141	143
Mindfulness (MBSR)	52	50	318	240
Pathways to Wellness	23	52	975	1178
Psychology Skills for Adolescents	7	29	273	247
Recovery Programme	195	83	1772	1246
SABE adolescents and families (New)	0	8	0	62
SAGE	53	18	251	159
Schema Group Therapy	18	16	246	228
SCEG (New)	0	9	0	41
Trauma Group Therapy	13	15	300	291
	1,780	**1,670**	**18,260**	**19,797**

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	2020	2021	2022
Clinical audits			
Number of complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**638**	**434**	**733**
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.	**2,349**	**2,029**	**2,139**
Root cause analyses and focused reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	**8**	**5**	**6**
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.	**80**	**72**	**64**
% 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.	**48% (39)**	**51% (37)**	**52% (33)**
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.	**35**	**28**	**19**
% of Section 14's which progress to involuntary admission (Section 15 - Form 6 Admissions) 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.	**88% (31)**	**85% (24)**	**84% (16)**
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.	**48**	**39**	**40**
Assisted admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**37**	**30**	**14**
Number of Section 60 – Medication reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of three months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	**22**	**11**	**7**
Number of Section 19 – Appeal to Circuit Court A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness.	**2**	**0**	**0**
Number of Tribunals held	**93**	**64**	**42**
Number of ECT Programme's completed within the year	**161**	**158**	**125**
Number of Physical Restraint Episodes (SPUH + SPL + WGAU)	**162**	**42**	**121**

3.2. Clinical audits

This section summarises clinical audit activity for St Patrick's Mental Health Services in 2022. 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 2022

The following table demonstrates the breakdown of projects by type undertaken in 2022, 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 working 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 Admission, Transfer and Discharge 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.	**Prescribing and monitoring of high dose antipsychotic therapy (HDAT)** To ensure adherence to hospital policy with respect to prescribing and monitoring high dose antipsychotic therapy (HDAT). To ensure that HDAT is appropriately monitored to promote safe use.	Clinical Governance Committee	Re-audit completed
8.	**Benzodiazepine and Hypnotic Snapshot** To determine the percentage of inpatients prescribed benzodiazepines and night sedation (z-drugs) in St Patrick's University Hospital, St Edmundsbury Hospital and Willow Grove Unit and to facilitate consideration of the findings by multidisciplinary teams.	Drug and Therapeutic Committee	Re-audit completed
9.	**Is ECG routinely performed on admission?** To ensure that ECGs are routinely performed on admission to inpatient services of St Patricks University Hospital, St Edmundsbury Hospital and Willow Grove Adolescent Unit.	Clinical Governance Committee	Re-audit completed
10.	**Prescribing practice of psychotropic medication in SPMHS adolescent services** To formally assess that the prescribing practice of psychotropic medication in the Dean Adolescent Clinic is in line with the best practice guidelines for adolescents and feedback to the team includes any indicated recommendations for improvement.	Clinical Governance Committee	Baseline audit completed
11.	**Use of Section 23(1) MHA 2001 between 2018-2020 in St Patrick's Mental Health Services** To examine the use of S.23(1) Mental Health Act 2001 at St Patrick's University Hospital and St Patrick's Lucan	Clinical Governance Committee	Service review completed

12.	**Processing of audio and visual data** To ensure that the practice of processing of audio and visual data adheres to the SMPHS policy with particular focus on: the approval of recording audio and visual data, data subject consent, recording method, storage and the relevant safeguards, data retention periods, safeguards if external sources are used to process recordings.	Data Protection Office Clinical Governance Committee	Baseline audit completed
13.	**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 2022
14.	**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
15.	**Venous Thromboembolism events in the SPMHS inpatient services** To establish the number of thrombolytic events in SPMHS over the past five years and to assess whether the ward closures due to C-19 measures have been a contributing factor to the increased occurrence of thrombolytic events.	Clinical Governance Committee	Service review completed
16.	**Nursing Metrics** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit.

3.2.2. Key audit outcomes for 2022

- A Clinical Audit Programme for routine audits and monitoring of compliance with all regulations, rules and the codes of practice for approved centres was continued during 2022. The findings confirmed that all clinical and non-clinical staff have been committed to maintaining good practices and provide best quality care and treatment.

- The findings from the audit on prescribing practice of psychotropic medication in SPMHS adolescent services were overall very positive and confirmed adherence to prescribing best evidence standards. The prescribers agreed to improve and reinforce current practice in the documentation of informed consent to pharmacological treatment and discussion with parents and service users the use of unlicensed medication, mostly melatonin, that although commonly prescribed and available over the counter in many countries, it is unlicensed in children in Ireland.

- A robust audit on management of audio and visual data recorded for, inter alia, research, therapy and professional training was completed in 2022. Based on the findings, further processes were agreed and implemented to strengthen adherence of the processing of audio and visual data to SPMHS policies and data protection legislation.

- A service review of the use of Section 23(1) of the Mental Health Act 2001 between 2018-2020 in St Patrick's Mental Health Services was completed. The findings indicated that SPMHS were compliant with this section of mental health legislation.

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

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

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

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

Clinical significance refers to whether a treatment was effective enough to change whether a patient met the criteria for a clinical diagnosis at the end of treatment. It is possible for a treatment to produce a significant difference and medium to large effect sizes but not to demonstrate a positive change in the service user's level of functioning.

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for care 2022

4.2.1. Objective

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

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

4.2.1.1. Background

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

The CGIS asks a clinician the question: "Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?" which is rated on the following seven-point scale: 1=normal, not at all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.

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

The Children's Global Assessment Scale (CGAS) provides a global measure of level of functioning in children and adolescents. CGAS is scored by the MDT on a scale of one 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 one, in need of constant supervision, to 100, superior functioning.

4.2.1.2. Data collection strategy

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

A random sample was chosen from admissions to SPUH and SPL. The chosen sample size was 331 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.

All WGAU 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		331	107
Admissions	First admission	36%	91%
	Re-admission	64%	9%
Average age ± standard deviation		52±20	16±1
Gender	Female	63%	73%
	Male	37%	27%

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		**2020**	**2021**	**2022**	**2020**	**2021**	**2022**
F30-F39	Mood disorders	50%	47%	45%	38%	32%	17%
F40-F48	Neurotic, stress-related and somatoform disorders	19%	21%	27%	22%	31%	35%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	10%	10%	12%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	9%	4%	0%	0%	0%
F50-F59	Behavioural syndromes associated with physiological	3%	3%	3%	27%	18%	15%

	disturbances and physical factors						
F00-F09	Organic, including symptomatic, mental disorders	1%	0%	2%	0%	0%	0%
F60-F69	Disorders of adult personality and behaviour	9%	8%	8%	1%	5%	0%
F80-F89	Disorders of psychological development	1%	0%	0%	0%	1%	6%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0%	12%	13%	28%

4.2.3. Baseline and final assessment scale scores

Table: Total adult service

CGIS - Baseline measure of severity of illness		**2020**	**2021**	**2022**
		TOTAL	**TOTAL**	**TOTAL**
1	Normal, not at all ill	0%	1%	0%
2	Borderline mentally ill	1%	2%	1%
3	Mildly ill	12%	12%	14%
4	Moderately ill	39%	40%	34%
5	Markedly ill	28%	27%	25%
6	Severely ill	12%	11%	14%
7	Extremely ill	1%	0%	0%
	Not scored	7%	8%	11%

Table: Total adult service

CGIC – Final global improvement or change score		**2020**	**2021**	**2022**
		Total	**Total**	**Total**
1	Very much improved	9%	8%	5%
2	Much improved	40%	41%	41%
3	Minimally improved	29%	29%	29%
4	No change	10%	12%	8%
5	Minimally worse	1%	1%	0%
6	Much worse	0%	0%	0%

7	Very much worse	0%	0%	0%
	Not scored	10%	9%	15%

Table: Willow Grove Adolescent Unit

Children's Global Assessment Scale		2020		2021		2022	
		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%	1%
80-71	No more than a slight impairment in functioning	0%	1%	0%	0%	1%	2%
70-61	Some difficulty in a single area, but generally functioning pretty well	1%	41%	1%	19%	2%	20%
60-51	Variable functioning with sporadic difficulties	1%	41%	3%	37%	12%	31%
50-41	Moderate degree of interference in functioning	17%	9%	17%	28%	40%	31%
40-31	Major impairment to functioning in several areas	67%	8%	67%	15%	35%	11%
30-21	Unable to function in almost all areas	9%	0%	9%	0%	10%	2%
20-11	Needs considerable supervision	2%	0%	3%	1%	0%	0%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	1%	0%	1%	0%	0%	3%
Mean ±SD		36±7	57±9	37±7	51±10	41±9	52±11
Median		35	59	37	52	41	52
Wilcoxon Signed Ranks Test:		Z=-5.973, p<.001		Z=-8.558, p<.001		Z= -7.745, 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		
	2020	2021	2022	2020	2021	2022
Baseline assessment scale score						
% of admission notes with recorded baseline scores	93%	92%	89%	99%	99%	100%
% compliance with clinical audit standard No 1	81%	81%	86%	97%	99%	98%
Final assessment scale score						
% of admission notes with recorded final scores	90%	91%	85%	100%	100%	97%
% compliance with clinical audit standard No 2	80%	85%	94%	97%	96%	95%

4.2.5. Summary of findings

- A sample was chosen out of a dataset of St Patrick's Mental Health Services discharges for 2022.

- A female to male ratio was 1.7:1 for adults and WGAU 2.7:1 for adolescents.

- In the 2022 sample, first admissions accounted for 36% of adult service users and 91% of adolescent service users.

- 2022 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 behavioral disorders due to psychoactive substance use.

- In 2022, 34% of SPUH and SPL service users were moderately ill. Another 25% were markedly ill. 14% were severely ill.

- Based on a sample of 280 (total cases with discharge CGI score documented), 90% of the sample were rated with an overall improvement (1 - very much improved (6%), 2 - much improved (49%) and 3 - minimally improved (35%)). This percentage of sample rated with an overall improvement is 5% higher than those observed in the 2021 data set.

- 2022 analysis of the primary ICD-10 codes showed that for the adolescent population, the most frequent reasons for admission were neurotic, stress related, somatoform disorders followed by behavioral and emotional disorders with onset usually occurring in childhood and adolescence.

- In 2022 the majority (67%) of Willow Grove Adolescent Unit service users were scored as having a moderate degree of interference in functioning on admission and another 35% had major impairment in functioning in several areas. 10% was unable to function in almost all areas.

- Overall improvement rate for Willow Grove Adolescent Unit was 84%.

- The audit shows stability in the levels recording the baseline and final assessment scales scores in adult and adolescent population. The calculated compliance with the standards increased for adults or slightly decreased for adolescents.

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 2022, 117 participants completed the full programme and returned pre and post data. 52% of participants were male and 48% 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 zero – 'never', to three – 'nearly always', with higher total scores (maximum score of 30) indicating greater dependence.

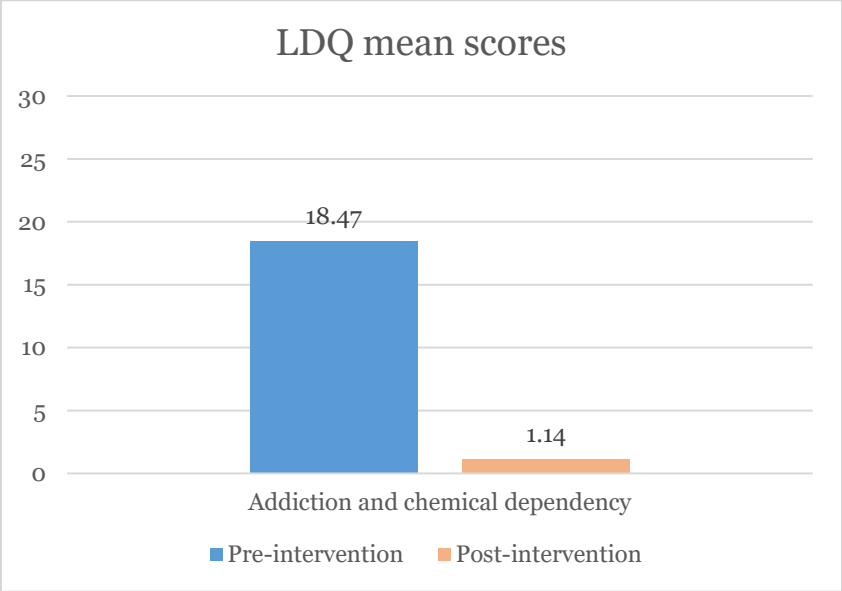
Analysis of the measure has shown it to have high internal consistency (alpha = .88), good test-retest reliability (r = 95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al 1994). The LDQ has also been suggested as an appropriate 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).

4.3.3. Results

This measure was completed by service users pre and post-programme participation. Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post-programme participation. 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, $z = -9.31$, $p < 0.05$, with a moderate to large effect size ($r = -0.61$). The mean score on the total LDQ scores decreased from pre-intervention ($M = 18.47$, SD = 7.84) to post-intervention ($M = 1.14$, $SD = 1.76$), as depicted in the graph below.

Graph: Leeds Dependency Questionnaire scores from pre to post-intervention



4.3.4. Summary

Significant and large reductions in psychological markers of substance and/or alcohol dependency were observed, following completion of the Alcohol and Chemical Dependency Programme. These findings are in line with previous research 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 (service users 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 individuals to achieve abstinence and recovery in relation to substance use, but also to facilitate awareness, understanding and to provide practical support and knowledge in relation to their mental health difficulties.

The programme aims to assist the service user 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 person.
- **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 service users 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.

- **Recovery plan:** This group facilitates and supports participants 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:** This counsellor-facilitated session provides a safe place to support the service user through the process of change and an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- **Family support:** The allocated therapist liaises with families/significant others and facilitates family meetings while the service user is an inpatient.
- **Relapse prevention and management groups:** This group focuses on developing successful relapse prevention and management strategies.

4.4.1. Descriptors

112 individuals with complete data were included in this analysis. These participants attended and completed the full or modified programme in 2022. Of these, 52% were male and 48% female. The age ranged from 20 to 77, with a mean age of 45.3 (*SD* = 14.2).

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).

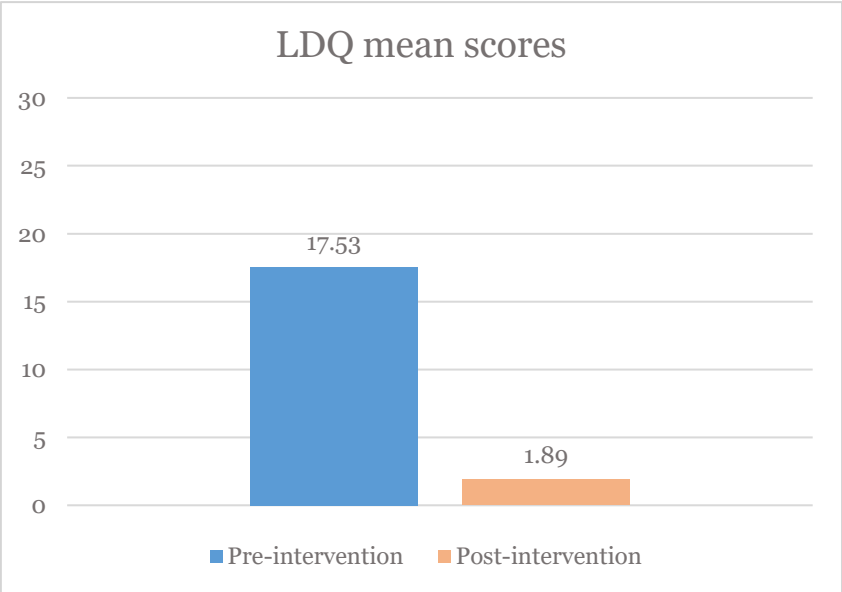
Items are scored on a four-point scale from zero – 'never', to three – 'nearly always', with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been 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 = -9.12, p < .0005, with a moderate to large effect size (r = -0.61). The mean score on the total LDQ decreased from 17.53 (SD=7.21) pre-programme to 1.89 (SD=2.77) post-programme, as depicted in the graph below.

Graph: Leeds Dependency Questionnaires scores from pre to post-intervention



4.4.4. Summary

Large and significant reductions in the psychological markers of alcohol and chemical dependency, as measured by the Leeds Questionnaire, were observed for individuals who took part in the Dual Diagnosis Programme.

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 twelve-week period for one half-day per week. During the twelve-week programme, participants engage in a range of experiential exercises to help them develop the six core processes of ACT; mindfulness, thought diffusion, acceptance, perspective taking, values and committed action. Participants are given three CDs to accompany the experiential exercises covered in session which assists in integrating ACT processes into their daily lives. The essential aim of this programme is to help people connect with what matters most to them and develop skills to help overcome the obstacles that get in the way of living a value-guided life. The programme aims to foster a key shift in terms of helping people to look at their lives in terms of workability; what helps them move closer towards who and where they want to be, and what brings them further away. This programme is primarily facilitated by an experienced counselling psychologist who also trains other clinicians in the ACT approach.

4.5.1. Descriptors

In 2022, data were available for a total of 111 participants. Both pre and post-measures were available for 76 of those completing the programme, representing 68.47% of the sample.

4.5.2. ACT outcomes measures

- **Acceptance and Action Questionaire II**

  The Acceptance and Action Questionnaire (AAQ II: Bond et al, 2011) is a seven-item measure of experiential avoidance or the tendency to avoid unwanted internal experiences – the opposite of which is psychological flexibility. The AAQ-II was developed to establish an internally consistent measure of ACT's model of mental health and behavioural effectiveness. Service users are asked to rate statements on a seven-point Likert scale from one - 'never true' - to seven - 'always true'. Scores range from one to 70 with higher scores indicating reduced psychological flexibility/increased experiential avoidance. The AAQ-II has good validity, reliability (Cronbach's alpha is .84 (.78 - .88)), and three and 12-month test-retest reliability (.81 and .79, respectively) (Bond et al, 2011).

- **Behavioural Activation for Depression Scale**

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

- **Five Facet Mindfulness Questionnaire**

  The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five facets of mindfulness; observing, describing, acting with awareness, non-reactivity to inner experience and non-judging of inner experience. The measure consists of 39 items which are responded to on a five-point rating scale ranging from one – 'never or very rarely true' - to five 'very often or always true'. Scores range from 39 to 195, with

higher scores suggesting higher levels of mindfulness. In a study of non-clinical samples participants who regularly practise mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practise mindfulness had a mean of 138.9 (*SD* = 19.2) (Lykins & Baer, 2009). The measure evidences good reliability (alpha co-efficient ranging from .72 to .92 for each facet) (Baer et al, 2006). Evidence for construct validity comes from analysis of data from samples with mindfulness meditation and no mindfulness meditation experience (Baer et al, 2006).

- **Work and Social Adjustment Scale**

The Work and Social Adjustment Scale (WSAS) is a simple five-item patient self-report measure, 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 zero – 'not at all', to eight – 'very severely'. Total scores for the measure can range from zero to 40, with higher scores indicating greater impairment in functioning. In a study including participants with obsessive compulsive disorder or depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Marks, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

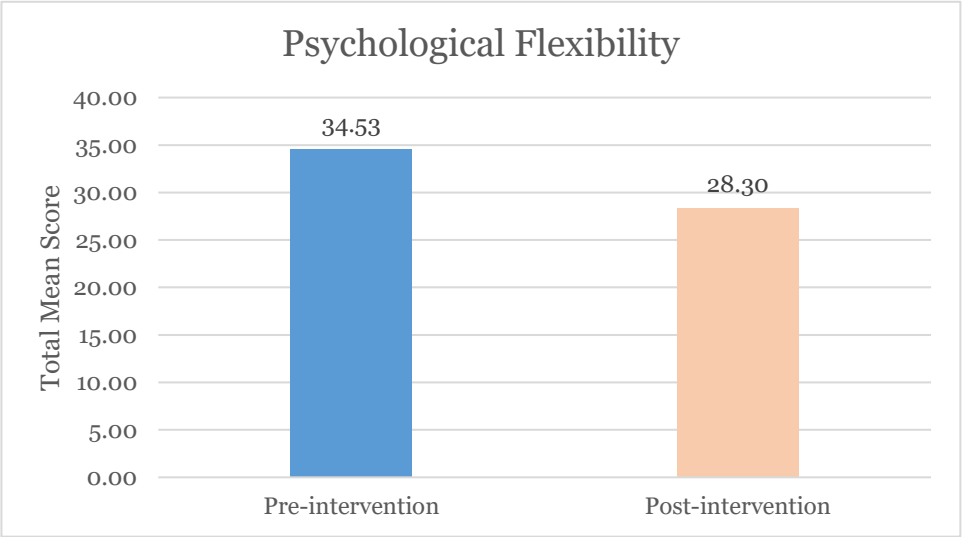
- **The Self-Compassion Scale**

The Self-Compassion Scale (SCS) is a 26-item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; self-kindness, self-judgement, humanity, isolation, mindfulness and identification or over-identification with thoughts. Each item is rated on a five-point Likert scale, from one – 'almost never', to five – 'almost always'.

4.5.3. Results

Acceptance and Action Questionnaire-II

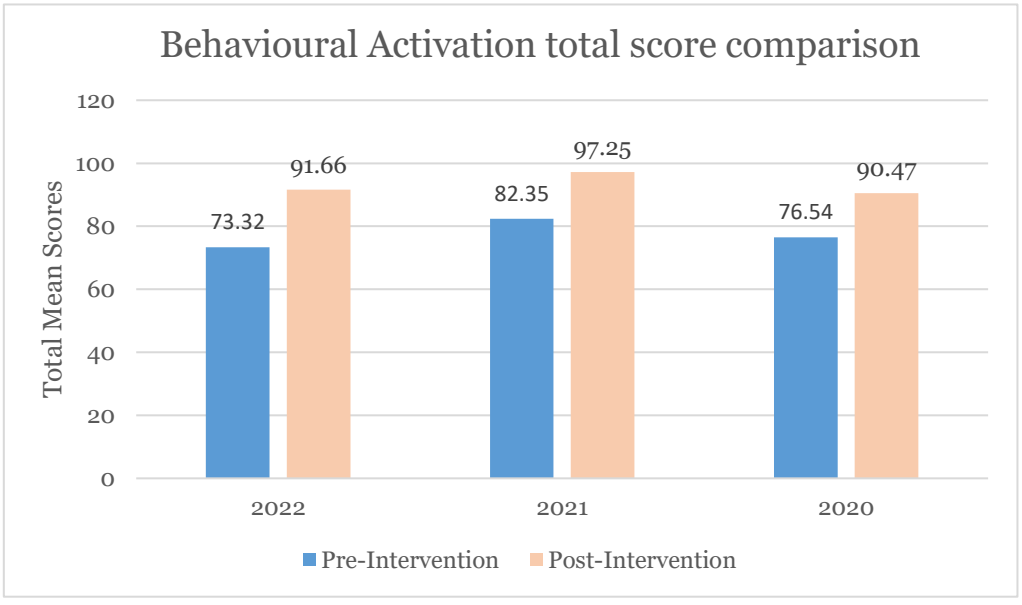
Graph: Total Mean Psychological flexibility (AAQ-II) scores



Mean scores on the AAQ-II decreased significantly from (M = 34.53, SD = 8.35) to (M = 28.30, SD = 9.18) indicating greater psychological flexibility post-intervention, t (75) = 7.63, p <.001, with a small effect size (Cohen's d = 0.44). Pre and post-data was captured for the AAQ-II from 76 participants in 2022 overall signifying an increase from 46 in 2021.

Behavioural Activation for Depression Scale (BADS)

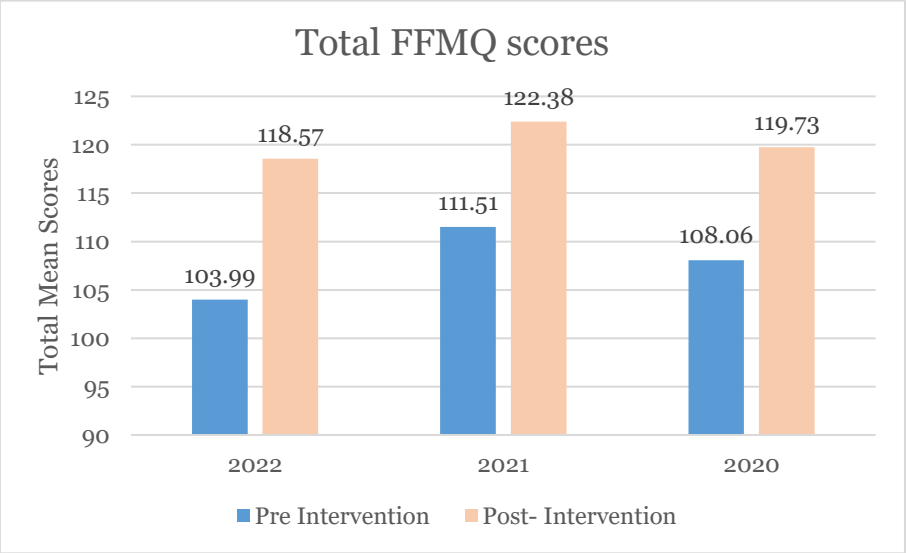
Graph: Total Mean Behavioural Activation scores in 2020, 2021 & 2022 pre and post-intervention comparison



Mean BADS scores increased significantly from (M = 73.32, SD = 26.76) to (M = 91.66, SD = 28.81 indicating greater behavioural activation, t (77) = -5.988, p < .001, representing a small effect size (Cohen's d = 0.32). 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 48/107 44.86% to 17/82 20.73% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

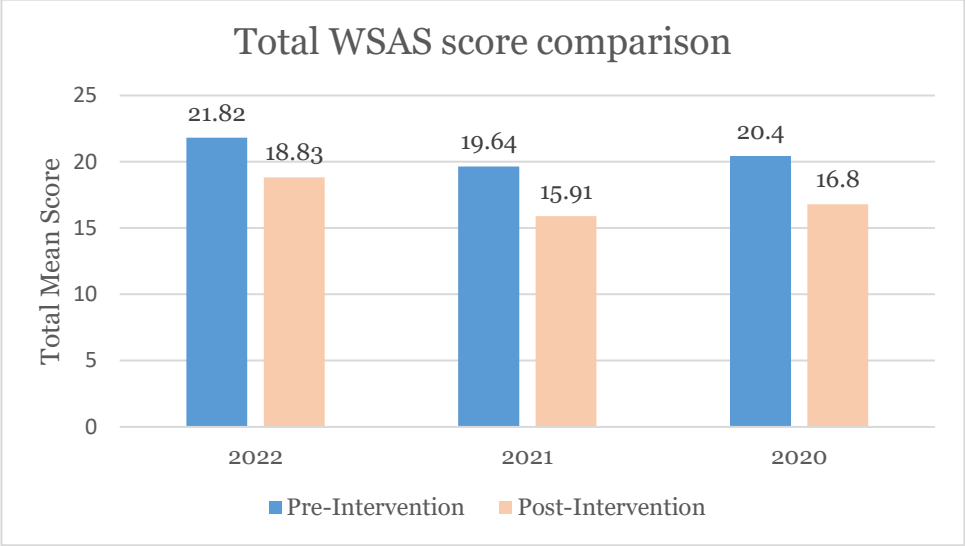
Graph: Total Mean FFMQ scores in 2020, 2021 & 2022 pre and post-intervention comparison



Total FFMQ scores increased significantly, t (51) = -5.46, p < .001, from pre (M = 99.98, SD = 23.05) to post (M =119.02, SD = 18.77) indicating greater levels of overall mindfulness, with a small effect size observed (Cohen's d = 0.37). 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)

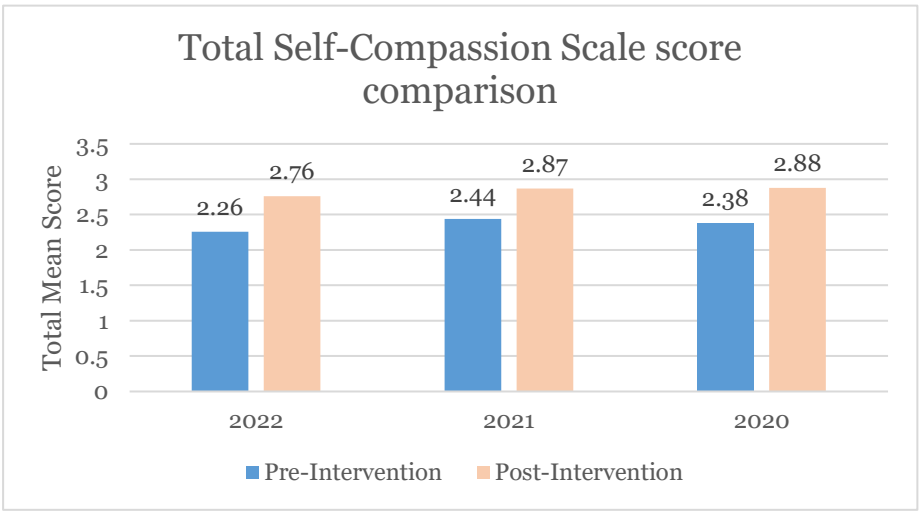
Graph: Total Work and Social Adjustment Scale (WSAS) scores in 2020, 2021 & 2022: A pre and post-intervention comparison



The total WSAS scale score was used to assess functioning pre and post the ACT programme in comparison to previous year. Mean scores decreased significantly, t (76) = 3.40, p < .002, from pre-intervention (M= 21.82; SD = 8.01) to post-intervention (M= 18.83; SD =9.35), with a small effect size observed (Cohen's d = 0.13). This finding indicates that those who completed the ACT programme indicated significantly less functional impairment post-intervention. These findings are in line with the 2021 and 2020 outcomes reports that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment post-intervention.

Self-Compassion Scale

Graph: Total Self-Compassion Scale scores in 2020, 2021 & 2022: A pre and post-intervention comparison



Total SCS scores increased significantly, t (76) = -7.280, p < .001, from pre (M = 2.26, SD = 0.60) to post (M = 2.76, SD = 0.64) indicating higher overall levels of self-compassion post-intervention. A small effect size was observed (Cohen's d =0.41). Self-compassion is measured in six domains: self-kindness, self-judgement, humanity, isolation, mindfulness and identification or 'over-identification'.

4.5.5. 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 2022, 2021 and 2020. 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 psychoeducation and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based therapy through behaviour workshops. These workshops aid experiential goal work, fine tune therapeutic goals and identify possible obstacles 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 outpatient.

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 113 people who completed the programme in 2022, in which 54 (47%) were male and 61 (53%) were female. Programme attendees ranged in age from 18 to 72 year (*M* = 37.03; *SD* = 14.77). Pre and post data were collected after Level 1 and Level 2 of the anxiety programme. 113 service users availed of Level 1 and 19 attended Level 2 of the anxiety programme.

Data regarding diagnosis were returned by 116 individuals. OCD accounted for the largest subgroup (46.6%), followed by social phobia/ anxiety (18.1%), GAD (15.5%), agoraphobia (with/without panic) (11.2%), panic disorder (6%) and specific phobia (2.6%). The table below shows the percentage of people with each diagnosis over the past three years.

	2020		**2021**		**2022**	
	N	**%**	**N**	**%**	**N**	**%**
OCD	57	47.1	61	46.2	54	46.6
GAD	30	24.8	33	25.0	18	15.5
Social	11	9.1	19	14.4	21	18.1
Panic Disorder	9	7.4	5	3.8	7	6.0
Agoraphobia	6	5.0	9	6.8	13	11.2
Health Anxiety	7	5.8	2	1.5	0	0
Specific Phobia	1	0.8	3	2.3	3	2.6

4.6.2. Anxiety Disorders 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 zero – 'would not avoid', to eight – 'always avoid'. Four scores can be obtained from the Fear Questionnaire: main phobia level of avoidance, total phobia score, global phobia rating and associated anxiety and depression. For the purposes of this analysis the total phobia score was used. This measure has been found to be psychometrically sound with good discriminant validity and internal consistencies from .71 to .83 (Oei, Moylan, & Evans, 1991).

- **Yale Brown Obsessive Compulsive Scale**

Yale Brown Obsessive Compulsive Scale (Y-BOCS: Goodman et al, 1989) is widely considered the best available measure for assessing the severity of OCD and to measure the response to treatment. Taylor (1995, p. 289) states that: "When breadth of measurement, reliability, validity, and sensitivity to treatment effects are considered together, the YBOCS appears to be the best available measure for treatment outcome research." It was designed specifically to measure the severity of OCD regardless of the type of obsessions and compulsions. The Y-BOCS enables the clinician to rate the severity of the obsessions and compulsions separately eg. (five items assess obsessions and five items assess compulsions) which enables the clinician to discern between the severity of obsessions and compulsions as well as have a global score of severity and response by adding the two separate scores.

Obsessions and compulsions are each assessed on a five-point Likert scale ranging from zero – '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 zero – '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; Connor 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.

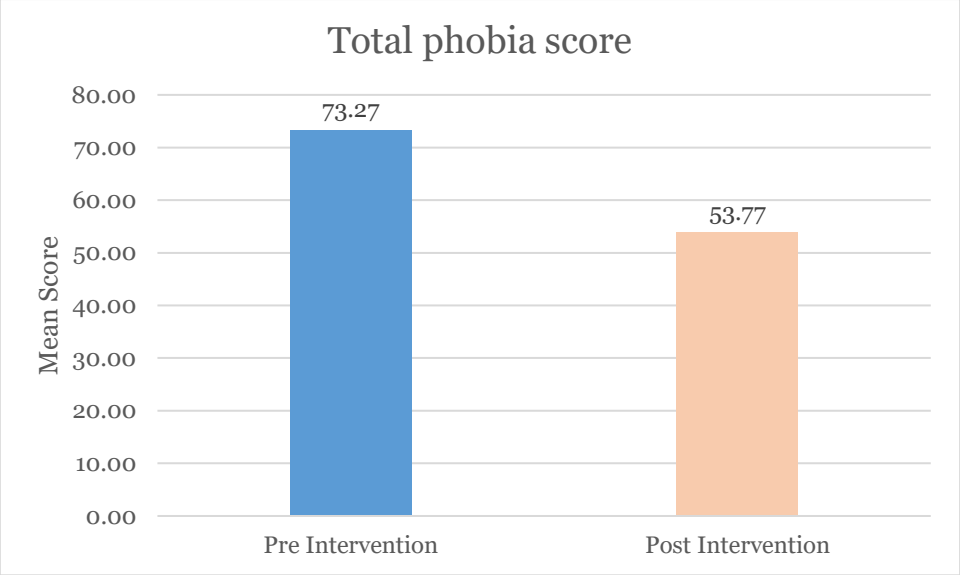
- **The Work and Social Adjustment Scale (WSAS)**

  The Work and Social Adjustment Scale (WSAS) is a simple five-item service user self[1]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 zero – 'not at all', to eight – 'very severely'. Total scores for the measure can range from zero 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 suggests 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.

Level 1 results

The Fear Questionnaire

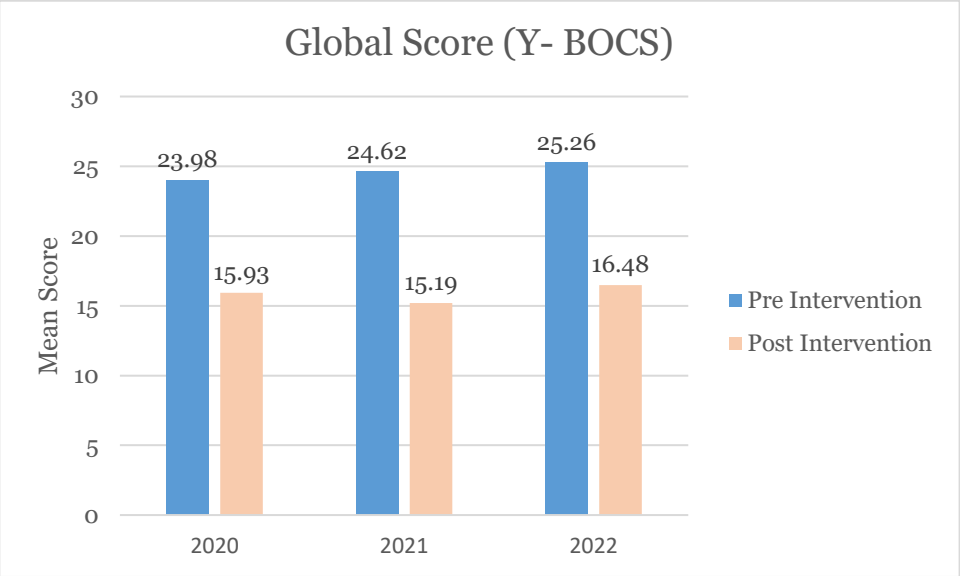
Graph: Fear Questionnaire mean Total Phobia scores pre and post intervention for 2022



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 (123) = 15.07, p < .001. The mean Total Phobia score decreased from 73.27 (*SD* = 125.35) to 53.77 (*SD* = 25.56), representing a medium effect size (Cohen's d= .67).

The Yale Brown Obsessive Compulsive Scale

Graph: Yale Brown Obsessive Compulsive Scale mean total scores pre and post intervention for 2020, 2021 and 2022.

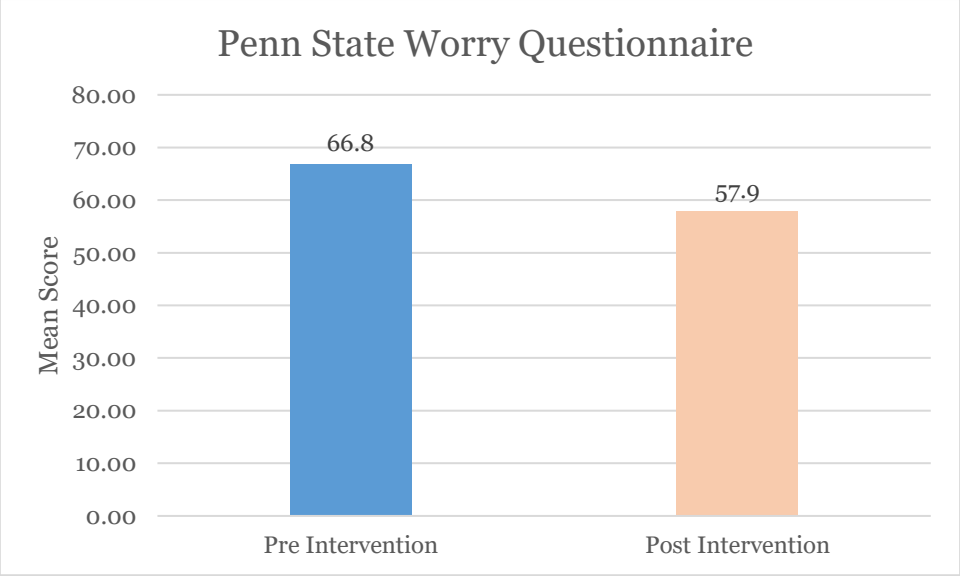


OCD symptomatology as measured by the Y-BOCS reduced from pre intervention to post-intervention. Analysis using a t-test indicated that scores on this measure

dropped significantly, t (53) = 12.84, p <.001, with the total mean score changing from 25.26 (SD = 4.09) to 16.48 (SD = 5.87). This indicates an overall significant reduction in the severity of OCD symptoms post intervention with a large effect size (Cohen's d = 0.76).

Penn State Worry Questionnaire (PSWQ)

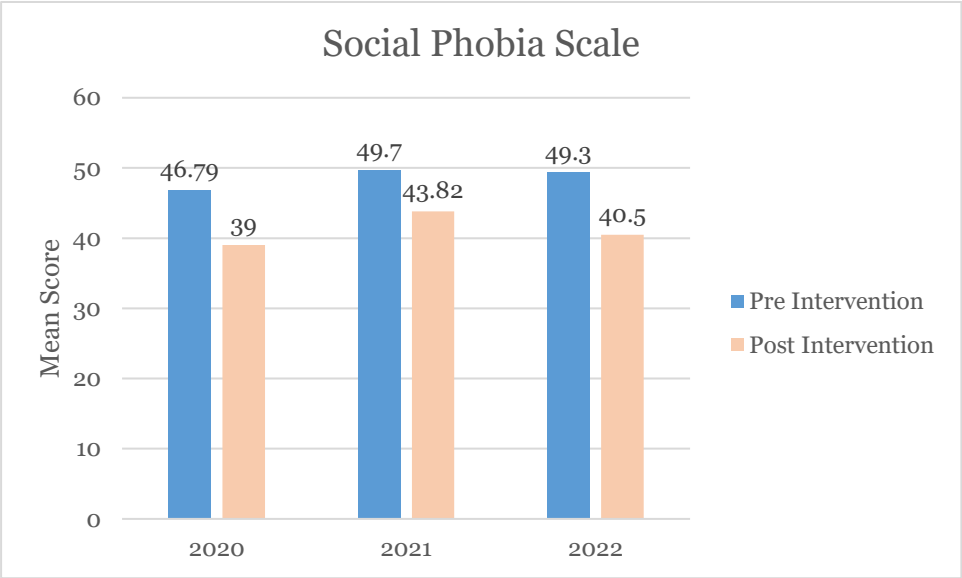
Graph: Penn State Worry Questionnaire mean scores pre and post-intervention for 2022.



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 (19) = 5.78, p < .001, between pre-intervention (M= 66.80, SD = 8.08) and post-intervention (M= 57.90, SD = 11.93). This change reflected a medium effect size (Cohen's d= 0.64).

Social Phobia Inventory (SPIN)

Graph: Social Phobia Inventory mean scores pre and post intervention in 2020, 2021 and 2022



Analysis of the SPIN using a paired sample t-test indicated a statistically significant reduction in service users scores, t (19) = 6.37, p < .001, from pre-intervention (M= 49.30, SD = 12.04) to post-intervention (M= 40.50, SD = 11.57). This reflected a medium effect size (Cohen's d= 0.68).

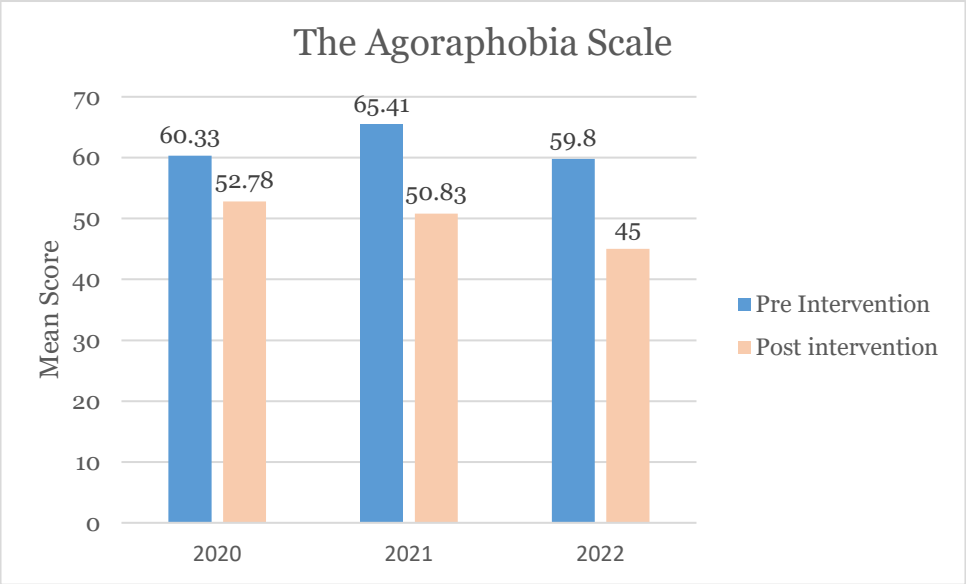
The Social Work and Leisure Questionnaire

Graph: Social Work and Leisure Questionnaire Group mean score pre and post-intervention for 2020, 2021 and 2022

Analysis of the SWLQ using a t-test indicated that there was a statistically significant reduction in mean scores observed, t (112) = 11.92, p < .001, from pre-intervention (M = 27.03, SD = 8.71) to post-intervention (M = 19.29, SD = 9.58) at Level 1. This result reflected a medium effect size (Cohen's d = 0.56).

The Agoraphobia Scale

Graph: The Agoraphobia Scale mean scores pre and post-intervention for 2020, 2021 and 2022

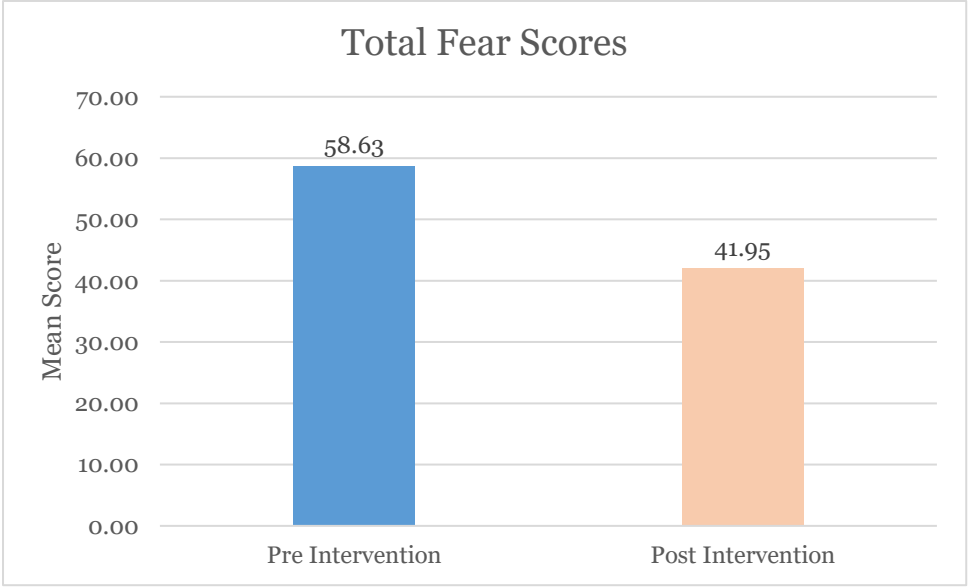


Scores on the Agoraphobia Scale reduced from pre-intervention (*M*= 59.80, *SD* = 20.77) to post-intervention (*M*= 45.00, *SD* = 18.24). Analysis of the Agoraphobia Scale using a paired samples t-test indicated that this result did represent a statistically significant reduction in mean total scores, *t* (19) = 5.13, p < .002. A medium effect size was observed (Cohen's *d*= 0.58).

Level 2 results

The Fear Questionnaire

Graph: The Fear Questionnaire, Mean Symptom pre and post-intervention

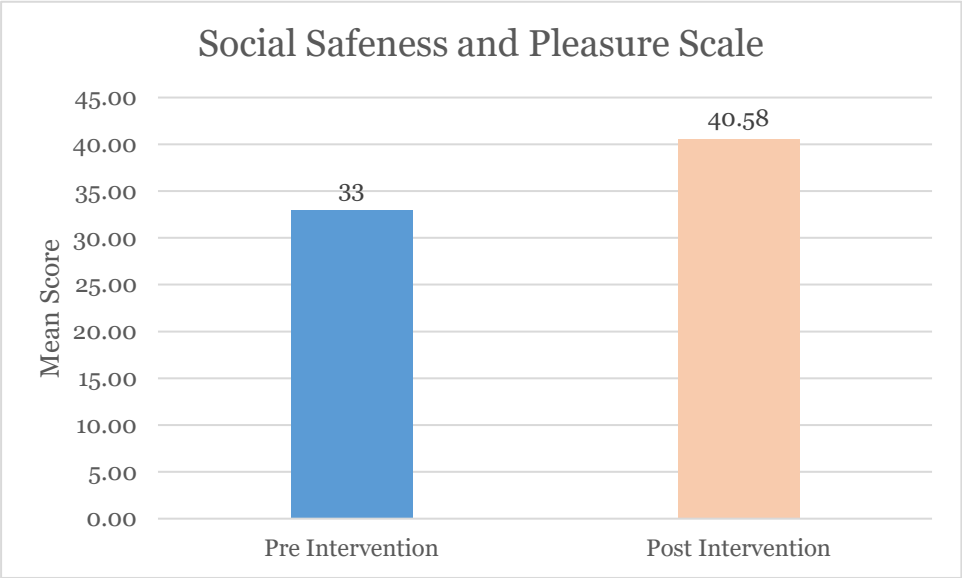


Total symptom scores on the Fear Questionnaire reduced from 58.63 (SD = 29.08) to 41.95 (SD = 28.27). A paired samples t-test indicated that this reduction was statistically significant, t (18) = 6.07, p <.001 with a medium effect size (Cohen's d = 0.67).

The Social Safeness and Pleasure Scale

Service users scores on the Social Safeness and Pleasure Scale showed a change from a mean of 33.00 (*SD*= 9.88) pre-intervention to 40.58 (*SD*= 8.60) post-intervention. A pairwise t-test was used to analyse the sample. This increase was statistically significant t (18) = -4.69, p < .001, with a small effect size (Cohen's d =0.49).

Graph: The Social Safeness and Pleasure Scale mean scores pre and post-intervention



4.6.3. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2022 suggested significant reductions in anxiety and depression symptoms, OCD symptoms and reductions in pathological worrying and social anxiety; in line with previous years.

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the Anxiety Disorders Programme in 2022 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. Bipolar Recovery Programme

The Bipolar Recovery Programme uses models and principles from Cognitive Behaviour Therapy (CBT), Compassion-Focused Therapy (CFT) and Mindfulness Based Stress Reduction (MBSR). It is run by a team of mental healthcare professionals with a wide range of experience and expertise, including cognitive behavioural therapists and specialist mental health nurses. Support from a multidisciplinary team (MDT), including a consultant psychiatrist, occupational therapist, pharmacist, and social worker, is also included.

There are four elements to the Bipolar Recovery Programme.

Bipolar Programme Workshop

The Bipolar Programme Workshop takes place while the service user is an inpatient in SPMHS or receiving care through our Homecare service. This single-session workshop is a chance for the service user to develop an initial understanding of bipolar disorder, the signs and symptoms, the phases of recovery, the triggers, and the treatment options available.

Bipolar Recovery Programme

The Bipolar Recovery Programme is a group programme available to service users who attend as day service user, one day per week for 10 weeks. It involves psychoeducation, which is a process of providing people with information and education about their mental health difficulties. The programme content includes psychoeducation on recognizing changes in mood, sleep hygiene, and awareness of triggers and early warning signs. The programme also provides peer support and guidance through the group experience, which has been found to be very beneficial in the recovery process.

Bipolar Aftercare Programme

The Bipolar Aftercare Programme is a group available one half day per month, to people who have completed the Bipolar Recovery Programme. It gives the service user the chance to continue developing skills around managing their bipolar disorder. This group focuses on developing self-compassion and mindfulness and provides ongoing supports for service users throughout their recovery.

Bipolar Seminar Series

The Bipolar Seminar Series is a series of talks, which take place one half day per month. The talks cover topics relevant to people living with bipolar disorder. Its goal is to help service users to manage symptoms of bipolar disorder and their mood. The kinds of topic covered relate to maintaining recovery, managing relapse, and other areas that may be beneficial to people with mood disturbance.

4.7.1. Descriptors

Paired data were available for 13 service users who completed the programme in 2022: 9 females (69.2%) and 4 males (30.8%). The age profile of participants ranged from 27 to 78 years, with the average age being 51.23 years.

4.7.2. Bipolar Recovery Programme outcome measures

- **The Work and Social Adjustment Scale (WSAS)**

The Work and Social Adjustment Scale (WSAS) (Mundt, J.C. Marks, I.M., et al. (2002). The work and social adjustment scale: A simple measure of impairment in functioning. British Journal of Psychiatry, 180: 461-464) is a brief global measure of functional impairment that is widely used in adult health. The WSAS is a simple, reliable, and valid measure of impaired functioning. It is a sensitive and useful outcome measure offering the potential for readily interpretable comparisons across studies and disorders. Its psychometric properties have been well established across different psychopathologies and unexplained medical symptoms. Its internal consistency, convergent/divergent validity and test–retest reliability are excellent Cronbach's alpha measure of internal scale consistency ranged from 0.70 to 0.94. Test-retest correlation was 0.73. Interactive voice response administrations of the WSAS gave correlations of 0.81 and 0.86 with clinician interviews. As are the correlations

between the self-report and expert clinicians' versions of the scale. As an outcome measure, it is highly sensitive to treatment change in a wide range of conditions such as obsessive–compulsive disorder (OCD), bipolar disorder, phobic disorders, anxiety and depression, chronic fatigue syndrome, and personality disorder. The maximum score of the W&SA is 40. Scores below 10 appear to be associated with subclinical populations. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. A WSAS score above 20 appears to suggest moderately severe or worse psychopathology.

- **The Goldberg Mania Scale**

The Goldberg Mania Scale is a self-administered questionnaire designed to measure the severity of manic thinking and behavior. This tool was designed by Dr Ivan K Goldberg, MD and this tool *is not* designed to diagnose any psychiatric disorder. It is only intended to measure the severity of manic symptoms. The test is made up of eighteen questions. The higher the number, the more severe the mania. If you take the questionnaire again weekly or monthly, changes of five or more points between tests may be significant. This questionnaire is only valid if for people aged 18 or older and where symptoms have caused distress and/or interfered with functioning in one or more important areas of life such as home, work, school, or interpersonal relationships.

Screening test scoring ranges; 0-9, No mania likely; 10-17 possibly mildly manic, or hypomanic; 18-21, borderline mania; 22-35, mild-moderate mania; 36-53, moderate-severe mania; 54 and up, severely manic.

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

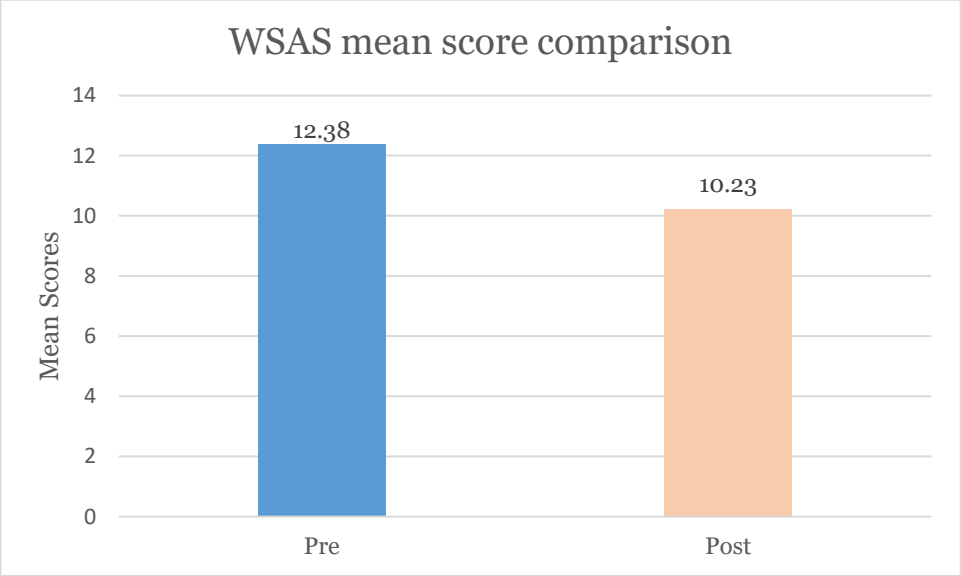
The Quick Inventory of Depression Symptomatology (Rush et al, 2003) is a 16-item measure used to assess the severity of depression symptoms. The items cover the nine diagnostic domains of depression as identified in the DSMS-IV: sad mood, concentration, self-criticism, suicidal ideation, interest, energy/fatigue, sleep disturbance and decrease or increase in appetite. It utilises a four-point rating scale, with a score of zero = 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).

4.7.3. Results

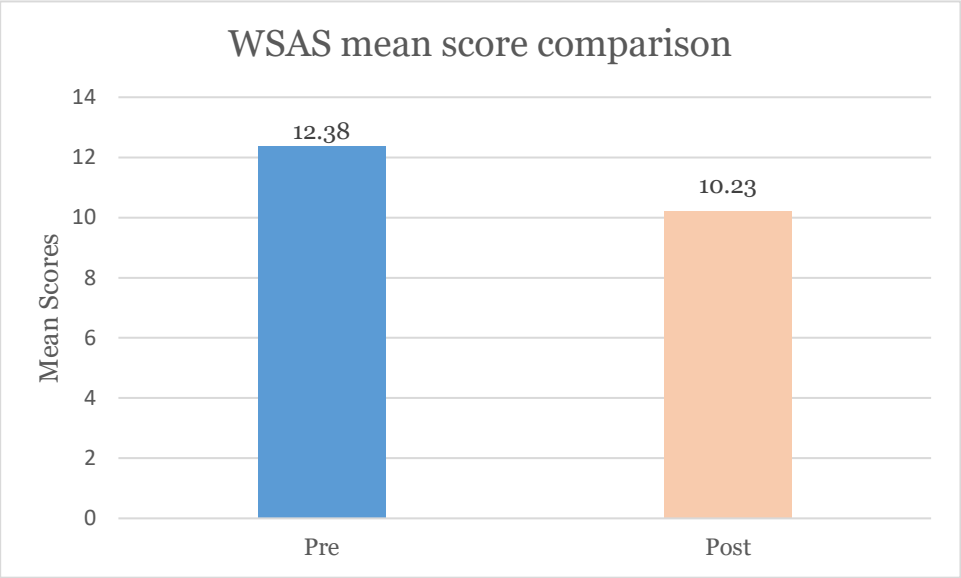
The Work and Social Adjustment Scale (WSAS)

Comparison of service user scores on the WSAS indicated a reduction of impairment functioning scores from pre-intervention (M = 14.23, SD = 6.07) to post-intervention (M = 10.15, SD = 4.74). This reduction in mean scores is statistically significant. A paired samples t-test revealed t (12)= 4.09 p < .002, with a medium effect size (Cohen's d = 0.58) (see graph below). This finding indicates that those who completed the programme in 2022 significantly improved their functioning post-intervention.



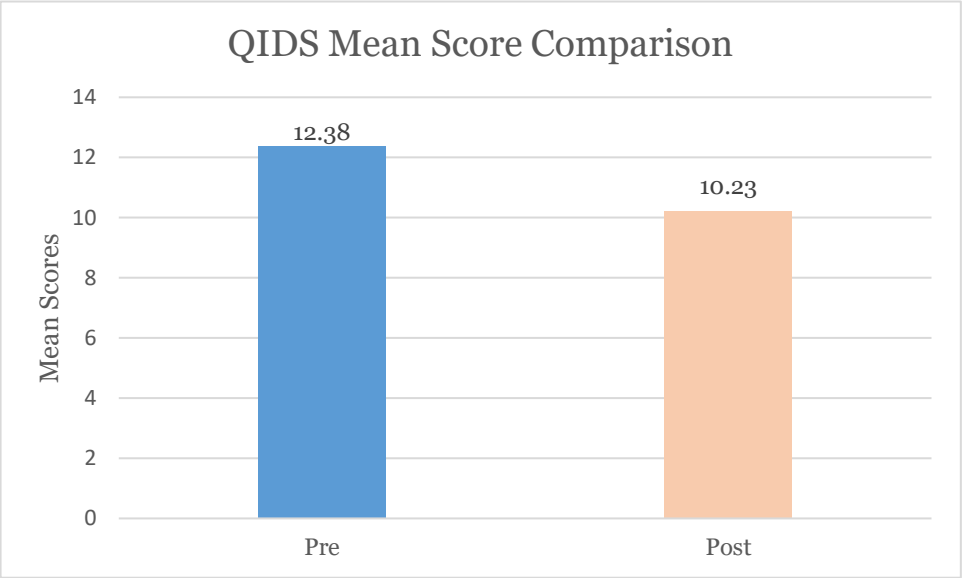
The Goldberg Mania Scale

Comparison of service user scores on the Goldberg Mania Scale indicated a reduction of mania severity scores from pre-intervention (M = 12.38, SD = 10.50) to post-intervention (M = 10.23, SD = 6.58). This reduction in mean scores is not statistically significant. A paired samples t test revealed t (12)= .637 p = .536 (see graph below).



Quick Inventory of Depression Symptomatology (QIDS)

Comparison of service user scores on the QIDS indicated a reduction of depression severity scores from pre-intervention (*M* = 10.92, *SD* = 5.68) to post-intervention (*M* = 8.92, *SD* = 5.66). This reduction in mean scores is not statistically significant. A paired samples t-test revealed *t* (12)= .871 *p* = .401 (see graph below).



4.7.4. Summary

This is the first year the bipolar programme has been included in the SPMHS Outcomes Report. The aim of the programme is to improve overall functioning and reduce the severity of bipolar symptoms such as mania and depression. In 2022, of

those who completed the programme, 13 people completed outcome measures. Three measures were used to assess the efficacy of the programme; the WSAS, which examines functioning impairment; the Goldberg Mania Scale which examines mania symptoms and the QIDS which assesses depression symptoms. The findings indicate that those who completed the programme in 2022 yielded overall reductions in their functioning impairment as well as symptoms of depression and mania. It should be noted that statistical differences were detected among the functioning measure only. However, due to the small sample size, statistical differences should be interpreted with caution. Overall, these results provide evidence to suggest that people who complete the programme experience a reduction in negative symptoms associated with bipolar disorders.

4.8. 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, mindfulness, and compassion-focused practices. CFT recognises the importance of being able to engage with our 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 service users 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 findings were associated with improvements in self-criticism and fears of self-compassion

(Cuppage, Baird, Gibson, Booth & Hevey, 2017). A further research study carried out at SPMHS investigated subjective bodily changes associated with attending a transdiagnostic CFT group (Mernagh, Baird & Guerin, 2020). Results suggest that service users who attended the 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 (CFT) group commenced in SPMHS in 2014 and is facilitated by the psychology department. In 2022, the CFT programme implemented a new structure including a Level 1 Introduction to CFT Psychoeducation Group, followed by a Level 2 Therapy Group. The shorter nature of the CFT psychoeducation group allowed for this intervention to be offered to a larger number of service users. This new structure also enabled clinicians to conduct a more accurate assessment of service users needs', in terms of whether they would benefit from a longer-term group based psychological intervention following completion of the psychoeducation group.

CFT Psychoeducation Group

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 the CFT therapy group. Group members have the opportunity to experience how working with others in a CFT group feels, and whether this is the right intervention and approach for them.

4.8.1. Descriptors for CFT Psychoeducation Group

73 individuals completed the CFT psychoeducational programme in SMPHS in 2022. Data was available for 38 participants representing a 52% return rate. 78.9% (n = 30) were female and 21.1% (n =8) were male. The mean age was 44.2 years (SD = 12.34) with a range of 22 to 71 years.

4.8.2. 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 established 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 encompass 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 zero – 'not at all like me', to four – 'extremely like me'. Cronbach alphas were .86 for inadequate self, .86 for hated self and .83 for reassured.

- **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, ie. 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 zero – 'not at all like me', to four – 'extremely like me'. Cronbach alphas were .87 for the self-correcting scale and .04 for the self-persecuting scale.

- **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 contain seven items, divided into sub-scales with similar content. Each item comprises a statement and four short response options to reflect severity. They are scored from zero – '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 non-clinical populations and clinical populations are essentially differences of degree. Cronbach alphas were .66 for the Anxiety Scale, .91 for the Depression Scale and .82 for the Stress Scale.

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

The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to self, compassion to others and compassion experienced from others (Gilbert et al, 2017). Each scale consists of 13 items which generate an engagement (ie. motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgmental) and an action sub-scale (ie. directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10-point Likert scale; one – 'never', to 10 – 'always'. High scores indicate high compassion. Cronbach alphas were .61 for compassion to self, .67 for compassion to others and .63 for compassion to others.

4.8.3. Results for CFT Psychoeducation Group

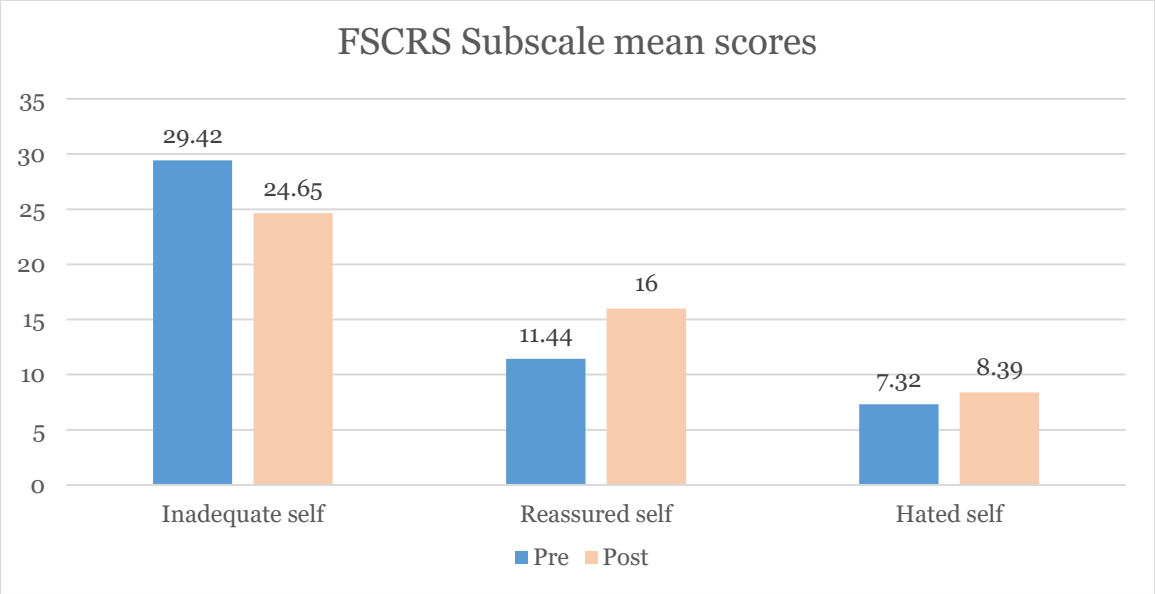
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Mean scores on the FSCRS 'inadequate self' subscale decreased significantly from pre-intervention (M = 29.42, SD = 6.84) to post-intervention (M = 24.65, SD = 9.61), $t(30) = 4.2$, $p < .000$.

Mean scores on the FSCRS 'hated self' subscale increased slightly from pre-intervention (M = 7.32, SD = 4.63) to post-intervention (M = 8.39, SD = 5.11), however this increase was not statistically significant, $z = -.9$, $p > .05$.

Mean scores on the FSCRS 'reassured self' subscale increased significantly from pre-intervention (M = 11.44, SD = 5.11) to post-intervention (M = 16, SD = 6.8), $t(26) = -4.69$, $p < .000$.

Graph: FSCRS Subscale scores

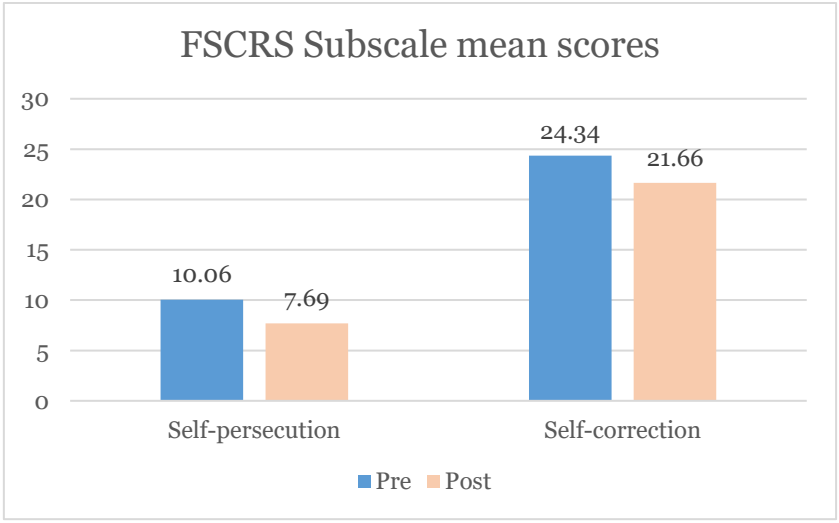


The Functions of Self-Criticising/Attacking Scale (FSCS)

Mean scores on the FSCS 'self-persecution' subscale decreased from pre-intervention (M = 10.06, SD = 7.59) to post-intervention (M = 7.69, SD = 5.58). However, this difference was not statistically significant, $z = -.96$, $p > .05$.

Mean scores on the FSCS 'self-correction' subscale decreased from pre-intervention (M = 24.34, SD = 11.58) to post-intervention (M = 21.66, SD = 10.58). However, this decrease was not statistically significant, $t(31) = 1.71$, $p > .05$.

Graph: FSCS mean scores



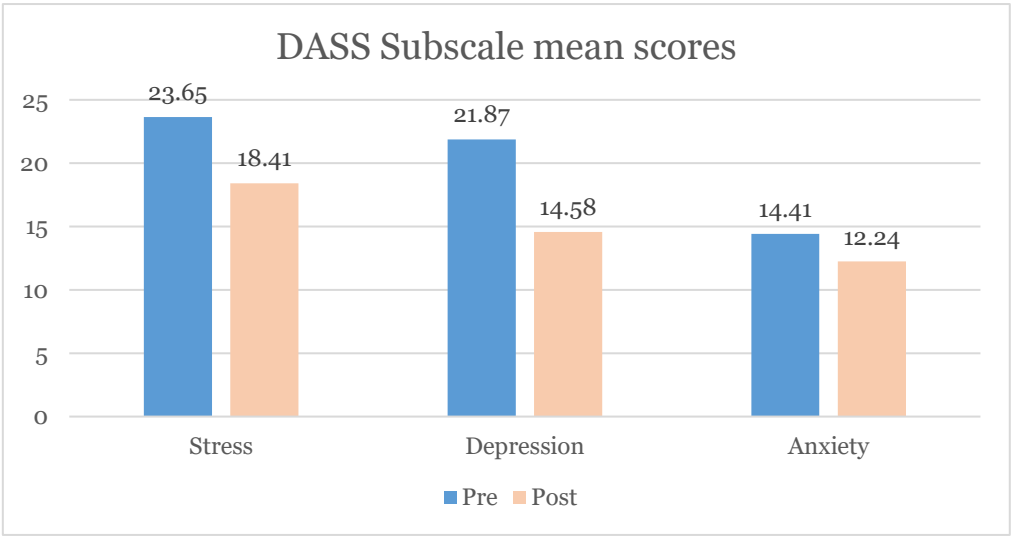
Depression Anxiety and Stress Scale (DASS)

Mean scores on the DASS depression subscale decreased significantly from pre-intervention (M = 21.87, SD = 11.85) to post-intervention (M = 14.58, SD = 11.98), $t(30) = 3.72$, $p < .05$.

Mean scores on the DASS stress subscale decreased significantly from pre-intervention (M = 23.65, SD = 8.3) to post-intervention (M = 18.41, SD = 8.95), $t(33) = 3.49$, $p < .05$.

Mean scores on the DASS anxiety subscale decreased from pre-intervention (M = 14.41, SD = 7.8) to post-intervention (M = 12.24, SD = 8.94). However, this decrease was not statistically significant, $t(33) = 1.7$, $p > .05$.

Graph: Depression, Anxiety and Stress Scores



Compassionate Engagement and Action Scale (CEAS)

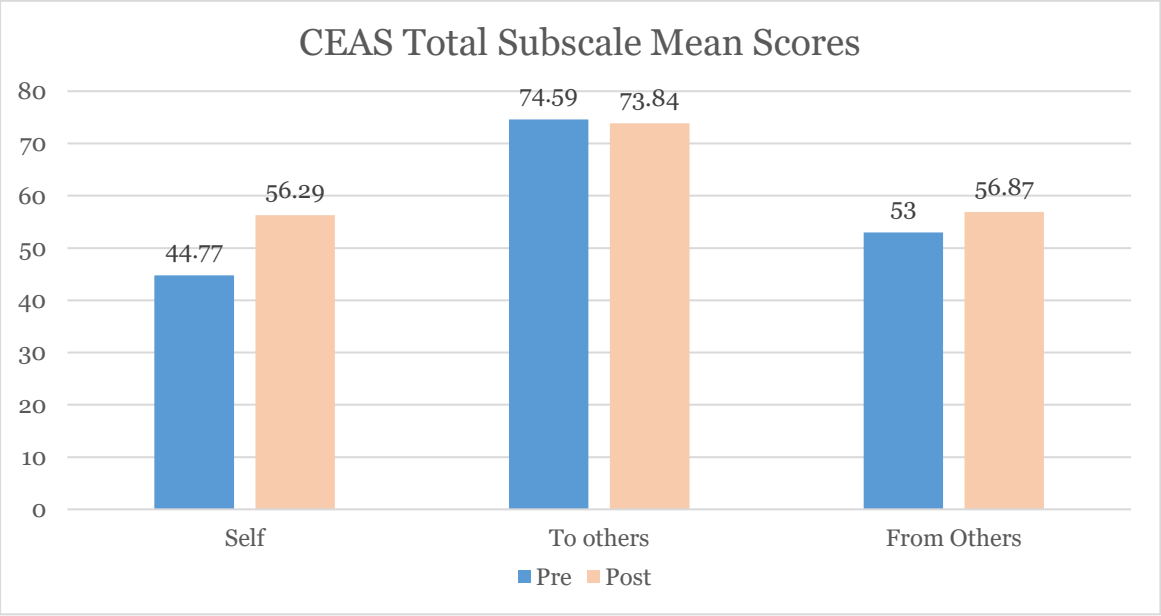
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores and scores on the engagement and action subscales are reported below.

Significant increases were reported on the overall Compassion to Self Scale from pre-intervention *(M* = 44.77, *SD* = 11.14) to post-intervention (*M* = 56.29, *SD* = 12.24), *t*(30) = -5.96, *p* < 0001, with a medium effect size (Cohen's *d* = 0.5). These findings illustrate that participants' self-directed compassion increased from pre to post-intervention.

Scores on the Compassion to Others Scale did not demonstrate a meaningful difference from pre-intervention (*M* = 74.59, *SD* = 13.21) to post-intervention (*M* = 73.84, *SD* = 10.82), *t*(31) = .415, *p* > .05. These findings illustrate that participants' compassion for others did not change from pre to post-intervention.

Mean scores on the Compassion from Others Scale did not yield a statistically significant difference from pre-intervention (*M* = 53, *SD* = 15.97) to post-intervention (*M* = 56.87, *SD* = 16.9), *t*(29) = -1.53, *p* > 0.05. These findings illustrate that participants' capacity to accept compassion from others did not change from pre to post-intervention.

Graph: Total Compassionate Subscale Scores

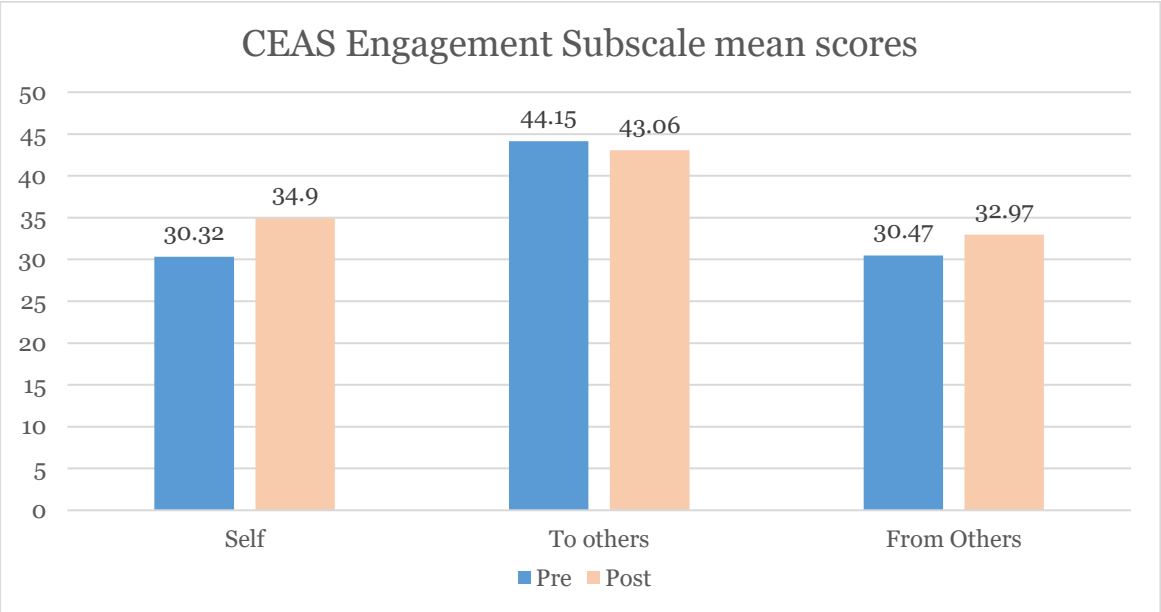


Within the Compassionate Engagement sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 30.32, SD = 7.98) to post-intervention (M = 34.9, SD = 7.16), $t(30) = -3.59$, $p < 005$, with a medium effect size (d = 0.3).

There was no significant difference observed on the Compassion to Others subscale within the Compassionate engagement scales, with participant mean scores of (M = 44.15, SD = 8.52) at pre-intervention and (M = 43.06, SD = 7) at post-intervention, $p > .05$.

Similarly, there was no significant difference observed on the Compassion from Others subscale within the Compassionate engagement scales, with participant mean scores of (M = 30.47, SD = 10.23) at pre-intervention and (M = 32.97, SD = 10.91) at post-intervention, $p > .05$.

Graph: Compassionate Engagement Subscale Scores



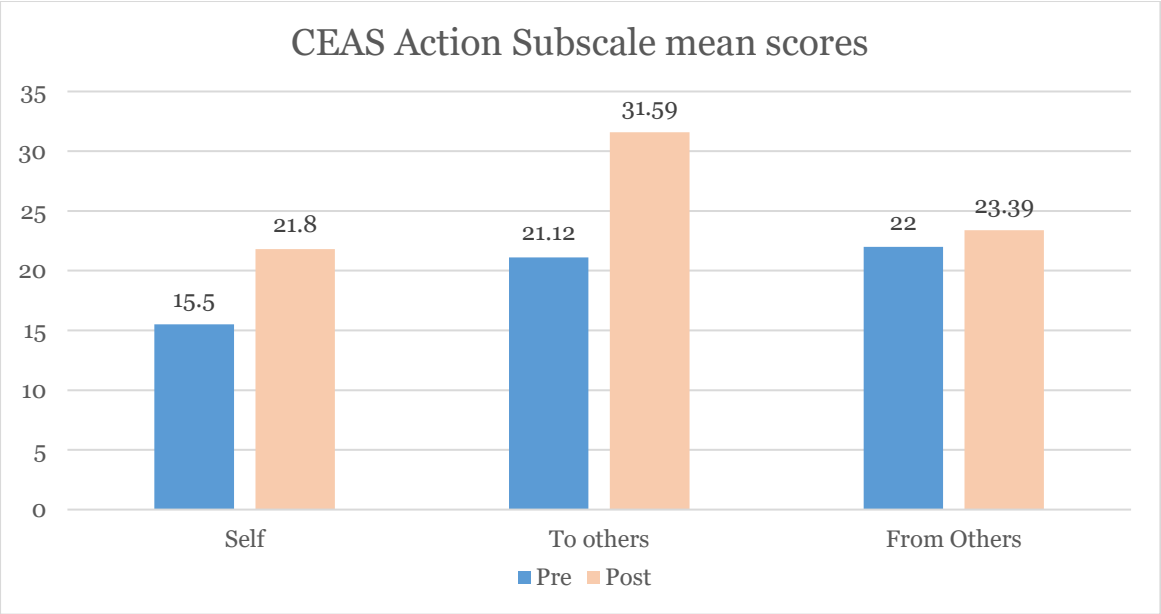
Within the Compassionate Action sub-scales, a statistically significant increase in mean scores was found on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 15.5, SD = 7) to post-intervention (M = 21.8, SD = 7.29), $t(35) = -6.04$, $p < .000$, with a medium effect size (d = 0.51).

There was no significant difference observed on the Compassion to Others subscale within the Compassionate engagement scales, with participant mean scores of (M =

21.12, *SD* = 6.46) at pre-intervention and (*M* = 31.59, *SD* = 4.17) at post-intervention, $p > .05$.

Similarly, there was no significant difference observed on the Compassion from Others subscale within the Compassionate Engagement scales, with participant mean scores of (*M* = 22, *SD* = 6.3) at pre-intervention and (*M* = 23.39, *SD* = 6.96) at post-intervention, $p > .05$.

Graph: Compassionate Action Subscale Scores



4.8.4. CFT Therapy Group

CFT is an effective intervention for many mental health difficulties and the group format offers a secure base with the potential to have corrective experiences with multiple others (Craig et al, 2020; Greiner et al, 2022). The focus of the longer Level 2 Therapy Group is to move towards a more experiential therapeutic experience, where service users are given opportunities to further explore their emotional learning, as well as how their fears, blocks and resistances to compassion have developed in the context of their life experiences. The group provides a safe space for service users to engage in chair work which highlights how the human 'multi-mind' is formed of various motivations, emotions, and cognitive competencies (Gilbert, 2010). CFT chair work also specifically utilizes the compassionate self and the compassionate mind as a

framework to consolidate, embody and enact the skills, attributes, and motivations of compassion (Gilbert, 2010).

Descriptors for CFT Therapy Group

48 individuals completed the CFT therapy programme in SPMHS in 2022. Pre and post data was available for 32 individuals, representing 67% return rate of both pre and post measures. 64.6% of these were female (N = 21) and 34.4% were male (N = 11). Programme attendees ranged in age from 23 to 64 years with a mean age of 40.66 years.

CFT Therapy Group outcome measures

All service users attending the CFT Therapy Group 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).

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

The Depression Anxiety and Stress Scales (DASS-21) is a 21-item questionnaire that measures the three related states of depression, anxiety and stress (Lovibond & Lovibond, 1995). Each item is rated on a four-point Likert scale from zero – '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. Cronbach alphas were .84 for the Anxiety subscale, .95 for the Depression subscale, and .83 for Stress subscale.

- **Fears of Compassion (FCS)**

The Fears of Compassion Scale (FCS) consists of three subscales 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") (Gilbert, McEwan, Matos & Rivis, 2011). The scale consists of 38 items in total, each rated on a five-point Likert scale from zero – 'don't agree at all', to four – 'completely agree'.

Higher scores are indicative of greater fears of self-compassion. Cronbach alphas were .89 for the fear of compassion for others scale, .89 for the fear of compassion from others scale, and .86 for the fear of compassion to self scale.

- **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 ("I am easily disappointed with myself"); and hated self ("I have become so angry with myself that I want to hurt or injury myself"), and one form to self-reassure ("I am able to remind myself of positive things about myself"). The responses are given on a five-point Likert scale ranging from zero – 'not at all like me, to four – 'extremely like me'. Cronbach alphas were .89 for the inadequate self scale, .89 for the hated self scale, and .85 for the reassured self scale.

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

The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to self, compassion to others and compassion experienced from others (Gilbert et al., 2017). Each scale consists of 13 items which generate an engagement and an action sub-scale. Responses are given on a 10-point Likert scale from one – never, to 10 – always. High scores indicate greater compassion. Cronbach alphas were .67 for the compassion to self scale, .71 for the compassion to others scale, and .72 for the compassion from others scale.

4.8.5. Results for CFT Therapy Group

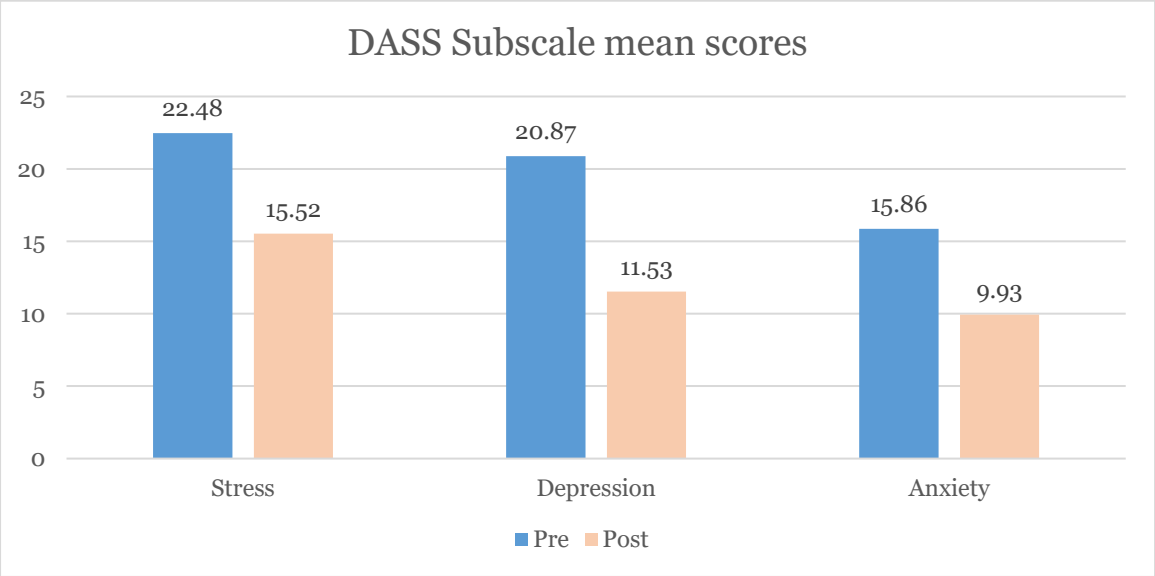
Depression Anxiety and Stress Scales (DASS)

Analysis of the DASS Stress scores from the CFT therapy programme indicated that there was a significant decrease in reported stress, $t(28) = 3.81$, $p < .05$. representing a medium effect size *(d = .73)*. Participants mean scores decreased from 22.48 (*SD* = 10) at pre-intervention to 15.52 (*SD* = 9.07) after completing the programme.

Analysis of the DASS Depression scores from the CFT therapy programme indicated that there was a significant decrease in reported depressive symptoms, $z = -4.24$, $p < 0.001$, representing a moderate effect size ($r = -0.56$). Participants mean scores decreased from 20.87 ($SD = 12.78$) at pre-intervention to 11.53 ($SD = 10.87$) after completing the programme.

Analysis of the DASS Anxiety subscale mean scores showed that levels of anxiety decreased significantly from 15.86 ($SD = 10.74$) at pre-intervention to 9.93 ($SD = 9.76$), following engagement in the therapy group, $t(28) = 4.19$, $p < .05$. This decrease demonstrated a medium effect size of $d = .58$.

Graph: Depression, Anxiety and Stress Scores



The Fears of Compassion Scale (FCS)

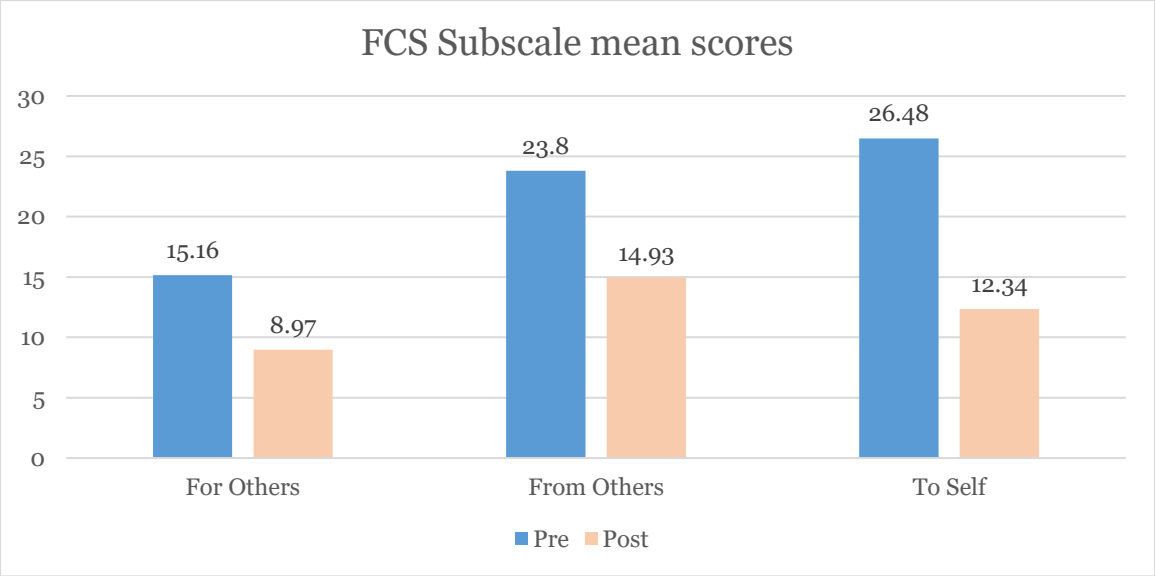
The FCS is divided into three scales; fear of expressing compassion for others, fear of responding to compassion from others, and fear of expressing kindness and compassion towards self. Mean scores on the subscales are presented below.

A paired samples t-test revealed a significant reduction in reported fear of expressing compassion for others, $t(30) = 5.05$, $p < 0.05$, representing a medium effect size (Cohen's $d = 0.74$). Mean scores fell from 15.16 ($SD = 8.94$) at pre-intervention to 8.97 ($SD = 7.65$) at post-intervention.

A Wilcoxon Signed Ranks Tests demonstrated a statistically significant reduction in reported fear of responding to compassion from others, z = -3.6, p < 0.001, representing a medium effect size (r = -.46). Mean scores fell from 23.8 (SD = 12.54) at pre-intervention to 14.93 (SD = 13.11) at post intervention.

A Wilcoxon Signed Ranks Tests demonstrated a statistically significant reduction in fears of expressing kindness and compassion towards self, z = -4.51, p < 0.001. At pre-intervention, participants mean scores were 26.48 (SD = 11.81), compared to 12.34 (SD = 10.56) at post-intervention, with a large effect size (r = -0.57).

Graph: Fears of Compassion Subscales



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

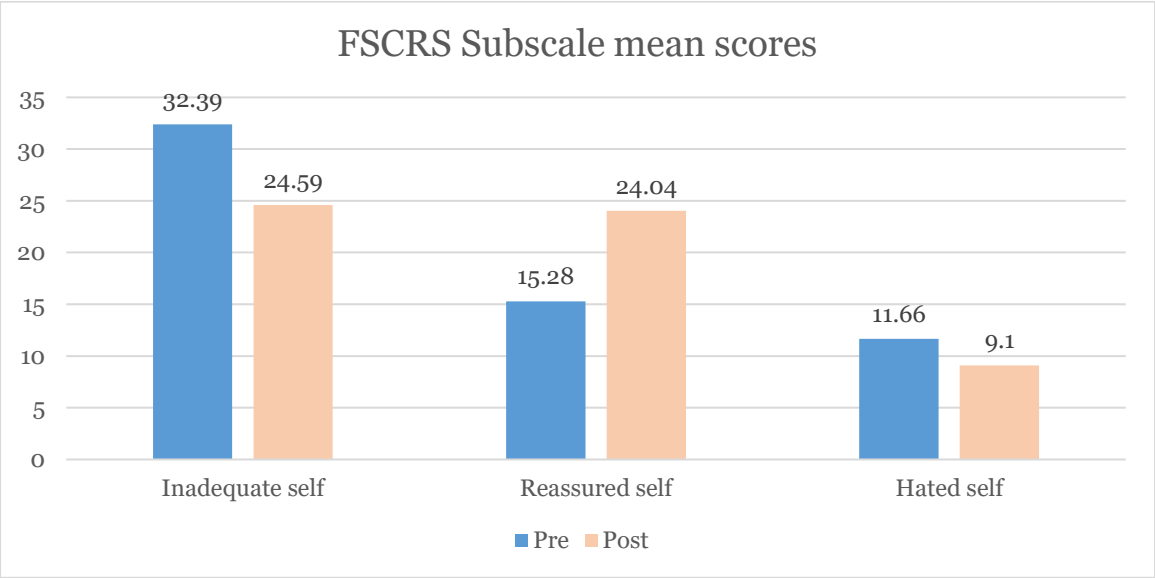
Mean scores on the FSCRS 'inadequate self' subscale showed a significant decrease following engagement with the therapy programme, $t(27)$ = 4.76, p < 0001. Mean scores fell from 32.39 (SD = 7.56) at pre-intervention to 24.59 (SD = 8.67) at post-intervention, demonstrating a large effect size, (d = 0.96). 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 = -3.84, p < 0001. Mean scores rose from 15.28 (SD = 7.17) at pre-intervention to 24.04 (SD = 8.02) at post-intervention,

demonstrating a robust effect size, (r = -0.57). 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, $t(28) = 2.45$, $p < 0.05$. Mean scores fell from 11.66 (SD = 5.75) at pre-intervention to 9.1 (SD = 4.05) at post-intervention, demonstrating a medium effect size, (d = .52). Decreases in scores indicate reduced feelings of self-hatred.

Graph: FSCRS Subscale Scores



Compassionate Engagement and Action Scale (CEAS)

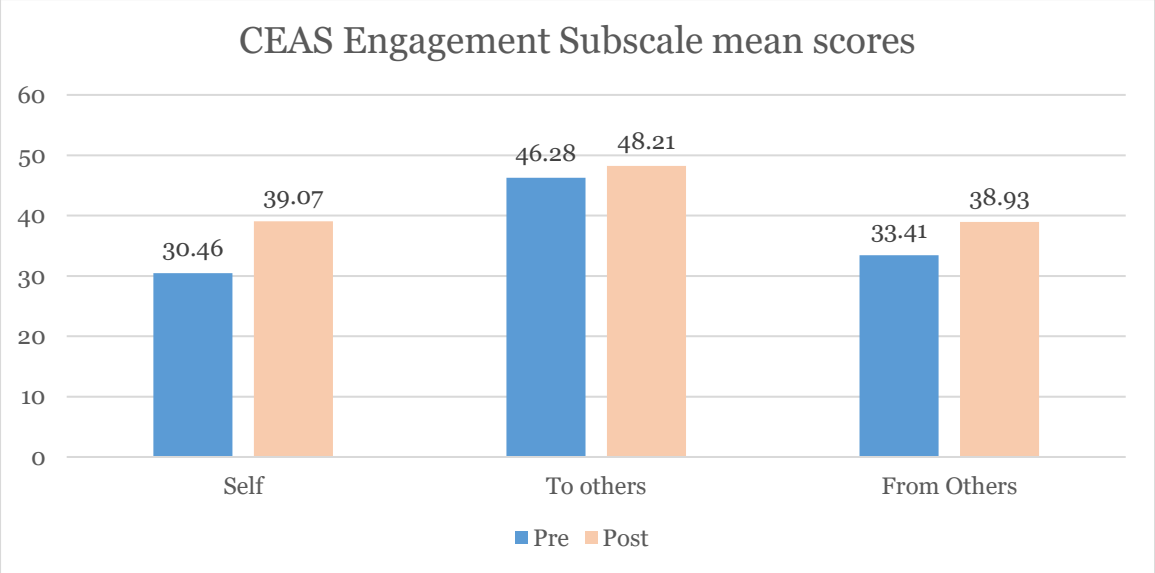
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores, and scores on the engagement and action subscales are reported below.

Significant increases were reported on the overall Compassion to Self-Scale from pre-intervention (M = 30.46, SD = 9.69) to post-intervention (M = 39.07, SD = 9.70), $t(27)$ = -4.07, p < 0001, with a strong effect size (Cohen's d = -0.88). These findings illustrate that participants' self-directed compassion increased from pre to post-intervention.

Mean scores on the Compassion to Others-Scale increased from pre-intervention (M = 46.28, SD = 9.2) to post-intervention (M = 48.21, SD = 6.76). However this increase was not statistically significant, p > .05.

Mean scores on the Compassion from Others Scale showed a statistically significant increase from pre-intervention (M = 33.41, SD = 9.13) to post-intervention (M = 38.93, SD = 8.97), $t(26)$ = -3.28, p < 0.05, demonstrating a medium effect size, d = -0.61. These findings illustrate that participants' capacity to receive compassion from others increased from pre to post-intervention.

Graph: Compassionate Engagement Subscale Scores



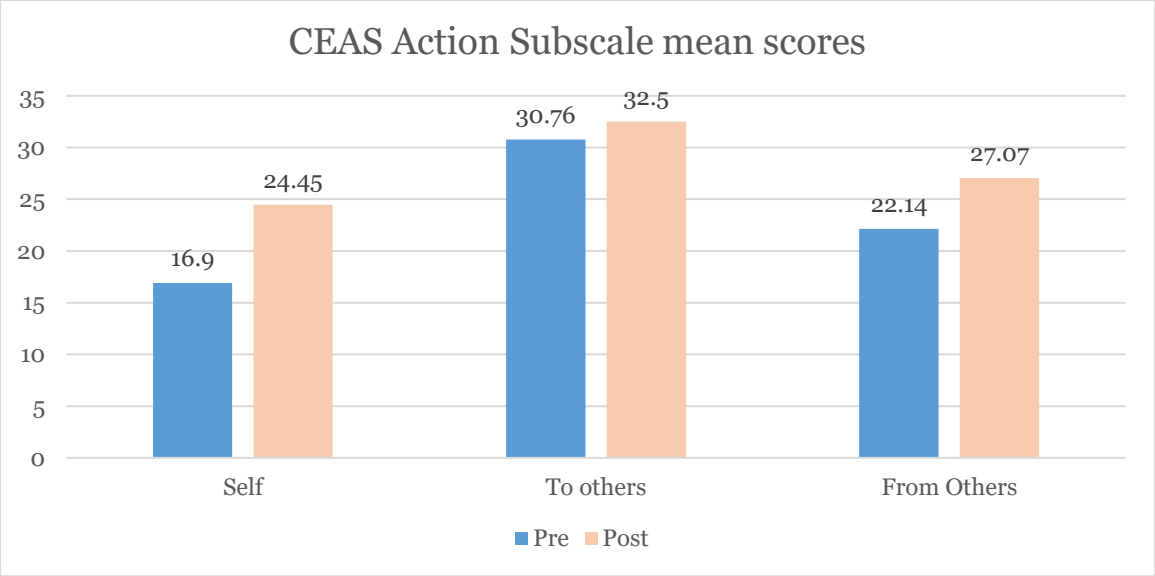
Within the Compassionate Action sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 16.9, SD = 7.14) to post-intervention (M = 24.45, SD = 8.76), $t(30)$ = -5.04, p < 0001, with a large effect size (d = -0.95).

A statistically significant increase in mean scores was observed on the Compassion to Others subscale within the Compassion Action subscales. Participant mean scores increased from pre-intervention (M = 30.76, SD = 6.88) to post-intervention (M = 32.5, SD = 4.61), z = -2.15, p < .05, with a small effect size (d = -0.29).

A statistically significant increase in mean scores was observed on the Compassion from Others subscale, z = -2.89, p < .05. Scores on this subscale increased from 22.14 (SD = 8.17) pre intervention to 27.07 (SD = 7.69) post-intervention, representing a medium effect size, r = -.39.

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

Graph: Compassion Action Subscales



4.8.6. Summary

The Compassion-Focused Therapy Programme started in SPMHS in 2014. Each year, the programme has evolved and continued to receive positive outcomes. The structure of the CFT programme changed in 2022. It now consists of a six-week Level 1 Introduction to CFT psychoeducation group followed by a 16-week Level 2 therapy group. This change in format has resulted in greater access for service users with reduced wait times.

Results from outcome measures and anecdotal feedback from service users who attended these groups are consistently positive, with service users reporting noticeable improvements in their lives. CFT continues to be an effective, well-received group-based psychological intervention to SPMHS service users.

4.9. 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 service users 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 service users 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. The programme is delivered by 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.

4.9.1. Descriptors

Nine participants began CFT-E cycle 10 and two participants dropped out post skills. Seven participants competed cycle 10. The skills part of the programme was online and then due to service user demand the therapy sessions were moved face to face with a hybrid option (where most group members were face to face and occasionally some group members attended online). All seven participants returned outcome measures post intervention. The programme welcomes participants with a range of eating disorder symptoms and diagnoses. Six of the seven participants were female, with one male participant in the programme. Participants ranged in age from 29 to 51 years with a mean age of 37.43. Pre and post-outcome data was available for all seven participants on all measures. 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 (Cheng & Evanston, 2013) the Expectation Maximisation method was applied before any total scores were computed or analyses carried out.

4.9.2. Compassion-Focused Therapy for Eating Disorders outcome measures

The following section presents a summary of the routine clinical outcome measures used by the CFT-E programme from in 2022. 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 service user 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 zero and four, with four 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) is a well-established self-report instrument that investigates eating disorder behaviours and attitudes. It is a 36-item self-report questionnaire that measures change in eating disorder symptoms over the course of treatment. It is considered the 'gold standard' measure of eating disorder psychopathology and is designed to assess past month cognitive sub-scales related to

eating disorders; restraint, eating concern, shape concern and weight concern, as well as behavioural symptoms related to these concerns (eg. frequency of binge-eating, vomiting, use of laxatives or diuretics and over-exercise).

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

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

The EDE-Q reports good internal consistency and 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.

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 zero – 'not at all like me', to four – 'extremely like me'.

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.

The Compassionate Engagement and Action Scales – (CEAS)

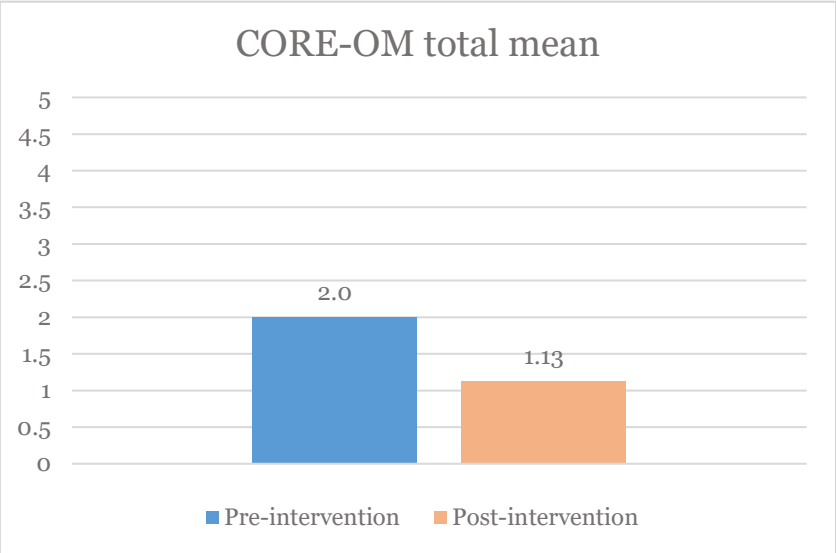
The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to the self, compassion to the other and compassion experienced from the other (Gilbert et al., 2017). Each scale consists of 13 items which generate an engagement (ie. motivation to care for wellbeing,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

4.9.3. Results

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

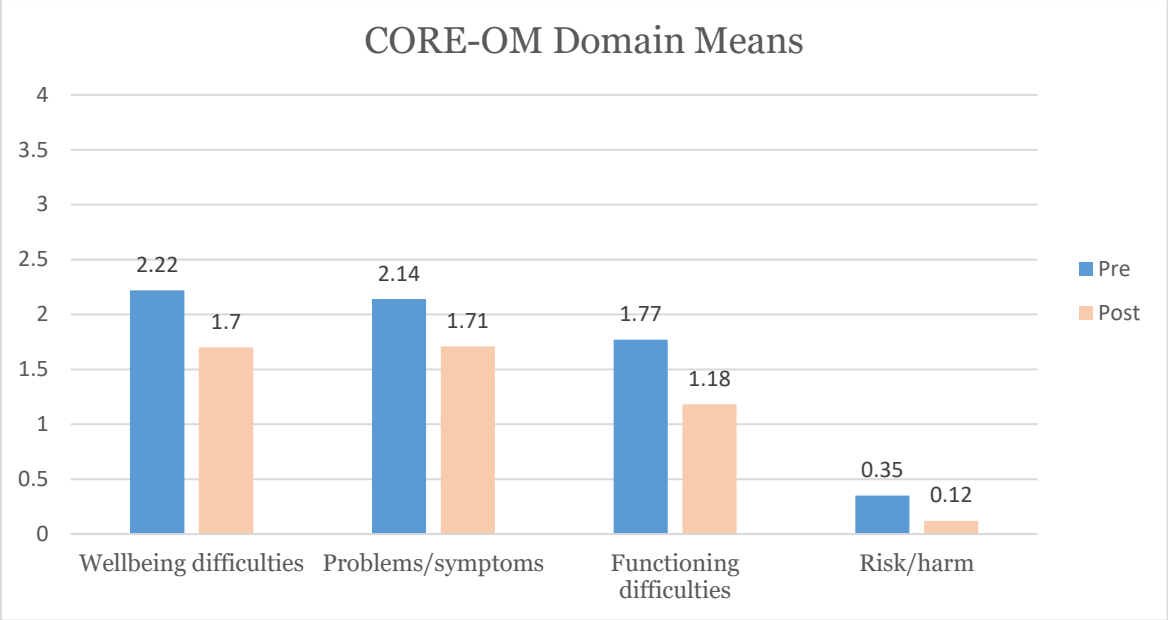
A Wilcoxon Signed Ranks Test revealed that participants experienced a decrease in psychological distress, moving from a mean total score of 2.00 (SD = 0.58) on the CORE-OM at pre-intervention to 1.13 (SD = 0.63) following completion of the programme, z = -2.2, $p < 0.05$, representing a large effect size (Cohen's d = 1.47).

Graph: CORE-OM total mean score



Analysis of the subscales indicates improvement in these domains, with statistically significant differences found across all subscales except for the risk/harm subscale which was already a low score so statistically significant change was not expected.

Mean scores on the subjective wellbeing subscale decreased from 2.82 (*SD* = .7) at pre-intervention to 1.57 (*SD* = 0.61) at post-intervention, $t(6) = 3.62$, $p < .05$. Mean scores on the problems/symptoms domain decreased from 2.4 (*SD* = 0.55) at pre-intervention to 1.46 (*SD* = 0.77) at post-intervention, $t(6) = 2.57$, $p < .05$. Mean scores on the functioning subscale decreased from 1.85 (*SD* = .54) at pre-intervention to 1.07 (*SD* = .66) at post-intervention, $z = -2.2$, $p < .05$. Mean scores on the risk/harm subscale decreased from 0.64 (*SD* = .8) at pre-intervention to .31 (*SD* = 0.41) at post-intervention, $t(6) = 1.73$, $p > .5$. These changes indicate that participants level of current psychological global distress improved following engagement with the programme.



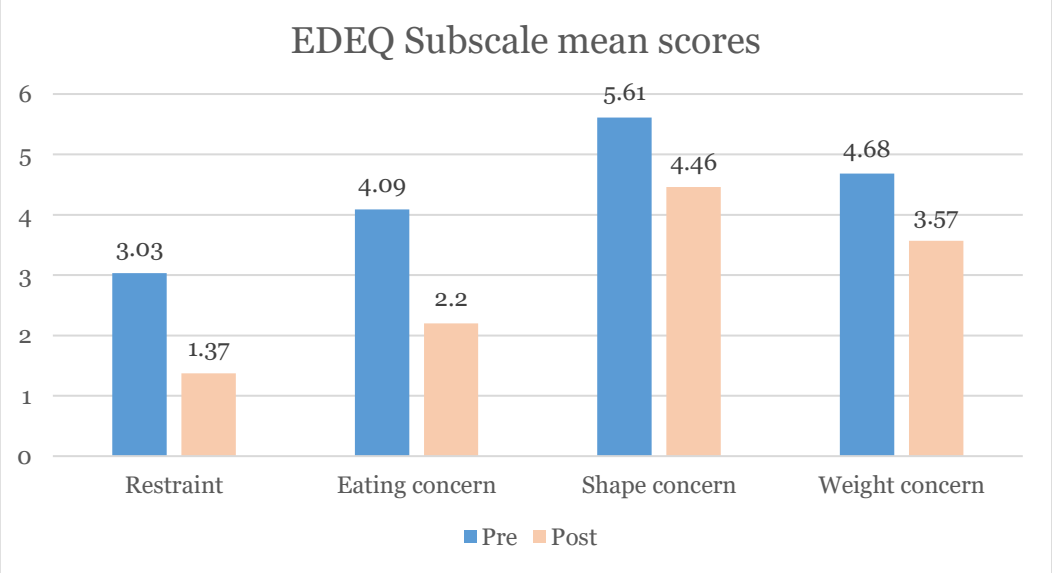
Eating Disorder Examination Questionnaire (EDE-Q)

Participants reported a reduction of eating disorder symptomatology as measured by scores on the EDE-Q. The global score on the EDE-Q reflected a statistically significant decrease in symptomatology between pre-intervention (M = 24.35, SD = .8) and post-intervention (M = 2.9, SD = .91), z = -2.37, p < .05. Similarly, statistically significant improvements were also found across the subscales of the EDEQ.

There are four sub-scales measured within the EDE-Q, which are restraint, eating concern, shape concern and weight concern. All four subscales demonstrated statistically significant improvements for those who completed CFT-E. Mean scores on restraint was found to decrease from 3.03 (SD = 1.42) at pre-intervention to 1.37 (SD = 1.41) at post-intervention, indicating a statistically significant improvement in this symptom of disordered eating, $t(6)$ = 2.8, p < .05. Eating concern showed a statistically significant decrease from 4.09 (SD = 1.29) to 2.2 (SD = 1), $t(6)$ = 4.66, p < .05. Preoccupation with shape also significantly decreased from 5.61 (SD = .38) to 4.46 (SD = .8), $t(6)$ = 3.09, p < .05. Preoccupation with weight similarly showed a significant decrease from 4.68 (SD = 1.2) to 3.57 (SD = 1.33), $t(6)$ = 2.79, p < .05.

EDE-Q subscale	Mean (SD) Pre	Mean (SD) Post	t	p-value	R
Restraint	3.03(1.42)	1.37(1.41)	2.8	0.03	0.39
Eating concern	4.09(1.29)	2.2(1)	4.66	0.03	0.59
Shape concern	5.61(.38)	4.46(.8)	3.09	0.02	-0.27
Weight concern	4.68(1.2)	3.57(1.33)	2.79	0.03	0.66

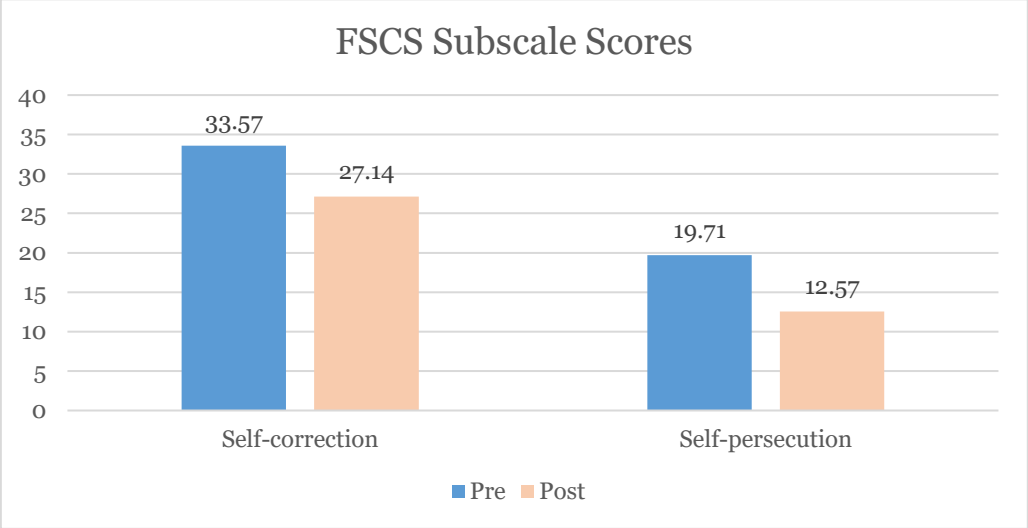
Graph: EDEQ Subscale means



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. Total scores on the self-persecution subscale were found to significantly decrease from 19.71 (*SD* = 7.16) to 12.57 (*SD* = 8.42), $t(6) = 4.11$, $p < 0.5$ for those who took part in the programme, representing a large effect size, *Cohen's d* = .91. Levels of self-correction did not show any statistically significant change from pre-intervention (*M* = 33.57, *SD* = 8.62) to post-intervention (*M* = 27.14, *SD* = 9.92).

Graph: FSCS Sub-scale scores



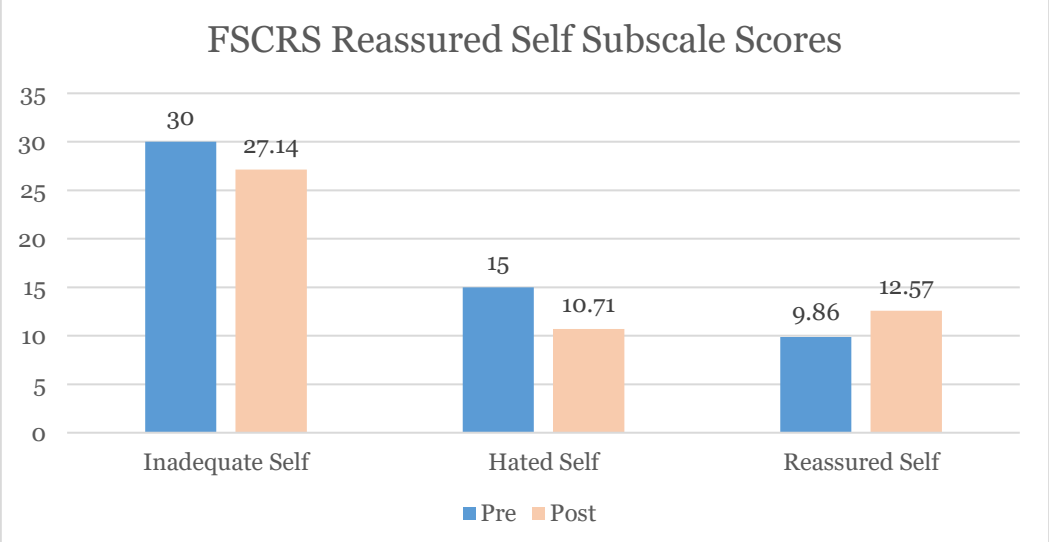
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS) Results

A paired samples t-test demonstrated no statistically significant difference in mean scores on the FSCRS 'inadequate self' sub-scale from pre (M = 30, SD = 2.83) to post-intervention (M = 27.14, SD = 5.96).

A statistically significant reduction in mean scores on the 'hated self' sub-scale was observed from pre (M = 15, SD = 3.74) to post-intervention (M = 10.71, SD = 6.32), z = -2.02, $p < 0.05$, demonstrating a medium effect size (*Cohen's d* = -0.54). These scores suggest that participant levels of self-directed hostility decreased upon completion of the programme.

No statistically significant change was found on the 'reassured self' sub-scale from pre-intervention (M = 9.86, SD = 5.58) to post-intervention (M = 12.57, SD = 6.16).

Graph: FSCRS Reassured Self sub-scale scores



Compassionate Engagement and Action Scale (CEAS)

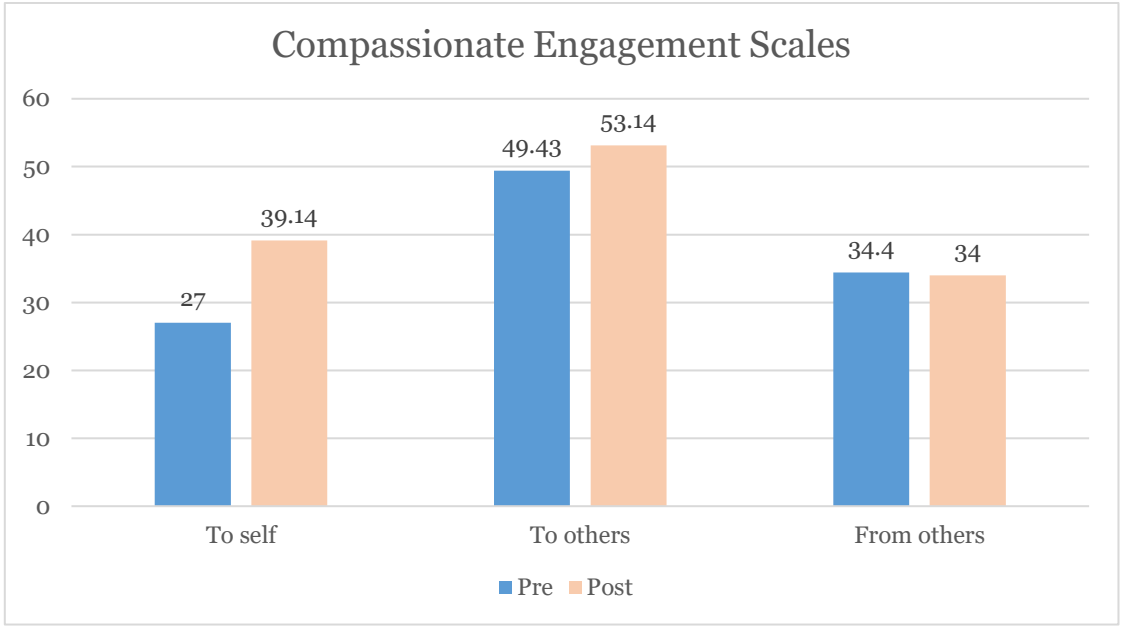
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores and scores on the engagement and action subscales are reported below.

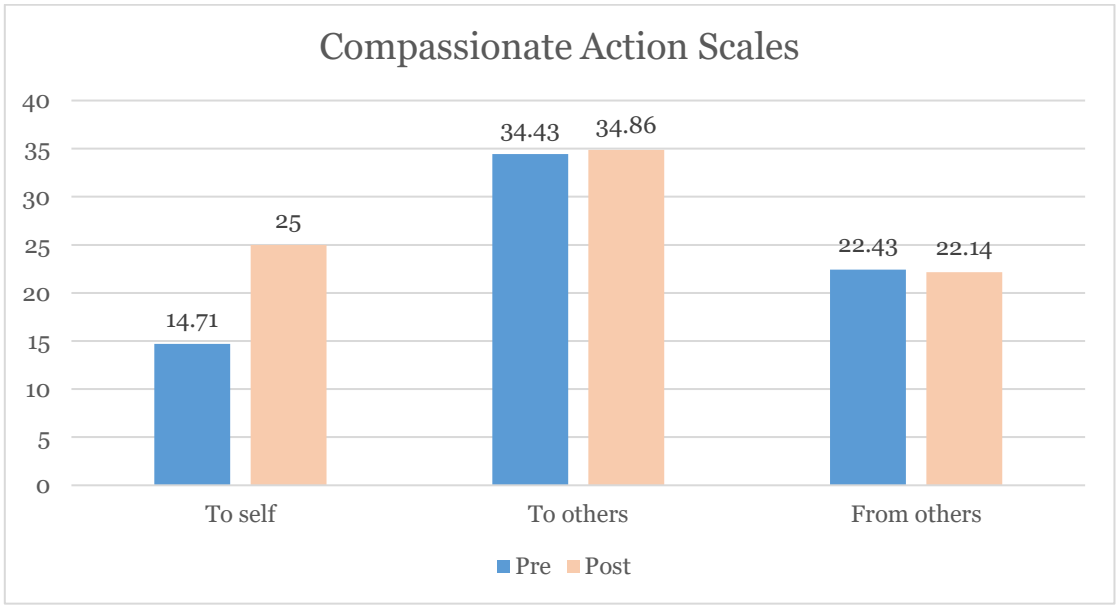
No statistically significant difference was demonstrated for the mean scores on the Compassion to Self engagement scale from pre-intervention *(M* = 27, *SD* = 11.79) to post-intervention (*M* = 39.14, *SD* = 7.69). There was a statistically significant increase on the Compassion to Self Action scale, with mean scores increasing from 14.71 (*SD* = 4.99) at pre-intervention to 25 (*SD* = 5.13) at post-intervention, $t(6) = -3.26$, $p < 0.05$. This represents a robust effect size (*Cohen's d* = 2.03). The total mean score for self-compassion also demonstrated a statistically significant increase from 41.71 (*SD* = 15.96) to 64.14 (SD = 12.72), $t(6) = -2.66$, $p < .05$, demonstrating a robust effect size, $d = 1.55$.

No statistically significant change was found on mean scores for the Compassion to Others Engagement scale from pre-intervention (*M* = 49.43, *SD* = 4.79) to post-intervention (*M*= 53.14, *SD* = 4.45). No statistically significant change was found on scores from the Compassion to Others Action scale from pre-intervention (*M* = 35.43, *SD* = 3.64) to post-intervention (*M* = 34.86, *SD* = 3.76). Overall mean scores on the Compassion to Others subscale showed no statistically significant change (M = 84.86, *SD* = 7.8, to M= 88, *SD* = 7.05).

Mean scores on the Compassion from Others Engagement Scale showed no significant change from pre-intervention (*M* = 34.4, *SD* = 9.69) to post-intervention (*M* = 34, *SD* = 11.70). Mean scores on the Compassion from Others Action Scale also stayed relatively the same, with a pre-intervention mean of 22.43 (*SD* = 6.6) to a post-intervention mean of 22.14 (*SD* = 5.4). The total mean scores on the Compassion from Others subscale showed no significant change, from 56.86 (*SD* = 15.82) at pre-intervention to 56.12 (*SD* = 17) at post-intervention.

Graph: CEAS Engagement and Action mean scores





4.9.4. Summary

Since CFT-E began in SPMHS in 2015, 10 cycles have been facilitated and the most recent cycle completed in 2022 was delivered in mixed format (online/hybrid/face to face). 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 2021. 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-hatred and an increase in self-compassion. The programme is meetings its aims in reducing eating disorder symptoms and improving service users' relationship with themselves. Please note the number of participants is small so all results must be interpreted with caution.

4.10. COAP (Coping for Older Adults Psychology Programme)

COAP is a psychological group programme which aims to nurture a broader sense of curiosity and openness to psychological approaches to mental health and wellbeing. In line with research supporting the benefits of group programmes with older adult service users, the programme helps in fostering an increased sense of agency over mental health management and connection with others. It follows an integrative approach drawing upon a multitude of models, including Compassion-Focused Therapy, Dialectical Behaviour Therapy, Group Radical Openness and trauma-informed approaches.

The group is held online and runs for four weekly sessions with a closed group format. Upon completion of the programme, a reflection session is offered to allow the service user to reflect on the experience of group and explore further avenues of psychological support if desired.

4.10.1. Descriptors

Pre and post data were available for the 28 service users that completed the programme in 2022. Of these, 22 were female (78.6%) and 6 were male (21.4%). The age of programme attendees ranged from 62 to 90 years old (M = 73, SD = 6.16).

4.10.2. Depression Anxiety and Stress Scale (DASS-21)

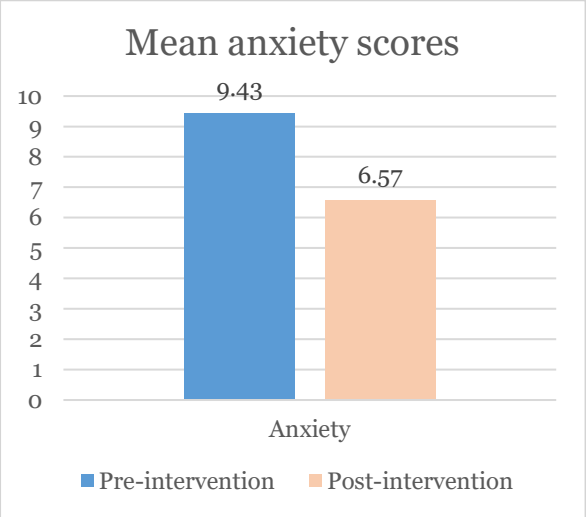
The 21-item Depression, Anxiety and Stress Scale (DASS-21) is a set of three self-report scales designed to measure depression, anxiety and stress. Each of the three DASS-21 scales contains seven items, divided into sub-scales with similar content. Each item comprises a statement and four short response options to reflect severity,

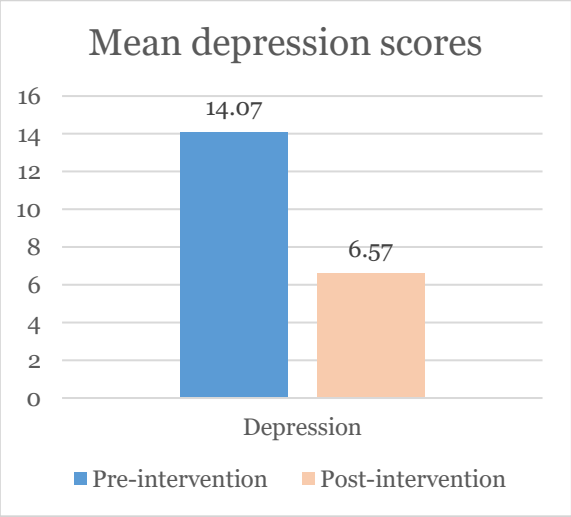
and scored from zero – 'did not apply to me at all', to three – 'applied to me very much, or most of the time'. The Depression Scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The Anxiety Scale assesses autonomic arousal, 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.

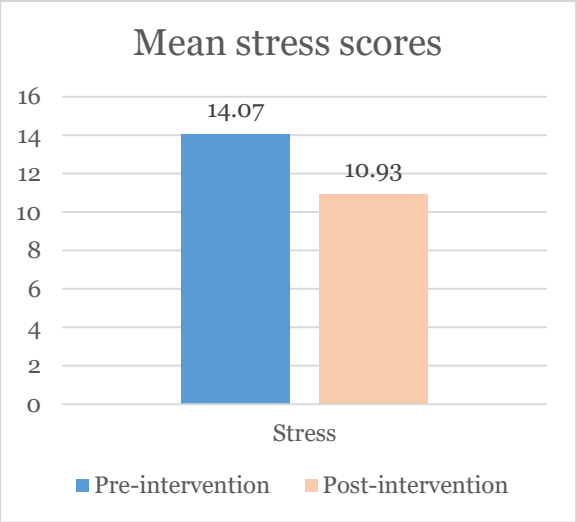
4.10.3. Results

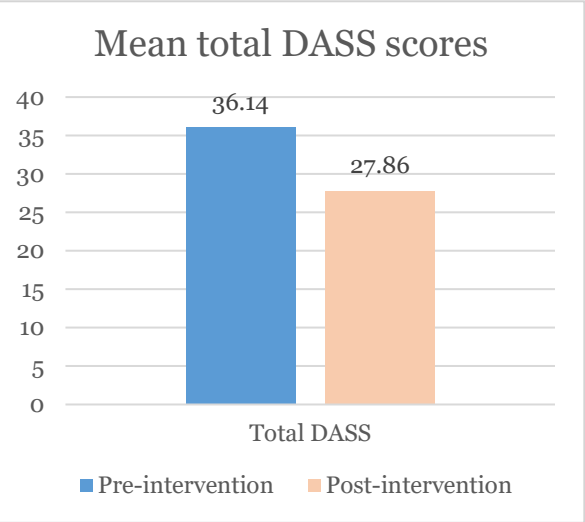
The mean total score results on the DASS decreased from 36.14 (*SD* = 29.03) to 27.86 (*SD* = 21.84). These figures indicate an improvement in psychological difficulties. However, this difference was not statistically significant. Scores on the anxiety subscale decreased from an average 9.43 (*SD* = 9.09) to 6.57 (*SD* = 6.08), and this improvement in anxiety from baseline was statistically significant, Z = -2.51, *p* = .01. Scores on the depression subscale also decreased from an average 14.07 (*SD* = 11.93) to 10.93 (*SD* = 12.17), while scores on the stress subscale decreased from an average 12.64 (*SD* = 11.16) to 10.36 (*SD* = 7.91). However, neither of these differences reached statistical significance.

Graphs: Mean scores on the DASS total and subscale scores









4.10.4. Summary

Reductions in average levels of depression, anxiety and stress were observed in individuals who took part in COAP. The improvement in anxiety from pre to post-intervention was found to be statistically significant. Ability to detect a statistically significant improvement in depression, stress and overall score may have been impacted by the small sample size.

4.11. 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.

Depression Recovery Workshop

Once referred to the Depression Recovery programme, the individual is invited to attend a half day one-off workshop. This aims to explain depression and to promote a healthy proactive lifestyle based on concepts from behavioral activation, CBT, CFT and mindfulness. It also aims to introduce participants to the concept of group therapy and to discuss their expectations.

Depression Recovery Programme

The Depression Recovery Programme is a 10-week psychotherapy group programme which combines approaches from CBT, CFT and MBSR. Sessions are led by cognitive behavioral psychotherapists and nurses with expertise in depression, group therapy, CFT, and mindfulness.

Depression Recovery Aftercare

Depression Recovery Aftercare is a 12-month psychotherapy group that meets for a half day once a month. It focuses on building on and maintaining the change made through the Depression Recovery Programme. The group is run by two accredited CBT therapists, and continues to apply the approaches of CBT, CFT and MBSR.

4.11.2. Descriptors

Paired data were available for 31 service users who completed the programme in 2022; 17 females (51.5%) and 16 males (48.5%). The age profile of participants ranged from 30 to 74 years, with the average age being 55.79 years.

4.11.1. Depression Recovery Programme outcome measures

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

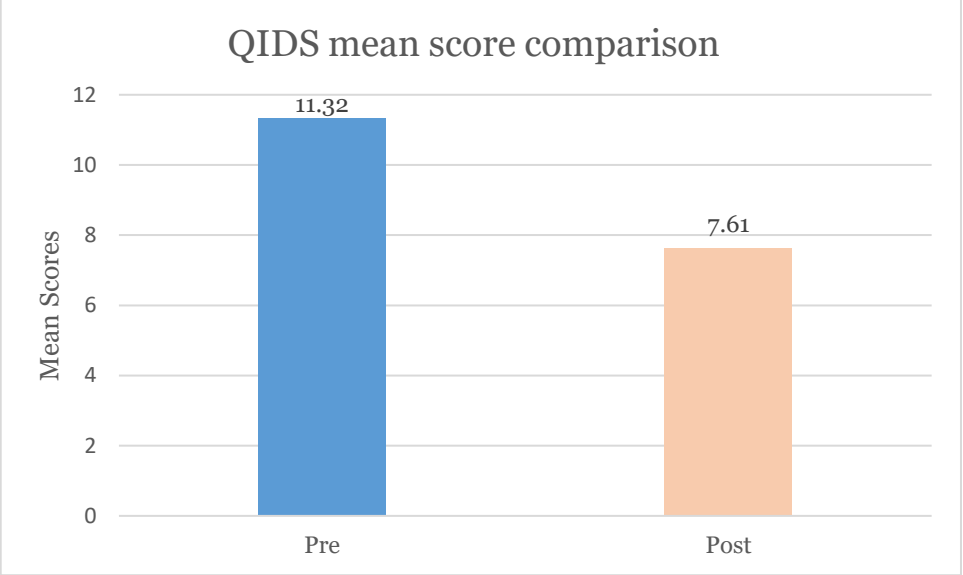
The Quick Inventory of Depression Symptomatology (Rush et al, 2003) is a 16-item measure used to assess the severity of depression symptoms. The items cover the nine diagnostic domains of depression as identified in the DSMS-IV: sad mood, concentration, self-criticism, suicidal ideation, interest, energy/fatigue, sleep disturbance and decrease or increase in appetite. It utilises a four-point rating scale, with a score of zero = 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).

4.11.3. 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 = 11.32, SD = 4.61) to post-intervention (M = 7.61, SD = 5.32). This reduction in mean scores is statistically significant. A paired samples t-test revealed t (30)= 4.06, p< .001, with a small effect size (Cohen's d = .35).

Graph: QIDS Pre and Post-intervention mean momparison



4.11.4. Summary

This is the eighth year the Depression Recovery 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.

4.12. 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 programme 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, a 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 spervision and dietetics
- Body image and self-esteem
- relaxation/self-reflection groups
- Recovery-focused intervention (WRAP)
- Social and relationship groups
- Psychology groups for skills training in regulating emotions and tolerating distress.

Following day services, outpatient care is offered in the Dean Clinic. Services offered at the Dean Clinic include psychiatry, nursing, and dietitian reviews, along with CBT-E, MANTRA and SSCM in order to support service users in their recovery.

4.12.1. Descriptors

Data was available for a total of 34 service users attending the EDP as an inpatient in 2022. Inpatient data was collected at two points, inpatient admission and discharge. Data was available for 23 service users who attended EDP as a day service user in 2022. Day service user data was collected at either inpatient discharge or day service user admission as a pre-intervention measure, and then day service user discharge as their post-intervention measure. 12 service users completed both the inpatient and day service programmes.

4.12.2. 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 zero 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.

4.12.3. 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 = 3.66) and post-treatment (M = 1.9). A pairwise sample t-test indicated this was a statistically significant change $t(30)= 8.77$, $p<.001$, with a medium effect size $d= .72$.

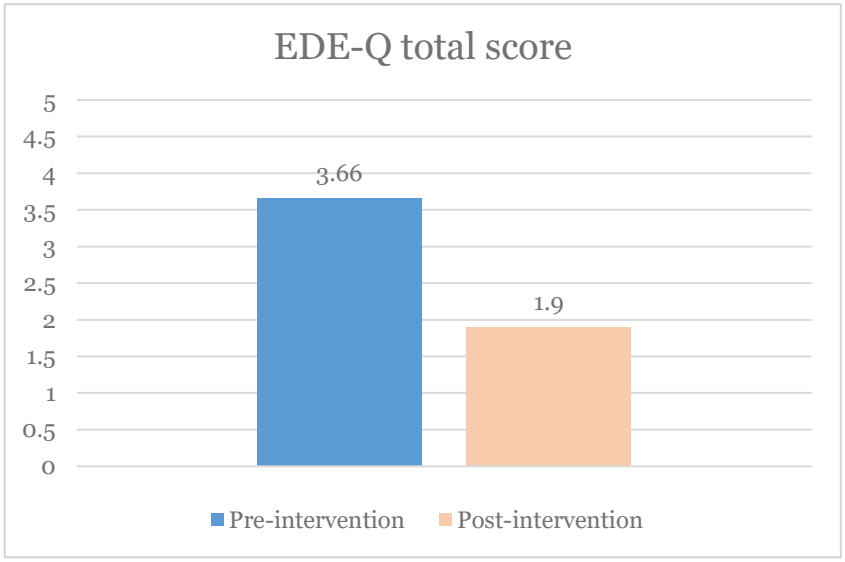
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restriction sub-scale significantly decreased from pre-treatment ($M= 3.28$) to post-treatment (M = 0.68), $t(30)= 10.19$, $p<.001$, with a medium to large effect size of $d=.78$.

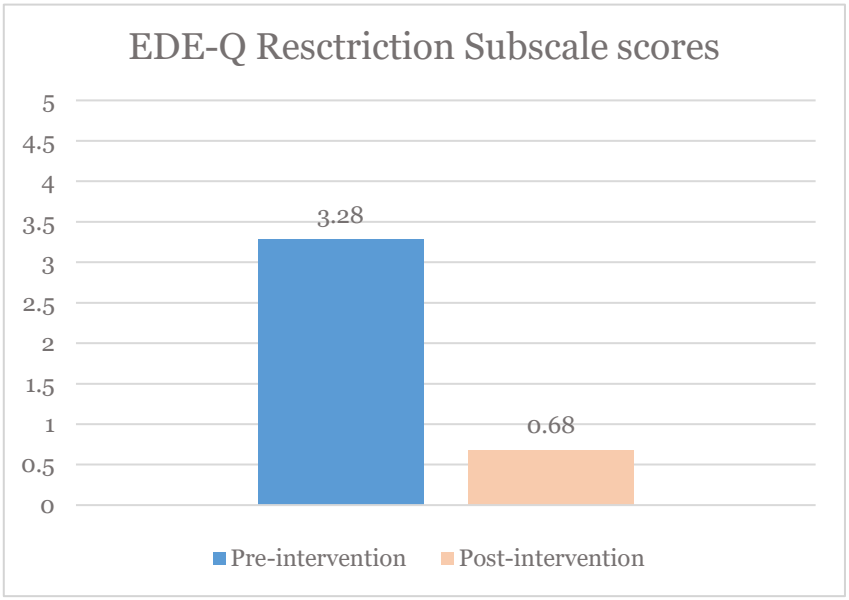
Secondly, symptomatology on the eating concern sub-scale significantly decreased from pre-treatment ($M= 2.97$) to post-treatment (M = 1.42), $t(30)= 8.38$, $p<.001$, with a medium effect size $d= .7$.

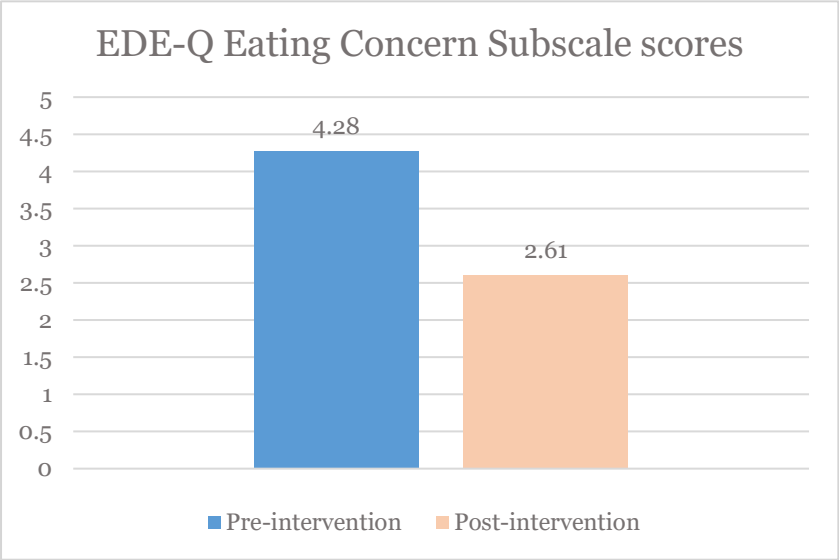
Additionally, symptomatology on the shape concern sub-scale significantly decreased from pre-treatment ($M= 4.11$) to post-treatment (M = 2.87), $t(30)= 4.79$, $p<.001$, with a medium effect size $d=.43$.

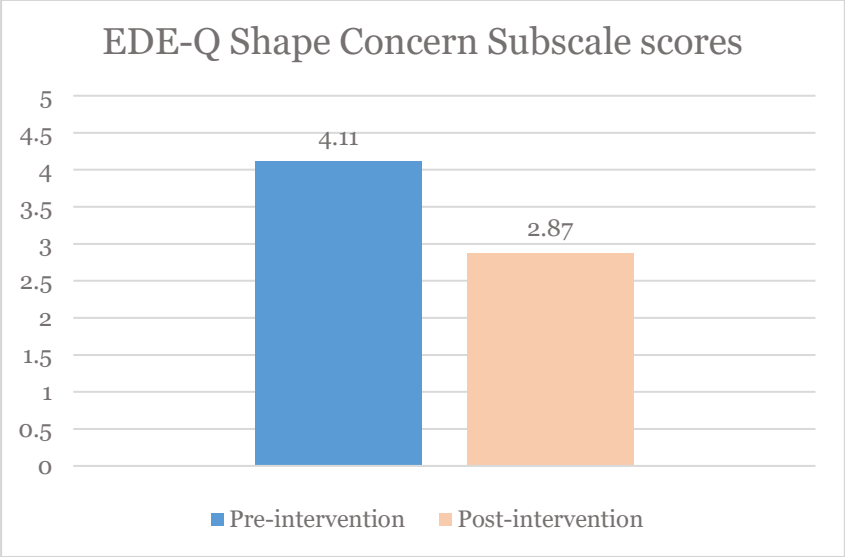
Finally, symptomatology on the weight concern sub-scale significantly decreased from pre-treatment (M= 4.28) to post-treatment (M = 2.61), $t(30)$= 5.7, p<.001, with a medium effect size d=.52.

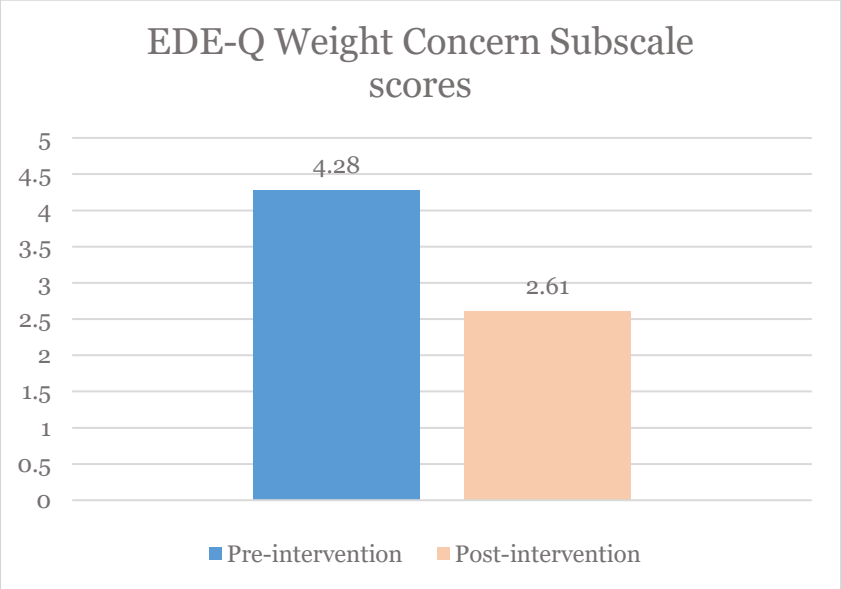
Graph: EDE-Q Global and sub-scale scores pre and post-intervention






EDE-Q Eating Concern Subscale scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.28
2.61
Pre-intervention
Post-intervention


EDE-Q Shape Concern Subscale scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.11
2.87
Pre-intervention
Post-intervention


EDE-Q Weight Concern Subscale scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.28
2.61
Pre-intervention
Post-intervention

State Self-Esteem Scale (SSES)

On the SSES, patients with measures at both timepoints showed increased overall self-esteem as well as increases across the three sub-scales: performance self-esteem, appearance self-esteem and social self-esteem. At time two (inpatient discharge) mean score across all scales had increased suggesting improvements across all domains.

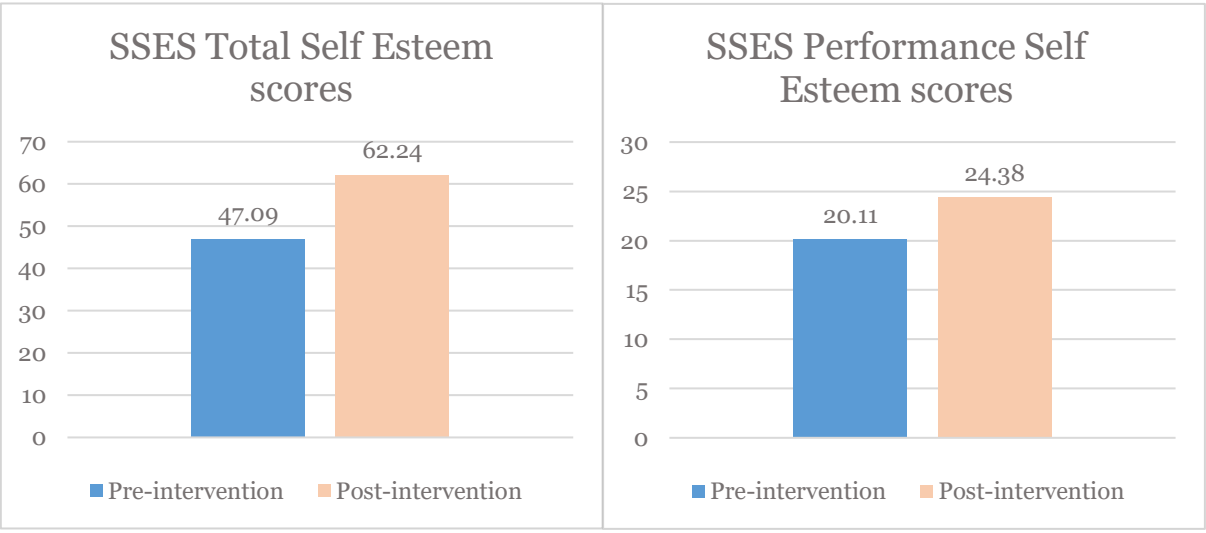
The total score on the SESS showed an increase between pre-treatment (M=47.09) and post-treatment (M=62.24). A Wilcoxen signed ranked test indicated this was a statistically significant change, z = -4.49, p <.001, with a medium to large effect size of .77.

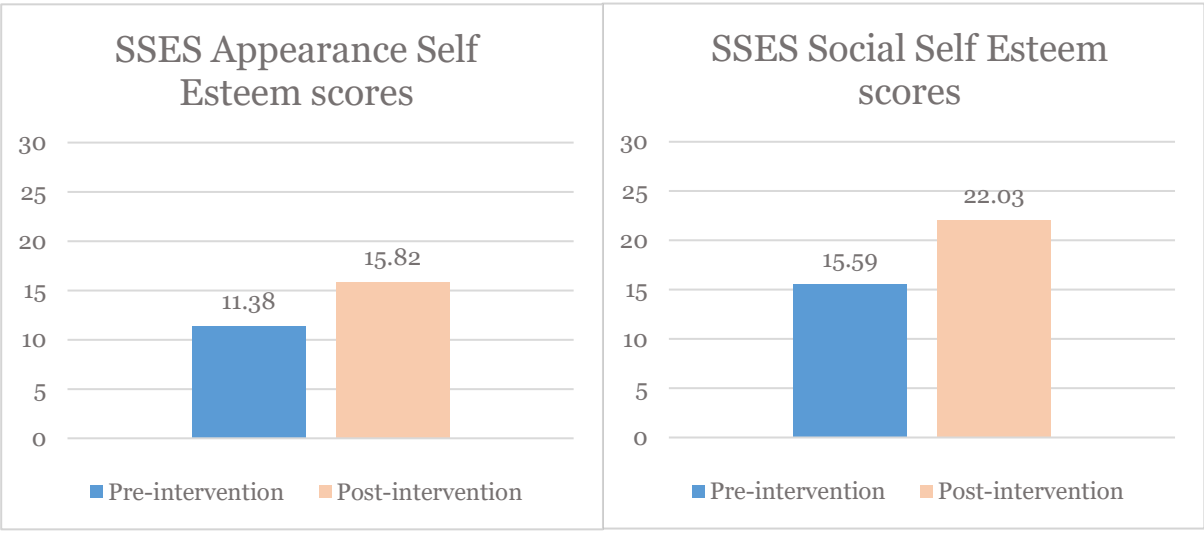
The performance self-esteem score on the SESS showed an increase between pre-treatment (M=20.11) and post-treatment (M=24.38). A Wilcoxen signed ranked test indicated this was a statistically significant change, z = -3.61, p <.05, with a medium effect size d=.62

The social self-esteem score on the SESS showed an increase between pre-treatment (M=15.59) and post-treatment (M=22.03). A pair wise sample t-test indicated this was statistically significant, $t(33)$= -5.27, p <.001, with a medium effect size of d = .46.

The appearance self-esteem score on the SESS showed an increase between pre-treatment (M=11.38) and post-treatment (M=15.82). A pair wise sample t-test indicated this was a statistically significant change, $t(33)$= -5.08, p <.001, with a medium effect size d=.44

Graphs: State Self-Esteem Scale total and subscale scores pre and post-intervention.





4.12.4. Day service user 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 = 2.27) and post-treatment (M = 1.96). A pairwise sample t-test indicated this was not a statistically significant change $t(20)$= 1.58, p>.05.

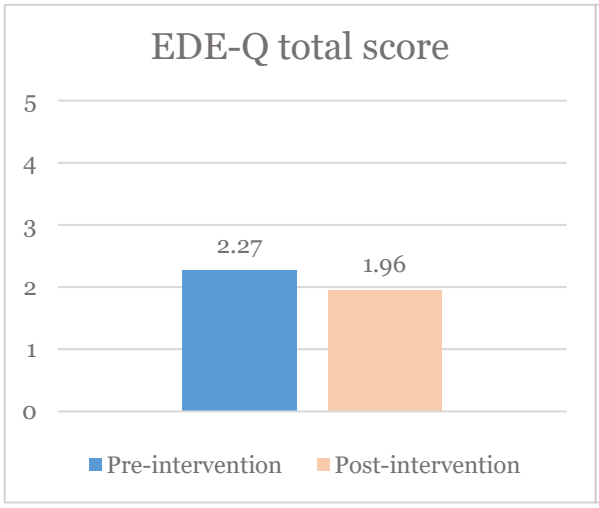
Symptomatology on the restriction sub-scale decreased from pre-treatment (M= 1.07) to post-treatment (M = 0.82), although this difference was not found to be statistically significant, z = -.64, p > .05.

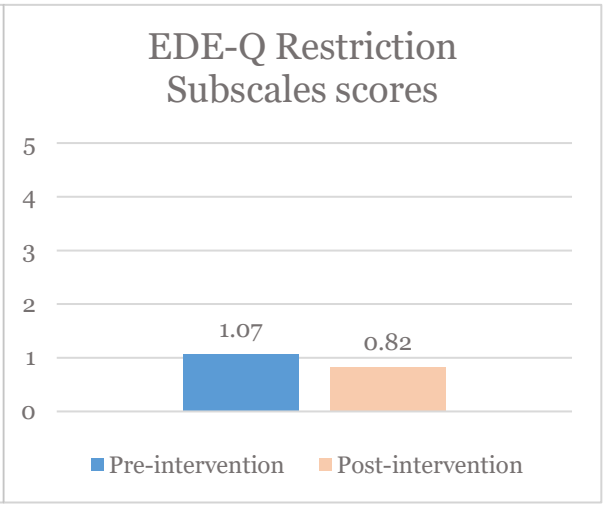
Symptomatology on the eating concern sub-scale significantly decreased from pre-treatment (M= 1.81) to post-treatment (M = 1.58), z = -1.97, p < .05, with a medium effect size d= -.43.

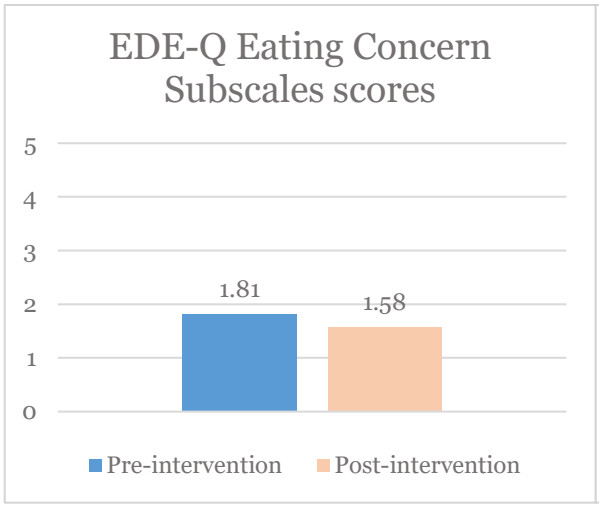
Additionally, symptomatology on the shape concern sub-scale decreased from pre-treatment (M= 3.11) to post-treatment (M = 2.82), although this difference was not statistically significant, $t(20)$= 1.31, p > .05.

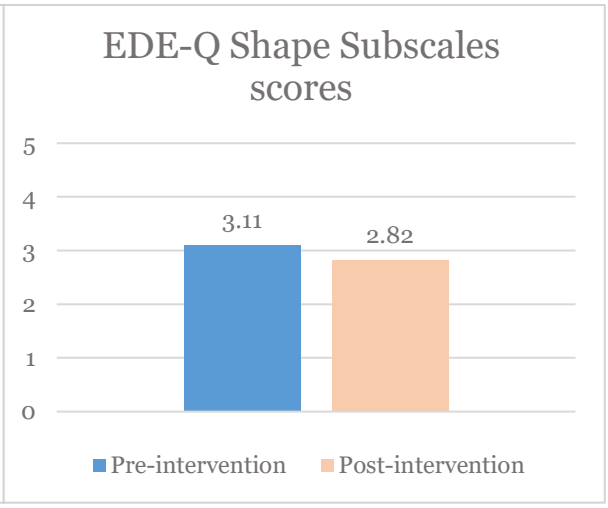
Finally, symptomatology on the weight concern sub-scale decreased from pre-treatment (M= 3.12) to post-treatment (M = 2.83), but again this was not significant, $t(20)$= 1.31, p > .05.

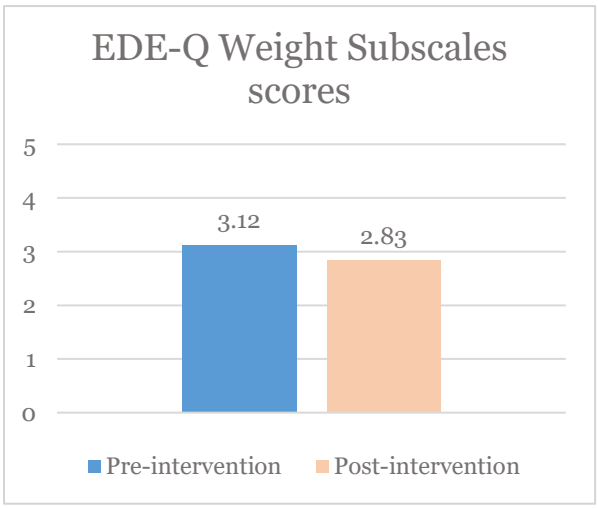
Graph: EDE-Q Global and sub-scale scores pre and post-intervention











State Self-Esteem Scale (SSES)

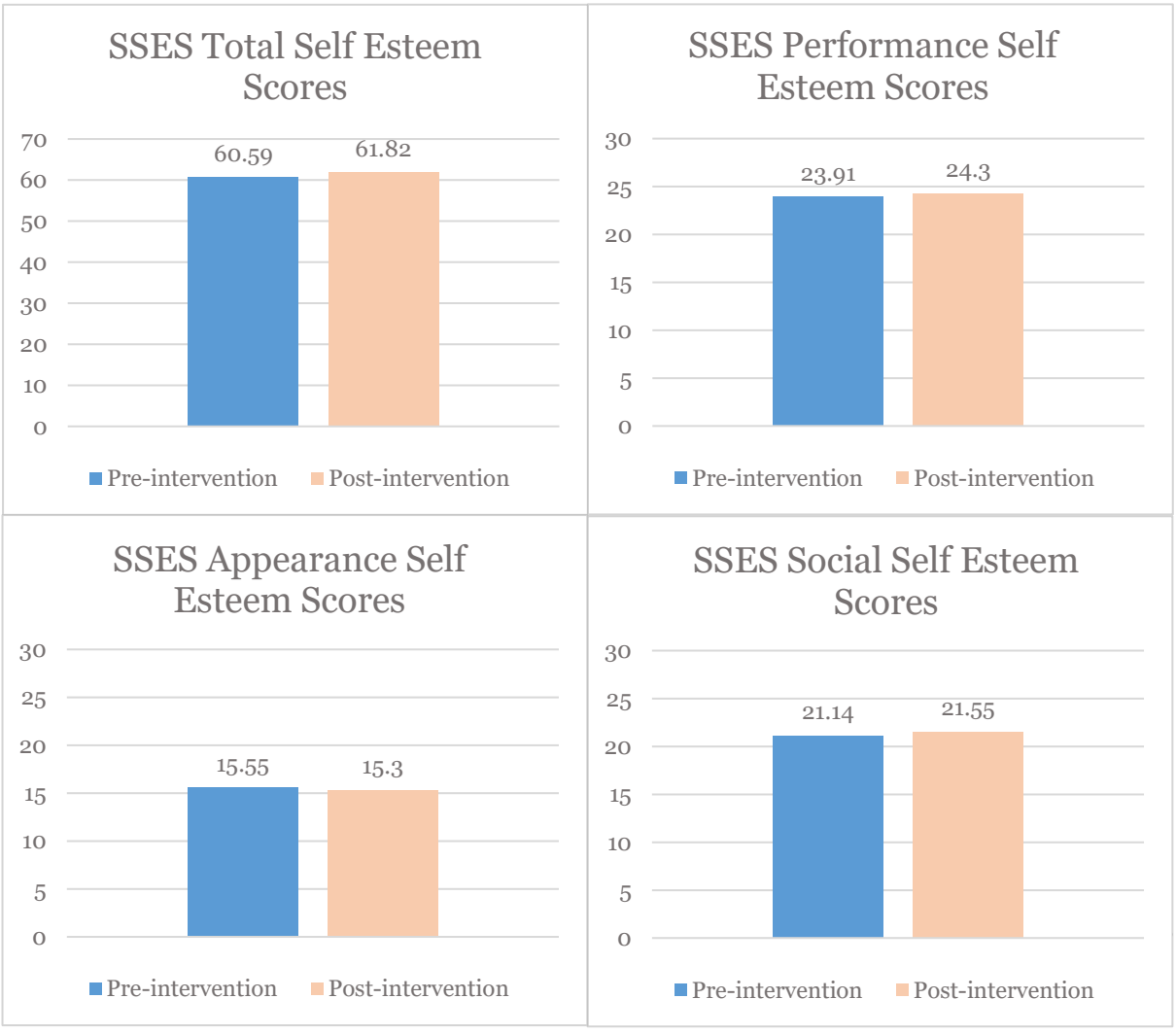
The total score on the SESS showed an increase between pre-treatment (M=60.59) and post-treatment (M=61.82). A paired samples t-test indicated this was not a statistically significant change, $t(21) = -.39$, $p > .05$.

The performance self-esteem score on the SESS showed an increase between pre-treatment (M=23.91) and post-treatment (M=24.3). A Wilcoxen signed ranked test indicated this was not a statistically significant change, $z = -1.0$, $p > .05$.

The social self-esteem score on the SESS showed an increase between pre-treatment (M=21.14) and post-treatment (M=21.55). A pair wise sample t-test indicated this was statistically significant, $t(21) = -.32$, $p > .05$.

The appearance self-esteem score on the SESS showed an increase between pre-treatment (M=15.55) and post-treatment (M=15.3). A Wilcoxen signed ranked test indicated this was not statistically significant change, $z = -.69$, $p > .05$.

Graphs: State Self-Esteem Scale total and subscale scores pre and post-intervention.



4.12.5. Summary

The findings presented provide insight into the effectiveness of the programme. Analysis of the data collected via outcome measures indicate that, on average, those who attend the Eating Disorder Programme as an inpatient 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. Smaller improvements were observed for those who took part in the Day Programme. One likely explanation for this finding is that those who had taken part in the inpatient programme beforehand may have already made gains and thus may have already met their goals in terms of eating disorder symptoms and self-esteem, leaving less scope for their scores to change. Overall, the Eating Disorder Programme has been demonstrated as an effective intervention for eating disorder behaviours and issues of self-esteem.

4.13. Emotion-Focused Therapy for Young Adults Programme

The Emotion-Focused Therapy for Young Adults (EFT-YA) programme proposes that the young adult population commonly describe finding themselves stuck at developmental points in their lives. These may take the form of vocational crisis (dropping out of college or repeatedly losing employment opportunities), systemic issues (difficulty in achieving psychological individuation and autonomy from family of origin), stuck in unhelpful patterns of behaviour (disorganised attachment/interpersonal difficulties), maladaptive coping strategies, difficulty in achieving developmental milestones (perception of being 'left behind' by 'more successful' peers). It is postulated that this sense of 'stuckness' is mirrored in the internal psychological processing issues experienced by the young adult. It suggests that a fear of/reluctance/inability to access and tolerate the affect associated with core pain leads the young person to engage in emotional and behavioural avoidance strategies which are successful to the extent that they frustrate effective and meaningful processing of this pain. The young person then finds themselves in a state of undifferentiated Global Distress, characterised by secondary emotional

experiencing, (ie. rejecting anger), anxiety, hopelessness, agitation etc. This state can be triggered by current and historic triggers which may be internal and external and is complicated by problematic self-treatment (excessive self-criticism (shame and fear). Only by accessing the core pain and by identifying the associated needs can the young adult move beyond global distress and begin to access the necessary compassion and protective anger required to support them in their journey towards relief from their pain and a sense of agency/empowerment.

The purpose of an EFT-YA group for this population would be to support a move to more adaptive emotional functioning through accessing, tolerating and, where possible, transforming/processing hitherto unavailable or aversive emotional experiences. All of this is to be enhanced on this program, by harnessing the healing power of a group experience where that which was previously experienced as shameful or frightening, can be overcome through connection with others and awareness of shared difficulties. The group will mainly utilise chair work techniques (two-chair dialogue for critical split and empty chair dialogue for unfinished business) to work towards resolving issues associated with fear and shame, by accessing the core emotional pain implicit in problematic emotion schemes which will be experientially evoked and worked within session.

Underlying principles/philosophy:

"EFT's theory of psychopathology places emotions at the centre of dysfunction/ function. Emotions are fulfilling many functions. They inform us as to whether our needs are being met, they communicate to others about our internal world, and they set the goals for our rational pursuits (Greenberg, 2011). In terms of psychopathology, EFT see service users as either not fully availing of the adaptive information embedded in their emotional experience (eg. *sadness tells me what I miss*) or, and more typically, as experiencing chronic, painful, and maladaptive emotions generated through complex memory-based emotional schematic processes (Greenberg, 2016)." (Timulak and Keogh, 2020)

Efficacy/ Effectiveness of EFT-YA

Emotion-Focused Therapy (EFT) is an empirically supported therapy (Greenberg, 2011; Greenberg and Watson, 2005; Greenberg and Watson, 2006) with roots in the person-centred, gestalt, experiential and existential therapies (Rogers, 1957, Gendlin,

1996; Elliott, Watson, Goldman & Greenberg, 2004). It has evolved gradually over twenty-five years through a systematic program of psychotherapy research and in its current incarnation, incorporates elements of contemporary cognitive and emotion theory (Greenberg, 2011). The evolution of EFT is directly attributable to its origins in a research-based investigation of change processes in psychotherapy (Greenberg, 1979; 1984; Rice & Greenberg, 1984) in tandem with a curiosity regarding the role of emotion (Greenberg & Safran, 1987).

This group program utilizes a transdiagnostic model of Emotion-Focused Therapy (EFT-T), which combines modular (targeting specific clusters of symptoms) and shared mechanisms (targeting underlying vulnerability) approaches to the treatment of depression, anxiety and related disorders (Timulak & Keogh, 2020). The program encompasses recent developments in EFT case-formulation (Timulak & Pascual-Leone, 2015; Timulak & McElvaney, 2016) and utilizes empirically supported principles of psychotherapeutic change (Pascual-Leone & Greenberg, 2007; Timulak, 2015)

Emotion-Focused Group Therapy (EFT-G) is a novel therapy format that utilizes individual Emotion-Focused Therapy (EFT) work in a group setting to evoke and transform painful emotions, both directly and vicariously (Thompson & Girz, 2018). Research into EFT-G has revealed participants report statistically and clinically significant decreases in depression and anxiety symptoms, as well as significant improvements in emotion regulation (Thompson & Girz, 2020).

The EFT team has undertaken research with EFT-YA attendees since its commencement. The preliminary effectiveness of EFT was supported for reducing anxiety and depressive symptoms and increasing self-reported overall wellbeing. In terms of feasibility and acceptability, improvements were found and reported across participants. This particular research was awarded first prize in the professional poster category at the Psychological Society of Ireland Conference 2022.

EFT-YA is a 14-week programme. The group starts with two individual sessions to help young people begin to understand what might be happening for them emotionally, so that they are ready to start working in the group.

4.13.1. Descriptors

A total of 19 people completed EFT- YA in 2022. Complete pre and post-outcome data were available for 14 people, representing a 73.68% total completion rate. 15 participants (77.9%) were female and 3 (15.8%) were male. Participants ages ranged from 19 to 25 years (*M* = 21.47; *SD* 1.50).

4.13. 2. Emotion-Focused Therapy for Young Adults Programme outcome measures

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

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 (α = .93), construct and predictive validity, and test-retest reliability in an article which described the development of this scale.

- **The Generalized Anxiety Disorder-7**

The Generalized Anxiety Disorder-7 (GAD-7) is a seven-item self-report measure which assesses the presence and severity of GAD symptoms over the past two weeks (Spitzer, Kroenke, Williams, & Löwe, 2006). A score of eight or greater represents a reasonable cut-point for identifying probable cases of generalized anxiety disorder. Research has demonstrated the reliability and validity of the GAD-7 in both primary care settings and the general population (Löwe et al., 2008).

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

The PHQ-9 is a nine-item self-report questionnaire. It is a clinically-validated screening tool that healthcare providers and is used to monitor the severity of depression and response to treatment (Kroenke, Spitzer, Williams, 2001). The questions address sleep, energy, appetite, and other possible symptoms of depression. It assesses how often service user has "been bothered by any of the following

problems" in the past two weeks. Scores are calculated based on how frequently a person experiences these feelings and aims to predict the presence and severity of depression. Scores represent: 0-5 mild, 6-10 moderate, 11-15 moderately severe anxiety, 15-21 moderately severe and 15-21 represents severe depression.

- **The Clinical Outcomes in Routine Evaluation - outcome measure (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 service user 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 zero and four, with four being the highest level of severity. The 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 (Perry et al. 2013). 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 (Palmieri et al. 2009).

4.13.3. Results

The Difficulties in Emotion Regulation Scale (DERS)

There was a significant reduction in total DERS scores from pre- intervention (M = 127.86; SD = 21.05) to post-intervention (M = 103.21; SD = 21.82), t (13) = 6.00, p <.001. The eta squared statistic (0.73) indicated a large effect size.

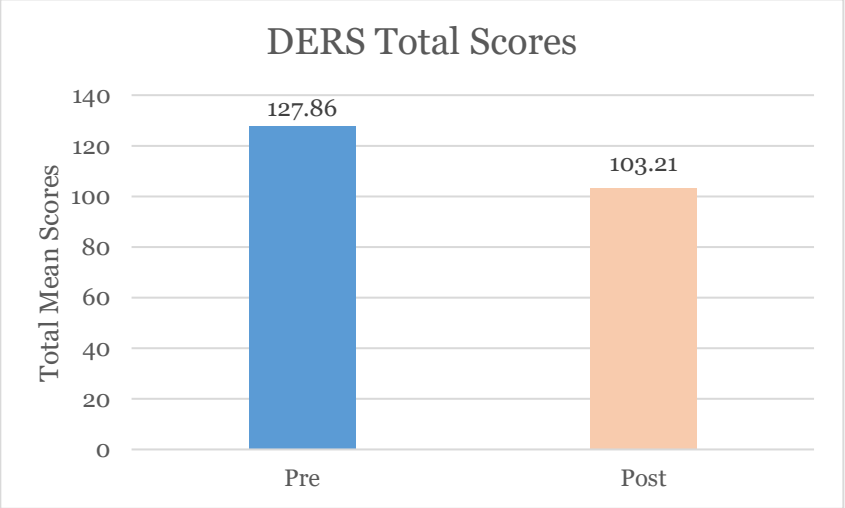
There were significant reductions in five out of six of the DERS sub-scales. There was a significant reduction in the DERS sub-scale Non-Acceptance of Emotions scores from pre-intervention (M = 22.87; SD = 6.08) to post-intervention (M = 17.33; SD =

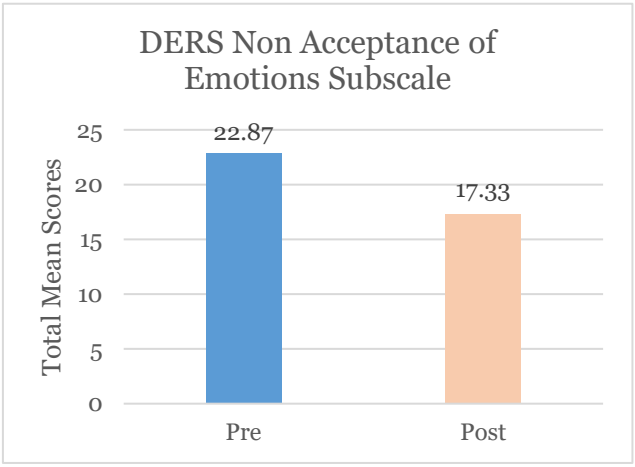
6.13), t (14) = 3.76, p <.003, with a medium effect size (Cohen's d = 0.50). There wasn't a significant reduction in the DERS sub-scale Inability to Engage in Goal-Directed Behaviors when Distressed from pre- ntervention (M = 18.29; SD = 2.80) to post-intervention (M = 16.71; SD= 3.44), t (16) = 1.92, p = .073. There was a significant reduction in the DERS sub-scale Impulse Control from pre-intervention (M = 18.73; SD = 4.76) to post-intervention (M = 14.73; SD = 4.08), t (14) = 3.35, p <.006, with a small effect size (Cohen's d = 0.45).

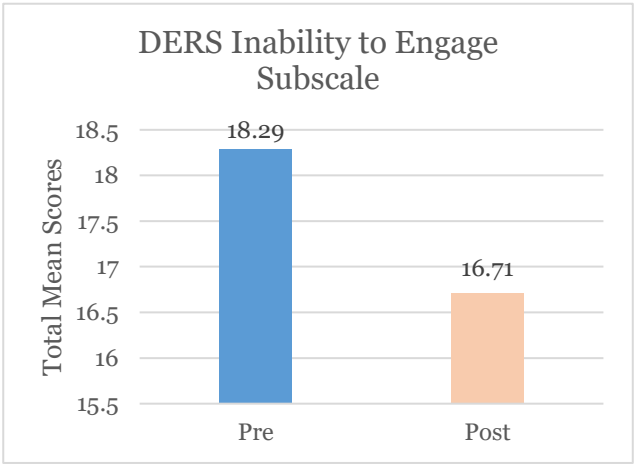
There was a significant reduction in the DERS sub-scale Emotional Awareness from pre-intervention (M = 19.29; SD = 6.56) to post-intervention (M = 15.12; SD = 4.54), t (16) = 3.01, p <.009, with a small effect size (Cohen's d = 0.36). There was a significant reduction in the DERS sub-scale Emotional Regulation Strategies from pre-intervention (M = 30.94; SD = 5.47) to post-intervention (M = 24.71; SD = 5.98), t (16) = 5.44, p <.001, with a large effect size (Cohen's d = 0.65).There was a significant reduction in the DERS sub-scale Emotional Clarity from pre-intervention (M = 16.47; SD = 4.57) to post-intervention (M = 12.82; SD = 2.90), t (16) = 3.98, p <.002, with a medium effect size (Cohen's d = 0.50).

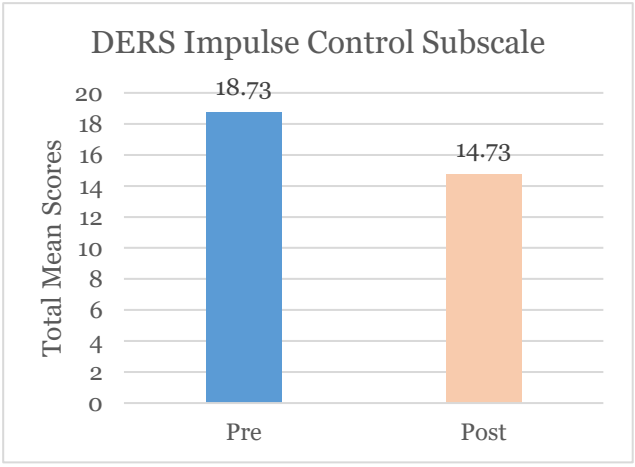
These findings indicate that those who completed the EFT-YA programme in 2022 successfully increased their capacity for emotional regulation as well as yielded improvements in acceptance of emotions, impulse control, emotional awareness and emotional clarity [see graphs below].

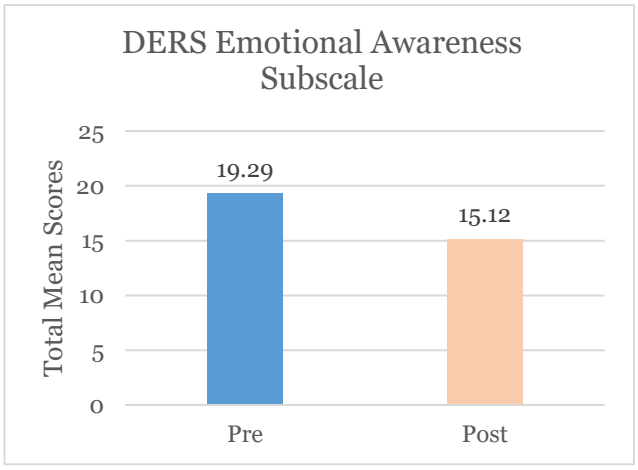
Graphs: Difficulties in Emotion Regulation Scale (DERS) mean total and sub-scale scores pre and post-intervention

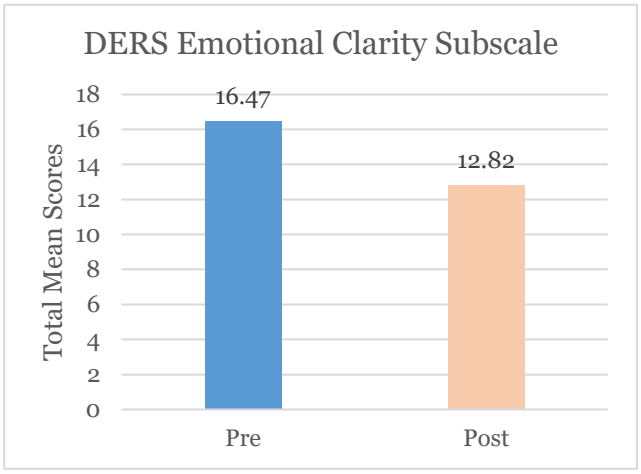








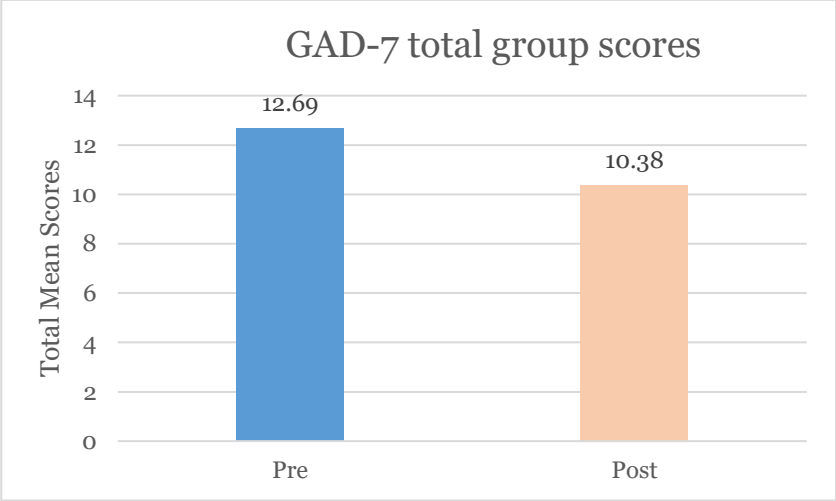




The Generalized Anxiety Disorder-7 (GAD-7)

There was a significant reduction in the GAD-7 total scores from pre-intervention (M = 12.69; SD = 5.07) to post-intervention (M = 10.38; SD = 4.38), t (15) = 2.18, p <.05, with a small effect size (Cohen's d = 0.24). This finding indicates that those who completed the programme significantly reduced their anxiety symptoms post-intervention (see graph below).

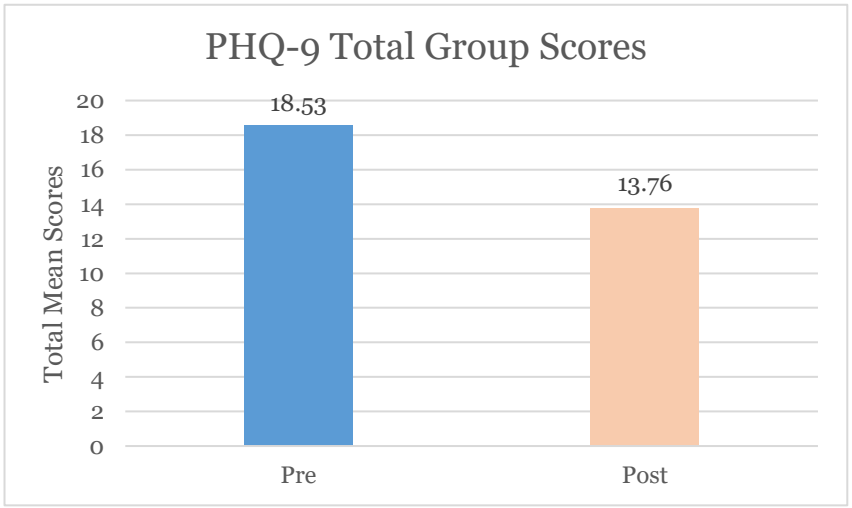
Graph: The Generalized Anxiety Disorder-7 (GAD-7) mean total scores pre and post-intervention



The Patient Health Questionnaire-9 (PHQ-9)

There was a significant reduction in the PHQ-9 total scores from pre-intervention (M = 18.53; SD = 4.46) to post-intervention (M = 13.76; SD = 5.89), t (16) = 4.58, p <.001, with a medium effect size (Cohen's d = 0.57). In addition, those who completed the programme moved from the moderately severe (15-19) clinical range to a moderate range (10-14). These findings illustrate that the young adults who completed the programme significantly and clinically reduced their symptoms related depression (see graph below).

Graph: The Patient Health Questionnaire-9 (PHQ-9) mean total pre and post-intervention

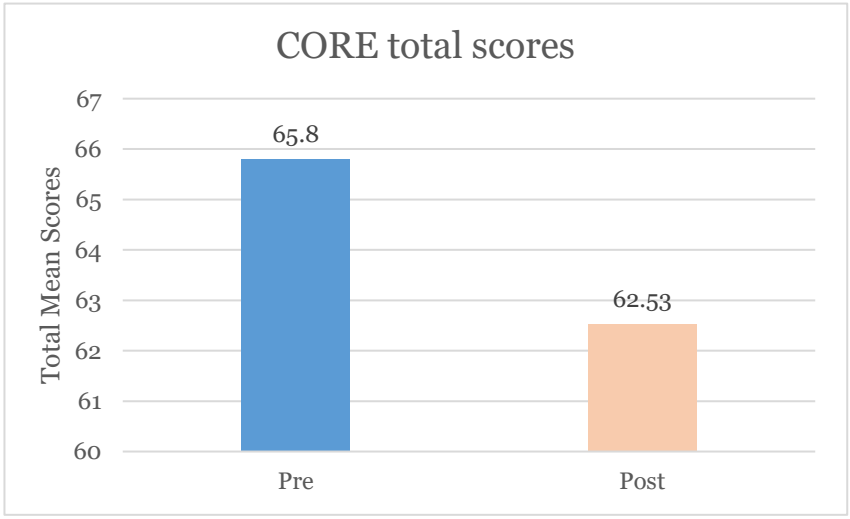


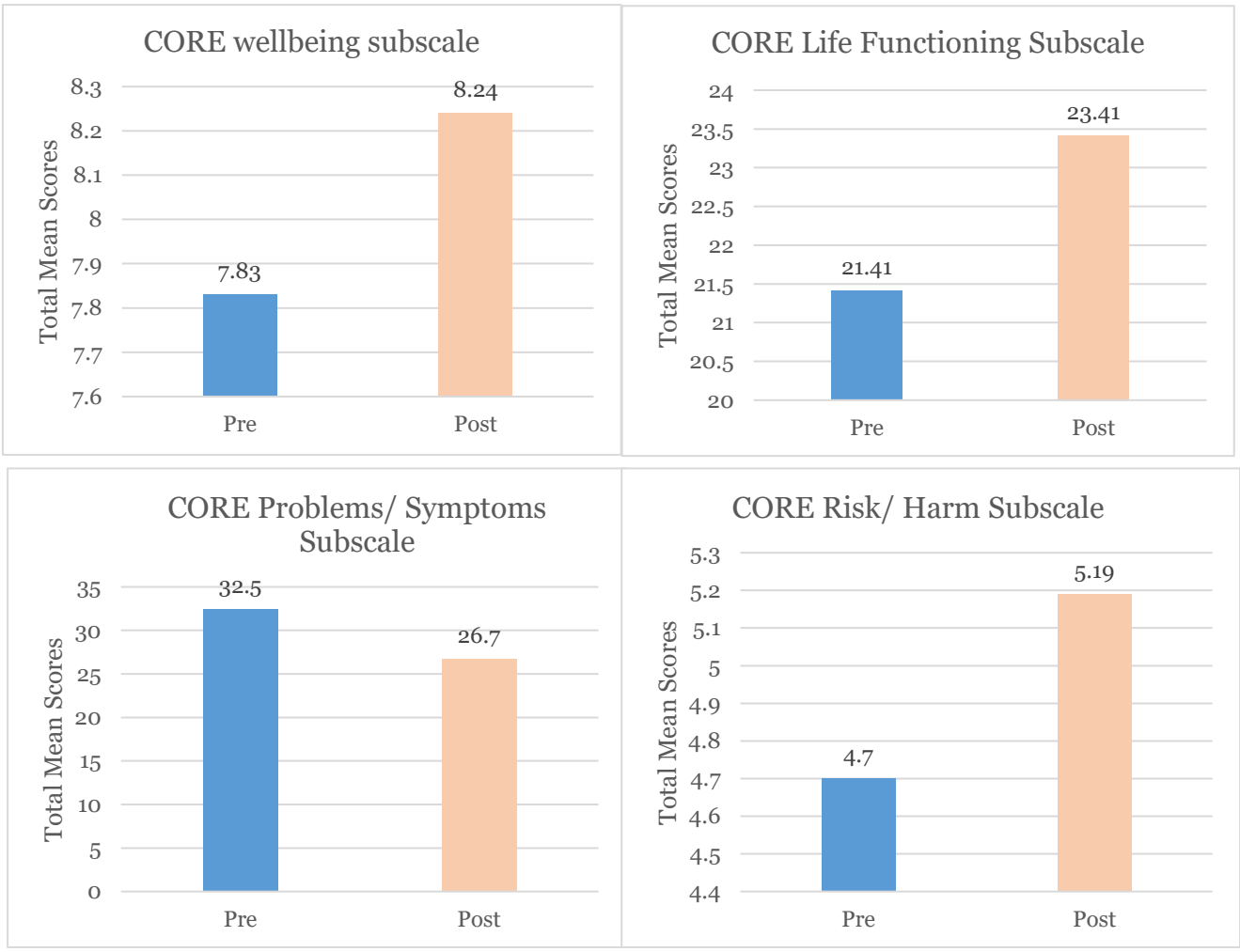
The Clinical Outcomes in Routine Evaluation (CORE)

There was no significant reduction in the CORE total scores from pre-intervention (*M* = 65.80; *SD* = 12.19) to post-intervention (*M* = 62.53; *SD*= 16.75), *t* (14) = 1.03, *p* = .320. Similar results were yielded from the CORE sub-scale wellbeing as there was no significant reduction in scores from pre (*M* = 7.83; *SD* = 1.88) to post (*M* = 8.24; *SD* = 1,44), *t* (16) = -.89, *p* = .386. The CORE subscale of problems/symptoms yielded a significant reduction from pre (*M* = 32.50; *SD* = 7.67) to post (*M* = 26.70; *SD* = 9.96), *t* (15) = 2.98, *p* <.010, with a small effect size (Cohen's *d* = 0.37). There was no significant reduction in the CORE subscale life functioning from pre-intervention (*M* = 21.41; *SD* = 5.84) to post-intervention (*M* = 23.41; *SD*= 4.32), *t* (16) = -1.48, *p* = .160. There was no significant reduction in the CORE subscale of risk/harm from pre-intervention (*M* = 4.70; *SD* = 3.24) to post-intervention (*M* = 5.19; *SD* = 5.36), *t* (15) = -.417 *p* = .682.

This measure assesses the overall functioning in the context of psychological distress of someone seeking intervention. The above findings indicate that those who completed the programme yielded no significant reduction in their total score or across the subscales that identify wellbeing, life functioning or risk/harm. Although the change is not statistically significant, it is clinically meaningful, as the total group score has moved from the clinical range to the non-clinical range. There was a significant improvement in the subscale that assesses problems/symptoms among those who completed the programme (see graph below).

Graph: The Clinical Outcomes in Routine Evaluation (CORE) mean total and subscale scores pre and post- intervention





4.13.4. Summary

This was the first year the Emotion-Focused Therapy for Young Adults (EFT-YA) programme was ran in the hospital. The programme targets difficulties related to anxiety, depression, stress and complex trauma. It does this by transforming maladaptive shame and fear by accessing primary emotion.

In 2022, the young adults who completed the novel programme showed significant increases in their capacity for emotional regulation as well as yielded improvements in acceptance of emotions, impulse control, emotional awareness and emotional clarity. Service users also yielded significant decreases in their symptoms of anxiety and depression following completion of the programme. However, results yielded from the CORE measure indicate no significant improvements in overall functioning in the context of psychological distress. Although this change is not statistically significant, it is clinically meaningful, as the total group score has moved from the clinical range to the non-clinical range.

Analysis of outcome measures of the EFT-YA indicates that this intervention had a positive impact on service users' lives across the majority of domains targeted by this intervention.

4.14. Dialectical Behavioural Therapy (DBT) Programme

The DBT programme aims to teach emotional regulation, distress tolerance, mindfulness and interpersonal effectiveness skills for individuals who experience out of control behaviour in the context of emotional dysregulation. DBT is a multimodal staged psychotherapeutic approach. 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). Service user 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 four DBT modes (skills training, one-to-one therapy, phone coaching and weekly therapist consultation team meetings). 24 group sessions occur in a three month period, and eight one-to-one sessions are offered across the 12 weeks. Five comprehensive groups took place in 2022. 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 three month period. This group is offered to service users who have not displayed pervasive patterns of self-harm or suicidal behaviour in the past six months but do experience emotional dysregulation and impulsive attempts to regulate emotion. Four skills groups took place in 2022. 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 service users 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 (eg. 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 two cycles of the programme are described below, all of which finished in 2022. Data analysis of the Comprehensive DBT and DBT skills group are reported separately. A combination of online and in-person groups are offered, with three of the comprehensive groups and two of the skills groups delivered online in 2022.

4.14.1. Descriptors

Pre and post-programme data were available for 24 participants who completed the DBT Comprehensive programme in 2022. 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, 75% were female and 25% were male. DBT attendees ranged in age from 18 to 52 years, with an average age of 28.7 years (SD = 11.8). Their level of educational attainment included Junior Cert (12.5%), Leaving Cert (33.3%), (4.2%), third level non-degree qualification (29.2%), third level degree (8.3%) and postgraduate qualification (12.5%).

Attendees' current employment status was also recorded. 20.8% were in part-time employment, 20.8% were in full-time employment, 4.2% worked in the home, 20.8% were unemployed, 25% were students and 4.2% chose other.

4.14.2. 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.

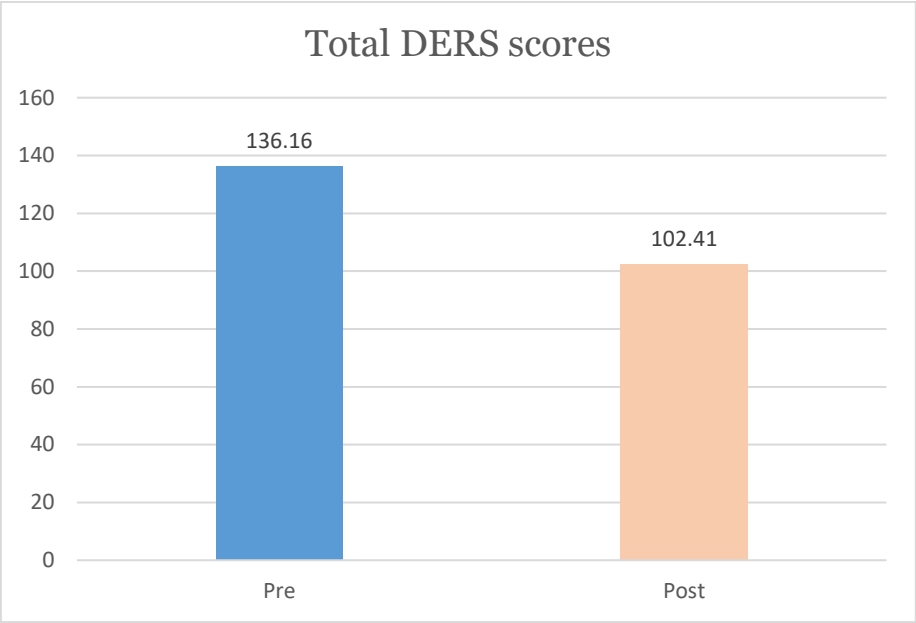
4.14.3. Results

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 136.16 (*SD* = 27.29) on the DERS at

pre-intervention to 102.41 (*SD* = 28.8) post-completion of the programme; $t(23) = 4.73$, $p < 0.05$. This change represented a small - medium effect size (Cohen's $d = 0.49$).

Graph: Difficulties in Emotion Regulation Scale total scores 2022

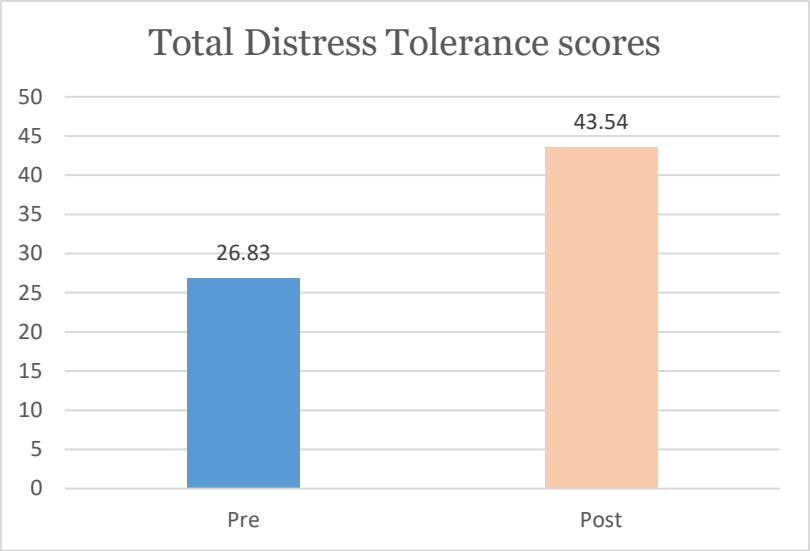


Note: Higher scores indicate greater difficulties with emotional regulation

Distress Tolerance Scale

Participants who completed the DBT programme demonstrated a significant increase in their ability to tolerate distress, moving from a mean total score of 26.83 (*SD* = 8.5) before the programme to 43.54 (*SD* = 13.56) after completing the programme, $t(23) = -6.2$, $p < 0.05$, representing a moderate effect size ($d = -0.63$).

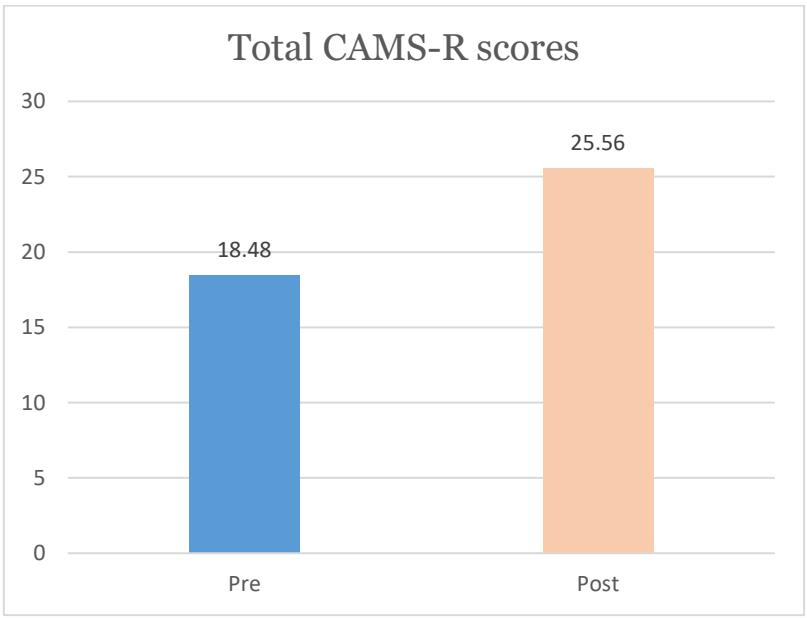
Graph: Distress Tolerance total scores pre and post-intervention



Cognitive and Affective Mindfulness Scale Revised (CAMS-R)

Participants also had greater mindful qualities after completing the programme. Mean scores of 18.48 (*SD* = 4.19) at pre-intervention increased to 25.56 (*SD* = 5.83) at post-intervention. This was a statistically significant change; $t(22) = -6.5$, $p < 0.05$, and represents a moderate effect size ($d = .64$).

Graph: Cognitive and Affective Mindfulness total scores pre and post-intervention



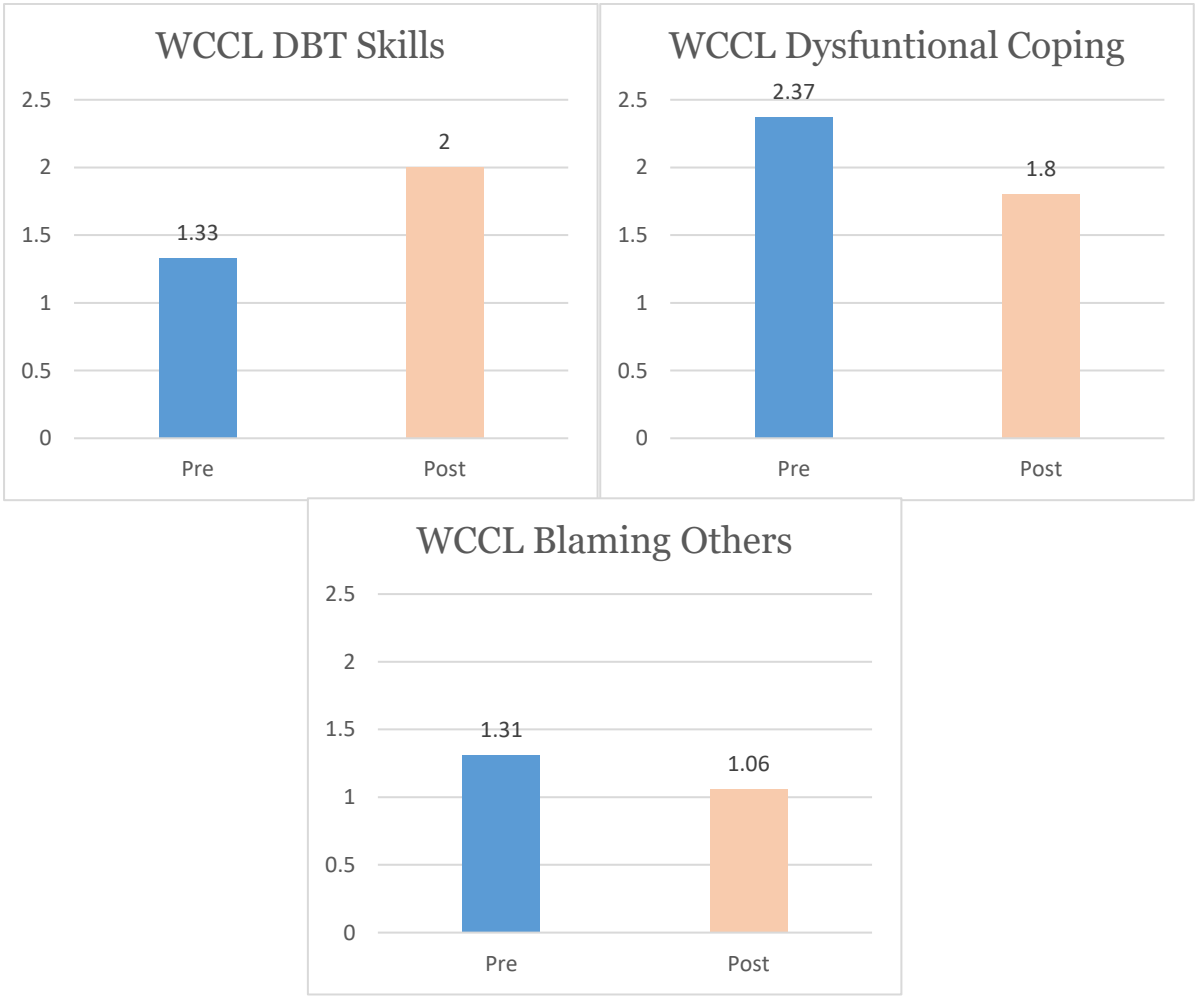
Ways of Coping Checklist (WCCL)

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 1.33 (*SD* = 0.63) at pre-intervention to 2 (*SD* = 0.53) at post-intervention, $t(23) = -6.31$, $p < 0.05$, with a moderate effect size ($d = .63$).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased from 2.37 (*SD* = 0.48) at pre-intervention to 1.8 (*SD* = 0.63) at post-intervention, $t(23) = 4.67$, $p < 0.05$. This represented a small effect size ($d = 0.49$). 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 1.31 (*SD* = 0.95) to 1.06 (*SD*= 0.78) post-intervention. However, this result was not statistically significant. See graphs below for visual representation.

Graph: Ways of Coping Checklist Subscale Scores



4.14.4. DBT Skills Programme

DBT Skills Programme 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 six months). This consists of 24 group sessions. Four cycles ran and completed in 2022, as presented below. *DBT Skills Only* uses the same outcome measures as the comprehensive strand.

4.14.5. Descriptors

Complete pre and post-data was available for 20 participants who completed the DBT Skills Only group in 2022. 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 20, 16 were female, three were male and one was non-binary. The mean age of participants was 35.45 (SD = 12.56), ranging from 18 to 52 years. Their highest level of educational attainment included primary school (5%), junior cert (5%), leaving certificate (25%), third level non-degree qualification (25%), third level degree (5%) and postgraduate qualification (25%). 10% chose 'other' as their highest level of educational attainment.

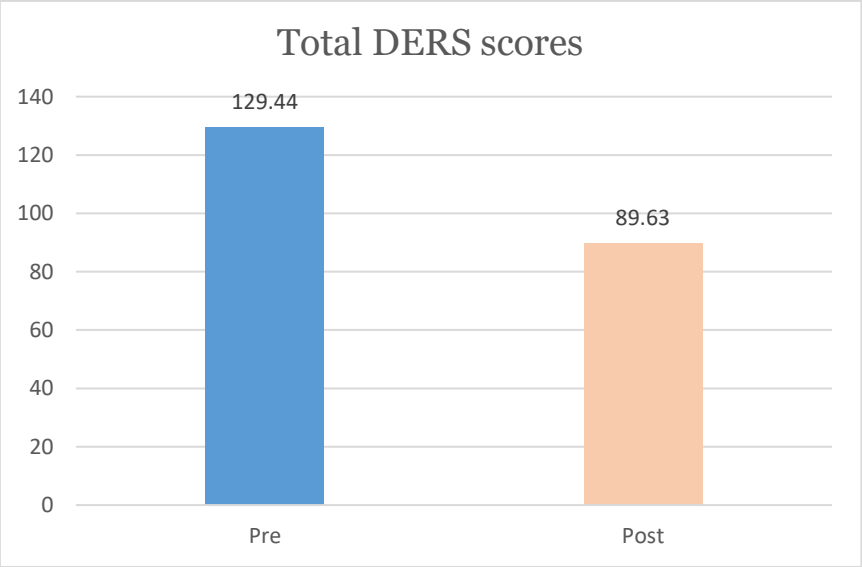
Attendees' current employment status was also recorded. 10% were in part-time employment, 30% were in full-time employment, 25% were unemployed, 10% were retired, 5% were students and 20% chose not to answer.

4.14.6. 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 129.44 (*SD* = 19.16) on the DERS at pre-intervention to 89.63 (*SD* = 23.6) post-completion of the programme; $t(15) = 5.59$, $p < 0.05$. This change represented a medium effect size (Cohen's $d = .68$). See graph below for visual representation.

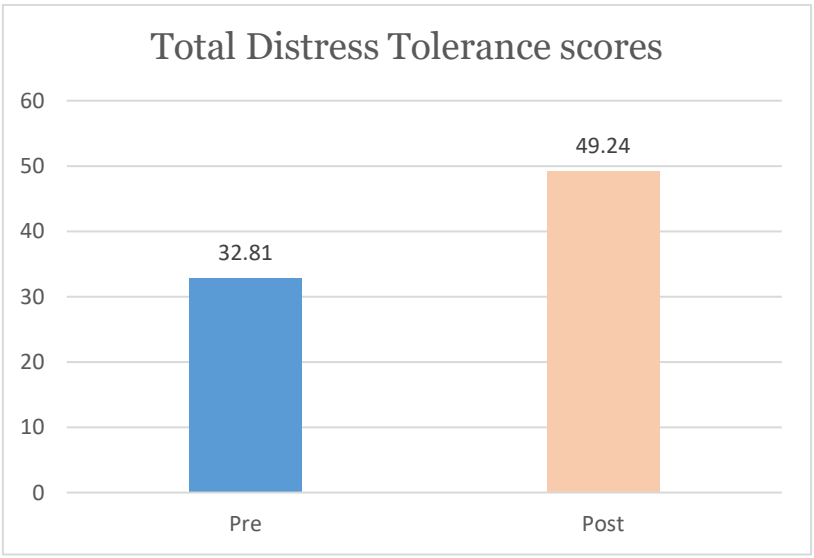
Graph: Difficulties in Emotion Regulation Scale Skills Only 2022



Distress Tolerance Scale (DTS)

Mean scores on the DTS increased following engagement in the group, from 32.81 (*SD* = 10.83) at pre-intervention to 49.24 (*SD* = 10.44) at post-intervention. This increase in overall ability to tolerate distress was statistically significant, $t(19) = -4.41$, $p > 0.05$, with a medium effect size of .51.

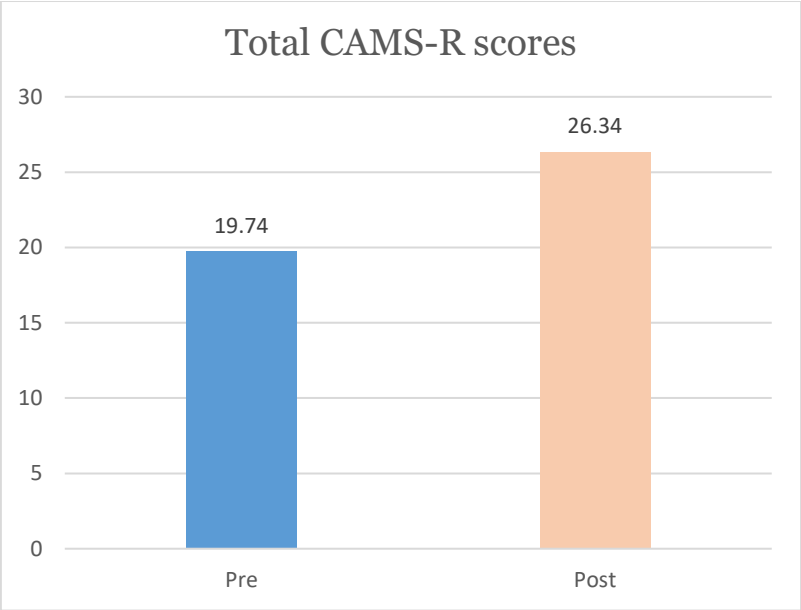
Graph: Distress Tolerance total scores Skills Group



Cognitive and Affective Mindfulness Scale revised (CAMS-R)

Participants also had greater mindful qualities after completing the skills only programme. Mean scores of 19.74 (*SD* = 3.23) at pre-intervention increased to 26.34 (*SD* = 4.30) at post-intervention. This was a statistically significant change; $t(19) = -6.3$, $p < 0.001$, and represents a medium effect size ($d = .69$).

Graph: Cognitive and Affective Mindfulness total scores pre and post-intervention



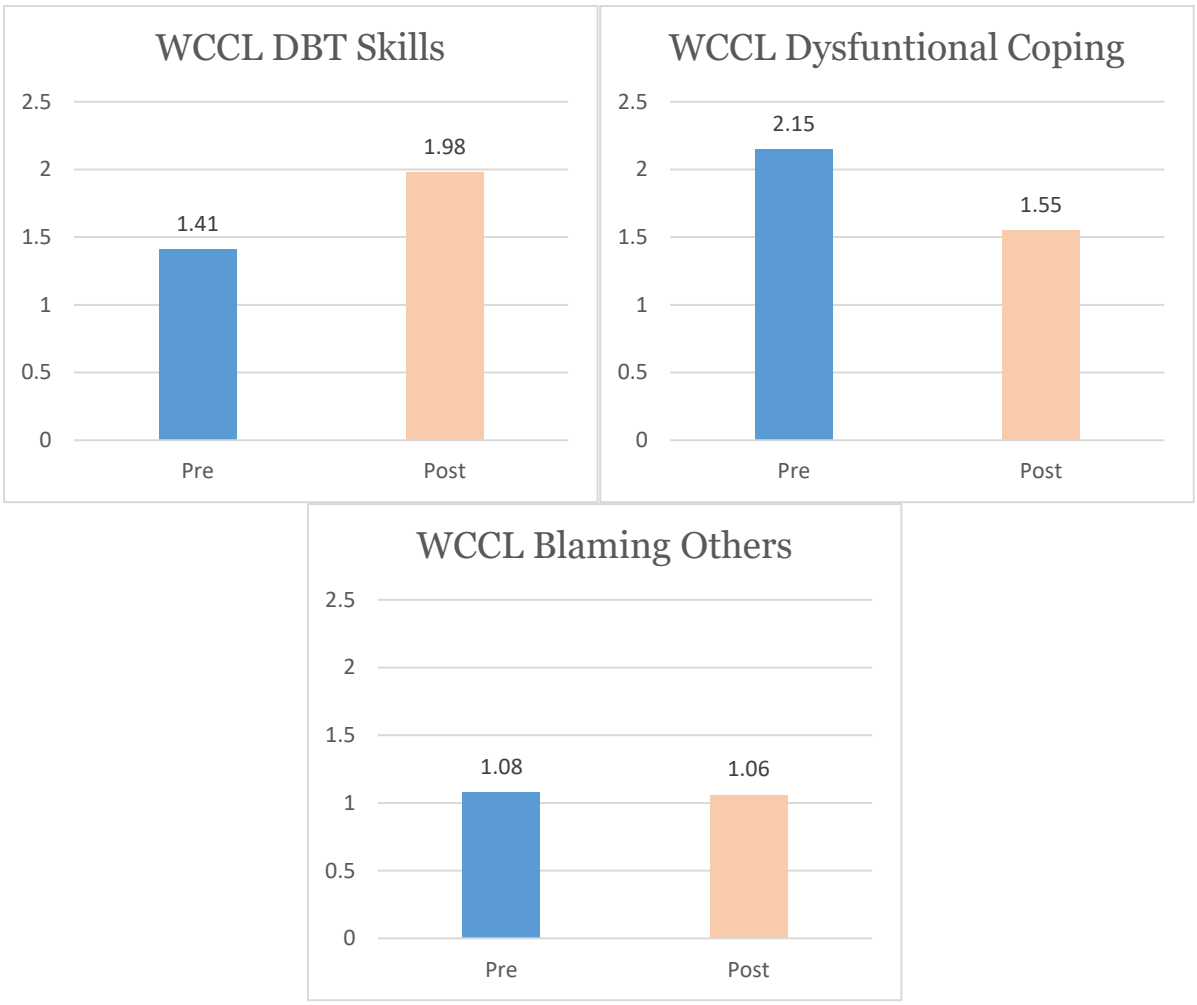
Ways of Coping Checklist (WCCL)

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 1.41 (*SD* = 0.46) at pre-intervention to 1.98 (*SD* = 0.53) at post-intervention, $t(19) = -6.35$, $p < 0.05$, with a moderate effect size ($d = .68$).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased from 2.15 (*SD* = 0.38) at pre-intervention to 1.55 (*SD* = 0.61) at post-intervention, $t(19) = 5.04$, $p < 0.05$. This represented a medium effect size ($d = 0.57$). 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 1.08 (*SD* = 0.53) to 1.06 (*SD*= 0.54) post-intervention. However, this result was not statistically significant. See graphs below for visual representation.

Graph: Ways of Coping checklist subscale scores



4.14.7. 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 mostly medium effect sizes for significant results.

4.15. 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 2022, 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.

To further develop the LTP programme, the team will be commencing two research projects in 2023. The first project is relatively brief. It encompasses an attitudinal survey of both MDT members and service users (who have not done LTP before) towards LTP. Historically within SPMHS, LTP has received a relatively small number of referrals compared with other psychology programmes, and this survey aims to shed light on why that may be, by identifying any blocks that MDT members might have in relation to referring service users to LTP, and any blocks that service users might have surrounding participating in LTP. The survey will also highlight general attitudes towards LTP, to potentially illuminate what is working well, and what needs to be further developed. The second project encompasses the introduction of structured formulation within LTP. Generally, formulation involves uncovering the links between life experiences, biological impacts, environmental factors, self-concept, and coping strategies—and how these links contribute to psychological distress. Some formulation work has been undertaken in the last several cycles of LTP and service users have generally responded very well to this in our clinical opinion; however, the existing use of formulation has been unstructured in that a clear map for how the formulation develops across the programme has not been followed. This project therefore entails

both introducing and evaluating (qualitatively) structured formulation on the LTP programme, with the first priorities pertaining to its acceptability, safeness, and further modifications based on initial feedback. This is quite an extensive piece of research that could take around 18 months to 24 months.

Additionally, in response to the small referral numbers and for continuous professional development the LTP team organized for Anne Cooke from Canterbury Christ Church University author of 'Understanding Psychosis and Schizophrenia' to provide a day training to the Psychology Department. The LTP team also received further training from Dr Charlie Heriot Maitland an extremely well renowned psychologist in the field of CFT for psychosis.

Results from outcome analysis on the LTP Level 1 group are described below for the three cycles of LTP that finished in 2022. The first group of the year continued to be delivered remotely via MS Teams in 2022 due to national public health restrictions. LTP switched to a hybrid model of in-person with service users who needed to access the group remotely being facilitated by using screens to accommodate service users' preferences. The LTP team collected qualitative feedback on the hybrid therapy model which is also presented below.

4.15.1. Descriptors

17 individuals completed the LTP programme in 2022, across three cycles. Pre and post self-report data was available for nine out of those 17 (53% rate of return). Programme attendees ranged in age from 19 to 71 years, with a mean age of 45.05 (SD = 16.43). Of the nine that completed the pre and post measures, three participants were male, and six 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.

4.15.2. 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.

- **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.

- **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 zero – 'strongly disagree', to six – 'strongly agree'. Total scale scores range from zero 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 zero – '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).

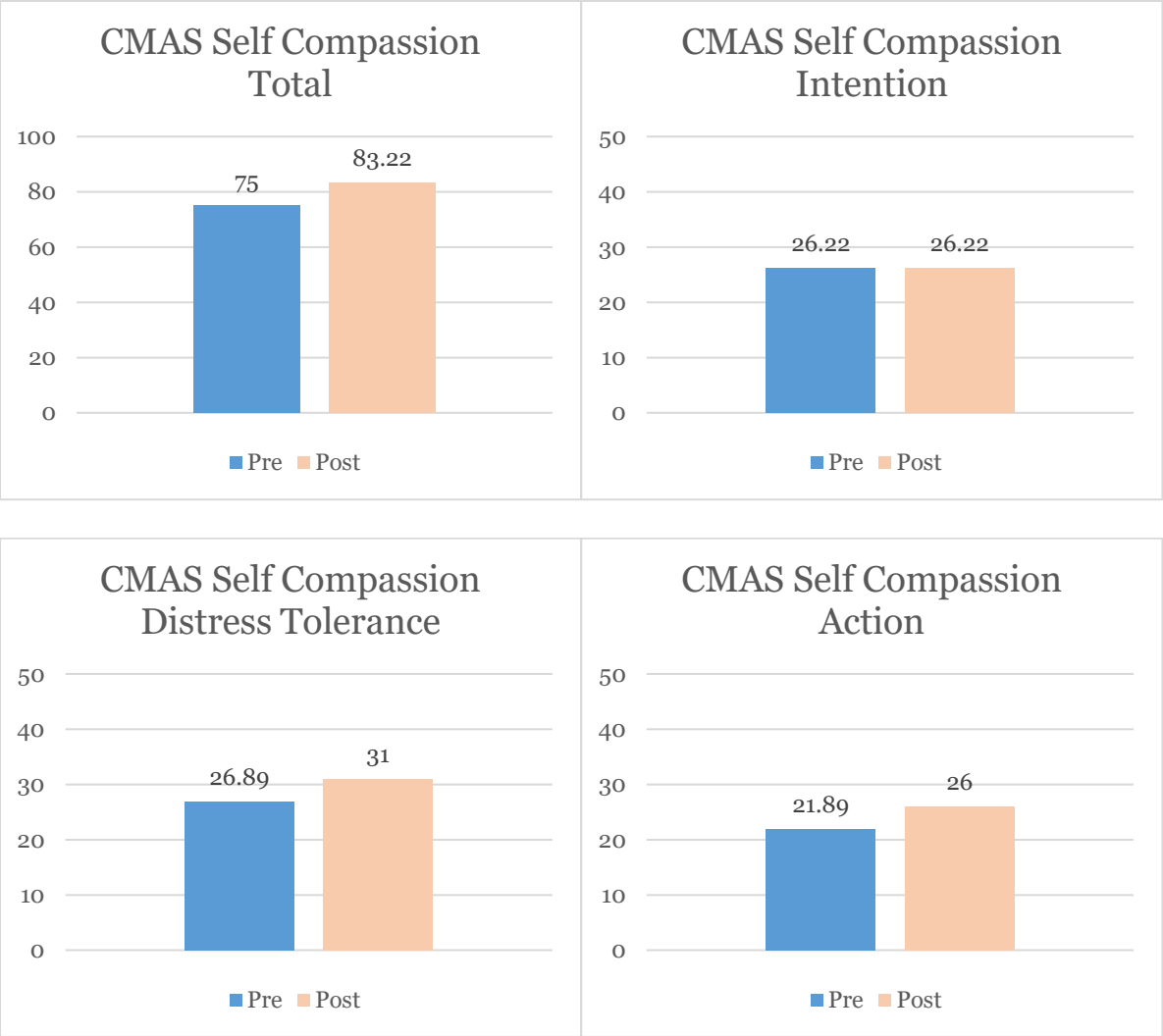
4.15.3. Results

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

Mean scores on the CMAS Self Compassion Scale demonstrated a statistically significant increase from 75 (*SD* = 8.49) pre intervention to 83.22 (*SD* = 7.76) following engagement in the programme, $t(8) = -3.54$, $p < .05$. This indicates that service users who completed the LTP programme had more compassion for themselves, having taken part in the group.

The three subscales within the Self Compassion Scale were analysed. The compassionate intention subscale mean score showed no change and remained at 26.22 from pre to post-intervention. The distress tolerance subscale mean score did significantly increase however from 26.89 (*SD* = 5.04) to 31 (*SD* = 3.94), $t(8) = -2.43$, $p < .05$. Similarly, the compassionate action subscale mean score increased from 21.89 (*SD* = 4.65) to 26 (*SD* = 4.61), which was again statistically significant, $t(8) = -2.55$, $p < .05$.

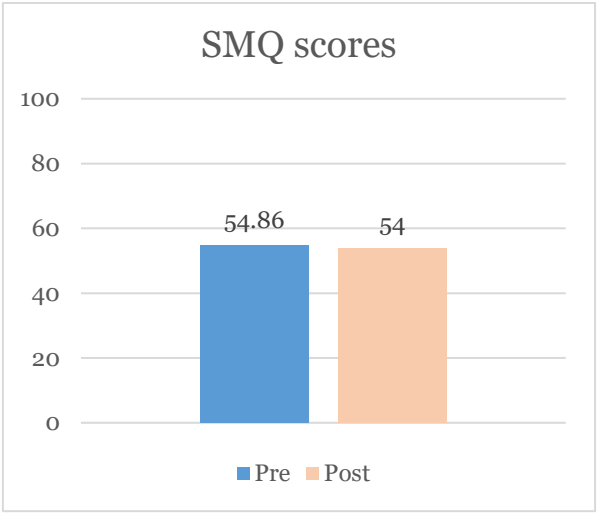
Graph: CMAS Total and Subscale Scores



Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ indicated that individuals' tendency to mindfully respond to distressing thoughts and images. Higher scores on this measure indicate greater mindful awareness. Service users demonstrated a mean score of 54.86 (*SD* = 8.9) at pre-intervention and a mean score of 54 (*SD* = 8.58) following the intervention, with no significant difference found between pre and post scores.

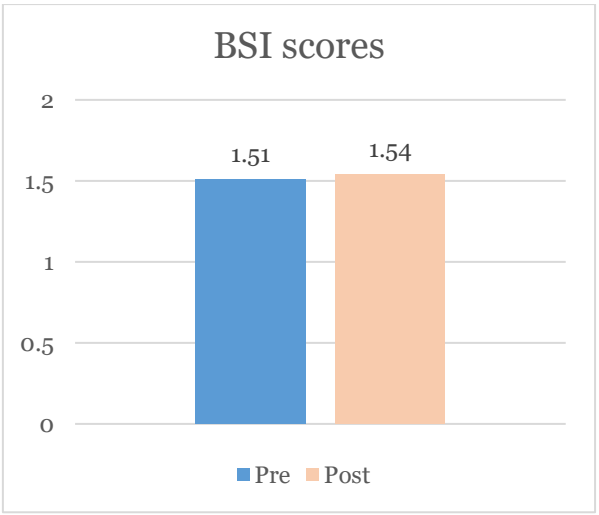
Graph: Southampton Mindfulness Questionnaire scores



The Brief Symptom Inventory (BSI)

Global distress levels as measured by the BSI Global Index score demonstrated a very small increase following the intervention. The mean score of 1.51 (*SD* = 0.46) pre-intervention remained relatively unchanged at 1.54 (*SD* = 0.3) post-intervention. This difference was not statistically significant; $z = -1.6$, $p > 0.05$.

Graph: The Brief Symptom Inventory scores

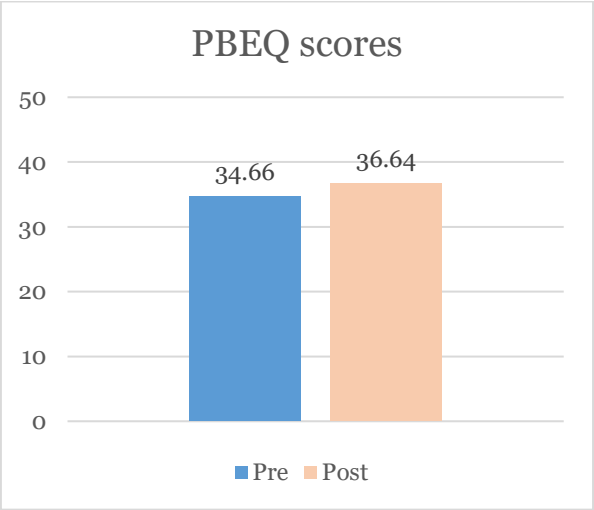


The Personal Beliefs about Experiences Questionnaire (PBEQ)

Mean scores on the PBEQ increased slightly following engagement with the programme. The mean score beforehand was 34.66 (*SD* = 3.29), this increased to 36.64 (*SD* = 3.26) at post-intervention. This increase in score reflects a slight increase

in negative appraisals of psychotic like experiences, however, this increase was not statistically significant; $t(8) = -2.16$, $p > 0.05$.

Graph: Personal Beliefs about Experiences Questionnaire scores



4.15.3. 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 compassion for the self and others in terms of both motivation and action. It is important to consider the impact of the small sample size when measuring significant change. The LTP team will continue to develop the programme offering during 2023 in order to address the psychological needs of service users with psychosis.

4.16. Mindfulness Programme

The Mindfulness Programme provides eight weekly group training sessions in mindful awareness. The course is offered online and in the evening to accommodate service users unable to attend during the day. 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).

4.16.1. Descriptors

Data was collected on 38 participants: 11 males (22.9%) and 27 females (56.3%). Pre and post data were available for 23 participants. Participants' age ranged from 24 to 66 years old (mean = 47.76 years).

4.16.2. Mindfulness Programme outcome measures

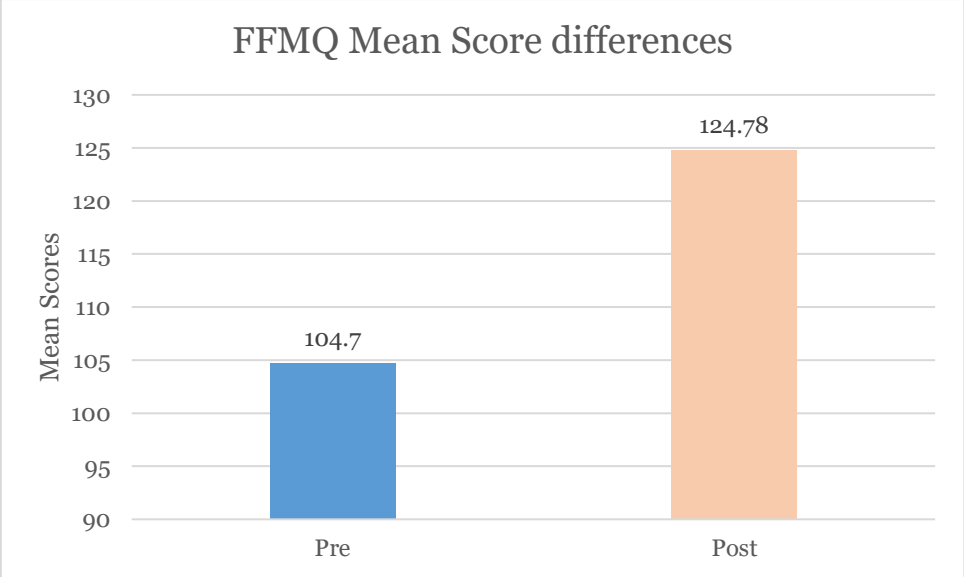
- **Five Facet Mindfulness Questionnaire**

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).

4.16.3. Results

Five Fact Mindfulness Scale (FFMQ)

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



Statistical analysis revealed a significant increase in total scores on the FFMQ from pre-intervention (*M* = 104.70; *SD* = 19.62) to post-intervention (*M* = 124.78; *SD* = 24.46). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (23) = -4.65, p<.001, with a medium effect size (Cohen's d = .50). These results suggest that on average, service users who completed the outcome measures showed an increase in their tendency to be mindful in their daily life.

Statistically significant increases were reported on all subscales. A medium effect size was detected for the 'non- reactivity' scale (Cohen's d = 0.54). A small effect size was yielded for the 'observe' (Cohen's d = .36), 'describe' (Cohen's d = .16), 'awareness' (Cohen's d = .49) and 'non- judgement' (Cohen's d = .30) sub- scale.

Table 1: FFMQ mean scores by subscales, t values and effect size

	Pre	**Post**	***n***	***t***	***df***	***p***	***d***
FFMQ Total	104.70 SD = 19.62	124.78 SD = 24.46	23	-4.65	23	**.000**	.50
Observe	24.35 SD = 6.89	28.30 SD = 5.32	23	-3.54	23	**.002**	.36
Describe	24.00 SD = 7.29	26.82 SD = 7.00	23	-2.08	23	**.050**	.16

Awareness	19.65 SD = 4.63	24.87 SD = 5.68	23	-4.60	23	**.000**	.49
Non-Judgement	20.17 SD = 5.46	24.00 SD = 5.76	23	-3.04	23	**.006**	.30
Non-Reactivity	16.52 SD = 4.66	21.62 SD = 5.05	23	-5.06	23	**.000**	.54

4.16.4. Summary

In line with the 2021 report, results for 2022 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 for the measure overall. Small to medium effect sizes were reported for all subscales.

4.17. Psychology Skills Group for Adolescents

The Psychology Skills Group for Adolescents is an online psychological group therapy that aims to support young people (and their parents) to understand themselves and their difficulties and learn new ways to manage them. The group teaches a range 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 group is comprised of 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.

4.17.1. Descriptors

In 2022, 17 families participated in PSG-A. Of these 17, seven families withdrew from the programme and their data has been excluded due to the absence of time two measures. Their demographic data will be included here for descriptive analyses. Pre and post data were available for 10 families. The average age of young people attending

was 16 years. All 10 of the young people were female. Two of the parents were male and eight of the parents were female.

4.17.2. Changes to Psychology Skills Group for Adolescents outcome measures

During 2022, the decision was made to add the Strengths and Difficulties Questionnaire (SDQ) and Strengths and Difficulties Questionnaire – Parent (SDQ-P) as outcome measures. This was added to measure change in the 'positive' and 'negative' traits that the young people attributed to themselves, and their parents attributed to them.

Difficulties in Emotion Regulation Scale (DERS)

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) was completed by young people before and after taking part in group. The 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 (one = almost never; five = 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 ($\alpha = .93$), 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 (zero = never used; three = 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 (one = not at all important; six = 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).

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 (zero = not at all; six = 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.

Strength and Difficulties Questionnaire (SDQ) and Strength and Difficulties Questionnaire – Parents (SDQ-P)

The Strengths and Difficulties Questionnaire (SDQ) was completed by the young people, while parents completed the Strength and Difficulties Questionnaire – Parents (SDQ-P). This questionnaire is used to assess children's mental health and can be completed by children and young people themselves, by their parents or by their teachers. It can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening. It measures five dimensions: emotional

problems, conduct problems, hyperactivity/inattention problems, peer problems, and prosocial behaviour. Items are measured on a three-point Likert scale (zero = not true; one = somewhat true; two = certainly true). This widely used measure has demonstrated good reliability and validity (Giannakopoulos et al, 2013; Mieloo et al, 2012).

Revised Children's Anxiety and Depression Scale (RCADS)

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire with subscales including: separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood (major depressive disorder). It also yields a Total Anxiety Scale (sum of the five anxiety subscales) and a Total Internalizing Scale (sum of all six subscales). Additionally, the Revised Child Anxiety and Depression Scale – Parent Version (RCADS-P) similarly assesses parent report of youth's symptoms of anxiety and depression across the same six subscales. The RCADS can be used for tracking symptoms as well as providing additional information for assessment. This measure has shown good reliability on subscales and total scale (Chorpita, Moffitt, & Gray, 2005) as well as high validity (Esbjørn et al, 2012; Donnelly, Fitzgeralds, Shevlin, & Dooley, 2017).

SCORE-15

The SCORE-15 is a self-report measure of family functioning and provides rich information about group member's experiences and perspectives on their familial relationships. It consists of 19 items, which are scored on a five-point Likert scale (one = describes us: very well; five = describes us: not at all). The SCORE-15 has been shown to have strong consistency and reliability and can be used to monitor proven indicators of progress in group therapy (Stratton et al, 2013).

Goal Based Outcomes (GBO)

The GBO tool is a way of evaluating progress towards goals in clinical work with children, young people, and their families and carers. The GBO compares how far a child or young person feels they have moved towards reaching a goal that they have set for themselves at the beginning of an intervention, on a 10-point Likert scale (one = goal not at all met; 10 = goal reached). Research on the reliability and validity of this

measure is ongoing but some studies have demonstrated good internal consistency (Edbrooke-Childs et al, 2015).

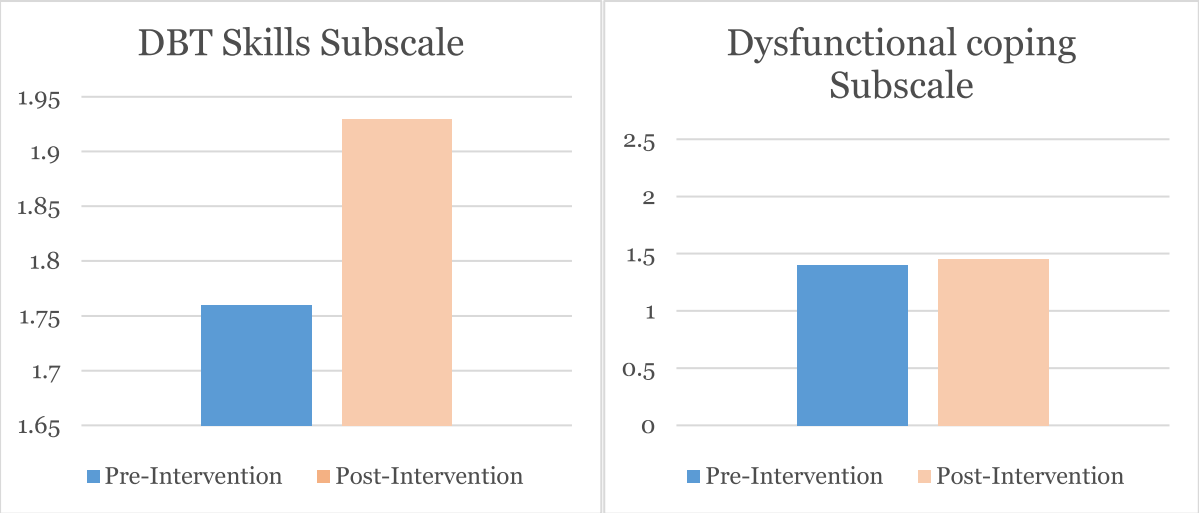
4.17.3. Results

DBT Ways of Coping Checklist (DBTWCCL)

The DBTWCCL was completed by parents and young people. Scores obtained demonstrate that DBT skill use (DSS) increased from pre-intervention to post-intervention. At pre-intervention, parents and young people had a mean DSS score of 1.76. Post-intervention, parents and young people achieved a mean DSS score of 1.93. A paired sample t-test indicated that this increase in effective coping skills was statistically significant change, $t(18) = -2.14$, $p = .04$, with a small effect size of .34.

Scores on the Dysfunctional Coping Skills subscale (DCS) remained relatively the same from pre to post-intervention, with a very slightly increase. At pre-intervention, parents and young people had a mean score of 1.4 on the DCS. At post-intervention, this was 1.45. Paired sample t-tests indicated that this was not a statistically significant change, $t(18) = -.98$, $p = 0.34$.

Graphs: DBT Skills Ways of Coping Subscale scores



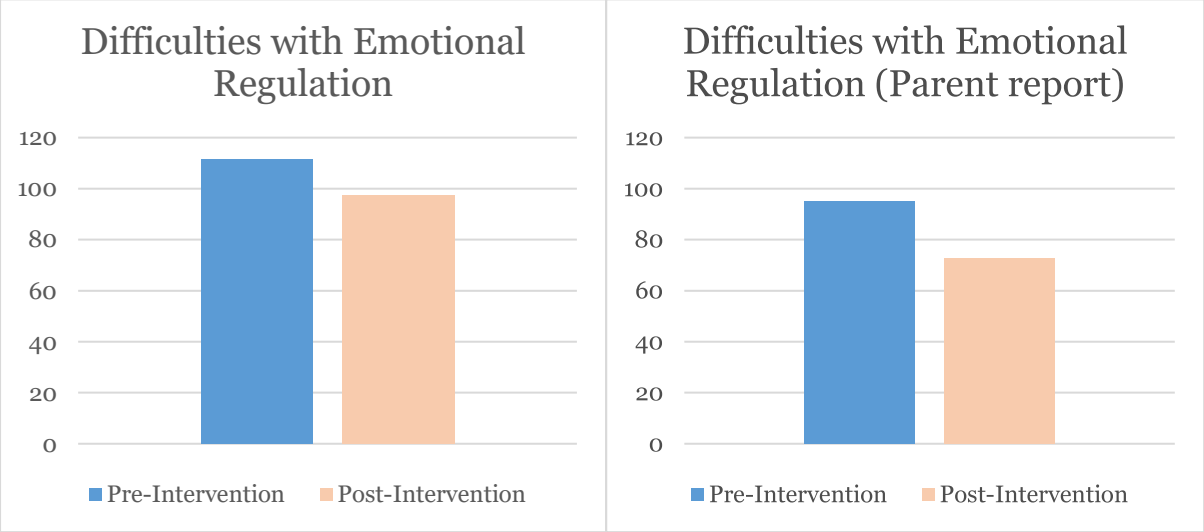
Difficulties in Emotional Regulation (DERS)

The DERS and DERS-P were completed by young people and their parents. Pre and post-intervention data were available for N=10 of the young people. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=111.4, *SD* = 12.65) to post-intervention (M=97.2, *SD* = 18.56). A Wilcoxen Signed Ranks test indicated that this was not statistically significant change, (Z = -1.89, *p* = .06).

Pre and post DERS-P responses were available for four of the parents. Analysis showed that parent's ratings of their child's difficulties with emotional regulation decreased from an average of 95.2 (*SD* = 22.97) to 72.8 (*SD*=10.68). This decrease was also not found to be statistically significant, (Z = -1.84, *p* = .07).

The lack of statistically significant differences found may be due to the small samples used included in the analysis.

Graphs: DERS and DERS-P scores from pre to post-intervention

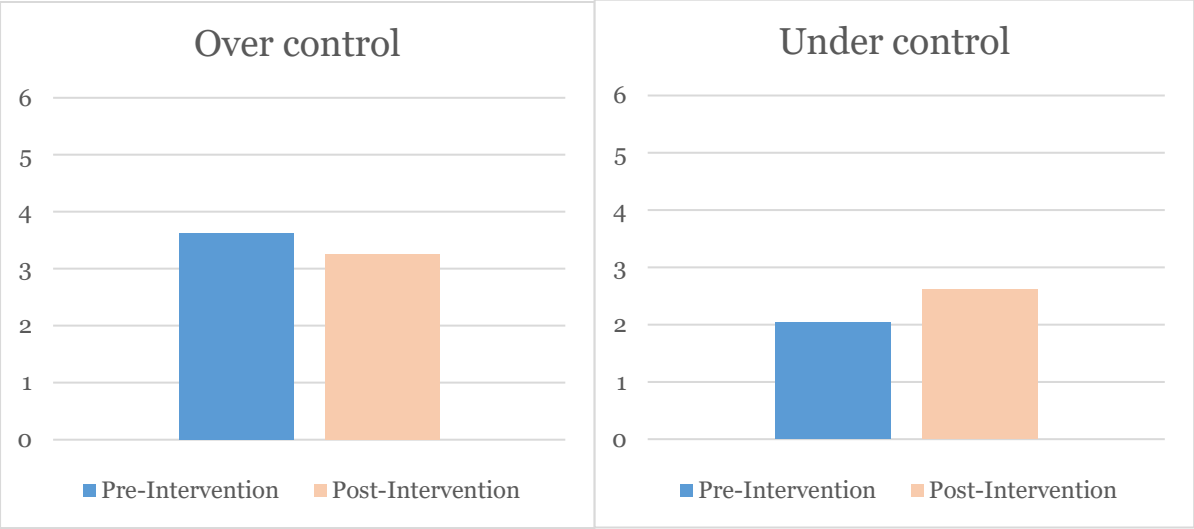


Adolescent Over and Under Control Trait Measure (OUTM)

The Adolescent Over and Under Control Trait Measure (OUTM) is comprised of two subscales, one measuring under control traits and one measuring over control traits. Pre-intervention, the mean under control subscale score was 2.03 (*SD* = 0.49). Post-intervention, this increased slightly to 2.61 (*SD* = 0.98). This increase in under control was found to be statistically significant, *t*(9) = -2.76, *p* =.02, with a small effect size of

Cohen's *d* = .46. Pre-intervention, the mean over control score was 3.62 (*SD* = 0.91). Post-intervention, this fell 3.26 (*SD* = 1.01). However, this difference was not statistically significant; $t(9) = 1.60$, $p > 0.05$. Numerically, these findings suggest over control decreased following engagement in the intervention, while under control actually increased.

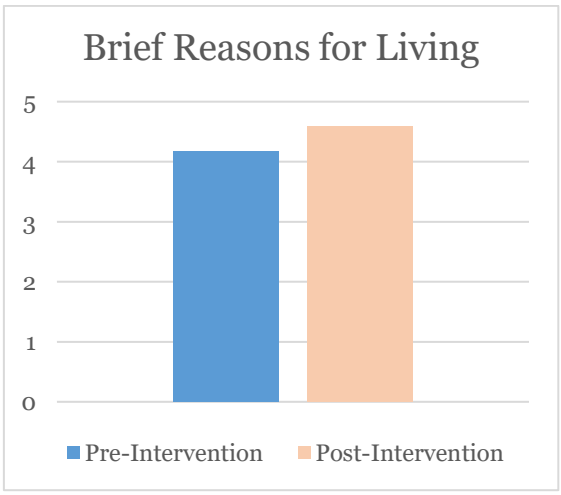
Graphs: over and under control scores from pre to post-intervention.



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

Pre-intervention, the mean BRFLA score was 4.17 (*SD* = 0.89). Post-intervention, this increased to 4.58 (*SD* = 0.98). A paired samples t-test found that this difference was not statistically significant; $t(9) = -1.81$, $p = 0.10$. These findings suggest that following engagement in the intervention, participants had slightly more reasons to live.

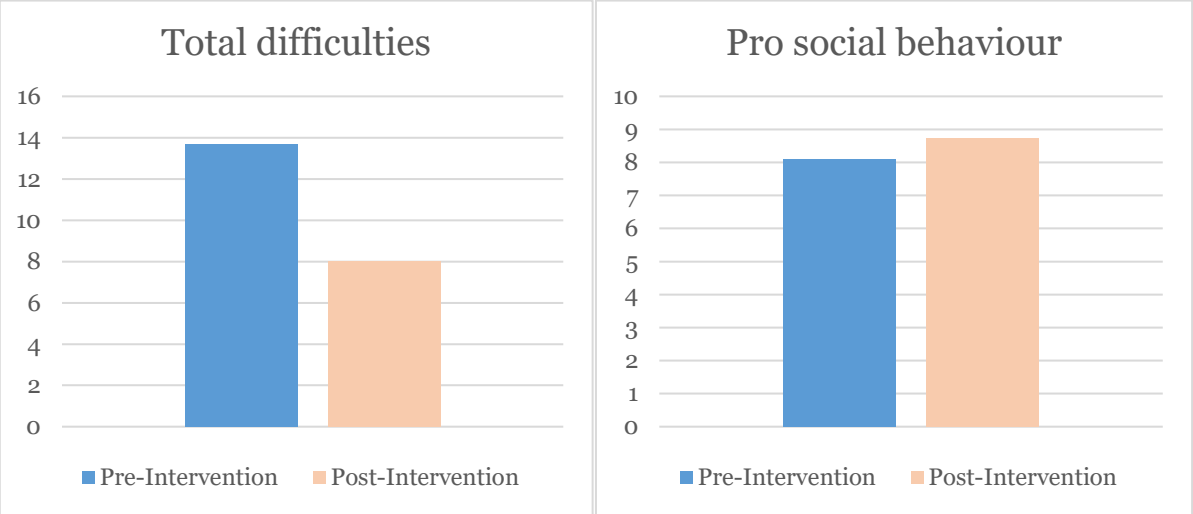
Graph: Brief Reasons for Living pre and post intervention



Strength and Difficulties Questionnaire (SDQ) and Strength and Difficulties Questionnaire – Parents (SDQ-P).

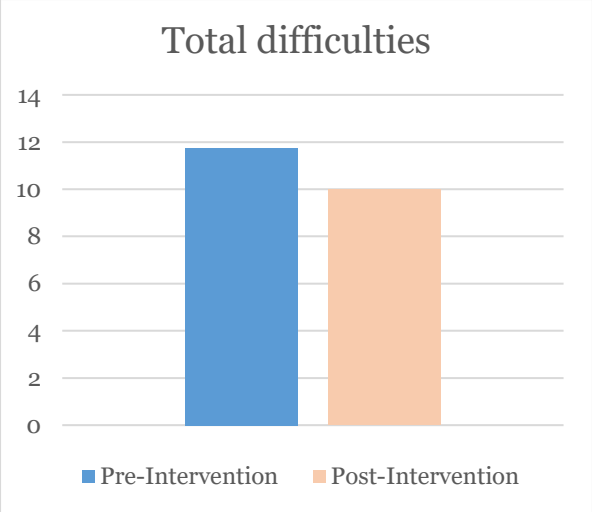
Pre-intervention, the mean total difficulties score was 13.67 (*SD*= 3.51). This fell to eight (*SD* = 1) post intervention. Statistical significance could not be determined due to the small sample size of N=3. Pro-social behaviour was found to increase slightly from a mean of 8.1 (*SD* = 1) to 8.75 (*SD* = .5). However again statistical significance could not be determined due to the small sample size.

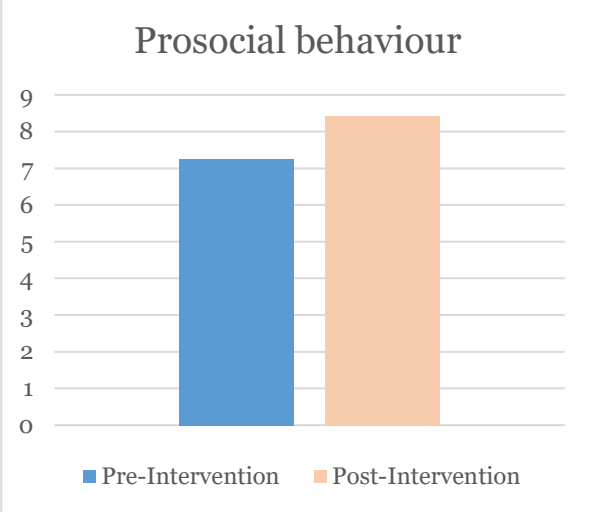
Graphs: SDQ difficulties and strengths (pro-social) pre and post-intervention



This improvement in total difficulties was also reflected in parental reports. Pre-intervention, parents reported a mean of 11.75 (*SD* = 4.79) which then decreased to 10 (*SD* = 3.65) at post-intervention. This decrease was not statistically significant, z = -1.6, p = .11. In terms of pro social behaviour in the young people, as reported by their parents, pre-intervention showed a mean of 7.25 (*SD* = 1.71) which then increased to 8.43 (*SD* = 1.51). However, this increase was not statistically significant, z = -1.63, p > .05).

Graphs: SDQ - Parent report of difficulties and strengths (pro-social) pre and post-intervention

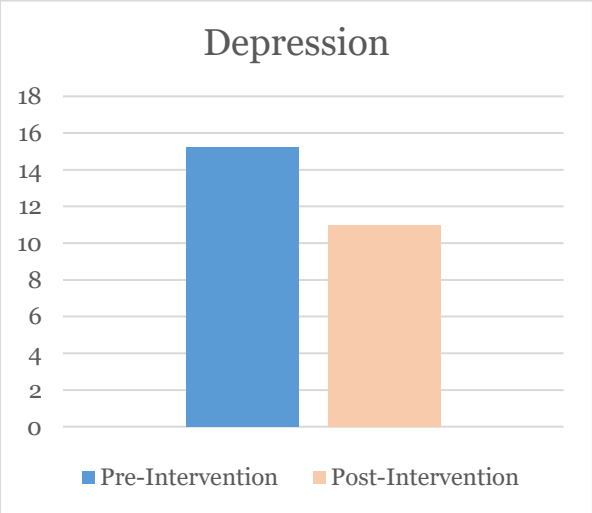


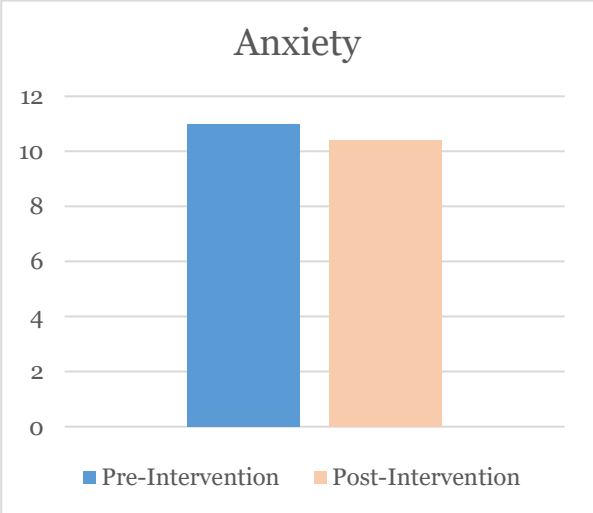


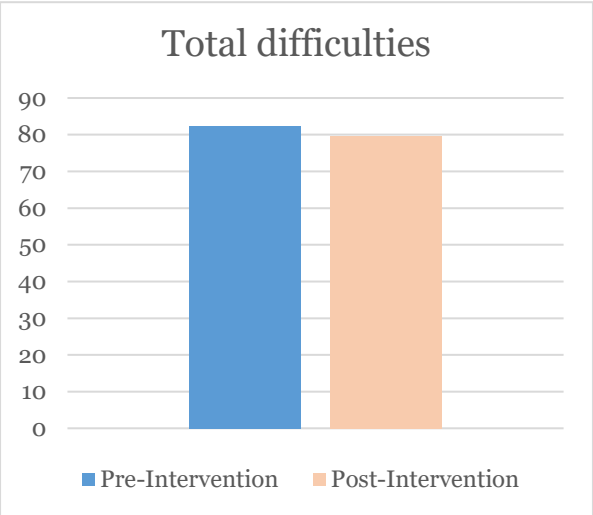
Revised Children's Anxiety and Depression Scale (RCADS)

Scores on the RCADS revealed that rates of depression decreased from a mean of 15.25 (*SD* = 6.90) to 11 (*SD* = 5.03) for the young people who completed PSGA. This decrease was not statistically significant, $t(3) = 1.53$, $p = .22$. Similarly, rates of anxiety, as measured by the RCADS, also showed a non-statistically significant reduction from a mean of 11 (*SD* = 2.92) pre-intervention to 10.4 (*SD* = 3.21) post-intervention. Total scores, comprising all six subscales, also revealed a decrease from a mean of 82.4 (*SD* = 13.53) at pre-intervention to 79.6 (*SD* = 20.45) at post-intervention. This decrease was not statistically significant, $t(4) = .43$, $p = .69$.

Graphs: Anxiety, depression and total scores from pre to post-intervention







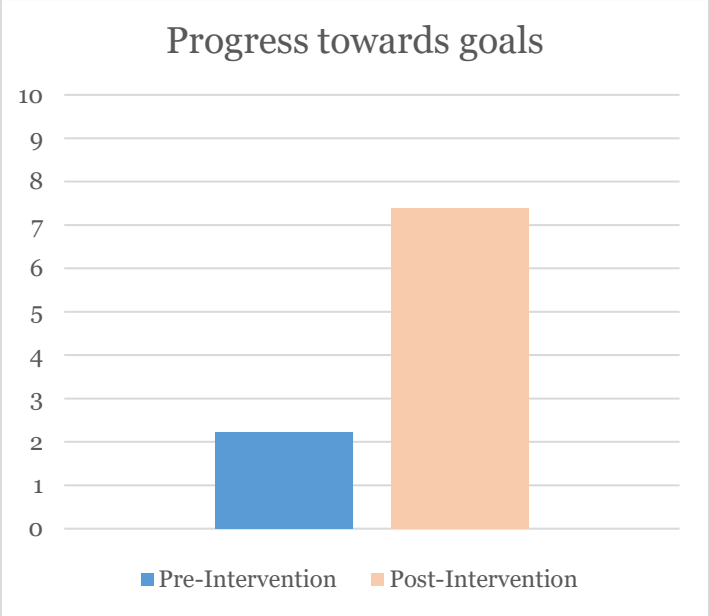
SCORE-15

Both parents and young people were asked to complete the SCORE-15 before and after taking part in the group, as a measure of family functioning. Levels of family functioning reported by young people and parents did not demonstrate significant change from before group (M = 1.69, *SD* = .30) to after group (M = 1.67, *SD* = .35).

Goal-based outcomes

Both parents and young people were asked to complete their goal-based outcomes for goals set out at the beginning of groups. Scores on this outcome reflect how close the young person/parent felt to achieving their goal, with higher scores indicating being closer to achieving that goal. GBO scores increased from a mean of 2.22 out of a possible 10 (*SD* = .79) to 7.39 out of a possible 10 (*SD* = 2.37), with a score of 10 indicating that the goal had been achieved. This increase was found to be statistically significant, $t(5) = -5.13$, $p < .001$. This difference had a large effect size of .84.

Graph: Mean difference in goal-based outcomes from pre to post-intervention



4.17.3. 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. Levels of over control traits decreased following the programme and reasons to live increased. They also reported an increase in their prosocial behaviour and a decrease in their difficulties. Their endorsement in protective factors against harm to themselves also increased following attendance. Rates of depression and anxiety also decreased for those who took part in the programme. Both parents and children who took part in the group reflected significant progress towards their goals, having completed the programme.

4.18. (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 Hospital. It is

a distinct group therapy approach where the service users 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.

Overcontrolled coping patterns are seen as key protective mechanisms that were important and needed at different points in the individual's life but are now costing them. 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 (ie. the overcontrol), leads to much better outcomes for our patients. GRO is offered over a five-month period, twice a week for 12 weeks and then once a week for the final three weeks.

4.18.2. Descriptors

A total of 53 people completed GRO in 2022. Of the 53 people, 33 completed the programme online and 20 completed the group in-person. Pre and post-outcome data were available for 52 people, representing an 98.11% return rate. 51.92% of the participants were female and 48.08% were male. Participant's ages ranged from 18 years to 67 years (M=41.94, SD=12.96).

4.18.1. 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 – Close Relationships Version (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 (Samuel et al, 2012) 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 (Samuel et al, 2012). Additionally, a strong similarity coefficient has been found between the long and short form of the measure. (Griffin, Suzuki, Lyman 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 zero (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 subscales indicate greater comfort with closeness and intimacy (depending on others) in everyday life. Lower scores on the Anxiety subscale 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 & Unterschute, 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)**

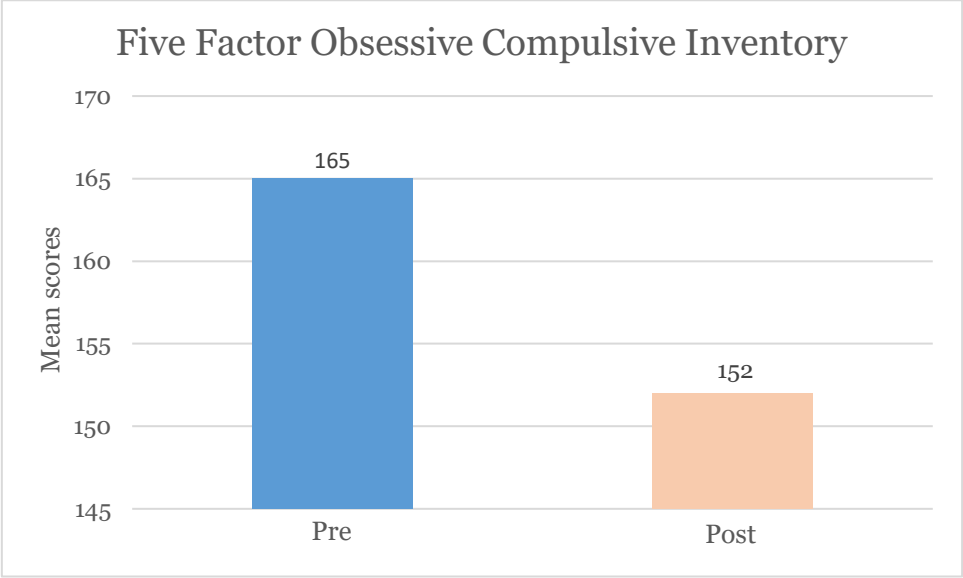
The ERQ (Gross & John, 2003) is a 10-item self-report measure consisting of two subscales: Cognitive Reappraisal and Expressive Suppression. Cognitive Reappraisal describes the process of confronting automatic thoughts and assumptions and reframing them in a more helpful way. Expressive Suppression describes 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).

4.18.3. Results

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

A statistically significant change was observed on the FFOCI-SF, whereby t (41) = 3.46, p<.001, reflecting a small effect size (Cohen's d = 0.57). This suggests that after completing the programme participants were experiencing a reduction in overcontrolled traits associated with OCPD.

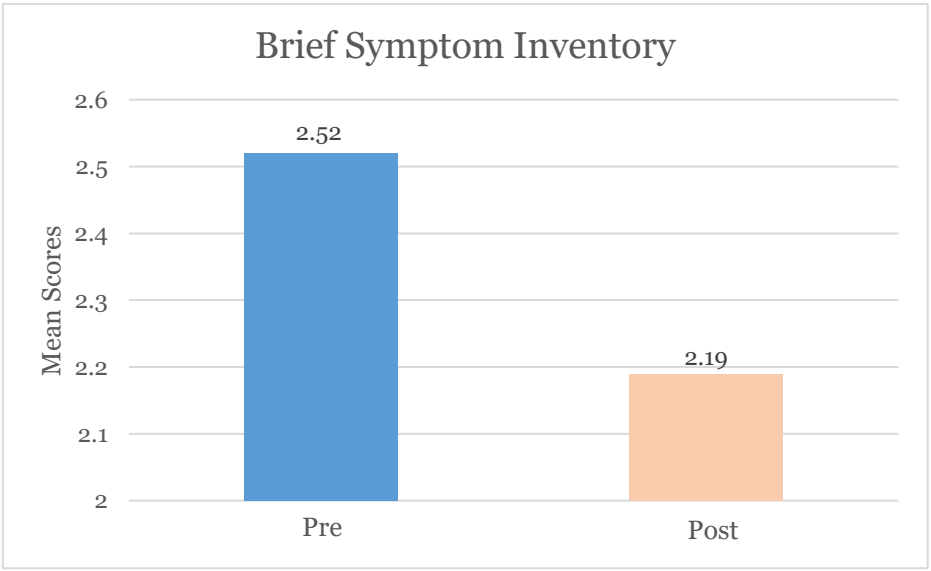
Graph: Five Factor Obsessive Compulsive Inventory – short form. Mean total scores pre and post-intervention



- **Brief symptom Inventory (BSI)**

A statistically 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 (51) = 3.911 =, p<.001, reflecting a medium effect size (*Cohen's d*= 0.555).

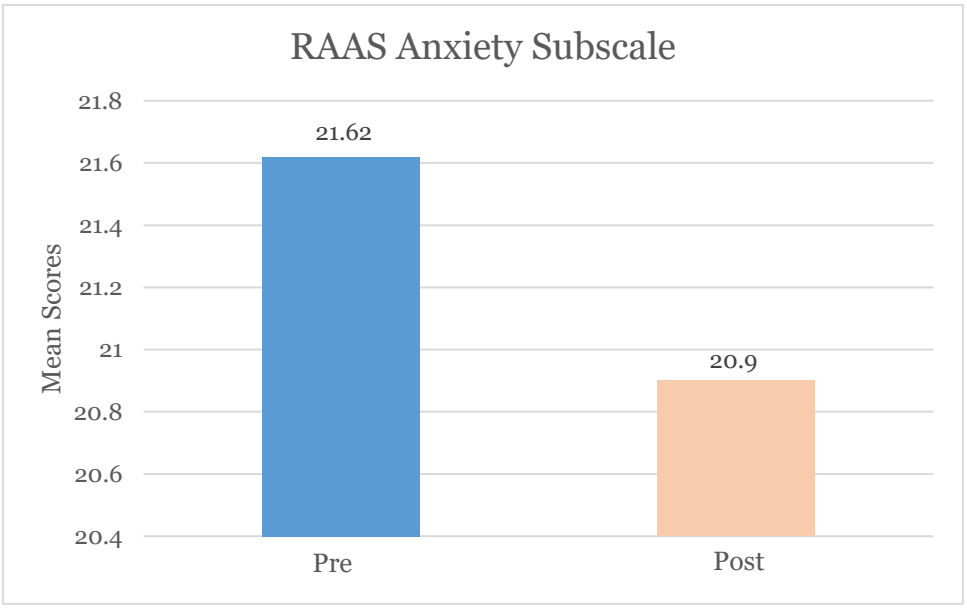
Graph: Brief Symptom Inventory, Global Severity Index (GSI) pre and post- intervention mean comparison

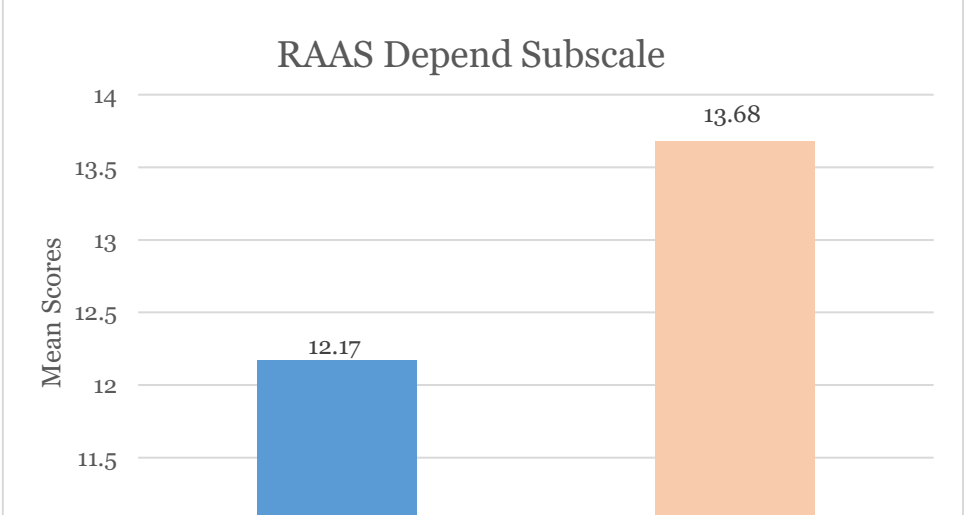


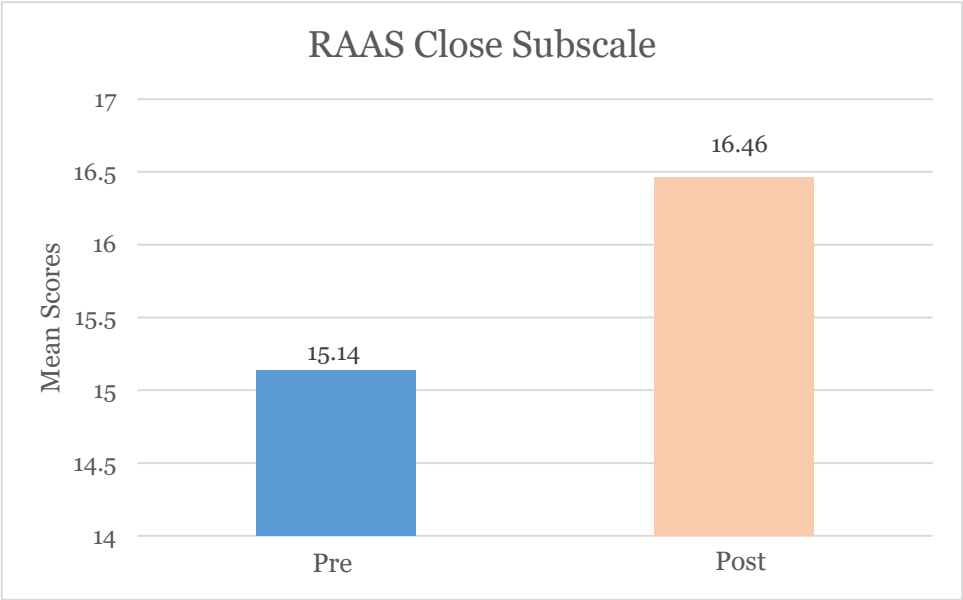
- **Revised Adult Attachment Scale – Close Relationships Version (RAAS)**

The Close subscale measures the extent to which a person is comfortable with closeness and intimacy. The Depend subscale measures the extent to which a person feels they can depend on others to be available when needed. The Anxiety subscale measures the extent to which a person is worried about being rejected or unloved. On the Close subscale, there were no statistically significant differences (t (39) = -1.88, p = .07) pre and post-intervention. On the Depend subscale, there were no statistically significant differences pre and post-intervention (t (40) = -2.25, p = .30). On the Anxiety subscale, there were no statistically significant differences pre and post-intervention (t (51) = 1.13, p = .27). These results indicate that participants did not feel greater closeness or intimacy following completion of the programme, and they did not report feeling less anxiety about being rejected or unloved. However, there was a trend towards improvement on all three subscales post-intervention.

Graphs: Revised Adult Attachment Subscales mean total score pre and post-intervention



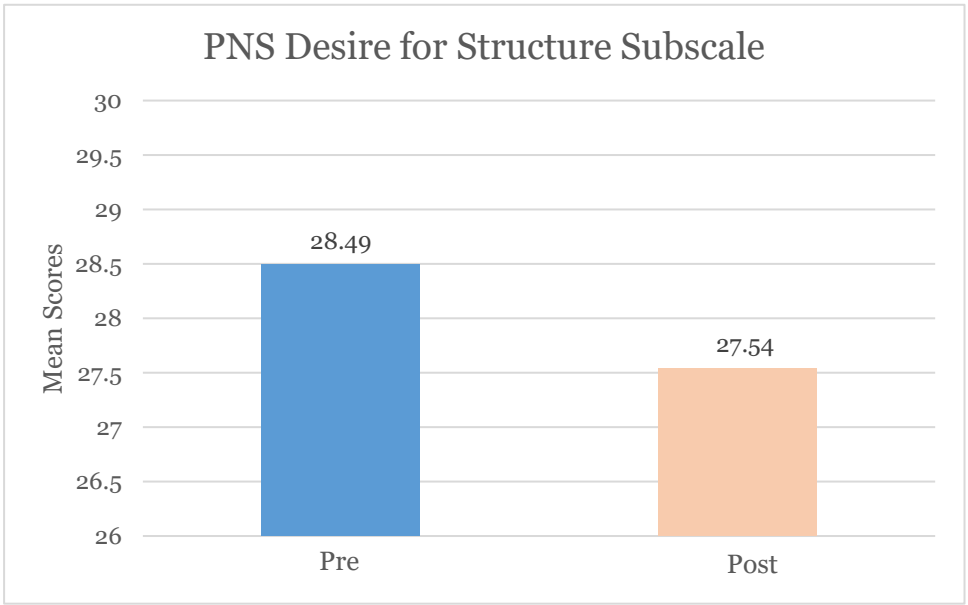




- **Personal Need for Structure Scale (PNS)**

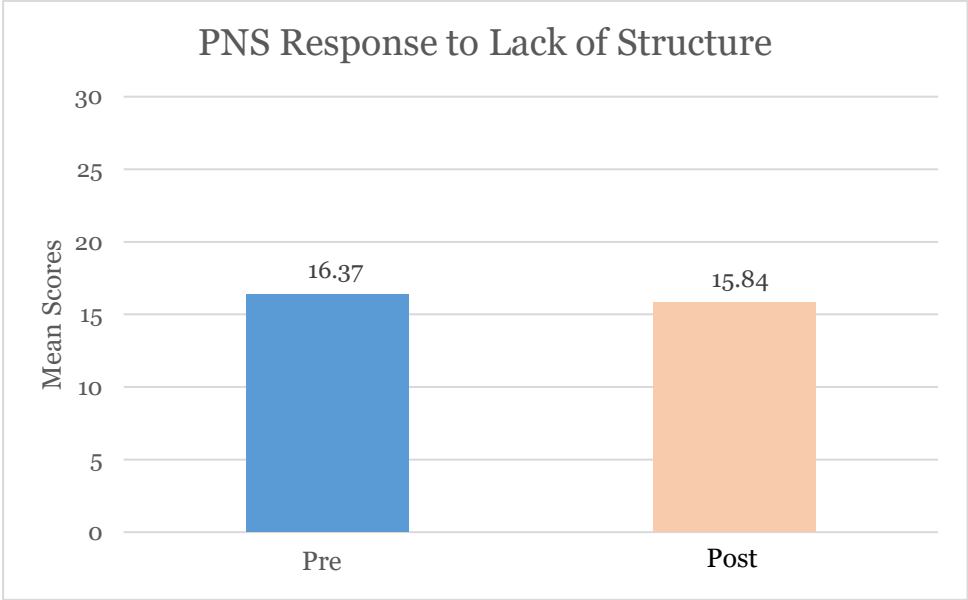
There was no statistically significant difference on the Desire for Structure subscale from pre to post-intervention t (51) = 1.57, p = .122. This indicates that participants' desire for structure in their daily lives did not significantly change after completing the programme.

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



No statistically significant changes were found on the Response to Lack of Structure subscale from pre to post-intervention t (51) = 1.19, p = .240. These findings indicate that participants did not report a change in distress in response to a lack of structure after completing the programme.

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



- **Emotion Regulation Questionnaire (ERQ)**

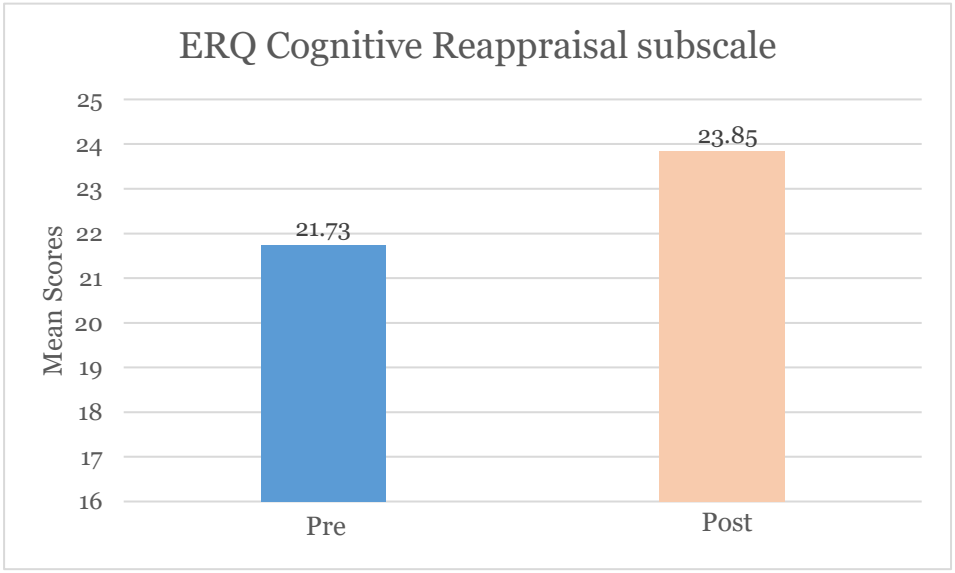
The ERQ consists of two subscales: Cognitive Reappraisal and Expressive Suppression.

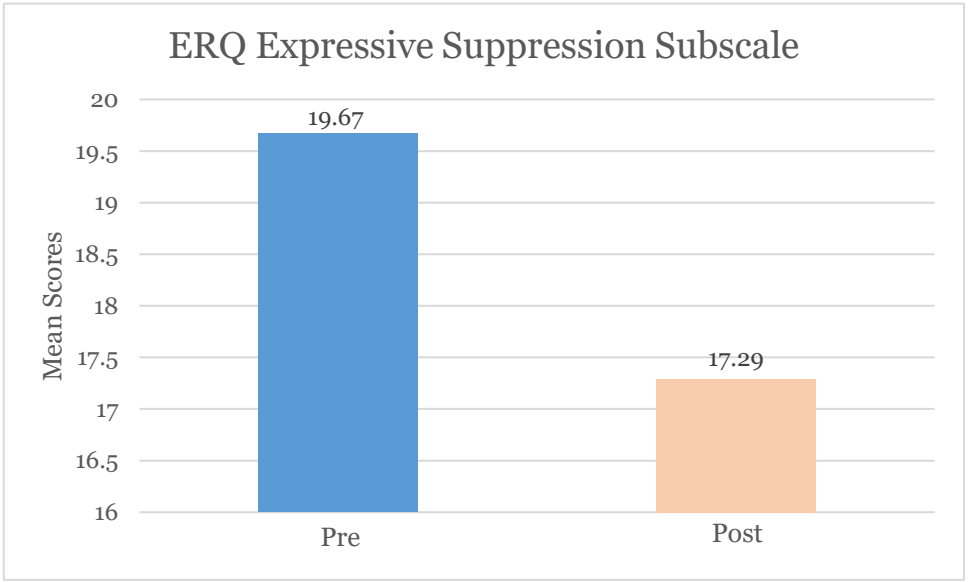
On the Cognitive Reappraisal subscale, there was no significant change pre to post-intervention whereby t (50) = -1.91, p = .061. This suggests that participants did not experience an increase in ability to confront unhelpful cognitions regarding emotions.

On the Expressive Suppression subscale, significant change was observed whereby, t (51) = 2.80, p= .01, with a small effect size (Cohen's d= 0.549). This suggests that

participants reported less suppression of their emotions following completion of the programme.

Graph: Emotion Regulation Questionnaire Subscales mean total scores pre and post-intervention





4.18.4. 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. This is a vital programme for service users who are often underserved in mental healthcare.

In 2022, service users who completed the GRO programme showed significant reductions in overcontrolled traits and reductions in overall psychological distress. Service users also showed significant reductions in their suppression of emotions. While there was no statistically significant change on their reported levels of closeness and intimacy in close relationships, there was a trend towards improvement in these areas. There were no significant changes in their desire for structure and response to lack of structure following completion of the programme.

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

4.19. Psychosis Recovery Programme

The Psychosis Recovery Programme is a 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, pharmacist, art therapist and input from a social work student at specified periods. Of note, art therapy input was only available for a limited period this year from a student art therapist on work experience. Groups for the most part were conducted in person due to the nature of the service user's illness but at times some online sessions were offered online when service users could not access groups due to various covid restrictions. The programme coordinator offered online family education sessions on psychosis when requested to do so.

4.19.1. Psychosis Programme outcome measures

- **Recovery Assessment Scale**

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability and quality of life. The RAS is a 41-item survey rated on a five-point Likert scale from one – 'strongly disagree', to five – 'strongly agree', 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 service user and clinician burden in completion of measures for this programme, which had previously resulted in low response rates.

4.19.3. Descriptors

In 2022, complete pre and post-RAS scores were available for 17 participants. Demographic data is presented for the 31 people who engaged in the programme in 2021. The average age of Psychosis Programme participants was 46.06 (SD = 16.96) years (ranging from 18 to 87 years). 51.61% were female (n = 15) and 48.39% were male (n= 16). 61.8% were single, 11.8% married, 5.9% were cohabiting with a partner and 2.9% were in a non-cohabitating relationship. 35.3% were in employment, 2.9% worked in the home, 23.5% were unemployed, 8.8% were students, 17.6% were receiving disability allowance and 18.8% were retired.

52.9% were living with family, 29.4% were living alone, 2.9% were living with friends and 8.8% were cohabiting.

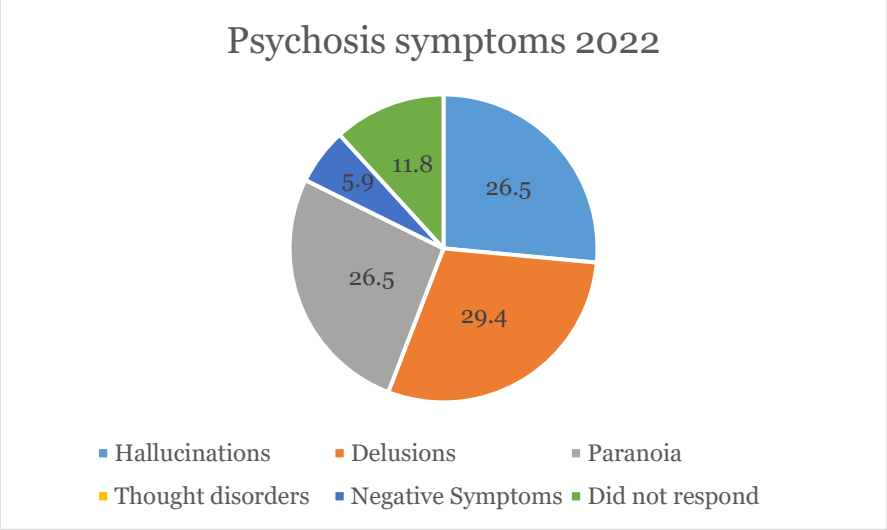
Regards of highest level of education attained indicated that 5.9% had completed the Junior Certificate, 32.4% had completed the Leaving Certificate, 8.8% had a non-

degree third level qualification and 41.2% had a third level degree. 91.2% of service users reported their ethnicity as white Irish, 2.9% as any other white background and 2.9% as any other including mixed race. Comparing 2021 to 2022, service users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

In 2021, there was an increase in service users reporting that delusions were the primary psychosis experience. This has decreased in 2022. There has also been a decrease in the reported primary experience of paranoia and thought disorders. However, there has been an increase in the reported primary experience of hallucinations and negative symptoms. In 2021, the primary reported symptoms were delusions (46.9%) and paranoia (28.1%), followed by hallucinations (15.6%), thought disorders (3.1%) and negative symptoms (3.1%).

In 2022, primary reported symptoms data was available for 30 service users. The primary reported symptoms were delusions (29.4%), paranoia (26.5%), hallucinations (26.5%) and negative symptoms (5.9%). 11.8% of participants did not provide an answer on primary symptoms. See graph below for reported primary psychosis symptoms in 2022. The average attendance at sessions per service user in 2022 was 7.68 (SD = 5.92). Participants are permitted to attend multiple cycles of the programme.

Figure: Primary psychosis symptoms 2022



4.19.4. Results

Recovery Assessment Scale (RAS)

A Wilcoxon Signed Rank test identified a statistically significant difference in mean total scores for the RAS from pre intervention (M = 3,87; SD = .69) to post-intervention (M = 4.31; SD = .40), z = -3.01, p < 0.05 with a large effect size (*r* = -0.73). This indicates that overall, service users experienced an increase in coping ability and quality of life following completion of the programme.

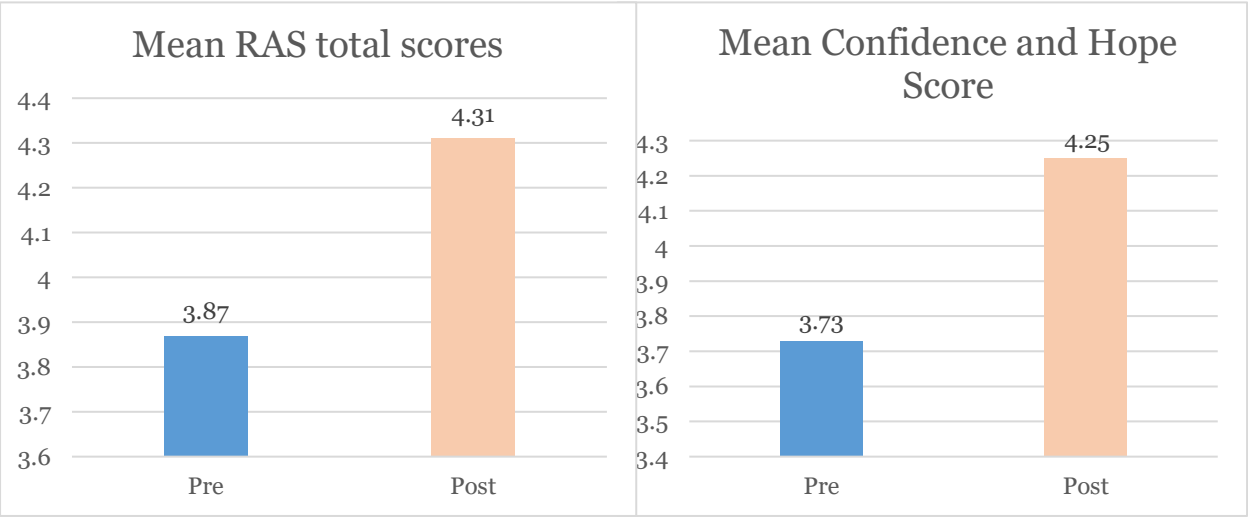
Significantly higher mean scores were identified post-intervention for services users on all RAS subscales bar the ability to rely on others scale. This indicates that participants had increased confidence and hope, had greater abilities to ask for help and could be goal directed. The table and graphs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

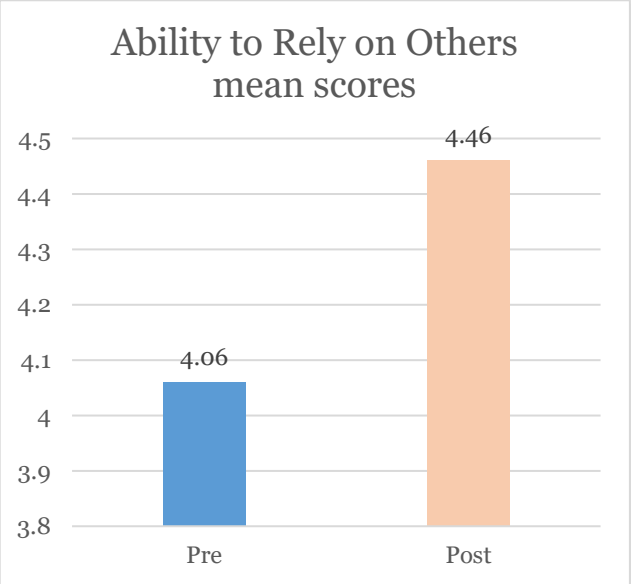
Table: *Results from Wilcoxon Signed Rank tests for the RAS pre and post scores*

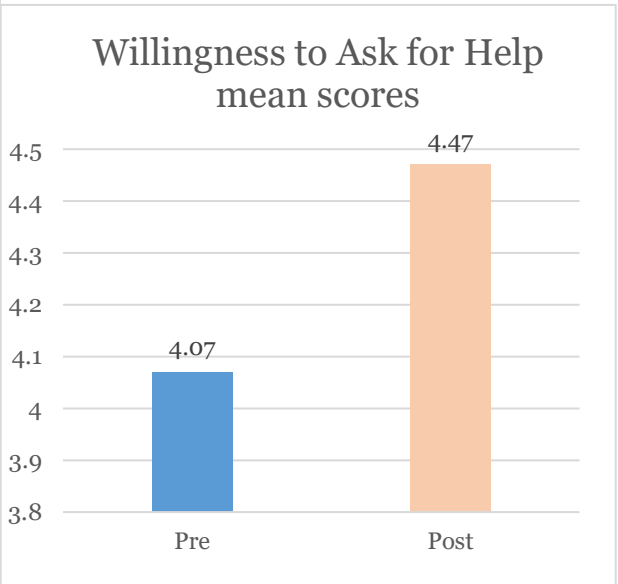
RAS = Recovery Assessment Scale

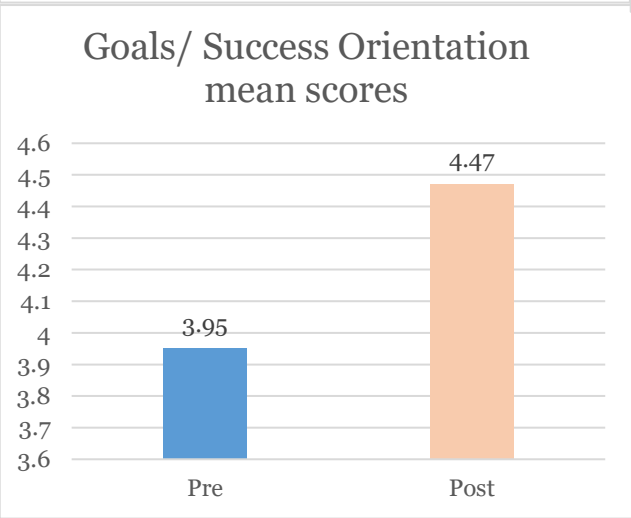
RAS	Pre mean	Post mean	*z*	*p*	*r*
Mean total	3.87	4.31	-3.01	0.03	-0.73
Confidence and hope	3.73	4.25	-2.64	0.008	-0.62
Willingness to ask for help	4.07	4.47	-3.096	.002	-0.71
Goal/success orientation	3.95	4.21	-2.248	0.025	-0.51
Ability to rely on others	4.06	4.46	-1.885	0.059	-0.43
Not dominated by symptoms	4.05	3.82	-2.328	0.020	-0.55

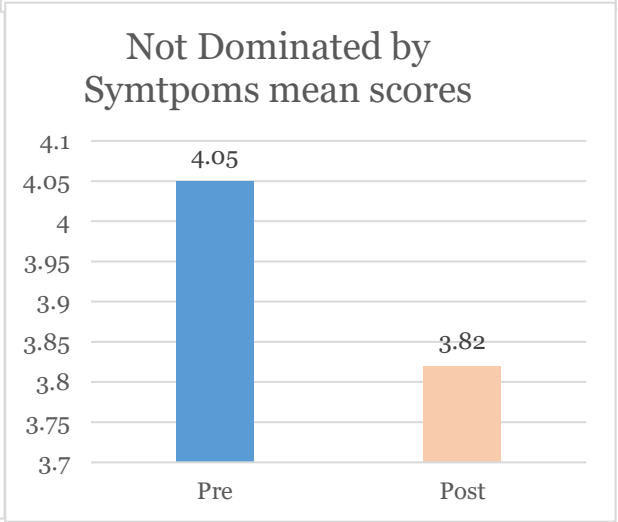
Graphs: Mean total and subscale scores for the RAS







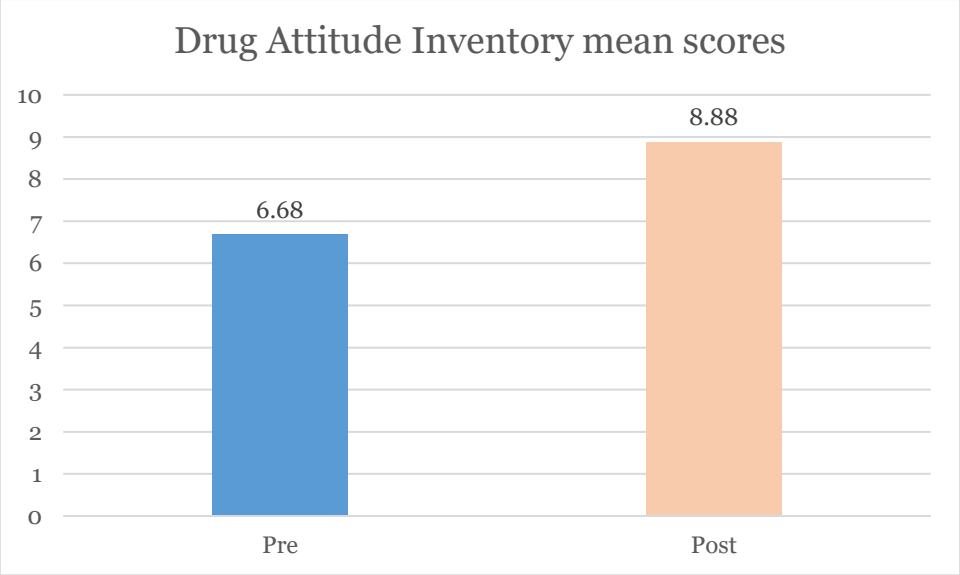




Drug Attitude Inventory (DAI)

Pre and post DAI scores were available for 19 service users. A Wilcoxon Signed Rank test identified an increase in mean scores on the DAI-10 from pre-intervention (M = 6.68, SD= 3.27) to post-intervention (M = 8.00; SD = 2.23); z = -2.97, p < 0.05, demonstrating a large effect size (*r* = -0.68). The mean scores indicate that the majority of service users who completed the measures reported more positive views towards medication after completing the programme.

Graph: Mean Drug Attitude Inventory (DAI) Scores pre and post-intervention



4.19.5. 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.

4.20. The 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. Themes addressed in the programme are difficulties with emotional inhibition, interpersonal aloofness, psychological rigidity and the role they play in maintaining mental health issues.

4.10.1. Descriptors

10 people completed the programme in 2022, five of whom were female (50%). Programme attendees ranged in age from 63 to 81 years old, with a mean of 70.3 (*SD*

= 4.72). Six attendees completed all measures, while four attendees completed all but the Emotional Regulation Questionnaire (ERQ) which was added into the battery starting with cycle 17 and has been continued within the current battery to date. Analysis was conducted using paired samples t-tests and Wilcoxon signed rank tests.

4.20.2. 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 (Lovibond & Lovibond, 1995). Higher scores are indicative of higher levels of depression, anxiety, and/or experienced stress.

Personal Need for Structure Questionnaire (PNS)

The Personal Need for Structure Questionnaire (Thompson et al, 2001) contains 11 items and aims to measure how people respond to new or uncertain situations. High scores are indicative of higher levels of rigidity and need for structure. Lower scores indicate a greater ability to manage novel situations, which in this context is interpreted as evidence of greater flexibility.

The Emotional Control Questionnaire 2 – Emotional Inhibition Subscale (ECQ2-EI) (Roger & Najarian, 1989)

The ECQ-EI (Roger & Najarian, 1989) 14-item subscale aims to measure emotional inhibition by assessing emotional experience and expression. Higher scores are indicative of increased emotional inhibition and suppression.

Revised Adult Attachment Scale (RAAS)

The RAAS (Collins, 1996) is an 18-item measure of relationship attachment. It contains three subscales: closeness, dependence and anxiety. Higher scores on the closeness and dependence subscales indicate greater comfort with closeness and intimacy in everyday life. Lower scores on the anxiety subscale indicate less fear of rejection. In this context, it is used as a measure of intimacy/aloofness in relationships.

Emotional Regulation Questionnaire (ERQ)

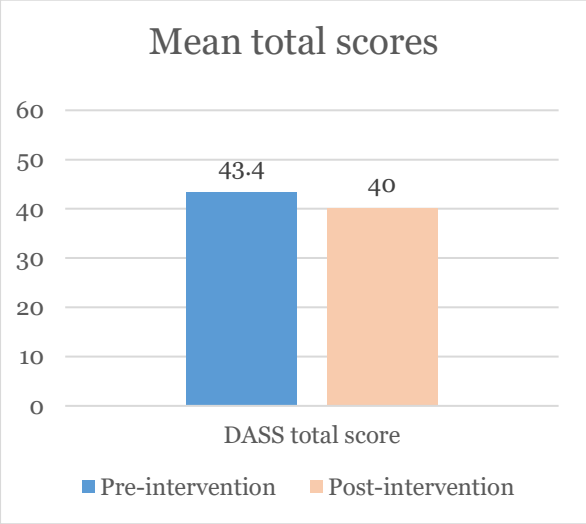
The Emotional Regulation Questionnaire (Gross & John, 2003) is a 10-item self-report measure designed to capture respondents' tendency to regulate their emotions in two ways, either predominantly through cognitive reappraisal or expressive suppression.

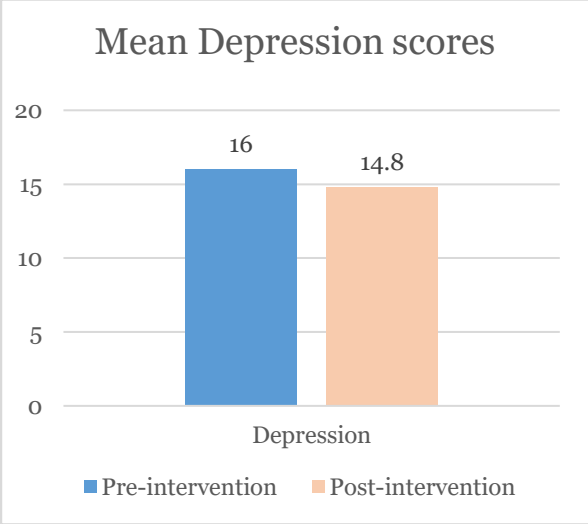
4.20.3. Results

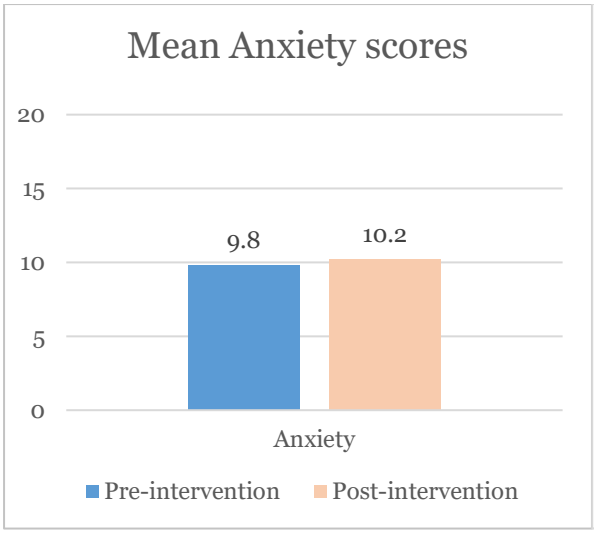
Depression Anxiety and Stress Scale (DASS-21)

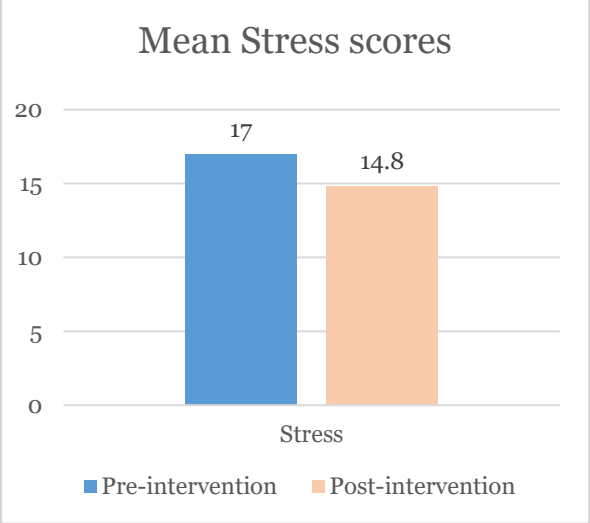
Analysis of the total of the three subscales (Depression, Anxiety and Stress) within the DASS-21 revealed a decrease in psychological difficulties from a pre-intervention mean of 43.4 (*SD* = 24.5) to 40 (*SD* = 31.27) at post-intervention, though this decrease was not statistically significant, $t(9) = .45$, $p = .67$. Scores on the Depression subscale showed a decrease from 16.6 (*SD* = 9.98) to 14.8 (*SD* = 12.3), and on the Stress subscale from 17 (*SD* = 7.96) to 15 (*SD* = 11.44). Neither of these decreases were statistically significant. Scores on the Anxiety subscale increased very slightly from 9.8 (*SD* = 7.69) to 10.2 (*SD* = 7.69) but again this was not statistically significant ($z = -.51$, $p = .61$).

Graphs: Mean scores on the DASS-21 Total score and Subscales





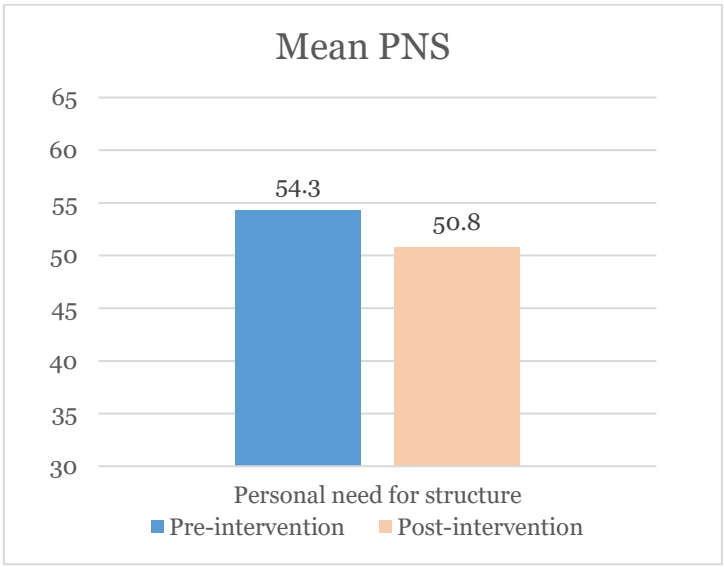




Personal Need for Structure (PNS)

The mean scores on the PNS decreased from 54.3 (*SD* = 6.36) at pre-intervention to 50.8 (*SD* = 8.93) at post-intervention, although this difference was not statistically significant, $t(9) = 1.58$, $p = .15$. Reduction in mean scores can be interpreted as indicating increased psychological flexibility.

Graph: Personal Need for Structure mean score

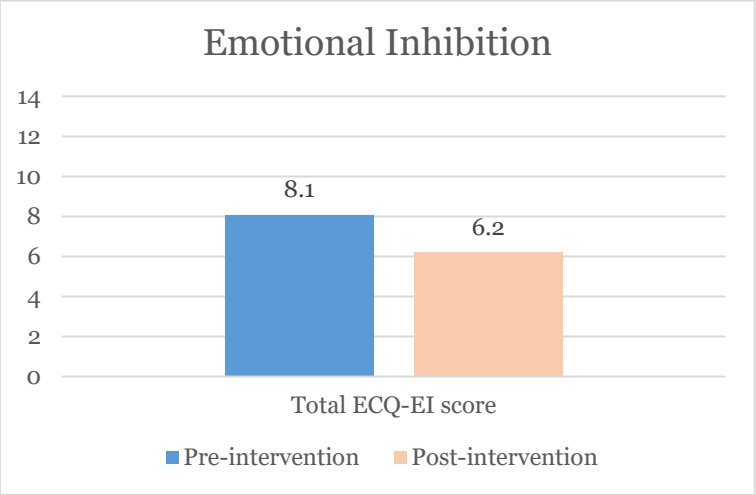


Emotion control questionnaire – Emotional inhibition (ECQ-EI)

The total mean score on the ECQ-EI showed a statistically significant decrease from 8.1 (*SD* = 2.23) at pre-intervention to 6.2 (*SD* = 2.35) at post-intervention, $t(9) = 4.39$,

p = .002. This significant decrease in ECQ-EI scores was interpreted as indicating that participants are reporting less suppression of their emotions and have improved ability to reappraise unhelpful cognitions regarding emotion.

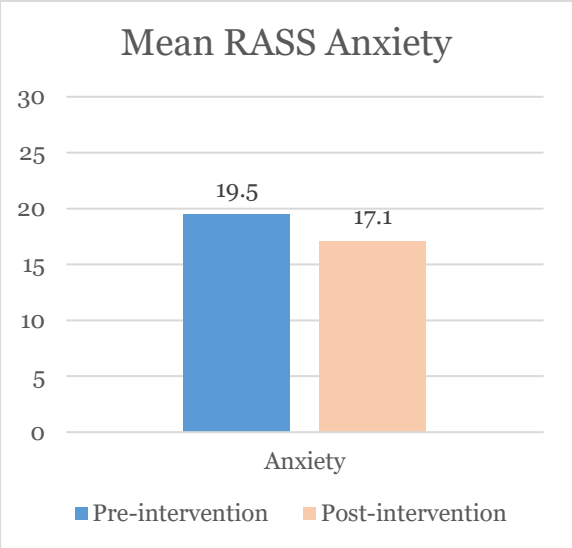
Graph: Emotion control questionnaire – emotional inhibition (ECQ-EI) mean scores

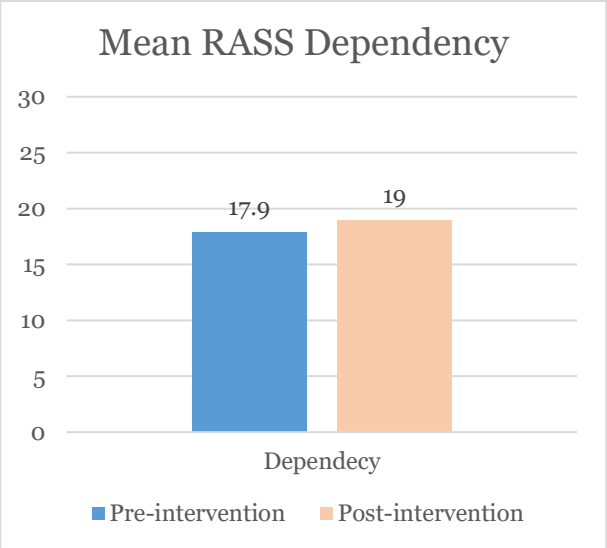


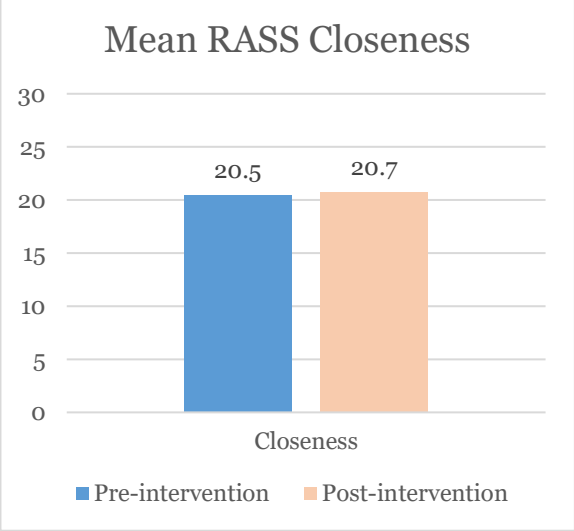
Revised Adult Attachment Scale (RASS)

Mean scores on the Closeness subscale increased very slightly from a mean of 20.5 (*SD* = 5.56) to 20.7 (*SD* = 4.63), although this increase was not statistically significant. Mean scores on the Dependency subscale also increased from a mean of 17.9 (*SD* = 3.98) to 19 (*SD* = 4.69), which was also not significant. This suggests a move towards greater tolerance for being close to and depending on others. Anxiety levels were found to decrease from 19.5 (SD = 4.48) to 17.1 (SD = 4.89) at post-intervention, a difference which was found to be approaching statistical significance, $t(9) = 2.25$, $p = .05$. This suggests that participants' fears about rejection reduced after completing the programme.

Graphs: Mean scores on RASS subscales



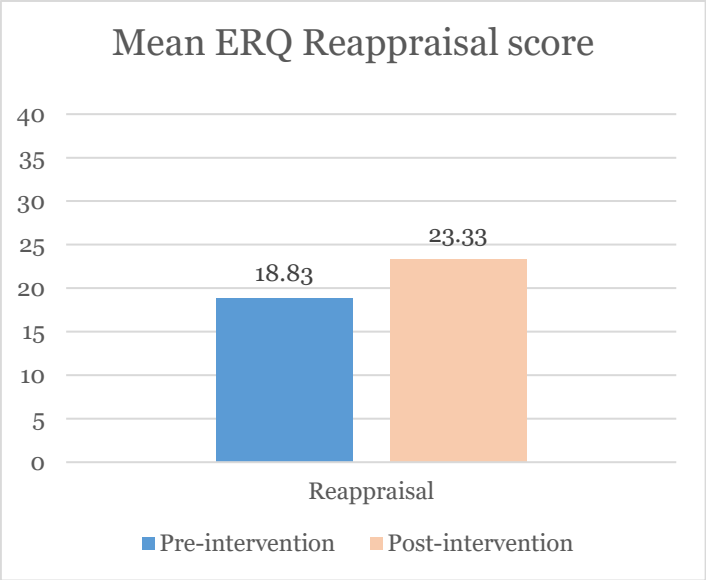


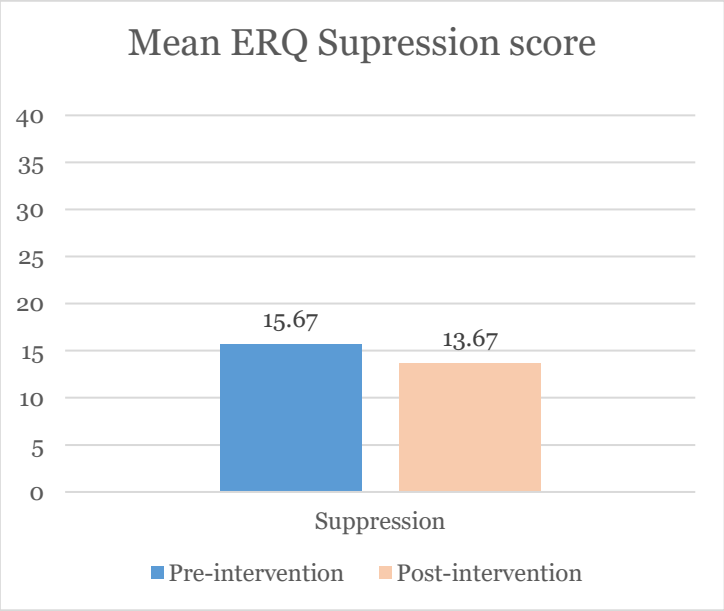


Emotion Regulation Questionnaire (ERQ)

The mean score for reappraisal increased from 18.83 (SD= 3.76) at baseline to 23.33 (SD= 5.16) post-intervention, although this increase was not statistically significant, $t(5) = -1.29$, $p = .25$. This suggests that there was some level of increasingly positive cognitive reappraisal of emotions increased from pre to post-intervention. Expressive suppression, which describes the ability to control or suppress the urge to respond to emotional experiences, decreased from a mean of 15.67 (*SD*= 6.41) to 13.67 (*SD*= 4.18). This decrease was not statistically significant, ($t(5) = .75$, $p = .49$) though the trend suggests a move towards more expression rather than suppression post-intervention.

Graphs: Mean ERQ subscale scores





4.20.4. Summary

Many measures in the battery of outcome measures show trends towards positive changes in the areas targeted by the programme: emotional expression, psychological flexibility and closeness and intimacy in relationships as well as in overall levels of distress as measured by the DASS. It is worth noting that the small sample sizes may influence the lack of statistical significance in the analyses above. Both cycles in 2022 were conducted online via MS Teams because of the ongoing COVID-19 pandemic. The

latest cycle, which began in 2023, has returned to face to face delivery, with the option for occasional hybrid attendance when required.

4.21. Trauma Group Programme

The Trauma Group Programme is a 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 (Herman, 1992). 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. This format of three stages is considered as best practice (Willis, Dowling, O' Reilly, 2023). 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. One cycle of the trauma programme (cycle four) was delivered online via MS Teams. The other cycle (cycle five) was delivered via a mixture of an online and hybrid format [stage one online; stage two hybrid (some people online and some in person) and stage three (online and hybrid). Group participants from cycle five attended stage one online. For stage two, the group chose a hybrid format to facilitate those who could not always attend in person, and for stage three the group chose a mainly face to face group for 10 out of the 12 remaining sessions.

4.21.1. Descriptors

A total of fifteen people who were referred completed cycle four and five of the Trauma Programme in 2022. Fourteen participants returned pre and post-outcome measures. Nine of the participants were female and five were male. Participant's ages ranged from 27 years to 65 years (M= 50.28, SD= 11.68). Pre-treatment completion of the Adverse Childhood Experience (ACEs) indicated that eight out of 14 returned ACEs measures scored above four, with one participant scoring four; two participants scoring five; three participants scoring seven, three participants scoring eight and one participant had an unknown score due to missing data. The higher the ACE score the more at risk the service user is to chronic health problems, mental health difficulties, social difficulties, and substance misuse in adulthood.

4.21.2. 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 zero – '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. 1994). 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, 1998). When used to track symptoms over time, a minimum 10-point change represents clinically significant change.

- **The Dissociative Experiences Scale-Taxon (DES-T)**

The Dissociative Experiences Scale-Taxon (DES-T) (Bernstein and Putnam, 1986) is an eight item self-report subscale of the DES which measures dissociation among clinical populations. Each item is rated from 0-100% which indicates what percentage of time the individual experiences dissociation. High numbers indicate higher levels of dissociation, and the mean score is calculated by summing the eight items.

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

The PTCI (Foa, Ehlers, Clark, Tolin & Orsillo, 1999) is a 36-item self-report scale that was designed to measure trauma-related thoughts and beliefs. Each item is rated on a seven-point Likert scale from one – 'totally disagree', to seven – 'totally agree'. The measure consists of three 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 three categories of individuals; a non-traumatised population, a traumatised population without PTSD and a traumatised population with PTSD. The median score for the non-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 (one =never to 10 = always). Higher scores indicate higher compassion levels.

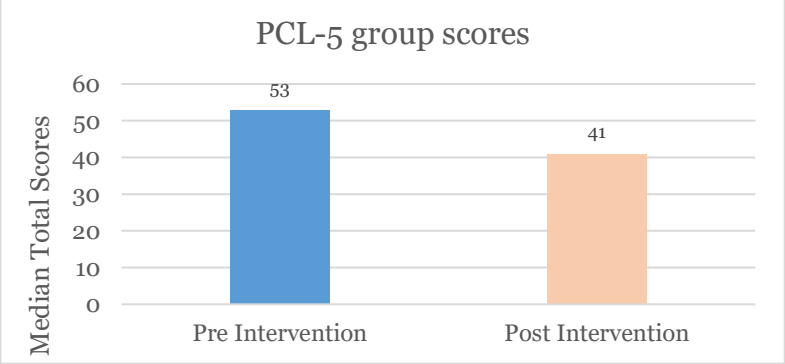
4.21.3. Results

Due to the discrepancy in group format between cycle four (online) and cycle five [mixture of online and hybrid (some participants online, some in person)], results were examined and compared in greater detail including overall mean, individual and cycle scores.

Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 [PCL-5]

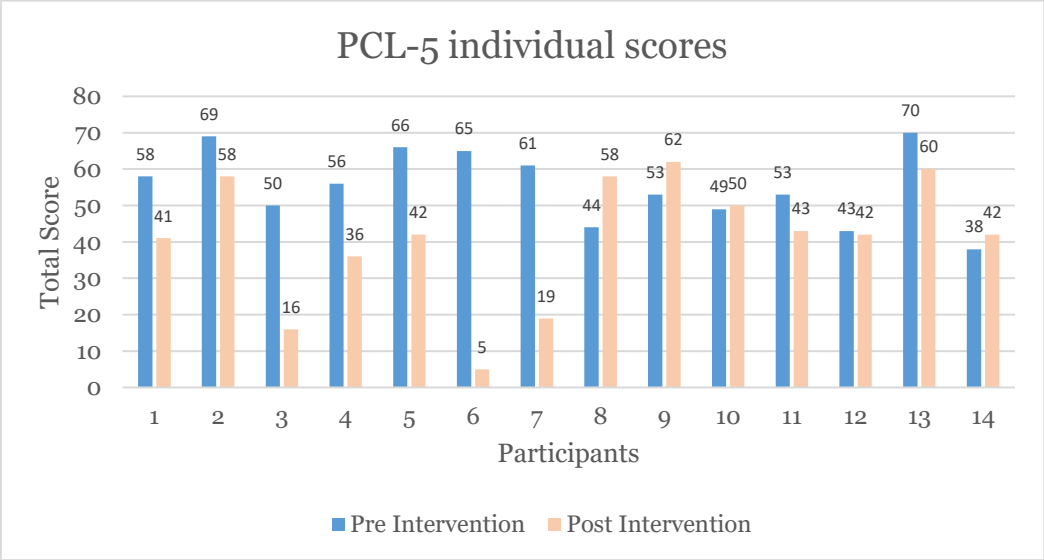
There was a significant decrease in total PTSD scores for the PCL-5 checklist from pre-intervention (M = 53; SD = 10.03) to post- intervention (M = 41.00; SD = 17.31), t (13), 2.61, p <.05 (two- tailed). The eta squared statistic (0.34) indicated a small effect size. This finding indicates that those who completed the trauma programme in 2022 had a significant reduction in PTSD symptoms post- intervention.

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



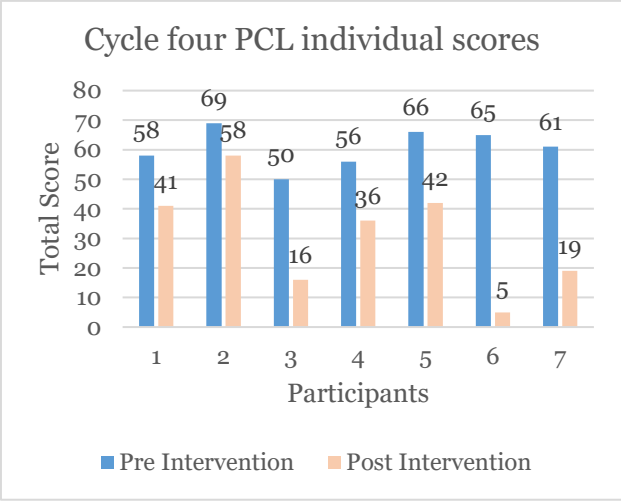
As can be seen from the below graph, further examination of the individual scores indicates that nine out of fourteen participants (64.29%) demonstrated a clinically significant reduction in PCL scores from pre-intervention to post-intervention (10 points or greater). Two participants (14.29%) demonstrated a clinically significant increase in PCL scores. In addition, four participants (28.57%) have moved from meeting criteria for a provisional diagnosis of PTSD pre-intervention (cut off score 38 or higher) to no longer meeting criteria post intervention. Please note that fifteen participants completed the programme, however, one participant did not return their outcome measure.

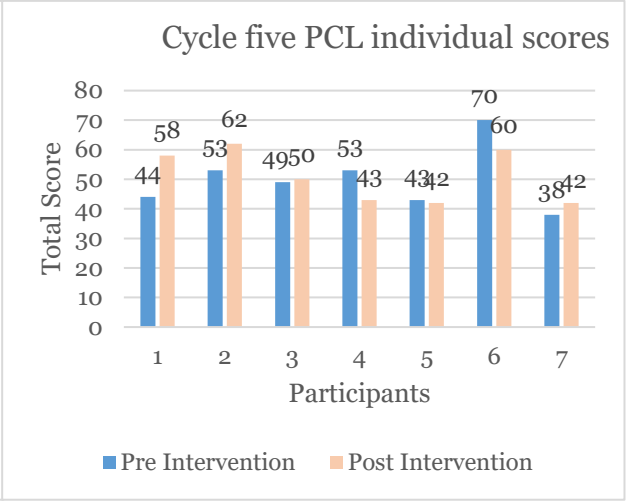
Graph: Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5) Individual median scores pre and post-intervention



As per the above graphs, in cycle four, seven out of seven (100%) participants demonstrated a clinically significant reduction in PCL scores from pre-intervention to post-intervention (10 points or greater). In addition, four out of seven participants (57.14%) have moved from meeting criteria for a provisional diagnosis of PTSD pre-intervention (cut off score 38 or higher) to no longer meeting criteria post intervention. In cycle five, two out of seven (28.57%) participants demonstrated a clinically significant reduction in PCL scores and zero out of seven participants moved from meeting for a provisional diagnosis of PTSD pre-intervention.

Graphs: Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5)
Cycle four and five individual median scores pre and post-intervention

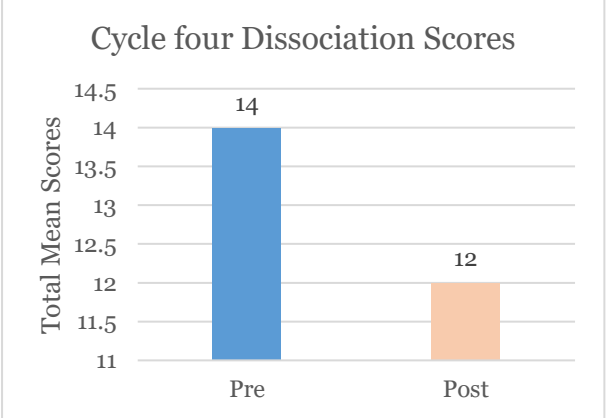


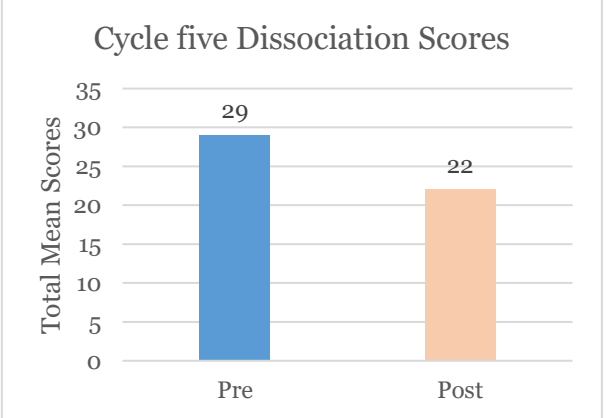


The Dissociative Experiences Scale-Taxon (DES- T)

The trauma team noticed that participants in cycle five reported more dissociation symptoms which may explain the differences in their PCL scores when compared to cycle four. Analyses were conducted comparing baseline mean differences in dissociation scores as well as between pre and post scores across cycle four and cycle five. When comparing baseline scores between cycle four and cycle five it was observed that there was a greater baseline score in total dissociation mean scores pre-intervention (M = 29.29; SD = 17.84) in cycle five when compared to cycle four. Cycle five had a greater clinical reduction than cycle four post-intervention (M = 22.32; SD = 16.65). In cycle four, there was a decrease in mean total dissociation scores from pre-intervention (M = 14.11; SD = 16.77) to post-intervention (M = 11.96; SD = 11.96). This finding suggests that participants from cycle five had higher levels of dissociative symptoms and further, their dissociative symptoms reduced more than those in cycle four (see graph below). As dissociation, can impact hypo-arousal for PTSD symptoms, its reduction explains the increase in distress as reflected on the PCL for cycle five.

Graphs: Dissociation median scores pre and post-intervention

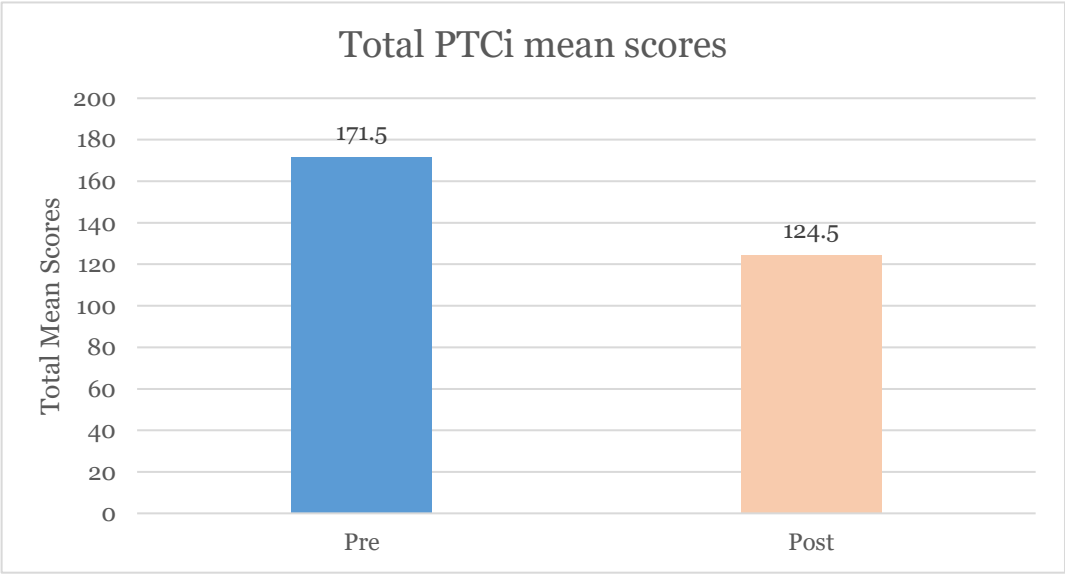




The Post Traumatic Cognitions Inventory (PTCI)

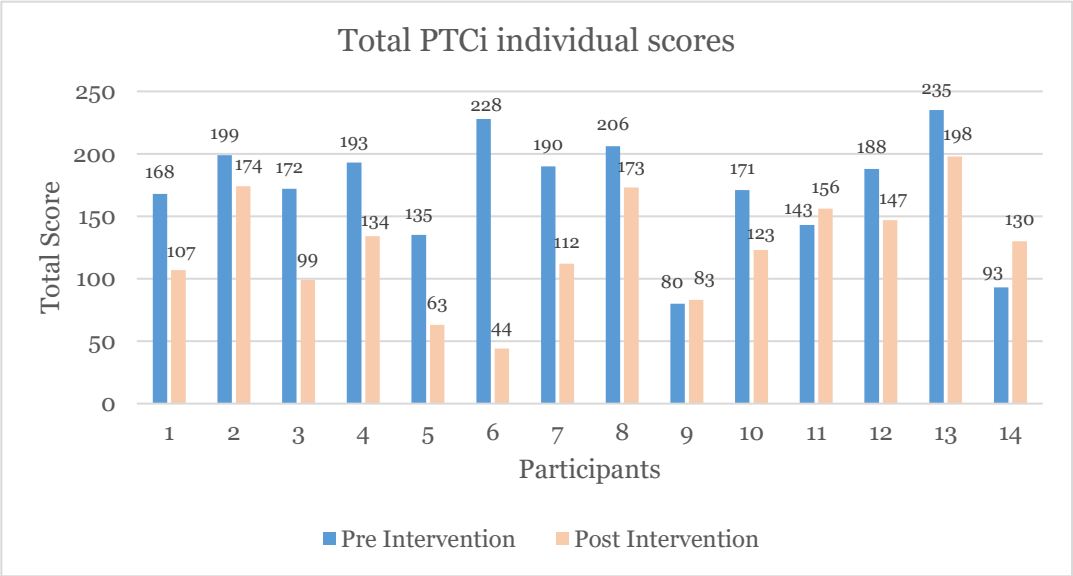
There was a significant decrease in total PTCI scores from pre-intervention (M = 171.50; SD = 45.52) to post-intervention (M = 124.50; SD = 43.76), t (13) = 3.37, p < .005 (two-tailed). The eta squared statistic (0.47) indicated a moderate effect size. This finding indicates that those who completed the programme in 2022 had a significant reduction in post-traumatic cognition symptoms post-intervention.

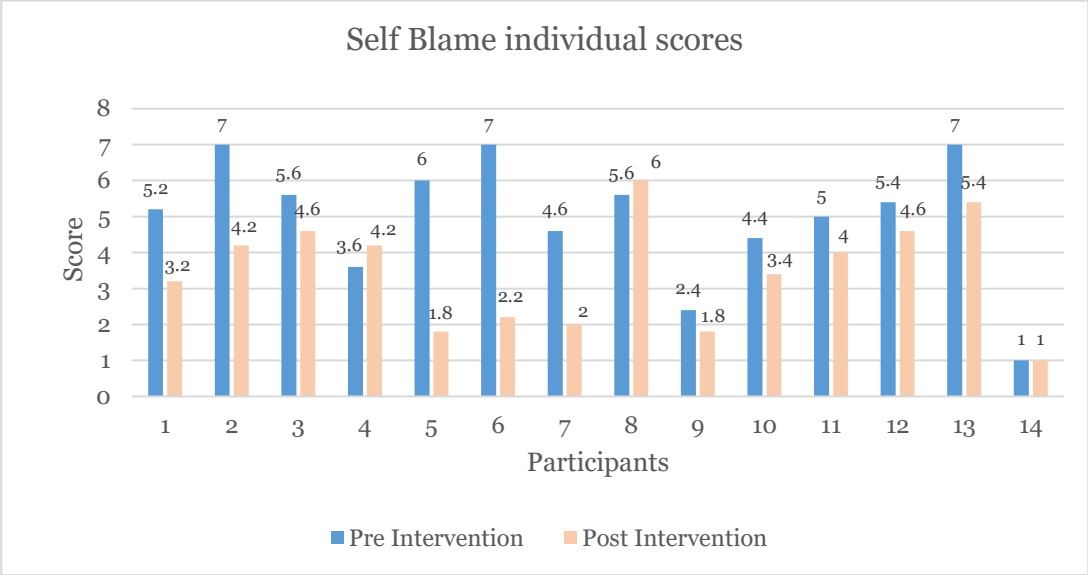
Graph: The Post Traumatic Cognitions Inventory Subscales median scores pre and post-intervention

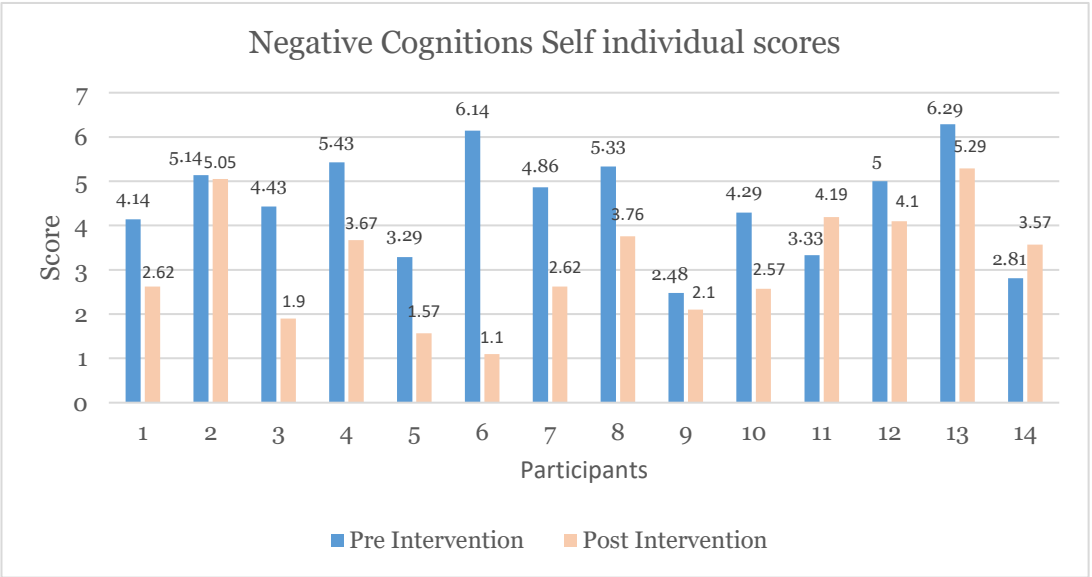


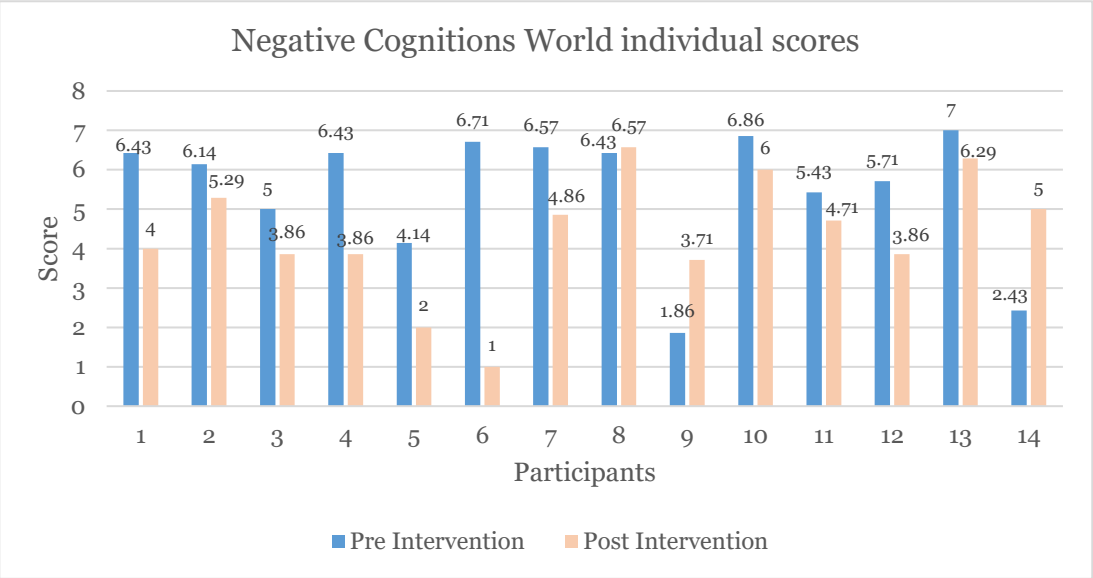
Further examination of individual total PTCI scores indicates that twelve out of fourteen (85.71%) participants scored 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. Twelve out of fourteen (85.71%) participants yielded reduction in post-traumatic cognition symptoms following completion of the programme. In addition, eleven out of fourteen (78.57%) demonstrated reductions across the subscale self-blame, twelve out of fourteen (85.71%) demonstrated reductions across the subscale negative cognitions about the self and eleven out of fourteen (78.57%) across the subscale negative cognitions about the world. These findings indicate that participants who completed the trauma programme significantly reduced their PTSD symptoms associated with trauma related thoughts and beliefs (see graphs below).

Graphs: The Post Traumatic Cognitions Inventory total and subscale individual scores pre and post-intervention



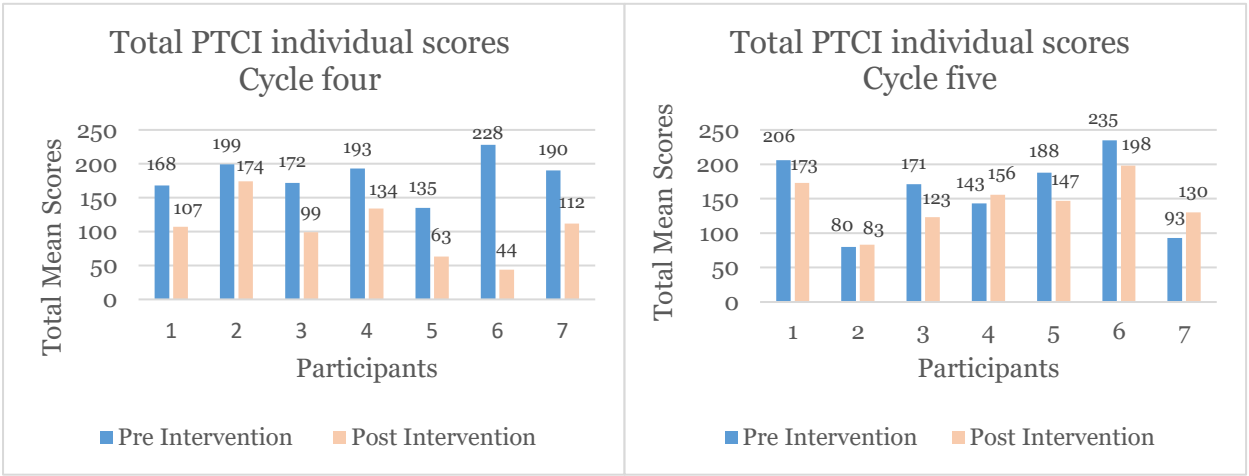






In cycle four, seven out of seven (100%) participants scored a total score of 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. Seven out of seven (100%) participants yielded a reduction in post-traumatic cognition symptoms following completion of the programme. In cycle five, five out of seven (71.43%) participants scored 133 or above at pre-intervention and four out of seven (57.14%) yielded reductions in PTCI symptoms post-intervention (see graphs below).

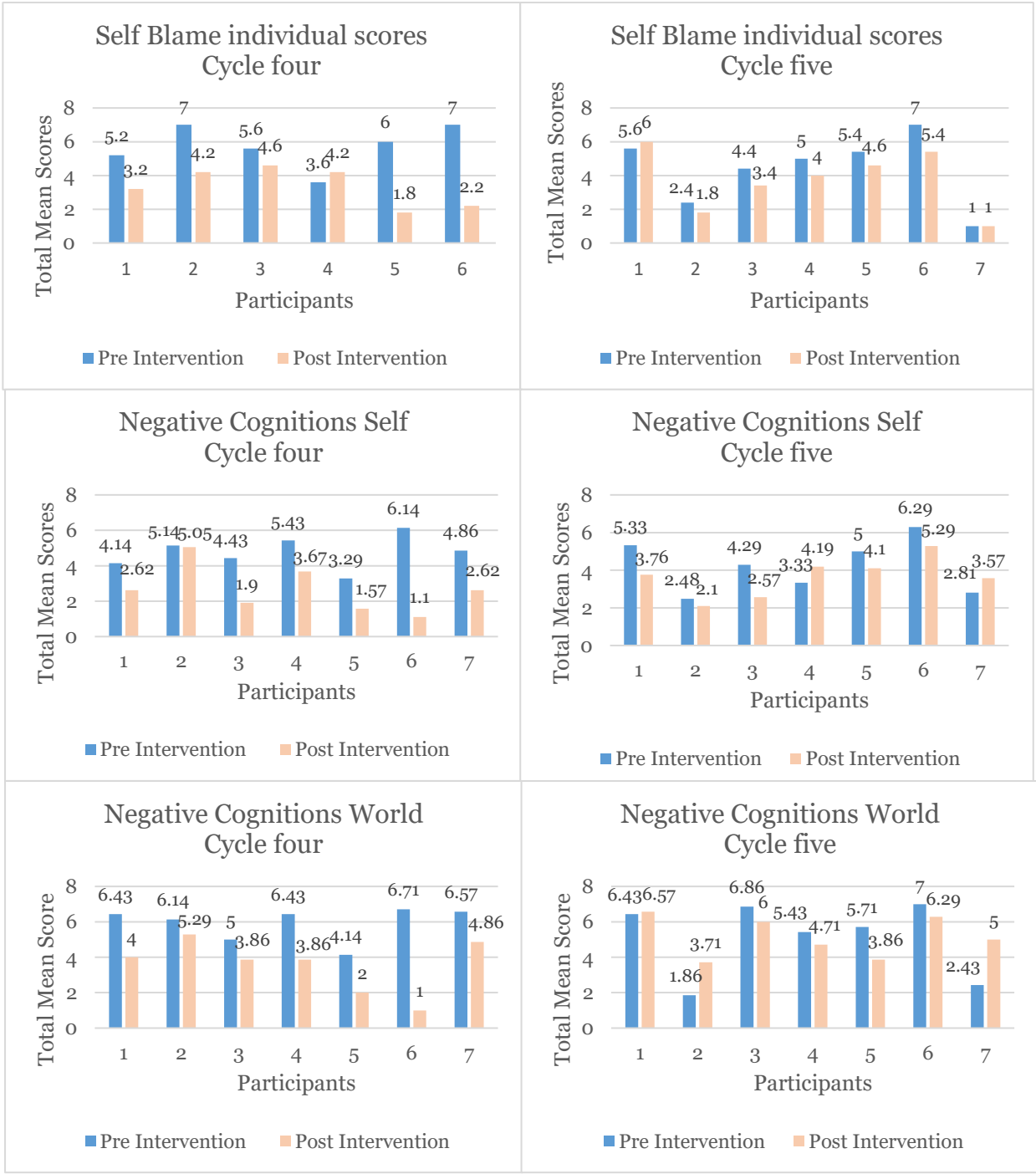
Graphs: The Post Traumatic Cognitions Inventory individual scores for cycle four and cycle five pre and post-intervention



In addition, seven out of seven (100%) participants demonstrated reductions across the subscale self-blame in cycle four, whereas five out of seven (71.43%) demonstrated reductions in cycle five. Seven out of seven (100%) of participants yielded reductions

in the PTCI subscale negative cognitions about the self in cycle four, and five out of seven (71.43%) yielded reductions in cycle five. Lastly, seven out of seven (100%) of participants demonstrated reductions across the subscale negative cognitions about the world in cycle four, and four out of seven (57.14%) of participants demonstrated reductions in cycle five. These findings indicate that while participants in cycle four had greater reductions across the PTCI measure in comparison to those from cycle five, overall, those who completed the programme in 2022 yielded significant reductions in post-traumatic cognitions and beliefs (see graphs below).

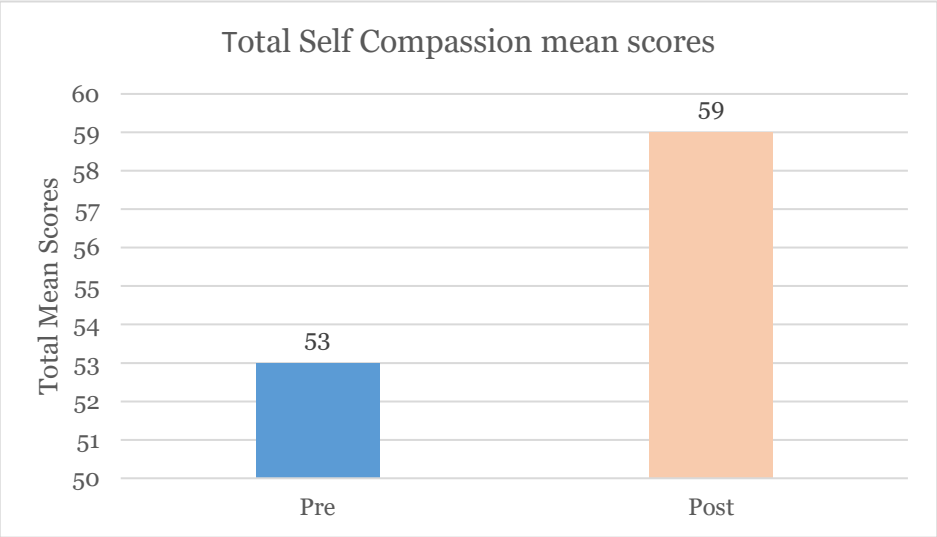
Graphs: The Post Traumatic Cognitions Inventory individual subscale scores for cycle four and cycle five pre and post-intervention



Compassionate Engagement and Action (CEA) Scales

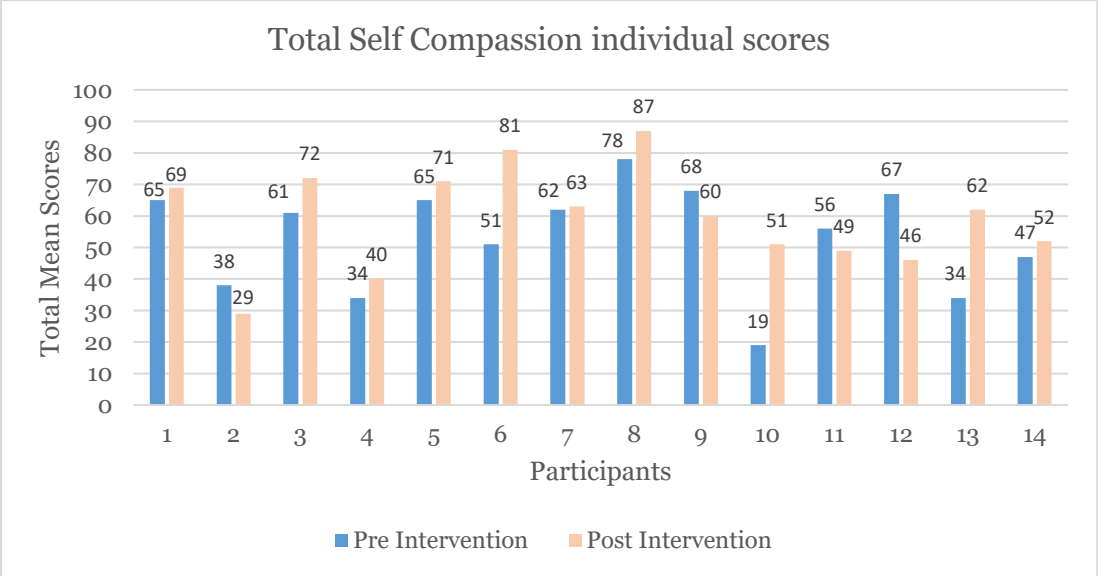
There was no statistically significant increase in total self-compassion scores from pre-intervention (M = 53.21; SD = 16.21) to post-intervention (M = 59.43; SD = 16.05), t (13) = -1.50, p = .157 (see graph below).

Graph: Self Compassion mean group scores pre and post-intervention



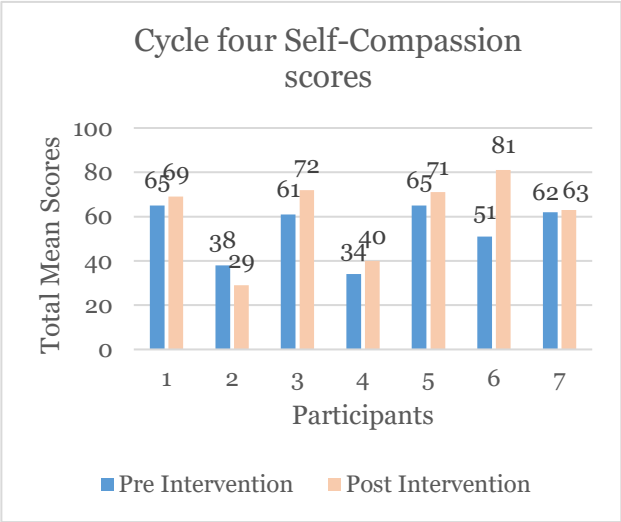
Further examination of the individual scores indicated that ten out of fourteen participants (71.43%) demonstrated an improvement on the self-compassion subscale (see graph below).

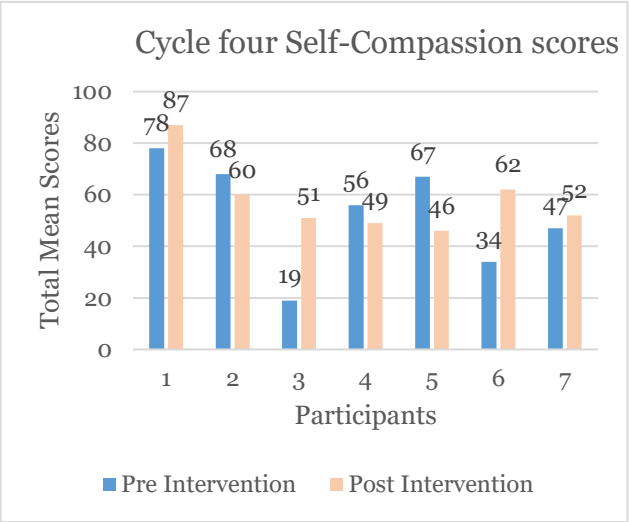
Graph: Self Compassion individual scores pre and post-intervention



In cycle four, six out of seven (85.71%) participants increased their self-compassion scores post-intervention and four out of seven (57.14%) yielded improvements in cycle five (see graphs below).

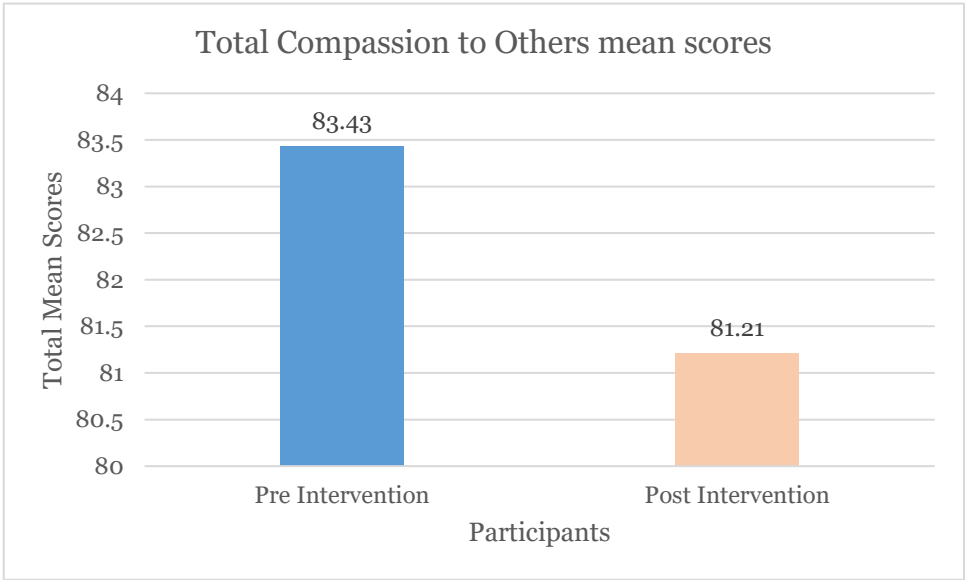
Graphs: Self-compassion individual scores for cycle four and cycle five pre and post-intervention





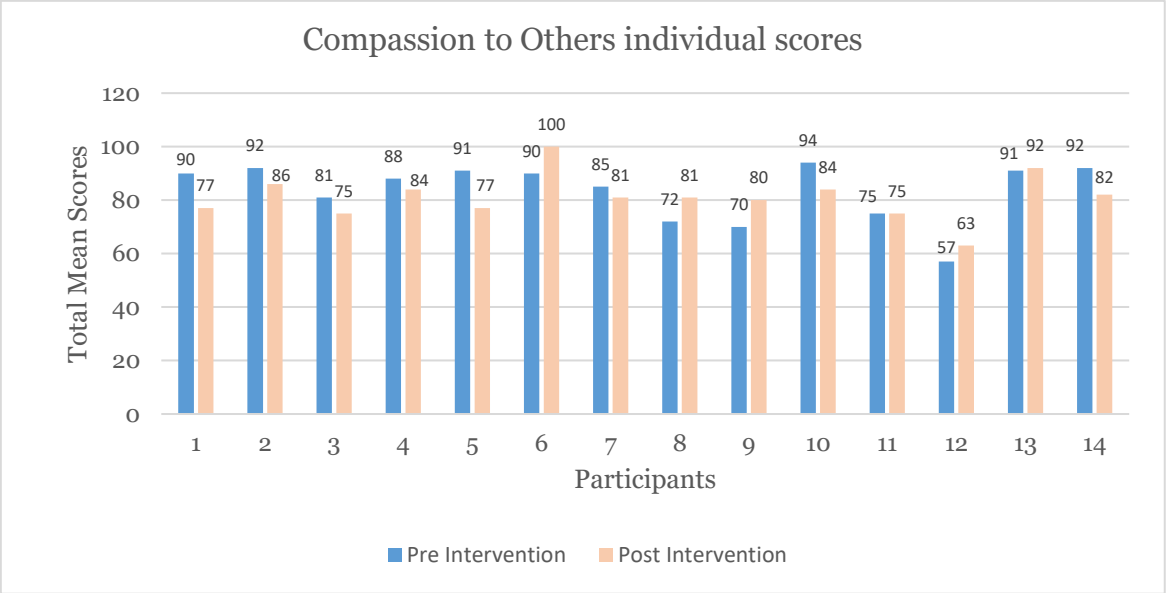
There was no significant increase in compassion to others from pre-intervention (M = 83.43; SD = 10.99) to post-intervention (M = 81.21; SD = 8.57), t (13) = .986, p = .342 (see graph below).

Graph: Compassion to Others mean scores pre and post-intervention



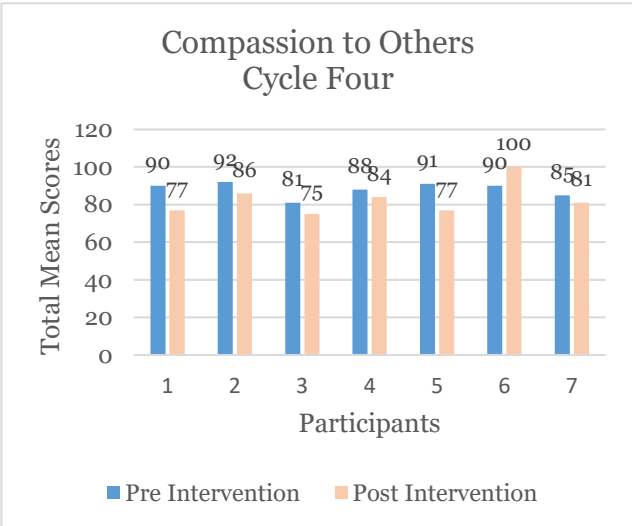
Further examination of individual scores indicate that five out of fourteen participants (35.71%) demonstrated an increase in compassion to others. It should be noted that participants scored highly on these measures at baseline (57- 92), therefore, it was predicted that there would be minimal difference post-intervention.

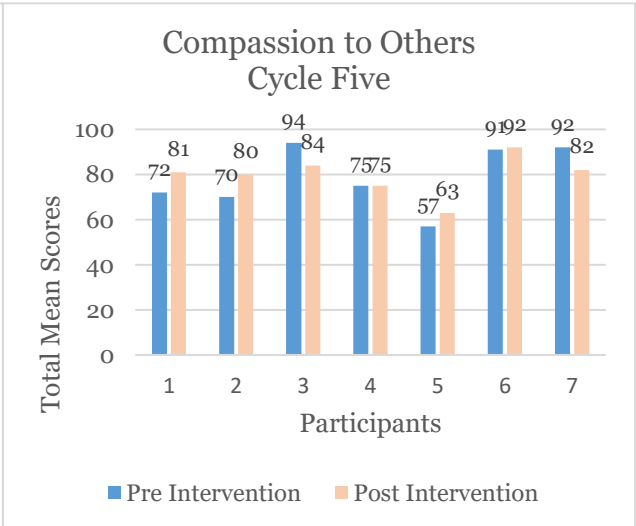
Graph: Compassion to Others individual scores pre and post-intervention



In cycle four, one out of seven (85.71%) participants increased their compassion to others scores post-intervention, and four out of seven (57.14%) yielded improvements in cycle five (see graphs below).

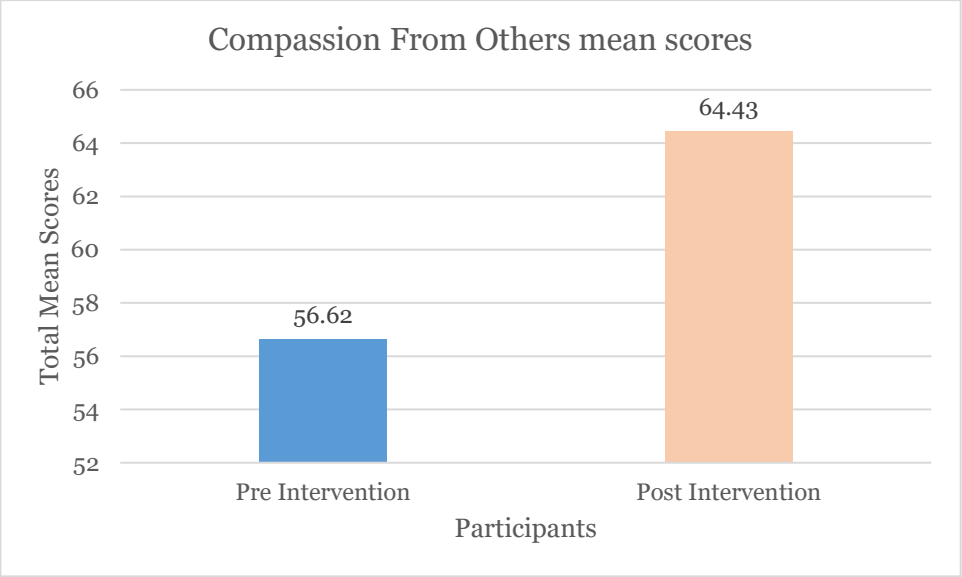
Graphs: Compassion to Others individual scores for cycle four and cycle five pre and post-intervention





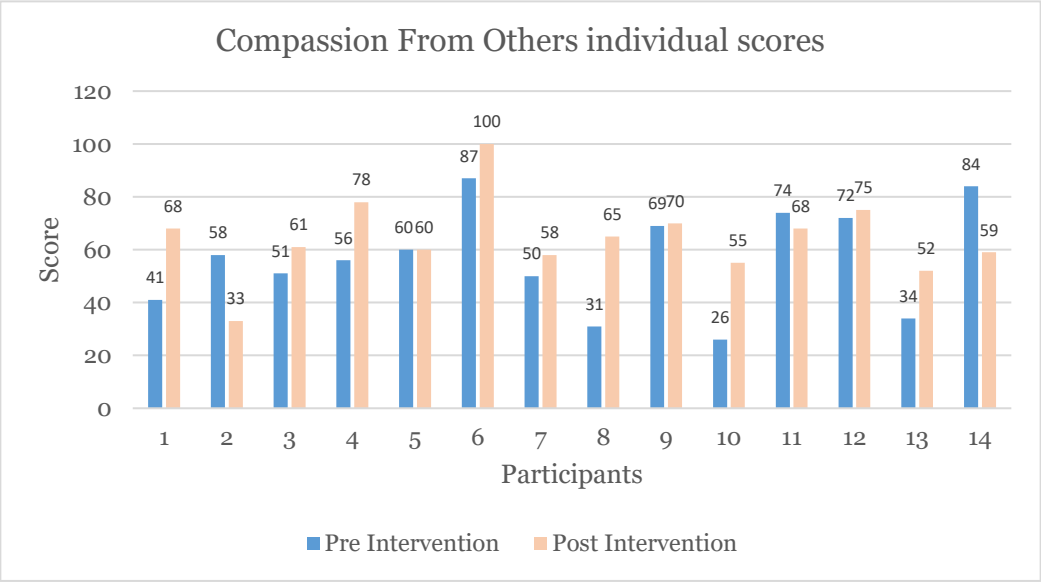
There was no significant increase in compassion from others total scores from pre-intervention (M = 56.62; SD = 19.22) to post-intervention (M = 64.43; SD = 15.07), t (13) = -1.60, p -.134 (see graph below).

Graphs: Compassion from Others mean group scores pre and post-intervention



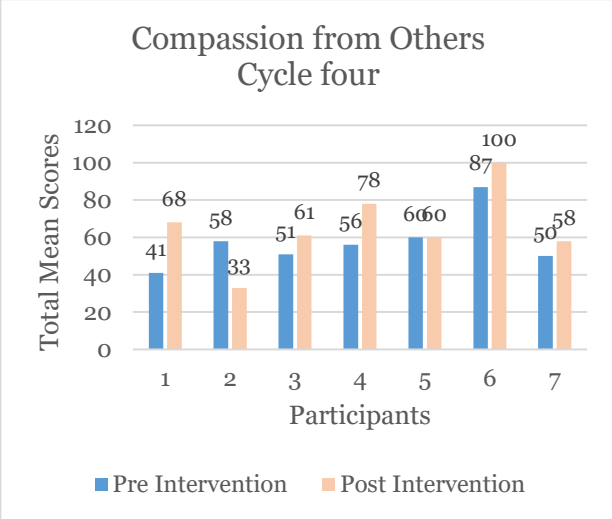
Further exploration of individual scores indicates that ten out of fourteen participants (71.43%) demonstrated an increase in perceived levels of compassion from others post-intervention.

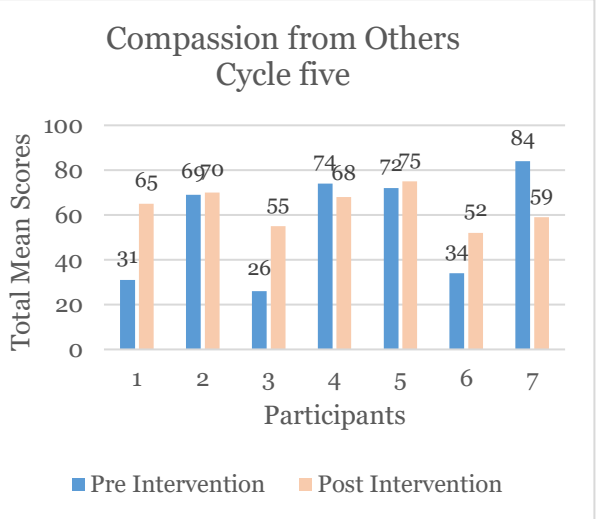
Graph: Compassion from Others individual scores pre and post-intervention



As per the below graphs, in cycle four, five out of seven (71.42%) participants increased their compassion from other's scores, and five out of seven (71.42%) increased their scores in cycle five (see graphs below).

Graphs: Compassion from Others individual scores for cycle four and cycle five pre and post-intervention





4.21.4. 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 fourth and fifth cycle of the programme. The programme aspires to reduce participants' symptoms of PTSD and increase their capacity for compassion in their relationships with themselves and others. The analysis of group and individual scores overall demonstrated promising positive results. These results indicate that the Trauma Programme is effective in delivering its aims. There were significant improvements in reducing PTSD symptoms post-intervention as demonstrated through findings from the PCL and PTCI measures. Further examination of the findings indicated that participants from cycle four yielded more reductions in PTSD symptoms compared to cycle 5. This may be due to differences in dissociation scores, as those in cycle five had higher baseline levels of dissociative symptoms and greater reductions in dissociative symptoms post-intervention. This may imply those in cycle five dissociated less often post-intervention which can impact PTSD by influencing hyper-arousal. In addition, cycle four was administered online while cycle five was administered online and through a hybrid format (some participants online, some in- person). Further research

is needed to understand participants' experiences and outcomes between group modalities (Maloney, Dowling, Deehan, O'Reilly 2022). Another aim of the programme was to increase participant's capacity for compassion in their relationships with themselves and others. Ten out of fourteen participants reported higher levels of self-compassion and compassion from others post-intervention. Five out of fourteen participants indicated improvements in compassion to others. However, it should be noted that baseline scores for this measure were high and minimal differences were expected to be yielded. In conclusion, the 2022 trauma programme demonstrated promising results in relation to reducing trauma symptoms and improving the capacity to cultivate compassion, these outcome reports are consistent with previous qualitative research exploring participants' experiences of attending the Trauma Programme (Willis, Dowling, Deehan, O' Reilly 2022)

4.22. 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 therapists, occupational therapists, registered advanced nurse practitioners 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

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.

4.22.1. 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 zero 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 HoNOSCA's were completed at admission and discharge by the young person (self-rated), MDT (clinicians) and parent.

4.22.2. Results

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

Table 1: Paired samples t-tests

	Pre	**Post**	***n***	***t***	***df***	***p***	***d***
Client rated	22.38 SD = 8.01	15.17 SD = 7.73	72	7.62	71	**.000**	0.45
Parent rated	19.47 SD = 7.14	13.18 SD = 7.67	79	6.78	78	**.000**	0.37

Pre and post scores on measures were available for 78 out of 96 service users (84%) who were admitted to and discharged from Willow Grove inpatient care in 2022. Analysis was run on pre and post data received.

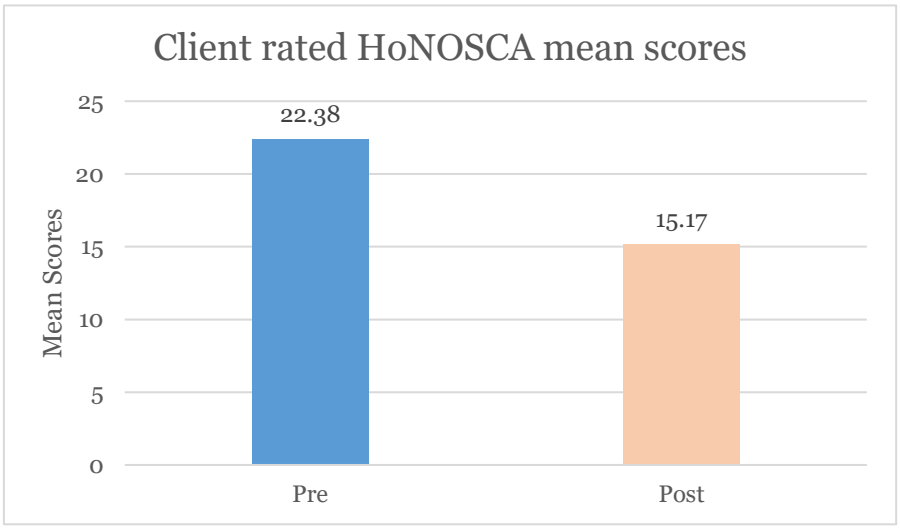
As illustrated in table 1, a significant decrease in total scores for the client self-rated HoNOSCA was apparent from pre-intervention (M = 22.38, SD = 8.01) to post-intervention (M = 15.17, SD = 7.73), t (71) = 7.62, p <. 0005 (two-tailed). The eta squared statistic (0.45) indicated a small to moderate effect size.

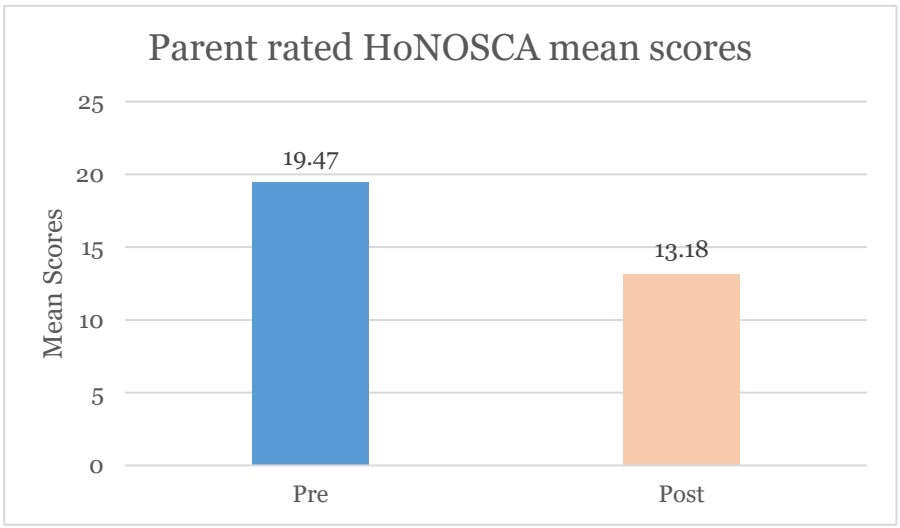
A significant decrease in total scores for the parent self- rated HoNOSCA was apparent from pre-intervention (M = 19.47, SD = 7.14) to post-intervention (M = 13.18, SD =

7.67), *t* (78) = 6.78, *p* <. 0005 (two- tailed). The eta squared statistic (0.37) indicated a small to moderate effect size.

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

Graphs: Health of the Nation Outcome Scales for Children and Adolescents subscales





4.22.3. 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 and parent rated HoNOSCA. Due to small numbers, statistical analyses were not able to be conducting among clinician rated HoNOSCA.

The Willow Grove team worked pro-actively to highlight the importance of the HoNOSCA's to evaluate the care and treatment the young people received, leading to a 22.4% increase in completed HoNOSCAS in 2022 in comparison to 2021.

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 2023.

SECTION FIVE
Measures of service user experience

5. Service user experience surveys

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, the Service User Experience 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 2022. The results of the Service User Experience 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 (eg. service users' perception of stigma after receiving mental healthcare). The Dean Clinic and day programme surveys were subsequently adapted from the inpatient survey and tailored to collect data regarding the respective services.

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

5.1.3. Data collection

The three surveys for the Dean Clinics, inpatient and day programmes were continually distributed from January to December 2022 to gather information about service users' journey through SPMHS, thus engaging a system in which service users

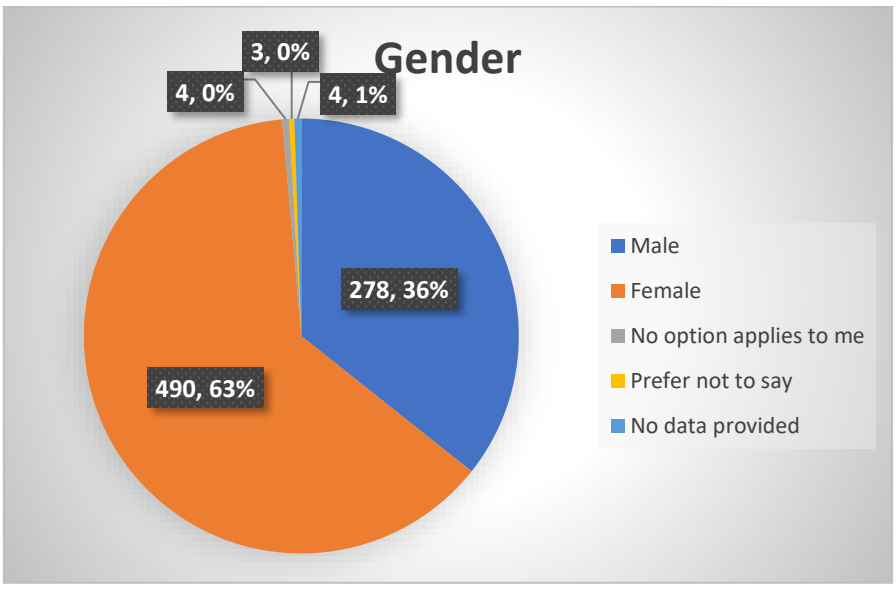
can offer feedback and take an active role in the provision of their care. Since March 2016, the Service User Experience Surveys for the Dean Clinics, inpatient and day programmes are also available online to increase accessibility. The employment of the service users' satisfaction survey is part of a larger quality improvement process undertaken by SPMHS. Data collection across SPMHS is continually facilitated as a key strategic objective to improve services.

5.2.5. Dean Clinics

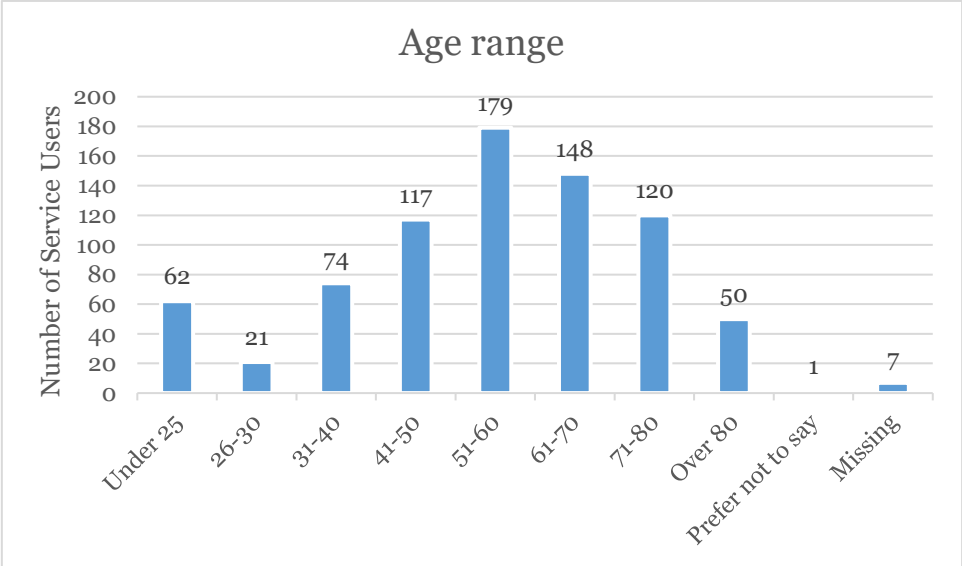
In 2022, Dean Clinic appointments were delivered face-to-face or remotely by technology-enabled care. Service User Experience Surveys were sent by email to service users attending Dean Clinic appointments remotely, with letters sent to service users who did not have an email or preferred to receive communication by post. Service users also sent responses via a QR code which was attached to Dean Clinic letters. Service users who attended appointments in person were given the Service User Experience Survey to complete onsite or to return by post. The mode of collection was 558 by email, 15 by post, 17 by QR Code and 189 onsite via paper or tablet device.

There has been a notable increase in the number of service users completing survey's this year from 318 in 2021 to 779 in 2022. This is due to the successful implementation of an awareness campaign by all clinics participating, informing service users that there is an avenue for feedback and emails sent to service users requesting feedback.

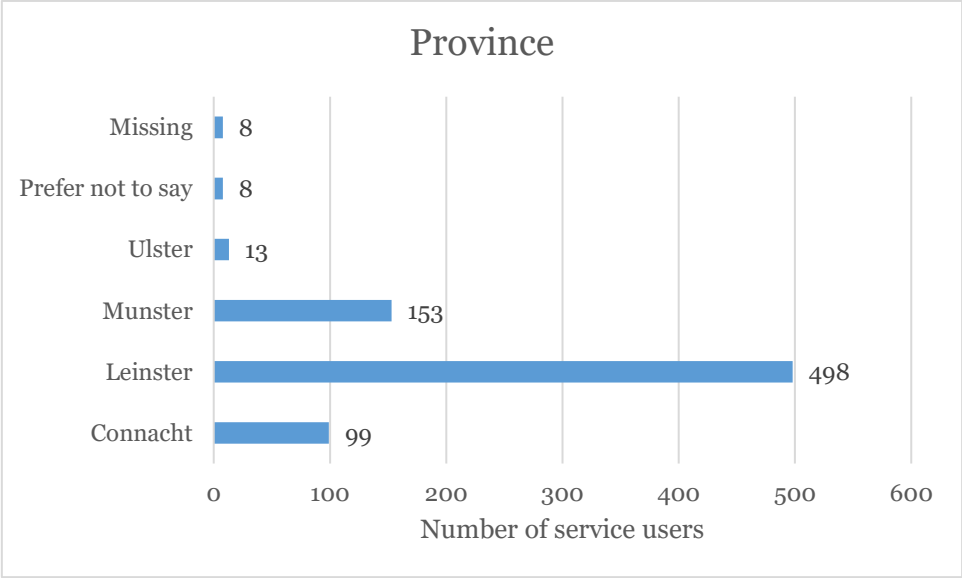
Graph: Service user gender



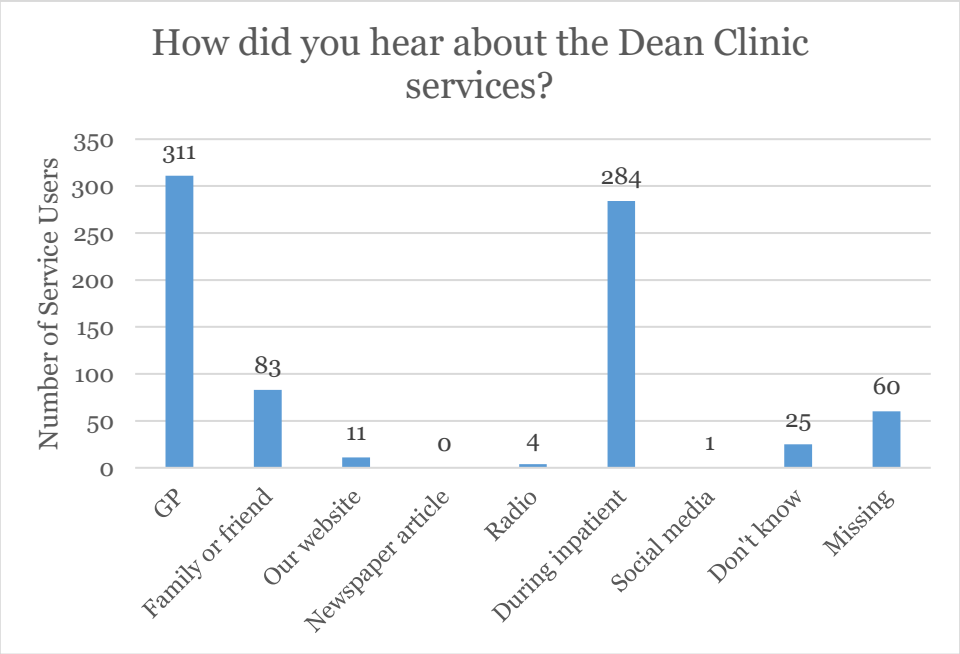
Graph: Service user age range



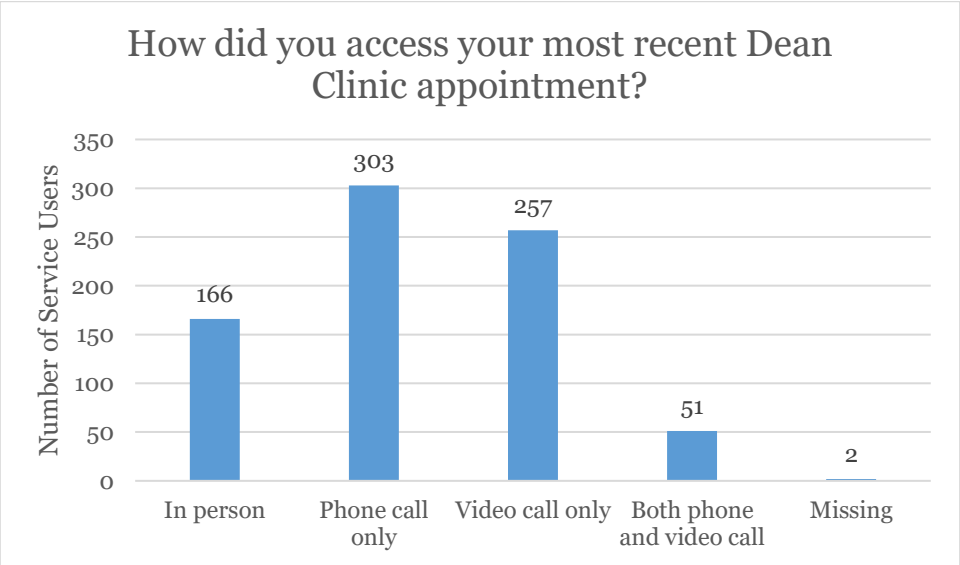
Graph: Service user age range



Graph: How did service user hear about Dean Clinic services?



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 and 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 the Dean Clinic	74	40.4	66	36.1	5	2.7	6	3.3	3	1.6	29	15.8
I was welcomed in a friendly and professional manner by the Dean Clinic staff	112	61.2	32	17.5	3	1.6	1	0.5	4	2.2	31	16.9
I was shown where the facilities were in the Dean Clinic, such as the bathroom and waiting room	88	48.1	48	26.2	8	4.4	4	2.2	5	2.7	30	16.4
I was treated with dignity and respect	113	61.7	38	20.8	3	1.6	0	0	2	1.1	27	14.8
My confidentiality was protected	104	56.8	40	21.9	5	2.7	0	0	2	1.1	32	17.5
My privacy was respected	107	58.5	37	20.2	6	3.3	1	0.5	1	0.5	31	16.9
Dean Clinic staff were courteous	111	60.7	43	23.5	1	0.5	1	0.5	2	1.1	25	13.7
I felt included in decisions about my treatment	105	57.4	36	19.7	5	2.7	2	1.1	3	1.6	32	17.5
I trusted my doctor or therapist or nurse	111	60.7	33	18.0	3	1.6	2	1.1	1	0.5	33	18.0

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

Service users who attended in person completed and returned the Service User Experience Survey between January and December 2022 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 8.86 (N=146). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.81 (N=148).

Table: In person respondents' ratings of a) care and treatment, b) the overall Dean Clinic

How would you rate...?	...your care & treatment		...the hospital overall	
	n	%	n	%
1	1	0.55	2	1.09
2	0	0.00	0	0.00
3	0	0.00	0	0.00
4	2	1.09	2	1.09
5	7	3.83	9	4.92
6	2	1.09	2	1.09
7	12	6.56	9	4.92
8	19	10.38	20	10.93
9	28	15.30	26	14.21
10	75	40.98	78	42.62
No Answer	37	20.22	35	19.13
1-5	10	5.46	13	7.10
6+	136	74.32	135	73.77
Total	183	100	183	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)
Your care and treatment at the Dean Clinic	146	8.86
Overall, the Dean Clinic	148	8.81

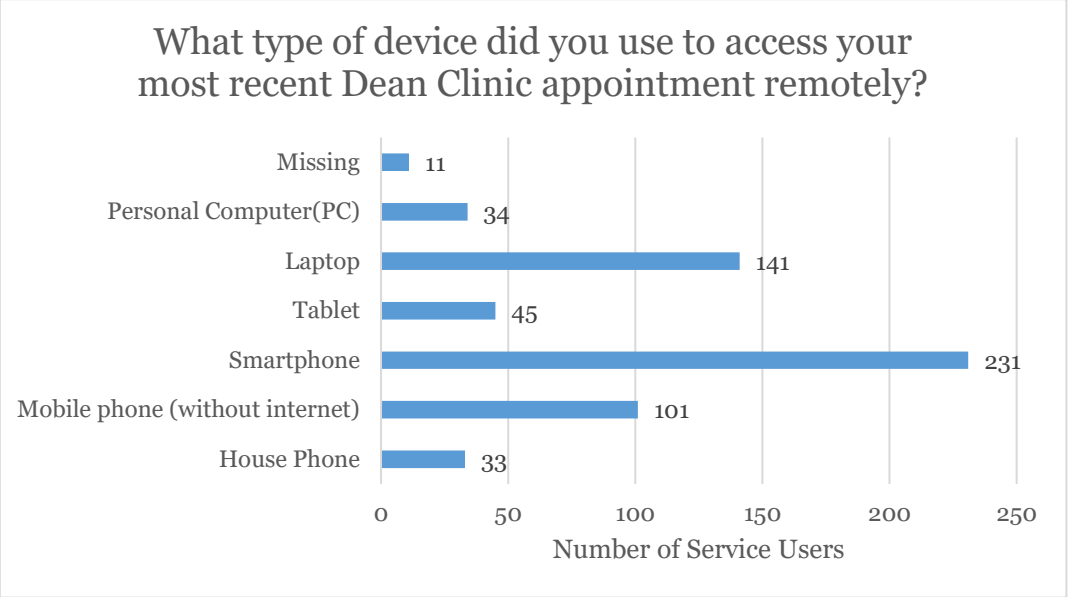
Remote

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

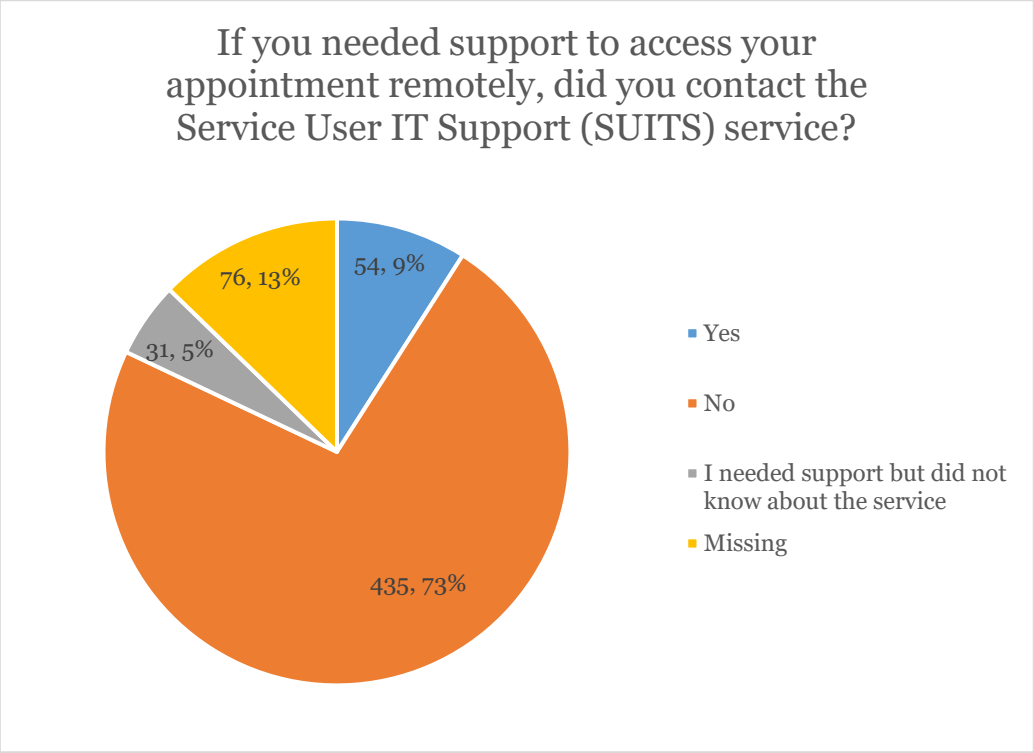
Respondents experience of assessment/therapy/review appointment

Experience of care and 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	247	41.4	189	31.7	55	9.2	23	3.9	17	2.9	65	10.9
It was clearly explained to me how to access my appointment using either phone or video	251	42.1	203	34.1	55	9.2	16	2.7	5	0.8	66	11.1
I felt using technology did not negatively impact on my care and treatment	190	31.9	163	27.3	62	10.4	84	14.1	30	5.0	67	11.2
I would consider the option of attending Dean Clinic appointments by phone or video in the future	200	33.6	155	26.0	70	11.7	69	11.6	38	6.4	64	10.7
I was treated with dignity and respect	395	66.3	118	19.8	11	1.8	3	0.5	4	0.7	65	10.9
My confidentiality was protected	386	64.8	126	21.1	17	2.9	0	0.0	2	0.3	65	10.9
My privacy was respected	384	64.4	125	21.0	13	2.2	1	0.2	2	0.3	71	11.9
Dean Clinic staff were courteous	395	66.3	115	19.3	4	0.7	2	0.3	4	0.7	76	12.8
I felt included in decisions about my treatment	350	58.7	138	23.2	25	4.2	9	1.5	9	1.5	65	10.9
I trusted my doctor or therapist or nurse	381	63.9	119	20.0	18	3.0	4	0.7	8	1.3	66	11.1

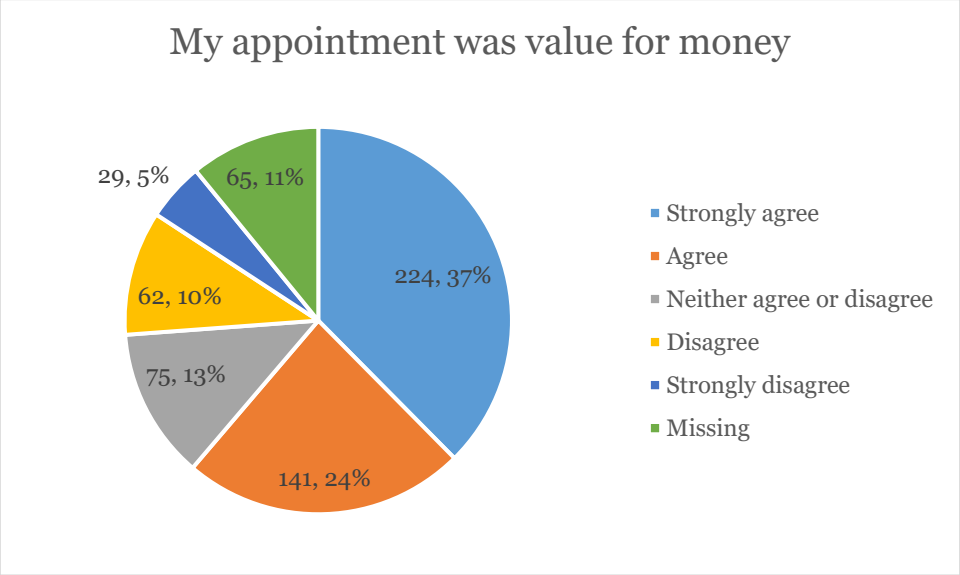
Graph: What type of device did you use to access your most recent Dean Clinic appointment remotely?



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 Experience 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 8.68 (N=516). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.51 (N=523).

Table: Remote respondents' ratings of a) care and treatment, b) the overall Dean Clinic

How would you rate...?	...your care & treatment		...the hospital overall	
	n	%	n	%
1	4	0.67	4	0.67
2	5	0.84	5	0.84
3	9	1.51	13	2.18
4	5	0.84	9	1.51
5	29	4.87	33	5.54
6	10	1.68	10	1.68
7	32	5.37	33	5.54
8	67	11.24	72	12.08
9	99	16.61	112	18.79
10	256	42.95	232	38.93

No Answer	80	13.42	73	12.25
1-5	52	8.72	64	10.74
6+	464	77.85	439	77.01
Total	596	100	596	100

Table: Mean and standard deviation of ratings of: a) care and treatment, b) the overall Dean Clinic

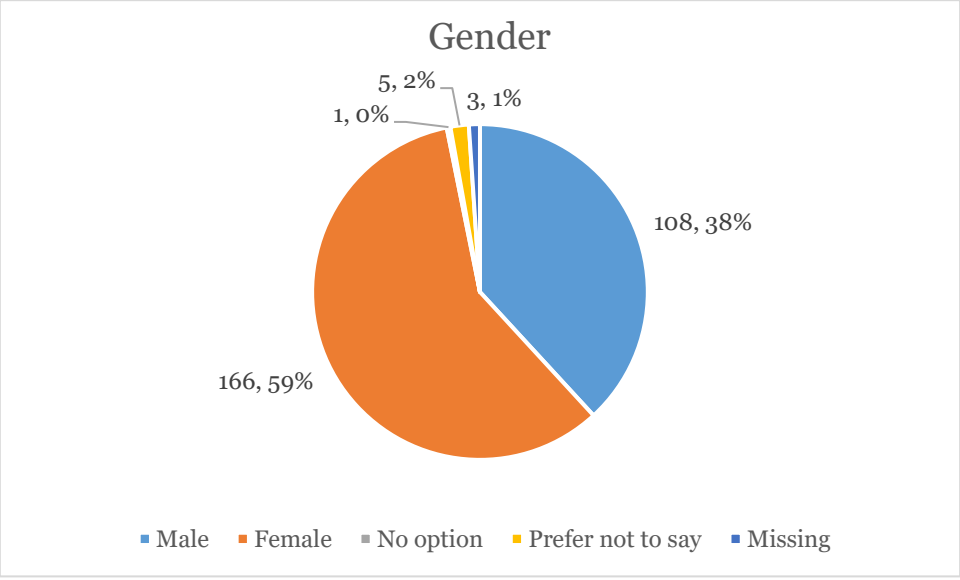
How would you rate...?	N	Mean (μ)
Your care and treatment at the Dean Clinic	516	8.68
Overall, the Dean Clinic	523	8.51

5.3. Adult inpatient services

5.3.1. Demographics

Service users discharged between January and December 2022 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. 283 surveys were returned to SPMHS adult inpatient services.

Graph: Inpatient gender break down - 2022



Graph: Home province breakdown - 2022

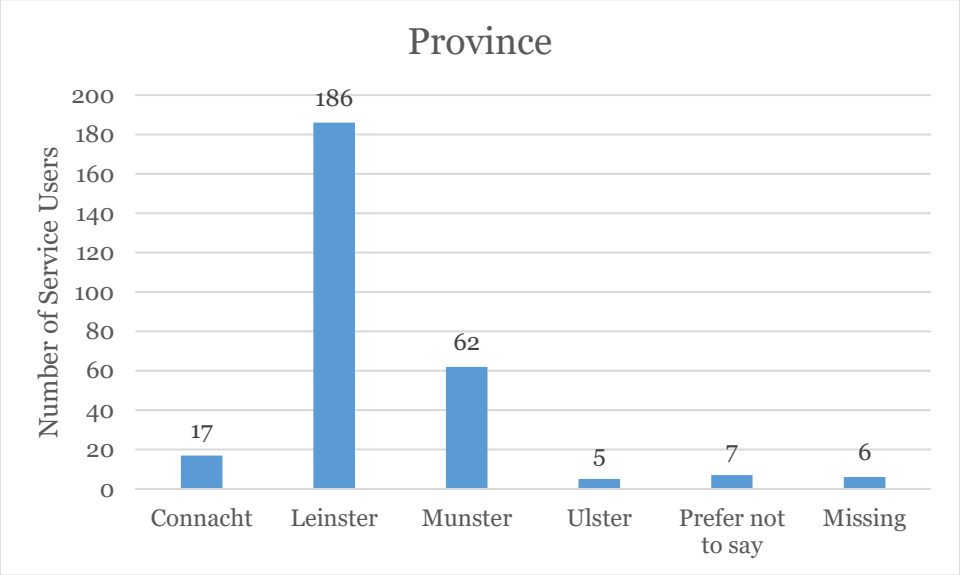


Table: Respondents' opinions regarding their experience of admission to hospital

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	107	37.8	118	41.7	14	4.9	23	8.1	17	6.0	4	1.4
A member of staff explained the ward routine such as mealtimes and visiting arrangements	107	37.8	110	38.9	31	11.0	17	6.0	12	4.2	6	2.1
A member of staff explained about activities available	77	27.2	87	30.7	56	19.8	40	14.1	17	6.0	6	2.1

Table: 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	15	5.2	80	28.3	185	65.4	0	0.0	3	1.1
Consultant Psychiatrist	29	10.2	67	23.7	178	62.9	4	1.4	5	1.8
Registrar	22	7.9	78	27.9	158	56.4	18	6.4	4	1.4
Key Worker	53	18.7	61	21.6	124	43.8	36	12.7	9	3.2
Psychologist	9	3.2	44	15.5	120	42.4	100	35.3	10	3.5
Occupational Therapist	13	4.6	53	18.7	94	33.2	115	40.6	8	2.8
Social Worker	16	5.7	46	16.3	71	25.1	138	48.8	12	4.2
Pharmacist	13	4.6	59	20.8	121	42.8	82	29.0	8	2.8
Healthcare Assistant	9	3.2	57	20.1	135	47.7	76	26.9	6	2.1
Household staff	9	3.2	67	23.7	179	63.3	24	8.5	4	1.4
Other	13	4.6	43	15.2	92	32.5	123	43.5	12	4.2

Table: 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	55	19.4	89	31.4	40	14.1	57	20.1	36	12.7	6	2.1
There was a good selection of food available	55	19.4	92	32.5	41	14.5	55	19.4	34	12.0	6	2.1
The daily activities provided were interesting and helpful	75	26.5	124	43.8	44	15.5	21	7.4	9	3.2	10	3.5
The weekend activities	43	15.2	95	33.6	65	23.0	44	15.5	25	8.8	11	3.9

were interesting and helpful												
The cleanliness in the hospital was of a high standard	144	50.9	102	36.0	12	4.2	11	3.9	7	2.5	7	2.5

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	119	42.0	109	38.5	24	8.5	12	4.2	10	3.5	9	3.2
I felt ready to go home	122	43.1	90	31.9	34	12.0	13	4.6	15	5.3	9	3.2
I was provided with details of the SPMHS Support and Information Service	99	34.6	101	35.7	24	8.5	32	11.3	21	7.4	7	2.5
I was provided with details about the SPMHS Day Services available	75	26.5	85	30.0	40	14.1	52	18.4	22	7.8	9	3.2
I was provided with details of my follow up appointments	103	36.4	93	32.9	25	8.8	35	12.4	18	6.4	9	3.2
I know what to do in the event of a further mental health crisis	115	40.6	84	29.7	28	9.9	24	8.5	20	7.1	12	4.2

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

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would disclose to others that they received support from SPMHS. The majority of respondents felt they had more positive views towards mental health difficulties in general (75.9%) and felt that they would share with others that they received support from SPMHS (60.1%).

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	117	41.3	98	34.6	32	11.3	15	5.3	12	4.2	9	3.2
I will tell people that I was admitted to St Patrick's Hospital	77	27.2	93	32.9	57	20.1	38	13.4	12	4.2	6	2.1
I would recommend St Patrick's Hospital to others	149	52.7	73	25.8	27	9.5	12	4.2	14	4.9	8	2.8

Overall views of SPMHS

Service users who completed and returned the Service user experience 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 7.76 (N=276). Respondents also demonstrated a high level of satisfaction with the hospital overall, rating the hospital on a scale of one to 10, with a mean of 7.69 (N=276)

Table: Inpatient respondents' ratings of care and treatment and overall experience of hospital for inpatients

How would you rate...?	...your care and treatment		...the hospital overall	
	n	%	n	%
1	6	2.12	8	2.83
2	8	2.83	7	2.47
3	10	3.53	10	3.53
4	13	4.59	14	4.95
5	12	4.24	12	4.24
6	13	4.59	13	4.59

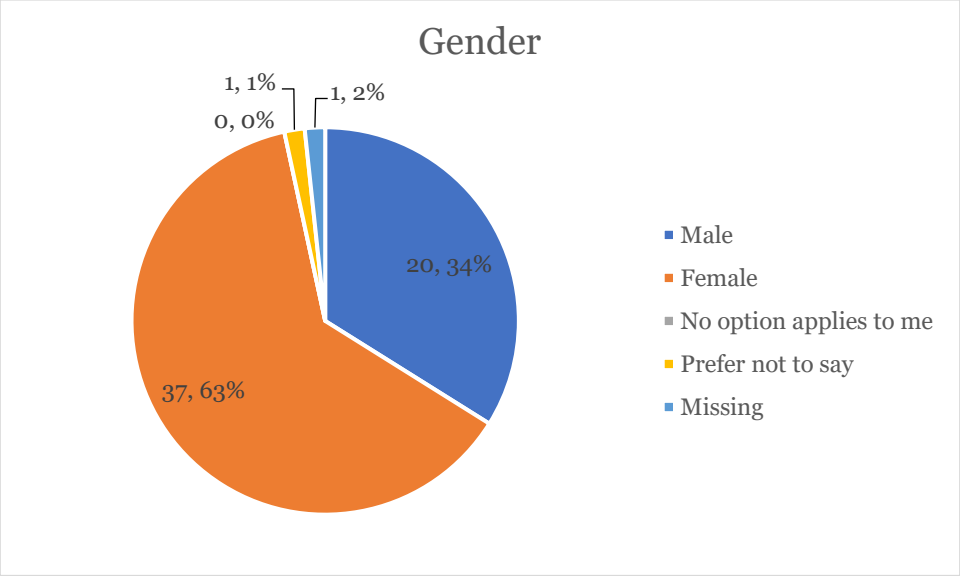
7	37	13.07	35	12.37
8	47	16.61	56	19.79
9	35	12.37	33	11.66
10	95	33.57	91	32.16
No answer	7	2.47	4	1.41
1-5	49	17.31	51	18.02
6+	227	80.21	228	80.57
Total	283	100	283	100

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

How would you rate...?	N	Mean (μ)
Your care and treatment in hospital	276	7.76
The hospital	279	7.69

5.4. Homecare Service User Experience Survey

Graph: Service user gender



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

A total of 59 responses were received (N = 59).

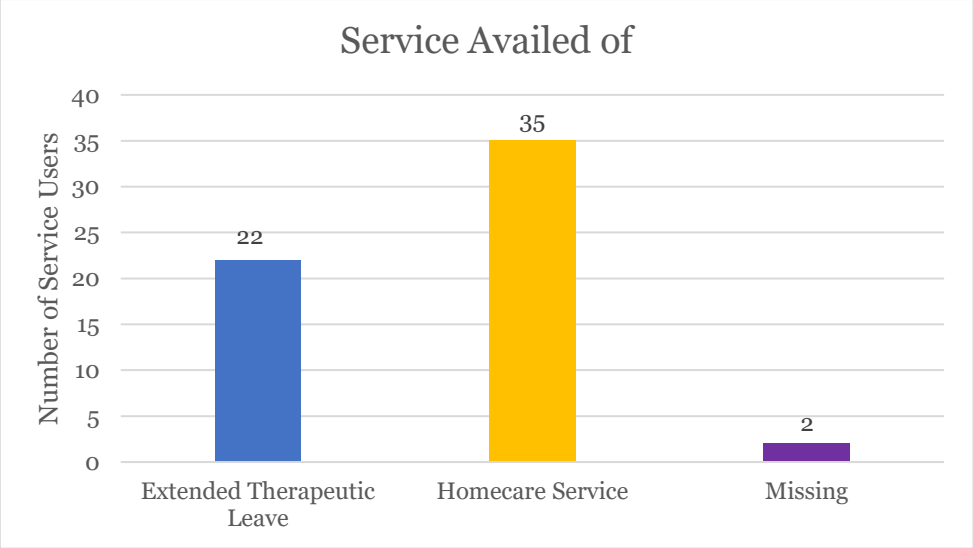


Table: Tell us about your experience of using phone and video calls to access our services?

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	22	37.3	23	39.0	3	5.1	3	5.1	3	5.1	5	8.5
I found it was easy to access my care and treatment video communications or phone	20	33.9	27	45.8	3	5.1	3	5.1	1	1.7	5	8.5
The quality of sound on phone calls or video calls was generally good	19	32.2	28	47.5	3	5.1	3	5.1	1	1.7	5	8.5
The quality of video was generally good	19	32.2	22	37.3	4	6.8	1	1.7	0	0	13	22.0
The internet connection was generally good	22	37.3	23	39.0	3	5.1	3	5.1	0	0	8	13.6
I found using technology to access services to be convenient	20	33.9	22	37.3	2	3.4	1	1.7	4	6.8	10	16.9
I felt using technology did not negatively	18	30.5	19	32.2	7	11.9	5	8.5	4	6.8	6	10.2

impact on my care and treatment												
I would consider the option of attending appointments by video or phone when visitor restrictions have been lifted and onsite services have fully resumed	16	27.1	24	40.7	5	8.5	3	5.1	3	5.1	8	13.6
I am comfortable using technology and regularly use video calls to stay in touch with friends and family	17	28.8	16	27.1	5	8.5	5	8.5	8	13.6	8	13.6

Table: 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	5	8.5	18	30.5	32	54.2	0	0	4	6.8
Consultant Psychiatrist	4	6.8	11	18.6	40	67.8	0	0	4	6.8
Registrar	3	5.1	17	28.8	32	54.2	3	5.1	4	6.8
Key Worker	7	11.9	11	18.6	20	33.9	15	25.4	6	10.2
Psychologist	1	1.7	5	8.5	28	47.7	19	32.2	6	10.2
Occupational Therapist	1	1.7	7	11.9	24	40.7	23	39.0	4	6.8
Social Worker	4	6.8	5	8.5	12	20.3	31	52.5	7	11.9
Pharmacist	3	5.1	11	18.6	19	32.2	21	35.6	5	8.5
Healthcare Assistant	2	3.4	6	10.2	9	15.3	35	59.3	7	11.9
Other	2	3.4	8	13.6	10	16.9	31	52.5	8	13.6

Table: 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	19	32.2	23	39.0	4	6.8	5	8.5	6	10.2	2	3.4

I felt using video/ and or telephone calls did not stop me from feeling understood by my team	21	35.6	20	33.9	3	5.1	7	11.9	6	10.2	2	3.4
I felt using video/ and or telephone calls did not stop me from understanding what was being said to me by team	25	42.4	22	37.3	3	5.1	3	5.1	3	5.1	3	5.1
I felt using video/ and or telephone calls did not stop me from understanding if changes were made to my medication	25	42.4	20	33.9	5	8.5	5	8.5	1	1.7	3	5.1
I had access to my medication	23	39.0	19	32.2	7	11.9	5	8.5	0	0	5	8.5
I received regular calls from my consultant	17	28.8	23	39.0	6	10.2	4	6.8	3	5.1	6	10.2
I received regular calls from nursing staff	29	49.2	18	30.5	3	5.1	3	5.1	0	0		10.2
I received regular calls from my key worker	11	18.6	12	20.3	12	20.3	13	22.0	6	10.2		8.5
I felt any issues I had were understood by my team	23	39.0	18	30.5	1	1.7	5	8.5	4	6.8		13.6
I felt any issues I had were addressed by my team	19	32.2	20	33.9	2	3.4	3	5.1	4	6.8		18.6

Table: 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	17	28.8	24	40.7	7	11.9	3	5.1	4	6.8	4	6.8

health in general are more positive than they were												
I will tell people that I was admitted to SPMHS	9	15.3	20	33.9	9	15.3	12	20.3	7	11.9	2	3.4
I would recommend SPMHS to others	32	54.2	16	27.1	4	6.8	1	1.7	4	6.8	2	3.4

Overall views of SPMHS

Service users who completed and returned the Service User Experience Survey demonstrated a high level of satisfaction with the care they received, rating their care and treatment in hospital on a scale of one to 10, with a mean of 8.04 (N=59). 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 7.95 (N=59).

How would you rate...?	...your care and treatment		...the hospital overall	
	n	%	n	%
1	2	3.39	3	5.08
2	2	3.39	3	5.08
3	2	3.39	0	0
4	0	0.00	0	0
5	1	1.69	1	1.69
6	1	1.69	2	3.39
7	9	15.25	8	13.56
8	7	11.86	10	16.95
9	12	20.34	7	11.86
10	20	33.90	22	37.29
No answer	3	5.08	3	5.08
0-5	7	11.86	7	11.86
6+	49	83.05	49	83.05
Total	59	100	59	100

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

How would you rate...?	N	Mean (μ)
Your care and treatment on Homecare	59	8.1
Overall experience	56	8.0

5.5. Day programme services

All service users who have completed a day programme are emailed a copy of the Service User Experience Survey and invited to 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 either in person at St Patricks University Hospital or remotely via MS Teams. The programmes aim to support people experiencing recovery from mental ill-health and promote positive mental health. The total number of surveys returned in 2022 was 99. 93 people responded to the question regarding what day programme that they attended.

Day service programmes attended by survey respondents

Programme	Number of respondents attending (N = 99)	Percentage of respondents attending
Access to Recovery	22	22.2%
Addiction and Chemical Dependence Programme	0	0%
ACT	15	15.2%
Aftercare	1	1%
Anxiety Programme	2	2.1%
Bipolar Programme	1	1%
Cognitive Behavioral therapy	2	2.1%
Compassion-Focused Therapy	4	4%
CFT-Eating Disorders	0	0%
Depression programme	2	2.1%
Dialectical Behavior Therapy	5	5.1%
Dual Diagnosis	1	1%
Eating Disorder Programme	6	6.1%
FACTS	0	0%

Formulation	1	1%
Group Radical Openness	2	2.1%
Living Through Distress	0	0%
Living Through Psychosis	0	0%
Mindfulness Based Stress Reduction	2	2.1%
Mindfulness	4	4%
Pathways to Wellness	4	4%
Psychology Skills Group (Adolescent)	2	2.1%
Regaining Recovery	0	0%
SAGE	0	0%
Schema	1	1%
Self-esteem	4	4%
Stepdown	1	1%
Temple Formulation Group	1	1%
Unknown	7	7.1%
WRAP	2	2.1%
Young Adult Programme	1	1%
Missing	6	6.1%
TOTAL	99	100%

The breakdown of respondents by province is presented in the table below

Province	N	Percentage
Connaught	9	9.1%
Leinster	72	72.7%
Munster	12	12.1%
Ulster	3	3%
Prefer not to say	2	2%
Missing	1	1%
TOTAL	99	100%

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 or

joining remotely and that the structure and organization 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	87	87.9	0	0	2	2	10	10.1
A member of staff explained the timetable	85	85.9	1	1	3	3	10	10.1

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. 69.7% (n = 69) strongly agreed that they trusted the members of their day programme team. 71.7% (n = 71) strongly agreed that they were always treated with dignity and respected as an individual. 72.7% (n = 72) also strongly agreed that their team were courteous and respectful. 61.6% (n = 61) 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	87	87.9%	0	0%	2	2%	10	10.1%
I was always treated with dignity and respect	88	88.9%	0	0%	1	1%	10	10.1%
Members of my programme team were courteous and respected me as an individual	88	88.9%	0	0%	1	1%	10	10.1%
Members of my team were knowledgeable and easy to understand	86	86.9%	0	0%	3	3%	10	10.1%

Tell us about your experience of finishing the programme

Most respondents experienced an informed ending to the programme, with 73.7% (n = 73) agreeing that they knew when the programme was to end. 74.7% (n = 74) of respondents felt that the programme met their expectations. 76.8% (n = 76) felt that they know what to do in the event of a further mental health crisis. 71.9% (n = 69) 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	73 (73.7%)	5 (5.1%)	10 (10.1%)	11 (11.1%)
The programme met all of my expectations	74 (74.7%)	3 (3%)	11 (11.1%)	11 (11.1%)

I know how to get help in the event of a further mental health crisis	69 (78.4%)	9 (10.2%)	10 (11.4%)	11 (11.1%)
I have been given details of St Patrick's Mental Health Services Support and Information Services	76 (76.8%)	5 (5.1%)	7 (7.1%)	11 (11.1%)

The Service User Experience 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
I feel my views and perceptions regarding my own mental health difficulties and mental health in general are more positive than they were	72 (72.7%)	3 (3%)	14 (14.1%)	10 (10.1%)
I will tell people that I have attended a day programme in St Patrick's Mental Health Services	56 (56.6%)	14 (14.1%)	19 (19.2%)	10 (10.1%)
I would recommend St Patrick's Mental Health Services day services to others	78 (78.8%)	2 (2%)	9 (9.1%)	10 (10.1%)

Experience of using technology

Respondents were asked to rate their experience of using technology to access day programme services as some of these programmes were delivered online. 79.8% of respondents (N = 79) agreed that it was clearly explained to them how to access their programme using telephone or video call. 76.8% (N = 76) agreed that they found using telephone or video call to be convenient. 64.6% (N = 64) agreed that they felt using technology did not negatively impact on their experience of attending the programme. 65.7% (N = 65) 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	79 (79.8%)	1 (1%)	4 (4%)	15 (15.2%)
I found using telephone or video calls to be convenient	76 (76.8%)	5 (5%)	3 (3%)	15 (15.2%)
I felt technology did not negatively impact on my experience of attending the programme	64 (64.6%)	10 (10.1%)	10 (10.1%)	15 (15.2%)
I would consider the option of attending programmes in the future using video or telephone call	65 (65.7%)	8 (8.1%)	11 (11.1%)	15 (15.2%)

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

If you needed support to access your programme	Yes	No	Needed support but did not	No answer

remotely, did you contact the Service User IT Support (SUITS) service?			know about the service	
N (%)	27(27.3)	44(44.4)	7(7.1)	21(21.2)

Those who accessed support from SUITS were asked to rate their satisfaction with the service. A total of 24 people rated the support received. 95.8% (N = 23) of respondents rated the support as 6 or above.

If you accessed SUITS for support, how would you rate the support?		
	(N)	%
1 (Poor)	0	0
2	0	0
3	0	0
4	1	1
5 (Good)	0	0
6	1	1
7	1	1
8	4	4
9	5	5.1
10 (Excellent)	12	12.1
Missing	75	75.8
1-5	1	1
6-10	23	23.2
Total	**99**	**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 ten is excellent. 85.9% of respondents (n = 88) rated their care and treatment a score of 6 or above. Respondents were also asked to rate the Wellness and Recovery Centre overall. 89.9% of respondents (n = 89) rated the Wellness and Recovery Centre overall a score of 6 or above. See the table below for further information.

How would you rate you…	… care and treatment?		… overall experience of the Wellness and Recovery center?	
	(N)	%	(N)	%
1	0	0	0	0
2	0	0	1	1
3	1	1	1	1
4	1	1	2	2
5	3	3	3	3
6	2	2	2	2
7	5	5.1	6	6.1
8	17	17.2	15	15.2
9	14	14.1	16	16.2
10	45	45.5	43	43.4
Missing	11	11.1	10	10.1
1-5	5	5.1	7	7.1
6-10	83	83.8	82	82.8
Total	99	100	99	100

5.6. Willow Grove Adolescent Unit Service User Experience

5.6.1. Survey 2022

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 2022.

5.6.2. 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.

5.6.3. Respondents

Parents and young people were asked to complete this measure on the day of discharge. 32 young people and 77 parents/carers completed the questionnaire. The number of surveys returned by young people decreased by 3% while the number of surveys returned by parents/carers increased by 32% in 2022 compared with 2021, where responses were provided from 35 young people and 48 parents/carers.

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 this five-point Likert scale ranging from one = very poor, to five = very good, printed with corresponding smiley faces to help young people to understand the response options.

5.6.4. Results

Quantitative responses

The median response (i.e, the most common response) for each question is listed in the table below. 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' (56.25%), followed by five - 'very happy' (40.63%) and three - 'mixed' (3.13%). For the parents/carers, the majority of responses on their experience of the care and treatment provided were five - 'very happy' (72.4%), followed by four - 'happy (25%) and three 'mixed' (2.6%).

The least positive answer given by service users was in relation to access to leisure activities and outings. 9.34% were 'very unhappy' with access to leisure activities/outings, 15.63% were unhappy with visiting arrangements, 37.5% were mixed, 21.88% were happy and 15.63% were very happy. Access to leisure activities and outings also yielded the least positive responses from parent surveys.

Service users most commonly rated five – 'very happy' for their access to keyworkers/allocated nurse, the opportunity to attend the discharge planning meeting, the environment and facilities, the overall atmosphere/feel of the unit, safety arrangements on the unit, access to group therapy, access to individual therapy, access to key workers/allocated nurses, access to educational supports, feeling listened to/respected, confidentiality within the service, and having a service identified for follow-up care.

Service users rated four – 'happy' for the items including: experience of accessing the service, information provided by the St Patrick's website, information given on admission, cleanliness of the unit, the meals provided, visiting arrangements, experience of care and treatment, access to a range of professionals, access to an independent advocacy group, level of contact with the treatment team, information received on treatment plan, involvement/collaboration in treatment plan, opportunity

to give feedback to the treatment group, information given to prepare for discharge and provision of family support.

Service users rated three – 'mixed' for the items including: information received prior to admission, access to leisure activities and outings, and weekend/mid-week therapeutic leave agreements.

Parents most commonly rated five – 'very happy' for the experience of accessing the service, information provided on the St Patrick's website, the information received prior to admission, the environment and facilities, atmosphere of the unit, the cleanliness of the unit, visiting arrangements, safety arrangements, experience of care and treatment, access to group therapy, access to individual therapy, access to professionals and keyworkers/allocated nurses, access to educational supports, access to an independent advocacy group, level of contact with the treatment team, information received on treatment plan, involvement in treatment plan, opportunity to give feedback, feeling listened to/respected, confidentiality, opportunity to attend discharge planning, leave agreements, information given to prepare for discharge, having a service identified for follow-up care, provision of family support, opportunity to attend parents support group and positive parenting course, usefulness in addressing mental health difficulties and providing skills to manage mental health.

Parents rated four – 'happy' for the meals provided and access to leisure activities and outings.

Table: Median responses to Willow Grove Service user Experience Survey

Please tell us how satisfied you were with aspects of the 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	5	4
The information given on admission	5	4
The environment and facilities	5	5
The overall atmosphere or feel of the unit	5	5

The cleanliness of the unit	5	4.5
The meals provided	4	4
Visiting arrangements	5	4
Safety arrangements on the unit	5	5
Experience of care and treatment	5	4
Access to group therapy	5	5
Access to individual therapy	5	5
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	5
Access to an independent advocacy group	5	4
Your level of contact with the treatment team	5	4
Information received on treatment plan	5	4
Your involvement (young person)/your collaboration (parent) in treatment plan	5	4
Your opportunity to give feedback to the treatment team	5	4
How you felt you were listened to/respected	5	5
Confidentiality of the service	5	5
Opportunity to attend discharge planning meeting	5	5
Weekend/mid-week therapeutic leave agreements	5	3
Information given to you to prepare for discharge	5	4
Having a service identified for follow up care	5	5
Provision of family support	5	4

Opportunity to attend parents support group	5	N/A
Opportunity to attend positive parenting course	5	N/A
Was your child's stay helpful in addressing their mental health difficulty?	5	N/A
Providing you with skills to manage mental health	N/A	5

SECTION SIX

CONCLUSIONS

6.1. Conclusions

1. The SPMHS twelth 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. The 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 continue to drive ways to expand or improve how outcomes are measured and utilised to maintain and improve services, despite the challenges posed by the COVID-19 pandemic. In 2022, some of the clinical programmes utilised a secure service user electronic portal (Your Portal), to send clinical outcome measures for completion by consenting service users attending their clinical programme. The service users were then able to complete the outcome measures via the secure portal, which were instantly accessible for review by the clinical staff delivering the programme of care.

4. The scope of audit across the organisation was further strengthened in 2022, 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 a detailed insight into service accessibility, efficacy of clinical programmes and service user experience. Reporting this breadth of routinely collected clinical outcomes, demonstrates a willingness to constantly re-evaluate the efficacy of clinical programmes and services in an open and transparent way. A detailed service user experience survey encompassing all service delivery within SPMHS is now well established, reinforcing the organisation's commitment for service user-centred care and treatment. In 2022, significant improvements were made in the overall Service User Experience Survey response rates, through changes in processes, including increased focus on technology mediated surveys. SPMHS staff have continued to effectively report outcome measures in 2022, in the context of continued challenges posed by the COVID-19 public health restrictions. Despite these ongoing challenges, two additional programmes were added to the Outcomes Report this year: The Bipolar Recovery Programme and the Emotion-Focused Therapy Programme for Young Adults. Technology-enabled 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 there is no access to comparible reports. 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.

SECTION SEVEN

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