St Patrick's
Mental Health Services

Outcomes Report 2023

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 thirteenth 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 consistently reviewed to ensure we are attaining the best possible standards of service delivery. The completion and publication of this report demonstrates 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. This 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, and the organisation established a new Homecare service. Technology-enabled care has not replaced inpatient admission, or other in-person care delivery where needed. SPMHS continued to deliver the Homecare service in 2023, 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 2023 report is divided into seven sections. Section one provides an introduction and summary of the report's contents.

Section two outlines information regarding how SPMHS services are structured and how community clinics, day programme and inpatient services were accessed in 2023. 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 three summarises the measures and outcomes of the organisation's clinical governance processes. Section four 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 2023, 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 four 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 six summarises the report's conclusions regarding the process and findings of outcome measurement within the organisation.

Section seven 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 2023.

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 appropriate, receive an 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 PAON Assessments

The table below provides the number and percentages of adult PAON assessments completed and the outcome of each PAON in 2022 and 2023. 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.

Table 2.1. *Outcomes of PAON Assessments 2022-2023*

	2022	%	2023	%
Dean Clinic referral	949	77%	793	86.5%
Discharge*	52	4%	14	1.5%
Admission referral	237	19%	110	12%
Total	**1238**	**100%**	**917**	**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, *The Future in Mind (2023 – 2027)* reinforces the organisation's commitment to further refine and improve our community-based mental health clinics. The Dean Clinic network is an essential component of the services provided by SPMHS. These community mental health clinics allow SPMHS to provide appropriate follow up to service users who have had periods of inpatient care and treatment and are now progressing on their recovery pathway. The obligation to provide adequate post-inpatient follow up care and treatment is a regulatory requirement, and this requirement is monitored by the mental health inspectorate.

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 2023, a total of 1,193 adult Dean Clinic referrals were received from the centralised Referral and Assessment Service (R&A). This presents a decrease of 16% comparing with 1,421 referrals received in 2022. This decrease is likely due to the centralised R&A service assessing and forwarding referrals to the

most suitable service thus decreasing the number of inappropriate referrals to the Dean clinics.

2.2.2. Dean Clinic referral source by province

The following table illustrates the geographical spread of Dean Clinic referrals by province from 2021 to 2023. The highest referral volumes continued to be from Leinster in 2023 with 864 referrals.

Table 2.2. *Dean Clinic Referrals by Province from 2021 to 2023*

Year	Leinster	Munster	Connaught	Ulster
2021	1,160	230	182	45
2022	1,021	217	143	40
2023	864	164	134	31

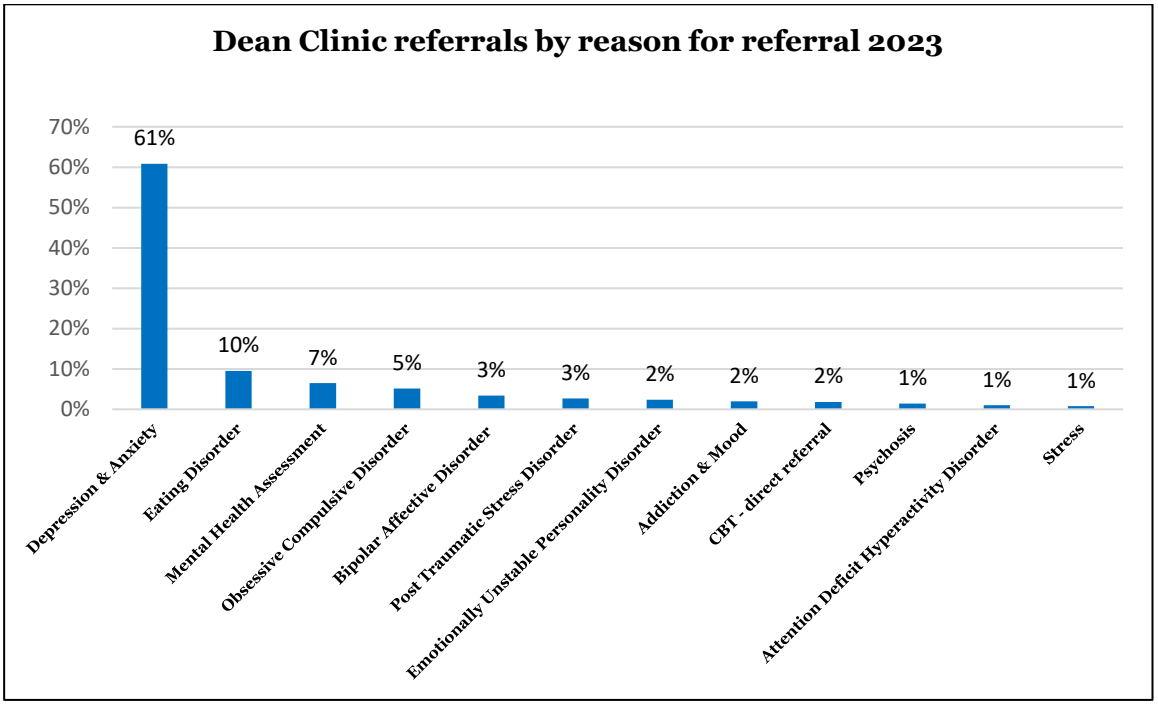
2.2.3. Dean Clinic referrals by gender

The female to male ratio of Dean Clinic adult referrals for 2023 was 1:0.79. Male referrals increased by 4% in comparison to 2022 – potentially indicating that more men are seeking mental health support.

2.2.4. Dean Clinic referrals by reason for referral

The reasons for referral to the Dean Clinics in 2023 are reflected in the chart on the next page. It shows depression and anxiety, eating disorders and GP's seeking mental health assessments for their service users as the most common reasons for referral.

Figure 2.1. *Dean Clinic referrals by reason for referrals in 2023*



2.2.5. Dean Clinic activities

The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2021. In 2023, 29.7% of referrals proceeded to have a mental health assessment – an 11.2% increase from 2022. 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 appointments and some service users have a more immediate need and are assessed for possible admission to inpatient care or are referred for a Homecare service admission. 53.2% of referrals suitable for assessment had to be declined as there was no capacity to assess them. The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2021.

Table 2.3. *A summary of the number of referrals and mental health assessments provided in the adult Dean Clinics from 2021 - 2023.*

Year	No. of Referrals	No. of Assessments
2021	1,618	310
2022	1,421	262
2023	1,193	354

A mental health assessment involves a comprehensive evaluation of a person's mental state carried out by a consultant psychiatrist and members of the multidisciplinary team. An individual care plan is agreed with the 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 across Dean Clinics nationwide from 2021 to 2023. Appointments include consultant reviews, Clinical Nurse Manager reviews, Clinical Nurse Specialist reviews, cognitive behavioural therapy, occupational therapy, social work and psychology. There was a 0.5% increase in adult Dean Clinic appointments in 2023. The "did not attend" (DNA) rate was 5.4% which is 7.6% below the national DNA rate of 13% for outpatient appointments in the Health Service Executive (HSE).

Table 2.4. *Adult Dean clinic appointments from 2021 - 2023.*

Year	Adult Dean Clinic appointments
2021	13,342
2022	13,198
2023	13,266

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 2021 to 2023. There was an increase of 13.4% in first time admissions from the Dean Clinics in 2023. This increase was potentially due to improvements made to the triaging process of referrals and the increase of initial assessments. The ability to transition to a Homecare service admission provided an acceptable alternative for service users who otherwise may have declined an in-person inpatient admission.

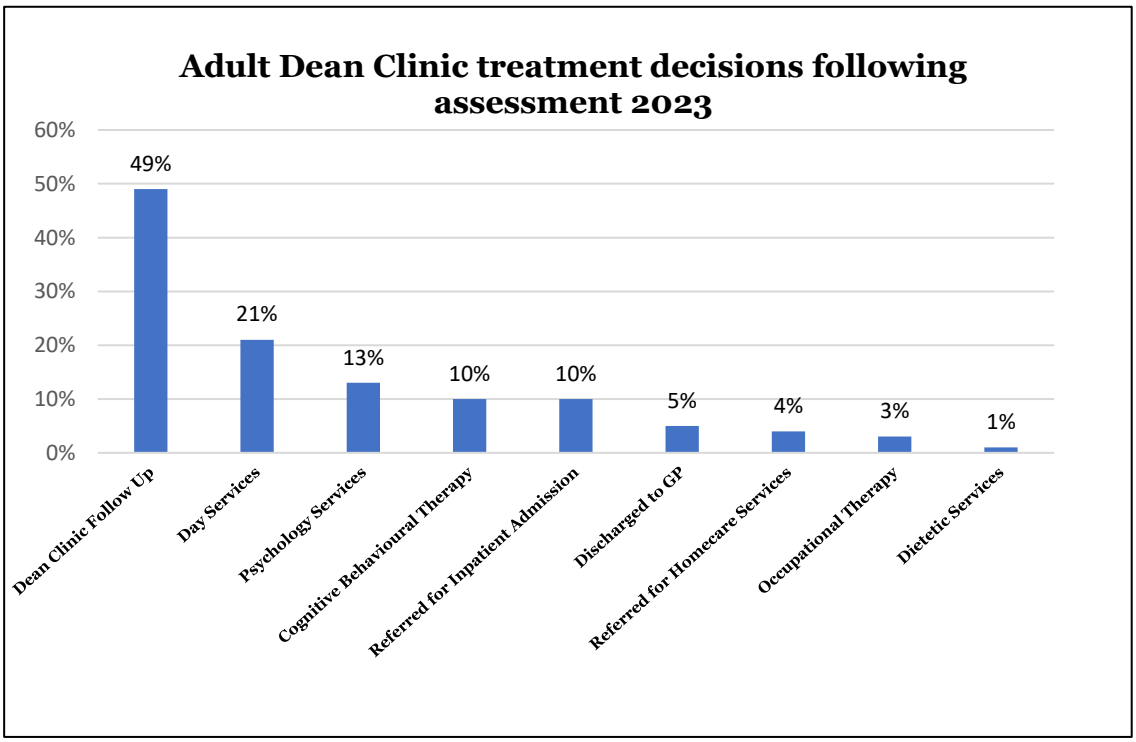
Table 2.5. *First time inpatient admissions from an initial Dean clinic referral.*

Year	First Admission
2021	152
2022	187
2023	212

2.2.6. Dean Clinic: Outcome of assessments

Figure 2.2 below summarises and compares the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics 2023.

Figure 2.2. *Adult Dean Clinic treatment decisions following Dean Clinic assessments.*



2.2.7. Adolescent Dean Clinic referral volume

The two Adolescent Dean Clinics are based in Dublin and Cork. In 2023, there were a total of 972 referrals received for the adolescent service – a decrease of 7% from 2022. The decrease in referrals can be attributed to unexpected reduction in referring capacity from referrers ie., waiting times to access Child and Adolescent Mental Health services (CAMHS) and vacant consultant posts in CAMHS potentially reducing referrals from being sent.

A total of 232 Adolescent Prompt Assessment of Needs (PAON's) were completed in 2023. This is a decrease of 22% in comparison with 2022. This decrease was most likely due to the reduction in referrals to the adolescent service and unexpected reduction in clinical capacity.

Referrals to the adolescent service are centrally received and reviewed by the Willow Grove Adolescent Unit (WGAU) clinical team. All referrals (n=972) were assessed to determine if inpatient admission, the Homecare service, or the Dean Clinics would be the best service to meet their needs.

In 2023, 738 (75.9%) of the 972 referrals received by the adolescent service were discharged prior to admission or Dean Clinic assessment. Of these, 508 (54.3%) referrals were declined by the adolescent team. The main reasons for declining the referrals were due to the adolescent service being at capacity and not able to offer prompt admission or a Dean Clinic assessment in an appropriate time frame to meet their urgent needs. The other main reason for declining referrals to the adolescent service was that we did not have an appropriate service to meet the young person's needs. In these instances, the clinical team would make recommendations for alternative treatment options. This referral-refusal rate is on par with the HSE CAMHS referral-refusal rate of 55% and the United Kingdom's (UK) National Health Service's (NHS) average referral-refusal rate of 54%.

The balance of the referrals received by the adolescent service that were discharged prior to admission or Dean Clinic assessment 230 (23.7%) were discharged for several reasons ie., due to the young person not meeting the required age parameters, the parents / young person declining services offered, or the young person being admitted to another service.

2.2.8. Adolescent referral source by province

The table below illustrates the geographical spread of adolescent referrals by province from 2021. The highest referral volume is from Leinster.

Table 2.6. *Adolescent service referrals by province*

Year	Leinster	Munster	Connaught	Ulster
2021	746	294	45	20
2022	695	291	44	15
2023	603	286	58	25

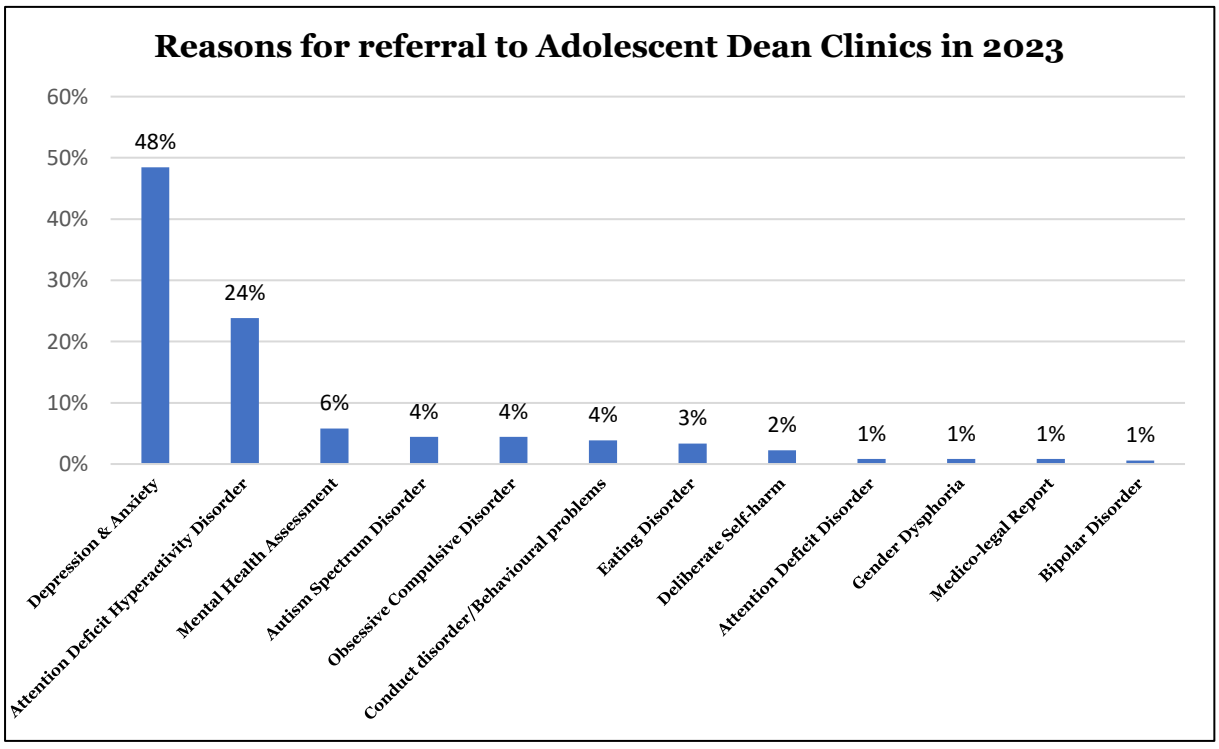
2.2.9. Dean Clinic referrals by gender

The female to male ratio of Dean Clinic adolescent referrals for 2023 was 1:0.59. There was a 1% decrease in male referrals in comparison to 2022.

2.2.10. Reasons for referral to adolescent Dean Clinics

Figure 2.3 reflects a sample of the reasons for referral from referrals to the Adolescent Dean Clinics throughout 2023 by General Practitioners (GPs), HSE CAMHS, private consultants, HSE adult mental health inpatient services and independent mental health services. The most common reasons for referral were depression and anxiety, attention deficit hyperactivity disorder (ADHD) and referrers seeking a mental health assessment for their service users.

Figure 2.3. *Reasons for referral to the Adolescent Dean clinics in 2023*



2.2.11. Dean Clinic Activities

The table below summarises the number of referrals received by the Adolescent Dean Clinics and the number of adolescent mental health assessments provided across the Adolescent Dean Clinics since 2021.

In 2023, 326 referrals were forwarded to the Adolescent Dean Clinics representing a decrease of 17.3% in comparison to the number of referrals in 2022. This reduction in referrals to the Adolescent Dean Clinic is in part due to the overall decrease in referrals to the adolescent service in 2023; as well as referrals declined at initial review due being at capacity and not being able to offer a prompt Dean Clinic assessment in an appropriate time frame to meet their urgent needs; or unavailability of an appropriate service within the Dean Clinics to meet the young person's needs. In these instances, the clinical team would make recommendations for alternative treatment options.

The increased capacity of the Homecare service increased accessibility to the service by creating an acceptable alternative to in-person 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 at assessment appointments; young people declining the assessment or being 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 also required prior to adolescent assessments taking place. Table 2.7 provides a summary of the number of referrals received and the number of assessments completed in 2023.

Table 2.7. *A summary of the number of referrals and mental health assessments provided in the adolescent Dean Clinics from 2021 - 2023.*

Year	No. of referrals to Adolescent Dean clinics	No. of assessments in the Adolescent Dean Clinics
2021	440	123

2022	394	109
2023	326	120

There was an 10.1% increase in the Adolescent Dean Clinic assessments in 2023. 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 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 in 2023 by the Adolescent Dean Clinics nationwide decreased by 1.5% in comparison to 2022. The "did not attend" (DNA) rate was 1.3%, which is 4.1% below the national DNA rate of 5.4% for CAMHS appointments in Ireland. The number of appointments is 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. Table 2.8 shows the number of Adolescent Dean Clinic appointments from 2021 – 2023.

Table 2.8. *The number of Adolescent Dean Clinic appointments from 2021 – 2023*

Year	Total no. of Adolescent Dean Clinic appointments
2021	2,049
2022	2,233
2023	2,200

The total number of admissions to WGAU included 73 in-person admissions and 70 Homecare admissions in 2023. This represents a decrease of 15.4% in the combined number of inpatient and Homecare admissions. The combined number of inpatient and Homecare first-time admissions was 86, which was a decrease of 6.5% in comparison to 2022. The reduction in admissions can be attributed to the

unexpected reduction in referring capacity from referrers ie., waiting times to access Child and Adolescent Mental Health Services (CAMHS) and vacant consultant posts in CAMHS potentially reducing referrals from being sent to the adolescent services.

The table below summarises the number of first-time inpatient admissions to WGAU from 2021.

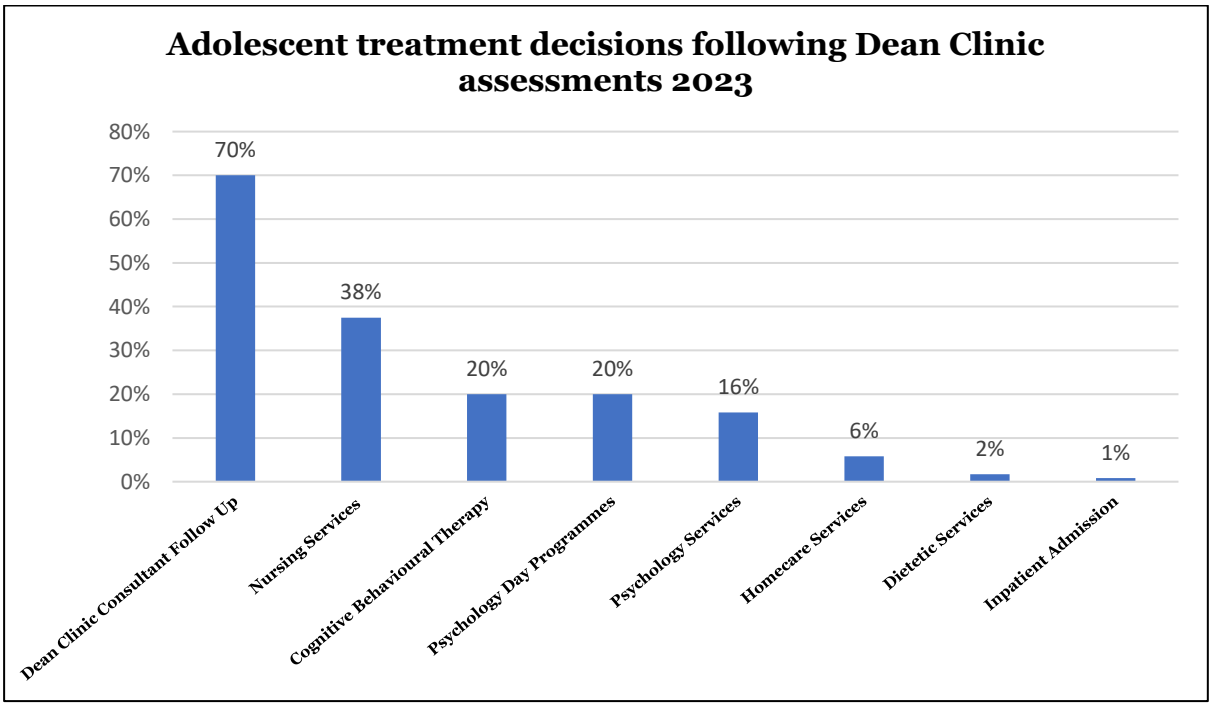
Table 2.9. *First-time inpatient admissions to WGAU from 2021 – 2023*

Year	First admission
2021	88
2022	92
2023	86

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 2023.

Figure 2.4. *Adolescent treatment decision following Dean Clinic assessments 2023*



2.3. SPMHS' Inpatient Care and Homecare Service

SPMHS inpatient services are provided in St Patrick's University Hospital (SPUH) with 241 inpatient beds, St Patrick's Lucan (SPL) contains 52 inpatient beds while Willow Grove Adolescent Unit (WGAU) 14 inpatient beds. In addition to our inpatient service provision, SPMHS provides its Homecare service, first introduced in March 2020. This service, offering all the elements of 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.

2.3.1. SPMHS inpatient and Homecare admission rates

The following information includes gender ratios, age and length of stay (LOS) distributions across SPUH, SPL, WGAU and Homecare for 2023. In 2023, 59.2% of admissions across all inpatient and Homecare were female, this compared to 61.7% in 2022.

Table 2.10. *No. of total admissions (% of total admissions) 2023*

Gender	Adult inpatient	Adult Homecare	WGAU inpatient	Adolescent Homecare	Total
Female	1,299 (57.3%)	497 (61.3%)	58 (79.5%)	55 (78.6%)	1,909 (59.2%)
Male	969 (42.7%)	314 (38.7%)	15 (20.5%)	15 (21.4%)	1,313 (40.8%)
Total	**2,268 (100%)**	**811 (100%)**	**73 (100%)**	**70 (100%)**	**3,222 (100%)**

The table below shows the numbers and percentages of admission care/treatment days delivered in 2023, providing a synopsis of the inpatient care days and the Homecare service days.

Table 2.11. *No. (%) of inpatient admission days and Homecare admission days 2023*

	Total adult	Total adolescent	Total
Homecare admission days	18,336 (18.1%)	2,645 (49.4%)	20,981 (19.6%)
Inpatient admission days	83,232 (81.9%)	2,706 (50.6%)	85,938 (80.4%)
Total admission days	**101,568**	**5,351**	**106,919**

The table below shows the average age of service users admitted across SPUH, SPL, WGAU and Homecare was 48.14 in 2023 (2022 - 47.82 years). The average age of adults admitted was 49.95 years in 2023 and was 49.79 years in 2022. The average age of adolescents admitted to WGAU, and adolescent Homecare was 15.40 years in 2023 and was 15.69 years in 2022.

Table 2.12. *Average age at admission (ALL) 2023*

Gender	Adult inpatient	Adult Homecare	WGAU inpatient	Adolescent Homecare	Total
Female	51.61	44.80	15.13	15.54	48.16
Male	49.19	46.57	16.25	15.29	48.11
Gender total	**50.54**	**45.43**	**15.36**	**15.49**	**48.14**

2.3.2. SPMHS inpatient length of stay 2023

The following tables present the 2023 average length of stay (LOS) for adult inpatients and Homecare service discharges (18 years of age and over) and adolescent inpatients and Homecare service discharges (under 18 years of age) across SPUH, SPL, WGAU and Homecare. 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.

Table 2.13. *SPMHS length of stay (LOS) for adults*

2023 adults	Number of discharges	Percentage
Under 1 week	615	20.2%
1 -<2 weeks	367	12.1%
2-<4 weeks	578	19.0%
4-<5 weeks	300	9.9%
5-<6 weeks	270	8.9%
6-<7 weeks	231	7.6%
7-<8 weeks	136	4.5%
8-<9 weeks	142	4.7%
9-<10 weeks	97	3.2%
10-<11 weeks	75	2.5%
11 weeks -< 3 months	120	3.9%
3-<6 months	101	3.3%
6 + months	13	0.4%
Total number of adult discharges 2023	**3,045**	**100.00%**

Table 2.14. *SPMHS length of stay (LOS) for adolescents (WGAU)*

2023 Adolescents	Number of discharges	Percentage
Under 1 week	20	14.0%
1 -<2 weeks	19	13.3%
2-<4 weeks	26	18.2%
4-<5 weeks	12	8.4%
5-<6 weeks	10	7.0%
6-<7 weeks	13	9.1%
7-<8 weeks	8	5.6%
8-<9 weeks	6	4.2%
9-<10 weeks	5	3.5%
10-<11 weeks	7	4.9%
11 weeks -< 3 months	9	6.3%
3-<6 months	8	5.6%
Total number of adolescents discharges 2023	143	100%

2.3.3. SPMHS analysis of inpatient Primary ICD Diagnoses (for all inpatients discharged in 2023)

The table below outlines the prevalence of diagnoses across SPMHS inpatient and Homecare settings during 2023 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 SPMHS Inpatient and Homecare settings. The data presented is based on all inpatient and Homecare discharges from SPMHS in 2023.

Table 2.15. *SPMHS analysis of inpatient Primary ICD Diagnoses*
(For all inpatients discharged in 2023)

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 2023**	SPUH Admissions		SPUH Discharges		Adult Homecare Admissions		Adult Homecare Discharges		SPL Admissions		SPL Discharges		WGAU Admissions		WGAU Discharges		Adolescent Homecare Admissions		Adolescent Homecare Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	25	1.2	29	1.4	1	0.1	1	0.1	1	0.8	3	2.3	0		0	0.0	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	335	16.0	362	17.3	31	3.8	33	4.0	14	10.6	14	10.6	0	0.0	0	0.0	0	0.0	0	0.0
F20-F29 Schizophrenia, schizotypal and delusional disorders	108	5.1	108	5.1	28	3.4	28	3.4	7	5.3	7	5.3	0	0.0	0	0.0	0	0.0	0	0.0
F30-F39 Mood [affective] disorders	962	45.9	924	44.0	325	39.9	319	39.1	65	49.2	64	48.5	15	23.1	10	15.4	14	21.5	10	15.4
F40-F48 Neurotic, stress-related and somatoform disorders	470	22.4	440	21.0	333	40.9	322	39.5	31	23.5	29	22.0	29	44.6	23	35.4	43	66.2	43	66.2
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	69	3.3	73	3.5	19	2.3	21	2.6	1	0.8	1	0.8	12	18.5	13	20.0	9	13.8	8	12.3
F60-F69 Disorders of adult personality and behaviour	123	5.9	151	7.2	76	9.3	85	10.4	12	9.1	13	9.8	1	1.5	4	6.2	0	0.0	0	0.0
F70-F79 Mental retardation	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
F80-F89 Disorders of psychological development	1	0.0	5	0.2	0	0.0	3	0.4	0	0.0	0	0.0	1	1.5	2	3.1	1	1.5	2	3.1
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	5	0.2	6	0.3	2	0.2	3	0.4	1	0.8	1	0.8	7	10.8	13	20.0	11	16.9	15	23.1
F99-F99 Unspecified	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Totals	2098	100	2098	100	815	100	815	100	132	100.0	132	100	65	100	65	100	78	120	78	120

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 2023, 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 (Mindfulness Based Stress Reduction)
7. Cognitive Based Therapy for Adolescents	20. Pathways to Wellness
8. Compassion-Focused Therapy (CFT)	21. Psychology Skills for Adolescents
9. CFT Eating Disorders	22. SABE Adolescents & families
10. Dialectical Behaviour Therapy (DBT)	23. SAGE
11. Depression Programme (incl Building Healthy Self Esteem)	24. SCEG
12. Eating Disorders Programme	25. Recovery Programme
13. Emotion Focused Therapy 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 2022 and 2023. Referrals come from a number of sources, including SPMHS multidisciplinary teams, Dean Clinics, GPs, and external mental health services. In 2023, the WRC received a total of 2,207 referrals compared to a total of 2,543 for 2022, a year-on-year decrease of 14%. This decrease is likely due to a number of new appointments within our consultant psychiatrist group during 2023, resulting in slightly different referral practices. Early indicators are suggestive of referral volumes reverting to normal levels in the first quarter of 2024. Of the day

programme referrals for 2023; 19% were received from Dean Clinics. This compares to a total of 26% referrals received from Dean Clinics in 2022. The majority of day programme referrals are created internally by the service users' multidisciplinary team. This is consistent with previous years.

Table 2.16. *Individual day programme referrals for 2022 and 2023*

SPMHS Day Programmes	Total day programme referrals 2022	Total day programme referrals 2023
Access to Recovery	217	189
Acceptance Commitment Therapy	279	305
Addictions Programmes	259	244
Anxiety Programme	202	206
Bipolar Programme	74	94
Building Strength and Resilience	77	38
CBT for Adolescents	45	5
Compassion-Focused Therapy	221	151
CFT Eating Disorders	23	24
DBT	147	90
Depression Programme (incl BHSE)	167	135
Eating Disorders Programme	88	84
EFT YA	50	30
Family Therapy for Anorexia	9	1
Formulation Group Therapy	85	84
Group Radical Openness	93	82
Living Through Psychosis (CFT-P)	28	26
Mindfulness (MBSR)	76	50
Pathways to Wellness	92	83
Psychology Skills for Adolescents	24	24
SABE Adolescents & Families	49	29
SAGE	29	18
SCEG	23	1
Recovery Programme	120	170
Schema Group Therapy	33	15
Trauma Group Therapy	33	29
Total	**2,543**	**2,207**

2.5.2. Day programme referrals by gender

Of all referrals to day services in 2023, 1,418 (64.25%) were female, 789 (35.74%) were male, a slight (4%) increase in male referrals and associated reduction in female referrals compared to previous years.

2.5.3. Day programme attendances for clinical programmes 2022-2023

In 2023, of the 2,207 referrals to a day programme, 1,652 commenced day programmes. This compares to 2,651 referrals and 1,670 commencing a programme in 2022. This represented a total of 19,797 (2022) and 18,679 (2023) half day attendances respectively. Therefore, in 2022 each registered day service user attended on average 11.30 half days while in 2023 each registered day service user attended on average 10.66 half days.

Not all service users referred to day programmes commence a programme. This is due to a variety of reasons including personal circumstances (work, family, travel) or the programme that the service user was referred to was established as not clinically appropriate, following assessment by the programme clinicians. Occasionally, a service user may be referred to multiple programmes and it is not recommended that a service user attend more than one programme at a time. Service users occasionally withdraw from programmes after commencement due to; relapse of mental health difficulties, inpatient admission, personal circumstances (work, family, travel) or not feeling the programme meets their needs or expectations.

Table 2.17. *Day programme attendances at clinical programmes 2022 and 2023*

SPMHS Day Programmes	Total day programme registrations 2022	Total day programme registrations 2023	Total day programme attendances 2022	Total day programme attendances 2023
Access to Recovery	133	139	1292	1340
Acceptance Commitment Therapy	206	235	1827	1829
Addictions Programmes	264	221	2622	2173
Anxiety Programme	132	145	1405	1239
Bipolar Programme	38	55	473	520
Building Strength and Resilience	35	20	187	106
CBT for Adolescents	25	5	155	13
Compassion-Focused Therapy	134	142	1281	1097
CFT Eating Disorders	19	20	221	235
DBT	84	84	1697	1523
Depression Programme (incl BHSE)	102	92	884	875
Eating Disorders Programme	20	21	219	244
EFT YA	57	49	1988	2137
Family Therapy for Anorexia	8	1	78	1
Formulation Group Therapy	61	66	400	460
Group Radical Openness	53	53	1233	1335
Living Through Psychosis (CFT-P)	19	18	143	97
Mindfulness (MBSR)	50	49	240	208
Pathways to Wellness	52	84	1178	1593
Psychology Skills for Adolescents	29	24	247	199
SABE Adolescents & Families	83	68	1246	681
SAGE	8	7	62	26
SCEG	18	21	159	217
Recovery Programme	16	19	228	198
Schema Group Therapy	9	0	41	0
Trauma Group Therapy	15	14	291	334
Total	**1,670**	**1,652**	**19,797**	**18,679**

Section Three

Clinical Governance

3. Clinical Governance measures 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	2021	2022	2023
Clinical audits			
Number of complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**434**	**733**	**816**
Number of incidents An event or crcumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	**2,029**	**2,139**	**2,239**
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.	**5**	**6**	**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.	**72**	**64**	**51**
% 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.	**51% (37)**	**52% (33)**	**53% (27)**
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.	**28**	**19**	**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.	**85% (24)**	**84% (16)**	**73% (14)**
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.	**39**	**40**	**41**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**30**	**14**	**16**
Number of Section 60 – Medication reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of three months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	**11**	7	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.	**0**	**0**	**0**
Number of Tribunals held	**64**	**42**	**52**
Number of ECT Programme's completed within the year	**158**	**125**	**146**
Number of Physical Restraint Episodes (SPUH + SPL + WGAU)	**42**	**121**	**75**

3.2. Clinical audits

This section summarises clinical audit activity for St Patrick's Mental Health Services in 2023. 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 2023

The following table demonstrates the breakdown of projects by type undertaken in 2023, 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.	**Admission protocol** To improve compliance with the admission protocol for adult service users being admitted for either physical admission. To change practice if standards on admission protocols are not being met to ensure that the initial care plan is appropriate, and the treatment chosen and implemented on admission is provided in timely manner.	Postgraduate Training Audit Committee	Re-audit completed
4.	**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
5.	**Is ECG routinely performed on admission?** To ensure that ECGs are routinely performed on admission to inpatient services of St Patricks University Hospital, St Patricks Hospital, Lucan and Willow Grove Adolescent Unit.	Clinical Governance Committee	Re-audit completed
6.	**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

No.	Audit title	Audit lead	Status at year end
7.	**Clozapine pathway** To ensure that Clozapine is prescribed according to guidelines in local policy. To ensure adherence to the SPMHS Clozapine Initiation Pathway.	Clinical Governance Committee	Re-audit completed
8.	**Monitoring of service users when lithium therapy is initiated** To ensure that the lithium therapy is efficacious and monitored effectively. To increase the safety of service users prescribed lithium. To ensure that a service user is effectively educated about the lithium therapy including the side effects and benefits. To assess compliance with local policy.	Clinical Governance Committee	Re-audit completed
9.	**Benzodiazepine and Hypnotic Snapshot** To determine the percentage of inpatients prescribed benzodiazepines and night sedation (z-drugs) in St Patrick's University Hospital, St Patrick's Hospital Lucan, and Willow Grove Unit and to facilitate consideration of the findings by multidisciplinary teams.	Drug and Therapeutic Committee	Re-audit completed
10.	**Appropriate use of benzodiazepines and hypnotic drugs on Vanessa** To ensure safe usage of benzodiazepines and hypnotics to service users receiving inpatient care on Vanessa in order to minimalize side effects that might be caused by these drugs and that are associated with increasing the risk of falls. To ensure compliance with local policy. To ensure the use of benzodiazepine and hypnotic drugs is appropriate, feedback the findings to the Teams and to change the practice if needed.	Clinical Governance Committee Multidisciplinary Team	Baseline audit completed
11.	**Appropriateness and effectiveness of antibiotic prescribing practice** To increase the effectiveness of infection management and to ensure that antibiotics are prescribed appropriately.	Infection Control Committee	Re-audit completed

No.	Audit title	Audit lead	Status at year end
12.	**The use of melatonin (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards and benchmark the results with the UK Trusts.	Clinical Governance Committee	Baseline audit completed
13.	**The quality of valproate prescribing in adult mental health services (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards and benchmark the results with the UK Trusts.	Clinical Governance Committee	Re-audit completed
14.	**Prescribing of antipsychotic medication in adult mental health services, including high dose, combined, and PRN (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards and benchmark the results with the UK Trusts. To ensure that high dose antipsychotic therapy and combined antipsychotic therapy is appropriately monitored to promote safe use.	Clinical Governance Committee	Re-audit completed
15.	**Prescribing of antipsychotic medication in adult mental health services, including high dose, combined, and PRN - supplementary local audit for SPMHS Homecare service** To assess adherence to best practice standards and benchmark the results with the UK Trusts. To ensure that high dose antipsychotic therapy and combined antipsychotic therapy is appropriately monitored to promote safe use.	Clinical Governance Committee	Baseline audit completed
16.	**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 2023
17.	**Nursing Metrics** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit.

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

3.2.2. Key audit outcomes for 2023

- A Clinical Audit Programme for audits of compliance with regulations for approved centres was continued in 2023. The findings confirmed that all clinical and non-clinical staff have been committed to maintaining good practice and to provide the highest standards of quality care and treatment.

- A full cycle clinical audit on admission protocols was facilitated by a group of non-consultant hospital doctors. This project looked at the specific aspects of the admission process that had been challenging in previous audits. Following implementation of a robust action plan for improvement, the second re-audit confirmed meaningful improvements in compliance levels with most standards. The audit was presented at a biannual College of Psychiatrists of Ireland conference.

- The local policy was reviewed and reinforced based on the clozapine pathway audit findings.

- Data from the benzodiazepine and hypnotic snapshot showed that it is WGAU practice to not prescribe this medication. In St Patrick's University Hospital, the rate of benzodiazepine and hypnotics prescribing was the lowest reported since 2010. In St Patrick's Hospital, Lucan, the rate of hypnotics prescribing was also the lowest reported and the rate of benzodiazepine prescribing was insignificantly higher than the rate reported in 2022, however still remarkably lower than reported in the initial snapshot in 2010.

- Following an audit on appropriateness and effectiveness of antibiotic prescribing practice, the local protocol on antibiotic prescribing, and management of urinary tract infections, is currently being updated in line with relevant national guidelines.

- SPMHS took part in the Prescribing Observatory for Mental Health (POMH-UK) baseline audit on melatonin use in adolescent services. Full compliance with the standard on evidence-based, non-pharmacological interventions being tried before melatonin is prescribed, and on the standard on clinical review of the response to melatonin, was achieved. The prescribers agreed to improve and reinforce current practice in the documentation of informed consent to treatment with melatonin and evidence of the discussion with parents and service users regarding the use of

unlicensed medication. Although melatonin is commonly prescribed and available over the counter in many countries, it is unlicensed in children in Ireland.

- SPMHS also participated in two further POMH-UK audits on prescribing practices in adult populations: sodium valproate and antipsychotic medication. The data showed that SPMHS levels of prescribing combination or high dose antipsychotic medication therapy is at the same level reported in the total POMH-UK national sample, and in most key metrics, SPMHS are exceeding the comparable benchmark data provided by POMH-UK.

- Analysis of the data from the POMH-UK re-audit on prescribing sodium confirmed that SPMHS clinicians practice on monitoring physical health of service users treated with sodium valproate achieved high standards in comparison to the POMH-UK national sample. A small number of females of childbearing potential under the care of SPMHS are prescribed valproate. Sodium Valproate is a mood stabilising medication and one of several medications associated with serious teratogenic effects. SPMHS has committed to ensure the safety of a potential unborn baby if a woman of childbearing potential is prescribed a medication with teratogenic effect. For this reason, continuous monitoring of adherence to the national protocol to minimise risks if valproate prescribing during pregnancy is being implemented.

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-programme 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 2023

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 333 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

Table 4.1. *Admission type, age and gender of sample*

		TOTAL ADULT SERVICE	WGAU
Sample size		333	91
Admissions	First admission	36%	96%
	Re-admission	64%	4%
Average age ± standard deviation		52±19	15±1
Gender	Female	62%	79%
	Male	38%	21%

4.2.2.1. ICD-10 admission diagnosis

Table 4.2. *The percentage of primary admission ICD-10 diagnosis codes recorded in the sample.*

		TOTAL ADULT SERVICE			WGAU		
ICD-10 Admission diagnosis category		**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
F30-F39	Mood disorders	47%	45%	39%	32%	17%	20%
F40-F48	Neurotic, stress-related and somatoform disorders	21%	27%	32%	31%	35%	52%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	10%	12%	12%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	9%	4%	5%	0%	0%	0%
F50-F59	Behavioural syndromes associated with physiological	3%	3%	4%	18%	15%	13%

	disturbances and physical factors						
F00-F09	Organic, including symptomatic, mental disorders	0%	2%	1%	0%	0%	0%
F60-F69	Disorders of adult personality and behaviour	8%	8%	8%	5%	0%	1%
F80-F89	Disorders of psychological development	0%	0%	0%	1%	6%	2%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0.3%	13%	28%	12%

4.2.3. Baseline and final assessment scale scores

Table 4.3. *Total adult service*

CGIS - Baseline measure of severity of illness		**2021 Total**	**2022 Total**	**2023 Total**
1	Normal, not at all ill	1%	0%	2%
2	Borderline mentally ill	2%	1%	2%
3	Mildly ill	12%	14%	13%
4	Moderately ill	40%	34%	37%
5	Markedly ill	27%	25%	21%
6	Severely ill	11%	14%	14%
7	Extremely ill	0%	0%	1%
	Not scored	8%	11%	12%

Table 4.4. *Total adult service*

CGIC – Final global improvement or change score		**2021 Total**	**2022 Total**	**2023 Total**
1	Very much improved	8%	5%	4%
2	Much improved	41%	41%	42%
3	Minimally improved	29%	29%	28%
4	No change	12%	8%	8%
5	Minimally worse	1%	0%	1%
6	Much worse	0%	0%	0%
7	Very much worse	0%	0%	0%
	Not scored	9%	15%	17%

Table 4.5. *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		**2021**		**2022**		**2023**	
		Baseline	**Final**	**Baseline**	**Final**	**Baseline**	**Final**
100-91	Superior functioning	0%	0%	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	1%	0%	2%
80-71	No more than a slight impairment in functioning	0%	0%	1%	2%	2%	13%
70-61	Some difficulty in a single area, but generally functioning pretty well	1%	19%	2%	20%	7%	27%
60-51	Variable functioning with sporadic difficulties	3%	37%	12%	31%	14%	22%
50-41	Moderate degree of interference in functioning	17%	28%	40%	31%	38%	26%
40-31	Major impairment to functioning in several areas	67%	15%	35%	11%	24%	8%
30-21	Unable to function in almost all areas	9%	0%	10%	2%	14%	0%
20-11	Needs considerable supervision	3%	1%	0%	0%	0%	0%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	1%	0%	0%	3%	0%	1%
Mean ±SD		37±7	51±10	41±9	52±11	43±11	57±12
Median		37	52	41	52	41	58
Wilcoxon Signed Ranks Test:		Z=-8.558, p<.001		Z= -7.745, p<.001		Z= -7.605, 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

Table 4.6. *Results of clinical audits*

	TOTAL ADULT SERVICE			WGAU		
	2021	**2022**	**2023**	**2021**	**2022**	**2023**
Baseline assessment scale score						
% of admission notes with recorded baseline scores	92%	89%	88%	99%	100%	100%
% compliance with clinical audit standard no. 1	81%	86%	78%	99%	98%	100%
Final assessment scale score						
% of admission notes with recorded final scores	91%	85%	83%	100%	97%	99%
% compliance with clinical audit standard no. 2	85%	94%	85%	96%	95%	99%

4.2.5. Summary of findings

- A sample was chosen out of a dataset of St Patrick's Mental Health Services discharges for 2023.

- A female to male ratio was 1.6:1 for adults and WGAU 3.8:1 for adolescents.

- In the 2023 sample, first admissions accounted for 36% of adult service users and 96% of adolescent service users.

- 2023 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 2023, 37% of SPUH and SPL service users were moderately ill. Another 21% were markedly ill. 14% were severely ill.

- Based on a sample of 275 (total cases with discharge CGI score documented) 89% of the sample were rated with an overall improvement (1 - very much improved (4%), 2 - much improved (51%) and 3 - minimally improved (34%)). This percentage of sample rated with an overall improvement is similar to observed in the 2022 data set (90% overall improvement).

- 2023 analysis of the primary ICD-10 codes showed for the adolescent population the most frequent reasons for admission were neurotic, stress related, somatoform disorders followed by mood disorders.

- In 2023, 38% of Willow Grove Adolescent Unit service users were scored as having a moderate degree of interference in functioning on admission and another 24% had major impairment in functioning in several areas. 14% was unable to function in almost all areas.

- Overall improvement rate for Willow Grove Adolescent Unit was 89%.

- 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 decreased for adults and slightly increased 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
- Aftercare
- 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 2023, 120 participants completed the full programme and returned pre and post data. 60% of participants were male and 40% 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.

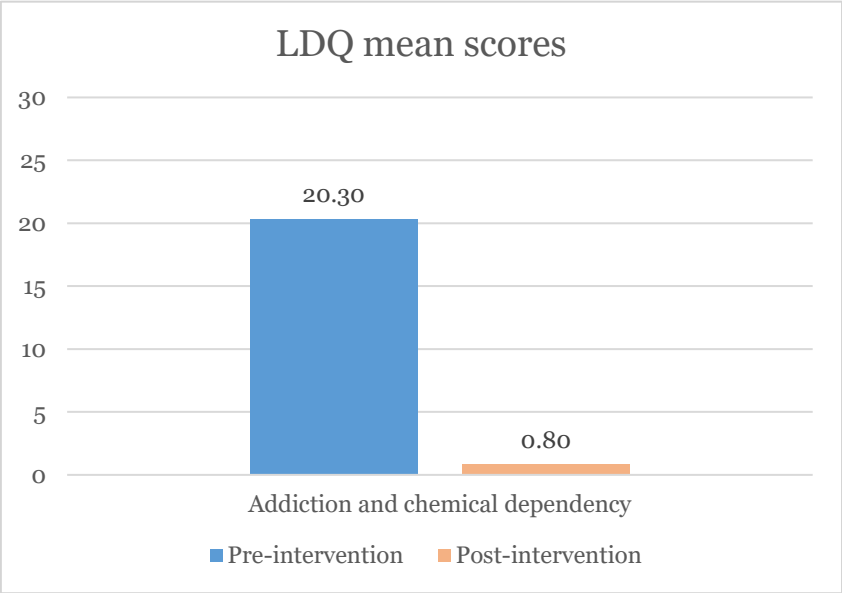
Analysis of the measure has shown it to have high internal consistency (alpha = .88), good test-retest reliability (r = 95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al 1994). The LDQ has also been suggested as an appropriate 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 paired samples t-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, t (119) = 32.81, p < 0.05, with a large effect size (d = 3.96). The mean score on the total LDQ scores decreased from pre-intervention (M = 20.30, SD = 6.81) to post-intervention (M = 0.80, SD = 1.42), as depicted in the graph below.

Figure 4.1. *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

111 individuals with complete data were included in this analysis. These participants attended and completed the full or modified programme in 2023. Of these, 49.5% were male and 50.5% female. The age of participants ranged from 19 to 74, with a mean age of 44.3 (*SD* = 14.80).

4.4.2. Dual Diagnosis Programme 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).

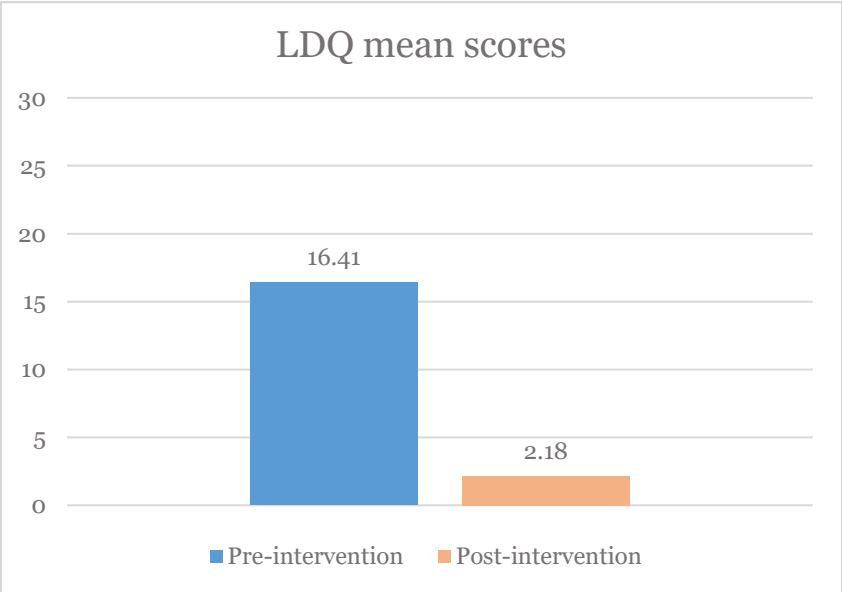
Items are scored on a four-point scale from zero – 'never', to three – 'nearly always', with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been 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 paired samples t -test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, t (110) = 20.66, p < .05, with a large effect size (d = 2.47). The mean score on the total LDQ decreased from 16.41 (SD=7.65) pre-programme to 2.18 (SD=2.82) post-programme, as depicted in the graph below.

Figure 4.2. *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 2023, 76 individuals completed pre and post-measures, including 44 females (57.9%) and 32 males (42.1%). The age of participants completing the programme ranged from 23 to 72 (mean age of 49.97).

4.5.2. ACT Programme 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**

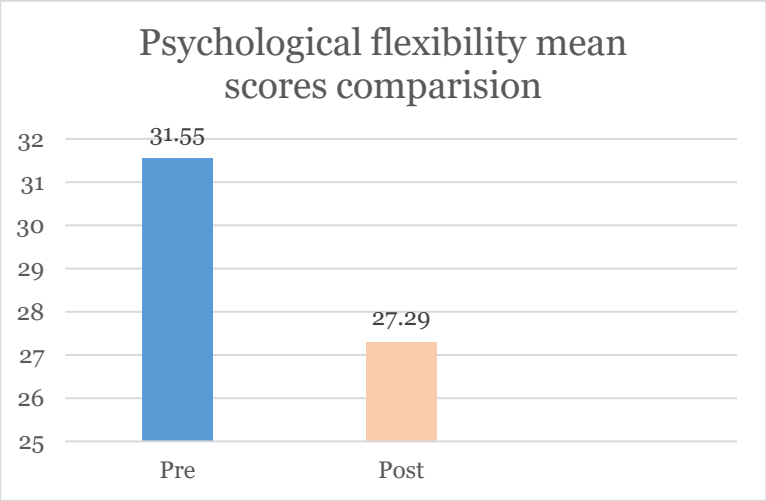
The Self-Compassion Scale (SCS) is a 26-item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; self-kindness, self-judgement, humanity, isolation, mindfulness and identification or over-identification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

Mean scores on the AAQ-II decreased significantly from (M = 31.55, SD = 8.98) to (M = 27.29, SD = 9.20) indicating greater psychological flexibility post-intervention, t (75) = 4.587.63, p <.001, with a small effect size (Cohen's d = 0.471).

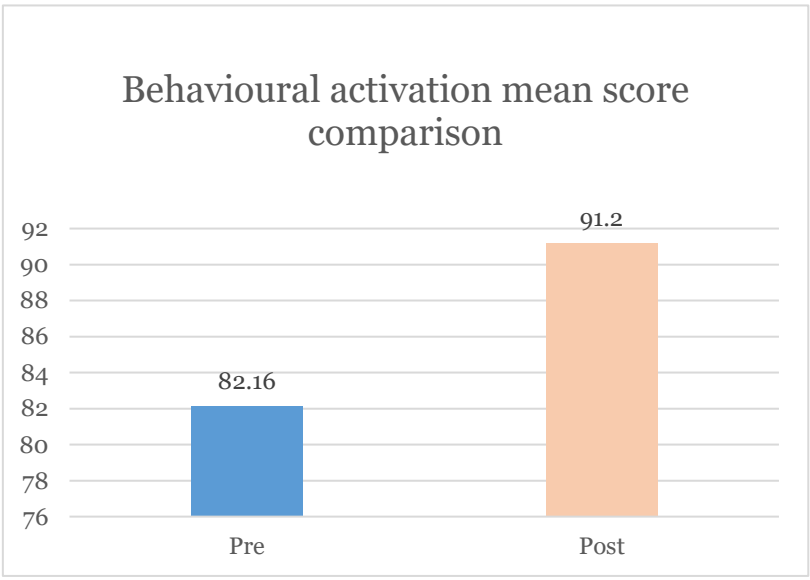
Figure 4.3. *Total mean psychological flexibility (AAQ-II) scores*



Behavioural Activation for Depression Scale (BADS)

Mean BADS scores increased significantly from (M = 82.16, SD = 29.79) to (M = 91.20, SD = 29.98) indicating greater behavioural activation, t (75) = -2.97, p < .001, representing a small effect size (Cohen's d = -0.302) (see graph below).

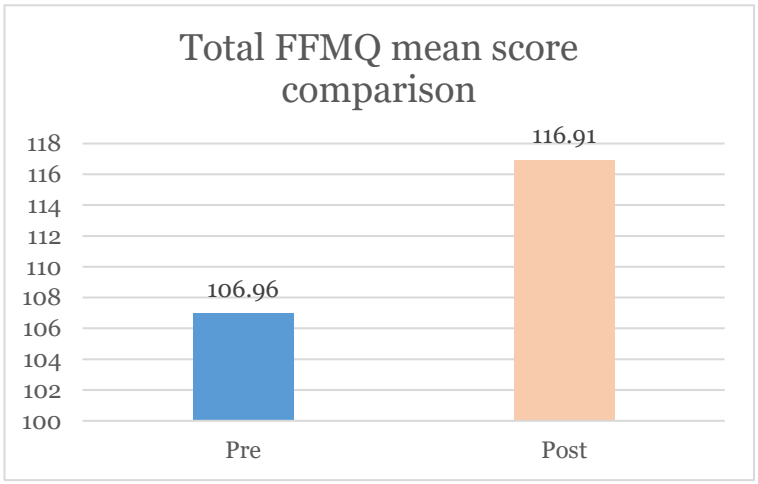
Figure 4.4. *Total mean behavioural activation scores*



Five Facet Mindfulness Questionnaire (FFMQ)

Total FFMQ scores increased significantly, t (75) = -3.78, p < .001, from pre (M = 106.96, SD = 22.74) to post (M =116.91, SD = 28.16) indicating greater levels of overall mindfulness, with a small effect size observed (Cohen's d = -0.389). Mindfulness is defined in this context as observing, describing, acting with awareness, non-reactivity to inner experience and non-judging of inner experience.

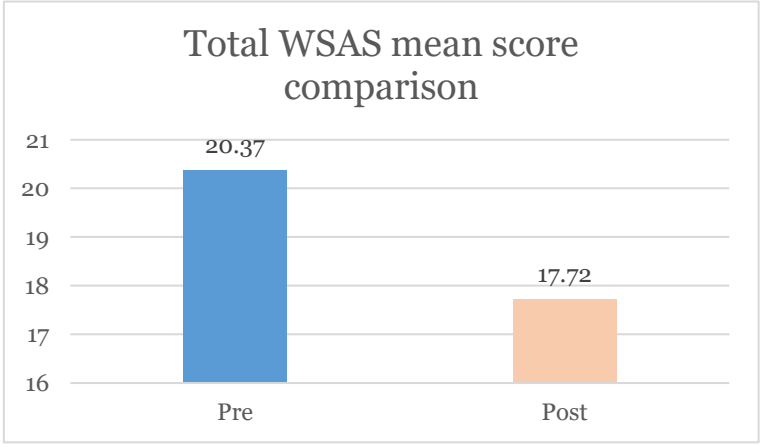
Figure 4.5. *Total Mean FFMQ scores pre and post-intervention*



Work and Social Adjustment Scale (WSAS)

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 (75) = 2.91, p = .005, from pre-intervention (M= 20.37; SD = 9.52) to post-intervention (M= 17.72; SD =11.12), with a small effect size observed (Cohen's d = 0.26). This finding indicates that those who completed the ACT programme indicated significantly less functional impairment post-intervention.

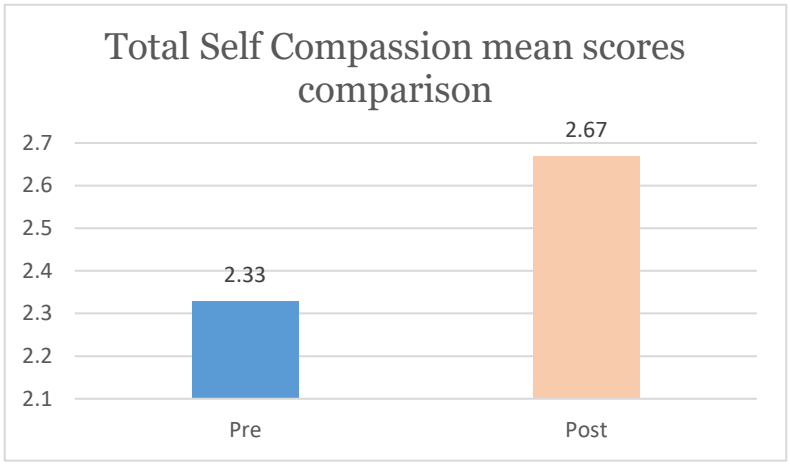
Figure 4.6. *Total Work and Social Adjustment Scale (WSAS) scores*



Self-Compassion Scale

Total SCS scores increased significantly, t (75) = -4.64, p < .005, from pre (M = 2.33, SD = 0.68) to post (M = 2.67, SD = 0.75) indicating higher overall levels of self-compassion post-intervention. A small-medium effect size was observed (Cohen's d =-0.475). Self-compassion is measured in six domains: self-kindness, self-judgement, humanity, isolation, mindfulness and identification or 'over-identification'.

Figure 4.7. *Total Self-Compassion Scale scores pre and post-intervention*



4.5.5. Summary

In 2023, service users who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. 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 110 people who completed the programme in 2023, in which 51 (46.4%) were male and 59 (53.6%) were female. Programme attendees ranged in age from 19 to 76 (M = 39.73; SD = 15.02). Pre and post data were collected after Level 1 and Level 2 of the anxiety programme. 92 service users availed of Level 1 and 19 attended Level 2 of the anxiety programme.

OCD accounted for the largest subgroup (43.2%), followed by GAD (21%), social phobia/ anxiety (11.1%), agoraphobia (with/without panic) (7.4%), specific phobia (4.9%), panic disorder (3.7%) and unspecified (1.3%).

The table below shows the percentage of people with each diagnosis over the past three years.

Table 4.7. *Percentage of diagnoses for 2021, 2022 and 2023*

	2021		2022		2023	
	N	**%**	**N**	**%**	**N**	**%**
OCD	61	46.2	54	46.6	35	43.2
GAD	33	25	18	15.5	17	21
Social Phobia/Anxiety	14.4	14.4	21	18.1	9	11.1
Panic Disorder	3.8	3.8	7	6.0	3	3.7
Agoraphobia	6.8	6.8	13	11.2	6	7.4
Health Anxiety	1.5	1.5	0	0	6	7.4
Specific Phobia	2.3	2.3	3	2.6	4	4.9
Unspecified	0	0	0	0	1	1.3

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 2023. 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-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

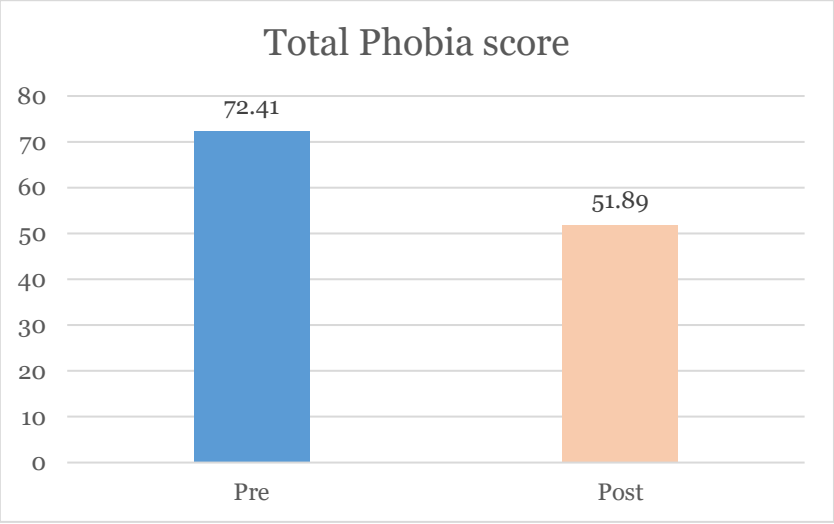
obsessive compulsive disorder or depression the scale developers report that a WSAS score above 20 suggests moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be 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

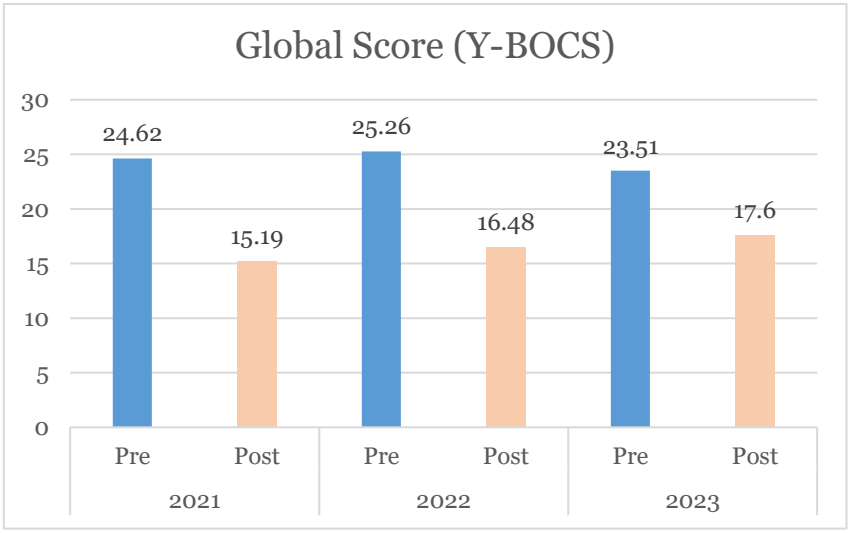
Analysis using a paired sample t-test revealed a statistically significant change between pre and post-intervention at Level 1 on the Total Phobia scores within the Fear Questionnaire, t (91) = 10.96, p < .001. The mean Total Phobia score decreased from 72.41 (SD = 29.17) to 51.89 (SD = 27.40), representing a medium effect size (Cohen's d= .725).

Figure 4.8. *Fear Questionnaire mean Total Phobia scores pre and post-intervention for 2023.*



The Yale Brown Obsessive Compulsive Scale

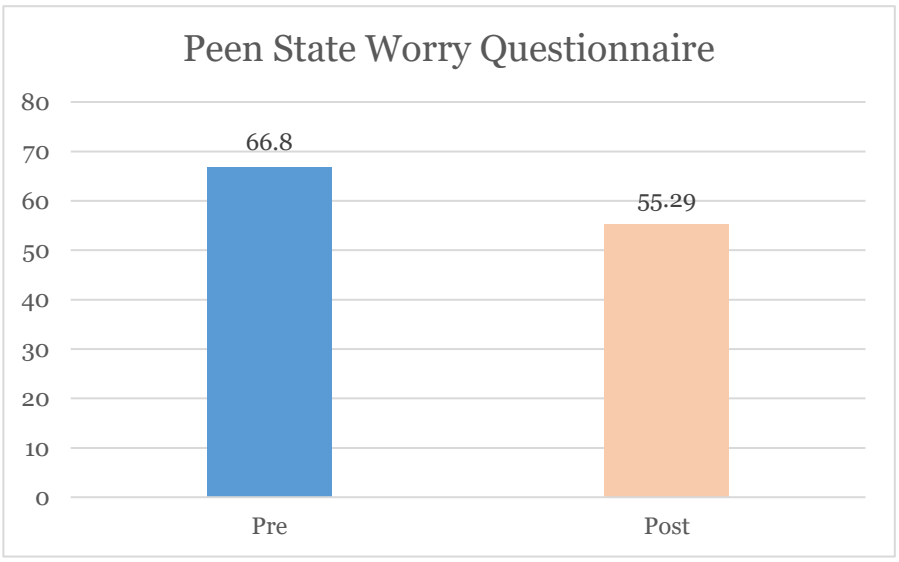
Figure 4.9. *Yale Brown Obsessive Compulsive Scale mean total scores pre and post-intervention for 2021, 2022 and 2023.*



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 (42) = 8.029, p <.001, with the total mean score changing from 23.51 (*SD* = 6.83) to 17.60 (*SD* = 6.65). This indicates an overall significant reduction in the severity of OCD symptoms post-intervention with a large effect size (Cohen's d = 0.88).

Penn State Worry Questionnaire (PSWQ)

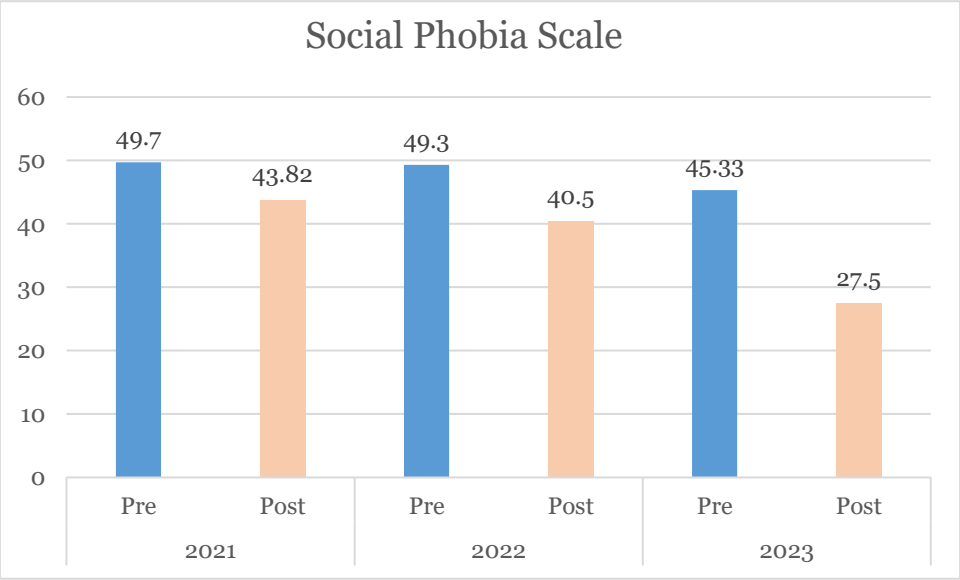
Figure 4.10. *Penn State Worry Questionnaire mean scores pre and post-intervention for 2023*



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 (23) = 7.62, p < .001, between pre-intervention (M= 66.17, SD = 8.19) and post-intervention (M= 55.29, SD = 10.6). This change reflected a large effect size (Cohen's d= 1.15).

Social Phobia Inventory (SPIN)

Figure 4.11. *Social Phobia Inventory mean scores pre and post intervention in 2021, 2022 and 2023.*

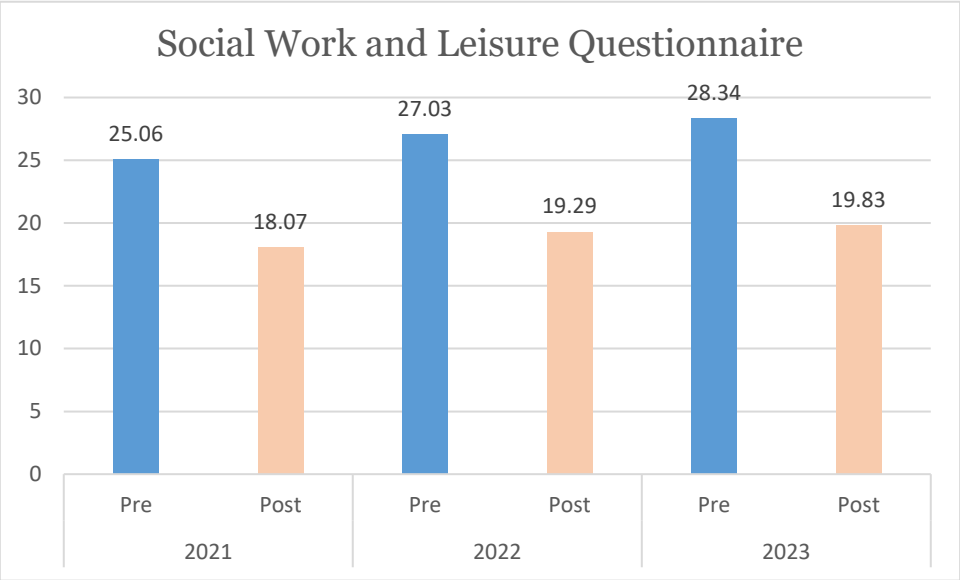


Analysis of the SPIN using a paired sample t-test indicated a statistically significant reduction in service users scores, t (17) = 5.24, p < .001, from pre-intervention (M= 45.33, SD = 9.98) to post-intervention (M= 27.5, SD = 11.74). This reflected a large effect size (Cohen's d= 1.64).

The Social Work and Leisure Questionnaire

Analysis of the SWLQ using a t-test indicated that there was a statistically significant reduction in mean scores observed, t (91) = 9.93, p < .001, from pre-intervention (M = 28.34, SD = 10.2) to post-intervention (M = 19.83, SD = 10.28) at Level 1. This result reflected a large effect size (Cohen's d = 0.83).

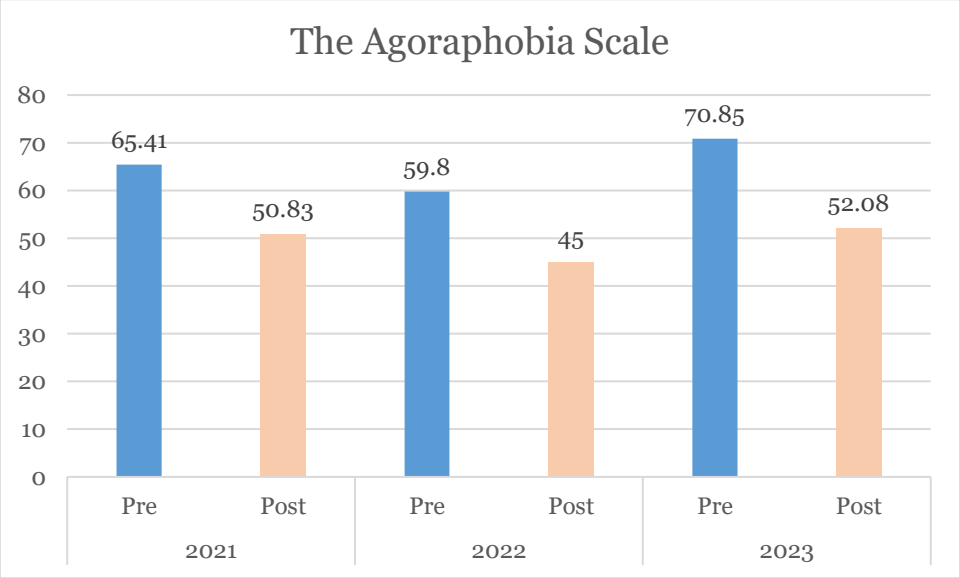
Figure 4.12. *Social Work and Leisure Questionnaire Group mean score pre and post-intervention for 2021, 2022 and 2023*



The Agoraphobia Scale

Scores on the Agoraphobia Scale reduced from pre-intervention (*M*= 70.85, *SD* = 29.66) to post-intervention (*M*= 52.08, *SD* = 27.87). 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* (12) = 5.67, p < .00. A medium effect size was observed (Cohen's *d*= 0.65).

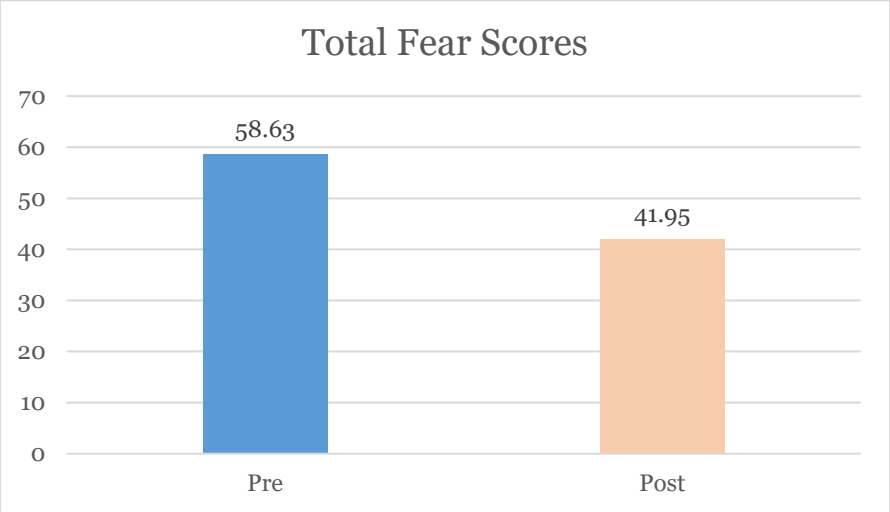
Figure 4.13. *The Agoraphobia Scale mean scores pre and post-intervention for 2021, 2022 and 2023*



Level 2 results

The Fear Questionnaire

Figure 4.14. *The Fear Questionnaire, Mean Symptom pre and post-intervention*

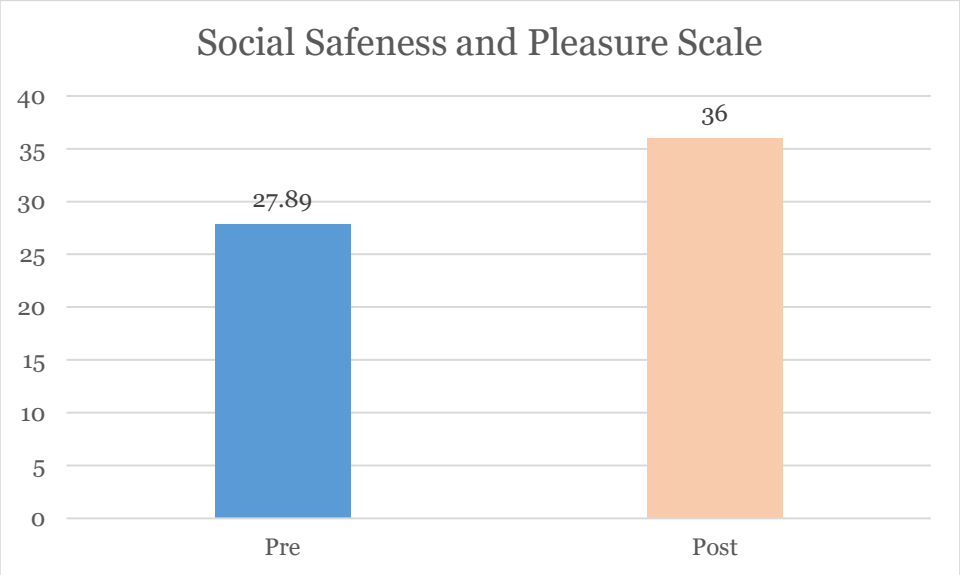


Total symptom scores on the Fear Questionnaire reduced from 88.67 (SD = 21.55) to 63.33 (SD = 23.97). A paired samples t-test indicated that there was no statistically significant difference, t (2) = 3.98, p =.058.

The Social Safeness and Pleasure Scale

Service users scores on the Social Safeness and Pleasure Scale showed a change from a mean of 27.89 (*SD*= 7.57) pre-intervention to 36 (*SD*= 7.51) post-intervention. A pairwise t-test was used to analyse the sample. This increase was statistically significant t (17) = -6.1, p < .001, with a trivial effect size (Cohen's d =-1.076).

Figure 4.15. *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 2023 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 2023 suggest further increases in feelings of safety, warmth, acceptance and belonging within their social world.

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 recognising 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 12 service users who completed the programme in 2023: 11 females (82.7%) and 1 male (8.3%). The age profile of participants ranged from 24 to 63 years, with the average age being 47.25 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 =

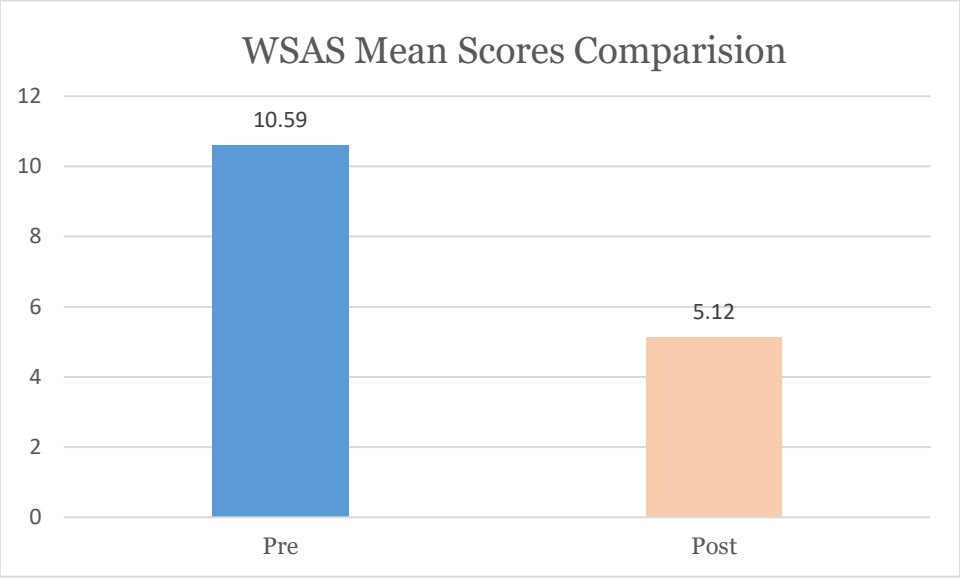
very severe. Total scores range from 0-27. The QIDS has been found to have high internal consistency with a Cronbach's alpha of 0.83. The QIDS is based on the 30-item IDS questionnaire, for which it has good concurrent validity (Ware et al, 1996). The IDS is shown to have comparative sensitivity and 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 = 10.59, SD = 7.78) to post-intervention (M = 5.12, SD = 6.58). This reduction in mean scores is not statistically significant. A paired samples t-test revealed t (12)=2. 09 p < .060, with a meduim effect size (Cohen's d = 0.705) (see graph below). This finding indicates that those who completed the programme in 2023 significantly improved their functioning post-intervention.

Figure 4.16. *Total WSAS Mean Scores pre and post-inervention*

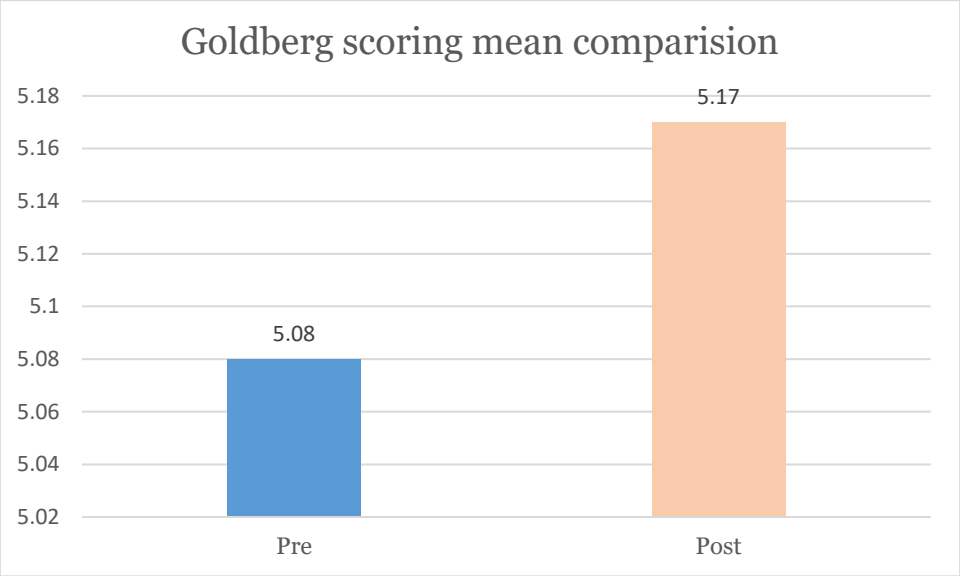


The Goldberg Mania Scale

Comparison of service user scores on the Goldberg Mania Scale indicated a reduction of mania severity scores from pre-intervention (M = 5.08, SD = 8.74) to post-intervention (M = 5.17, SD = 9.27). This reduction in mean scores is not statistically

significant. A paired samples t-test revealed t (12)= -0.62 p < 0.952 , with a trivial effect size (Cohen's d = -0.01) (see graph below). The Goldberg Mania scale is completed as part of the assessment for suitability to engage in the programme. Service users would need to be stable in terms of their symptoms of mania before completing the programme, to ensure they can adaquetly theraputically engage. Therefore, the lack of statistically signifant change in the results of the Goldberg Mania Scale results are to be expected.

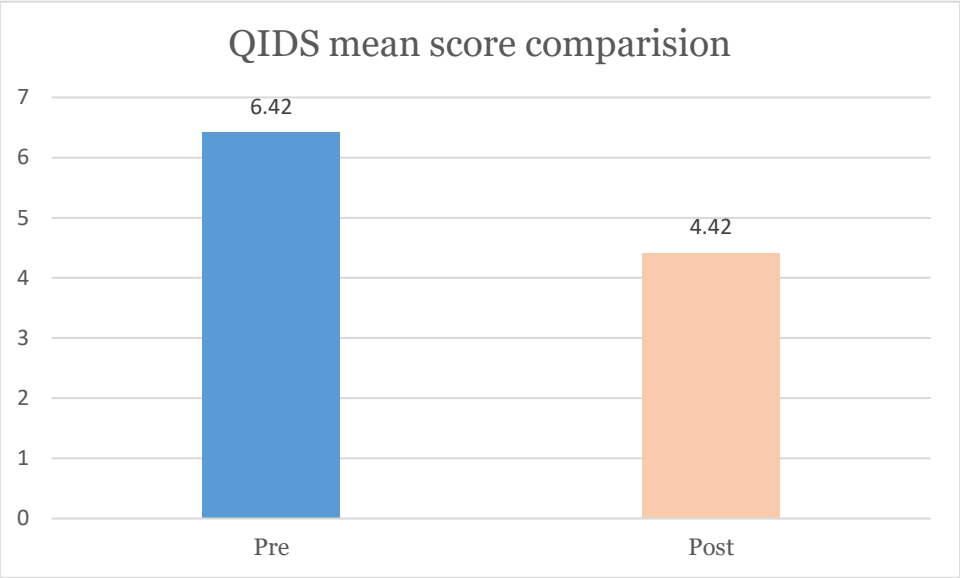
Figure 4.17. *Total Goldberg Mean scores pre and post-intervention.*



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 = 6.42, SD = 2.94) to post-intervention (M = 4.42, SD = 2.1). This reduction in mean scores is not statistically significant. A paired samples t-test revealed t (12)= 1.78 p < .102, with a small effect size (Cohen's d = 0.39) (see graph below). This finding indicates that those who completed the programme in 2023 significantly improved their functioning post-intervention.

Figure 4.18. *Total QIDS mean scores pre and post-intervention*



4.7.4. Summary

This is the second 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 2023, of those who completed the programme, 12 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 2023 yielded overall reductions in their functioning impairment in both WSAS and QIDS, however there was no change in Goldberg mania symptoms pre and post-intervention as this was not measure expected to change within the programme content.

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. Building Healthy Self-Esteem Programme

The Building Healthy Self-Esteem (BHSE) Programme is designed to help individuals build healthy self-esteem using cognitive behavioural therapy. The course is aimed for service users with low self-esteem. This can be debilitating phenomenon often leading to, or exacerbating, anxiety and/ or depression. CBT can help the individual address their low self-esteem and develop a more positive attitude towards themselves, whereby the individual acts in an accepting, respectful and trusting manner towards themselves. The group is facilitated by a team of mental health professionals, including a cognitive behavioural therapist and nurses with expertise in cognitive psychotherapy, compassion- focused therapy and mindfulness-based stress reduction.

The programme runs for a half day a week for 10 weeks over Microsoft Teams. There are 12 participants per cycle.

4.8.1. Descriptors

A total of 24 people completed BHSE in 2023. Complete pre and post-outcome data were available for 14 people, representing a 58.33% total completion rate. 12 participants (85.7%) were female and 2 (14.3%) were male. Participants ages ranged from 22 to 63 years with an average age of 50.29 years old.

4.8.2. Building Healthy Self-Esteem Programme outcome measures

- **Rosenberg Self Esteem Scale (RSES)**

The Rosenberg Self Esteem Scale (RSES) is a ten-item scale that measures self-esteem on a four-point Likert-type scale — from strongly agree, to strongly disagree. The RSES is one of the most widely used measures of self-esteem (Sinclair et al., 2010). Self-esteem is not a singular construct and has been divided equally to measure two 5-item facets; self-competence and self-liking. The minimum total score is 0 and the maximum is 30, with higher scores representing higher self-esteem. The scale has good predictive validity, as well as internal consistency and test–retest reliability (Schmitt & Allik, 2005; Torrey, Mueser, McHugo, & Drake, 2000).

- **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)**

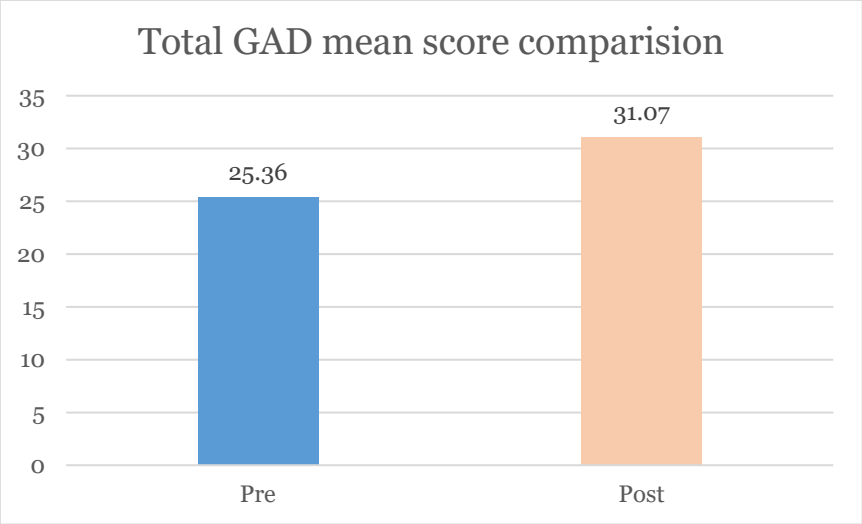
The PHQ-9 is a nine-item self-report questionnaire. It is a clinically validated screening tool that healthcare providers use to monitor the severity of depression and response to treatment (Kroenke, Spitzer, Williams, 2001). The questions address sleep, energy, appetite, and other possible symptoms 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 = severe depression.

4.8.3. Results

The Generalized Anxiety Disorder-7 (GAD-7)

There was a significant reduction in the GAD-7 total scores from pre-intervention (M = 8.21; SD = 5.59) to post-intervention (M = 4.0; SD = 4.46), t (13) = 2.90, p =.012, with large effect size (Cohen's d = 0.833). This finding indicates that those who completed the programme significantly reduced their anxiety symptoms post-intervention (see graph below).

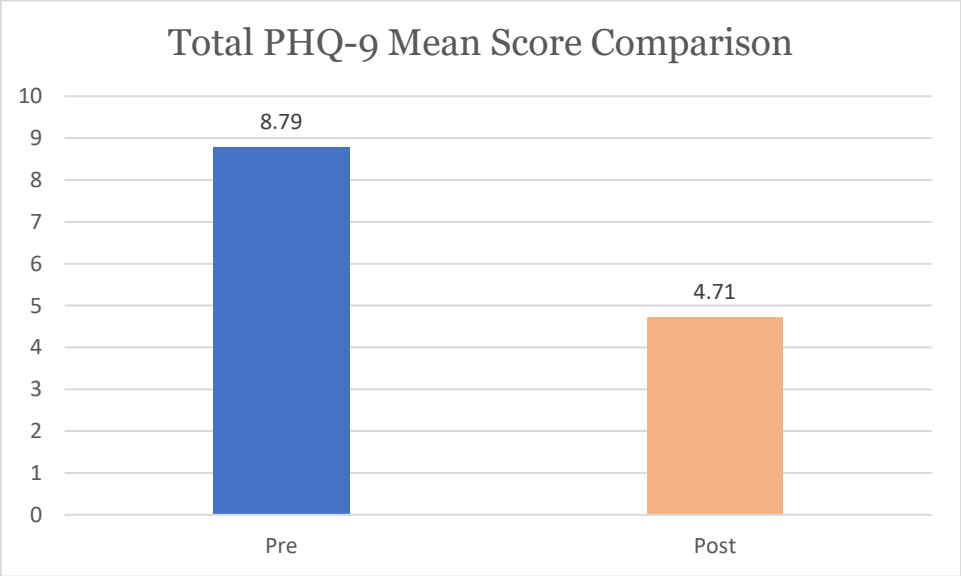
Figure 4.19. *The Generalized Anxiety Disorder-7 (GAD-7) mean total scores pre and post-intervention.*



The Patient Health Questionnaire-9 (PHQ-9)

There was a significant reduction in the PHQ-9 total scores from pre-intervention (M = 8.79; SD = 5.87) to post-intervention (M = 4.71; SD = 4.74), t (13) = 3.75, p =.002, with a medium effect size (Cohen's d = 0.77). These findings illustrate that the participants who completed the programme significantly reduced their symptoms related to depression (see graph below).

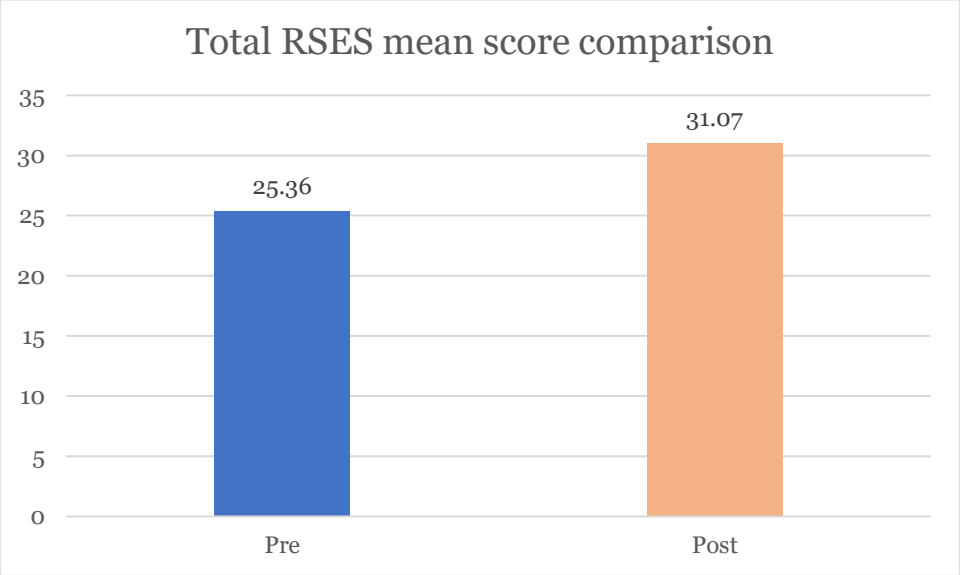
Figure 4.20. *The Patient Health Questionnaire-9 (PHQ-9) mean total pre and post-intervention*



The Rosenberg Self Esteem (RSES) Questionnaire

There was an increase in the RSES total scores from pre-intervention (M = 25.36; SD =4.53) to post-intervention (M = 31.07 SD = 4.81), t (13) = -4.73, p =.000, with a trivial effect size (Cohen's d = -1.222). These findings illustrate that the participants who completed the programme significantly increased their self-esteem (see graph below).

Figure 4.21. *The Rosenberg Self Esteem (RSES) mean total pre and post-intervention*



Summary

The Building Healthy Self-Esteem Programme has been run in St Patrick's Mental Health Services for two years, and this is the first year the outcomes have been included within this report. The results of the programme show that there were significant reductions in both symptoms related to depression and severity of depressive symptoms reduced, and post-intervention there was a significant increase in their self-esteem.

4.9. Compassion-Focused Therapy Programme

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 was implemented for 18 months from 2022 until mid 2023. The aim of the new programme structure was to reduce the waiting times for service users wishing to access the CFT group. Waiting times to access the group, and the number of individuals waiting to access CFT group, substantially reduced by 2023. As such,

from the second half of 2023 onwards, the CFT programme returned to its original structure of combined psychoeducation and therapy within the 18-session model CFT group. It was felt that the combined structure was the best fit for the needs of the current service users and staff group.

Four cycles of the CFT psychoeducation group ran in the first half of 2023. These outcomes will be reported first, followed by outcomes for the seven cycles of CFT therapy group that ran in 2023.

Compassion-Focused Therapy 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.

4.9.1. Descriptors for CFT Psychoeducation Group

Complete pre and post data was available for 11 participants of the CFT psychoeducational programme in SMPHS in 2023. 55% (n = 6) were female and 45% (n =5) were male. The mean age was 42 (SD = 13.37) with participants ranging in age from 24 to 74 years old. Due to the small sample size available for these measures, the statistical significance of changes in mean scores could not be determined. Instead, descriptive statistics for these measures pre and post-intervention are presented in the section below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

4.9.2. 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.

4.9.3. Results for CFT Psychoeducation Group

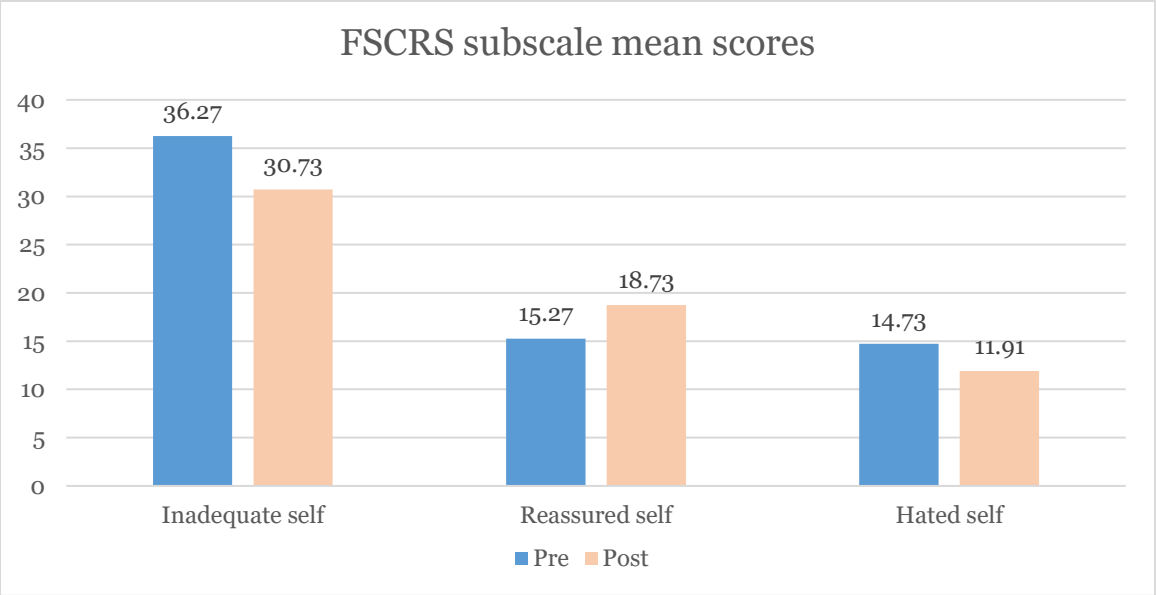
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Mean scores on the FSCRS 'inadequate self' subscale decreased from pre-intervention (M = 35.27, SD = 4.2) to post-intervention (M = 30.73, SD = 7.43).

Mean scores on the FSCRS 'hated self' subscale decreased from pre-intervention (M = 14.73, SD = 5.55) to post-intervention (M = 11.91, SD = 4.72).

Mean scores on the FSCRS 'reassured self' subscale increased from pre-intervention (M = 15.27, SD = 6.83) to post-intervention (M = 18.73, SD = 8.03).

Figure 4.22. *FSCRS subscale mean scores pre and post-intervention.*

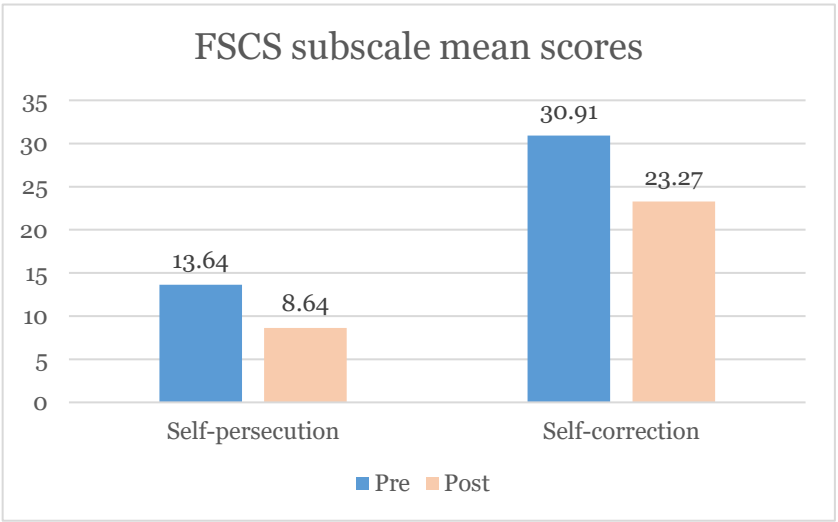


The Functions of Self-Criticising/Attacking Scale (FSCS)

Mean scores on the FSCS 'self-persecution' subscale decreased from pre-intervention (M = 13.64, SD = 9.16) to post-intervention (M = 8.36, SD = 8.16).

Mean scores on the FSCS 'self-correction' subscale decreased from pre-intervention (M = 30.91, SD = 13.17) to post-intervention (M = 23.27, SD = 12.40).

Figure 4.23. *FSCS subscale mean scores pre and post-intervention.*



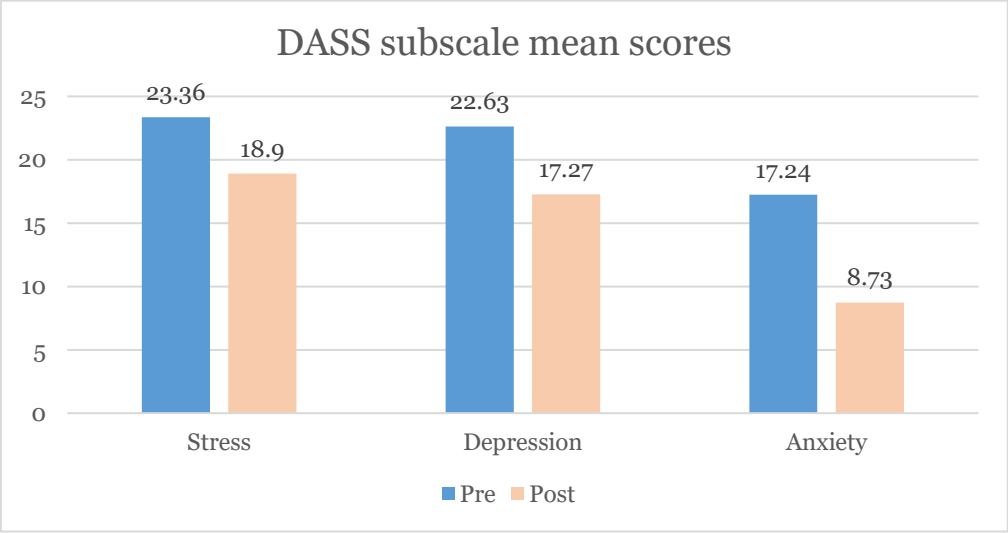
Depression Anxiety and Stress Scale (DASS)

Mean scores on the DASS depression subscale decreased significantly from pre-intervention (M = 22.63, SD = 8.70) to post-intervention (M = 17.27, SD = 11.57).

Mean scores on the DASS stress subscale decreased significantly from pre-intervention (M = 23.36, SD = 7.88) to post-intervention (M = 18.90, SD = 8.60).

Mean scores on the DASS anxiety subscale decreased from pre-intervention (M = 17.24, SD = 10.63) to post-intervention (M = 8.73, SD = 6.53).

Figure 4.24. *DASS - Depression, Anxiety and Stress Subscale mean scores pre and post-intervention.*



Compassionate Engagement and Action Scale (CEAS)

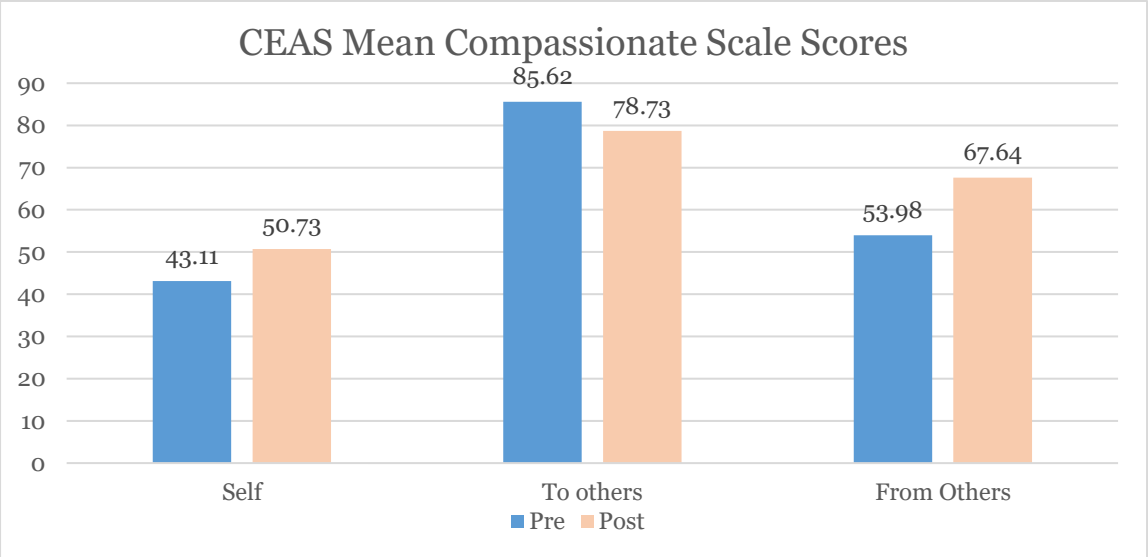
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores and scores on the engagement and action subscales are reported below.

Increases in mean scores were reported on the overall Compassion to Self Scale from pre-intervention (*M* = 43.11, *SD* = 12.40) to post-intervention (*M* = 50.73, *SD* = 15.48).

Mean scores on the Compassion to Others Scale decreased slightly from pre-intervention (*M* = 85.62, *SD* = 9.82) to post-intervention (*M* = 78.73, *SD* = 10.56).

Mean scores on the Compassion from Others Scale increased from pre-intervention (*M* = 53.98, *SD* = 23.40) to post-intervention (*M* = 67.64, *SD* = 9.03).

Figure 4.25. *CEAS Mean Compassionate Scale scores pre and post-intervention.*

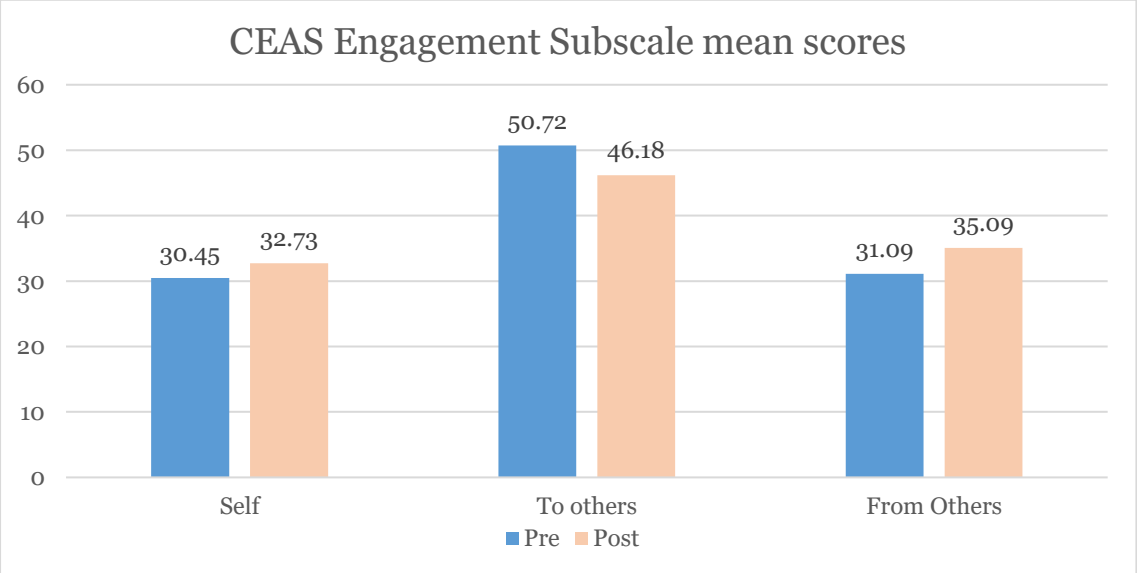


Within the Compassionate Engagement sub-scales, there was a small increase in mean scores on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 30.45, SD = 9.10) to post-intervention (M = 32.73, SD = 8.96).

There was a decrease in mean scores on the Compassion to Others subscale within the Compassionate engagement scales, with participant mean scores of (M = 50.72, SD = 6.92) at pre-intervention and (M = 46.18, SD = 7.67) at post-intervention.

There was an increase in mean scores on the Compassion from Others subscale within the Compassionate Engagement scales, with participant mean scores of (M = 31.09, SD = 14.31) at pre-intervention and (M = 35.09, SD = 8.80) at post-intervention.

Figure 4.26. *CEAS Compassionate Engagement Scale mean scores pre and post-intervention.*

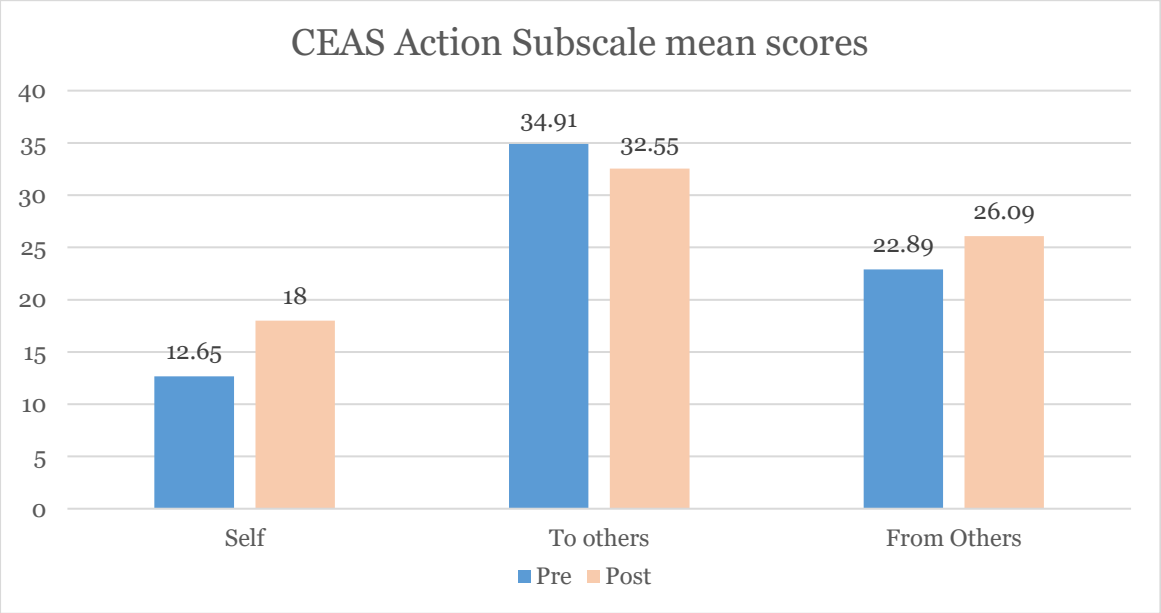


Within the Compassionate Action sub-scales, an increase in mean scores was displayed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (*M* = 12.65, *SD* = 4.27) to post-intervention (*M* = 18.00, *SD* = 7.12).

There was a small decrease observed on the Compassion to Others subscale within the Compassionate Action sub-scales, with participant mean scores of (*M* = 34.91, *SD* = 4.06) at pre-intervention and (*M* = 32.55, *SD* = 3.42) at post-intervention.

There was an increase observed on the Compassion from Others subscale within the Compassionate Action sub-scales, with participant mean scores of (*M* = 22.89, *SD* = 9.43) at pre-intervention and (*M* = 26.09 *SD* = 6.96) at post-intervention. Please see the graph below for visual representation.

Figure 4.27. *CEAS Compassionate Action Scale mean scores pre and post-intervention.*



4.9.4. Compassion-Focused 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 CFT 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

Pre and post data was available for 20 individuals who completed the CFT therapy programme in SPMHS in 2023. 50% of these were female (N = 10) and 50% were male (N = 10). Programme attendees ranged in age from 26 to 72 years old with a mean age of 45 (*M* =45.05, *SD*= 10.96).

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.

4.9.5. Results for CFT Therapy Group

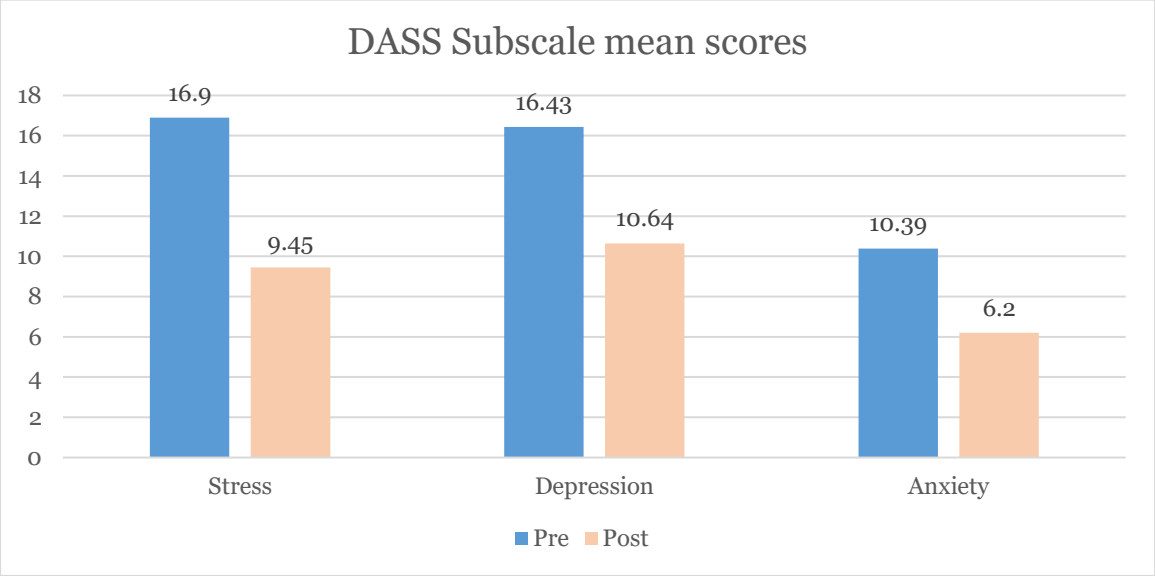
Depression Anxiety and Stress Scales (DASS)

Analysis of the DASS Stress scores from the CFT therapy programme indicated that there was a significant decrease in reported stress, t (19) = 4.49, p < .05. representing a large effect size *(d* = 1.11*)*. Participants mean scores decreased from 16.9 (*SD* = 8.06) at pre-intervention to 9.45 (*SD* = 4.94) 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, t (19) = 3.48, p <.05, with a medium effect size (d = .55). Participants mean scores decreased from 16.43 (*SD* = 11.13) at pre-intervention to 10.64 (*SD* = 9.94) after completing the programme.

Analysis of the DASS Anxiety subscale mean scores showed that levels of anxiety decreased significantly from 10.39 (*SD* = 8.59) at pre-intervention to 6.20 (*SD* = 6.74), following engagement in the therapy group, t (19) = 2.70, p < .05. This decrease demonstrated a medium effect size of d = .54.

Figure 4.28. *DASS - Depression, Anxiety and Stress Subscale mean scores pre and post-intervention.*



The Fears of Compassion Scale (FCS)

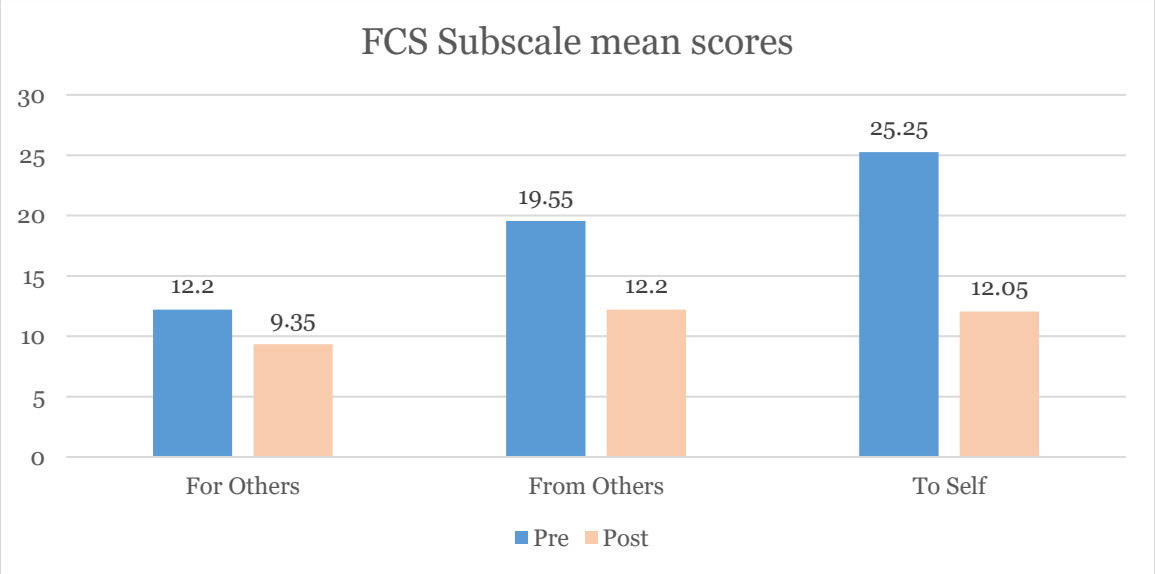
The FCS is divided into three scales: fear of expressing compassion for others, fear of responding to compassion from others, and fear of expressing kindness and compassion towards self. Mean scores on the subscales are presented below.

Mean scores on the fear of expressing compassion for others scale fell from 12.20 (*SD* = 8.14) at pre-intervention to 9.35 (*SD* = 5.94) at post-intervention. However, this reduction was not found to be statistically significant, $p > 0.05$.

A paired samples t-test demonstrated a statistically significant reduction in reported fear of responding to compassion from others, t (20) = 3.72, $p < 0.05$, representing a large effect size (d = .79). Mean scores fell from 19.55 (*SD* = 10.90) at pre-intervention to 12.20 (*SD* = 7.19) at post-intervention.

A paired samples t-test demonstrated a statistically significant reduction in fears of expressing kindness and compassion towards self, t (20) =5.30, $p < 0.05$. At pre-intervention, participants mean scores were 25.25 (*SD* = 13.70), compared to 12.05 (*SD* = 8.29) at post-intervention, with a large effect size (d = 1.17).

Figure 4.29. *Fears of Compassion Subscale mean scores pre and post-intervention.*



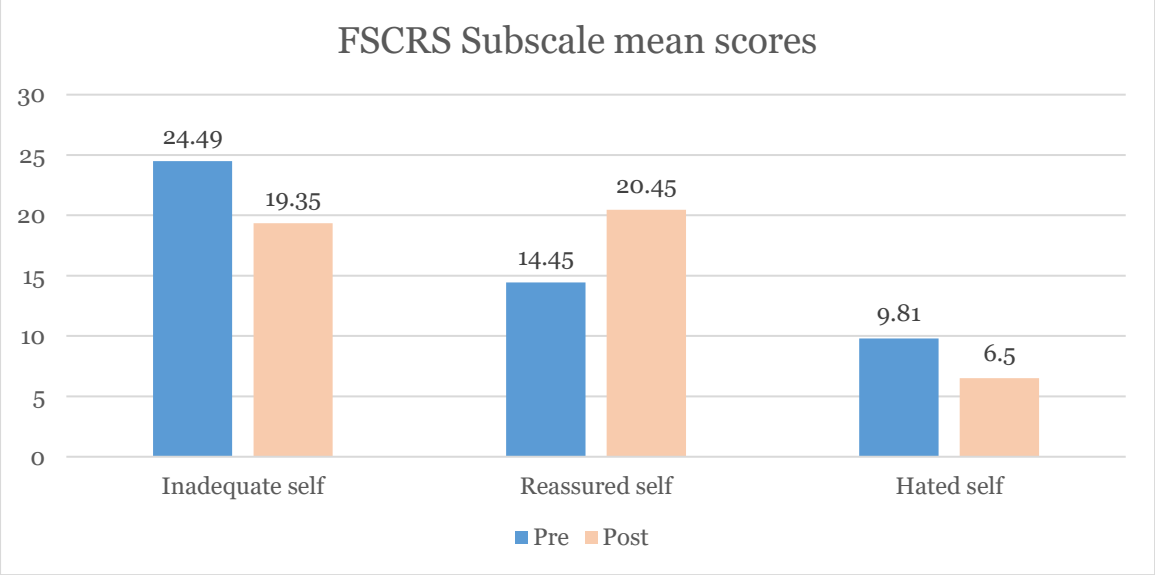
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Mean scores on the FSCRS 'inadequate self' subscale showed a significant decrease following engagement with the therapy programme, t (19) = 2.24, p <.05. Mean scores fell from 24.49 (SD = 8.01) at pre-intervention to 19.35 (SD = 6.35) at post-intervention, demonstrating a medium effect size, (d = 0.71). 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 t (19) = -4.37, p < .05. Mean scores rose from 14.45 (SD = 7.43) at pre-intervention to 20.45 (SD = 7.66) at post-intervention, demonstrating a large effect size, (d = 0.80). 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 (19) = 2.98, p < 0.05. Mean scores fell from 9.81 (SD = 5.08) at pre-intervention to 6.5 (SD = 3.41) at post-intervention, demonstrating a large effect size, (d = .77). Decreases in scores indicate reduced feelings of self-hatred.

Figure 4.30. *FSCRS Subscale mean scores pre and post-intervention.*



Compassionate Engagement and Action Scale (CEAS)

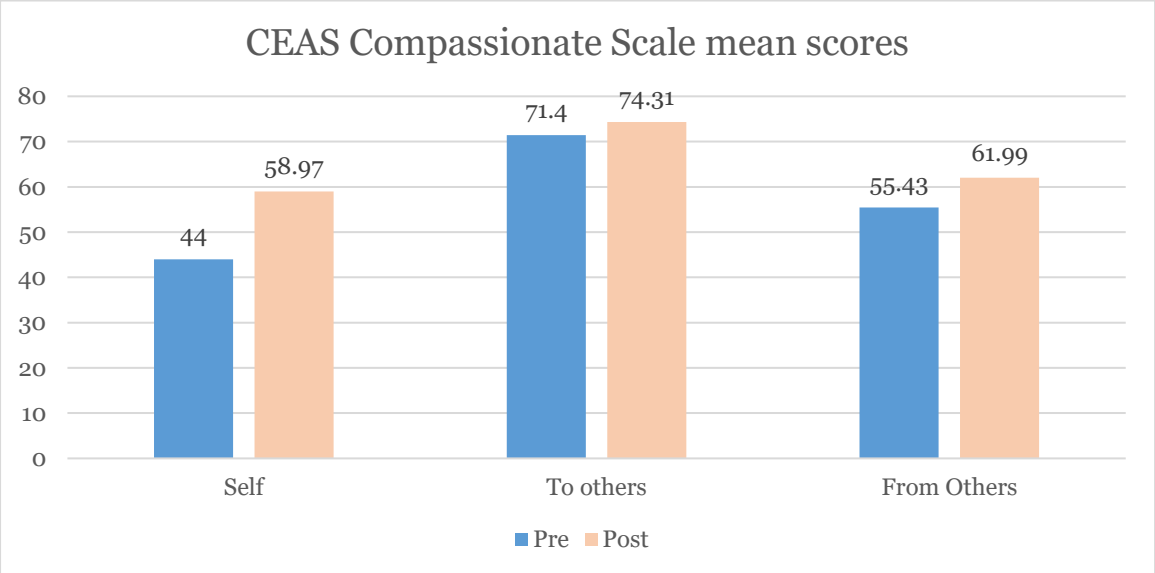
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores, and scores on the engagement and action subscales are reported below.

Significant increases were reported on the overall Compassion to Self-Scale from pre-intervention (M = 44.00, SD = 15.16) to post-intervention (M = 58.97, SD = 14.51), t (19) = -4.08, p <.05, with a large effect size (Cohen's d = 1.00). 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 = 71.4, SD = 12.62) to post-intervention (M = 74.31, SD = 12.03). However, this increase was not statistically significant, p > .05.

Mean scores on the Compassion from Others Scale increased from pre-intervention (M = 55.43, SD = 18.41) to post-intervention (M = 61.99, SD = 13.95). However, this increase was not statistically significant, p > .05.

Figure 4.31. *CEAS Compassionate Scale mean scores pre and post-intervention.*



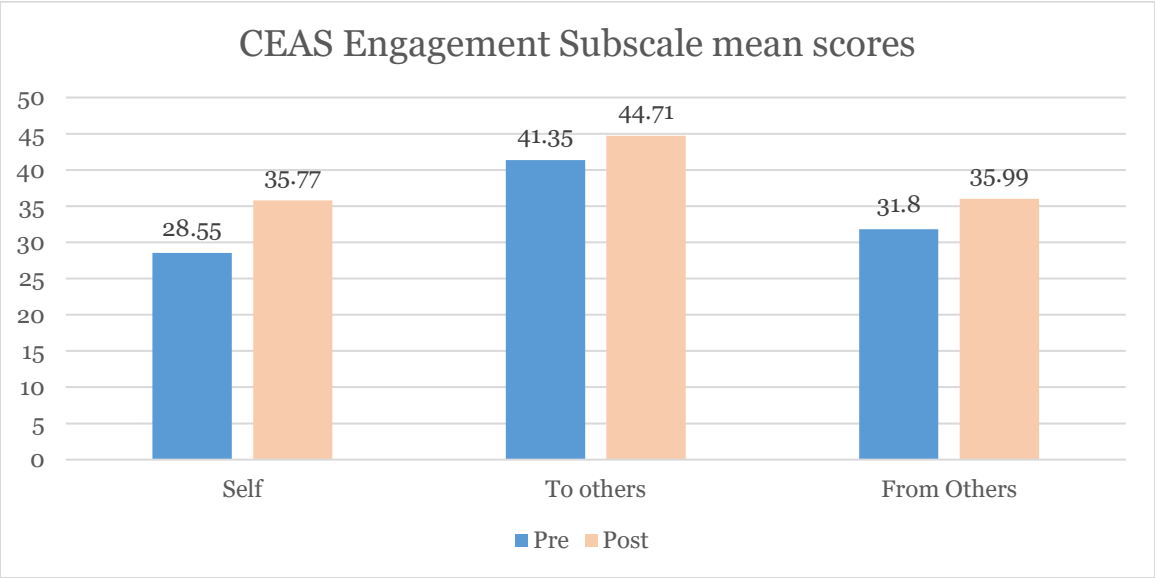
Within the Compassionate Engagement sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 28.55, SD = 9.55) to post-intervention (M = 35.77, SD = 9.21), t(19) = -2.79, p < .05, with a large effect size (d = 0.77).

Mean scores was increased significantly on the Compassion to Others subscale within the Compassion Engagement subscales. Participant mean scores increased marginally from pre-intervention (*M* = 41.35, *SD* = 8.47) to post-intervention (*M* = 44.71, *SD* = 7.66), t (19) = -2.80, p <. 05, with a small to medium effect size (*d* = .42).

An increase in mean scores was observed on the Compassion from Others subscale within the Compassionate Engagement sub-scales. Scores on this subscale increased from 31.80 (*SD* = 10.83) pre-intervention to 35.99 (*SD* = 8.20), *t*(19) = -2.32, *p* < .05, with a small to medium effect size (*d* = 0.44).

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

Figure 4.32. *CEAS Compassionate Engagement Subscale mean scores pre and post-intervention.*

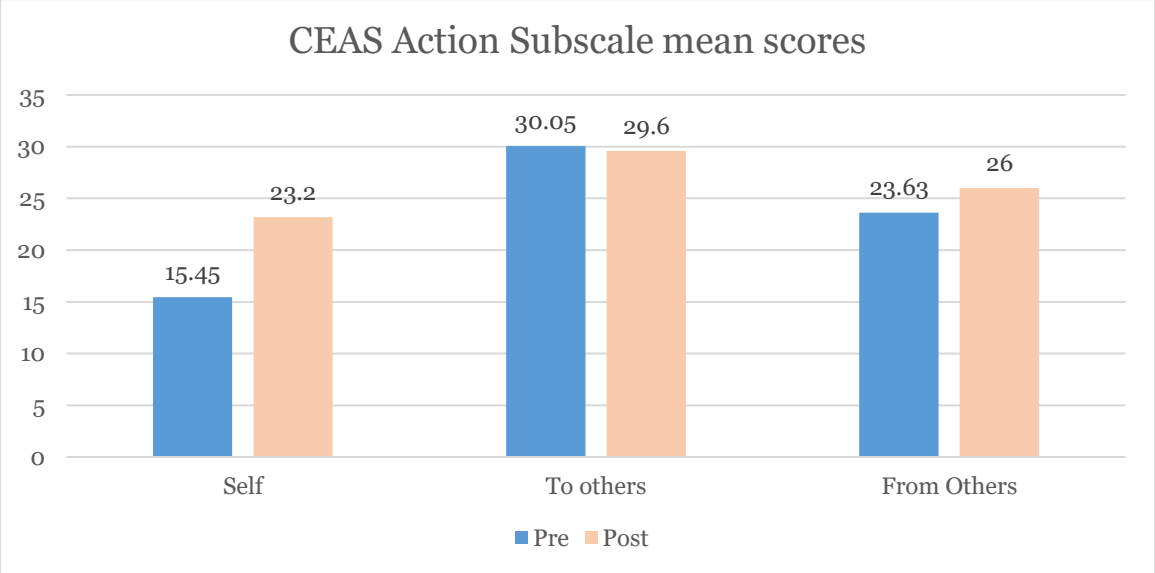


Within the Compassionate Action sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (*M* = 15.45, *SD* = 6.76) to post-intervention (*M* = 23.20, *SD* = 6.19), *t*(19) = -5.44, *p* < .05, with a large effect size (*d* = 1.24).

Mean scores remained relatively unchanged on the Compassion to Others subscale within the Compassion Action subscales. Participant mean scores decreased marginally from pre-intervention (*M* = 30.05, *SD* = 4.98) to post-intervention (*M* = 29.60, *SD* = 5.59). However, this was not statistically significant.

An increase in mean scores was observed on the Compassion from Others subscale within the Compassionate Action subscales. Scores on this subscale increased from 23.63 (*SD* = 8.63) pre-intervention to 26.00 (*SD* = 6.36), however this difference was also not statistically significant.

Figure 4.33. *CEAS Compassionate Action Subscale mean scores pre and post-intervention.*



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. Effect size calculations for data from the CFT groups in 2023 demonstrated medium to large effect sizes for significant results on outcome measures.

The CFT programme structure changed during 2022 and 2023 to address issues related to waiting times for service users. Those changes successfully reduced the wait times and as such the original structure of the CFT programme (combined psychoeducation and therapy) has been reintroduced. This change in programme structure meant that separate outcome measures for the CFT Psychoeducation groups were only collected in the first half of 2023, resulting in a lower number of completed measures being reported above for the CFT Psychoeducation programme than in 2022.

Results from outcome measures and anecdotal feedback from service users who attended these groups are consistently positive. Service users report noticeable

improvements in their lives due to reductions in levels of self-criticism and increased ability to engage with compassion. CFT continues to be an effective, well-received group-based psychological intervention to SPMHS service users.

4.10. Compassion-Focused Therapy for Older Adults (CFT-OA)

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.

When considering the older adults who attend St Patricks Mental Health Service (SPMHS), this cohort may face multiple losses, an increased dependency on others and reduced ability to engage in everyday activities, which can increase their likelihood of experiencing shame and self-criticism (Mirowsky & Ross, 1992; Atavilla & Strudwick, 2022). Compassion-Focused Therapy draws upon compassion to alleviate the impact of self-criticism and shame on mental health. Given this, it was felt that CFT could be a useful intervention for older adults attending SPMHS. This thinking led to the development of the Compassion-Focused Therapy for Older Adult Programme (CFT-OA).

The first CFT-OA pilot group commenced in October 2022 and finished in March 2023. The second cycle of this programme began in October 2023 and is due to finish in March 2024. The group is held in person in SPMHS and is a closed group. The CFT-OA programme consists of 16 group sessions running once per week. Each group member also attends an individual reflection session at the halfway point, which provides them with an opportunity to reflect on their experience of the group before completing the remaining group sessions. At the end of the group, each group member attends a final individual review appointment to reflect on their experience of being in group and to think about next steps.

4.10.1. Descriptors for CFT Older Adults Group

Five service users completed the first cycle of CFT-OA which ran in 2023. All five service users are included in the following demographic data. The age of service users ranged from 71 to 87 years old (M = 77.2, SD = 6.72). All five service users were female. Pre and post data on the outcomes measures below was available for all five service users. Due to the small sample size available, the statistical significance of these differences could not be determined. Instead, descriptive statistics are presented for pre and post-intervention mean scores, as well as individual service user scores are presented below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

4.10.2. CFT Older Adults 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.

4.10.3. Results for CFT Older Adults Group

Depression, Anxiety and Stress Scale (DASS 21)

In order to analyse the DASS-21 outcome measures, the pre and post group mean scores on DASS-21 were explored first, including the 'DASS-21 Total' score, the 'Anxiety Subscale', the 'Depression Subscale' and the 'Stress Subscale' scores.

Following this, each group members pre and post group mean scores on the DASS-21 were explored. Finally, a Reliable Change Index (RCI) was conducted. Please see details of this analysis below.

The mean for the 'DASS-21 Total' score decreased from pre-intervention (M= 39.6, SD= 14.03) to post-intervention (M =30.4, SD = 11.78), see Graph below. Analysis of individual total scores showed that total DASS-21 scores decreased for four out of five (80%) service users, as illustrated in the Graph below.

Figure 4.34. *Pre and post-group mean scores for the DASS-21 total score.*

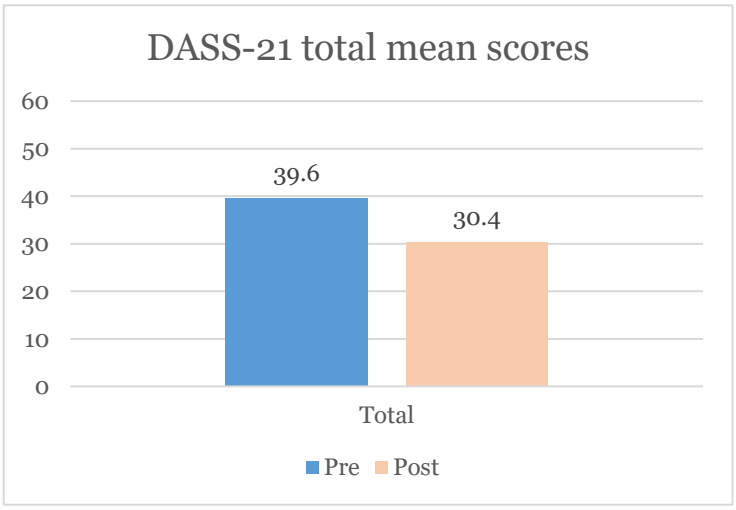
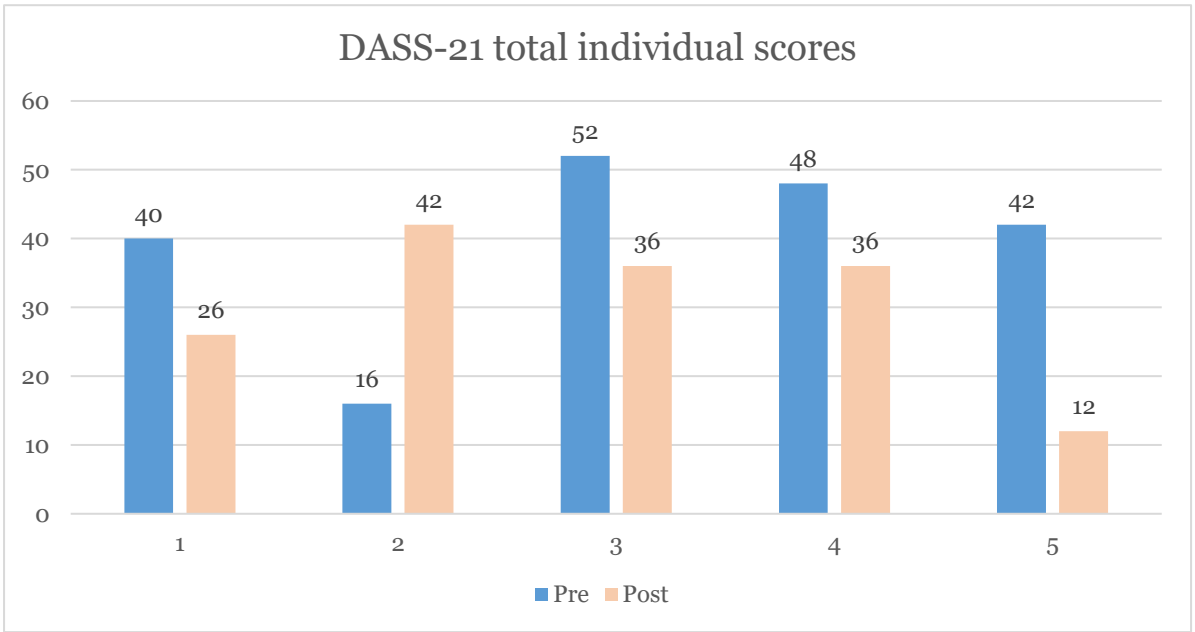
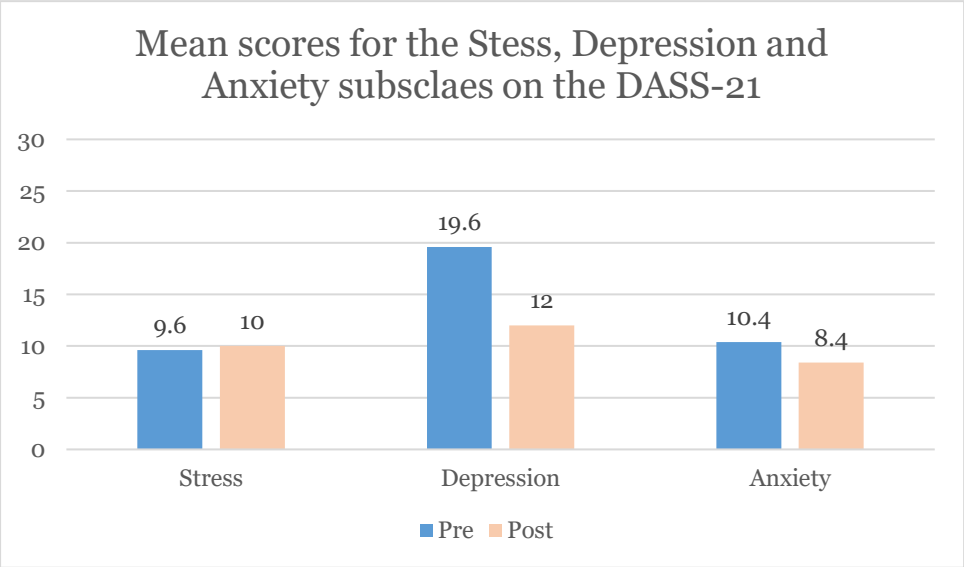


Figure 4.35. *Pre and post-group mean scores for the DASS-21 total score for each individual group member.*



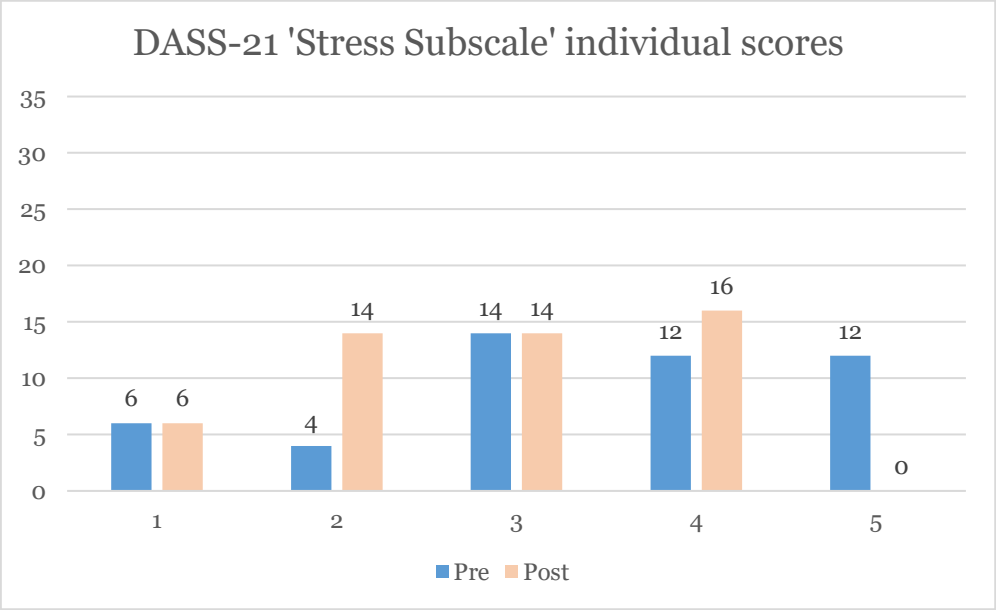
The pre and post-group mean scores for each of the DASS-21 subscales were also calculated, please see the graphs below for visual representation of this.

Figure 4.36. *Pre and post-group mean scores for the 'Stress Subscale', the 'Depression Subscale' and the 'Anxiety Subscale' Score on the DASS-21.*



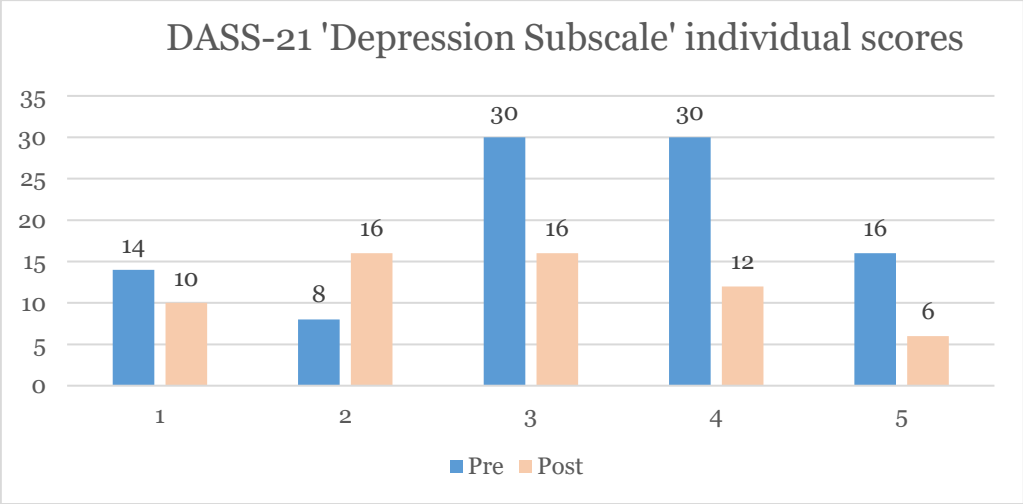
As illustrated in Graph above, the mean scores on the DASS-21 'Stress Subscale' increased slightly from pre-intervention (M = 9.60, SD = 4.34) to post-intervention (M = 10.00, SD = 6.78). Scores on this subscale increased or remained unchanged for four out of five service users (80%), while decreasing for one (20%) service user, see Graph below.

Figure 4.37. *Pre and post-group mean scores for the 'Stress Subscale' for each individual group member.*



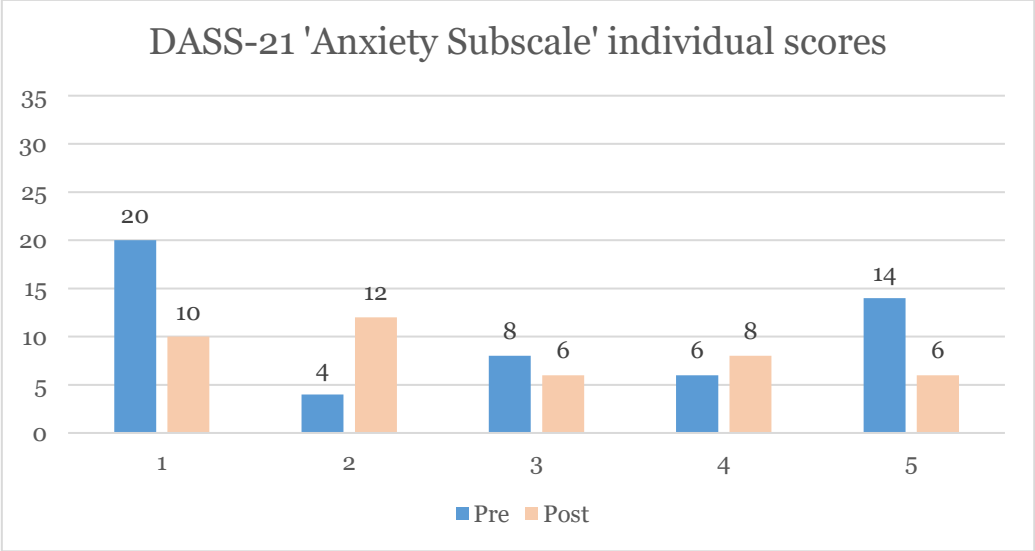
The mean scores on the DASS-21 'Depression Subscale' decreased from pre-intervention (M = 19.60, SD = 9.94) to post-intervention (M = 12.00, SD = 4.24), see graph. Similarly, analysis of individual scores found a decrease in scores for four out of five (80%) service users on this subscale as illustrated on graph below.

Figure 4.38. *Pre and post-group mean scores for the 'Depression Subscale' for each individual group member.*



The mean scores on the DASS-21 'Anxiety Subscale' decreased from pre-intervention (M = 10.4, SD = 6.54) to post-intervention (M = 8.40, SD = 2.61), see graph. As illustrated in the graph below, scores on this subscale decreased for three of five (60%) service users.

Figure 4.39. *Pre and post-group mean scores for the 'Anxiety Subscale' for each individual group member.*



Due to the small sample size available, the statistical significance of these differences could not be determined. Changes in total DASS-21 scores were analysed using the Reliable Change Index (RCI) for each group member. In order to ensure that changes in DASS scores were not attributable to chance or measurement error a RCI was calculated for each group member using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The cut-off score indicating clinically meaningful improvement on the DASS-21 for this sample was calculated to be 31. Group members were classified as "clinically meaningful improvement" (passed RCI criterion and DASS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below DASS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, one group member (20%) reported uncertain change, one group member (20%) reported reliable improvement, one group member (20%) reported reliable deterioration, while two group members (40%) reported reliable and clinically significant improvement.

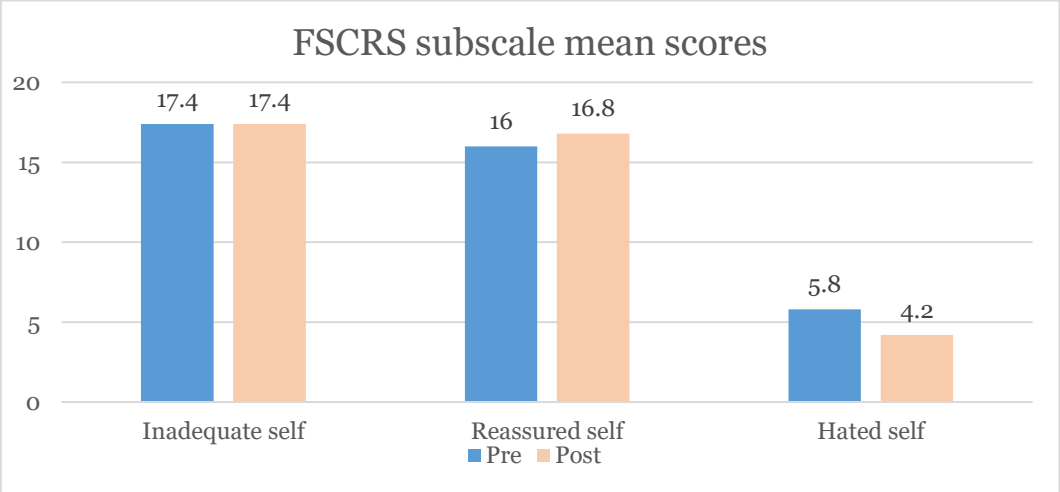
Table 4.8. *Results from Reliable Change Index (RCI) for the Depression, Anxiety and Stress Scale (DASS-21) pre and post scores*

Group Member	Pre Score	Post Score	RCI Value	Category
1	40	26	-1.94	Uncertain Change
2	16	42	3.60	Reliable Deterioration
3	52	36	-2.21	Reliable Improvement
4	48	36	-1.66	Clinically Significant Improvement
5	42	12	-4.15	Clinically Significant Improvement

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

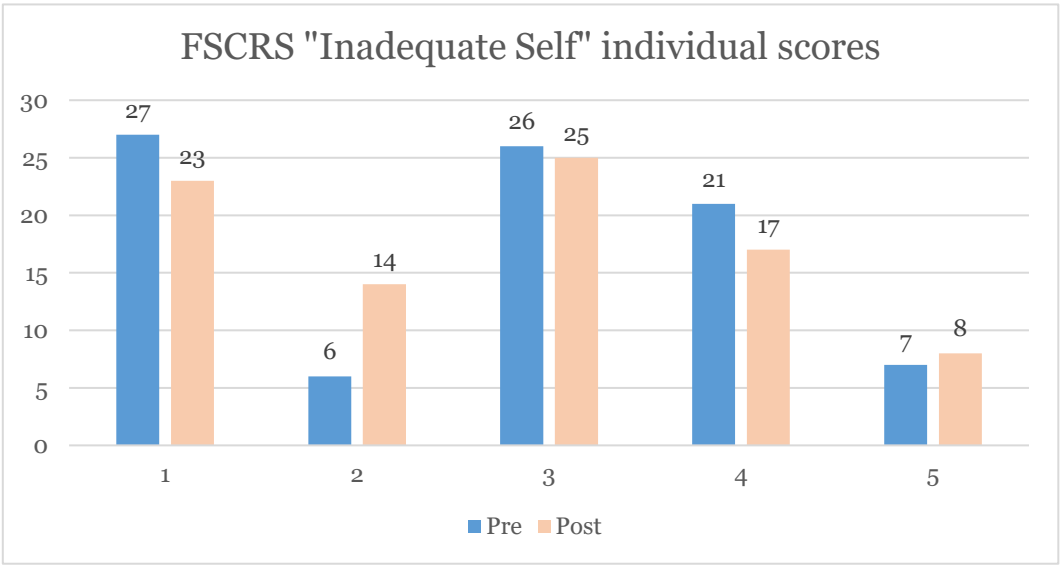
The pre and post-group mean scores for each of the 'Inadequate Self', 'Reassured Self' and 'Hated Self' scales on the FSCRS were calculated, please see graph below.

Figure 4.40. *Pre and post mean scores for the 'Inadequate Self', 'Reassured Self' and 'Hated Self' scales on the FSCRS.*



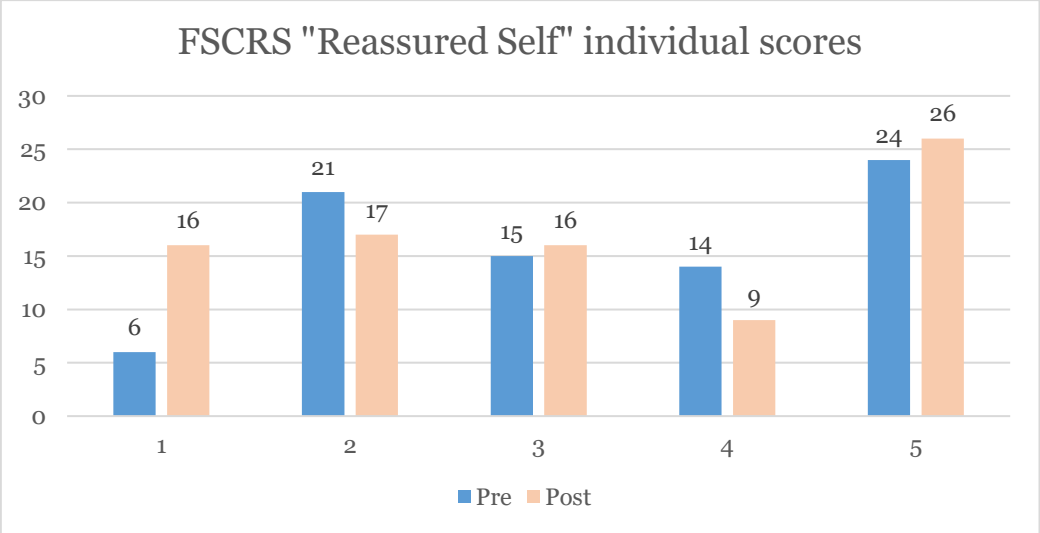
As illustrated in graph above, the mean scores on the FSCRS 'Inadequate Self' subscale remained unchanged from pre-intervention (M = 17.40, SD = 10.21) to post-intervention (M = 17.40, SD = 6.88). Analysis of individual scores showed that scores on this subscale for three out of the five (60%) service users, see graph below.

Figure 4.41. *Pre and post mean scores for the 'Inadequate Self' subscale for each individual group member on the FSCRS.*



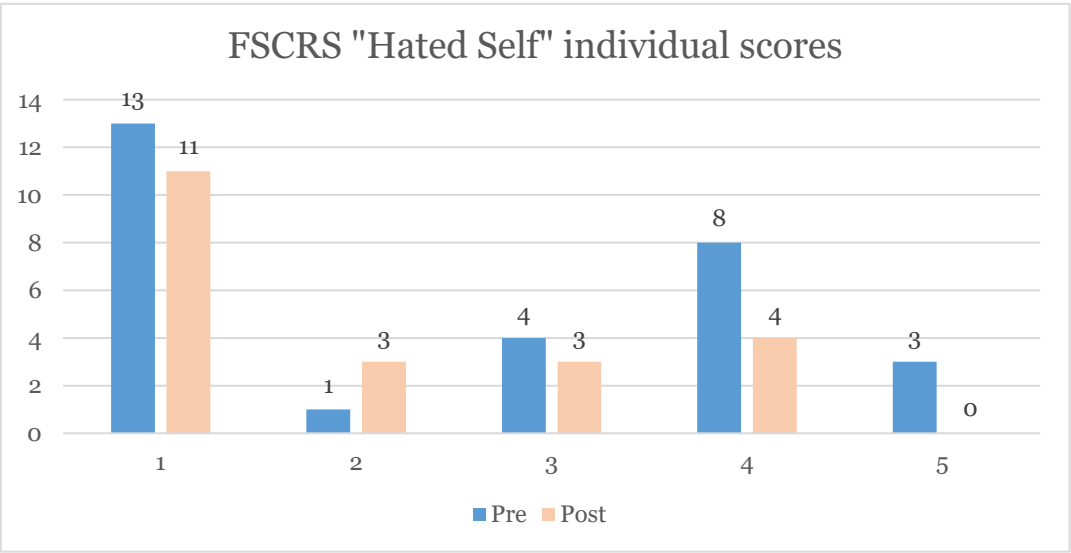
The mean scores on the FSCRS 'Reassured Self' subscale increased slightly from pre-intervention (M = 16.00, SD = 6.96) to post-intervention (M = 16.80, SD = 6.06). Individual scores increased for three out of five service users (60%) on this subscale, see graph below.

Figure 4.42. *Pre and post mean score for the 'Reassured Self' subscale for each individual group member on the FSCRS.*



The mean scores on the FSCRS 'Hated Self' subscale decreased slightly from pre-intervention (M = 5.80, SD = 4.76) to post-intervention (M = 4.20, SD = 4.09), see Graph. As illustrated in Graph below individual scores decreased for three out of five (60%) service users on this subscale.

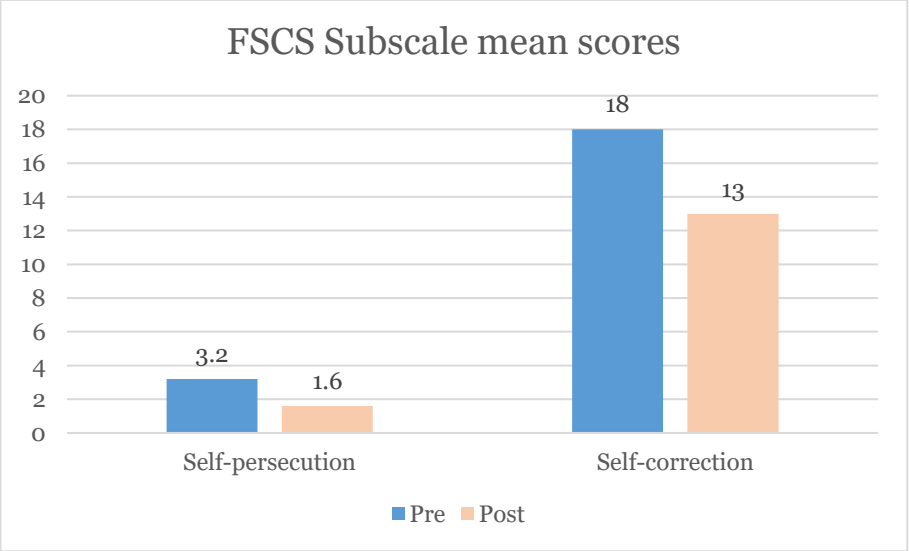
Figure 4.43. *Pre and post mean scores for the 'Hated Self' subscale for each individual group member on the FSCRS.*



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

The pre and post-group mean scores were calculated for the 'Self Persecution' and 'Self-Correction' scale on the FSCS, please see graph below.

Figure 4.44. *Pre and post mean scores for the 'Self-Persecution' and 'Self-Correction' scales on the FSCS.*



As illustrated in graph above, the mean scores on the FSCS 'Self-Persecution' subscale decreased from pre-intervention (M = 3.20, SD = 2.77) to post-intervention (M = 1.60, SD = 2.30). Individual scores decreased for three of five (60%) service users on this scale, see graph below.

Table 4.9. *Pre and post mean scores for the 'Self-Persecuted' subscale for each individual group member on the FSCS.*

Participant	Pre score	Post score
1	6	3
2	0	0
3	3	0
4	1	5
5	6	0

The mean scores on the FSCS 'Self-Correction' subscale decreased from pre-intervention (M = 18, SD = 11.94) to post-intervention (M = 13, SD = 13.64), see graph. As illustrated on graph below, individual scores however, only decreased for two of five (40%) service users, while increasing for three of five (60%) service users on this scale.

Table 4.10. *Pre and post mean scores for the 'Self-Correction' subscale for each individual group member on the FSCS.*

Participant	Pre score	Post score
1	24	4
2	0	2
3	22	32
4	13	23
5	31	4

Compassionate Engagement and Action Scale (CEAS)

Please see below the results obtained on the 'Compassion to Self' scale, the 'Compassion to Others' scale and the 'Compassion experienced from Others' scale, as well as the results obtained on the 'Engagement' and 'Action' subscales of the CEAS. The results of this analysis are displayed in graphs below. Pre and post data was only available for four group members on this measure as one group member did not complete this measure at the pre-intervention stage. As illustrated on graph below, the mean scores increased on the 'Compassion to Self Scale' from pre-intervention (*M* = 42.25, *SD* = 19.96) to post-intervention (*M* = 52.25, *SD* = 9.74). Individual scores increased for three out of four (75%) service users on this scale, see graph below.

Figure 4.48. *Pre and post mean scores for the 'Compassion to Self' scale, the 'Compassion to Others' scale and the 'Compassion experienced from Others' scale on the CEAS.*

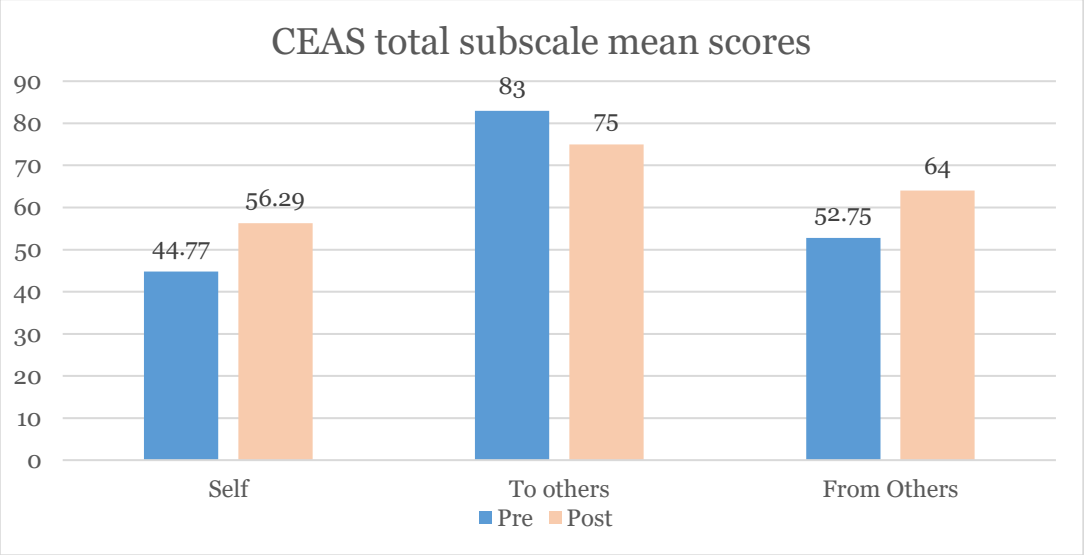
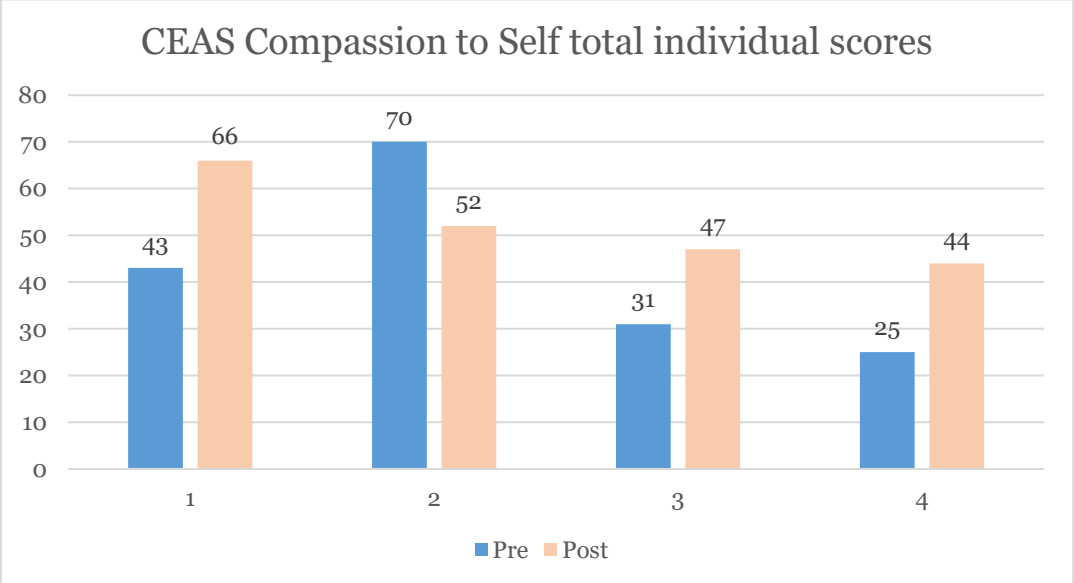
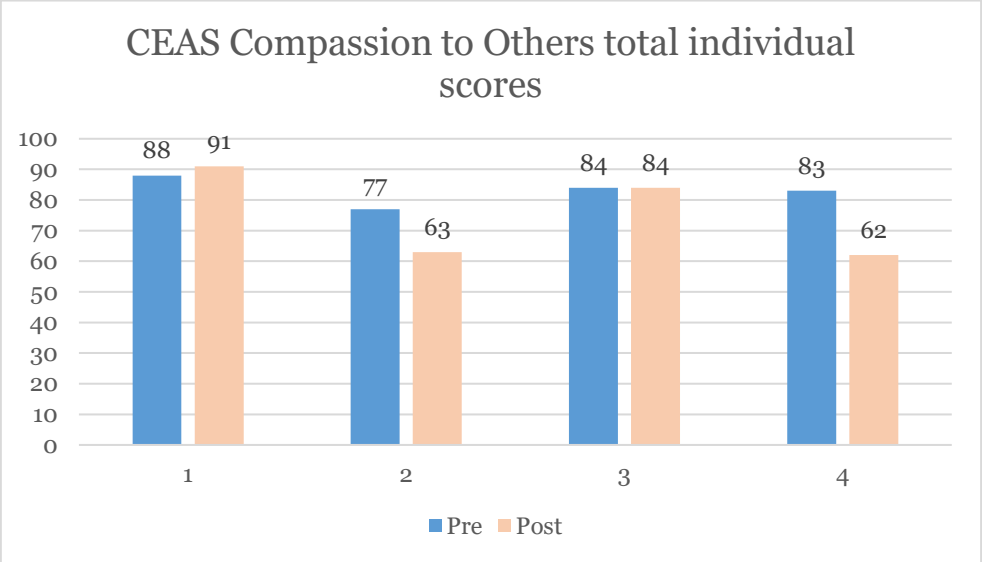


Figure 4.49. *Pre and post mean scores for the 'Compassion to Self' scale for each individual group member on the CEAS.*



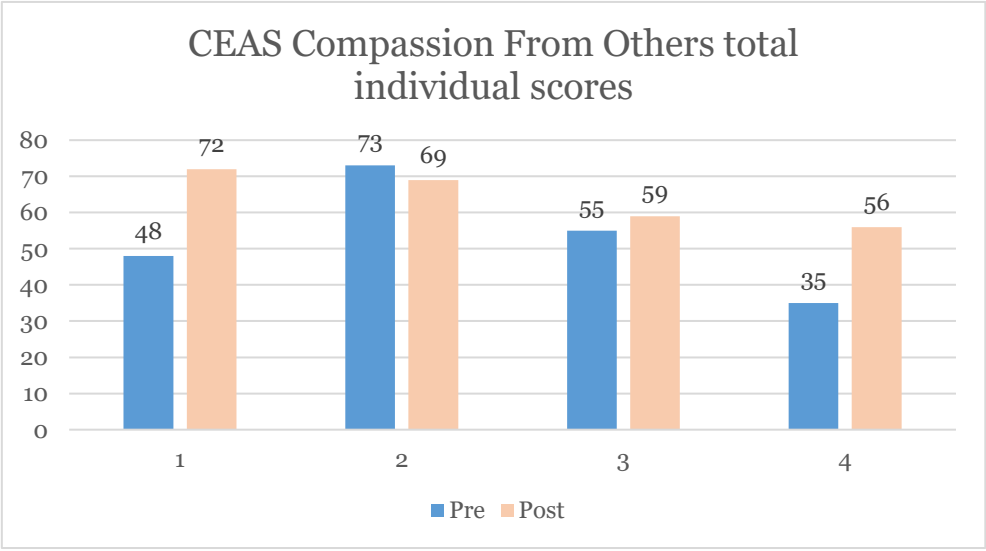
The mean scores on the 'Compassion to Others Scale' were observed to decrease from pre-intervention (M = 83.00, SD = 4.55) to post-intervention (M = 75.00, SD = 14.72). Individual scores remained unchanged/decreased for three out of four (75%) service users on this scale, see graph below.

Figure 4.50. *Pre and post mean scores for the 'Compassion to Other' scale for each individual group member on the CEAS.*



The mean scores on the 'Compassion Experienced from Others Scale' increased from (*M* = 52.75, *SD* = 15.84) to post-intervention (*M* = 64, *SD* = 7.70), see graph above. As illustrated in the graph below, individual scores increased for three out of four (75%) service users on this scale.

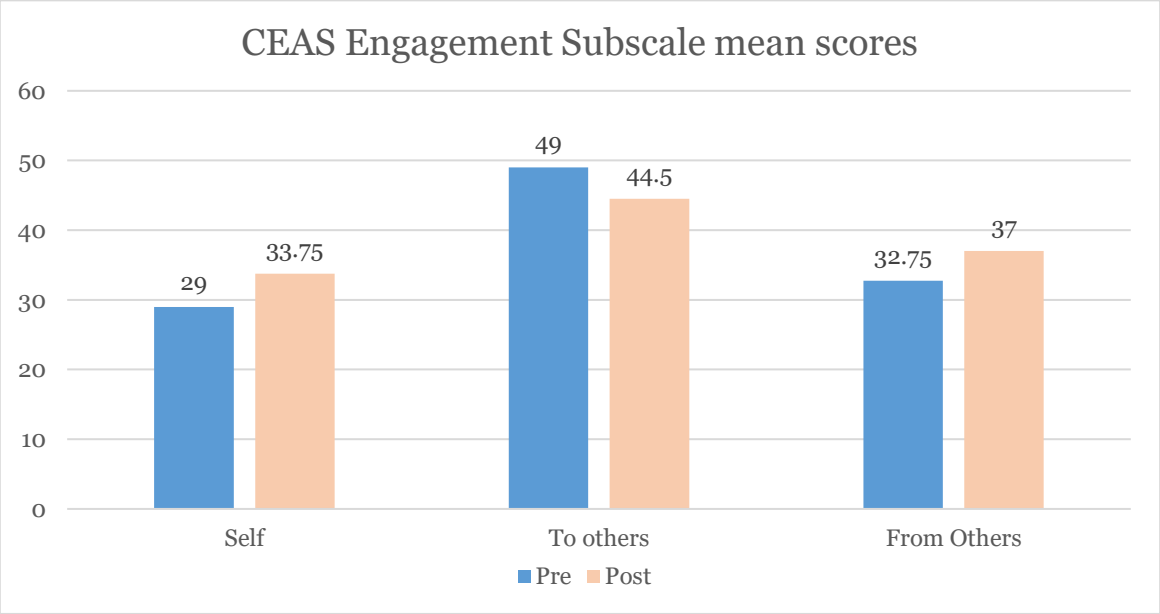
Figure 4.51. *Pre and post mean scores for the 'Compassion Experienced from Other' scale for each individual group member on the CEAS.*



Within the 'Engagement' sub-scales, an increase in mean scores was observed on the Compassion to Self subscale. Group member mean scores increased from pre-

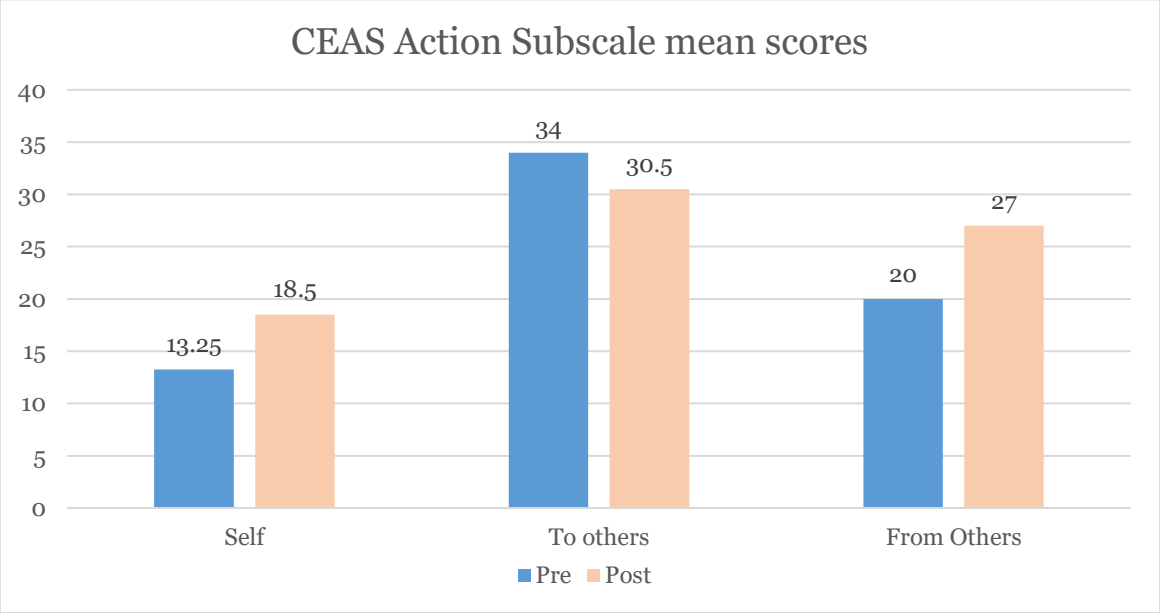
intervention (*M* = 29.00, *SD* = 13.39) to post-intervention (*M* = 33.75, *SD* = 9.64). There was a decrease observed on the Compassion to Others subscale within the Engagement scales, with group member mean scores of (*M* = 49.00, *SD* = 4.32) at pre-intervention and (*M* = 44.50, *SD* = 8.96) at post-intervention. There was an increase observed on the Compassion from Others subscale within the Engagement scales, with group member mean scores of (*M* = 32.75, *SD* = 7.76) at pre-intervention and (*M* = 37.00, *SD* = 4.76) at post-intervention. Please see graph below.

Figure 4.52. *Pre and post mean scores for 'Compassion to Self', 'Compassion to Others' and 'Compassion Experienced from Others' within the Engagement Subscale of the CEAS.*



Within the action sub-scales, group member mean scores on the Compassion to Self subscale increased from pre-intervention (*M* = 13.25, *SD* = 7.18) to post-intervention (*M* = 18.5, *SD* = 1.73). There was a decrease in mean scores observed on the Compassion to Others subscale within the Compassionate engagement scales, with group member mean scores of (*M* = 34, *SD* = 2.16) at pre-intervention and (*M* = 30.5, *SD* = 7.23) at post-intervention. There was an increase in mean scores observed on the Compassion from Others subscale within the Compassionate Engagement scales, with group member mean scores of (*M* = 20, *SD* = 8.21) at pre-intervention and (*M* = 27.00, *SD* = 2.94) at post-intervention. Please see graph below.

Figure 4.53. *Pre and post mean scores for Compassion to Self, Compassion to Others and Compassion Experienced from Others scales within the Action Subscale of the CEAS.*



Summary

The Compassion-Focused Therapy for Older Adults (CFT-OA) Programme was added to the psychology group programmes offered by SPMHS in 2022. The CFT-OA group is a compassion focused group therapy programme specifically designed for older adult service users. It aims to reduce self-criticism and enhance self-compassion amongst it's group members. The first cycle of CFT-OA started in October 2022 and ended in March 2023. Five service users completed this first cycle of CFT-OA. They were all female and ranged in age from 71 to 87 years old (M = 77.2, SD = 6.72).

In order to evaluate the effectiveness of the CFT-OA group in reducing self-criticism and enhancing self-compassion, all service users were asked to complete the 'Depression, Anxiety and Stress Scale (DASS-21)', the 'Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)', the 'Function of Self-Criticising/Attacking Scale (FSCS)' and the 'Compassion Engagement and Action Scale'. Service users were asked to complete these outcome measures at the start of the CFT-OA group and when the group finished in March 2023.

Analysis of the pre and post mean scores on these outcome measures showed trends towards positive changes in the areas targeted by the programme: including reductions in levels of self-criticism as measured by the FSCRS (see FSCRS graphs) and the FSCS (see FSCS graphs); increases in levels of compassion to self and compassion from others as measures by the CEAS (see CEAS graphs) and overall levels of distress as measured by the DASS-21 (see DASS021 table and graph). Pre and post mean scores on the CEAS also show trends towards increases in observed levels of compassionate 'engagement' (ie. motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgement) and compassionate 'action' (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). Due to the small sample size available, the statistical significance of these differences could not be determined; however, the trends observed on these outcome measures suggest that the CFT-OA programme is meeting it's aims in seeking to reduce the levels self-criticism experienced by older adult group members and cultivate greater compassion amongst these individuals. The CFT-OA group has now continued into a second cycle which began in October 2023 and is scheduled to finish in March 2024.

4.11. 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). A recent randomised control trial demonstrated that CFT-E is effective for reducing eating disorders, is as effective as CBT-E and maintained better outcomes than CBT-E for those with childhood trauma (Vrabell et al., 2024).

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.

4.11.1. Descriptors

Eight participants completed CFT-E cycle 11 and demographic information is included for all eight participants. All participants completed the programme Most of the programme was completed face to face with one online group and 2 hybrid session due to service user request. The programme welcomes participants with a range of eating disorder symptoms and diagnoses. Six of the eight participants were female, with two male participants in the programme. Participants ranged in age from 27 to 50 years with a mean age of 38.75. Pre and post-outcome data was available for seven participants of the eight 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.

4.11.2. 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 2023. All service users attending the CFT-E programme are invited to complete the measures listed below at assessment for the programme and again upon completion.

Due to the small sample size, the statistical significance of changes in mean scores could not be calculated. Instead, participants individual pre and post measure scores are reported below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

- **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.

4.11.3. Results

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

Participants total scores decreased from a mean of 1.41 (*SD* = 0.44) on the CORE-OM at pre-intervention to 1.13 (*SD* = 0.62) post-intervention. These scores indicate an overall low level of global psychological distress pre and post intervention.

Figure 4.54. *CORE-OM total mean scores*

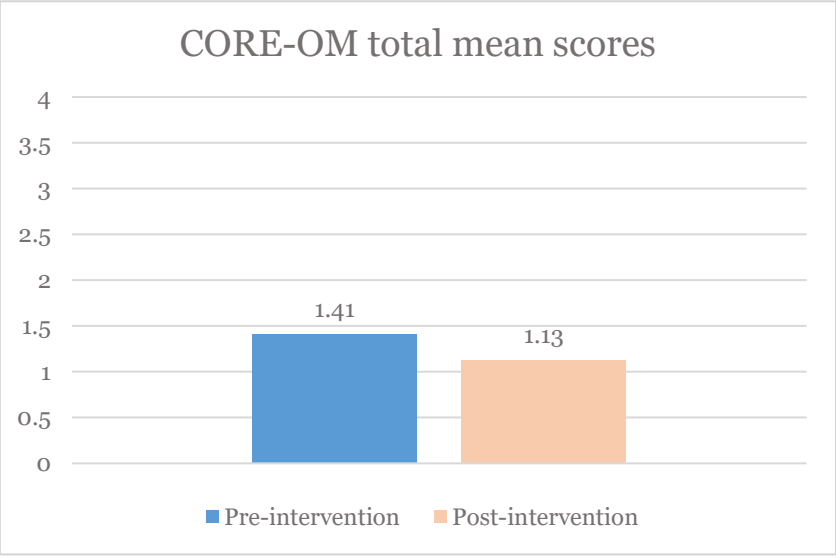
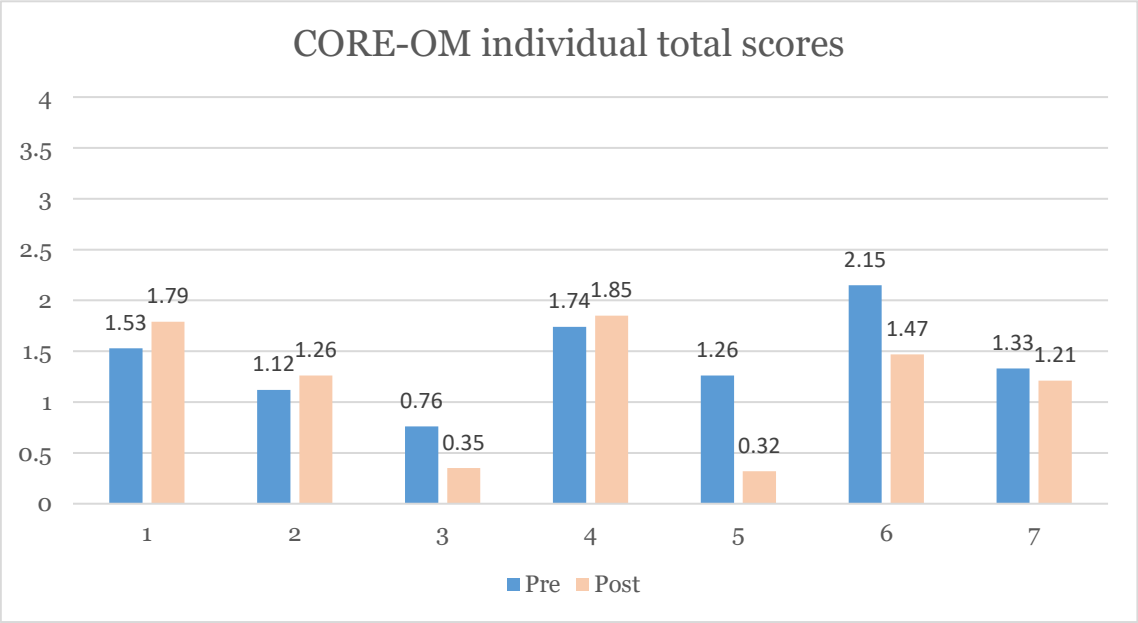


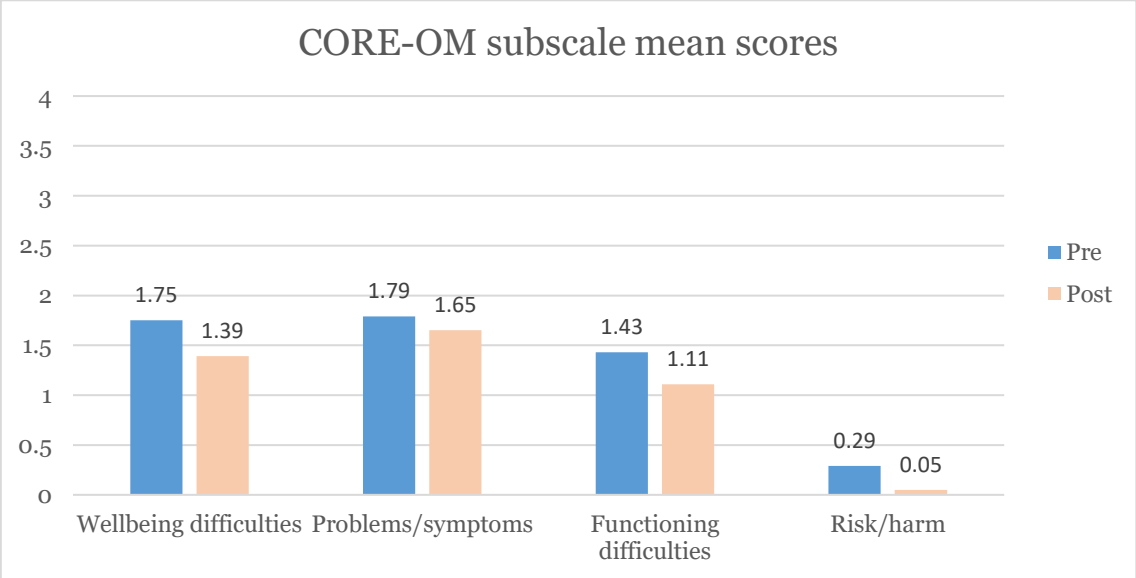
Figure 4.55. *CORE-OM total individual scores*



Analysis of the subscales indicates improvement in these domains, with participants scores decreasing across all subscales following completion of the intervention.

Mean scores on the subjective wellbeing subscale decreased from 1.75 (*SD* = .84) at pre-intervention to 1.39 (*SD* = 0.75) at post-intervention. Mean scores on the problems/symptom's domain decreased from 1.79 (*SD* = 0.56) at pre-intervention to 1.65 (*SD* = 0.87) at post-intervention. Mean scores on the functioning subscale decreased from 1.43 (*SD* = .54) at pre-intervention to 1.11 (*SD* = .65) at post-intervention. Mean scores on the risk/harm subscale decreased from 0.29 (*SD* = .34) at pre-intervention to .05 (*SD* = 0.08) at post-intervention.

Figure 4.56. *CORE-OM subscale mean scores*



Eating Disorder Examination Questionnaire (EDE-Q)

Participants reported a reduction of eating disorder symptomatology as measured by scores on the EDE-Q. The mean global score on the EDE-Q showed a decrease in symptomatology between pre-intervention (*M* = 2.70, *SD* = 1.16) and post-intervention (*M* = 1.90, *SD* = 1.08).

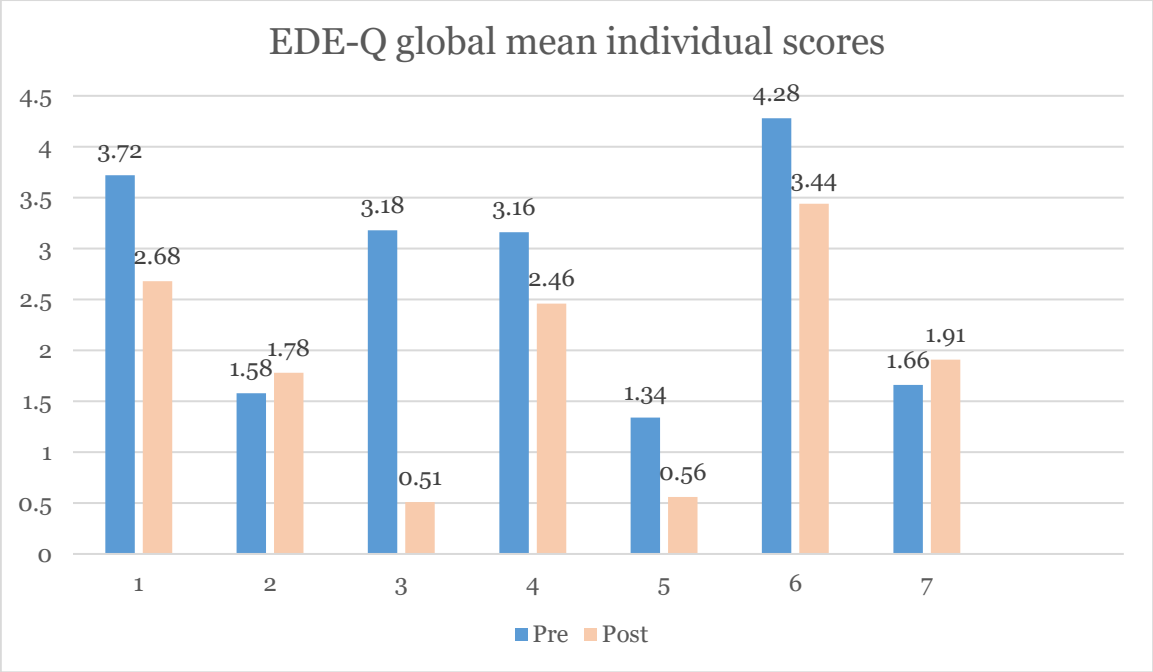
Due to the small sample size, changes in total CORE-OM scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in CORE-OM scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and EDEQ score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below EDEQ cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, five participants (71.4%) reported uncertain change while two participants (28.6%) reported reliable improvement.

Table 4.11. *Results from Reliable Change Index (RCI) for EDE-Q pre and post scores.*

EDE-Q = Eating Disorder Examination Questionnaire

Participant	Pre Score	Post Score	RCI Value	Category
1	3.72	2.68	-2.00	Reliable Improvement
2	1.58	1.78	0.39	Uncertain Change
3	3.18	.51	-5.15	Reliable Improvement
4	3.16	2.46	-1.35	Uncertain Change
5	1.34	.56	-1.50	Uncertain Change
6	4.28	3.44	-1.62	Uncertain Change
7	1.66	1.31	.48	Uncertain Change

Figure 4.57. *EDE-Q global mean individual scores*



There are four sub-scales measured within the EDE-Q, which are restraint, eating concern, shape concern and weight concern. All four subscales suggested improvements in each domain for those who completed CFT-E. Mean scores on restraint was found to decrease from 1.55 (*SD* = 1.15) at pre-intervention to .80 (*SD* = .89) at post-intervention. Six participants (85.7%) scores decreased on this subscale showing a decrease in the symptom of disordered eating. Eating concern showed a decrease from 2.43 (*SD* = 1.50) to 1.76 (*SD* = 1.16), with four participants (57%) decreasing on this subscale at post-intervention. Preoccupation with shape also decreased from 3.45 (*SD* = 1.07) to 2.48 (*SD* = 1.23), with six participants (85.7%) decreasing on this subscale. Preoccupation with weight similarly decreased from 3.39 (*SD* = 1.42) to 2.57 (*SD* = 1.39), with six participants (85.7%) scores decreasing on this subscale.

Table 4.12. *EDE-Q mean subscale scores*

EDE-Q subscale	Mean (SD) Pre	Mean (SD) Post
Restraint	1.55 (1.15)	0.80 (.89)
Eating concern	2.43 (1.50)	1.76 (1.16)
Shape concern	3.45 (1.07)	2.48 (1.23)
Weight concern	3.39 (1.42)	2.57 (1.39)

Figure 4.58. *EDEQ subscale mean scores*

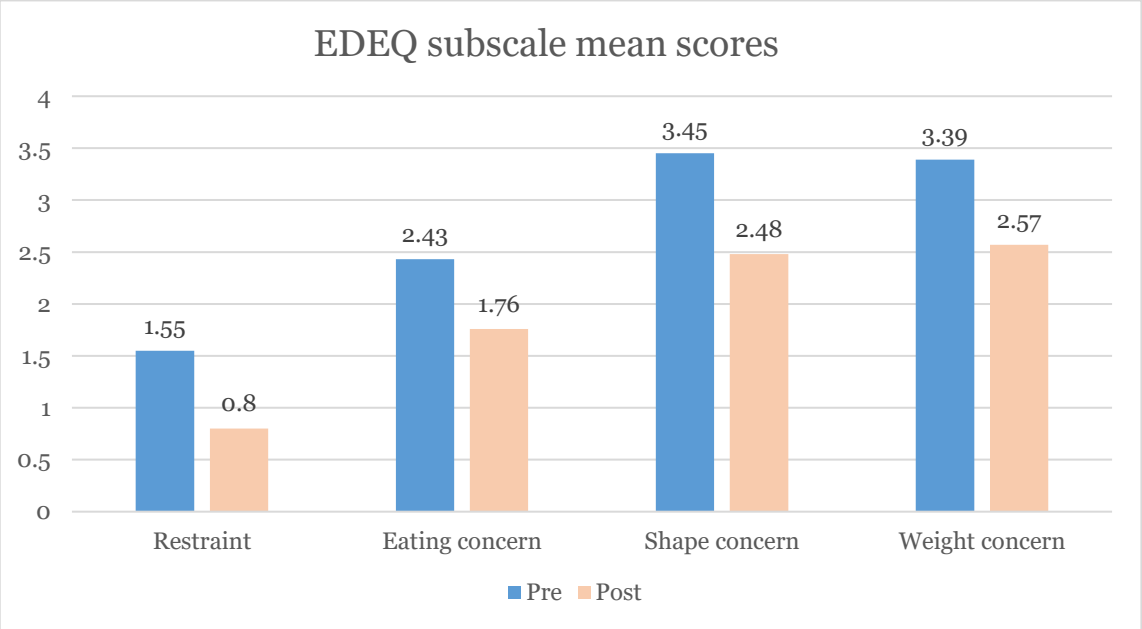


Figure 4.59. *EDEQ Restraint total individual scores*

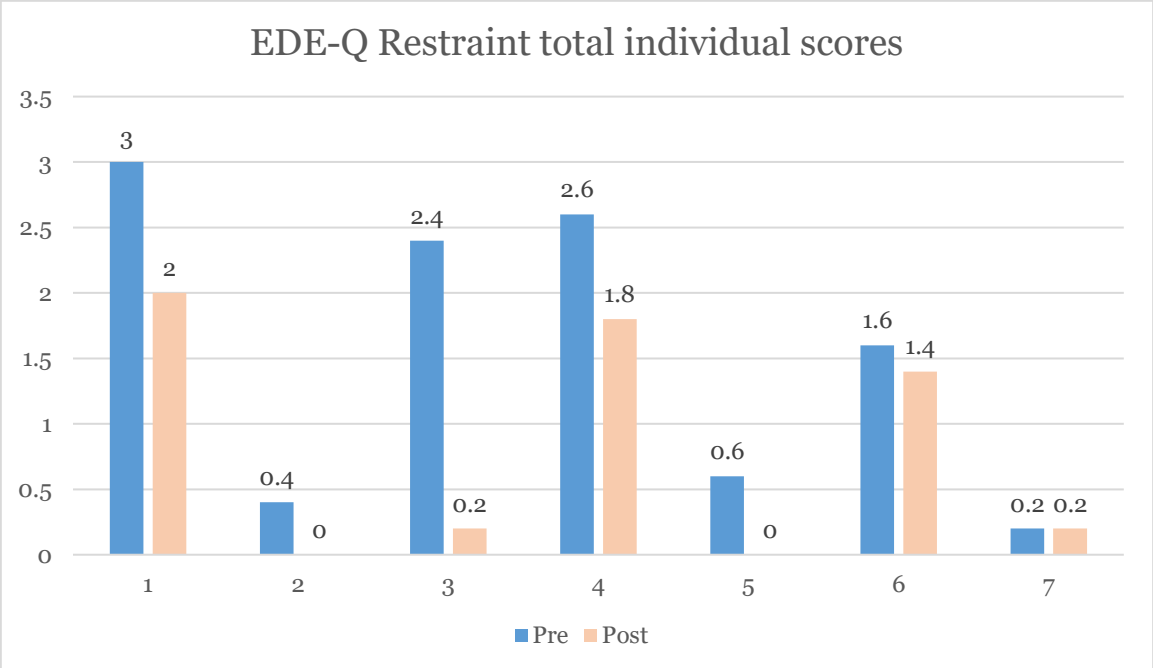


Figure 4.60. *EDEQ Eating Concern total individual scores*

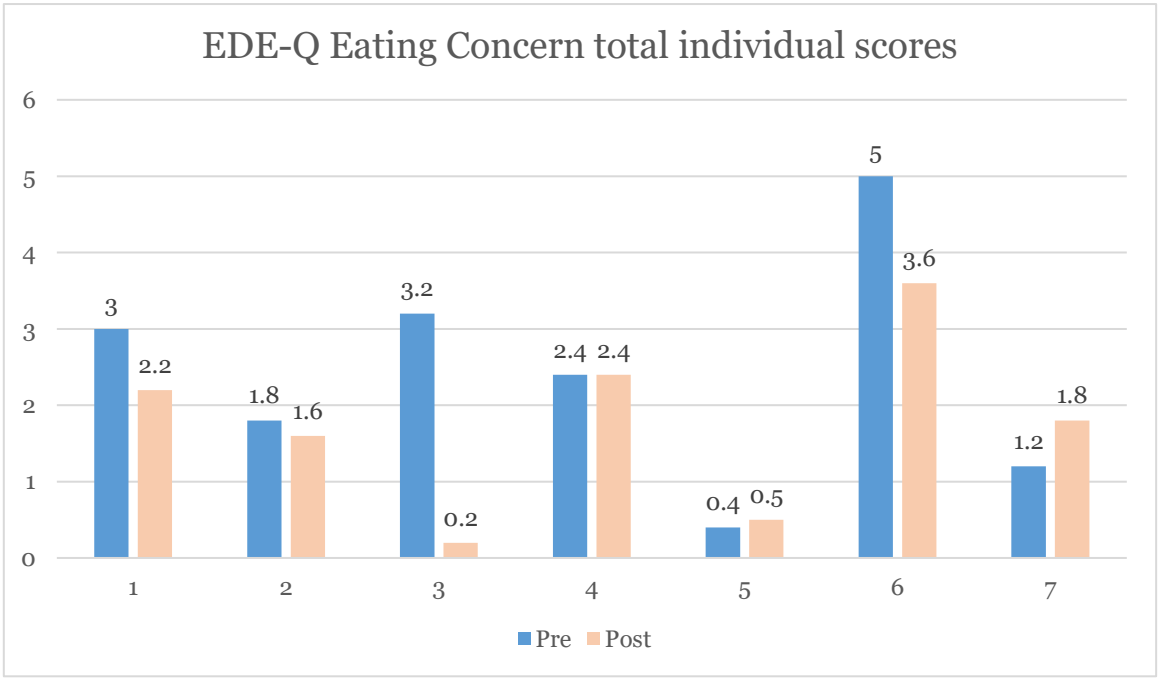


Figure 4.61. *EDEQ Shape Concern total individual scores*

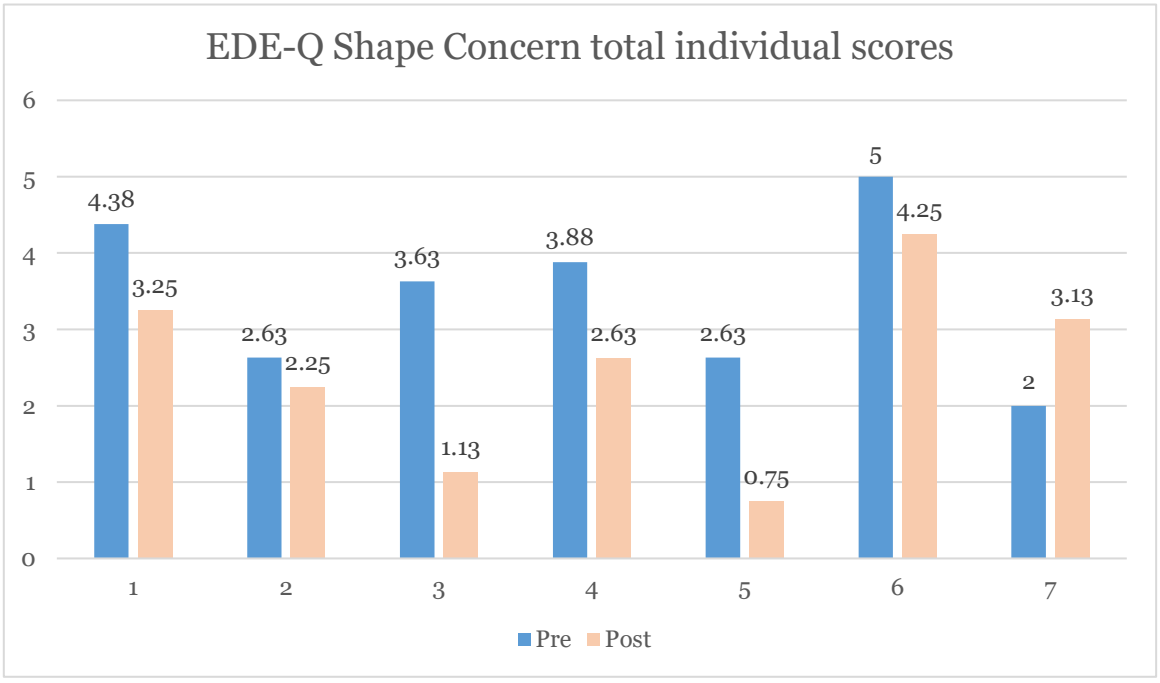
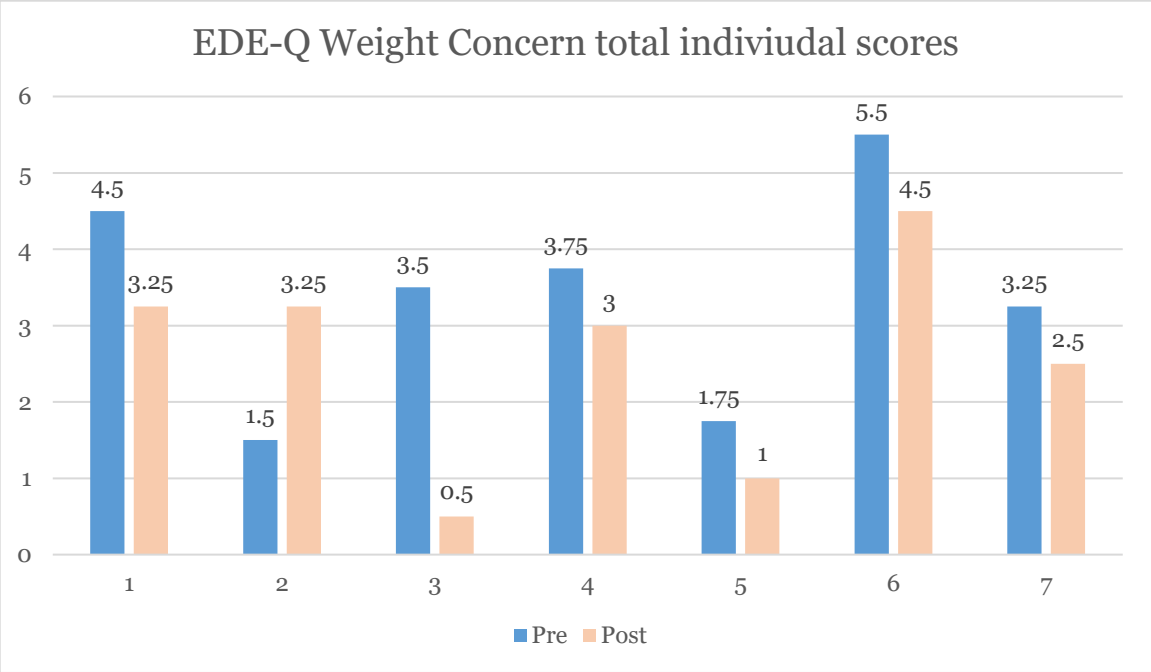


Figure 4.62. *EDEQ Weight Concern total individual scores*



The Functions of Self-Criticising/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 decrease from 17.29 (*SD* = 6.60) to 8.00 (*SD* = 6.76), with seven participants (100%) scores decreasing on this scale.

Levels of self-correction decreased from pre-intervention (*M* = 24.29, *SD* = 16.58) to post-intervention (*M* = 15.00, *SD* = 15.06), with five out of seven participants (71.4%) scores decreasing on this scale.

Figure 4.63. *FSCS subscale mean scores*

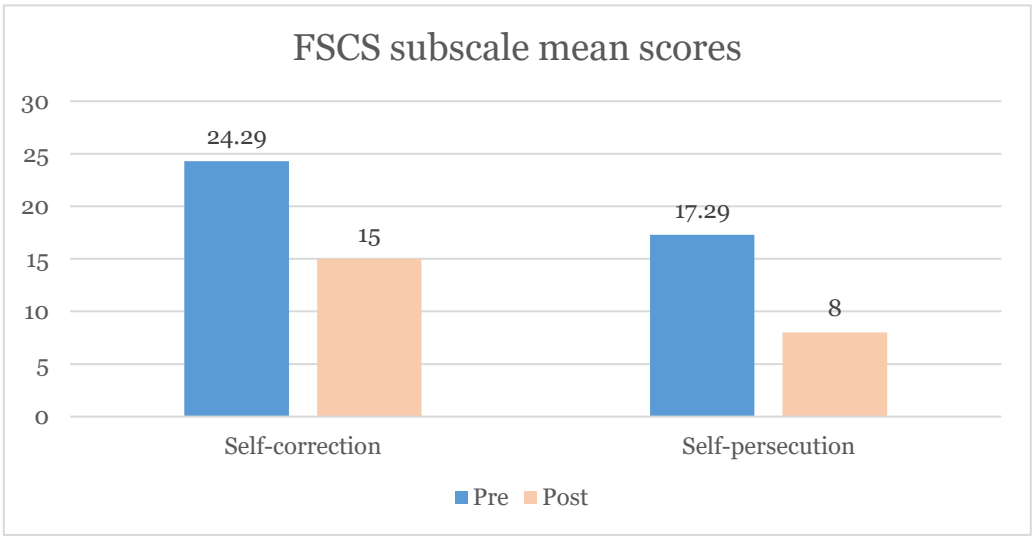


Figure 4.64. *FSCS Self Correction individual scores*

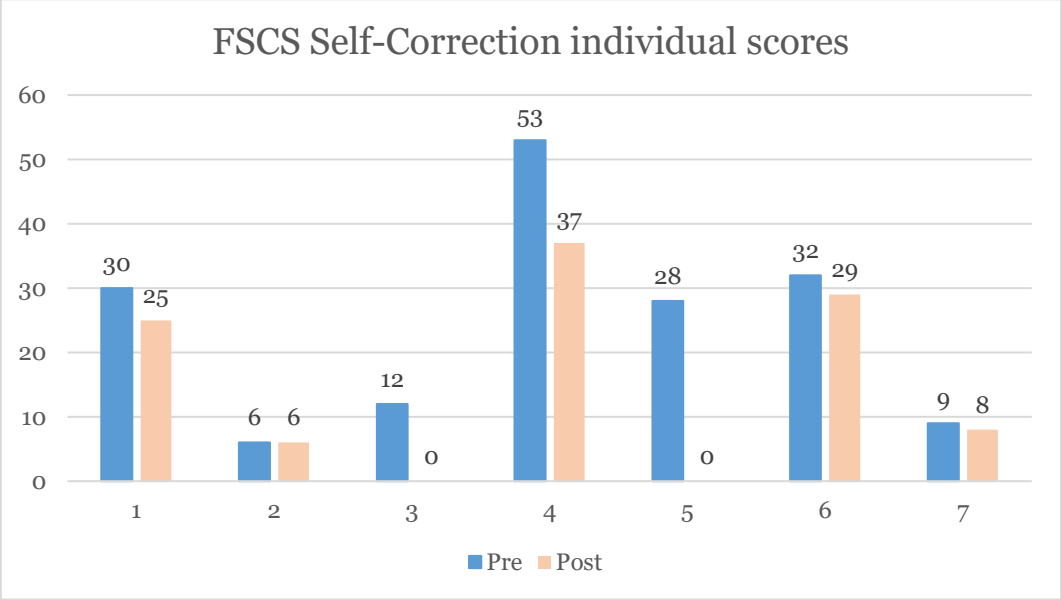
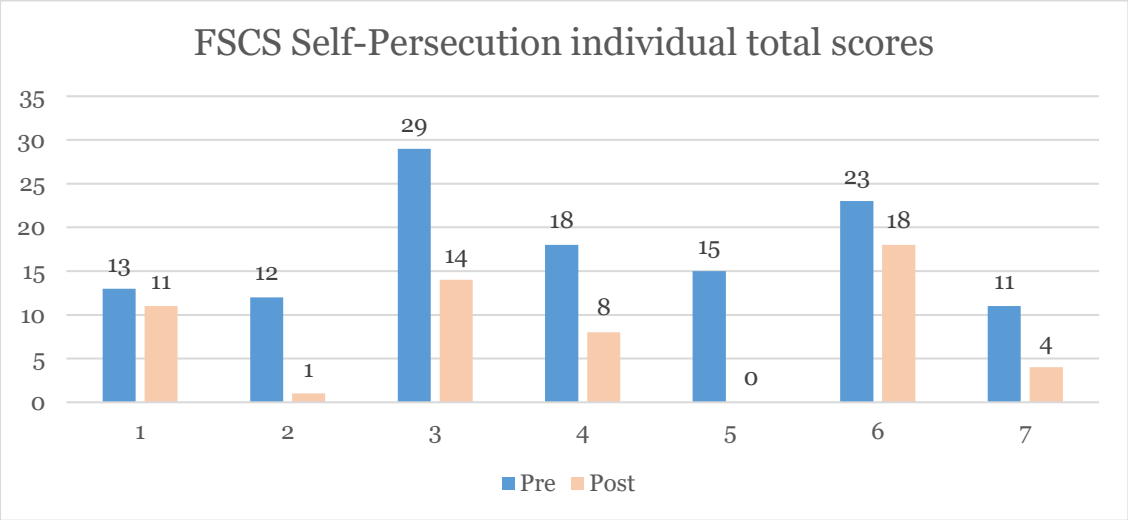


Figure 4.65. *FSCS Self-Persecution individual total scores*



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

Mean scores on the FSCRS 'inadequate self' sub-scale decreased from pre (M = 26, SD = 7.83) to post-intervention (M = 15.86, SD = 11.78), with six of seven participants (85.7%) scores decreasing on this scale.

A reduction in mean scores on the 'hated self' sub-scale was observed from pre (M = 10, SD = 5.03) to post-intervention (M = 4.23, SD = 2.51), with six of seven participants scores also decreasing on this scale (85.7%).

Mean scores on the 'reassured self' sub-scale increased from pre-intervention (M = 14.00, SD = 5.03) to post-intervention (M = 18.43, SD = 5.74), with scores increasing for six (85.7%) of seven participants.

Figure 4.66. *FSCRS mean subscale scores*

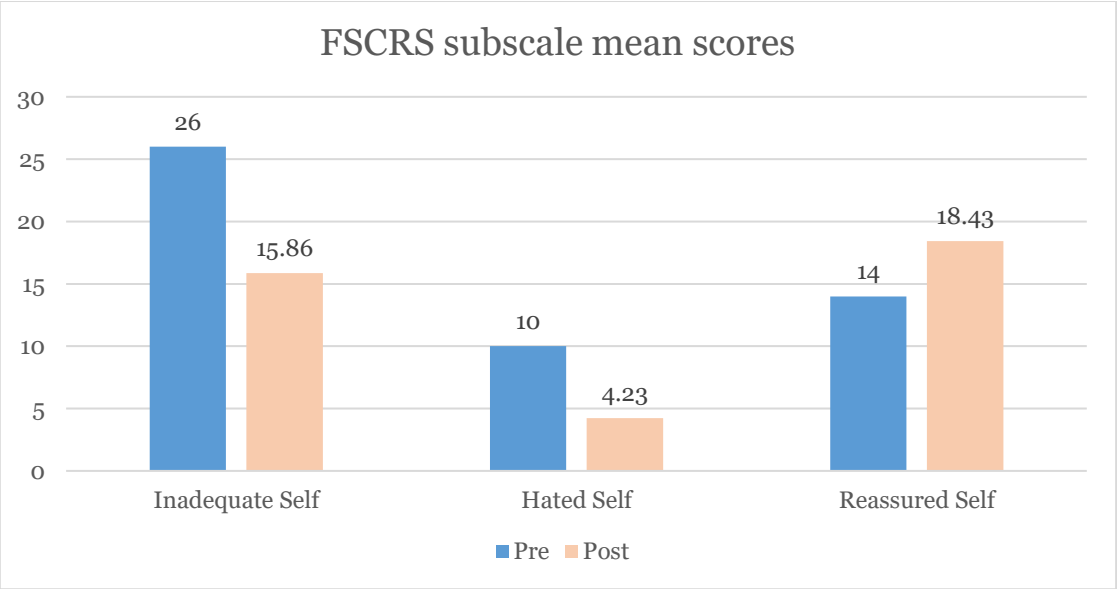


Figure 4.67. *FSCRS Inadequate Self individual scores*

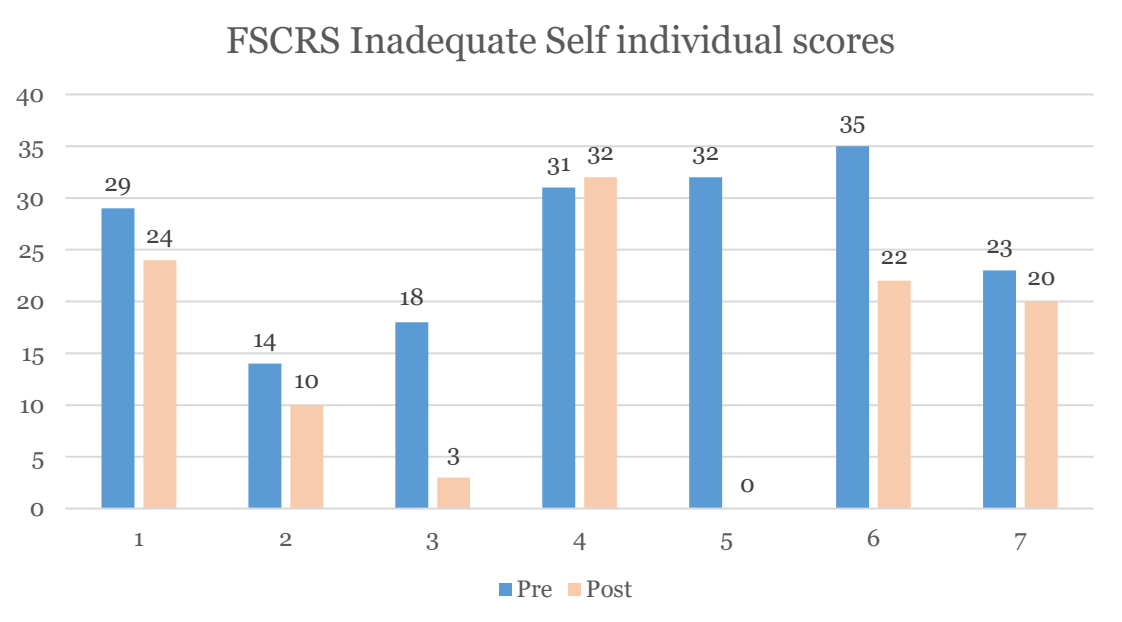


Figure 4.68. *FSCRS Hated Self individual scores*

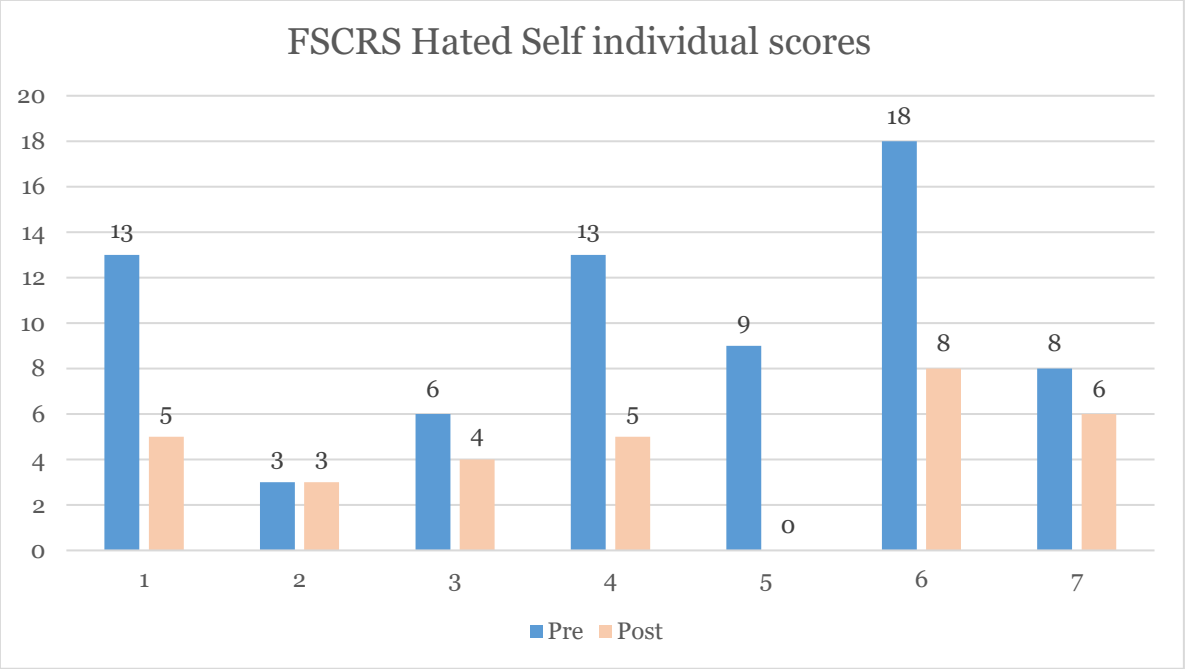
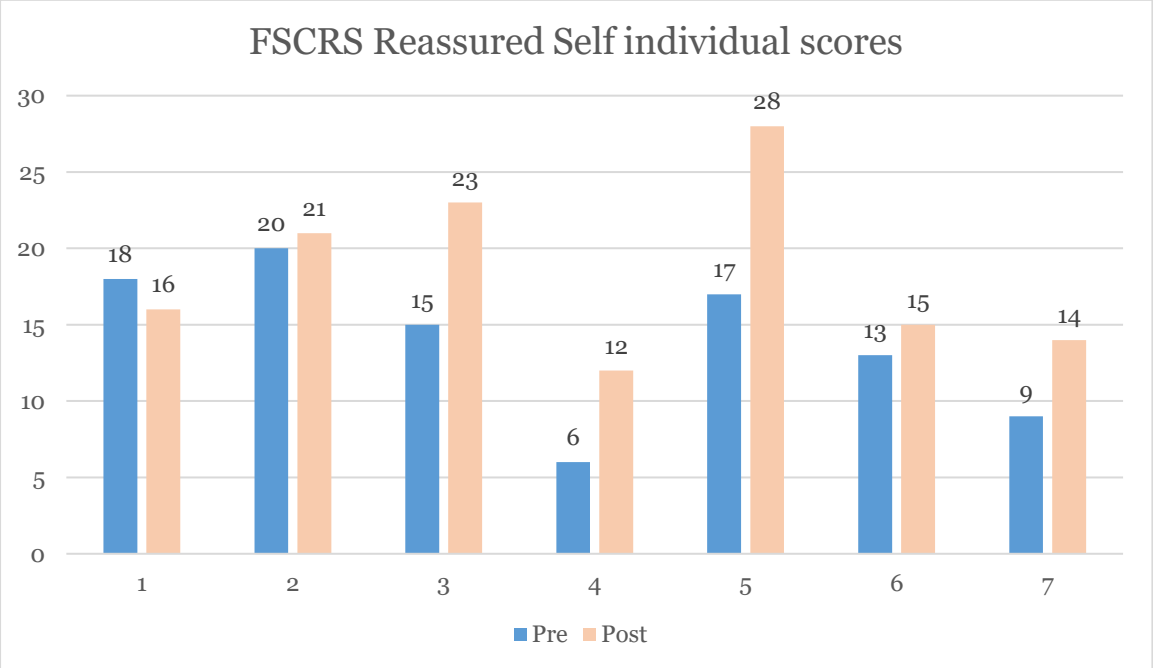


Figure 4.69. *FSCRS Reassured Self individual scores*



Compassionate Engagement and Action Scale (CEAS)

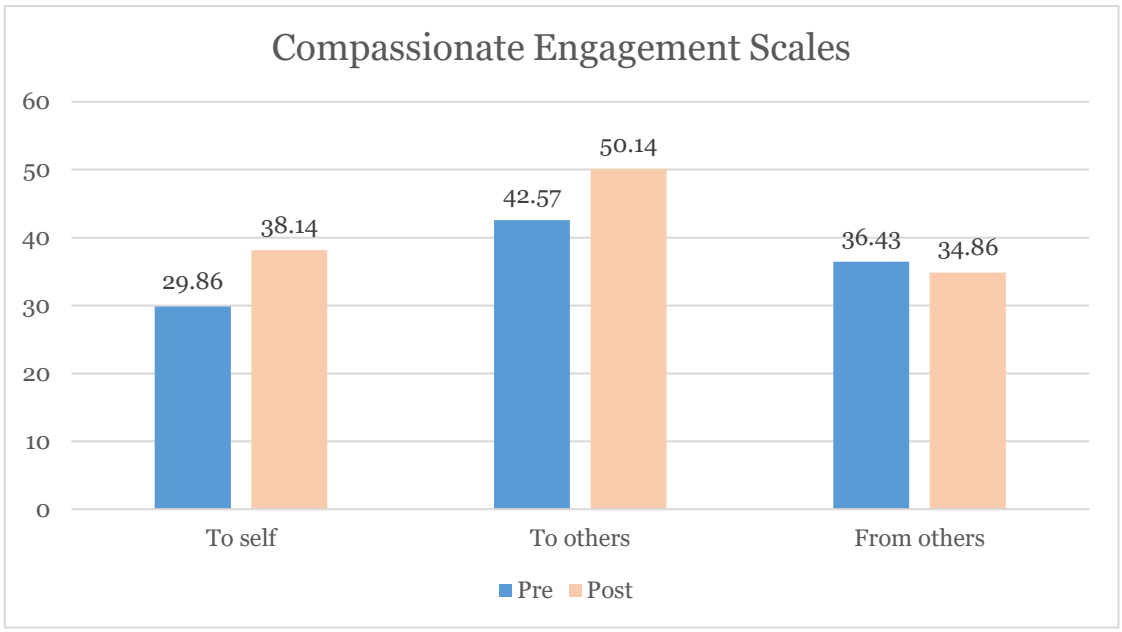
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores and scores on the engagement and action subscales are reported below.

Mean scores on the Compassion to Self engagement scale increased from pre-intervention *(M* = 29.86, *SD* = 4.60) to post-intervention (*M* = 38.14, *SD* = 7.52). Mean scores also increased on the Compassion to Self Action scale, with scores increasing from 16.14 (*SD* = 5.90) at pre-intervention to 22.86 (*SD* = 6.44) at post-intervention. The total mean score for self-compassion also increased from 46.00 (*SD* = 8.14) to 61.00 (SD = 13.49), with five of seven participants (71.4%) reporting increased levels of self compassion post-intervention.

Mean scores for the Compassion to Others Engagement scale also increased from pre-intervention (*M* = 42.57, *SD* = 13.48) to post-intervention (*M*= 50.14, *SD* = 5.01). There was a small increase in mean scores from the Compassion to Others Action scale from pre-intervention (*M* = 30.14, *SD* = 8.38) to post-intervention (*M* = 33.14, *SD* = 3.72). Overall mean scores on the Compassion to Others subscale increased from (M = 72.71, *SD* = 21.49, to M= 83.29, *SD* = 8.46), with four out of seven (57%) participants reporting an increase on this scale.

Mean scores on the Compassion from Others Engagement Scale decreased slightly from pre-intervention (*M* = 36.43, *SD* = 11.87) to post-intervention (*M* = 34.86, *SD* = 8.84). Mean scores on the Compassion from Others Action Scale also remained relatively unchanged, with a pre-intervention mean of 25.43 (*SD* = 8.16) to a post-intervention mean of 25.29 (*SD* = 7.70). The total mean scores on the Compassion from Others subscale also remained relatively unchanged, from 59.00 (*SD* = 21.71) at pre-intervention to 60.14 (*SD* = 15.95) at post-intervention, with three of the seven (42.9%) participants reporting an increase in their perceived level of compassion from others post-intervention.

Figure 4.70. *CEAS Engagement and Action Scales mean scores*



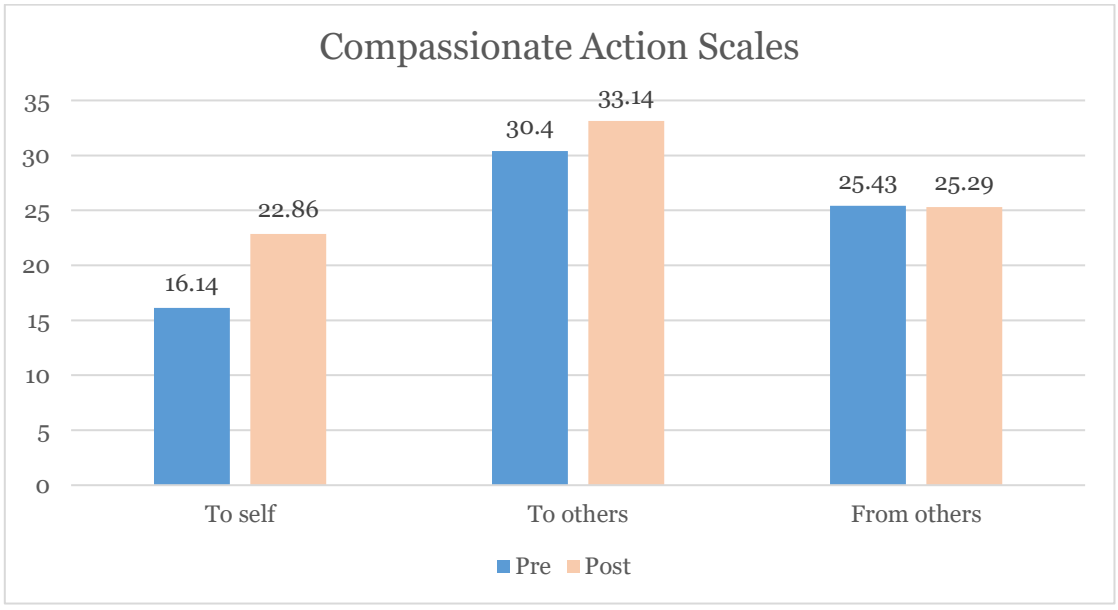


Figure 4.71. *CEAS Self-Compassion individual scores*

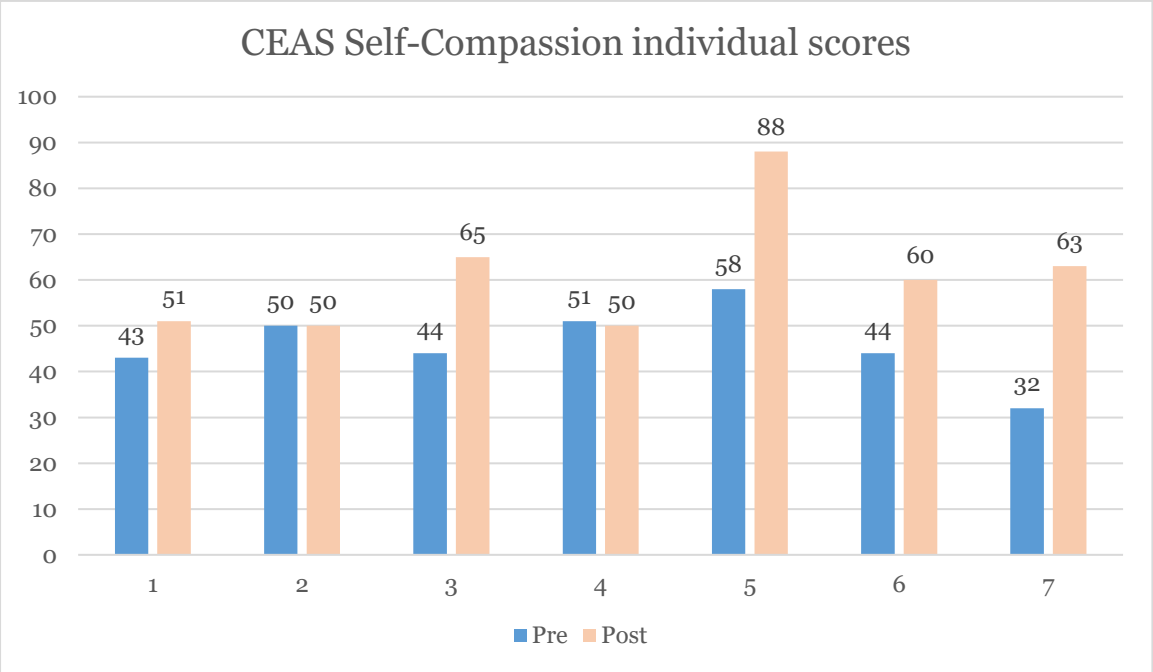


Figure 4.72. *CEAS Compassion for Others individual scores*

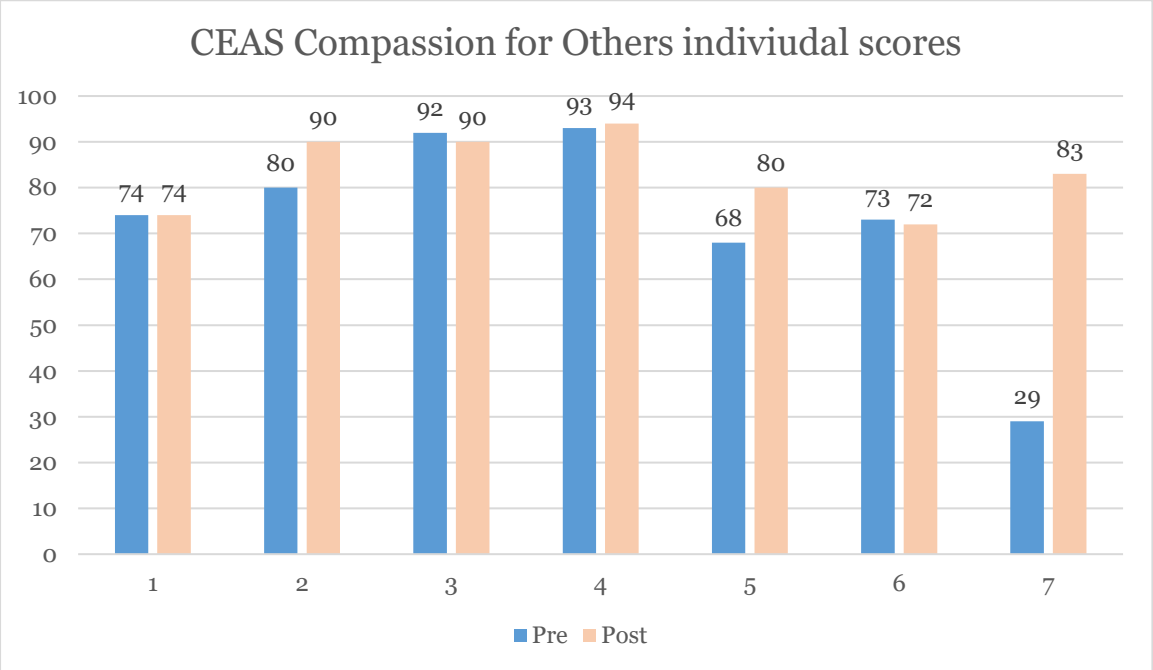
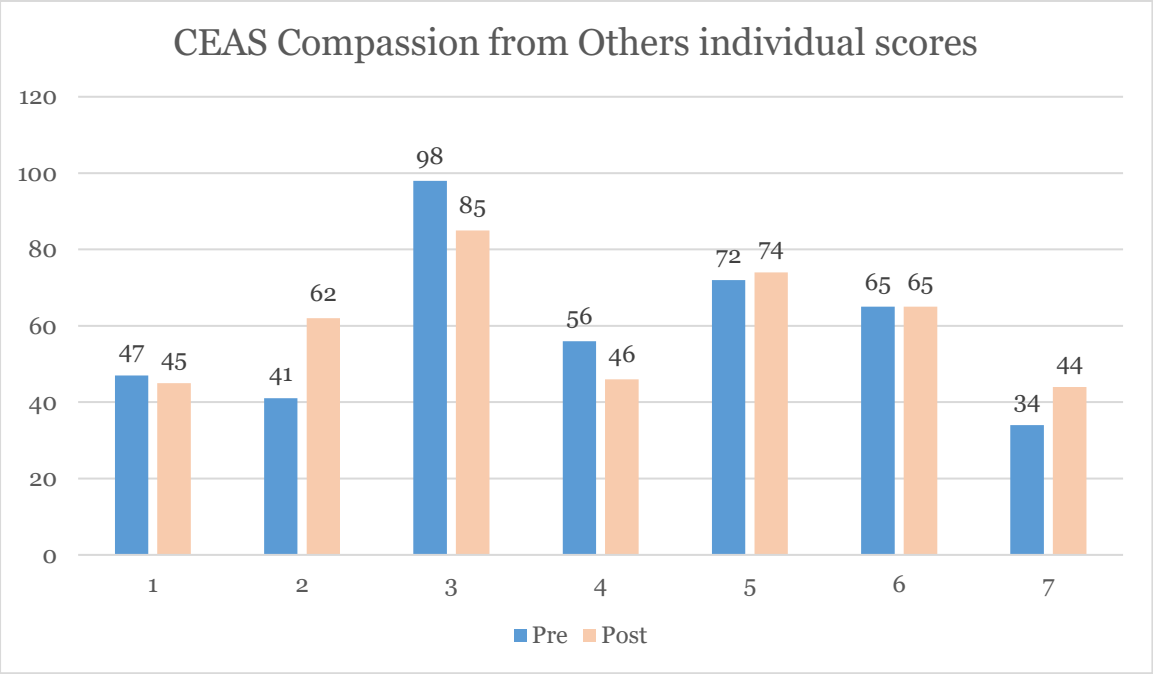


Figure 4.73. *CEAS Compassion from Others individual scores*



4.11.4. Summary

Since CFT-E began in SPMHS in 2015, 11 cycles have been facilitated and the most recent cycle completed in 2023 was delivered in mainly a face-to-face format with one session being online and two hybrid sessions due to service user requests. The programme receives referrals from within the hospital and from external referrers. The outcomes report above illustrates the efficacy of the CFT-E programme, all participants completed the intervention which is unusual in eating disorder treatment. Participants reported a reduction in eating disorder symptoms, self-hatred, feelings of inadequacy with an increase in self reassurance and 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.

4.12. 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 and trauma-informed approaches.

The group is held online or in-person (depending on need) 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.

4.12.1. Descriptors

Pre and post data were available for six of the nine service users that attended the programme in 2023. Of these, two were female (33%) and four were male (67%). The age of programme attendees ranged from 67 to 81 years old (M = 74, SD = 5.22). Due to the small sample size, statistical significance could not be determined for changes in scores pre-to-post intervention. Instead, participants individual pre and post measure scores are reported below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

4.12.2. 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, scored from 0 – 'did not apply to me at all', to three – 'applied to me very much, or most of the time'. The Depression Scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety Scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress scale is sensitive to levels of

chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal and being easily upset/agitated, irritable/over-reactive and impatient. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal populations and clinical populations are essentially differences of degree.

4.12.3. Results

In order to analyse the outcome measures, the pre and post-group mean scores on DASS-21 were explored first, including the 'DASS-21 Total' score, the 'Anxiety Subscale', the 'Depression Subscale' and the 'Stress Subscale' scores. Following this, each group members pre and post group mean scores on the DASS-21 were explored. Finally, a Reliable Change Index (RCI) was conducted. Please see details of this analysis below.

The mean for the 'DASS-21 Total' score decreased from 46.00 (*SD* = 16.35) to 38.67 (*SD* = 10.78). As seen in the graph below, the total DASS-21 scores decreased for three of six (50%) group members.

Figure 4.74. *Pre and post-group mean scores for the DASS-21 total score*

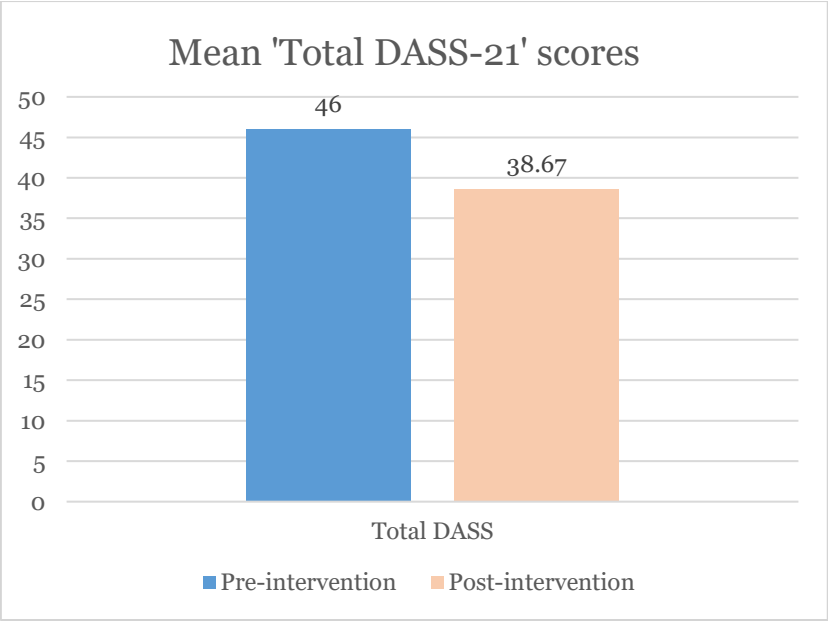
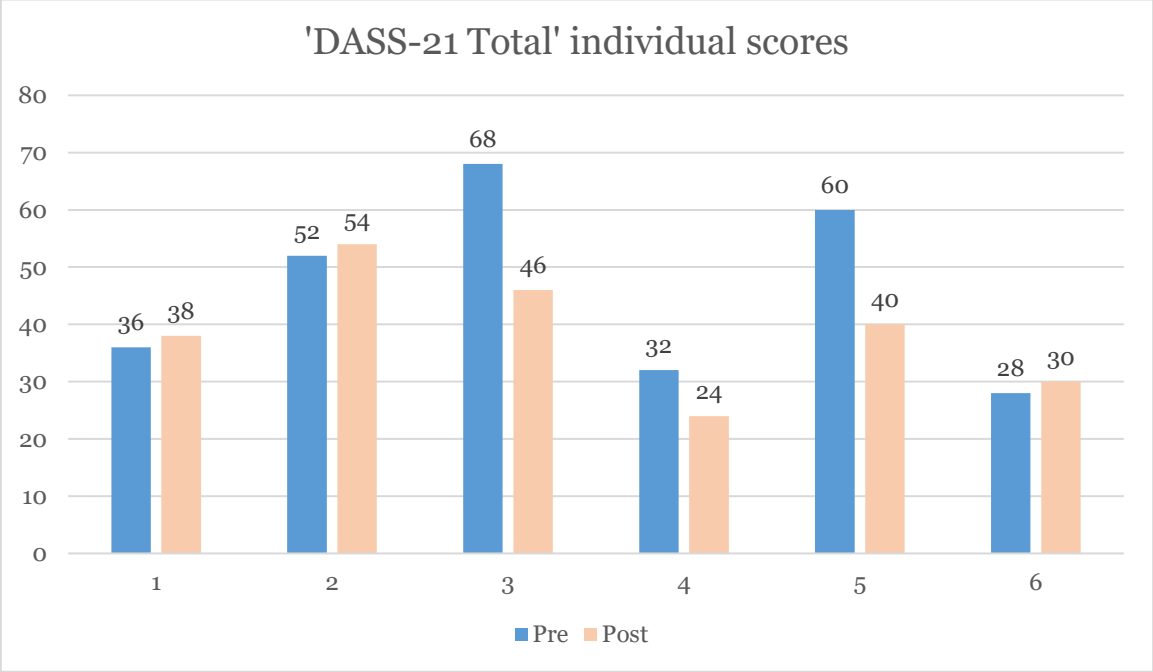


Figure 4.75. *Pre and post-group mean scores for the DASS-21 total score for each individual group member*



The mean score on the 'Anxiety Subscale' on the DASS-21 decreased from an average 13.67 (*SD* = 7.74) to 10.33 (*SD* = 5.43), please see graph below. Scores on this subscale decreased for four out of six (66.7%) group members, as illustrated in the graph below.

Figure 4.76. *Pre and post-group mean scores for the 'Anxiety Subscale' score on the DASS-21*

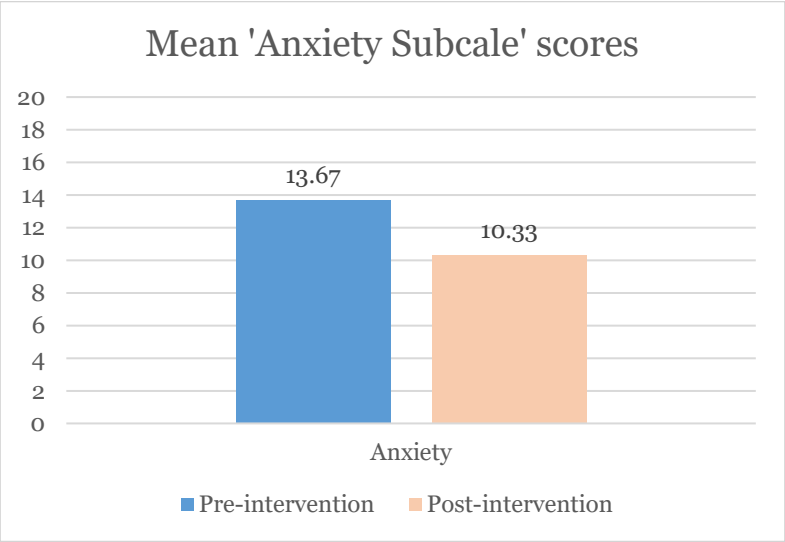
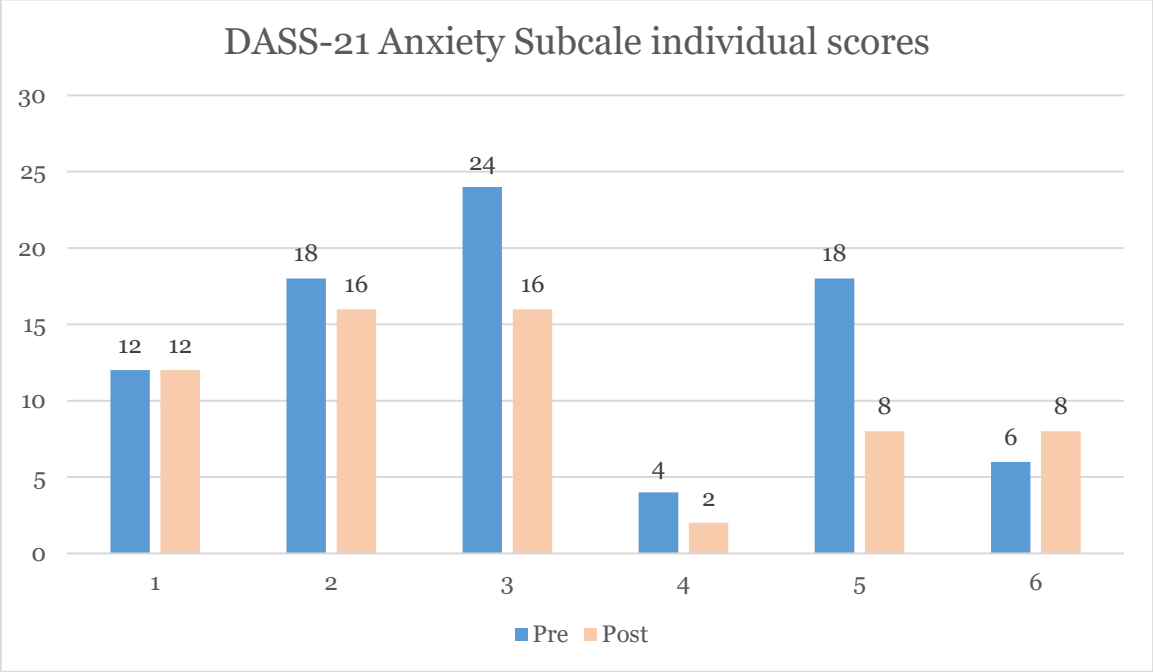


Figure 4.77. *Pre and post-group mean scores for the 'Anxiety Subscale' Score for each individual group member*



The mean scores on the 'Depression Subscale' on the DASS-21 also decreased from an average 17.33 (*SD* = 6.02) to 12.67 (*SD* = 2.07), please see graph below. Similarly, scores on this subscale decreased for four out of six (66.7%) group members as illustrated on graph below.

Figure 4.78. *Pre and post-group mean scores for the 'Depression Subscale' score on the DASS-21.*

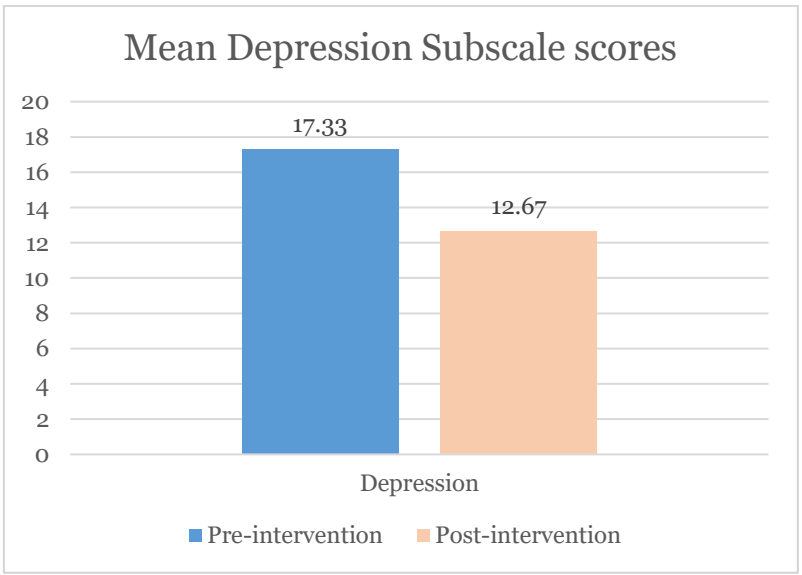
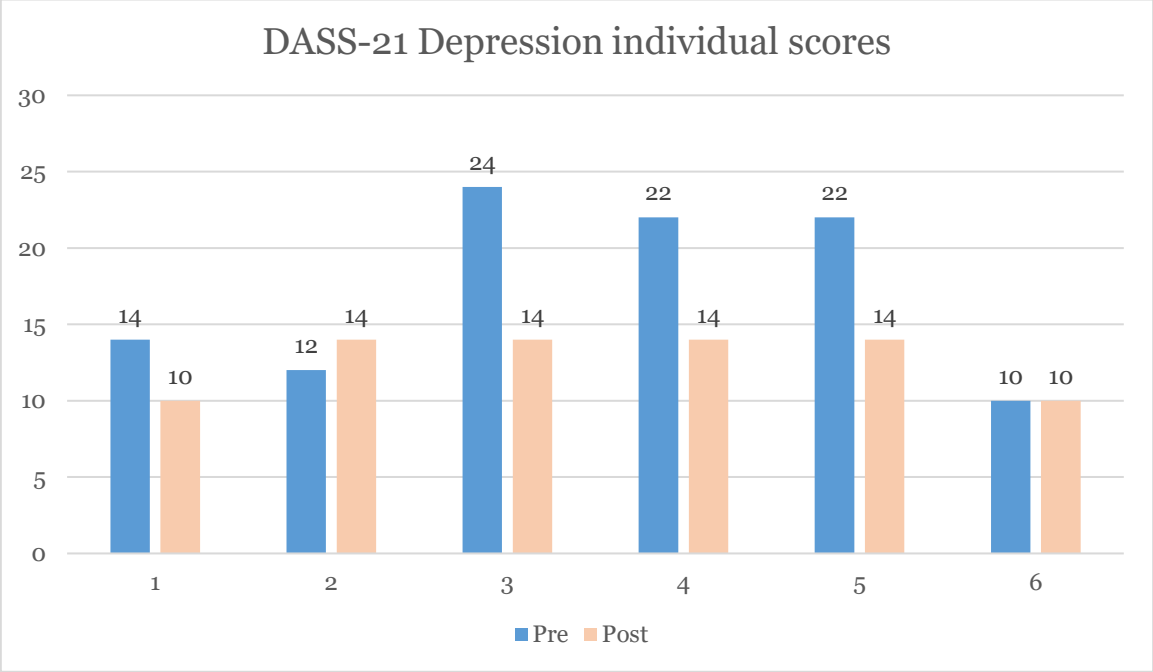


Figure 4.79. *Pre and post-group mean scores for the 'Depression Subscale' score for each individual group member*



The mean score on the 'Stress Subscale' score on the DASS-21 increased slightly from an average 15.00 (*SD* = 6.54) to 15.67 (*SD* = 5.43), please see graph below. As illustrated in the graph below, scores on this scale decreased for two out of six (33.3%) group members, while increasing for three out of six group members (50%), and remaining unchanged for one group member (16.7%).

Figure 4.80. *Pre and post-group mean scores for the 'Stress Subscale' score on the DASS-21.*

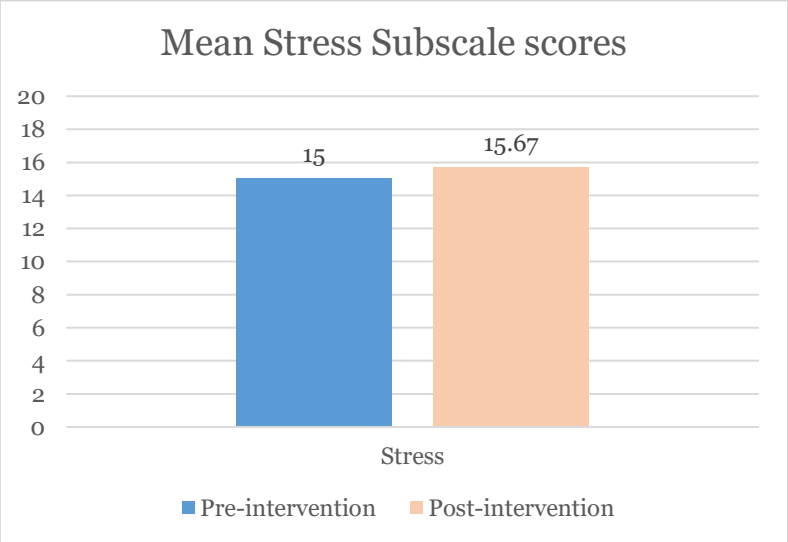
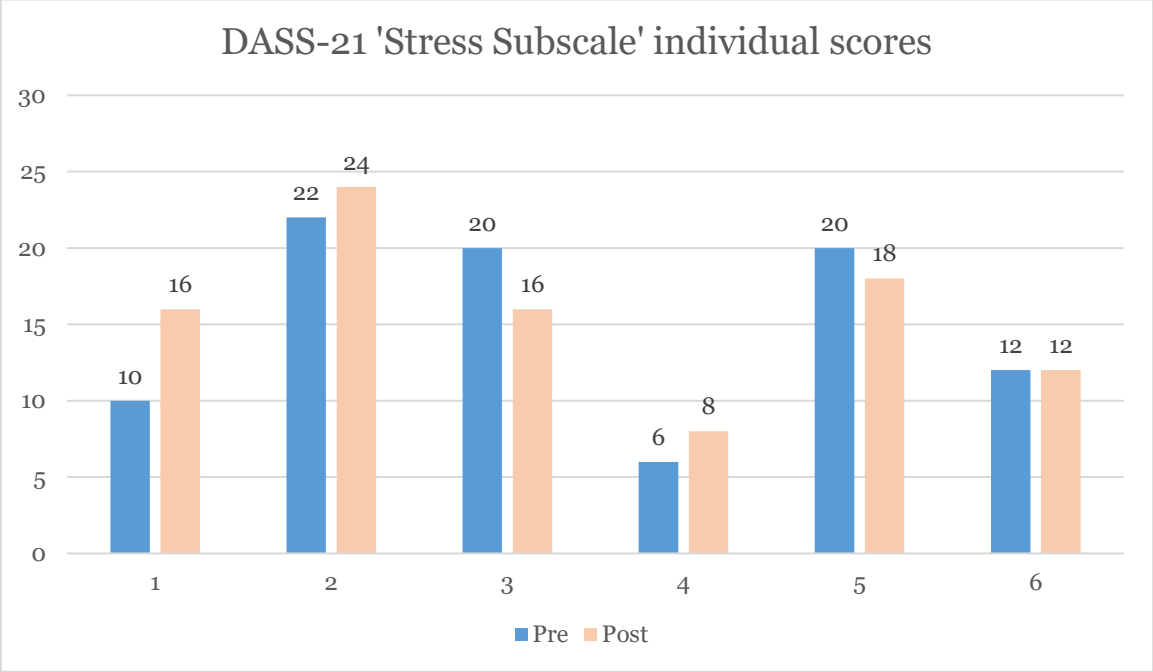


Figure 4.81. *Pre and post-group mean scores for the 'Stress Subscale' for each individual group member*



Due to the small sample size, changes in total DASS scores were analysed using the Reliable Change Index (RCI) for each group member. In order to ensure that changes in DASS scores were not attributable to chance or measurement error a RCI was calculated for each group member using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The calculated cut-off score indicating clinically meaningful improvement on the DASS was 34. Group members were classified as "clinically meaningful improvement" (passed RCI criterion and DASS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below DASS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, four group members (66.7%) reported uncertain change, while two group members (33.3%) reported reliable improvement.

Table 4.13. *Results from Reliable Change Index (RCI) for the DASS-21 pre and post scores for each group member*

DASS = Depression Anxiety and Stress Scale

Group member	Pre score	Post score	RCI value	Category
1	36	38	.28	Uncertain Change
2	52	54	.28	Uncertain Change
3	68	46	-3.04	Reliable Improvement
4	32	24	-1.11	Uncertain Change
5	60	40	-2.77	Reliable Improvement
6	28	30	0.28	Uncertain Change

4.12.4. Summary

Reductions in average levels of depression and anxiety were observed in individuals who took part in COAP while average levels of stress remained relatively unchanged, with a slight increase reported. Due to the small sample size, it was not possible to determine whether these differences achieved statistical significance. Inclusion of a Reliable Change Index (RCI) for DASS-21 total scores provides further insight into the level of change on this measure for each group member. This analysis showed that four group members (66.7%) reported uncertain change, while two group members (33.3%) reported reliable improvement following the COAP group. There was as a reduction in the number of completed pre and post-outcome measures reported on compared to 2022. This was due to only one cycle of the COAP programme running in 2023 compared to five cycles being run in 2022. The COAP programme resources are shared with the Compassion-Focused Therapy for Older Adults (CFT-OA) psychology programme, a new programme that was introduced in 2023. The CFT-OA programme also targets a similar population, offering a longer intervention targeting shame and self-criticism among older adults experiencing mental health difficulties, impacting the number of cycles run and service users attending the COAP programme.

4.13. 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 Programme

The Depression Recovery Programme is a 10-week psychotherapy group programme which combines approaches from Cognitive Behavioural Therapy (CBT), Compassion-Focused Therapy (CFT) and Mindfulness-Based Stress Reduction (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.

4.13.2. Descriptors

Paired data were available for 29 service users who completed the programme in 2023; 21 females (72.4%) and 8 males (27.6.5%). The age profile of participants ranged from 23 to 71 years of age, with the average age being 53.31 years.

4.13.1. 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).

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

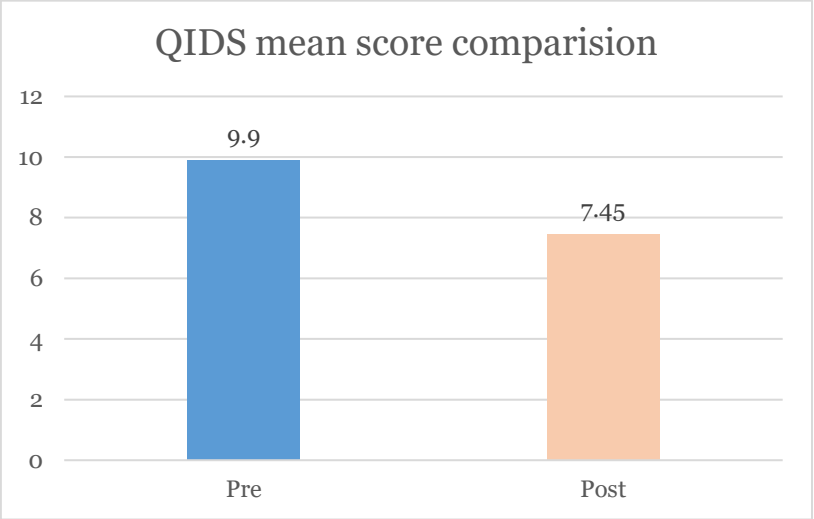
The Work and Social Adjustment Scale (WSAS) (Mundt, J.C. Marks, I.M., et al. (2002). The work and social adjustment scale: A simple measure of impairment in functioning. *British Journal of Psychiatry*, 180: 461-464) is a brief global measure of functional impairment that is widely used in adult health. 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.

4.13.3. 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 = 9.9, SD = 6.41) to post-intervention (M = 7.45, SD = 4.71). This reduction in mean scores is statistically significant. A paired samples t-test revealed t (29)= 2.13, p< .042, with a small effect size (Cohen's d = .435).

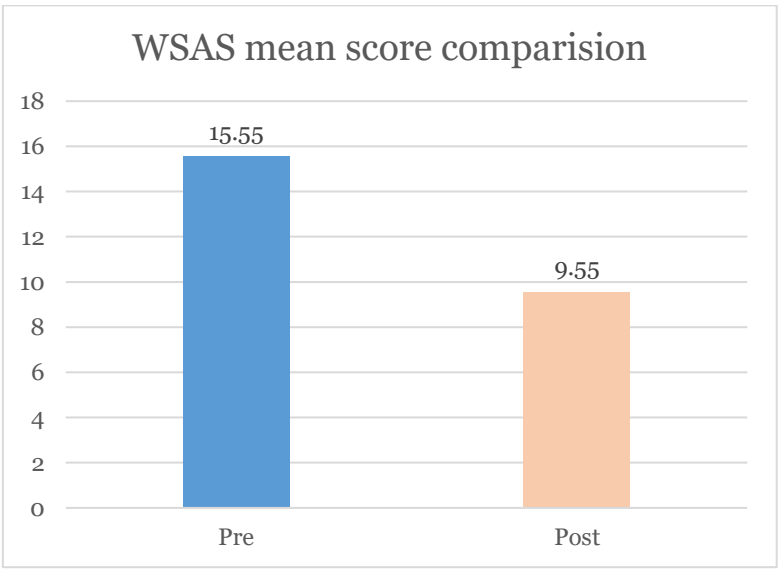
Figure 4.82. *Pre and post-group mean scores for the QIDS*



The Work and Social Adjustment Scale (WSAS)

Comparison of service user scores on the WSAS indicated a reduction of severity scores from pre-intervention (M = 15.55, SD = 7.92) to post-intervention (M = 9.55, SD = 5.96). This reduction in mean scores is statistically significant. A paired samples t-test revealed t (29)= 3.62, p< .001, with a large effect size (Cohen's d = .856).

Figure 4.83. *Pre and post-group mean scores for the WSAS*



4.11.4. Summary

This is the ninth year the Depression Recovery Programme has been included in the SPMHS *Outcomes Report*. This is the first year the the Work and Social Adjustment Scale (WSAS) which measures functioning impairment has been measured pre and post-intervention. This is fourth year 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, and their functioning impairment.

4.14. 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; weekly cookery session

- Family support and education individual psychotherapy
- Psychology groups for compassionate mind training which aims to help participants begin to understand, engage with and alleviate their distress.

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

- Occupational therapy groups
- Goal-setting and care planning
- Meal planning, preparation and cooking groups
- Meal supervision and dietetics
- Body image and self-esteem
- Relaxation/self-reflection groups
- Recovery-focused intervention (WRAP)
- Social and relationship groups
- Psychology groups for skills training in regulating emotions and tolerating distress.

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

4.14.1. Descriptors

Data was available for a total of 15 service users attending the EDP as an inpatient in 2023. Inpatient data was collected at two points, inpatient admission, and discharge. Data was available for 21 service users who attended EDP as a day service user in 2023. 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. Seven service users completed outcome measures for both the inpatient and day service programmes.

4.14.2. 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.

4.14.3. 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 = 3.97) and post-treatment (M = 2.45). A pairwise sample t-test indicated this was a statistically significant change $t(14) = -5.60$, $p<.001$, with a large effect size $d= 1.15$.

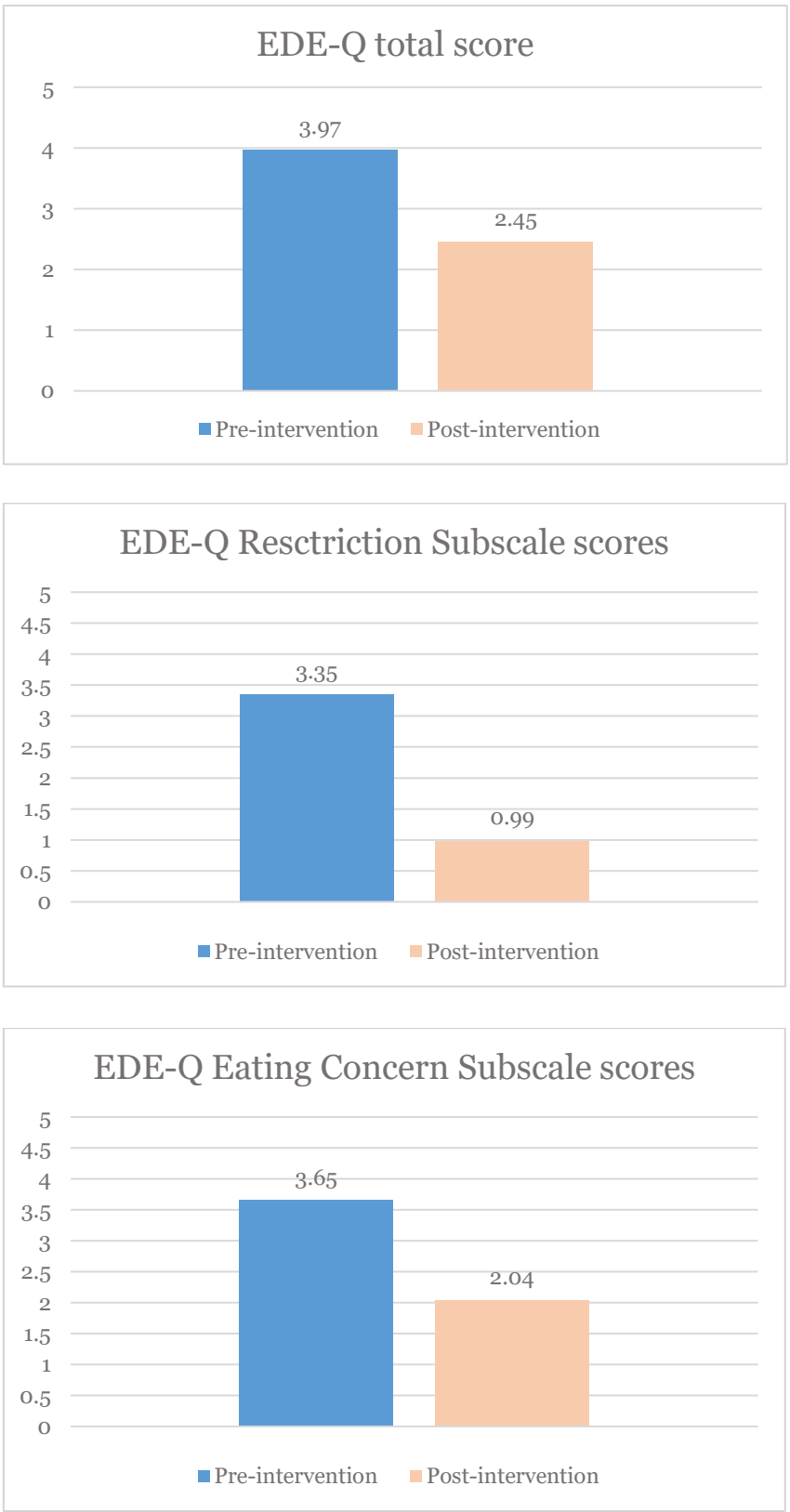
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restriction sub-scale significantly decreased from pre-treatment ($M= 3.35$) to post-treatment (M = 0.99), $t(14)= -4.82$, $p<.001$, with a large effect size of $d=1.48$.

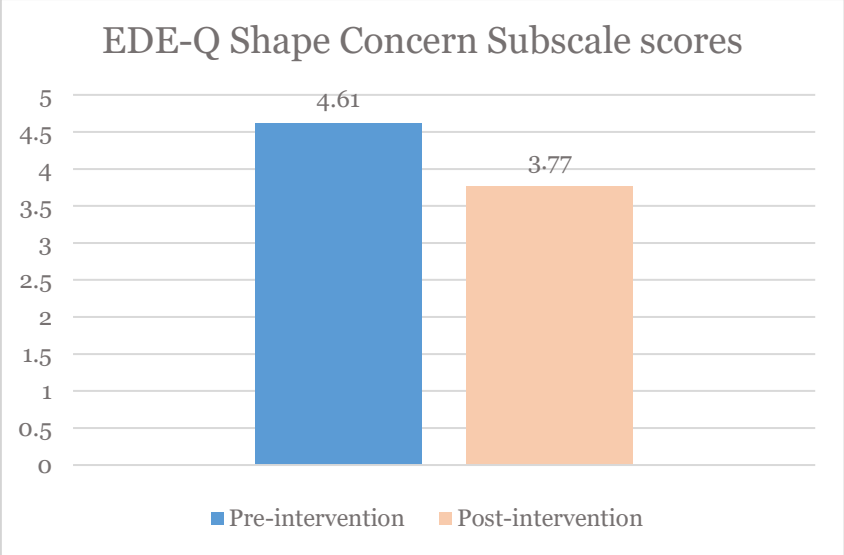
Secondly, symptomatology on the eating concern sub-scale significantly decreased from pre-treatment ($M= 3.65$) to post-treatment (M = 2.04), $t(14)= -4.64$, $p<.001$, with a large effect size $d= 1.08$.

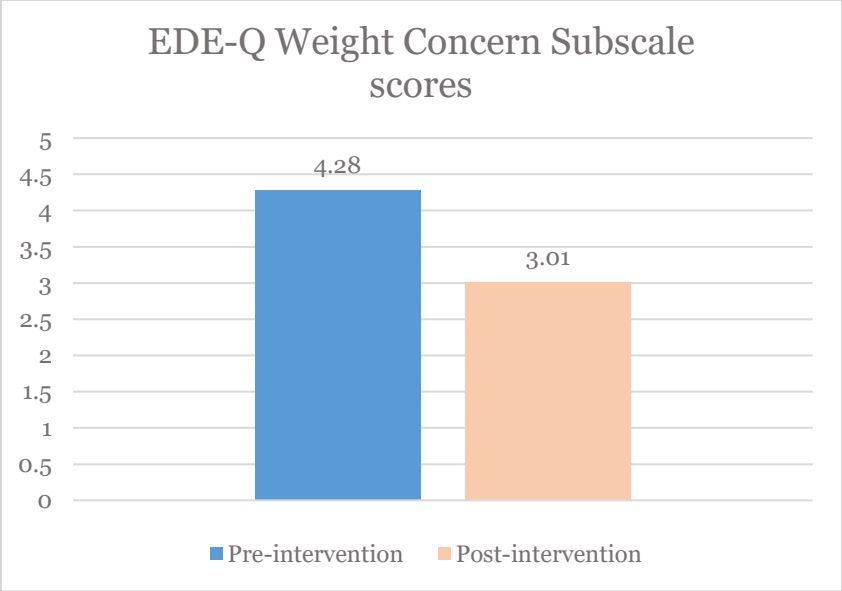
Additionally, symptomatology on the shape concern sub-scale significantly decreased from pre-treatment ($M= 4.61$) to post-treatment (M = 3.77), $t(14)= -3.05$, $p= .009$, with a medium effect size $d=.56$.

Finally, symptomatology on the weight concern sub-scale significantly decreased from pre-treatment ($M= 4.28$) to post-treatment (M = 3.01), $t(14)= -3.49$, $p= .004$, with a large effect size $d=.80$.

Figure 4.84 *Pre and post-group mean scores for the EDE-Q total and sub-scale scores*







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.

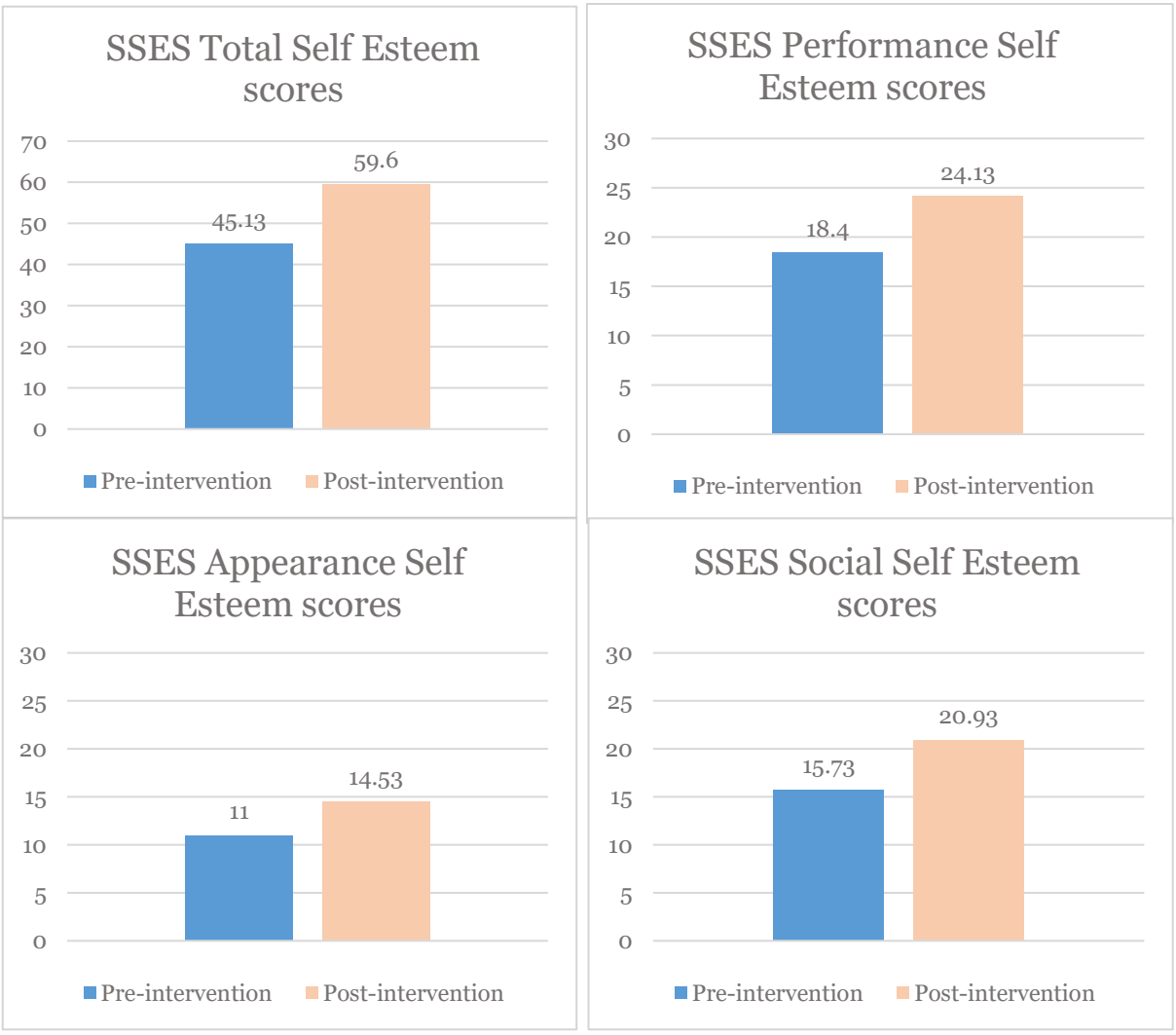
The total score on the SESS showed an increase between pre-treatment (M=45.13) and post-treatment (M=59.60). A pair wise sample t- test indicated this was a statistically significant change, t (14) = 4.67, p <.001, with a medium to large effect size d=.77.

The performance self-esteem score on the SESS showed an increase between pre-treatment (M=18.40) and post-treatment (M=24.13). A pair wise sample t- test indicated this was a statistically significant change, t (14) = 5.75, p <.001, with a large effect size d=1.01

The social self-esteem score on the SESS showed an increase between pre-treatment (M=15.73) and post-treatment (M=20.93). A pair wise sample t-test indicated this was statistically significant, t(14)= -3.23, p = .006, with a medium to large effect size of d = .73.

The appearance self-esteem score on the SESS showed an increase between pre-treatment (M=11.00) and post-treatment (M=14.53). A pair wise sample t-test indicated this was a statistically significant change, t(14)= -3.19, p =.007, with a medium to large effect size d=.74

Figure 4.85. *Pre and post-group mean scores for the State Self Esteem Scale total and subscale scores*



4.14.4. Day Programme 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 = 2.84) and post-treatment (M = 2.48). A pairwise sample t-test indicated this was not a statistically significant change $t(20)$ = -1.68, p>.05.

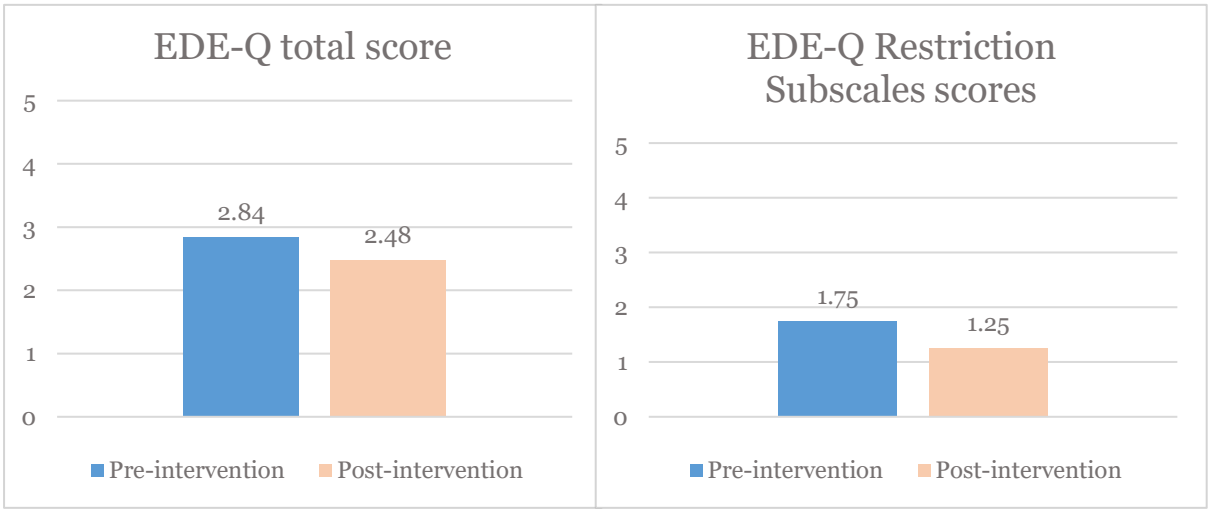
Symptomatology on the restriction sub-scale decreased from pre-treatment (M= 1.75) to post-treatment (M = 1.25), although this difference was not found to be statistically significant, t= -1.70, p > .05.

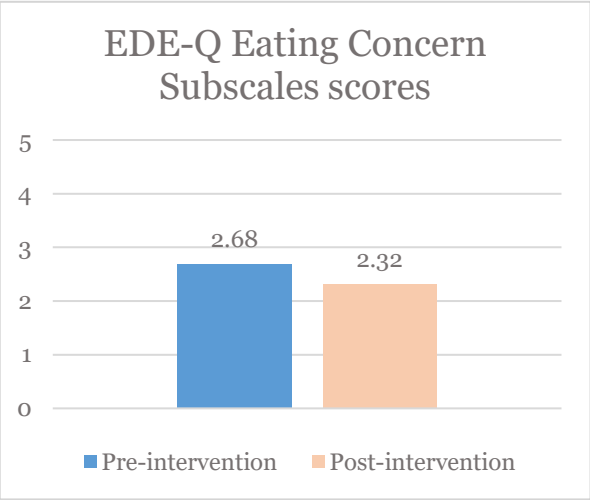
Symptomatology on the eating concern sub-scale decreased from pre-treatment (M= 2.68) to post-treatment (M = 2.32), although this difference was not found to be statistically significant, $t(20)$ = -1.10, p >.05.

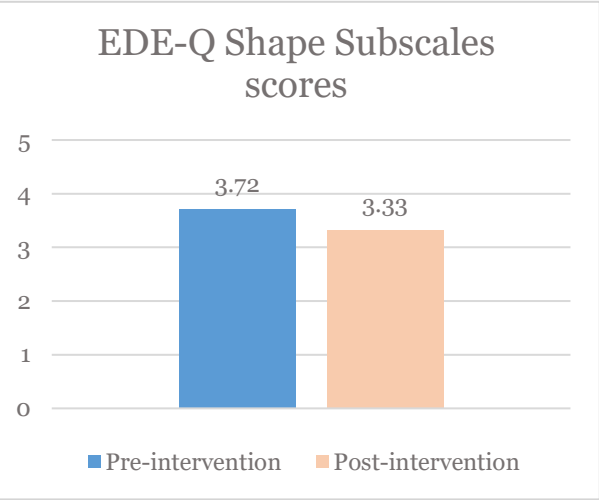
Additionally, symptomatology on the shape concern sub-scale decreased from pre-treatment (M= 3.72) to post-treatment (M = 3.33), although this difference was not statistically significant, $t(20)$= -2.05, p > .05.

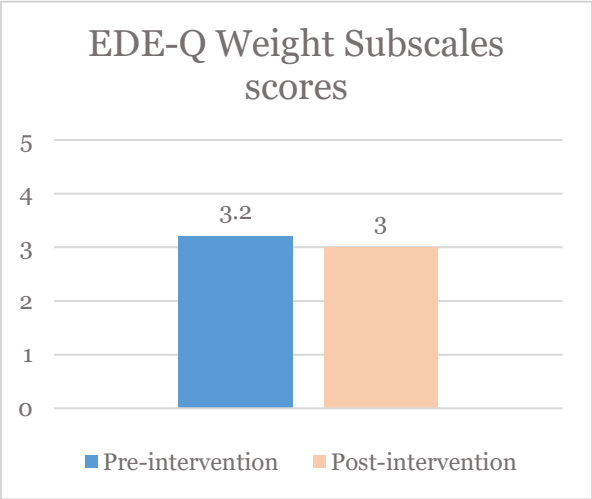
Finally, symptomatology on the weight concern sub-scale decreased from pre-treatment (M= 3.20) to post-treatment (M = 3.00), but again this was not statistically significant, $t(20)$= -.81, p > .05.

Figure 4.86. *Pre and post-group mean scores for the EDE-Q Global and subscale scores.*









State Self-Esteem Scale (SSES)

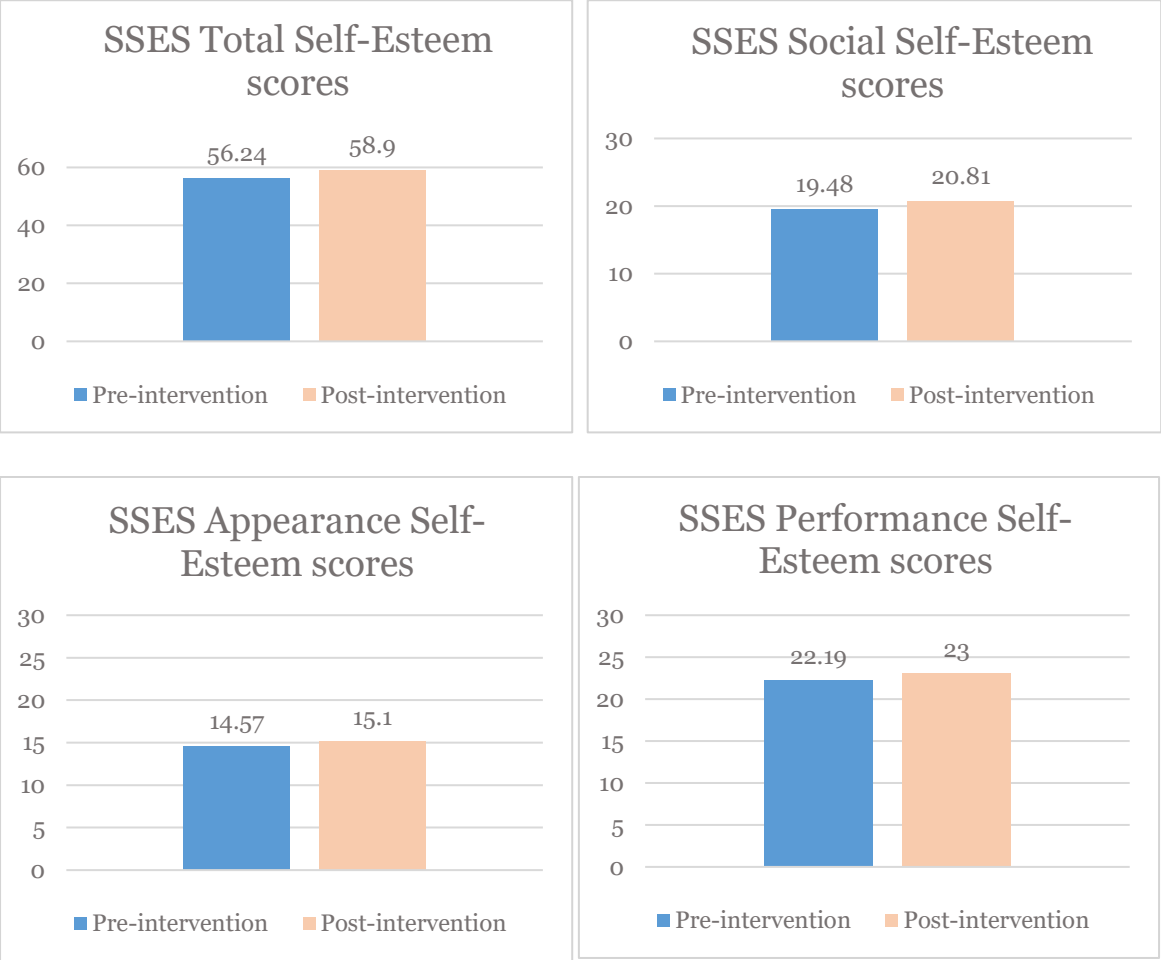
The total score on the SESS showed an increase between pre-treatment (M=56.24) and post-treatment (M=58.90). A paired samples t-test indicated this was not a statistically significant change, t (20) = .964, p >.05.

The performance self-esteem score on the SESS showed an increase between pre-treatment (M=22.19) and post-treatment (M=23.00). A paired samples t-test indicated this was not a statistically significant change, t (20) = .713, p >.05.

The social self-esteem score on the SESS showed an increase between pre-treatment (M=19.48) and post-treatment (M=20.81). A pair wise sample t-test indicated this was not a statistically significant change, t (20) = 1.05, p >.05.

The appearance self-esteem score on the SESS showed an increase between pre-treatment (M=14.57) and post-treatment (M=15.10). A paired samples t-test indicated this was not statistically significant change, t (20) = .65, p >.05.

Figure 4.87. *Pre and post-group mean scores for the State Self-Esteem scale total and subscale scores*



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.

Whilst the number of outcomes measures collected for individuals completing the day programme were comparable to those gathered in 2022, there was a decline in the number of pre and post measures collected for individuals completing the inpatient programme. The EDP team are confident that the number of inpatient pre and post outcome measures collected will improve during 2024 following changes to the process for collection of outcome measures. In 2024, the EDP programme will utilise a secure service user electronic portal (Your Portal), to send clinical outcome measures for completion by consenting service users attending the programme. Service users will then be able to complete the outcome measures via the secure portal, which are instantly accessible for review by the clinical staff delivering the programme. It is anticipated this change will result in an increase in the number of pre and post outcome measures completed by service users attending the EDP programme.

4.15. 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 programme, 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 sees 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 programme 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.

4.15.1. Descriptors

A total of 20 people completed EFT- YA in 2023. Complete pre and post outcome data were available for 13 people, representing a 65% total completion rate. Of 13 participants (85%) were female and 3 (15%) were male. Participants ages ranged from 20 to 24 years (*M* = 21.9; *SD* 1.33).

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.

4.15.2. 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).

4.15.3. Results

The Difficulties in Emotion Regulation Scale (DERS)

There was no statistically significant difference in total DERS scores from pre-intervention (M = 101.63; SD = 22.16) to post-intervention (M = 107.14; SD = 23.73), t (13) = -1.109, p =.29.

There were significant reductions in four out of six of the DERS sub-scales.

There was a significant increase in the DERS sub-scale Non-Acceptance of Emotions scores from pre-intervention (M = 23.80; SD = 5.85) to post-intervention (M = 19.80; SD = 5.27), t (14) = -3.64 , p <.003, with a trivial effect size (Cohen's d = -0.718).

There was a significant reduction in the DERS sub-scale Impulse Control from pre-intervention (M = 19.93; SD = 6.77) to post-intervention (M = 15.87; SD = 5.70), t (14) =2.73 , p=0.016, with a medium effect size (Cohen's d = 0.65).

There was a significant reduction in the DERS sub-scale Emotional Awareness from pre-intervention (M = 18.50; SD = 5.80) to post-intervention (M = 15.36; SD = 4.73), t (13) = 2.74, p =.017, with a medium effect size (Cohen's d = 0.54).

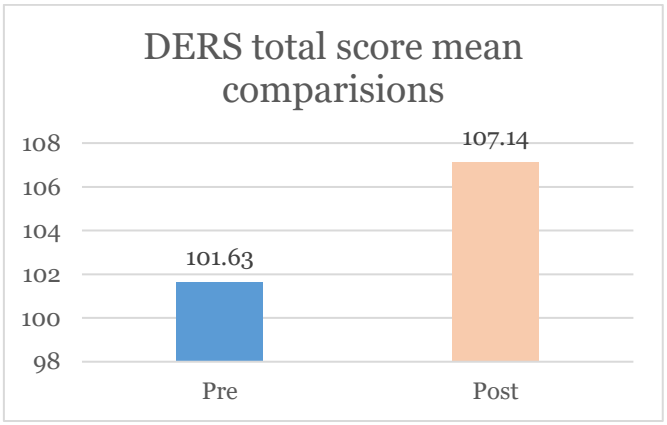
There was a significant reduction in the DERS sub-scale Emotional Regulation Strategies from pre-intervention (M = 30.59; SD = 6.54) to post-intervention (M = 24.6; SD = 6.27), t (14) = 3.66, p =.003, with a large effect size (Cohen's d = 0.94).

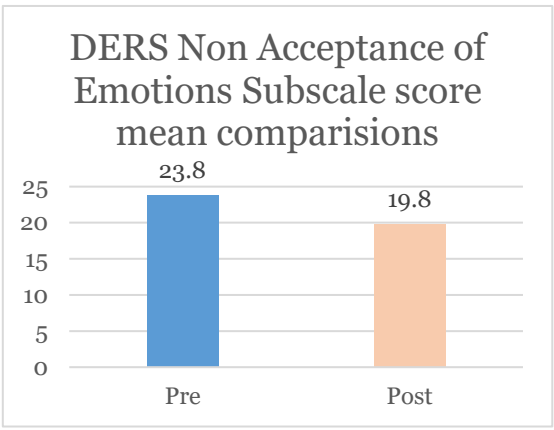
There was no difference in pre and post-intervention scores for DERS subscale Emotional Clarity from pre-intervention (M = 12.6; SD = 3.24) to post-intervention (M = 12.6 ; SD = 3.24). No correlation or t value was computed because the standard error of the difference was zero.

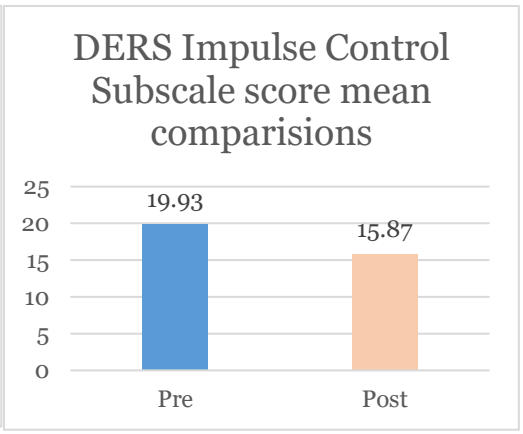
There was no significant reduction in the DERS sub-scale Inability to Engage in Goal-Directed Behaviours when Distressed from pre-intervention (M = 18.87; SD = 3.09) to post-intervention (M = 18.27; SD= 3.41), t (14) = 0.84, p = 0.42.

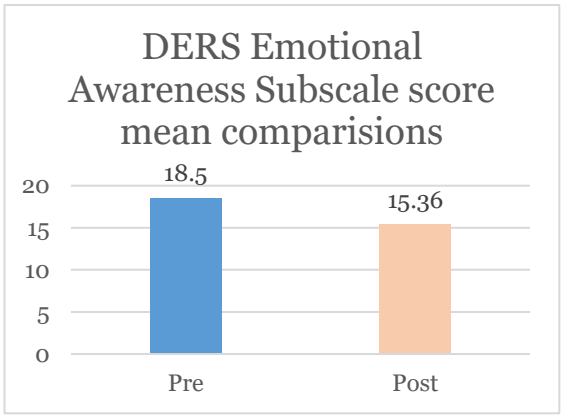
These findings indicate that those who completed the EFT-YA programme in 2023 successfully increased their capacity for emotional regulation as well as yielded improvements in impulse control and emotional awareness (see graphs below).

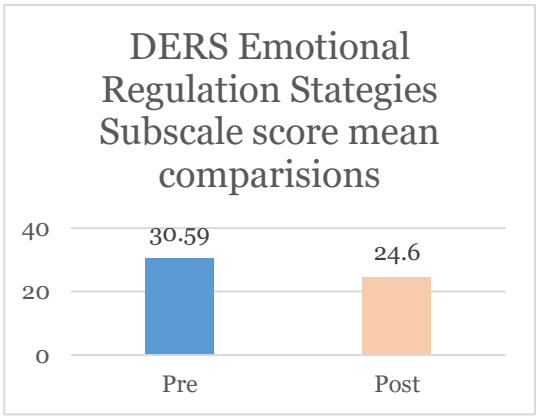
Figure 4.88. *Pre and post-group mean scores for the Difficulties in Emotion Regulation Scale (DERS) total and subscale scores*

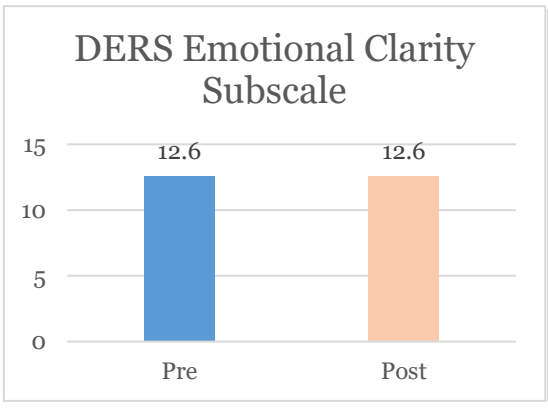


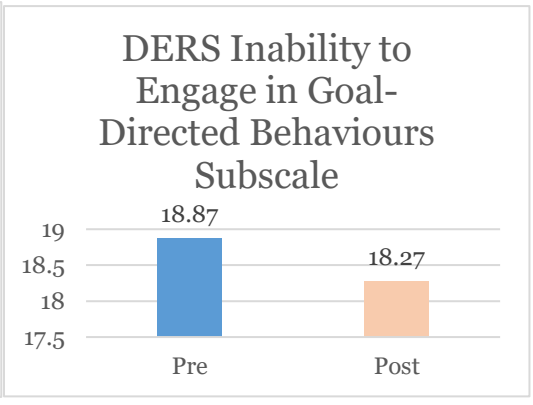








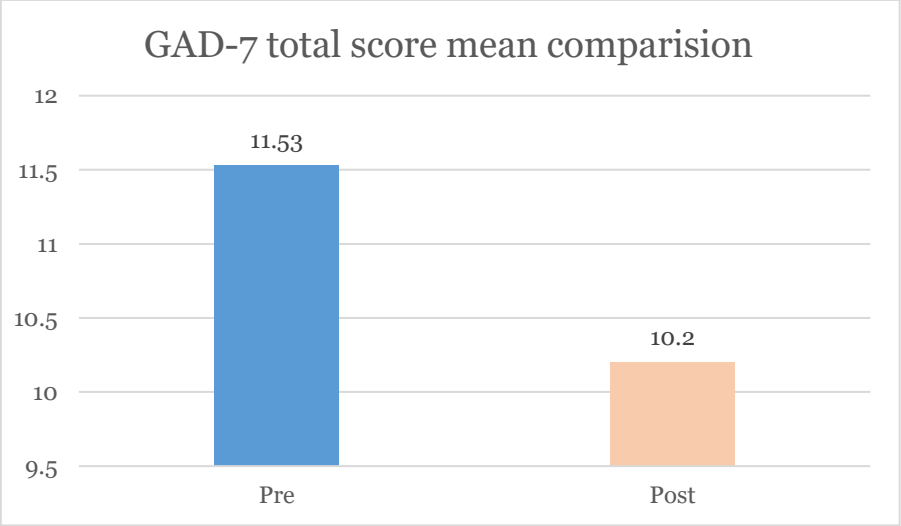




The Generalised Anxiety Disorder-7 (GAD-7)

There was no statistically significant reduction in the GAD-7 total scores from pre-intervention (M = 11.53; SD = 6.31) to post-intervention (M = 10.2; SD = 5.21), t (14) =1.011 , p =.329. This finding indicates that those who completed the programme did reduce their anxiety symptoms, but this wasn't a significant result (see graph below).

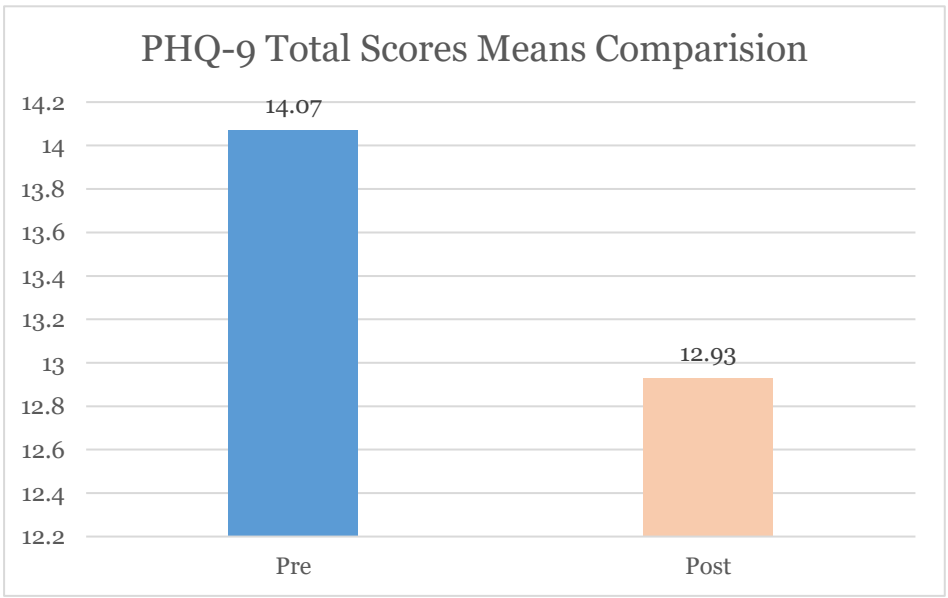
Figure 4.89. *Pre and post-group mean scores for the Generalised Anxiety Disorders-7 (GAD)*



The Patient Health Questionnaire-9 (PHQ-9)

There was not a statistically significant reduction in the PHQ-9 total scores from pre-intervention (M = 14.07; SD = 7.2) to post-intervention (M = 12.93; SD = 7.69), t (14) = 1.048, p =.313. These findings illustrate that the young adults who completed the programme reduced their symptoms related depression (see graph below).

Figure 4.90. *Pre and post-group mean scores for the Patient Health Questionnaire-9 (PHQ-9)*

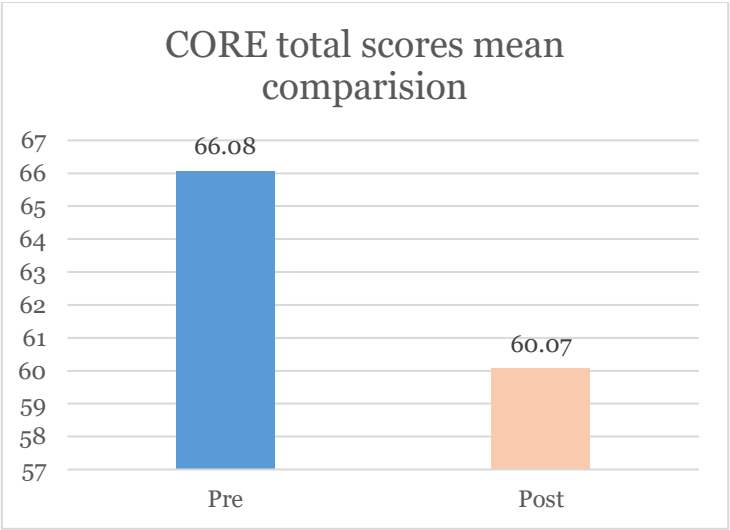


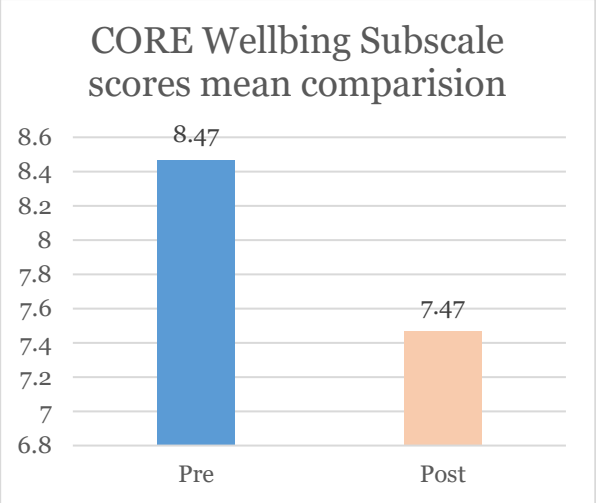
The Clinical Outcomes in Routine Evaluation (CORE)

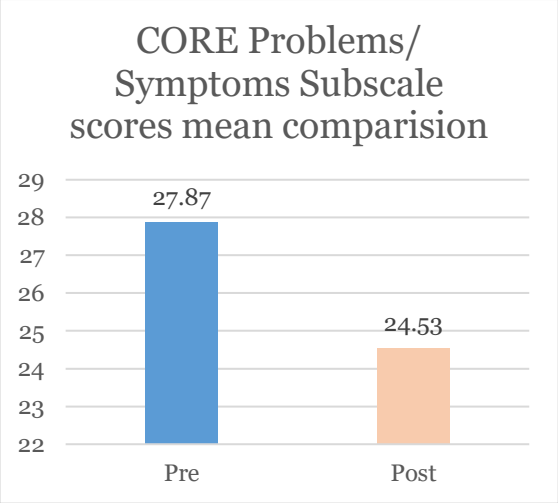
There was no significant reduction in the CORE total scores from pre-intervention (*M* = 66.08; *SD* = 20.65) to post-intervention (*M* = 60.07; *SD*= 20.1), *t* (14) = 1.8 *p* = .093. Similar results were yielded from the CORE sub-scale wellbeing as there was no significant reduction in scores from pre (*M* = 8.47; *SD* = 1.6) to post (*M* = 7.47; *SD* = 2.17), *t* (14) = 1.69 *p* = .114. The CORE subscale of problems/symptoms did not have a significant reduction from pre (*M* = 27.87; *SD* = 12.76) to post (*M* = 24.53; *SD* = 12.05), *t* (14) = 1.52, *p*= *0.151*. There was no significant reduction in the CORE subscale life functioning from pre-intervention (*M* = 24.81; *SD* = 5.76) to post-intervention (*M* = 23.47, *SD*= 4.52), *t* (14) = .82, *p* = .43. There was no significant reduction in the CORE subscale of risk/harm from pre-intervention (*M* =4.93 ; *SD* =5.56) to post-intervention (*M* = 4.6; *SD* = 6.12), *t* (14) =.346 *p* = .735.

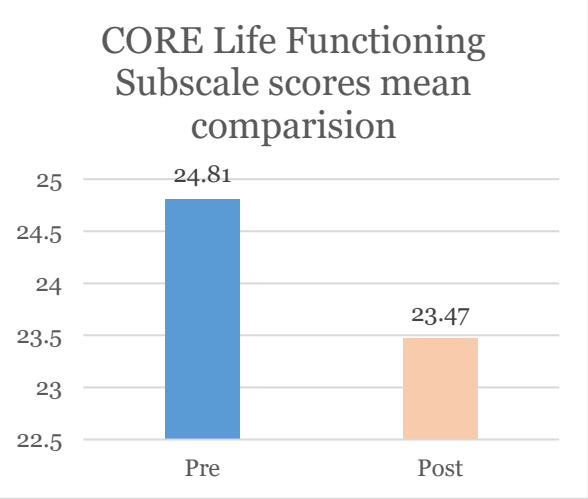
This measure assesses the overall functioning in the context of psychological distress of someone seeking intervention. The above findings indicate that those who completed the programme yielded no significant reduction in their total score or across the subscales that identify wellbeing, life functioning 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 (see graph below).

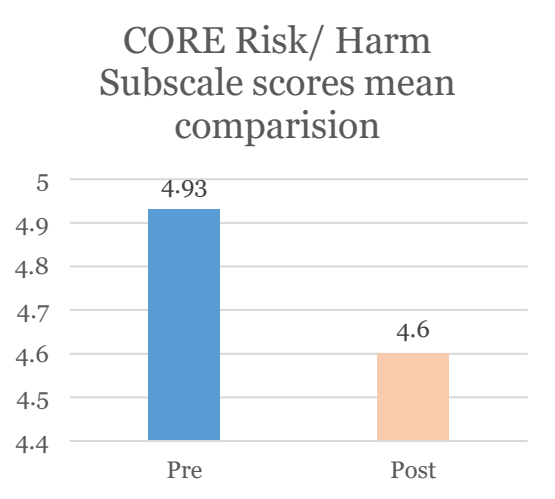
Figure 4.91. *Pre and post-group mean scores for the Clinical Outcomes in Routine Evaluation (CORE) total and subscale scores*











4.15.4. Summary

This was the second 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 2023, the young adults who completed the novel programme showed significant increases in their capacity for emotional regulation strategies, as well as yielded improvements in non-acceptance of emotions, impulse control and emotional awareness. However, results yielded from the CORE, PQN-9 and GAD-7 measure indicate no significant improvements in overall functioning in the context of psychological distress, anxiety and depressive symptoms. 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.

4.16. Dialectical Behavioural Therapy (DBT) Programme

Dialectical Behaviour Therapy (DBT) was originally developed as treatment for borderline personality disorder (BPD), which is characterised by patterns of emotional and behavioural dysregulation, that often lead to self-harming and suicidal behaviours (Flynn et al, 2019). DBT is an integration of behaviour therapy, Zen Buddhism, and an overarching dialectical philosophy (Robins et al., 2018).

DBT directly targets 1) life threatening behaviour, 2) behaviours by therapist and client that interfere with delivery of the therapy, and 3) other dangerous, severe or destabilising behaviours (Linehan et al., 2006). To address these targets DBT seeks to address five functions 1) increasing behavioural capabilities, 2) improving motivation for skilful behaviour, 3) assuring generalisation of gains to the environment, 4) structuring the treatment environment to reinforce adaptive or functional behaviours, and 5) enhancing therapist capabilities and motivation to treat clients effectively (Linehan et al., 2006). These functions are spread across four modes of therapy 1) weekly individual psychotherapy sessions, 2) weekly group skills training, 3) phone coaching as needed (within the therapist's limits), and 4) weekly therapist consultation team meetings (Linehan, 1993). Standard DBT is delivered over the course of a year, with the entire skills repertoire being repeated twice in the skills training group.

Efficacy/ Effectiveness of DBT

Standard DBT

Multiple randomised controlled trials have evaluated the efficacy of the standard 12-month version of DBT (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 et al., 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.

Brief DBT

A promising research focus investigates the effectiveness of DBT delivered in briefer timeframes. There is no evidence base for what constitutes an optimal psychotherapy length for BPD (McMain et al., 2018). The first randomised control trial of DBT (Linehan et al., 1991) showed that significant improvements appeared as early as four months into the 12-month intervention, suggesting that shortened DBT interventions may be effective (Seow et al., 2021). However, currently the optimal length of intervention is unknown (McMain et al, 2018).

Delivering DBT in a briefer timeframe has a number of advantages for service users. Firstly, risk of self-harm is reduced more rapidly, potentially increasing safety more quickly and reducing the need for inpatient admission. Secondly, a briefer treatment means that more people can be treated by a specific service provider, thus reducing cost. Finally, a briefer treatment period may reduce the amount of dropout, which remains high in comprehensive and skills only DBT (Seow et al., 2021).

While research in this area is scant, there are existing studies that have focussed on briefer models of DBT. One RCT has been conducted comparing six months of standard DBT to treatment as usual, for female veterans with a diagnosis of BPD. Although the sample was small (n=10 in each group), six months of DBT resulted in greater improvement in the areas of suicidal ideation, hopelessness, depression and anger expression (Koon et al., 2001). An Australian non-randomised study with a larger sample (n = 45) showed significant improvement compared to treatment as usual, in suicidal ideation/ non-suicidal self-injury, emergency department visits, hospital admissions and bed days. Participant self-report showed a significant improvement in for depression, anxiety, and general symptom severity (Connor & Pasieczny, 2010). McMain et al. (2022), in a randomised control non-inferiority trial discovered that six months of DBT is non-inferior to 12 months of DBT in terms of clinical effectiveness.

Skills Only DBT

In recent years, research has reflected attempts to adapt DBT to address resource requirements. One direction was to offer only the skills group modality. Lyng et al (2020) compared six months of standalone DBT skills training group for adults with BPDto six months of standard DBT. The standalone skills took a stepped care approach, excluding individuals who had engaged in self-harming or suicidal behaviour in the past six months. They found no difference between outcomes between the two treatment conditions. Skills only research has generally led to recommendations that skills only DBT be utilised as an adjunctive or stepped down approach (eg. Lyng et al., 2020; Neacsiu et al., 2014), working with individuals who are not currently engaging in self-harmful or suicidal behaviour.

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). DBT in St Patrick's Mental Health Services is offered transdiagnostically. Rather than in response to one specific diagnoses, intervention is offered to individuals who exhibit a pervasive history of difficulties understanding and managing their emotions and impulsive attempts to regulate emotion with actions or behaviours that are maladaptive. DBT in St Patrick's Mental Health Services is delivered in a more intensive fashion, with group skills teaching occurring twice weekly over a three-month period.

In 2023, nine DBT groups took place in St Patrick's Mental Health Services. Three were brief intensive comprehensive streams, three were DBT informed skills groups delivered in person, and three were DBT informed skills groups delivered online to those unable to travel to St Patrick's University Hospital. All groups were closed, meaning no new members join once the group has commenced. See table below for details of all interventions.

Table 4.14. Types of DBT interventions

Programme Type	Brief Intensive DBT (Comprehensive DBT)	DBT Informed Skills Group	Online DBT Informed Skills Group
Frequency of intervention	3 cycles per calendar year	3 cycles per calendar year	3 cycles per calendar year
Duration	12 weeks	12 weeks	12 weeks
Pre-treatment sessions	Up to 4 pre-treatment sessions	2 pre-treatment sessions	2 pre-treatment sessions
Modes of DBT included in the intervention	• 8 individual psychotherapy sessions • Bi-weekly group skills training • Phone coaching within office hours • Weekly therapist consultation team meetings	• Bi-weekly group skills training • Brief check in meetings to support commitment building and skills acquisition/ generalisation. • Weekly therapist consultation team meetings	• Bi-weekly group skills training • Brief check in meetings to support commitment building and skills acquisition/ generalisation. • Weekly therapist consultation team meetings
Method of delivery	In-person	In-person	Online via Microsoft Teams
Number of group sessions	24 sessions (twice weekly)	24 sessions (twice weekly)	24 sessions (twice weekly)
Frequency of intervention	3 cycles per calendar year	3 cycles per calendar year	3 cycles per calendar year

Data from nine cycles of the programme are described below, all of which finished in 2023. Data analysis of the Comprehensive DBT and DBT skills group are reported separately.

4.16.1. DBT outcome measures

In 2023 the outcome measures used by the DBT programme were updated. This decision was made based on an intention to rationalise measures and ensure that they best capture the work of the programme, and to work in keeping with evidence-based practice.

At the beginning of 2023 the following measures were in place:

- Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004)
- Distress Tolerance Scale (DTS; Simons & Gaher., 2005)
- Cognitive and Affective Mindfulness Scale-Revised (CAMS-R; Feldman et al., 2007)
- Dialectical Behaviour Therapy Ways of Coping Checklist (DBT-WCCL; Neacsiu et al., 2010)

In May 2023, the Distress Tolerance scale was removed prioritising focus on emotion regulation and mindfulness as gains, based on the evidence that these are key mechanisms of change in DBT (Lynch et al., 2006). Reducing the number of questionnaires also reduces potential demands on service users. The mindfulness outcome measure was also substituted, with the shorter version of the Five Facet Mindfulness Questionnaire (Bohlmeijer at al., 2011), which has the advantage of being a shorter questionnaire while also focussing on the facets of mindfulness that relate closely to mindfulness skills in DBT.

From May 2023 the following outcome measures were in place:

- Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004)
- Five Facet Mindfulness Questionnaire - Short Form (FFMQ-SF; Bohlmeijer at al., 2011)
- Dialectical Behaviour Therapy Ways of Coping Checklist (DBT-WCCL; Neacsiu et al, 2010)

Below is a description of all measures used in 2023.

- **Difficulties in Emotion Regulation Scale**

Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004): The Difficulties in Emotion Regulation Scale (DERS) 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.

- **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.

- **DBT Ways of Coping Checklist**

The Dialectical Behaviour Therapy Ways of Coping Checklist (DBT-WCCL; Neacsiu et al, 2010) is a 59-item self-report inventory measuring DBT skills use. It contains two main subscales the DBT skills subscale (DSS) and the Dysfunctional Coping Subscale (DCS). Test-retest reliability and content validity analyses showed the scale to have good to excellent properties (Neacsiu et al., 2010). The test has been validated for use

as a measure of DBT skills use in a psychiatric population beyond the original borderline personality disorder sample the originators studied (Stein et al, 2016).

- **Five Facet Mindfulness Questionnaire – Short Form**

The Five Facet Mindfulness Questionnaire - Short Form (FFMQ-SF; Bohlmeijer at al., 2011) is a 24-item shortened version of the five-facet mindfulness questionnaire (Baer et al. 2006). It measures five facets of mindfulness, observing, describing, acting with awareness, non-judging and nonreactivity. It was originally tested in a sample of adults with depression and anxiety and subsequently cross validated in a sample of adults with fibromyalgia (Bohlmeijer et al., 2011). It has also previously used to assess DBT participants' acquisition of mindfulness (Kells et al., 2020). The five facets of mindfulness displayed adequate internal consistency with alpha coefficients ranging from 0.73 for nonreactivity to 0.91 for describing (Bohlmeijer et al., 2011). Confirmatory factor analysis showed a good model fit for a correlated five-factor structure of the FFMQ-SF (Bohlmeijer et al., 2011).

4.16.2. Descriptors for DBT Comprehensive Programme

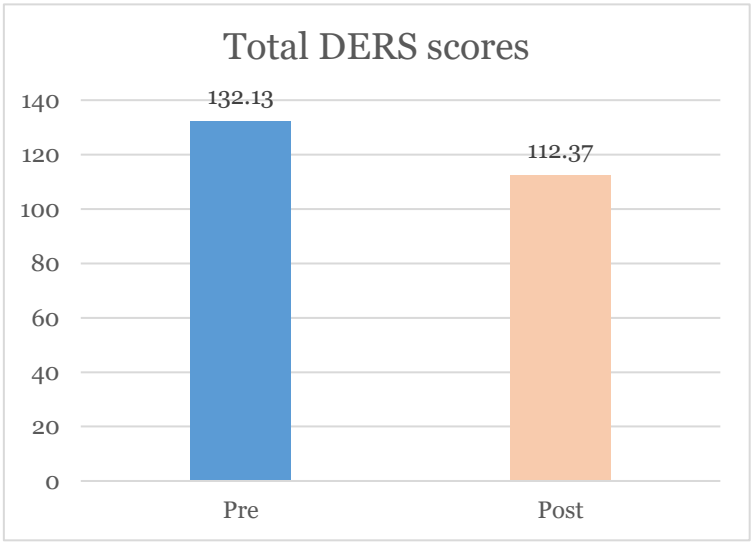
Pre and post-programme data were available for 19 participants who completed the DBT Comprehensive programme in 2023. Of the 19 participants, 58% were female and 42% were male. DBT attendees ranged in age from 19 to 55 years, with an average age of 26.7 years (SD = 8.92). Their level of educational attainment included Junior Certificate (5%), Leaving Certificate (42%), third level non-degree qualification (21%), third level degree (21%) and postgraduate qualification (11%). Attendees' current employment status was also recorded. 31.6% were in part-time employment, 21.1% were in full-time employment, 5.3% were retired, 31.6% were unemployed, and 5.3% were students.

4.16.3. Results: DBT Comprehensive Programme

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 132.14 (SD = 17.00) on the DERS at pre-intervention to 112.32 (SD = 21.39) post-completion of the programme; t (17) = 4.61, $p < 0.05$. This change represented large effect size (Cohen's d = 1.08).

Figure 4.92. *Pre and post-group mean scores for the Difficulties in Emotion Regulation (DERS)*

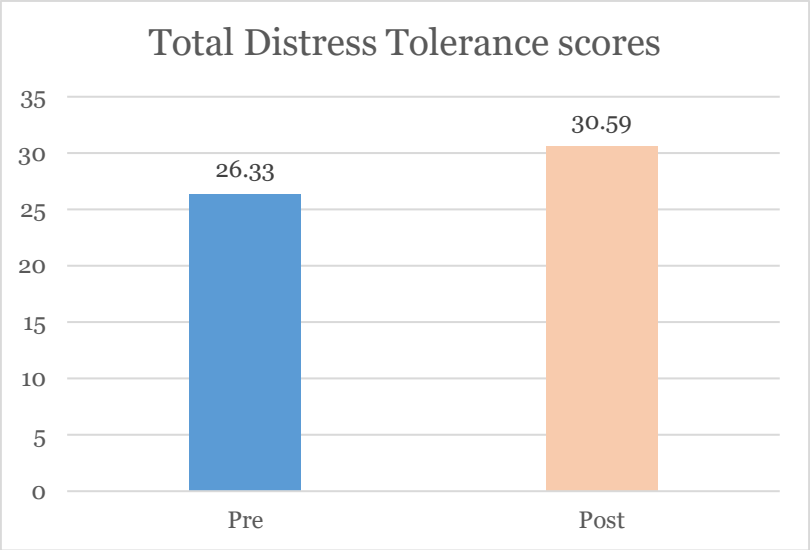


Note: Higher scores indicate greater difficulties with emotional regulation

Distress Tolerance Scale (DTS)

Pre and post data was only available for six participants who completed this measure prior to the change in outcome measures used during 2023. These participants scores indicated an increase in their ability to tolerate distress, moving from a mean total score of 26.33 (*SD* = 3.38) before the programme to 30.59 (*SD* = 7.42) after completing the programme. Due to the small sample size available, the statistical significance of this change could not be determined.

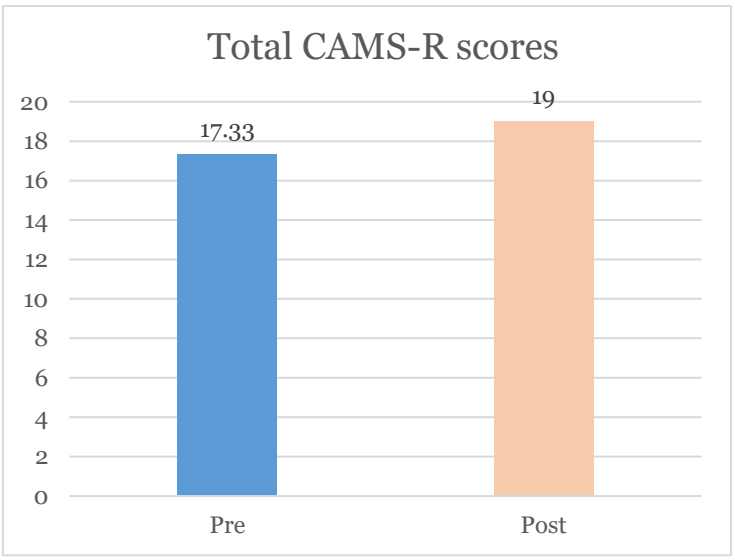
Figure 4.93. *Pre and post-group mean scores for Distress Tolerance Scale*



Cognitive and Affective Mindfulness Scale Revised (CAMS-R)

Pre and post data was available for six participants who completed this measure prior to the change in outcomes measures used during 2023. Mean scores of 17.33 (*SD* = 1.86) at pre-intervention increased to 19.00 (*SD* = 3.09) at post-intervention, suggesting that participants had greater mindful qualities upon completion of the programme. Due to the small sample size available, the statistical significance of this change could not be determined.

Figure 4.94. *Pre and post-group mean scores for Cognitive and Affective Mindfulness Scale*



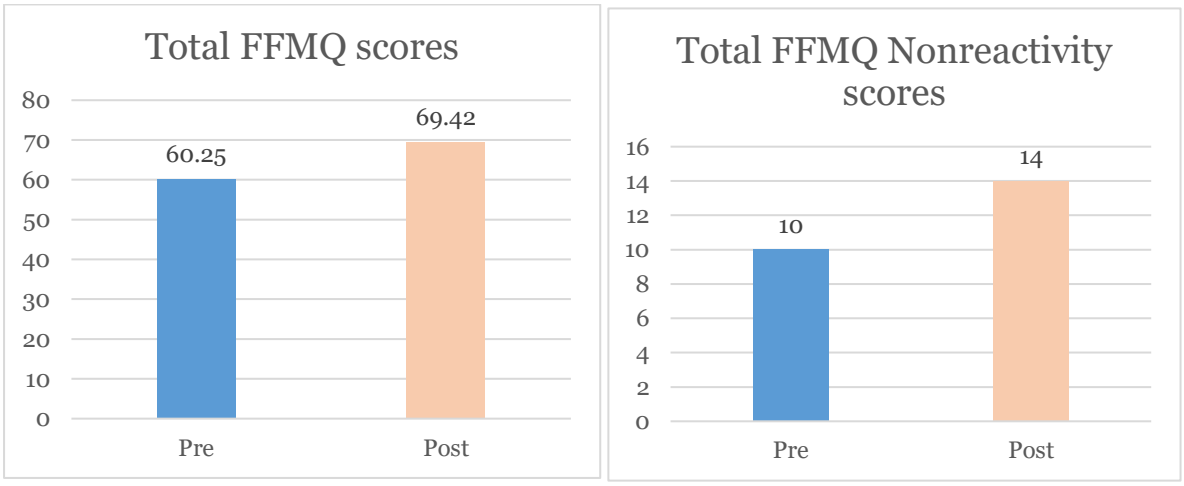
Five Facet Mindfulness Questionnaire (FFMQ)

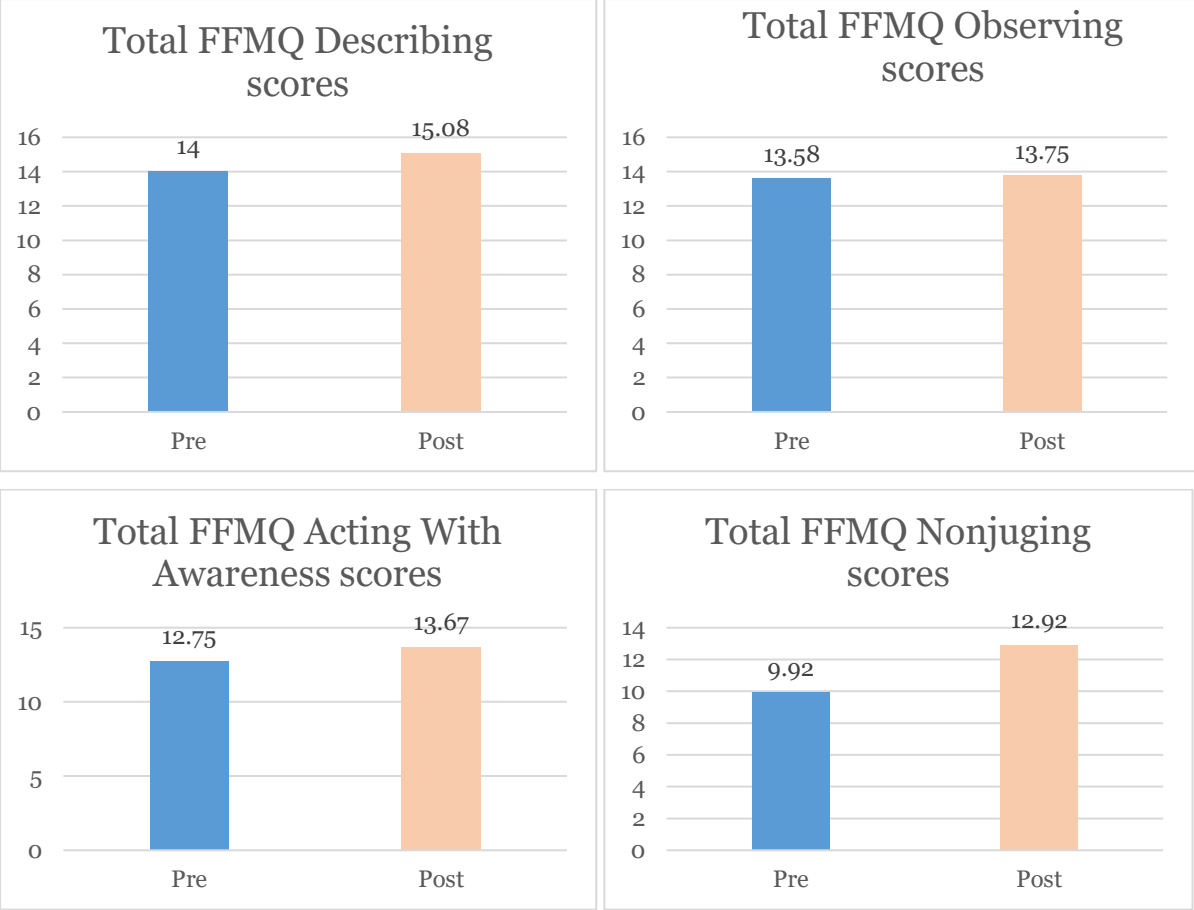
Pre and post data was available for 12 participants who completed this measure which was introduced following the change in outcomes measures used during 2023. Total mean scores of 60.25 (*SD* = 7.96) at pre-intervention increased to 69.42 (*SD* = 12.25) at post-intervention, suggesting that participants had greater mindful qualities upon completion of the programme. This was a statistically significant change, t (11) = -2.62, $p < 0.05$, with a large effect size (*d* = .08).

Total scores on the nonreactivity subscale increased significantly from 10.00 (*SD* = 3.10) at pre-intervention to 14.00 (*SD* = 3.28) at post-intervention, *t* (11) = -3.59, $p < 0.05$, with a large effect size (*d* = 1.04).

Although scores on the other four subscales increased, no significant changes were found. Total scores on the observing subscale increased from 13.58 (*SD* = 4.46) at pre-intervention to 13.75 (*SD* = 2.86) at post-intervention. Total scores on the describing subscale increased from 14.00 (*SD* = 4.81) at pre-intervention to 15.08 (*SD* = 3.42) at post-intervention. Total scores on the Acting with Awareness subscale increased from 12.75 (*SD* = 2.42) at pre-intervention to 13.67 (*SD* = 2.23) at post-intervention. Lastly, total scores on the nonjudging subscale increased from 9.92 (*SD* = 3.37) at pre-intervention to 12.92 (*SD* = 4.29) at post-intervention.

Figure 4.95. *Pre and post-group mean scores for FFMQ total and subscale scores*





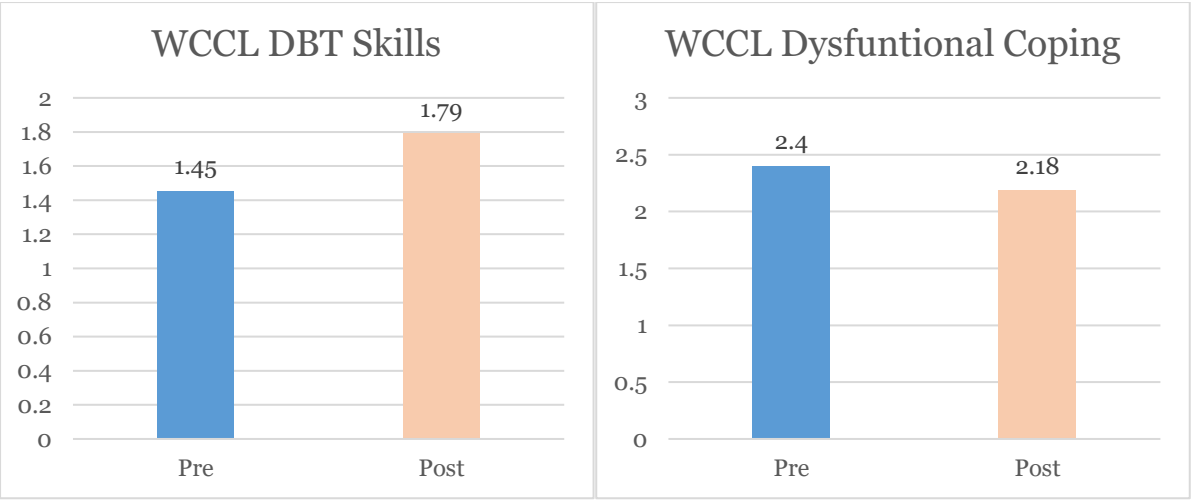
DBT Ways of Coping Checklist (WCCL)

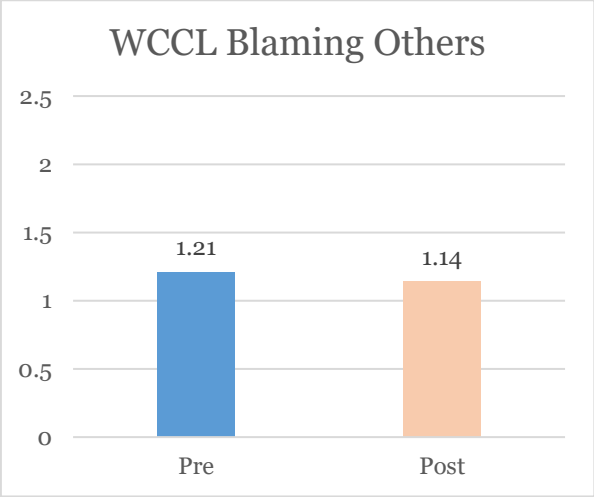
Results for the DBT WCCL sub-scales indicated that participants reported a significant increase in the use of their DBT Skills. Mean scores on the Skills Use Subscale increased from 1.45 (*SD* = 0.47) at pre-intervention to 1.78 (*SD* = 0.40) at post-intervention, t (18)= -2.63, $p < 0.05$, with a moderate effect size (d = .60).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased from 2.40 (*SD* = 0.22) at pre-intervention to 2.18 (*SD* = 0.47) at post-intervention, t (18) = 2.15, $p < 0.05$. 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 1.22 (*SD* = 0.61) to 1.14 (*SD*= 0.53) post-intervention. However, this result was not statistically significant, p >.05. See graphs below for visual representation.

Figure 4.96. *Pre and post-group mean scores for Ways of Coping Checklist Subscales*





4.16.4. Descriptors for DBT Skills Only Group

Complete pre and post data was available for 29 participants who completed the DBT Skills Only group in 2023. Of these 29, 17 were female and 12 were male. The mean age of participants was 30.60 (SD = 10.29), ranging from 19 to 60 years. Their highest level of educational attainment included Junior Certificate (3.4%), Leaving Certificate (24.1%), third level non-degree qualification (31%), third level degree (13.8%) and postgraduate qualification (24.1%). 3.4% chose 'other' as their highest level of educational attainment. Attendees' current employment status was also recorded. 37.9% were in part-time employment, 31% were in full-time employment, 17.2% were unemployed, 10.3% were students and 3.4% chose other.

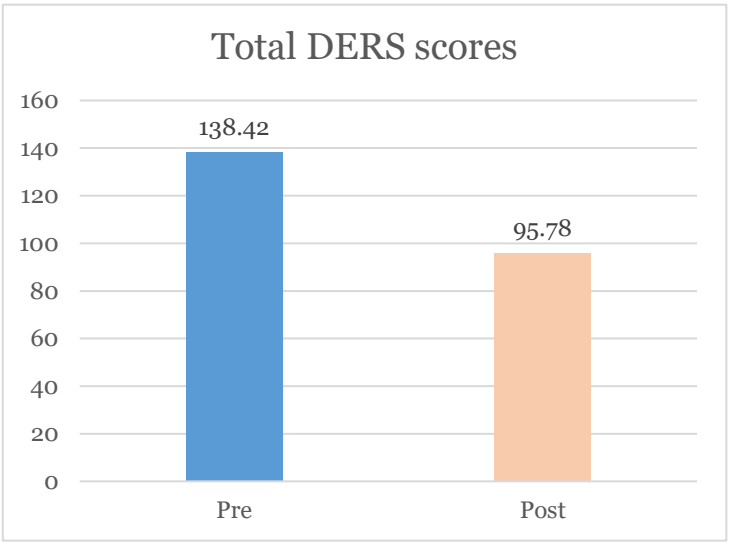
4.16.5. Results for DBT Skills Only Group

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 138.42 (*SD* = 13.53) on the DERS at pre-intervention to 95.78 (*SD* = 22.94) post-completion of the programme; *t* (28) = 8.22, *p* < *0.05*. This change represented a large effect size (Cohen's *d* = 1.53). See graph below for visual representation.

Figure 4.97. *Pre and post-group mean scores of Difficulties in Emotion Regulation Scale (DERS)*

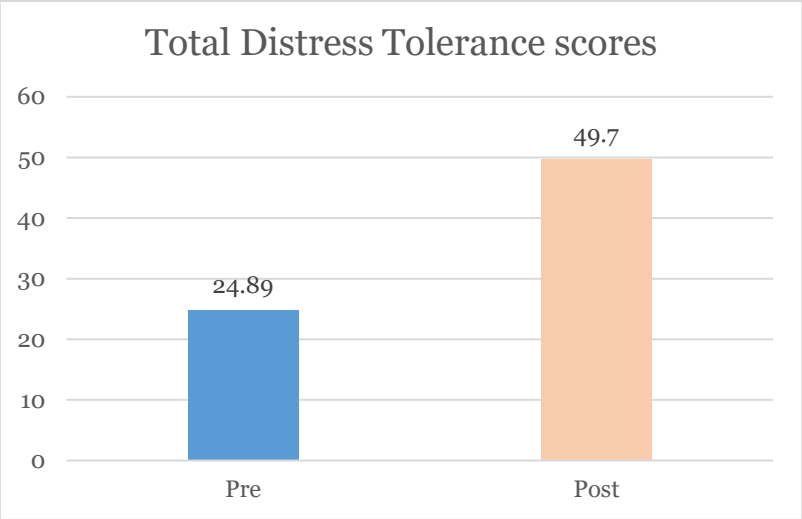


Note: Higher scores indicate greater difficulties with emotional regulation

Distress Tolerance Scale (DTS)

Significant gains were made on the Distress Tolerance Scale (DTS). Pre and post-intervention scores on the DTS were available for 13 participants who completed the programme prior to the change in outcome measures. Mean scores on the DTS increased following engagement in the group, from 24.89 (*SD* = 7.15) at pre-intervention to 49.7 (*SD* = 10.23) at post-intervention post-completion of the programme; *t* (12) = -6.34, *p* < *0.05*. This change represented a large effect size (Cohen's *d* = 1.76). See graph below for visual representation.

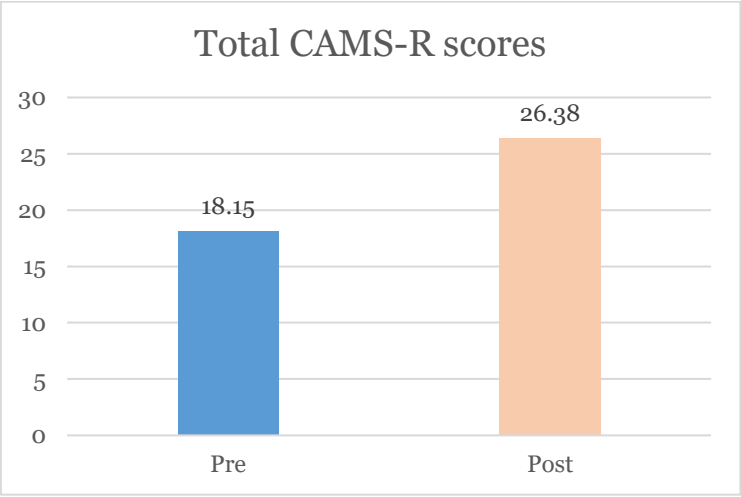
Figure 4.98. *Pre and post-group mean scores Distress Tolerance Scale*



Cognitive and Affective Mindfulness Scale revised (CAMS-R)

Pre and post intervention scores on the CAMS-R were available for 13 participants who completed the programme prior to the change in outcome measures. These participants had greater mindful qualities after completing the skills only programme. Mean scores of 18.15 (*SD* = 3.11) at pre-intervention increased to 26.38 (*SD* = 4.84) at post-intervention. This was a statistically significant change; t (12) = -6.10, $p < 0.001$, and represents a large effect size (d = 2.02). See graph below for visual representation.

Figure 4.99. *Pre and post-group mean scores of Cognitive and Affective Mindfulness Scale*



Five Facet Mindfulness Questionnaire (FFMQ)

Pre and post data was available for 16 participants who completed this measure which was introduced following the change in outcomes measures used during 2023. Total mean scores of 57.63 (*SD* = 10.64) at pre-intervention increased to 74.06 (*SD* = 10.90) at post-intervention, suggesting that participants had greater mindful qualities upon completion of the programme. A paired samples t-test indicated that this increase was statistically significant, $p<.05$, t (15) = -6.22, with a large effect size (d=1.53).
Significant increases were observed across all five subscales in the FMMQ. Total scores on the observing subscale increased from 11.69 (*SD* = 3.96) at pre-intervention to 13.63 (*SD* = 3.59) at post-intervention, t (15) = -2.71, $p < 0.05$. This was a moderate effect size (d = .67).

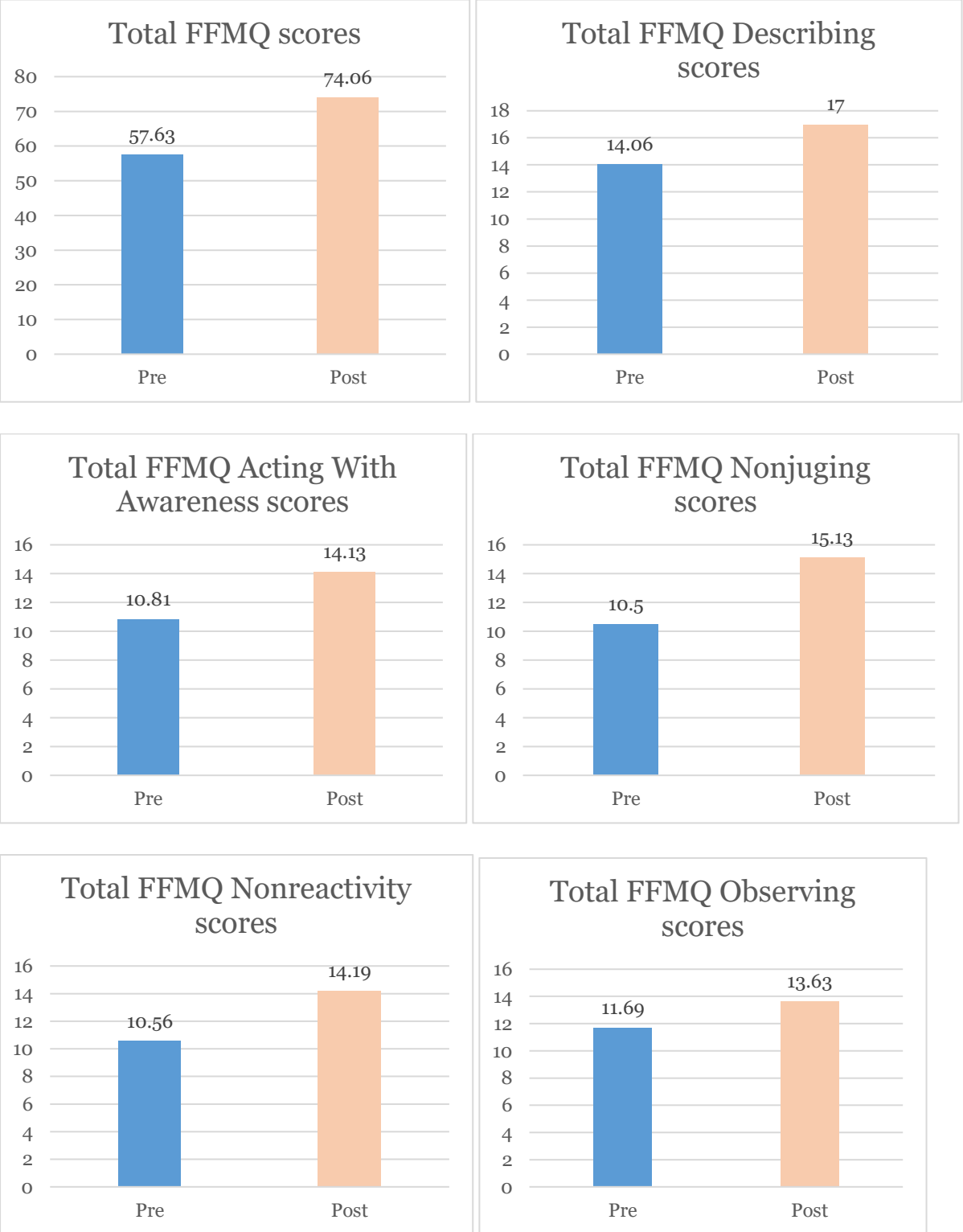
Total scores on the describing subscale increased from 14.06 (*SD* = 5.07) at pre-intervention to 17.00 (*SD* = 3.31) at post-intervention, t (15) = -5.12, $p < 0.05$. This was a large effect size (d = 1.28) .

Total scores on the Nonreactivity subscale increased from 10.56 (*SD* = 2.97) at pre-intervention to 14.19 (*SD* = 4.22) at post-intervention, t (15) = -4.59, $p < 0.05$. This was a large effect size (d = 1.65).

Total scores on the nonjudging subscale increased from 10.50 (*SD* = 3.65) at pre-intervention to 15.13 (*SD* = 4.67) at post-intervention, t (15) = -4.38, $p < 0.05$. This was a large effect size (d = 1.10)

Total scores on the Acting with Awareness subscale increased from 10.81 (*SD* = 3.33) at pre-intervention to 14.13 (*SD* = 4.21) at post-intervention. , t (15) = -2.97, $p < 0.05$. This was a moderate effect size (d = .71)

Figure 4.100. *Pre and post-group mean scores of Total FFMQ And Total Subscale Scores*



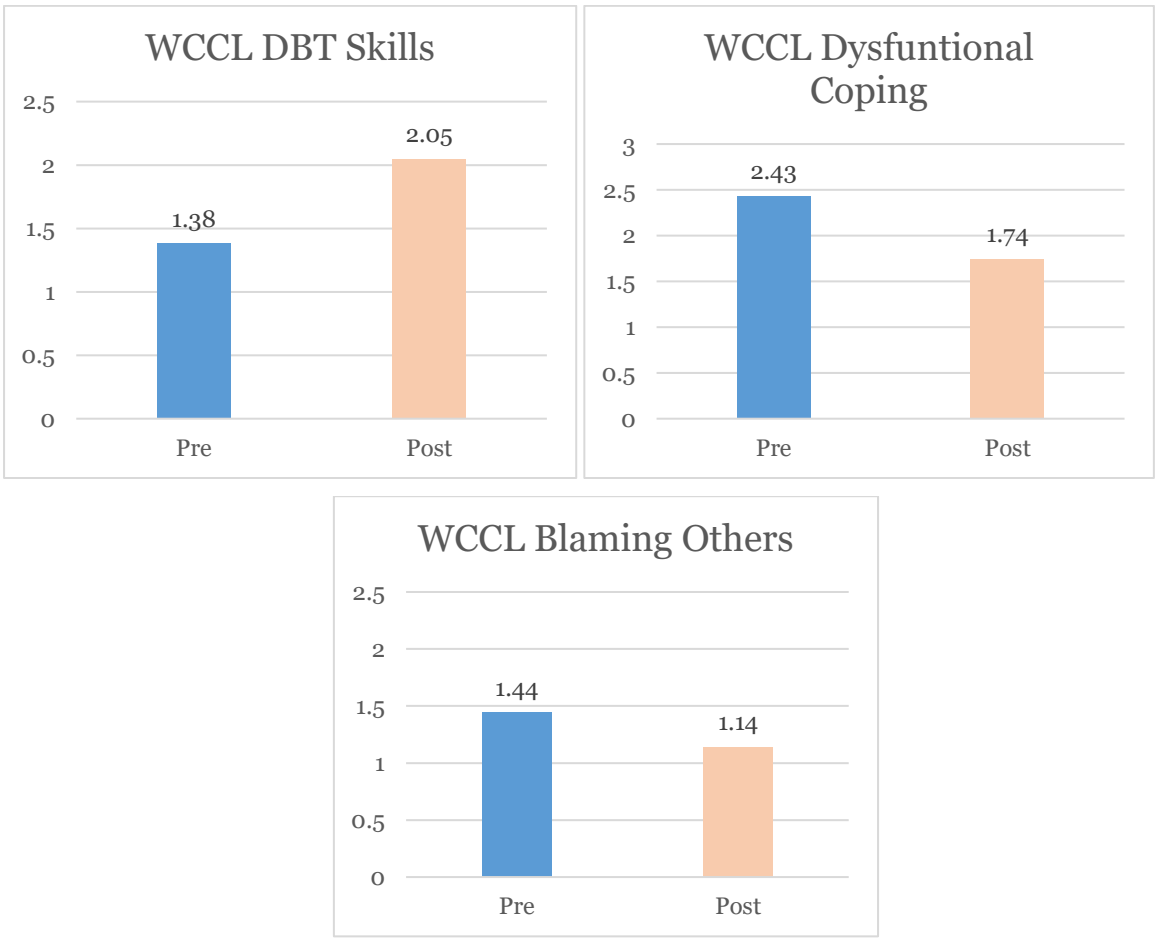
Ways of Coping Checklist (WCCL)

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 1.38 (*SD* = 0.48) at pre-intervention to 2.05 (*SD* = 0.34) at post-intervention, t (28) = -7.04, $p < 0.05$, with a large effect size (d = 1.31).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased significantly from 2.43 (*SD* = 0.26) at pre-intervention to 1.74 (*SD* = 0.50) at post-intervention, t (28) = 6.45, $p < 0.05$. This represented a large effect size (d = 1.19). This indicates that participants' abilities to cope improved upon completing the intervention.

Participants mean scores on the Blaming Others Subscale also showed a significant reduction from 1.44 (*SD* = 0.65) to 1.14 (*SD*= 0.46) post-intervention, t (28) = 2.56, $p < 0.05$, with a small effect size (d = .47).

Figure 4.101. *Pre and post-group mean scores of Ways of Coping checklist subscales*



4.16.6. Summary

For participants with pre and post-data, significant improvements were observed in a variety of mindfulness facets, coping styles, and emotion regulation in both the comprehensive and skills only groups with variations across both streams. Significant increases in distress tolerance were found for individuals in the skills groups. Effect size calculations demonstrated small to large effect sizes for significant results. However, caution is required when interpreting these results. Given the changes in measures between DBT cycles, some samples are smaller and such samples are more susceptible to missing an effect that exists in the data or may also lead to the over estimation of a true effect size (Button et al., 2013).

4.17. Group Schema Therapy Programme

The Group Schema Therapy (GST) Programme is a therapeutic group delivered by the Psychology Department. Group Schema Therapy is a closed long-term group designed to treat individuals with complex and enduring mental health problems which stem from unmet core needs in childhood. Group Schema Therapy provides an evidenced-based treatment to service users which reduces difficulties associated with depression, anxiety, eating disorders, substance misuse, emotional dysregulation, relationships poor self-image and improves psychosocial functioning (Farrell, Shaw & Webber, 2009; Fassbinder et al. 2016). GST has been shown to increase life satisfaction and reduce early maladaptive schemas (Altın & Alsancak-Akbulut, 2018).

GST helps service users to change their entrenched, self-defeating life patterns or schemas using cognitive, behavioural and emotion-focused techniques. We also introduce some sensorimotor elements and build on somatic resources to aid with this. The treatment focuses on the relationship with the therapists, daily life and trigger patterns inside and outside of therapy, and the processing of traumatic childhood experiences, that are common in this disorder. Group Schema Therapy is a long-term (20 sessions over 5 months) closed group running one morning each week. Until August 2022, GST was delivered via 70 sessions over 18 months. However, the group was restructured in August 2022 in line with international evidenced based practice in order to provide greater accessibility and feasibility of this intervention.

4.17.2. Descriptors

22 participants completed the Schema programme in 2023. Pre- and post- outcome data on all measures were available for 16 participants, representing 72% complete response rate. 93.8% of the participants were female (15) and 6.3% of the participants were male (1).

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.

4.17.1. Group Schema Therapy Programme outcome measures

- **Schema Mode Inventory (SMI)**

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

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

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

- **Quality of Life (WHOQOL)**

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

4.17.3. Results

Schema Mode Inventory (SMI)

The Schema Mode Inventory (SMI) has fourteen subscales. There were significant reductions in eleven of fourteen SMI subscales.

On the Vulnerable Child subscale, a significant decrease in SMI scores were observed from pre-intervention (M = 4.08; SD = 1.14) and post-intervention (M = 3.36; SD = 1.12), t (15) = 2.6, p = .02, with a medium effect size (Cohen's d = 0.634).

On the Angry Child mode subscale, a significant decrease in SMI scores were reported from pre-intervention (M = 3.26; SD = 0.92) to post-intervention (M = 2.64; SD = 0.65), t (15) = 4.56, p =.000 with a medium effect size (Cohen's d = 0.78).

Scores on the Enraged Child subscale decreased significantly from pre-intervention (M = 1.78; SD = 0.76) and post-intervention (M =1.44; SD = 0.47), t (15) = 2.23, p = .04, with a medium effect size (Cohen's d = 0.54).

On the Impulsive Child subscale, a significant decrease in SMI scores were reported from pre-intervention (M = 3.17; SD = 0.83) to post-intervention (M = 2.44; SD = 0.65), t (15) = 4.38, p =.001 with a large effect size (Cohen's d = 0.98).

On the Undisciplined Child subscale, a significant decrease in SMI scores were observed from pre-intervention (M = 3.81; SD = 0.98) to post-intervention (M = 2.89; SD = 0.85), t (15) = 5.19, p =.000 with a small effect size (Cohen's d = 0.32).

On the Happy Child subscale, a significant increase in SMI scores were observed from pre-intervention (M = 2.71; SD = 0.92) and post-intervention (M = 3.21; SD = .88), t (15) = -2.46, p = .03 with a small effect size (Cohen's d = -0.56).

On the Detached Protector subscale, a significant decrease was observed in SMI scores from pre-intervention (M = 3.34; SD = 0.95) and post-intervention (M = 2.76; SD = 1.07), t (15)= 2.84, p = 0.01 with a medium effect size (Cohen's d = 0.57).

On the Detached Self subscale, a significant decrease in SMI scores were observed from pre-intervention (M = 3.95; SD = 0.82) to post-intervention (M = 3.48; SD = 0.64), t (15) = 2.44, p =.028 with a medium effect size (Cohen's d = 0.64).

A significant decrease in SMI scores were observed on the Self Aggrandiser subscale from pre-intervention (M = 2.55; SD = 0.58) to post-intervention (M = 2.24; SD = 0.65), t (15) = 2.78, p =.014 with a medium effect size (Cohen's d = 0.5).

A significant decrease in SMI scores were observed on the Punitive Parent subscale from pre-intervention (M = 3.51; SD = 1.23) to post-intervention (M = 2.95; SD = 1.1), t (15) = 2.94, p =.01 with a small effect size (Cohen's d = 0.48).

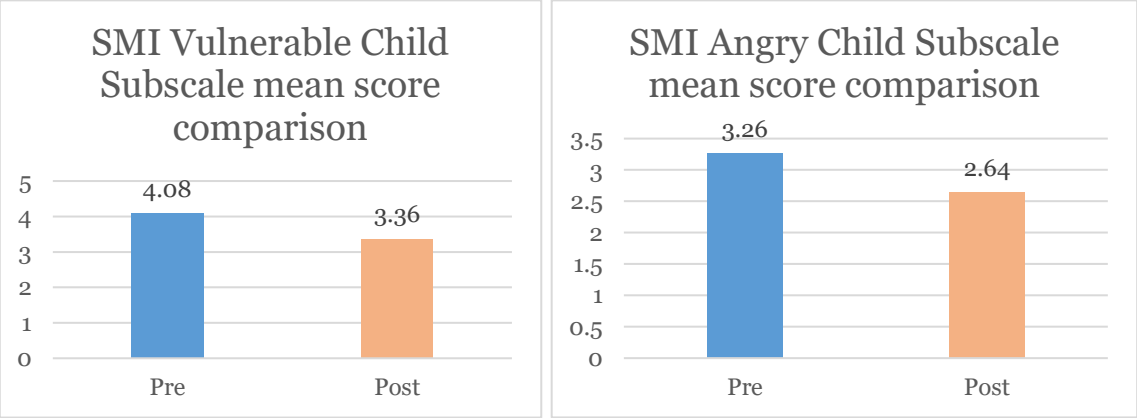
The Happy Adult subscale measured a significant decrease in SMI scores from pre-intervention (M = 3.13; SD = 0.99) and post-intervention (M = 3.75; SD = 0.67), t (15) =-3.46, p = .003. with a small effect size (Cohen's d = -0.73).

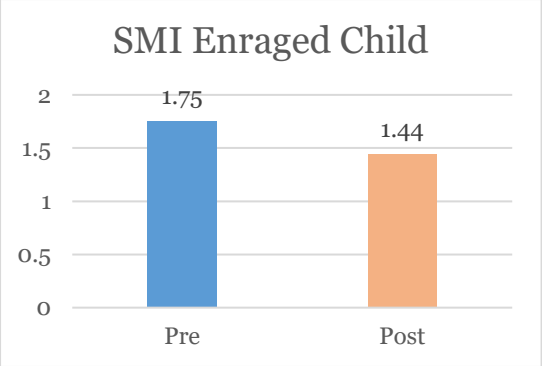
On the Compliant Surrender subscale there were no statistically significant differences in SMI scores from pre-intervention (M = 4.10; SD = 1.09) and post-intervention (M = 3.86; SD = 1.07), t (15) = 1.05, p = 0.31.

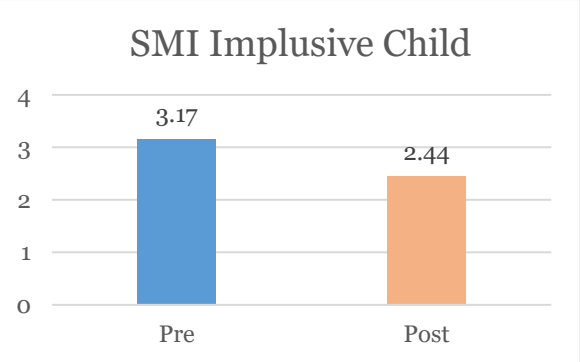
On the Bully Attack subscale there were no statistically significant differences in SMI scores from pre-intervention (M = 1.9; SD = 0.51) and post-intervention (M = 1.66; SD = 0.51), t (15) = 1.99, p = .064.

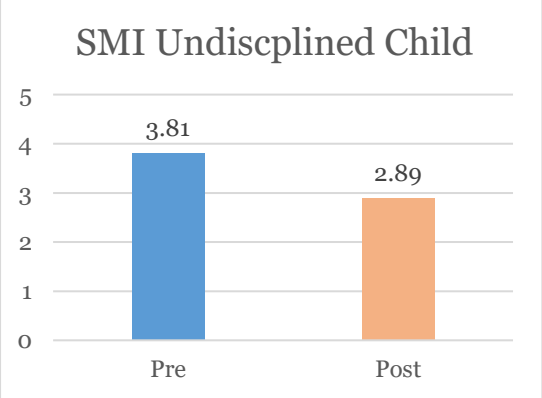
On the Demanding Parent subscale there were no statistically significant differences in SMI scores from pre-intervention (M =3.85; SD = 0.9) and post-intervention (M = 3.85; SD = 0.9), t (15) = -0.02, p = .98.

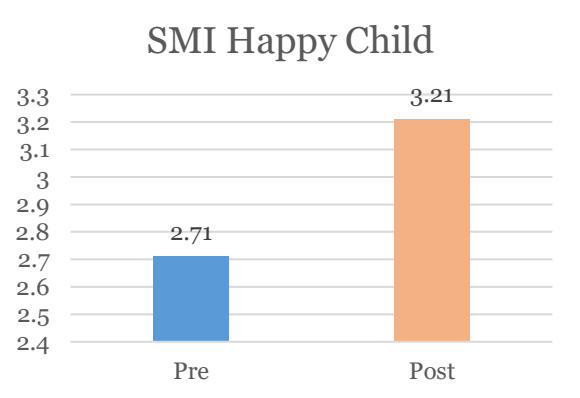
Figure 4.102. *Pre and post-group mean scores of Schema Mode Inventory (SMI) subscales*

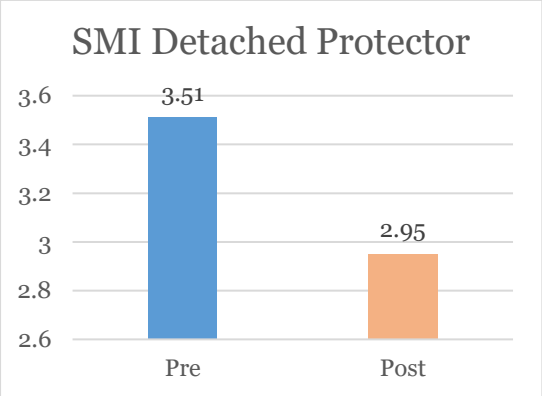


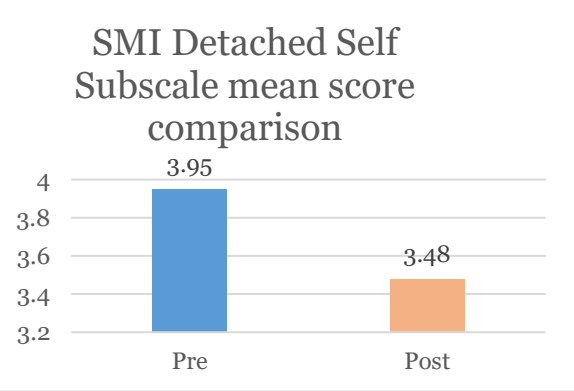

SMI Enraged Child
2
1.5
1
0.5
0
1.75
1.44
Pre
Post

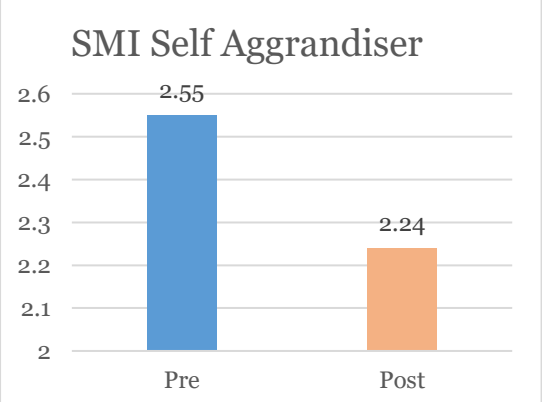

SMI Implusive Child
4
3
2
1
0
3.17
2.44
Pre
Post

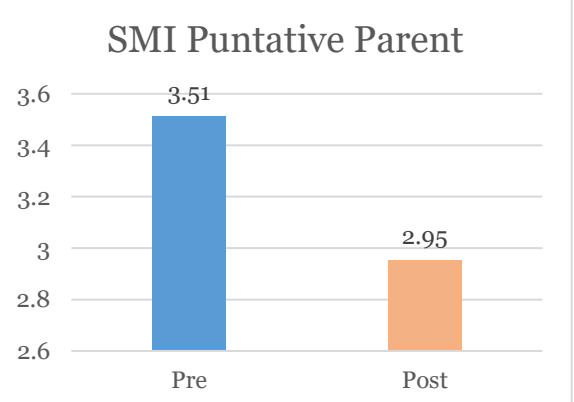

SMI Undiscplined Child
5
4
3
2
1
0
3.81
2.89
Pre
Post

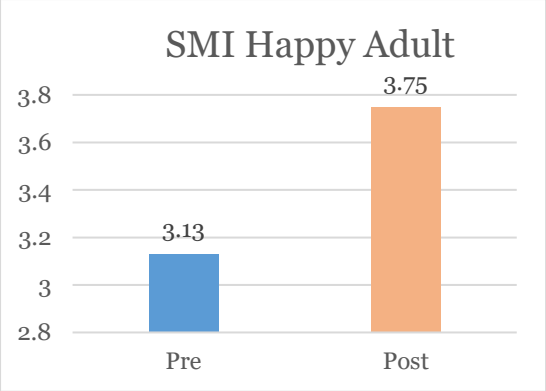

SMI Happy Child
3.3
3.2
3.1
3
2.9
2.8
2.7
2.6
2.5
2.4
2.71
3.21
Pre
Post

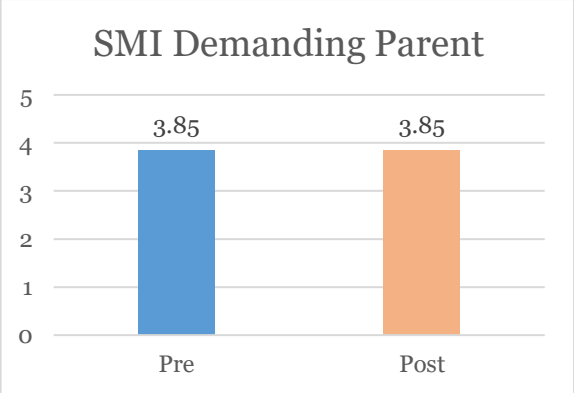

SMI Detached Protector
3.6
3.4
3.2
3
2.8
2.6
3.51
2.95
Pre
Post

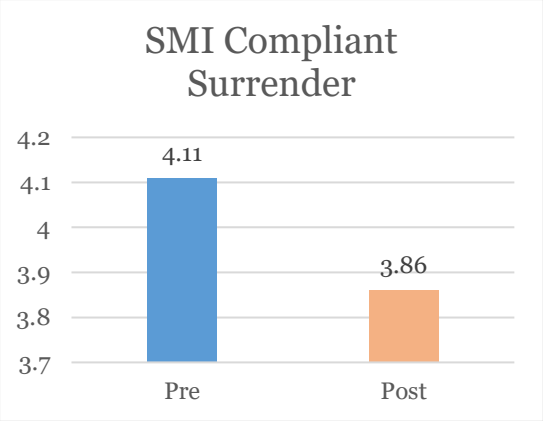

SMI Detached Self Subscale mean score comparison
4
3.8
3.6
3.4
3.2
3.95
3.48
Pre
Post

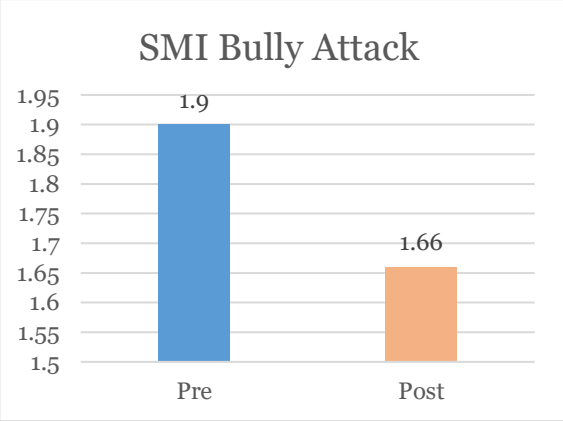

SMI Self Aggrandiser
2.6
2.5
2.4
2.3
2.2
2.1
2
2.55
2.24
Pre
Post


SMI Puntative Parent
3.6
3.4
3.2
3
2.8
2.6
3.51
2.95
Pre
Post









Young Schema Questionnaire (YSQ)

There are 18 schemas measured in the YSQ. There were nine statically significant results out of 18. A reduction in mean scores was observed on all 18 schemas from pre- to post-intervention.

The Abandonment schema subscale resulted in significant decrease in YSQ scores from pre-intervention (M = 70; SD = 17.14) to post-intervention (M = 55.83; SD =20.10, t (15) = 4.81, p =.000 with a medium effect size (Cohen's d = 0.76).

A statistically significant decrease was observed on the Social Isolation schema subscale from pre intervention (M = 40.44; SD = 12.84) and post-intervention (M = 34.64; SD =12.59), whereby t (15) =2.36, p=.031, reflecting a small effect size (Cohen's d = 0.3).

On the Defectiveness schema subscale, there was a significant decrease in scores from pre-intervention (M = 65.14; SD = 18.85) and post-intervention (M = 51.76; SD = 18.99), t (15) =3.82, p = 0.002 with a medium effect size (Cohen's d = 0.71).

A significant decrease in scores on the Dependence schema subscale was observed from pre-intervention (M = 48.49; SD = 16.18) to post-intervention (M = 38.44; SD = 15.3), t (15) = 3.77, p =.002 with a medium effect size (Cohen's d = 0.64).

The Vulnerability schema subscale resulted in significant decrease in scores from pre-intervention (M = 38; SD = 12.19) to post-intervention (M = 28.6; SD = 9.58), t (15) = 4, p =.001 with a large effect size (Cohen's d = 0.86).

A significant decrease in scores on the Emotional Inhibition subscale were observed from pre-intervention (M = 31.23; SD = 10.43) and post-intervention (M = 25.73; SD = 9.04), t (15) =2.84, p = .01 with a medium effect size (Cohen's d = 0.56).

A significant decrease on the Insufficient Self Control schema subscale was observed from pre-intervention (M = 54.96; SD = 13.59) and post-intervention (M = 46.98; SD = 11.77), t (15) = 3.26 p = .005 with a medium effect size (Cohen's d = 0.563).

A significant decrease on the Negativity schema subscale was observed from pre-intervention (M = 44.06; SD = 12.34) and post-intervention (M = 34.43; SD = 7.75), t (15) =3.1, p = .007 with a large effect size (Cohen's d = 0.94).

On the Punitiveness schema subscale, a significant decrease in YSQ scores were observed from pre-intervention (M = 49.06; SD = 13.83) and post-intervention (M = 39.98; SD = 12.47), t (15) = 2.83, p = .013 with a medium effect size (Cohen's d = 0.69).

On the Emotional Deprivation schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 37; SD = 12.6) and post-intervention (M = 34.37; SD =10.76), t (15) =1.24, p = .233.

On the Mistrust Abuse schema subscale there were no statistically significant differences in YSQ scores from pre intervention (M = 54.13; SD =17.24) and post-intervention (M =52.05; SD = 14.06), t (15) =0.81, p = .43.

On the Failure schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 34.98; SD = 11.74) and post-intervention (M = 31.49; SD = 10.67), t (15) =1.45, p = .16.

On the Enmeshment schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 28.78; SD = 12.66) and post-intervention (M = 26.25; SD = 9.03), t (15) = 0.756, p = .461.

On the Subjugation schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 38.73; SD = 10.84) and post-intervention (M = 38.79; SD = 10.81), t (15) =-0.33, p = .97.

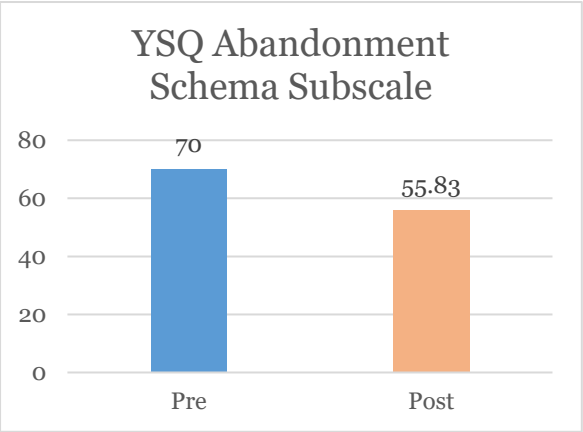
On the Self-Sacrifice schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 71.31; SD = 13.24) and post-intervention (M = 65.8; SD = 14.64), t (15) =1.996, p = .064.

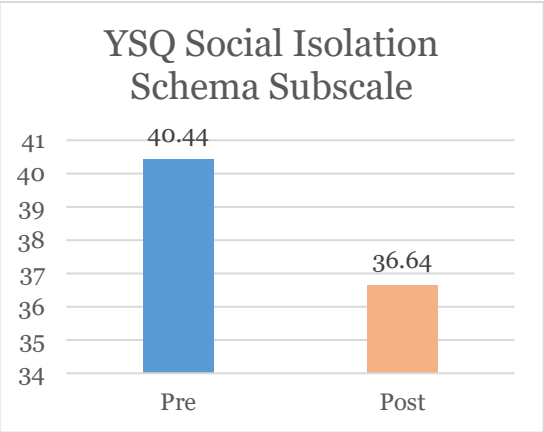
On the Unrelenting Standards subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 58.41; SD = 18.02) and post-intervention (M = 53.23; SD = 14.91), t (15) =1.15, p = .267.

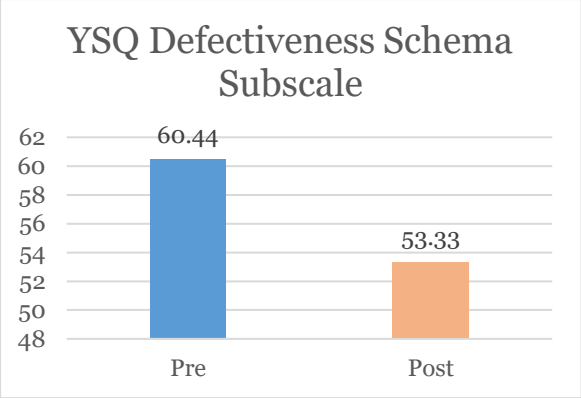
The Entitlement schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 27.44; SD = 9.65) to post-intervention (M = 25.3; SD = 7.6), t (15) = 1.06, p =.306.

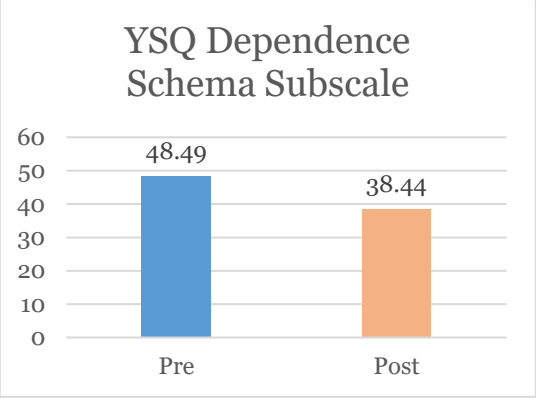
On the Approval Seeking schema subscale there were no statistically significant differences in YSQ scores from pre-intervention (M = 53.5; SD = 17.38) and post-intervention (M =49.78; SD = 15.27), t (15) =1.2, p = .249.

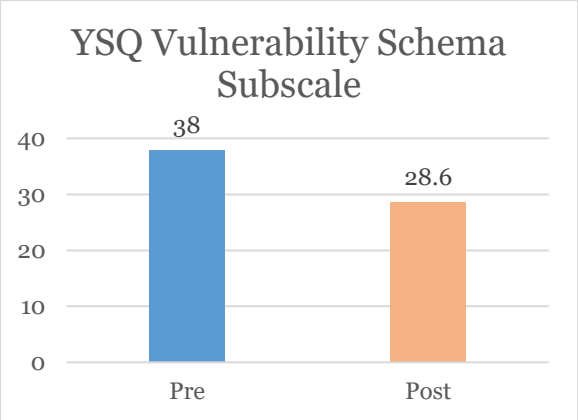
Figure 4.103. *Pre and post-group mean scores of Young Schema Questionnaires (YSQ) subscales.*

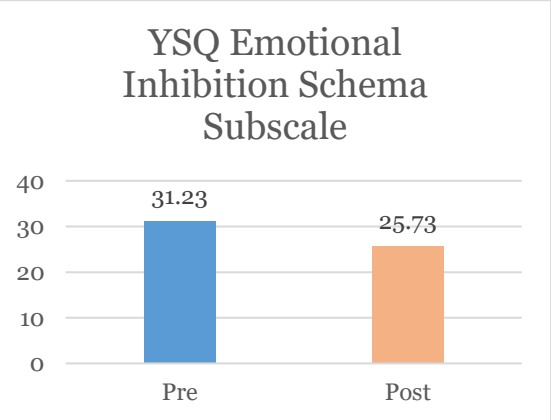


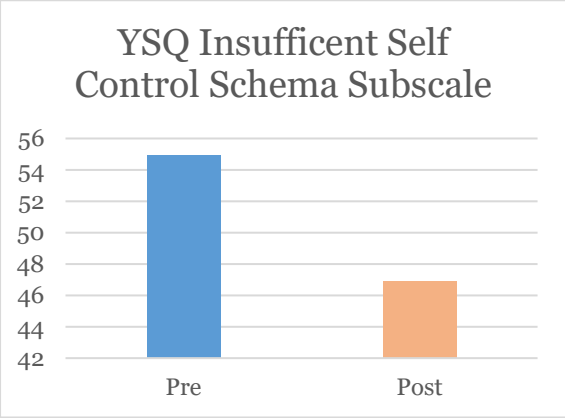


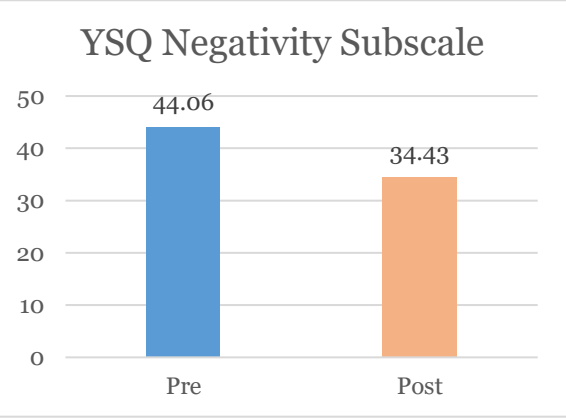

YSQ Defectiveness Schema Subscale
62
60
58
56
54
52
50
48
60.44
53.33
Pre
Post

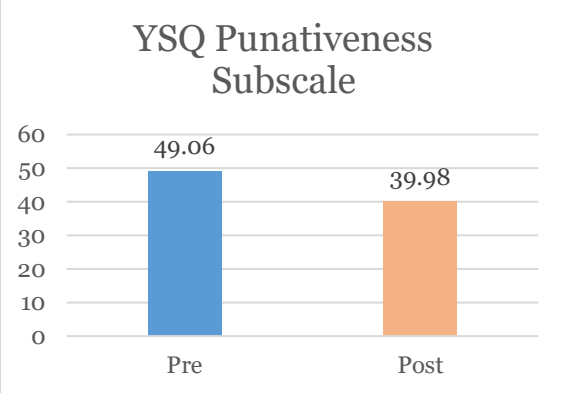

YSQ Dependence Schema Subscale
60
50
40
30
20
10
0
48.49
38.44
Pre
Post

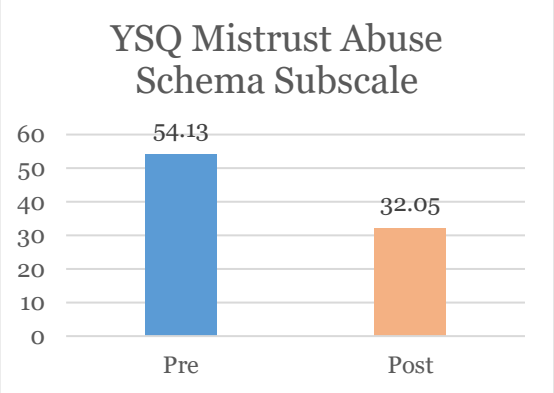

YSQ Vulnerability Schema Subscale
40
30
20
10
0
38
28.6
Pre
Post

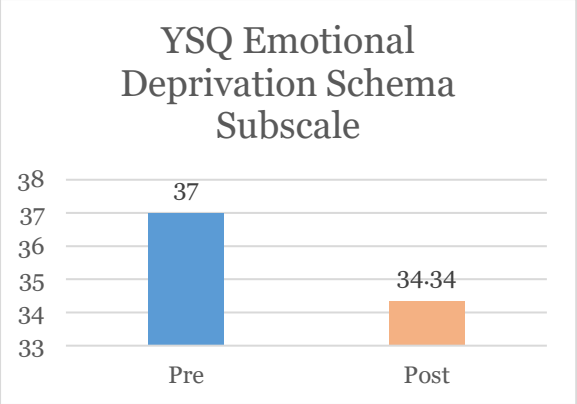

YSQ Emotional Inhibition Schema Subscale
40
30
20
10
0
31.23
25.73
Pre
Post

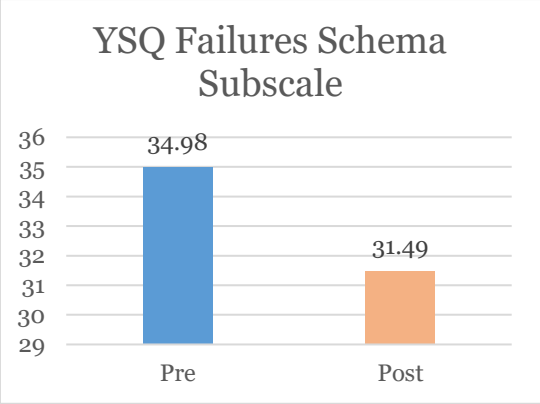

YSQ Insufficent Self Control Schema Subscale
56
54
52
50
48
46
44
42
Pre
Post

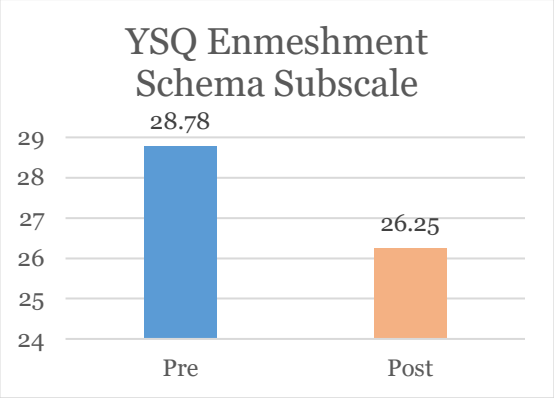

YSQ Negativity Subscale
50
40
30
20
10
0
44.06
34.43
Pre
Post

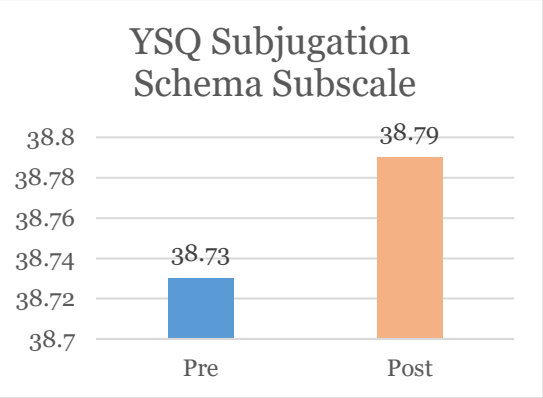

YSQ Punativeness Subscale
60
50
40
30
20
10
0
49.06
39.98
Pre
Post

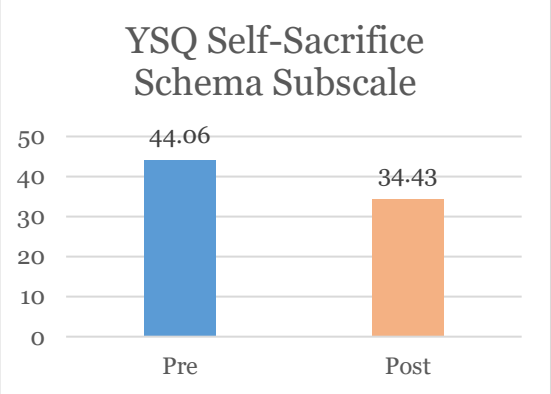

YSQ Mistrust Abuse Schema Subscale
60
50
40
30
20
10
0
54.13
32.05
Pre
Post

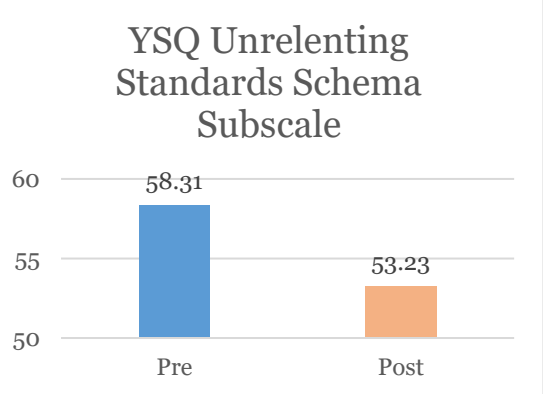

YSQ Emotional Deprivation Schema Subscale
38
37
36
35
34
33
37
34.34
Pre
Post

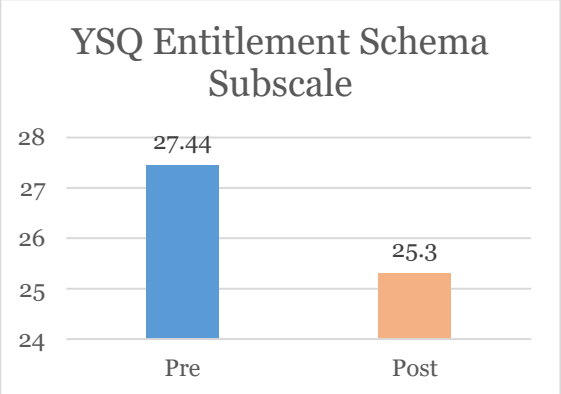

YSQ Failures Schema Subscale
36
35
34
33
32
31
30
29
34.98
31.49
Pre
Post

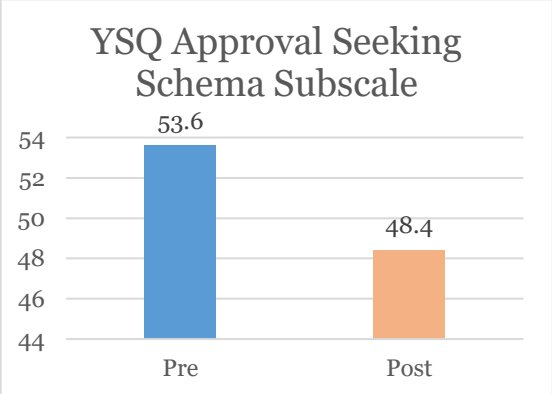

YSQ Enmeshment Schema Subscale
29
28
27
26
25
24
28.78
26.25
Pre
Post


YSQ Subjugation Schema Subscale
38.8
38.78
38.76
38.74
38.72
38.7
38.73
38.79
Pre
Post


YSQ Self-Sacrifice Schema Subscale
50
40
30
20
10
0
44.06
34.43
Pre
Post


YSQ Unrelenting Standards Schema Subscale
60
55
50
58.31
53.23
Pre
Post


YSQ Entitlement Schema Subscale
28
27
26
25
24
27.44
25.3
Pre
Post


YSQ Approval Seeking Schema Subscale
54
52
50
48
46
44
53.6
48.4
Pre
Post

WHO Quality of Life

Increases in participant's quality of life was observed across all four domains of the WHO Quality of Life (WHOQOL): Physical Health, Psychological Health, Social Relationships, and Environment.

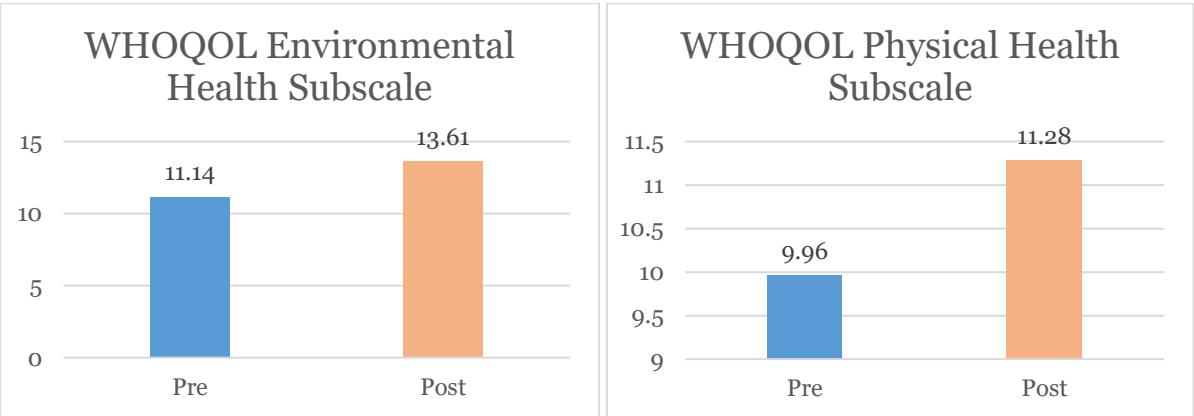
There were statistically significant reductions in all four of the WHOQOL subscales. The Environmental Health subscale resulted in significant increase in WHOQOL scores from pre-intervention (M = 11.14; SD = 2.33) post-intervention (M = 13.61; SD = 2.7), t (15) = -3.81, p =.002 with a large effect size (Cohen's d = -0.98).

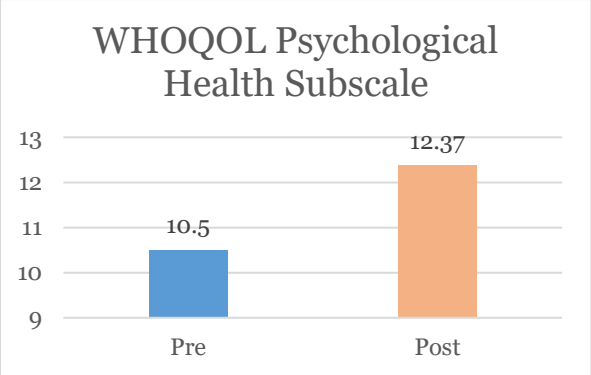
The Physical Health subscale resulted in statistically significant increases in WHOQOL scores from pre-intervention (M = 9.96; SD = 2.13) and post-intervention (M = 11.28; SD = 2.66), t (15) = -2.76, p = .015 with a medium effect size (Cohen's d = -0.55).

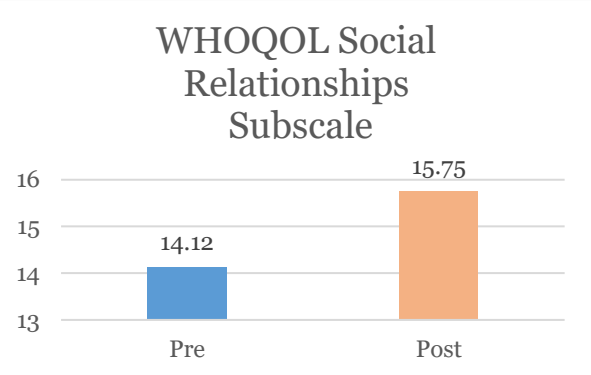
On the psychological health subscale, there were statistically significant increases in WHOQOL scores from pre-intervention (M = 10.5; SD = 3.51) and post-intervention (M = 12.37; SD = 2.76), t (15) = -2.59, p = .02 with a medium effect size (Cohen's d = -0.59).

A statistically significant increase was observed on the social relationships subscale from pre-intervention (M = 14.12 ; SD = 2.17) and post-intervention (M = 15.75; SD = 1.8), whereby t (15) = -3.82, p = .002 reflecting a large effect size (Cohen's d = -0.817).

Figure 4.104. *Pre and post-group mean scores of WHO Quality of Life (WHOQOL) subscales.*







4.17.4. Summary

The Group Schema Therapy programme helps individuals to change their entrenched, self-defeating life patterns or schemas, using cognitive, behavioural and emotion-focused techniques. In 2023, service users who completed Group Schema Therapy showed reductions in areas of each of the measures used. The findings indicate that there were statistically significant improvements in a variety of modes in the SMI such as vulnerable child, angry child, enraged child, impulsive child, undisciplined child and happy child as well as self-aggrandised, punitive parent, detached self, detached protector and happy adult. In the YSQ there were statistically significant improvements in abandonment, social isolation, defectiveness, dependence, vulnerability, emotional inhibition, insufficient self, negativity and punitive schemas, alongside observed improvements in other schemas. Group members are asked to identify and work with their three most highly rated schemas and modes throughout the group, as measured using the YSQ and SMI. The narrow focus is to allow a focus on specific therapy goals associated with schemas and modes and to ensure clarity for group members. This focus facilitates schema change and the recognition and modification of schema coping strategies. However, the narrow focus may limit significant change across some YSQ subscales. There was a significant improvement to environmental health, physical, psychological, and social relationships all reported in the WHOQOL. These findings suggest that participants who completed the GST programme, improved their complex and enduring difficulties related to unmet core needs in childhood.

4.18. Compassion-Focused Therapy for Psychosis Programme

Compassion-Focused Therapy for Psychosis (CFT-P) is a group-based psychology programme for adults who have experienced or live with psychosis. It aims to help individuals to learn how to cope with emotional and psychological difficulties associated with living with psychosis. The programme was formerly known as Living Through Psychosis (LTP). It was decided to change the name of the programme in keeping with the content of the sessions which are compassion therapy focused.

In 2023, the programme continued to offer a group informed predominantly by Compassion-Focused Therapy (CFT; Gilbert, 2014), which includes eleven weekly group sessions as well as a screening pre-group, a mid-way individual review session and an end of therapy session. Areas of focus in the 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; iv) learning new skills to cope with difficult emotions and to feel more calm/soothed; and, v) a new addition to the group – to formulate their experiences of psychosis in the context of their lives. It is hoped that through addressing these areas, service users will experience a reduction in self-judgment, shame and distress relating to their experiences.

4.18.1. Descriptors

11 individuals completed the CFT-P programme in 2023, across two cycles. Pre and post self-report data was available for 10 out of those 11 (91% rate of return). One participant did not complete all measures post-intervention. Programme attendees ranged in age from 20 to 64 years, with a mean age of 41.10 (SD = 12.02). Of the ten participants that completed the pre and post measures, six participants were male, and four 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. Due to the small sample size, statistical significance could not be determined for changes in scores pre to post intervention. Instead, participants individual pre and post measure

scores are reported below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

4.18.2. Compassion-Focused Therapy for Psychosis Programme outcome measures

The following section presents a summary of the routine clinical outcome measures used by the CFT-P programme from in 2023. All service users attending the CFT-P programme are invited to complete the measures listed below at assessment for the programme and again upon completion.

Due to the small sample size, statistical significance could not be determined for changes in scores pre to post intervention. Instead, participants individual pre and post measure scores are reported below.

- **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.

- **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).

4.18.3. Results

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

Mean scores on the CMAS Self Compassion Scale increased from 78.67 (*SD* = 18.75) pre intervention to 99.11 (*SD* = 18.14) following engagement in the programme. As seen in the graphs below, eight of nine participants (88.9%) reported an increase in overall self compassion from pre to post-intervention.

Due to the small sample size, changes in total CMAS self-compassion scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in DASS scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The calculated cut-off score indicating clinically meaningful improvement on the CMAS self compassion scale was 85. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and CMAS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below CMAS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, five participants (55.6%) reported clinically significant improvement, while two participants (22.2%) reported reliable improvement, one participant reported uncertain change (11.1%), and one participant (11.1%) reported reliable deterioration.

Table 4.15. *Results from Reliable Change Index (RCI) for the CMAS pre and post scores for each group member*

CMAS = Compassionate Motivation and Action Scales

Participant	Pre-Score	Post Score	RCI Value	Category
1	86	118	5.27	Reliable Improvement
2	67	94	4.45	Clinically Significant Improvement
3	117	119	.33	Uncertain Change
4	72	109	6.10	Clinically Significant Improvement
5	89	103	2.31	Reliable Improvement
6	63	95	5.27	Clinically Significant Improvement
7	56	94	6.26	Clinically Significant Improvement
8	90	58	-5.27	Reliable Deterioration
9	68	102	5.60	Clinically Significant Improvement

The three subscales within the Self-Compassion Scale were also analysed. The compassionate intention subscale mean score remained relatively unchanged increasing slightly from 30.56 (*SD* = 2.96) to 31.11 (*SD* = 3.22) from pre to post-intervention. Analysis of individual scores showed that this increased for three out of nine participants (33.3%), while remaining unchanged for four of nine participants (44.4%). The distress tolerance subscale mean score increased from 24.89 (*SD* = 9.97) to 34.44 (*SD* = 9.66), with individual scores increasing on this subscale for eight of nine participants (88.9%). Similarly, the compassionate action subscale mean score increased from 23.22 (*SD* = 9.54) to 33.56 (*SD* = 7.92), with seven of nine participants (77.8%) reporting increased scores on this subscale post-intervention.

Figure 4.105. *Pre and post-group mean scores of Compassionate Motivation and Action Scales (CMAS) total and subscales scores*

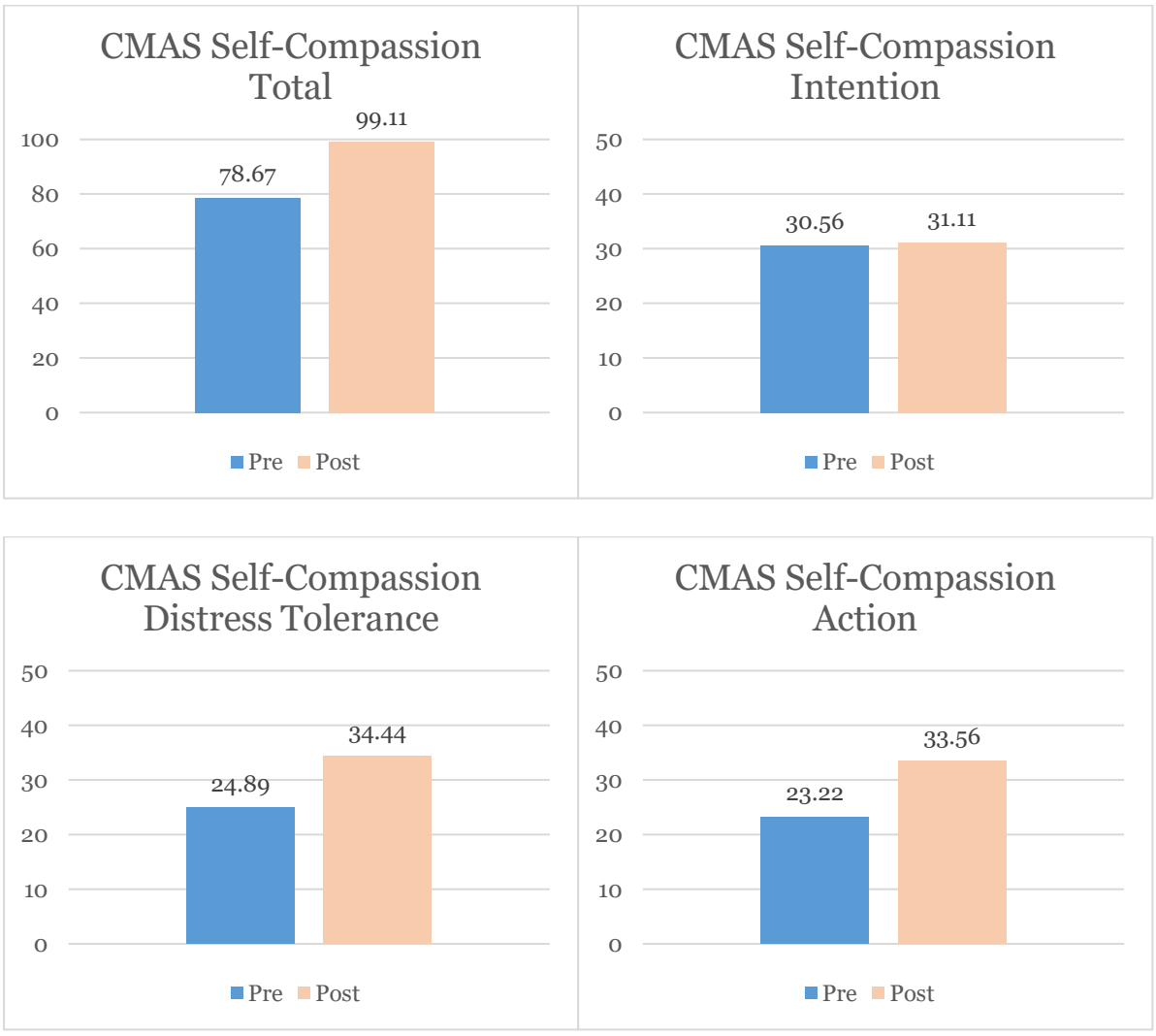
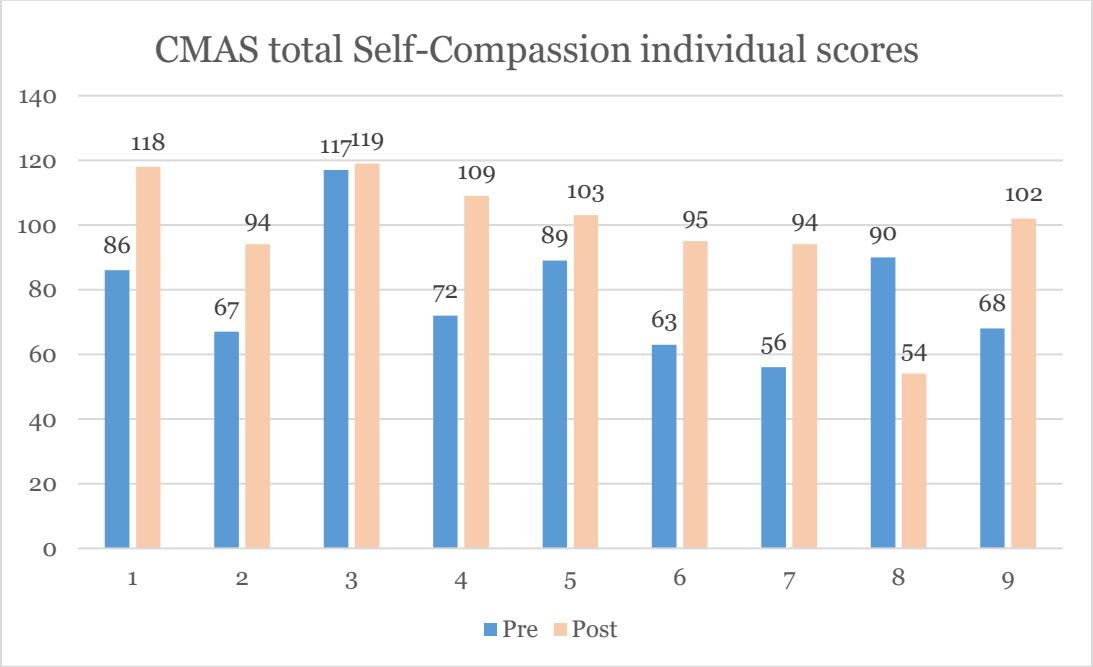
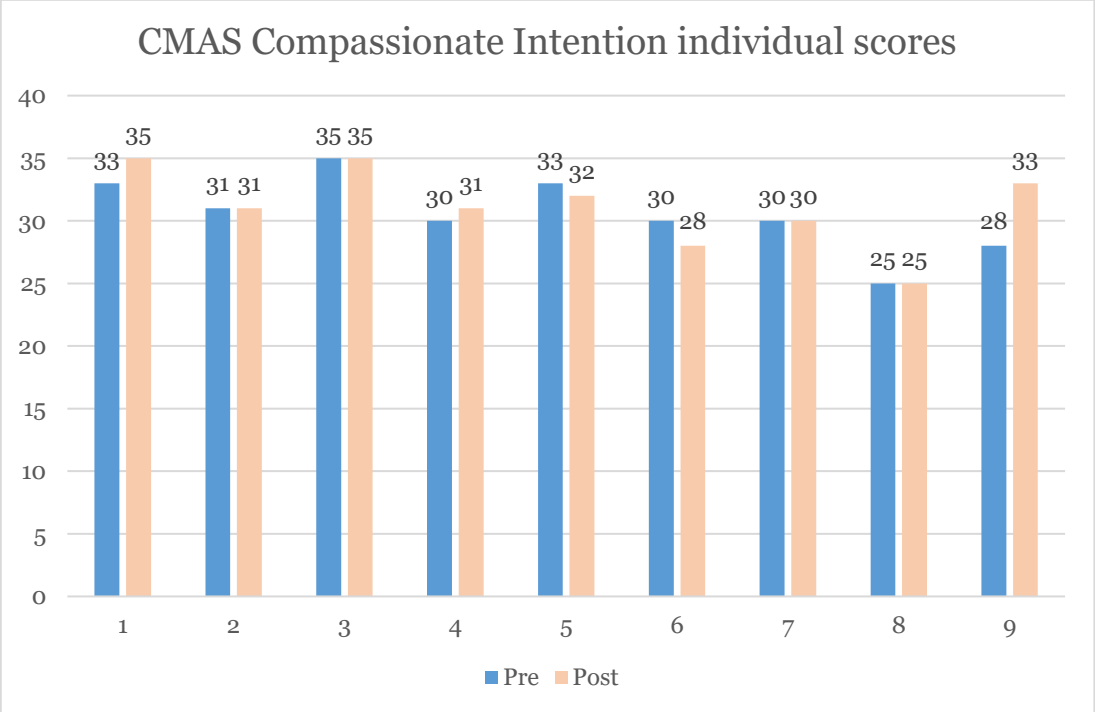
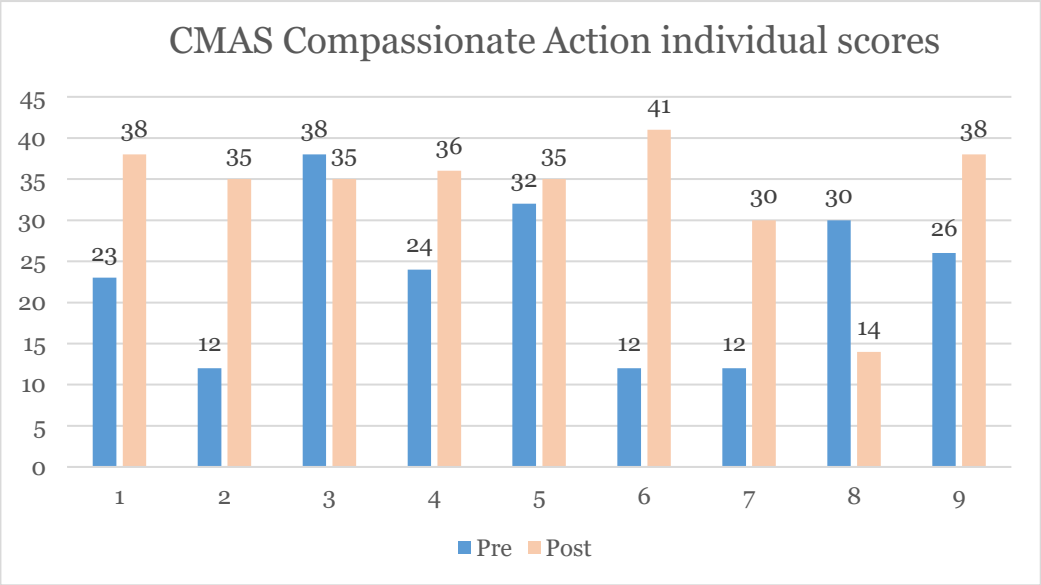
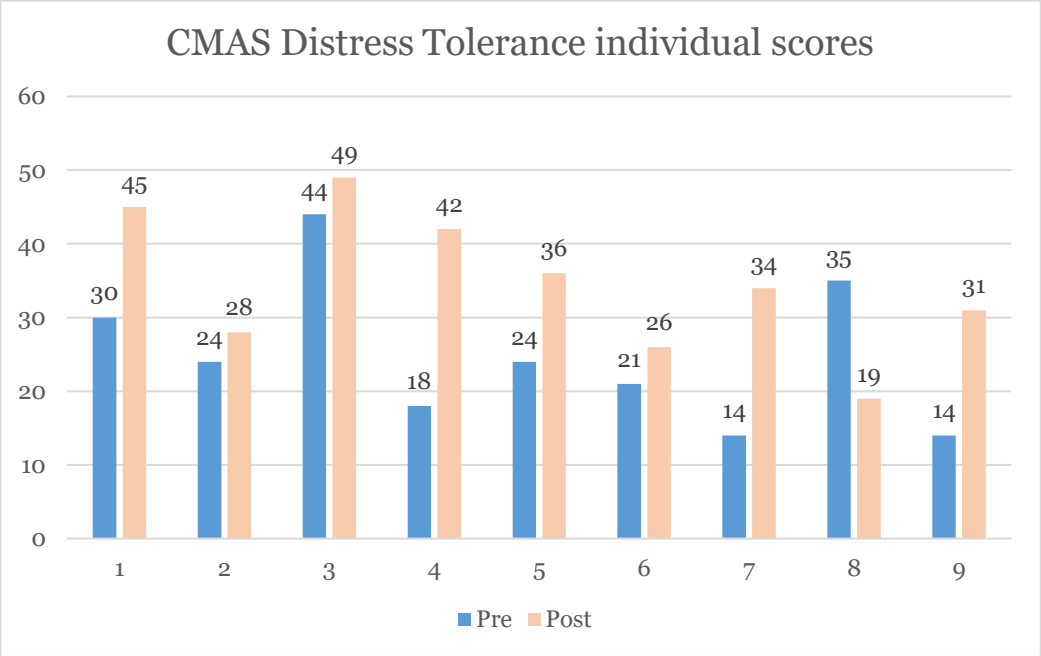


Figure 4.106. *Pre and post group individual scores of Compassionate Motivation and Action Scales (CMAS) total and subscales scores*





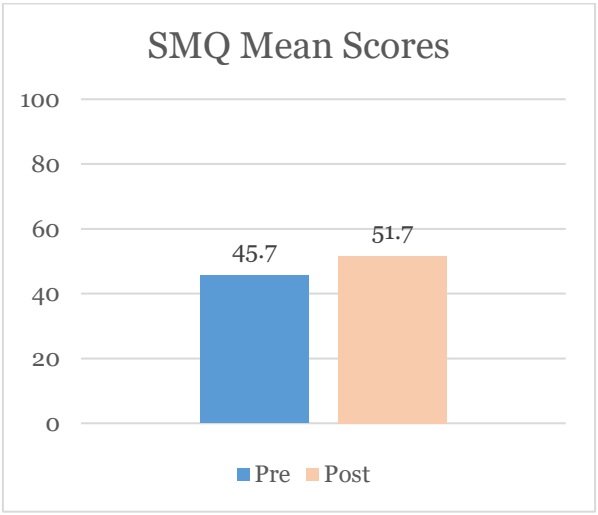


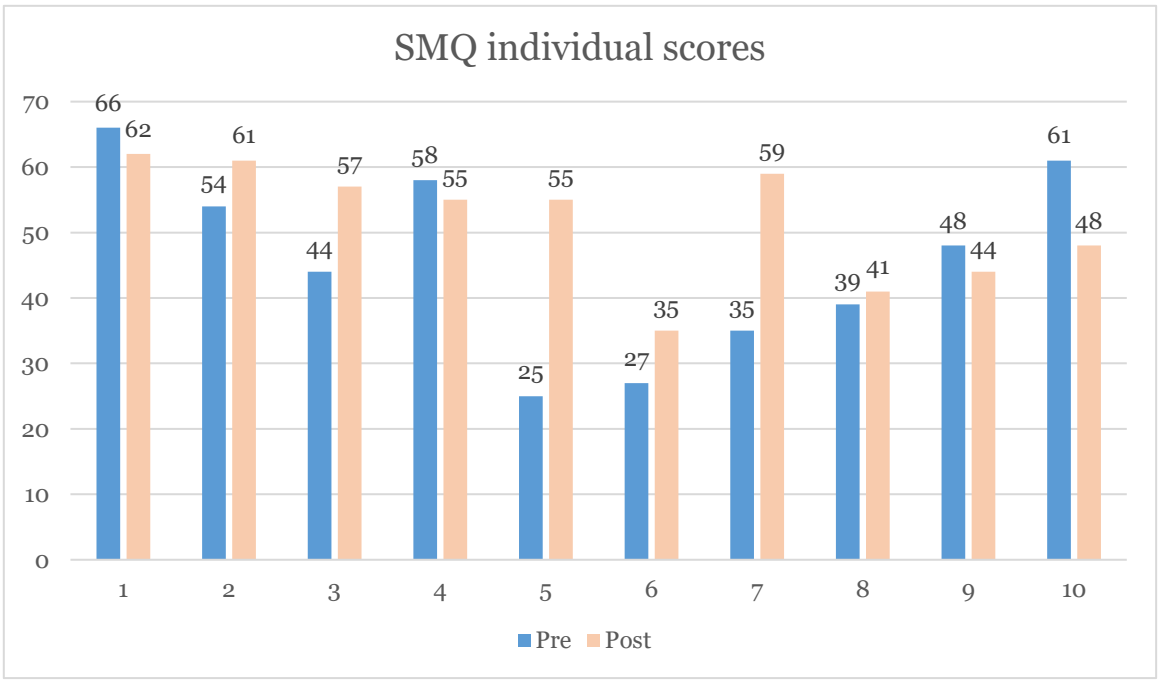


Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ mean scores suggests that individuals' tendency to mindfully respond to distressing thoughts and images increased. Higher scores on this measure indicate greater mindful awareness. Service users demonstrated a mean score of 45.7 (*SD* = 14.19) at pre-intervention and a mean score of 51.7 (*SD* = 9.20) following the intervention. As shown in the graph below, mindfulness scores increased for six out of ten participants (60%) post-intervention.

Figure 4.107. *Pre and post-group total and individual mean scores of Southampton Mindfulness Questionnaire (SMQ)*

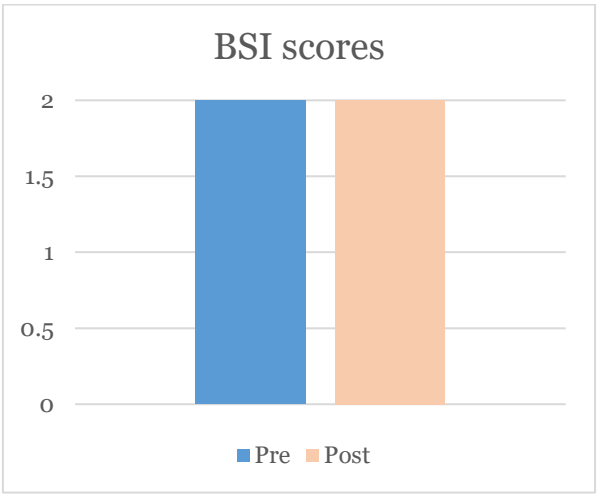


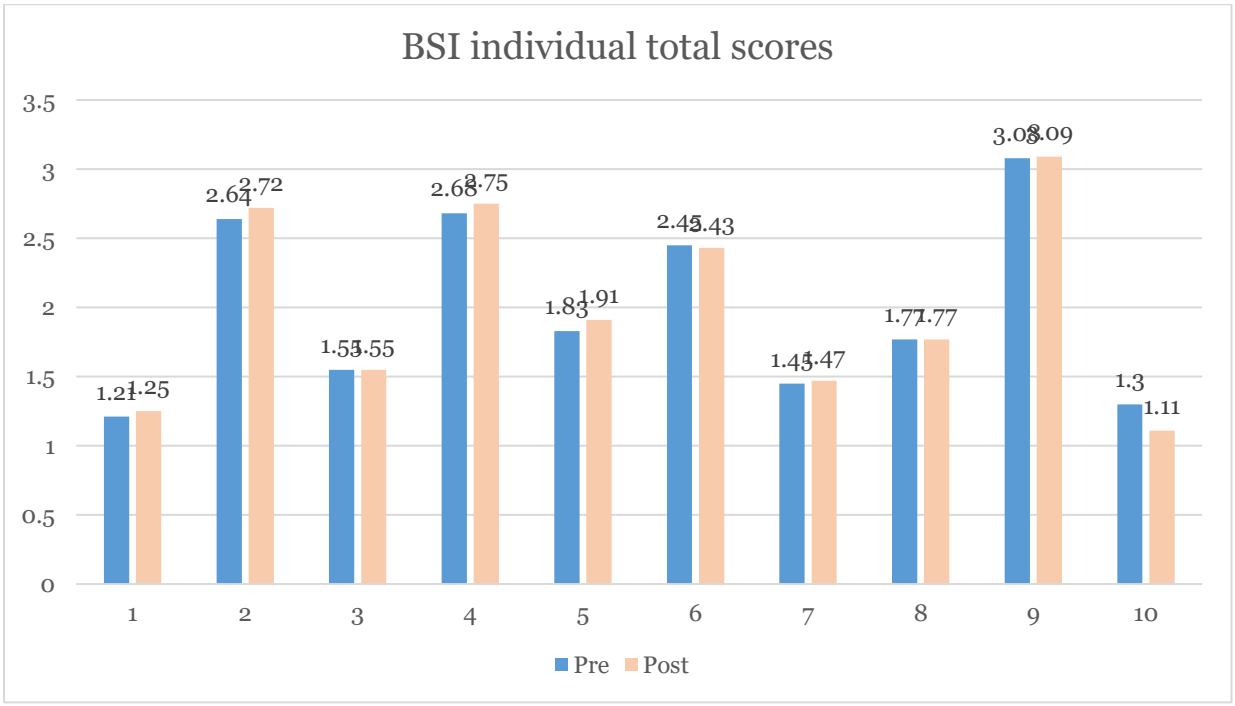


The Brief Symptom Inventory (BSI)

Global distress levels as measured by the BSI Global Index score demonstrated a very small increase following the intervention. The mean score of 2.07 (*SD* = 0.65) pre-intervention remained relatively unchanged at 2.10 (*SD* = 0.66) post-intervention. Scores on this measure increased for five out of ten participants (50%) post-intervention.

Figure 4.108. *Pre and post-group total and individual mean scores of Brief Symptom Inventory (BSI)*

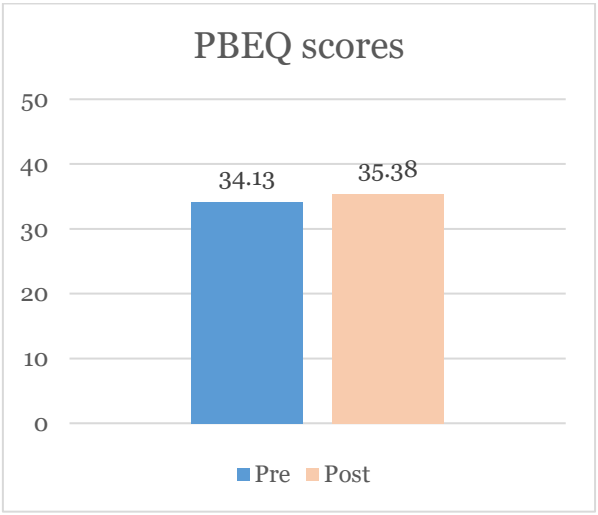


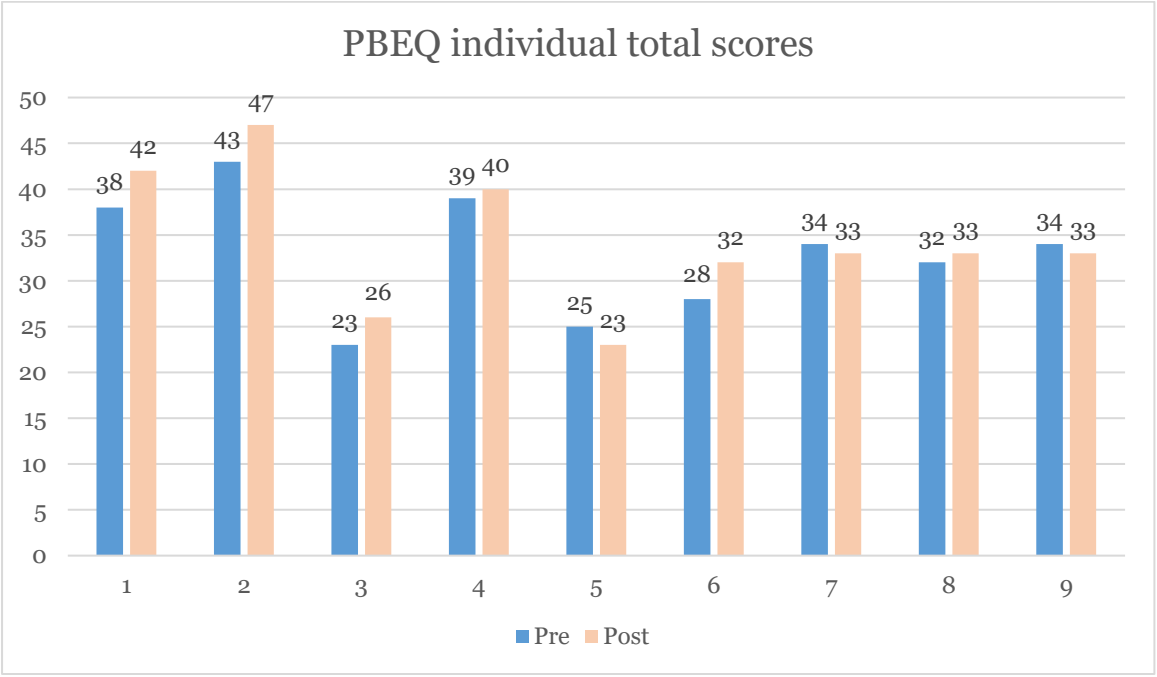


The Personal Beliefs about Experiences Questionnaire (PBEQ)

Mean scores on the PBEQ increased slightly following engagement with the programme. The mean score beforehand was 34.13 (*SD* = 5.89), this increased to 35.38 (*SD* = 7.39) at post-intervention. Scores on this measure increased for six of nine participants (66.7%) post-intervention.

Figure 4.109. *Pre and post-group total and individual mean scores of Personal Beliefs about Experiences Questionnaire (PBEQ)*





4.18.3. Summary

The CFT-P 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 CFT-P team will continue to develop the programme offering during 2024 in order to address the psychological needs of service users with psychosis.

4.19. 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).

4.19.1. Descriptors

Pre and post-intervention data was collected on 25 participants: 6 males (24%) and 19 females (79%). Participants' age ranged from 28 to 73 years old (mean = 55.6 years).

4.19.2. Mindfulness Programme outcome measures

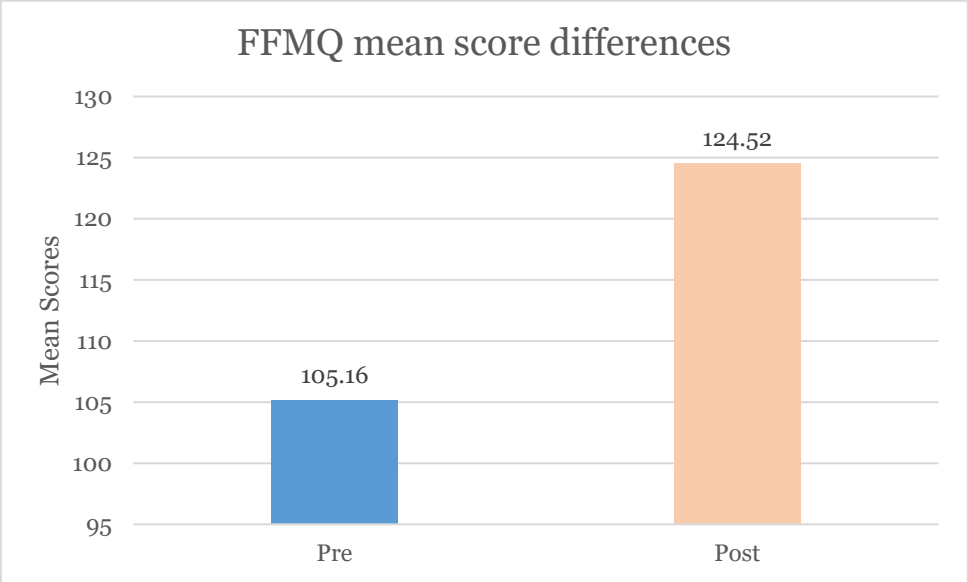
- **Five Facet Mindfulness Questionnaire**

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).

4.19.3. Results

Five Fact Mindfulness Scale (FFMQ)

Figure 4.110. *Pre and post-group mean score of Five Facet Mindfulness Scale (FFMQ)*



Statistical analysis revealed a significant increase in total scores on the FFMQ from pre-intervention (M = 105.16; SD = 21.14) to post-intervention (M = 124.52; SD = 21.62). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (24) = -4.86, p<.001, with a large effect size (Cohen's d = -0.91). 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 large effect size was yielded for the 'observe' (Cohen's d = -1.35) and a medium effect size was yielded for the 'describe' (Cohen's d = -0.514), 'awareness' (Cohen's d = -0.56) and 'non-judgement' (Cohen's d = -0.65) sub- scales.

Table 4.16. *FFMQ mean scores by subscales, t values and effect size*

	Pre	**Post**	***n***	***t***	***df***	***p***	***d***
FFMQ Total	105.16 SD = 21.14	124.52 SD = 21.62	24	-4.86	24	**.000**	-0.91
Observe	23.6 SD = 5.72	29.80 SD = 4.92	24	-5.31	24	**.000**	-1.35
Describe	22.2 SD = 6.23	25.32 SD = 5.91	24	-3.66	24	**.001**	-0.51
Awareness	20.76 SD = 6.1	24.6 SD = 7.57	24	-3.57	24	**.002**	-0.56
Non-Judgement	20.04 SD = 4.93	23.36 SD = 5.28	24	-2.66	24	**.012**	-0.65
Non-Reactivity	18.56 SD = 4.99	21.44 SD = 4.01	24	-2.66	24	**.014**	-0.64

4.19.4. Summary

In line with the 2022 report, results for 2023 indicates that the programme continues to be successful in helping service users develop their capacity for mindfulness in daily life, and increase ability to observe more, describe within their life, act with awareness, increase non-reactivity to inner experience and be non-judging of inner experiences.

4.20. Psychology Skills Group for Adolescents

The Psychology Skills Group for Adolescents (PSGA) 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 for Adolescents (DBT-A), Radically Open Dialectical Behaviour Therapy (RO-DBT), and Group Radical

Openness (GRO) in a multi-family context. 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 22 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 two and five sessions.

4.20.1. Descriptors

In 2023, 17 families participated in PSGA. Of these 17, 6 families withdrew from the programme and their data have been excluded due to the absence of time two measures. Their demographic data will be included here for descriptive analyses. The mean age of young people attending was approximately 16 years old (M=15.89, SD =1.28). 16 of the 17 young people were female, with 1 male participant. 4 of the parents were male and 13 of the parents were female. Pre and post data were available for eight families.

4.20.2. Psychology Skills Group for Adolescents outcome measures

The following section presents a summary of the routine clinical outcome measures used by the PSGA programme in 2023. All service users and their parents attending the PSGA programme are invited to complete the measures listed below at assessment for the programme and again upon completion.

Due to the small sample size statistical significance could not be determined for changes in scores on a number of measures below. For these measures, participants individual pre and post measure scores are reported instead. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

- **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 (1 = almost never; 5 = almost always). Total scale scores range from 36 to 180 with higher total scores indicating greater difficulties in emotion regulation. The DERS demonstrates good internal consistency (α = .93), construct and predictive validity, and test-retest reliability (Gratz & Roemer, 2004).

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

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

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

The Brief Reasons for Living Inventory – Adolescents (BRFL-A; Osman et al., 1996) was completed by young people at pre and post-intervention. The BRFL-A assesses factors protecting against suicidal behaviour in adolescents and is comprised of five subscales: Family Alliance (FA), Suicide-Related Concerns (SRC), Self-Acceptance (SA), Peer-Acceptances and Support (PAS), and Future Optimism (FO). In the BRFL-A, specific reasons that people might have for not ending their life are presented and participants are asked to rate how important each reason is to them for staying alive. The measure consists of 32 items scored on a six-point Likert scale (1 = not at all important; 6 = extremely important). Higher mean scores on subscales indicate greater perceived importance of factors protecting against suicide. The BRFL-A demonstrates good internal consistency and good construct, convergent, predictive, and discriminant validity (Osman et al., 1996).

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

The Over and Under Controlled Traits Measure for Adolescents (OUT-Ma; James et al., in preparation) was completed by young people at pre and post-intervention. The

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

- **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 3-point Likert scale (0 = not true; 1 = somewhat true; 2 = 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 5-point Likert scale (1 = Describes us: Very well; 5 = 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 (1 = 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).

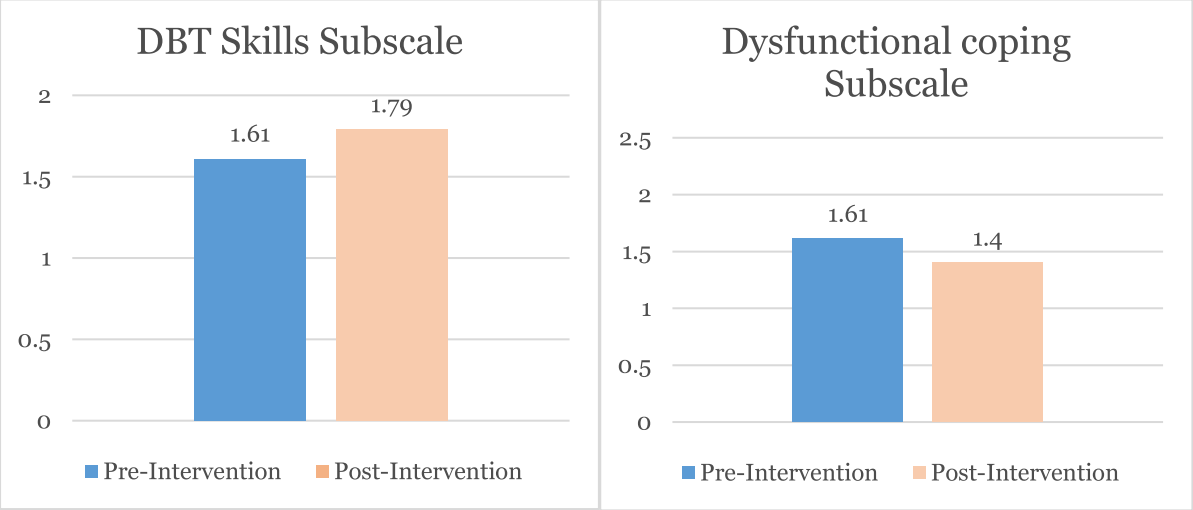
4.20.3. Results

DBT Ways of Coping Checklist (DBTWCCL)

The DBTWCCL was completed by parents and young people. Mean scores indicated 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 1.61 (*SD*=.40). Post-intervention, parents and young people achieved a mean DSS score of 1.79 (*SD*=.32). Both pre and post scores fell within the "Typical Clinical" range.

Mean scores on the Dysfunctional Coping Skills subscale (DCS) decreased from pre to post-intervention. At pre-intervention, parents and young people had a mean score of 1.61 (*SD*=.51) on the DCS, pre-group scores fell within the "Typical Clinical" range, post-group scores fell within the "Low Clinical" range. At post-intervention, this was 1.4 (*SD*=.57). Due to the small sample size, the statistical significance of these changes could not be determined.

Figure 4.111. *Pre and post-group mean score of DBT Ways of Coping Checklist (DBTWCCL) subscales*



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 eight of the young people. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=121.75, *SD* = 14.62) – High Average to post-intervention (M=96.38, *SD* = 19.76) - Average.

Due to the small sample size, changes in total DERS scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in DERS scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The calculated cut-off score indicating clinically meaningful improvement on the DERS was 105. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and DERS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below DERS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, two participants (25%) reported clinically significant improvement, while two participants (25%) reported reliable improvement, three participants reported uncertain change (37.5%), and one participant (12.5%) reported reliable deterioration.

Table 4.17: *Results from Reliable Change Index (RCI) for the DERS pre and post scores for each group member*

DERS = Difficulties with Emotion Regulation Scale

Participant	Pre-Score	Post Score	RCI Value	Category
1	125	106	-2.19	Reliable Improvement
2	130	60	8.06	Clinically Significant Improvement
3	121	119	-0.23	Uncertain Change
4	113	105	-0.92	Uncertain Change
5	99	73	-3.00	Reliable Improvement
6	120	98	-2.53	Clinically Significant Improvement
7	108	101	-0.81	Uncertain Change
8	86	109	2.65	Reliable Deterioration

Pre and post DERS-P responses were available for seven of the parents. Analysis showed that parent's ratings of their child's difficulties with emotional regulation decreased from an average of 106.43 (*SD* = 26.78) to 84 (*SD*=26.00).

As shown in the graphs below, seven of eight young people (87.5%) reported a decrease in overall difficulties regulating emotions post-intervention. Similarly, six out of seven parents (85.7%) also reported a decrease in overall difficulties regulating emotions post-intervention.

Figure 4.112. *Pre and post-group mean score of Difficulties in Emotional Regulation (DERS) and Difficulties in Emotional Regulation- Parents (DERS-P)*

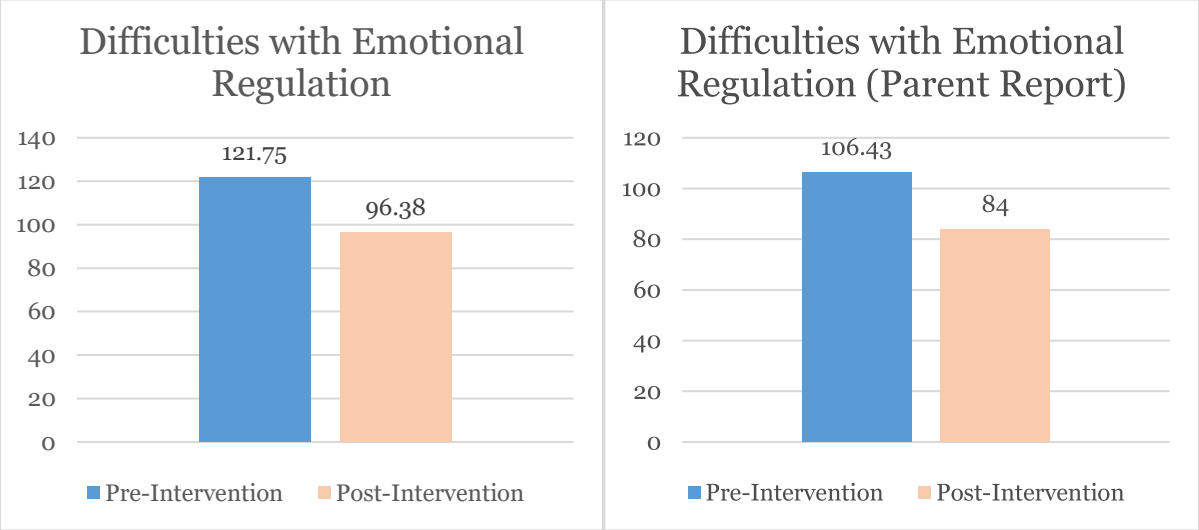
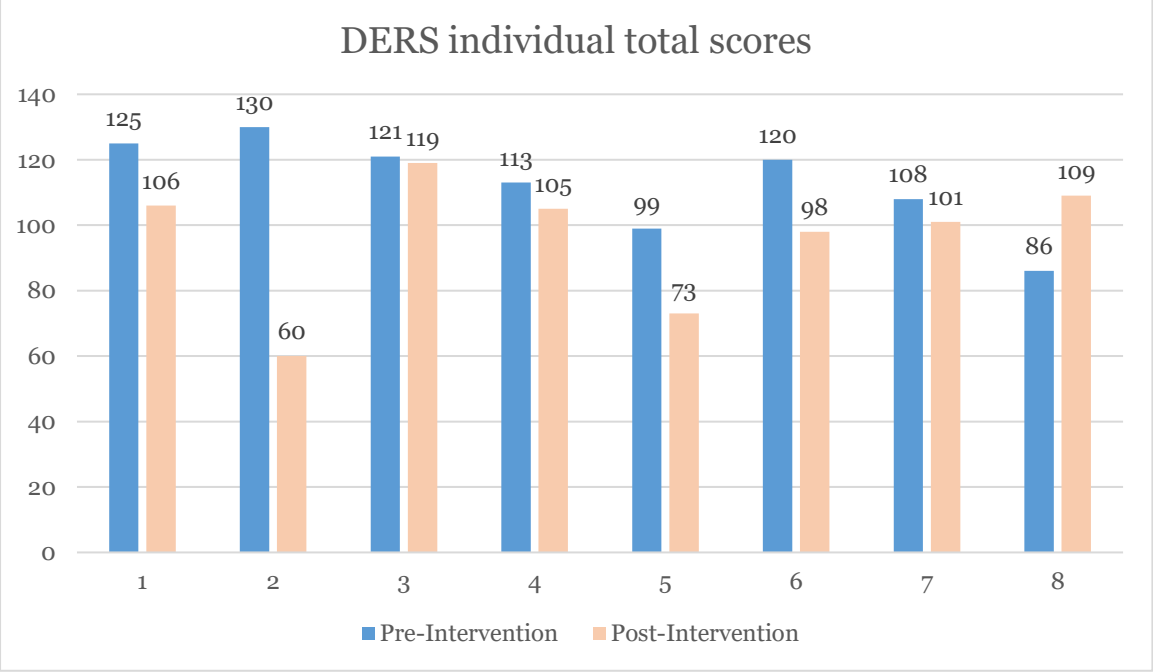
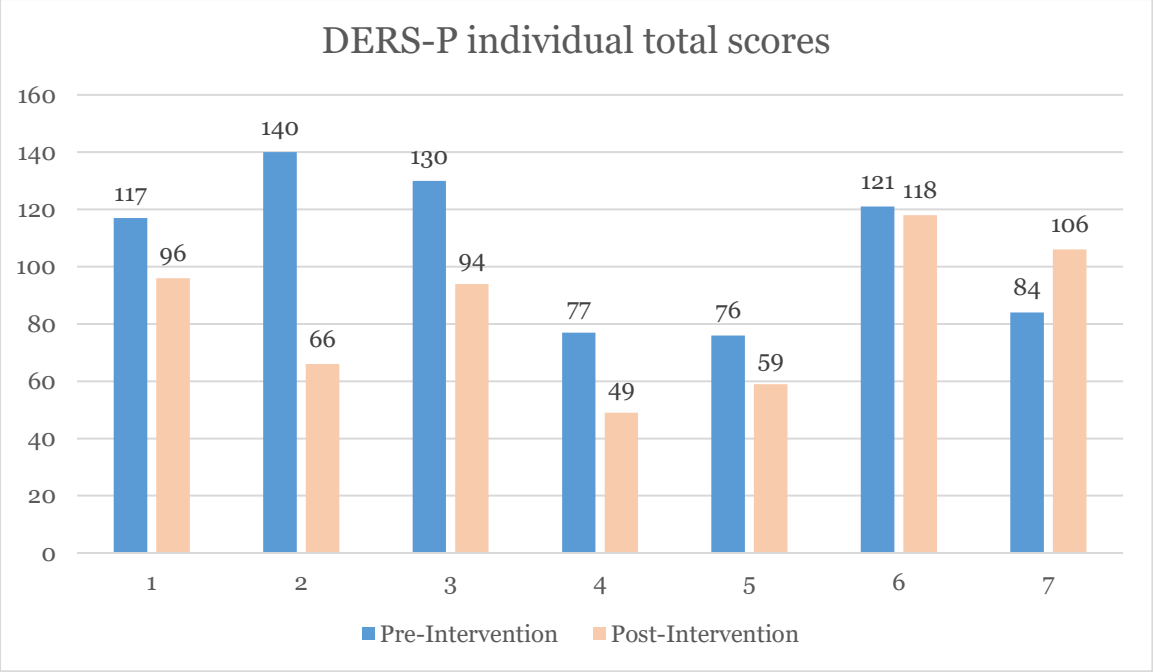


Figure 4.113. *Pre and post individual total scores of Difficulties in Emotional Regulation (DERS) and Difficulties in Emotional Regulation- Parents (DERS-P)*





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 2.01 (*SD* = 0.99). Post-intervention, this decreased slightly to a mean of 1.85 (*SD* = .81). Pre-intervention, the mean over control score was 3.16 (*SD* = .49). Post-intervention, this increased to a mean of 3.42 (*SD* = 1.08). Numerically, these findings suggest under control decreased following engagement in the intervention, while over control actually increased.

As illustrated in the graphs below, five out of eight young people (62.5%) reported a decrease in under-control traits post-intervention, while six out of eight (75%) young people reported an increase in over-control traits post-intervention.

Figure 4.114. *Pre and post-group mean score of Adolescent Over and Under Control Trait Measure (OUTM)*

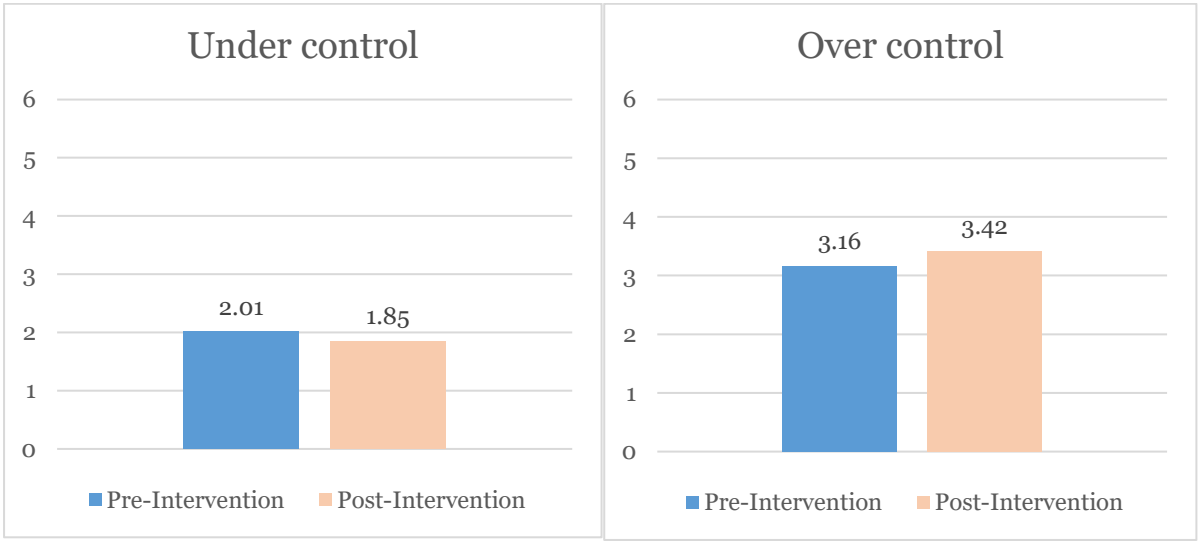


Figure 4.115. *Pre and post individual total scores of Adolescent Overcontrol (OUTM)*

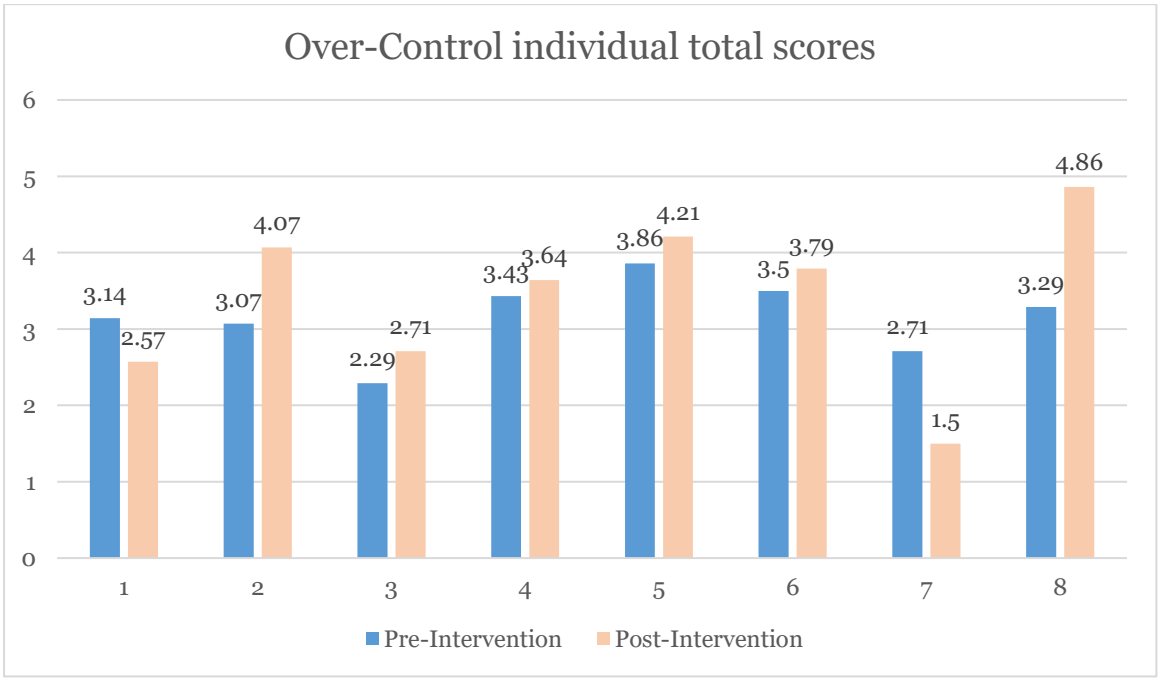
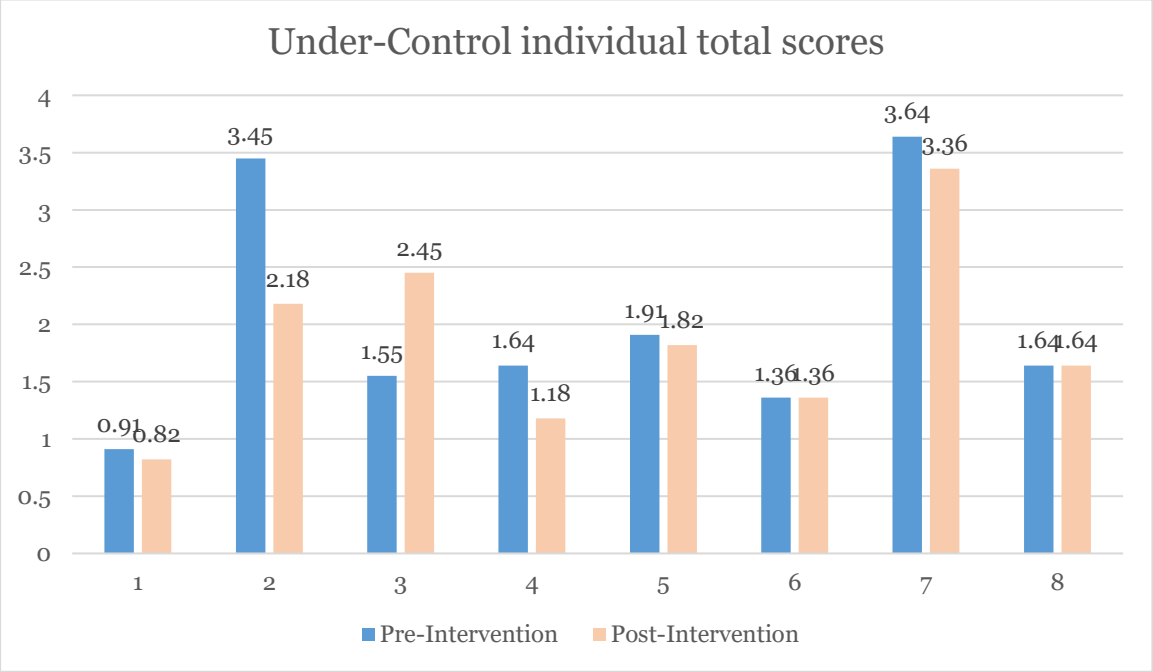


Figure 4.116. *Pre and post individual total scores of Adolescent Under-control (OUTM)*



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

Pre-intervention, the mean BRFLA score was 4.41 (*SD* = .74). Post-intervention, this increased to a mean of 4.87 (*SD* = .55). Both of these scores are considered to fall within the "Typical Clinical" range. This trend suggests that following engagement in the intervention, participants scores higher on factors protecting against suicidal behaviour. As shown in the graph below, five out of eight young people (62.5%) reported an increase in reasons for living post-intervention.

Figure 4.117. *Pre and post total mean scores of Brief Reasons for Living Inventory - Adolescent (BRFL-A)*

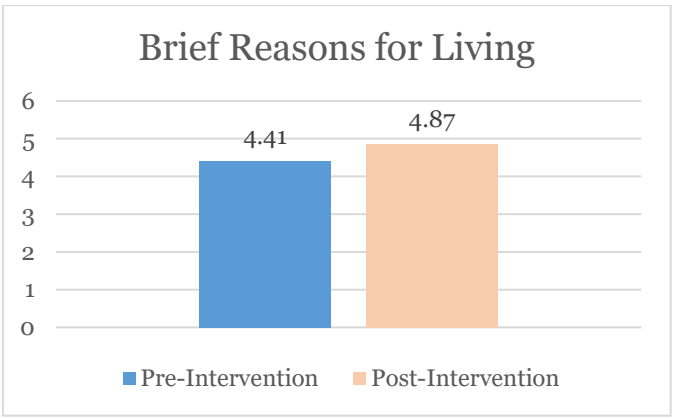
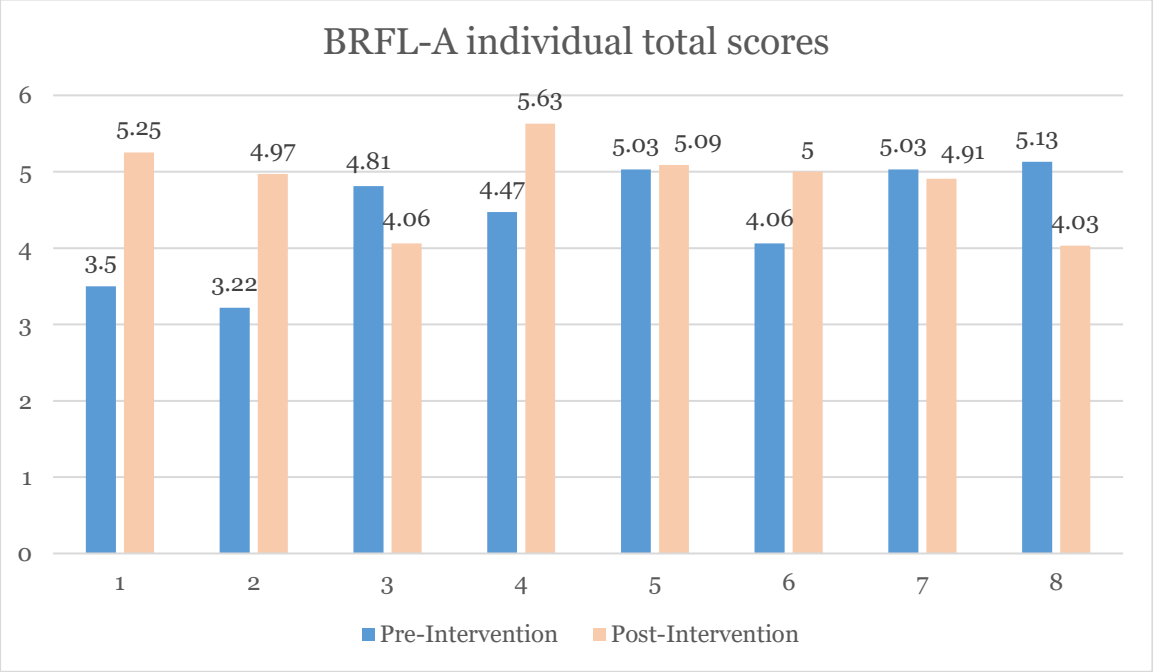


Figure 4.118. *Pre and post individual total scores Brief Reasons for Living Inventory - Adolescent (BRFL-A)*

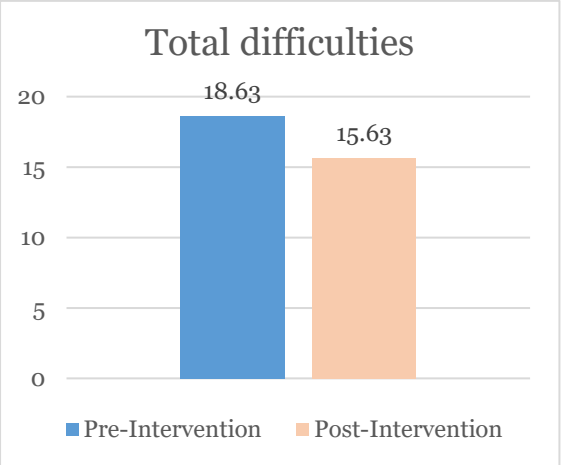


Strength and Difficulties Questionnaire (SDQ) and Strength and Difficulties Questionnaire – Parents (SDQ-P).

Pre-intervention, the mean total difficulties score was 18.63 (*SD*= 3.62) - Clinical Range. This fell to 15.63 (*SD* = 6.80) – Below Clinical Range post-intervention. Pro-social behaviour was found to increase slightly from a mean of 7.5 (*SD* = 1.69) to 8.13 (*SD* = 1.13). Both of these scores fell within the "Below Clinical" range. As shown in the graph below, six out of eight young people (75%) reported a decrease in total difficulties post-intervention.

This improvement in total difficulties was also reflected in parental reports. Pre-intervention, parents reported a mean of 16.14 (*SD*= 7.63) – "Clinical" range. This fell to 13.86 (*SD* = 8.09) – "Below Clinical" range post-intervention. Pro-social behaviour was found to increase slightly from a mean of 8.71 (*SD* = .95) to 9 (*SD* = 1). Both of these scores were in the "Below Clinical" range. Five out of seven parents (71.4%) reported a decrease in total difficulties post-intervention.

Figure 4.119. *Pre and post mean scores of Strength and Difficulties Questionnaire (SDQ) total and subscales*



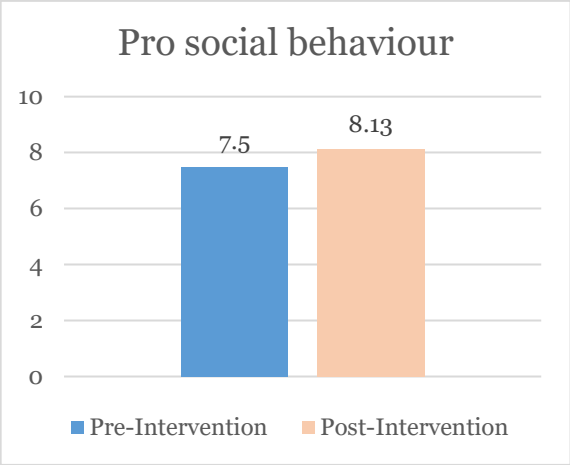


Figure 4.120. *Pre and post individual scores of Strength and Difficulties Questionnaire (SDQ)*

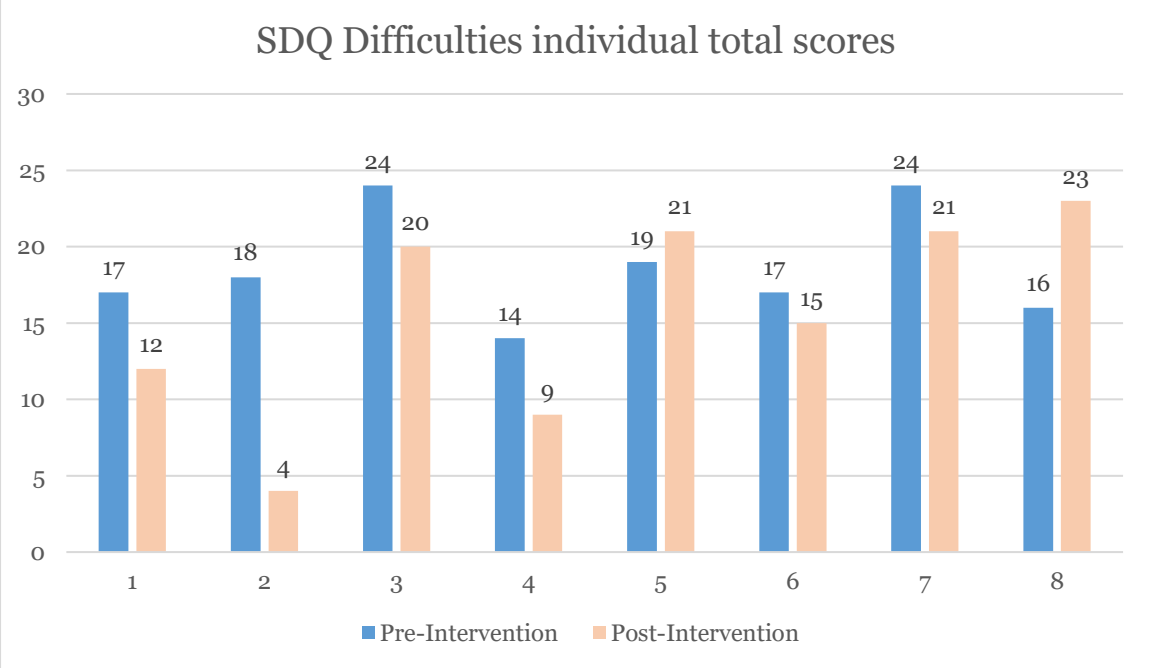


Figure 4.121. *Pre and post mean scores of Strength and Difficulties Questionnaire - Parents (SDQ-P)) total and subscales*

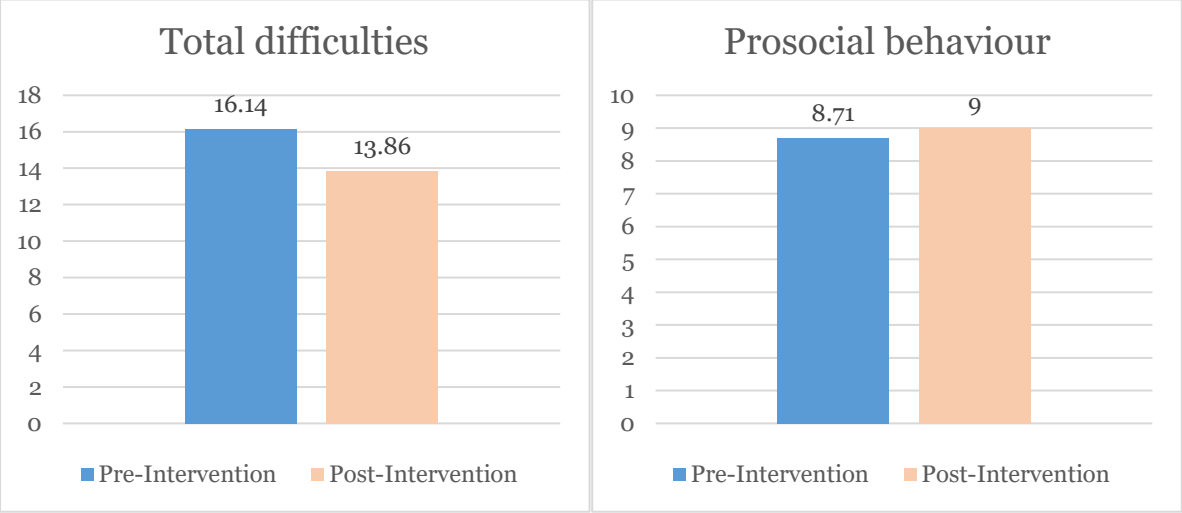
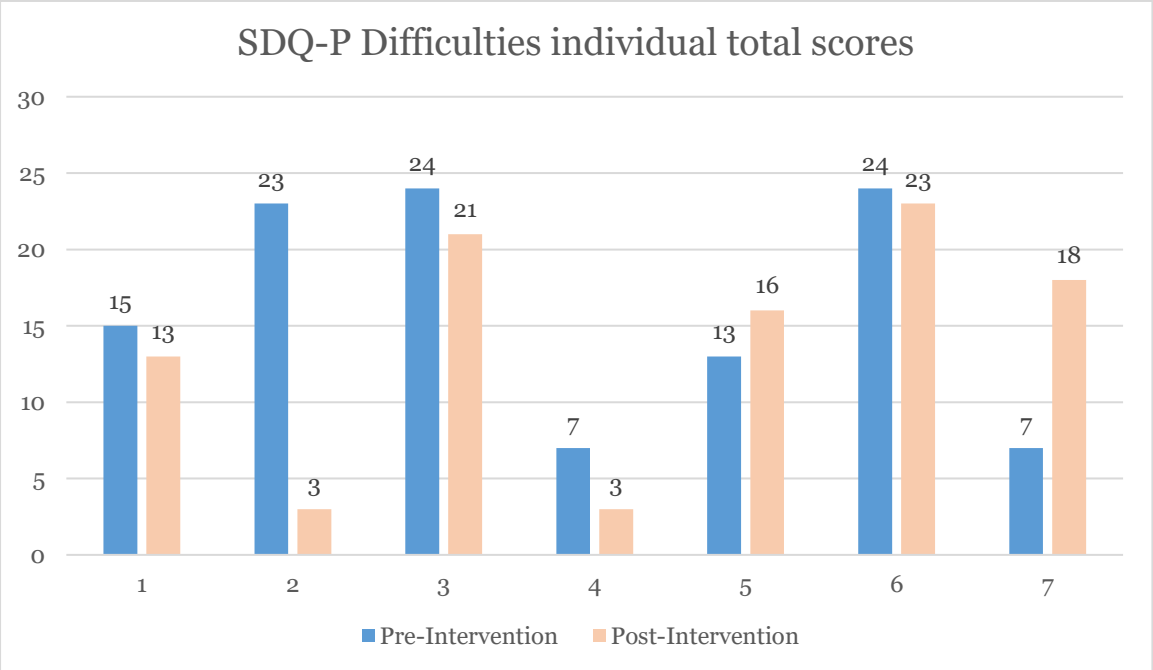


Figure 4.122. *Pre and post individual scores of Strength and Difficulties Questionnaire= Parent (SDQ-P)*



Revised Children's Anxiety and Depression Scale (RCADS)

Scores on the RCADS revealed that rates of depression decreased from a mean of 18.88 (*SD* = 5.62) to 15 (*SD* = 7.31) for the young people who completed PSGA. Similarly, rates of anxiety, as measured by the RCADS, also showed a reduction from a mean of 10.75 (*SD* = 4.03) pre-intervention to 7.5 (*SD* = 5.53) post-intervention. Total scores, comprising all six subscales, also revealed a decrease from a mean of 81.5 (*SD* = 18.09) – "Clinical" range at pre-intervention to 63.38 (*SD* = 30.56) "Non-Clinical" range at post intervention. Upon analysis of individual scores, it was found that seven out of eight young people (87.5%) reported a decrease in total difficulties post-intervention, as seen in the graph below.

Figure 4. 122.. *Pre and post mean scores of Revised Children's Anxiety and Depression Scale (RCADS) total and subscales.*

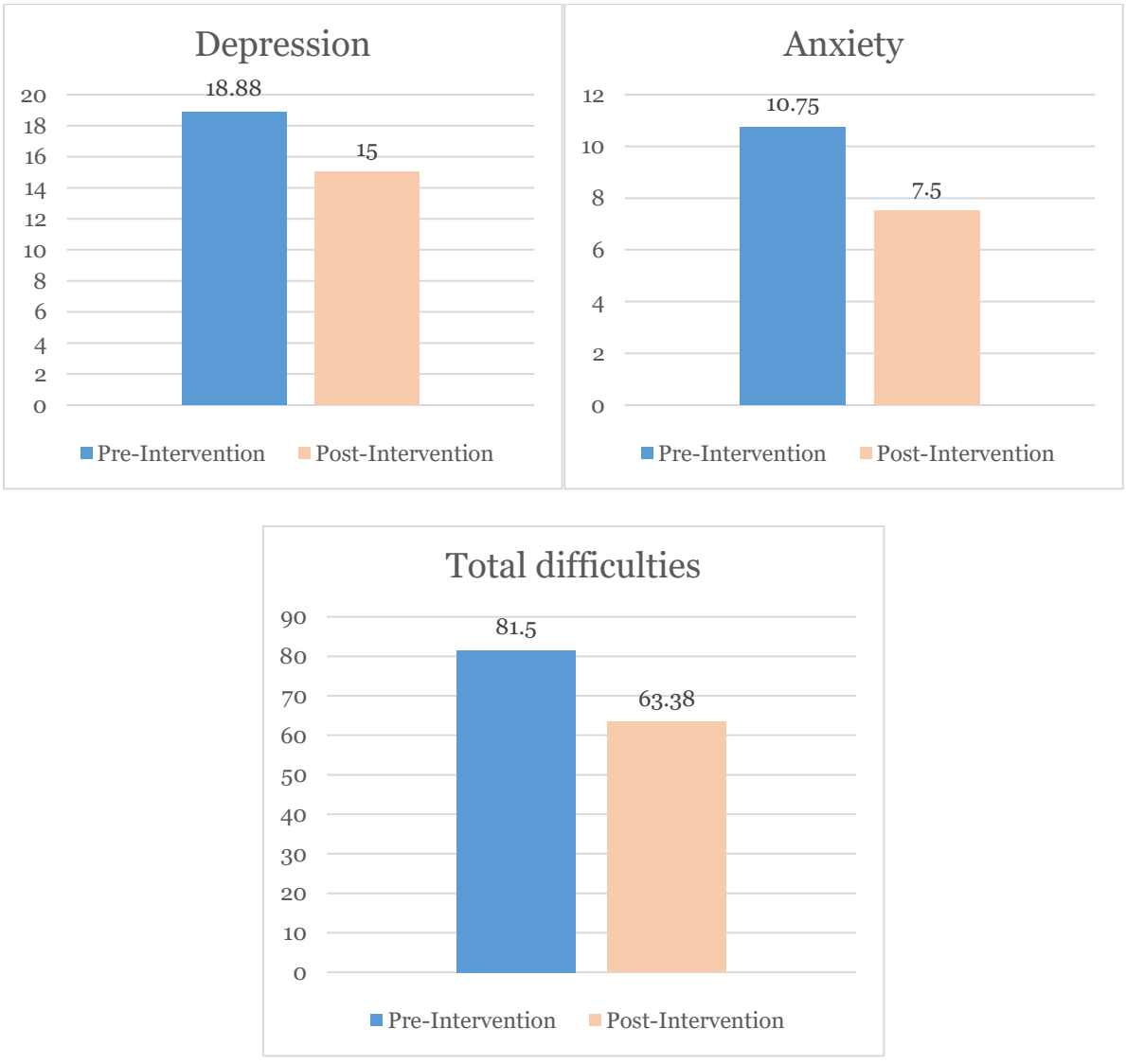
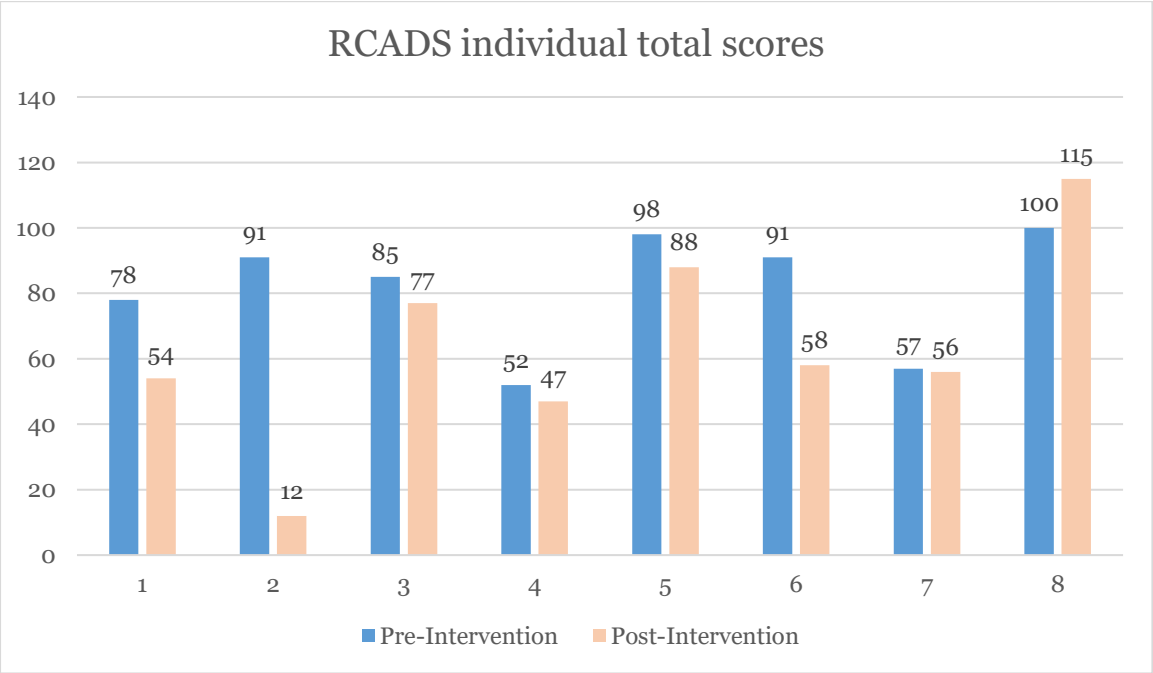


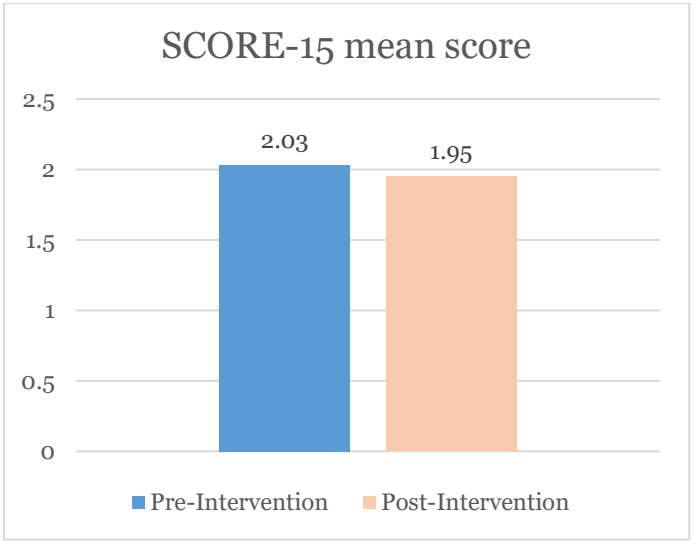
Figure 4. 123. *Pre and post individual mean scores of Revised Children's Anxiety and Depression Scale (RCADS)*



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 remained relatively unchanged from before group (M = 2.03, *SD* = .39) to after group (M = 1.95, *SD* = .44). Due to the small sample size statistical significance could not be determined for this change. However, scores remained within the "Below Clinical" range.

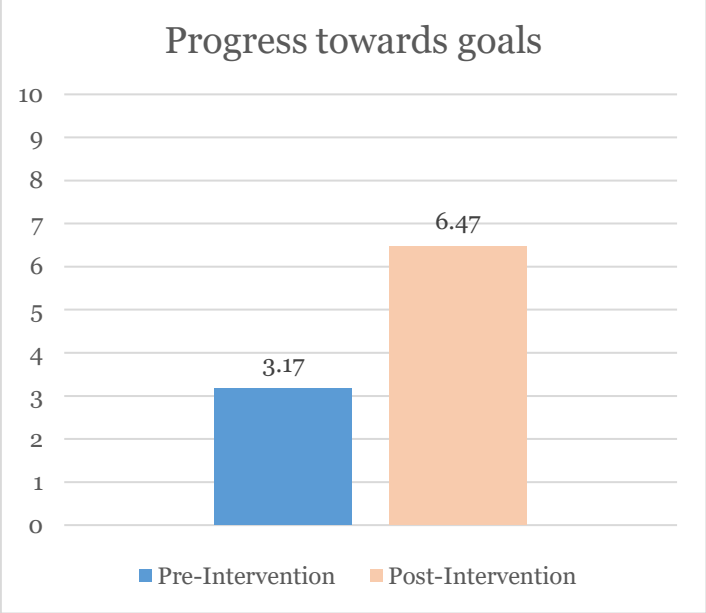
Figure 4. 124. *Pre and post total mean scores of Score 15*



Goal-based outcomes (GBO)

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 3.17 out of a possible 10 (*SD* = 1) to 6.47 out of a possible 10 (*SD* = 2.68), with a score of 10 indicating that the goal had been achieved. This trend indicated parents and young people made progress in achieving their goals post intervention.

Figure 4. 125. *Pre and post total mean scores of goal-based outcomes*



4.20.3. 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 under 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 progress towards their goals, having completed the programme.

4.21. (Group) Radical Openness Programme

Group Radical Openness (GRO) is a transdiagnostic group therapy intervention for service users presenting with mental health difficulties associated with costly and harmful overcontrol. GRO was developed in St Patrick's Mental Health Services. Overcontrol, sometimes referred to as too much self-control, underlies a range of mental health difficulties. These include certain Axis I mood and eating disorders and Axis II presentations, such as Obsessive-Compulsive Personality Disorder and Avoidant Personality Disorder.

GRO is a structured group therapy approach. In GRO, the participants work on three core themes of overcontrol: Distance in Relationships, Rigidity, and Inhibited Emotion. The therapeutic process facilitates developing understanding, awareness, and insight into each individual's struggles with overcontrol. Safety is core to the treatment and through a series of experiential exercises, the group work out ways to develop more intimate and connected relationships, develop more flexibility in their lives, and experience and express their emotions.

GRO consists of 27 sessions and is delivered over a five-month period. Group sessions occur twice per week for 12 weeks and then once a week for the final three weeks.

4.21.2. Descriptors

A total of 53 people completed GRO in 2023. 51.9% of the participants were male, 46.3% were female and 1.9% were non-binary. Participant's ages ranged from 21 years to 68 years (M=43.19, SD=13.04). Of the 53 people, 33 completed the programme online and 20 completed the group in-person. Pre and post-outcome data were available for 37 people, representing an 69.81% return rate.

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.

4.21.1. 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 which 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

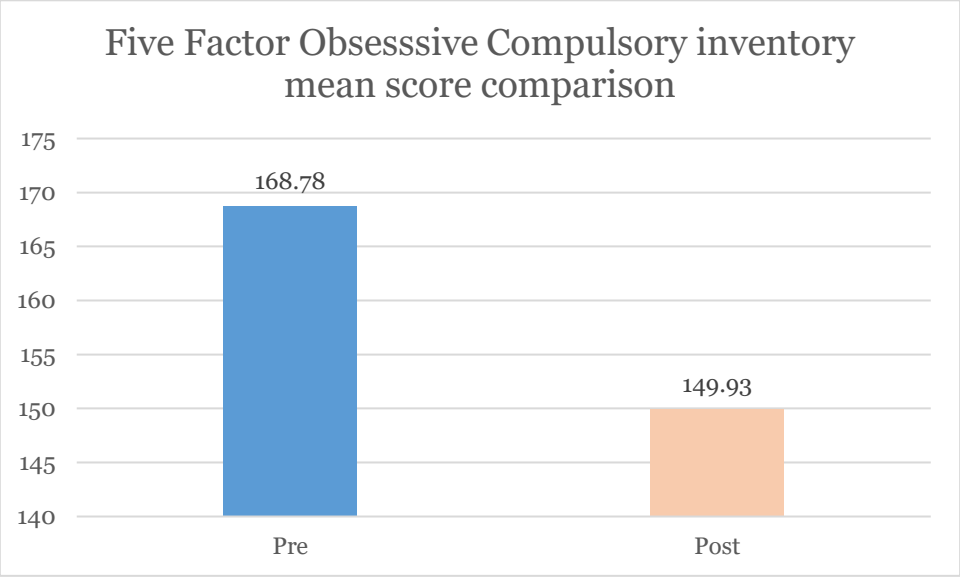
(strongly agree). The ERQ has been found to have high internal validity, and convergent and discriminant validity (Preece, Becerra, Robincon et al. 2019).

4.21.3. Results

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

A statistically significant change was observed on the FFOCI-SF, whereby t (36) = 5.98, p=0.00, reflecting a large effect size (Cohen's d = 0.). This suggests that after completing the programme participants were experiencing a reduction in overcontrolled traits associated with OCPD.

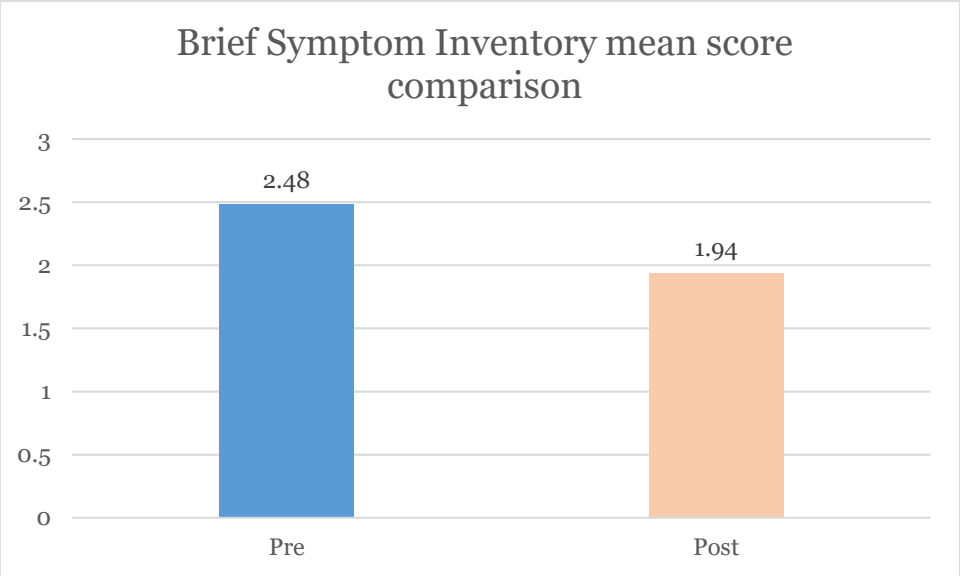
Figure 4. 126. *Pre and post total mean scores of Five Factor Obsessive Compulsive Inventory (Short Form) (FFOCI-SF)*



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 (36) = 5.79, p=.000 reflecting a large effect size (*Cohen's d*= 0.902).

Figure 4. 127. *Pre and post total mean scores of Brief symptom Inventory (BSI)*



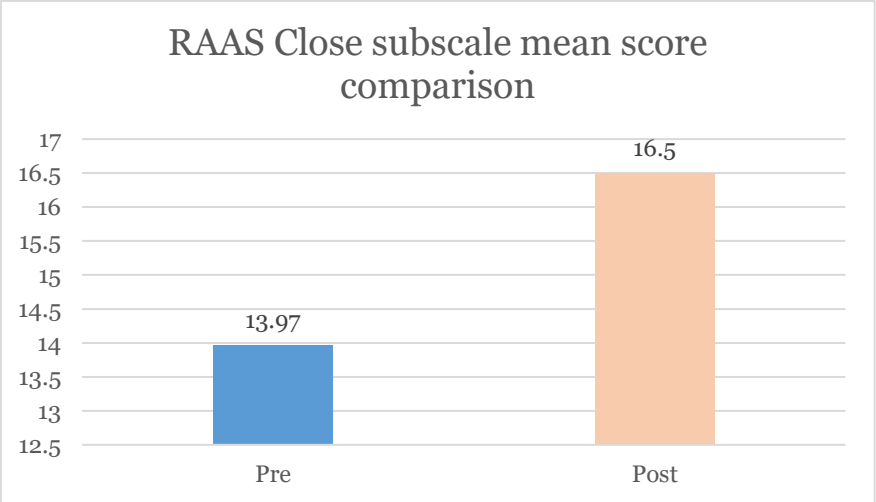
Revised Adult Attachment Scale – Close Relationships Version (RAAS)

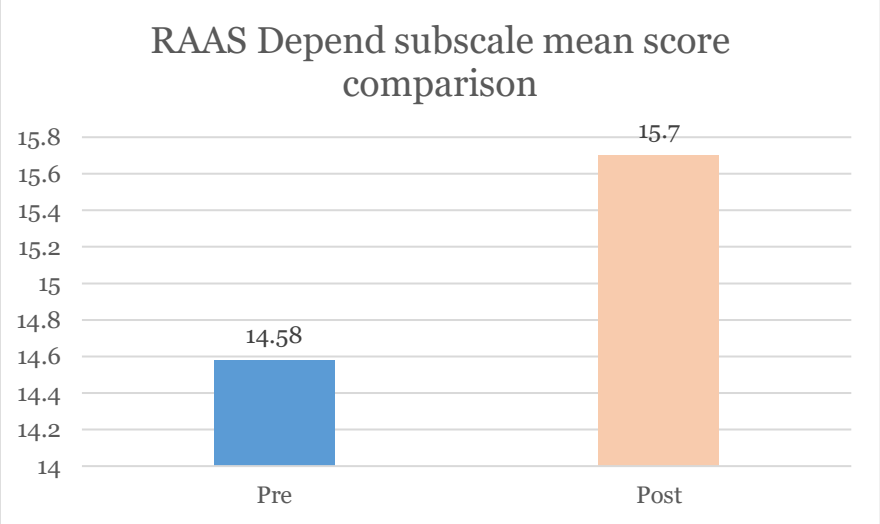
The Close subscale measures the extent to which a person is comfortable with closeness and intimacy. The Depend subscale measures the extent to which a person feels they can depend on others to be available when needed. The Anxiety subscale measures the extent to which a person is worried about being rejected or unloved.

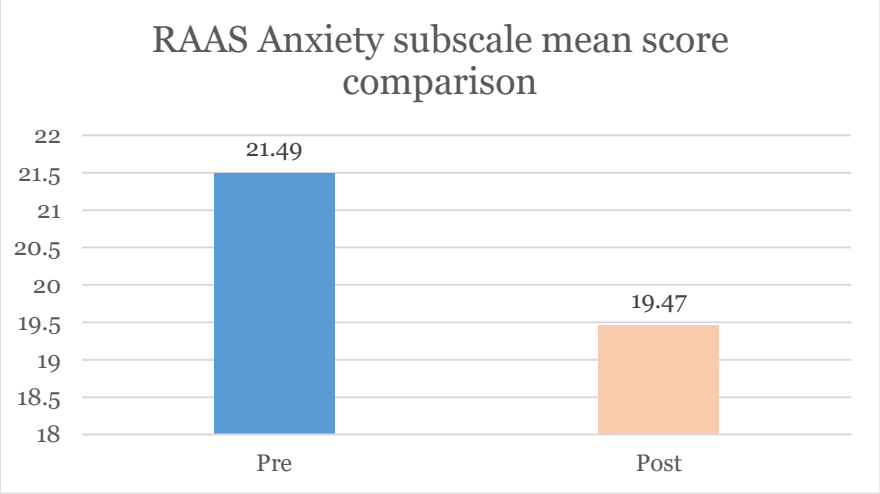
On the Close subscale, there was a statistically significant improvement pre and post-intervention (t (35) = -3.459, p = .001) reflecting a small effect size (*Cohen's d*= 0.593). On the Anxiety subscale, there was a statistically significant improvement pre and post-intervention, (t (36) =2.86, p = .007), reflecting a small effect size (*Cohen's d*= 0.34). On the Depend subscale, there were no statistically significant differences pre and post-intervention (t (35) = -1.44, p = .16).

These results show that participants felt more closeness in their relationships and less fear about being rejected or unloved post intervention. There were no significant results in the depend subscale suggesting that participants did not experience any change in how comfortable they felt depending on others to be available when needed post-intervention.

Figure 4. 128. *Pre and post mean scores of Revised Adult Attachment Scale – Close Relationships Version (RAAS) total and subscales*



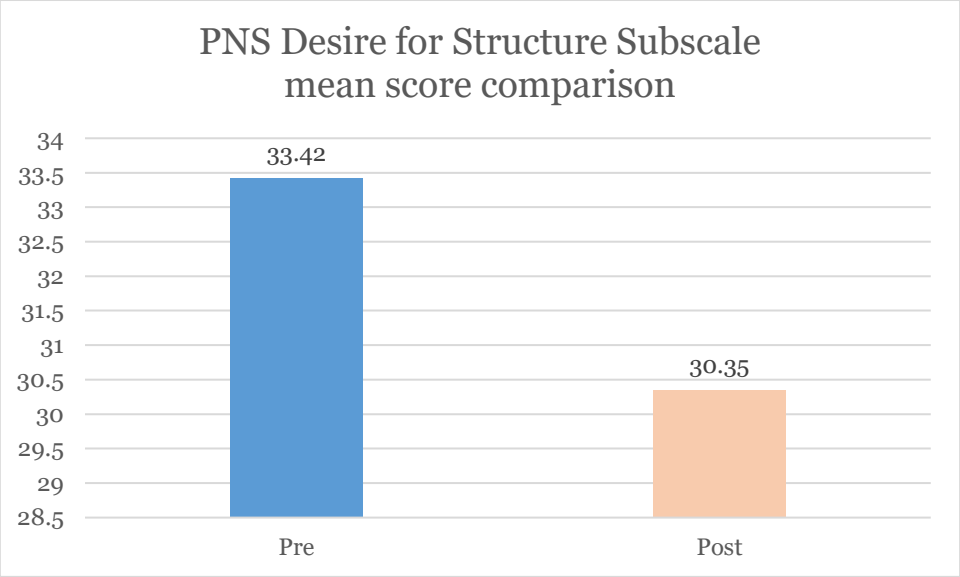




Personal Need for Structure Scale (PNS)

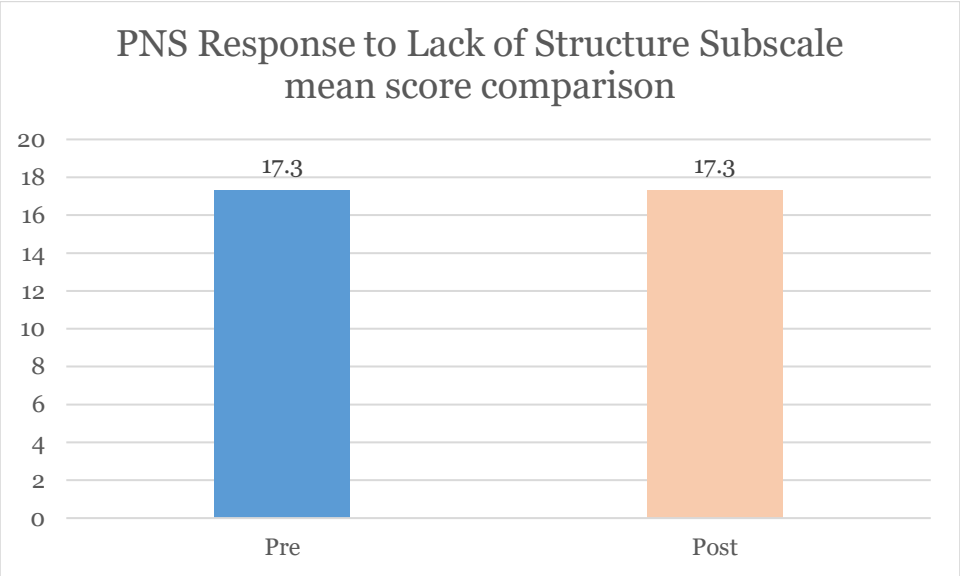
There was a statistically significant difference on the Desire for Structure subscale from pre to post-intervention t (36) = 3.27, p = .002, with a medium effect size (*Cohen's d*=0.515.) This indicates that participants' desire for structure in their daily lives reduced (indicating more flexibility) after completing the programme.

Figure 4. 129. *Pre and post total mean scores of Personal Need for Structure Scale (PNS)*



No statistically significant changes were found on the Response to Lack of Structure subscale, as no correlation or t-tests can be computed because the standard error difference between the pre and post-intervention was zero. These findings that are measured immediately after the programme indicate that participants did not report a change in their response to a lack of structure between pre and post-intervention. However, past research on the GRO programme has shown that there were significant changes in participant's response to lack of structure six months post completion of GRO (Egan, Long, McElvaney, & Booth, 2021). This indicates that improvements in flexibility occurred in the months following the programme, when service users had time to implement and embed their learning.

Figure 4. 130. *Pre and post mean scores of Personal Need for Structure Scale (PNS) subscale*



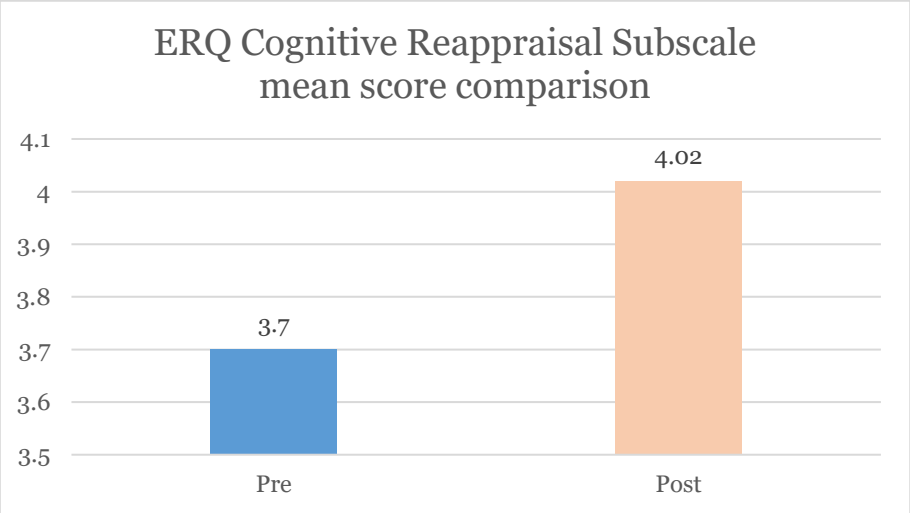
Emotion Regulation Questionnaire (ERQ)

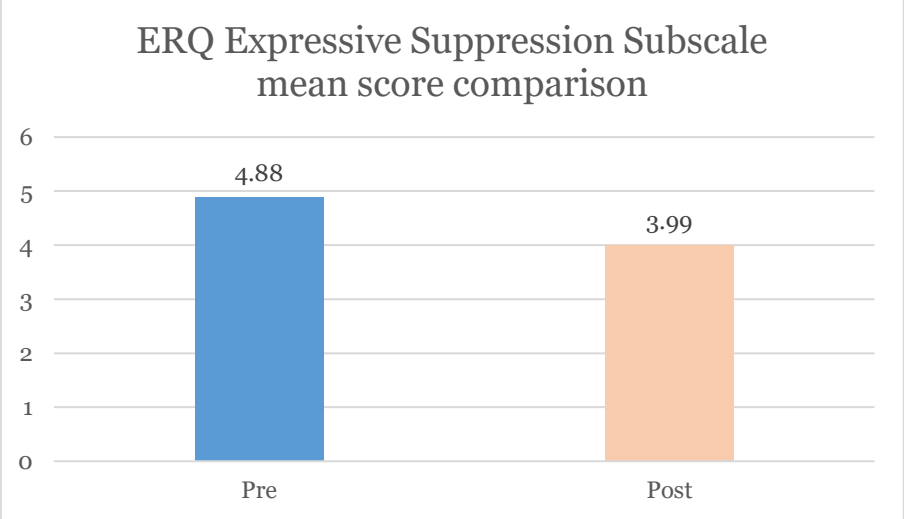
The ERQ consists of two subscales: Cognitive Reappraisal and Expressive Suppression.

On the Cognitive Reappraisal subscale, there was no significant change pre to post-intervention whereby t (36) = -1.47, p = 0.15. 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 (36) = 3.87, p= .000, with a medium effect size (Cohen's d= 0.67). This suggests that participants reported less suppression of their emotions following completion of the programme.

Figure 4. 131. *Pre and post mean scores of Emotion Regulation Questionnaire (ERQ) subscales*





4.21.4. 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 2023, service users who completed the GRO programme showed significant reductions in overcontrolled traits and reductions in overall psychological distress. Results also found that service users reported feeling closer and more connected to

people in their lives and less anxious about being rejected by others after completing the programme. There were significant changes in participant's desire for structure following completion of the programme indicating more flexibility in their lives. Service users also showed significant reductions in their suppression of emotions.

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

4.22. 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 and arts-based expression through art therapy. The programme is delivered by members of an MDT which includes a consultant psychiatrist, clinical nurse specialist, pharmacist, and art therapist. Of note, art therapy input was only available for a limited period this year from a student art therapist on clinical placement. 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.

4.22.1. Psychosis Recovery Programme outcome measures

- **Recovery Assessment Scale**

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability and quality of life. 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.

4.22.3. Descriptors

In 2023, complete pre and post-RAS scores were available for nine participants. Demographic data is presented for the 28 people who engaged in the programme in 2021. The average age of Psychosis Programme participants was 42.64 (SD = 14.30) years (ranging from 20 to 71 years). 50% were female (n = 14) and 50% were male (n= 14). 67.9% were single, 10.7% married, 3.6% were cohabiting with a partner, 3.6% were separated and 3.6% were divorced. 32.1% were in employment, 3.6% worked in the home, 7.1% were unemployed, 7.1% were students, 39.3% were receiving disability allowance and 7.1% were retired.

46.4% were living with family, 28.6% were living alone, 3.6% were homeless and 10.7% were cohabiting.

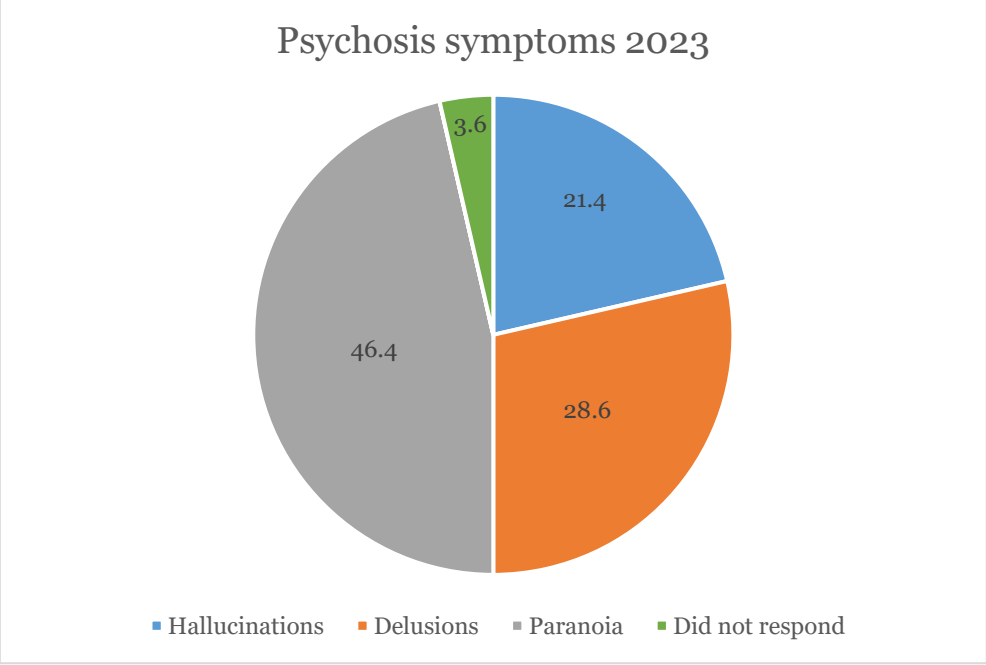
Regards of highest level of education attained indicated that 7.1% had completed the Junior Certificate, 28.6% had completed the Leaving Certificate, 21.4% had a non-degree third level qualification and 25% had a third level degree. 92.9% of service users reported their ethnicity as white Irish, 3.6% as any other white background and 3.6%

as African. Comparing 2022 to 2023, service users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

In 2022, there was a decrease in service users reporting that delusions were the primary psychosis experience. This has continued in 2023. There has also been a decrease in the reported primary experience of hallucinations, negative symptoms and thought disorders. However, there has been a marked increase in the reported primary experience of paranoia. In 2022, the primary reported symptoms were delusions (29.4%) and paranoia (26.5), followed by hallucinations (26.5%), and negative symptoms (5.9%). 11.8% of participants did not provide an answer on primary symptoms in 2022.

In 2023, primary reported symptoms data was available for 28 service users. The primary reported symptoms were paranoia (46.4%), delusions (28.6%) and hallucinations (21.4%). 3.6% of participants did not provide an answer on primary symptoms. See graph below for reported primary psychosis symptoms in 2023. The average attendance at sessions per service user in 2023 was 5.78 (SD = 3.95). Participants are permitted to attend multiple cycles of the programme.

Figure 4. 132. *Primary psychosis symptoms 2023*



4.22.4. Results

Recovery Assessment Scale (RAS)

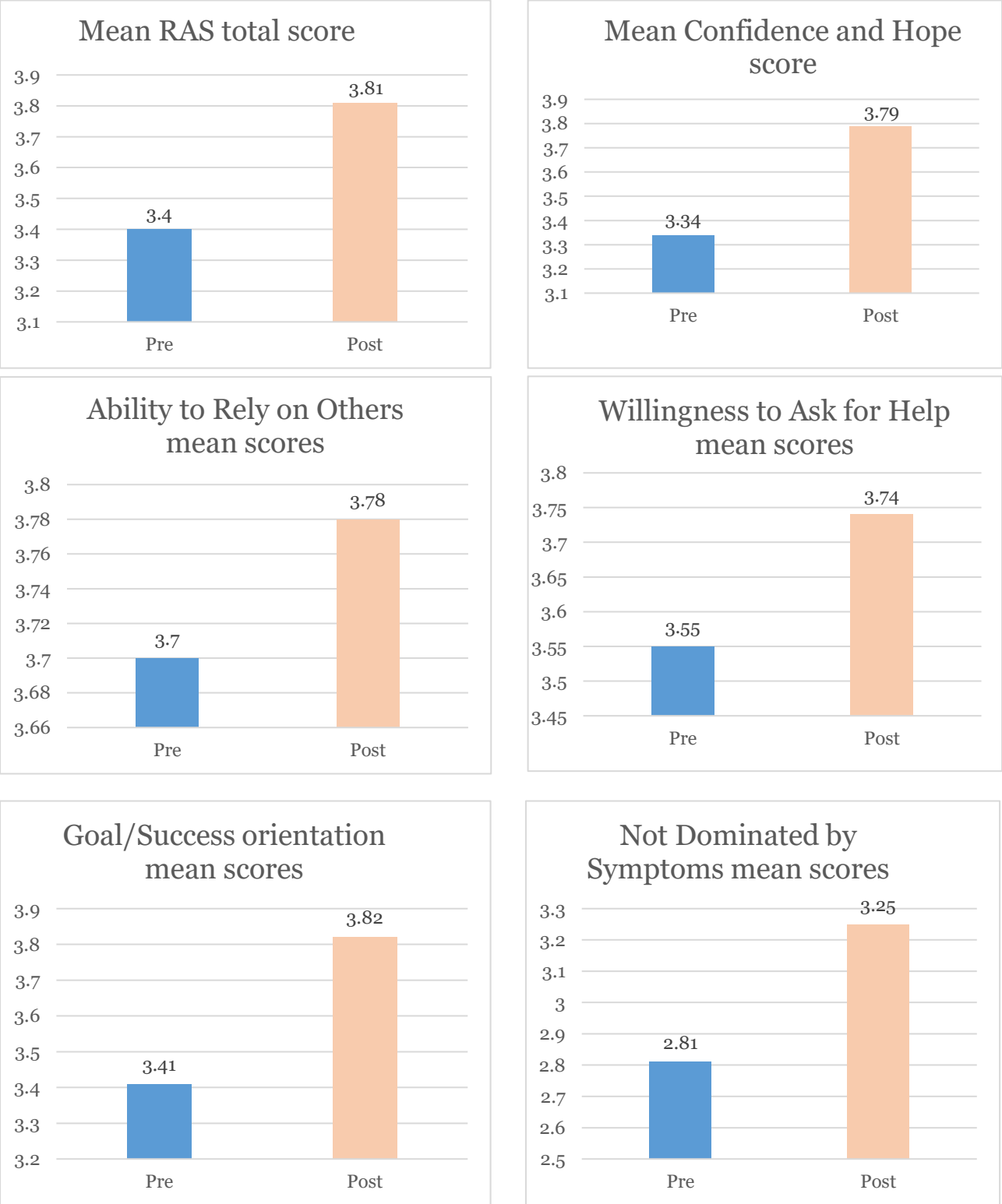
A paired samples t-test identified a statistically significant difference in mean total scores for the RAS from pre-intervention (M = 3.40; SD = 1.08) to post-intervention (M = 3.81; SD = 1.13), t (8) = -3.10, $p < 0.05$ with a small to medium effect size (d = 0.37). This indicates that overall, service users experienced an increase in coping ability and quality of life following completion of the programme.

Higher mean scores were identified post-intervention for services users on all RAS subscales, however none of these subscale increases were statistically significant. 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 outline test statistics and figures in mean differences for pre- and post-intervention.

Table 4.18: *Recovery Assessment Scale (RAS) mean differences for pre and post-intervention*

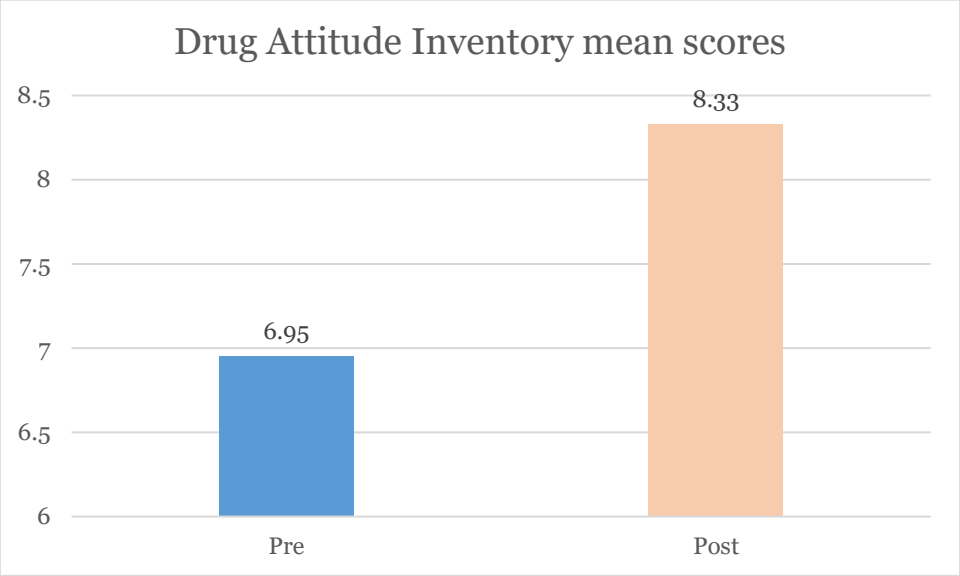
RAS	Pre mean	Post mean	*p*
Mean total	3.40	3.81	0.02
Confidence and hope	3.34	3.79	0.08
Willingness to ask for help	3.55	3.74	0.52
Goal/success orientation	3.41	3.82	0.08
Ability to rely on others	3.70	3.78	0.55
Not dominated by symptoms	2.81	3.25	0.12

Figure 4. 133. *Pre and post mean scores of Recovery Assessment Scale (RAS) total and subscales*



Pre and post DAI scores were available for nine service users. A paired samples t-test identified an increase in mean scores on the DAI-10 from pre-intervention (M = 6.95, SD= 2.29) to post-intervention (M = 8.33; SD = 3.11); t (8) = 2.79, p < 0.05, demonstrating a medium effect size (d = 0.51). The mean scores indicate that the majority of service users who completed the measures reported more positive views towards medication after completing the programme.

Figure 4. 134. *Pre and post mean scores* of Mean Drug Attitude Inventory (DAI)



4.22.5. Summary

Analysis of data from this programme has consistently suggested benefits for service users. It is worth noting that the small sample sizes may have influenced the lack of statistical significance in the analyses above. Due to the nature of service users presenting difficulties many service users do not fully complete pre and post outcome measures which contributed to the small sample size reported above. 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.

4.23. SAGE Older Adults Psychology Skills Group

SAGE is a psychological therapy group for older adults who are experiencing difficulties with anxiety and/or depression and are interested in applying a psychological approach to their difficulties. The group is adapted from psychological theories based on emotional regulation and emotional over-control (Lynch 2018; Booth & Egan, 2023), 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. The SAGE programme incorporated a hybrid mode of attendance in 2023, whereby a large television screen was used to allow service users to join in-person groups remotely when they were occasionally unable to attend in-person, usually for physical health reasons.

4.23.1 Descriptor

Eight people completed the programme in 2023, seven of whom were female (87.5%), and one of whom were male (12.5%). Programme attendees ranged in age from 65 to 78 years old, with a mean of 72 (*SD* = 4.81). Pre and post data was available on the measures below for all eight participants. There were no missing items in any of the measures completed in 2023.

4.23.2. 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.

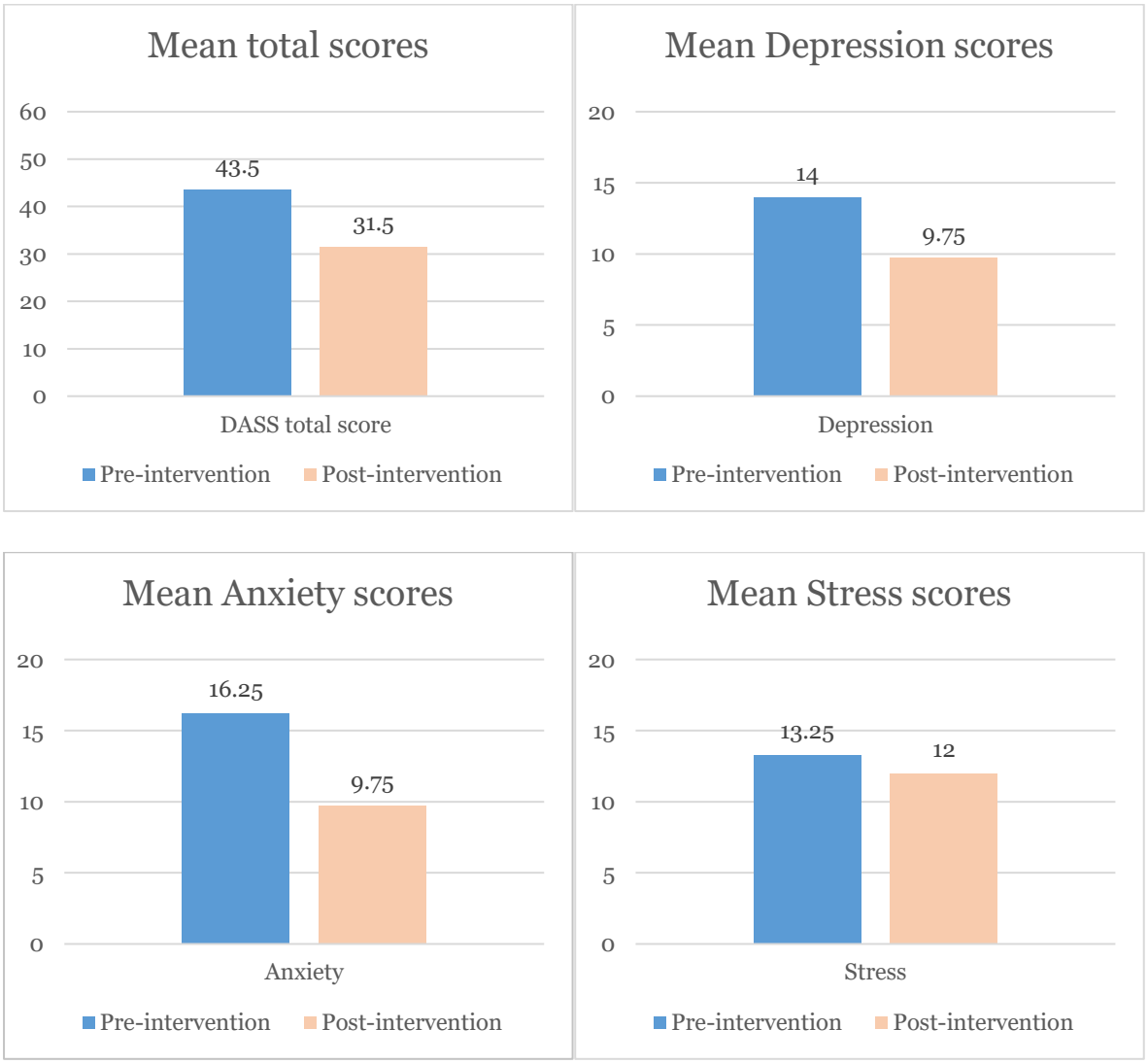
4.23.3. Results

Due to the small sample size, statistical significance could not be determined for changes in scores pre to post-intervention. Means and individual scores are displayed instead, with the exception of further analysis of the DASS-21 scores. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

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 43.5 (*SD* = 17.26) to 31.5 (*SD* = 10.68) at post-intervention. Scores on the Depression subscale showed a decrease from 14 (*SD* = 8.14) to 9.75 (*SD* = 5.60), and on the Stress subscale from 13.25 (*SD* = 6.45) to 12 (*SD* = 4.78). Scores on the Anxiety subscale also decreased from 16.25 (*SD* = 12.58) to 9.75 (*SD* = 4.33), see graphs below.

Figure 4. 135. *Pre and post mean* scores of Depression Anxiety and Stress Scale (DASS-21) total and subscales



Total scores on the DASS-21 decreased for four out of eight participants (50%) post-intervention. Five out of eight participants (62.5%) reported reduced anxiety and depression scores at the end of the intervention, while three out of eight participants reported reduced stress (27.5%) scores post-intervention. Please see the graphs below for visual representation of changes in individual scores from pre to post intervention.

Figure 4. 136. *Pre and post individual total mean* scores of Depression Anxiety and Stress Scale (DASS-21)

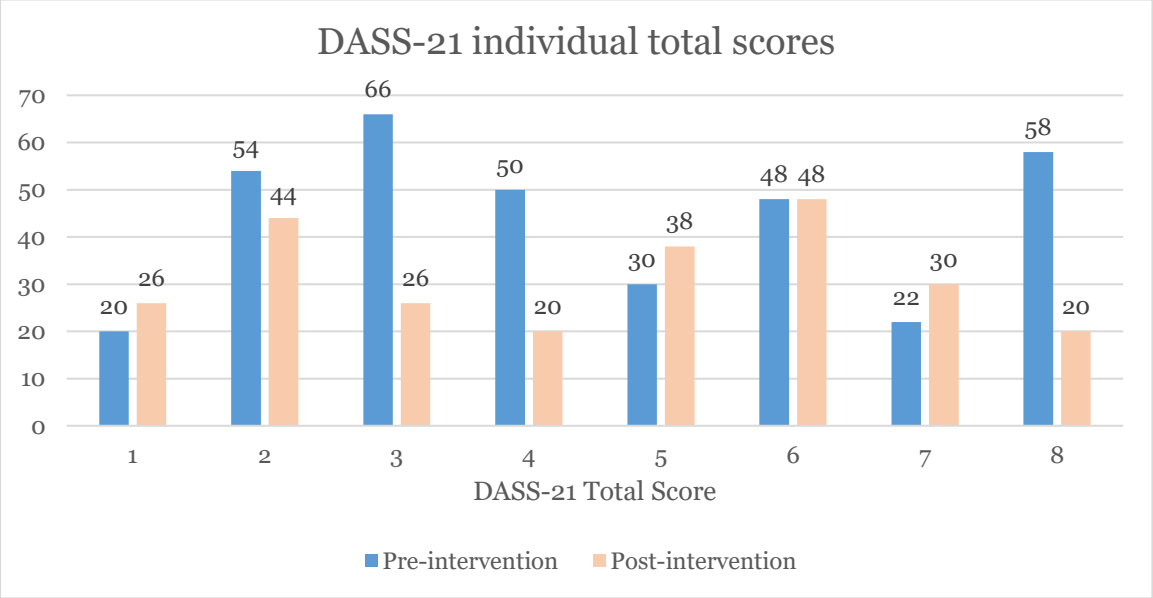
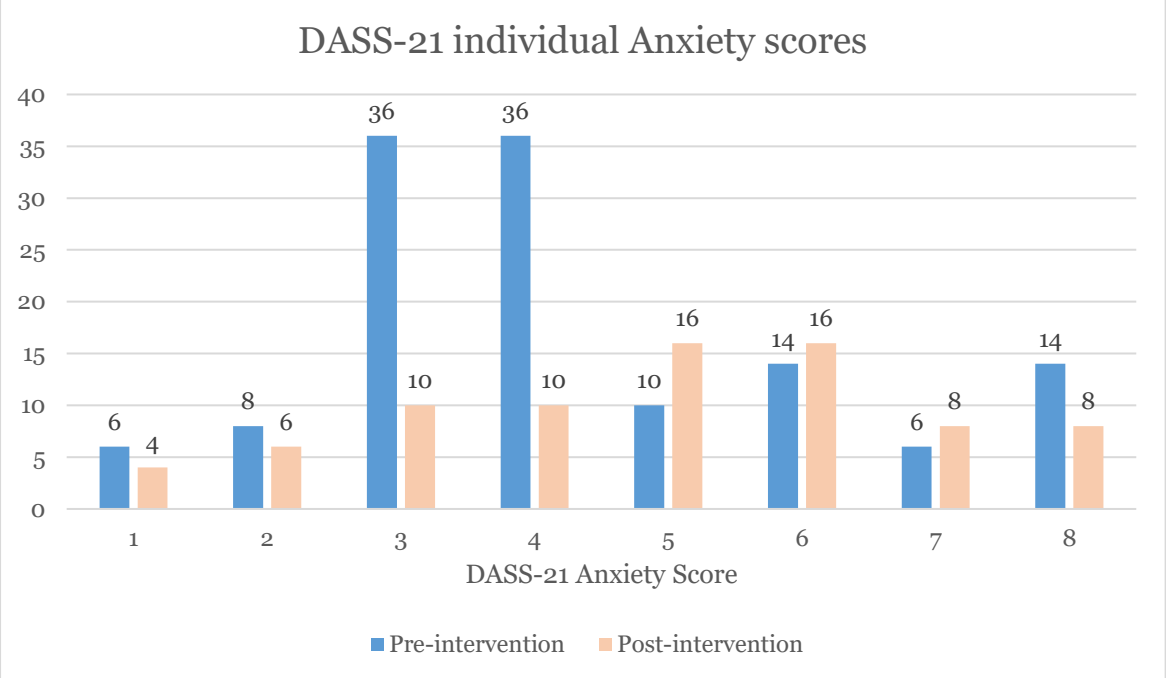
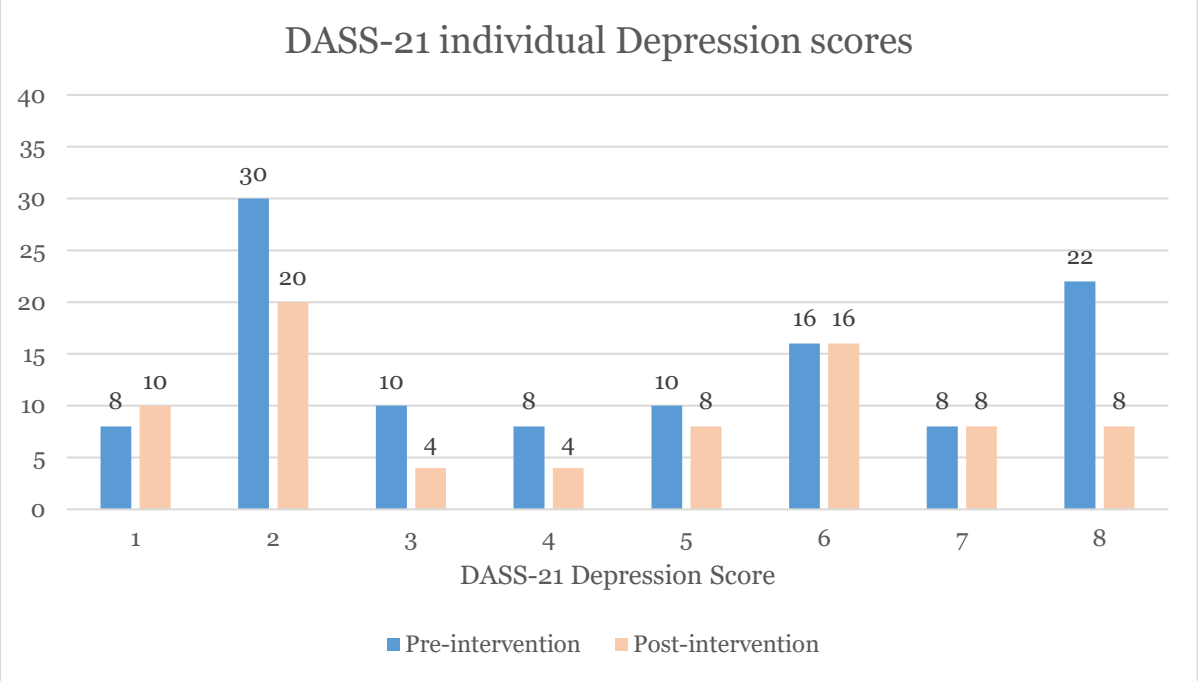
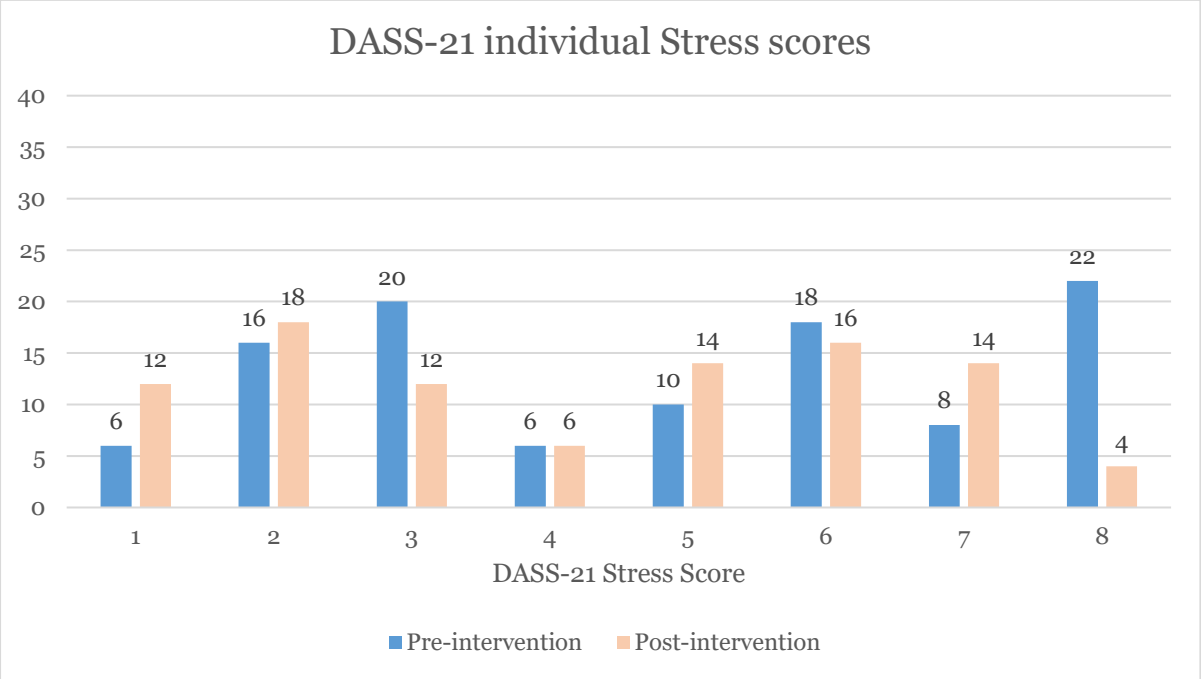


Figure 4. 137. *Pre and post individual mean* scores of Depression Anxiety and Stress Scale (DASS-21) subscales







Due to the small sample size, changes in total DASS scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in DASS scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The cut-off score indicating clinically meaningful improvement on

the DASS for this sample was calculated to be 34. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and DASS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below DASS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in the table below, five participants (62.5%) reported uncertain change, while three participants (37.5%) reported reliable and clinically significant improvement.

Table 4.19: *Results from Reliable Change Index (RCI) for the DASS-21 pre and post scores for each group member*

DASS-21 = Depression, Anxiety and Stress Scale

Participant	Pre score	Post score	RCI value	Category
1	20	26	.83	Uncertain Change
2	54	44	-1.38	Uncertain Change
3	66	26	-5.53	Clinically Significant Improvement
4	50	20	-4.15	Clinically Significant Improvement
5	30	38	1.11	Uncertain Change
6	48	48	0	Uncertain Change
7	22	30	1.11	Uncertain Change
8	58	20	-5.26	Clinically Significant Improvement

Personal Need for Structure (PNS)

The mean scores on the PNS decreased from 52.25 (*SD* = 8.46) at pre-intervention to 49.63 (*SD* = 7.32) at post-intervention, see graph below. Five out of eight participants (62.5%) reported a greater ability to manage novel situations, which in this context is

interpreted as evidence of greater flexibility, having completed the intervention. Individual scores are displayed in a further graph below.

Figure 4. 138. *Pre and post mean* scores of *Personal Need for Structure (PNS)*

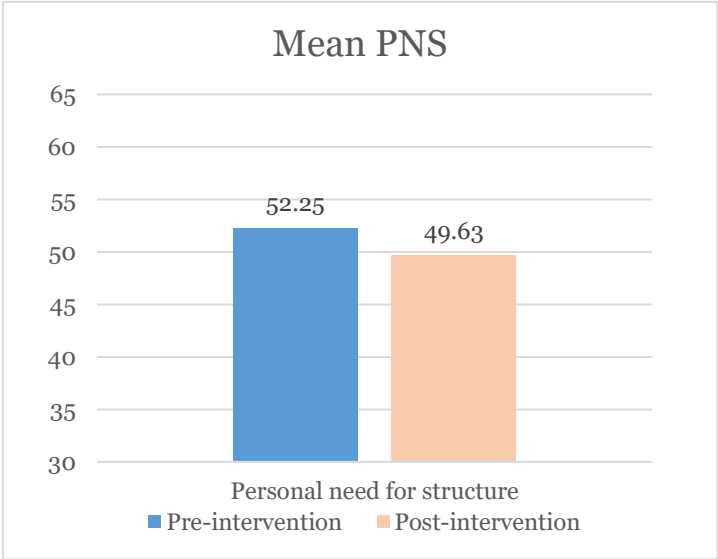
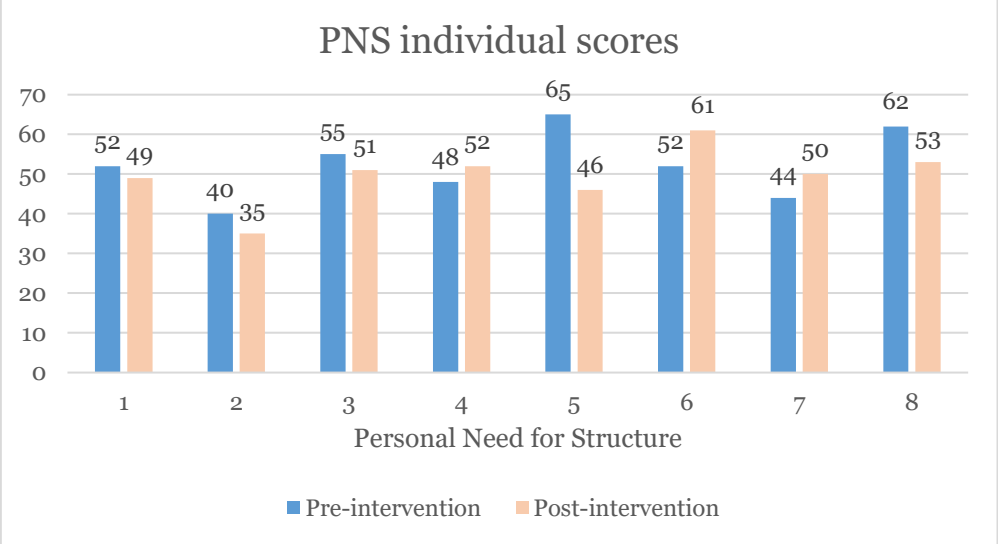


Figure 4. 139. *Pre and post individual mean* scores of *Personal Need for Structure (PNS)*



Emotion control questionnaire – Emotional inhibition (ECQ-EI)

The total mean score on the ECQ-EI showed a decrease from 7.25 (*SD* = 2.60) at pre-intervention to 6.13 (*SD* = 2.75) at post-intervention, graph below. Individual scores are displayed in a further graph, with five out of eight participants (62.5%) endorsing decreased levels of emotional inhibition and suppression.

Figure 4. 140. *Pre and post total mean* scores of *Emotional Inhibition subscale (ECQ-EI)*

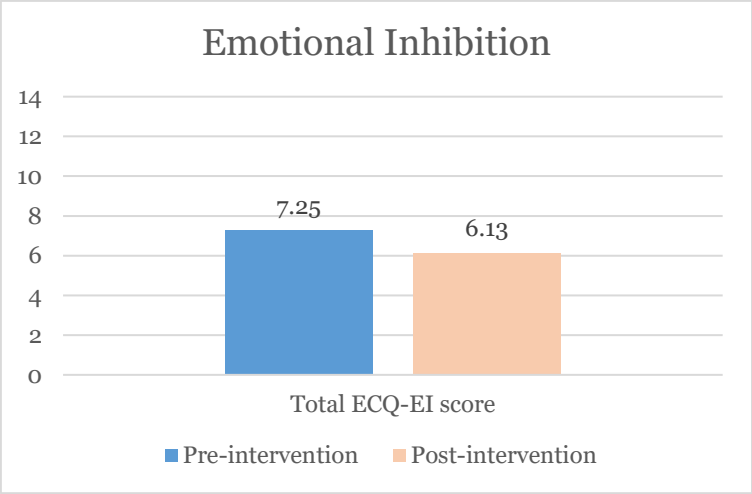
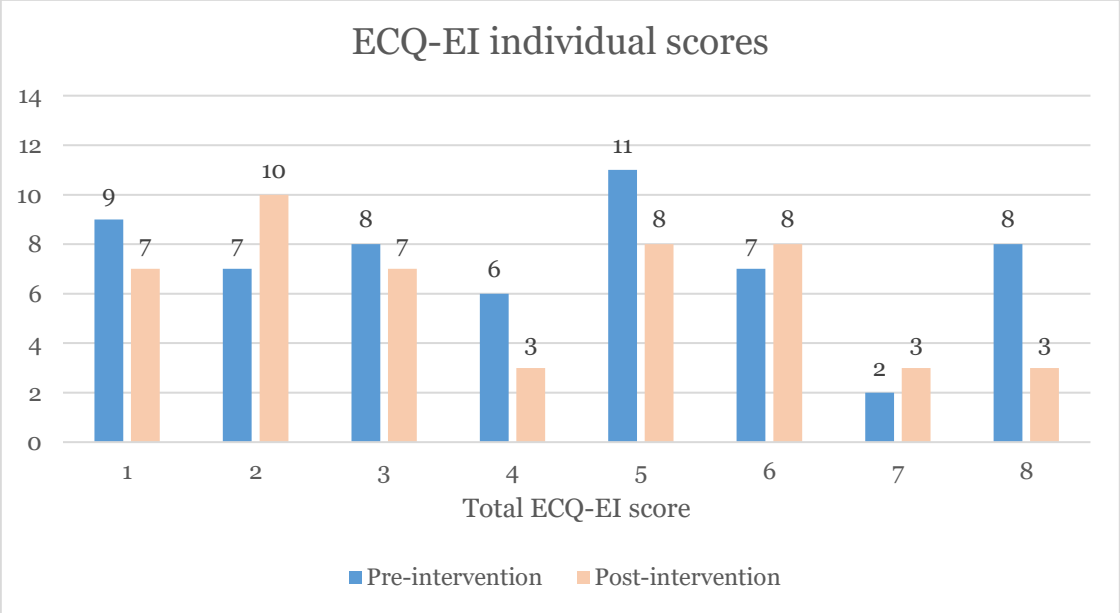


Figure 4. 141. *Pre and post individual mean* scores of *Emotional Inhibition subscale (ECQ-EI)*



Revised Adult Attachment Scale (RAAS)

Mean scores on the Closeness subscale remained unchanged from a mean of 18.75 both pre-intervention (*SD* = 3.99) and post-intervention (*SD* = 4.43), see graphs below. Mean scores on the Anxiety levels were found to increase from 16.88 (SD = 7.06) to 18.5 (SD = 5.88) at post-intervention, with one outlier noted, see graph below. Mean scores on the Dependency subscale increased from a mean of 15.25 (*SD* = 3.01) to 16.38 (*SD* = 3.25), see further graph below for individual scores on these subscales.

Figure 4. 142. *Pre and post mean* scores of *Revised Adult Attachment Scale (RAAS) Closeness Subscale*

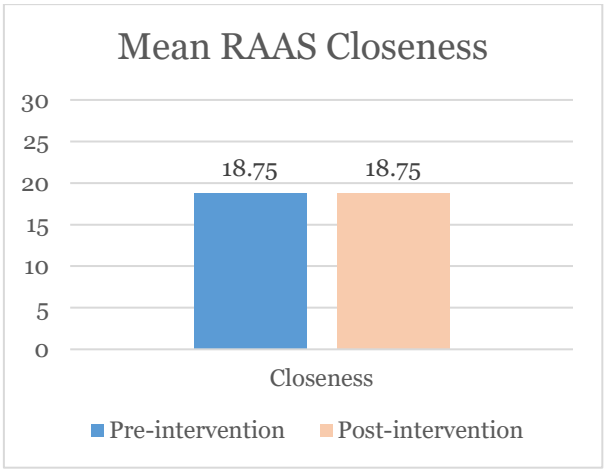


Figure 4. 143. *Pre and post mean* scores of *Revised Adult Attachment Scale (RAAS) Anxiety and Dependency Subscales*

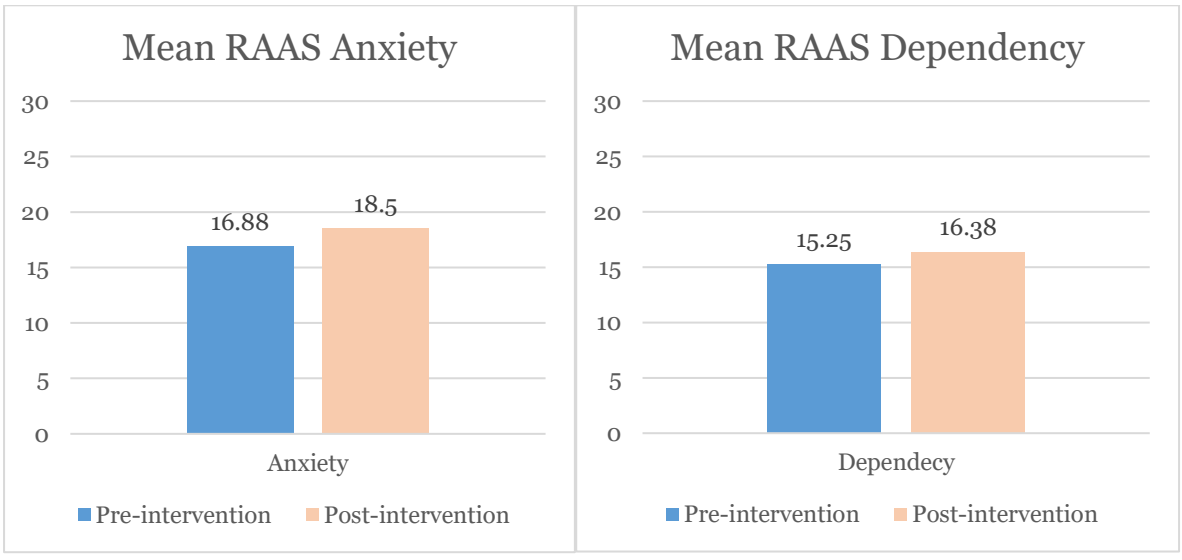
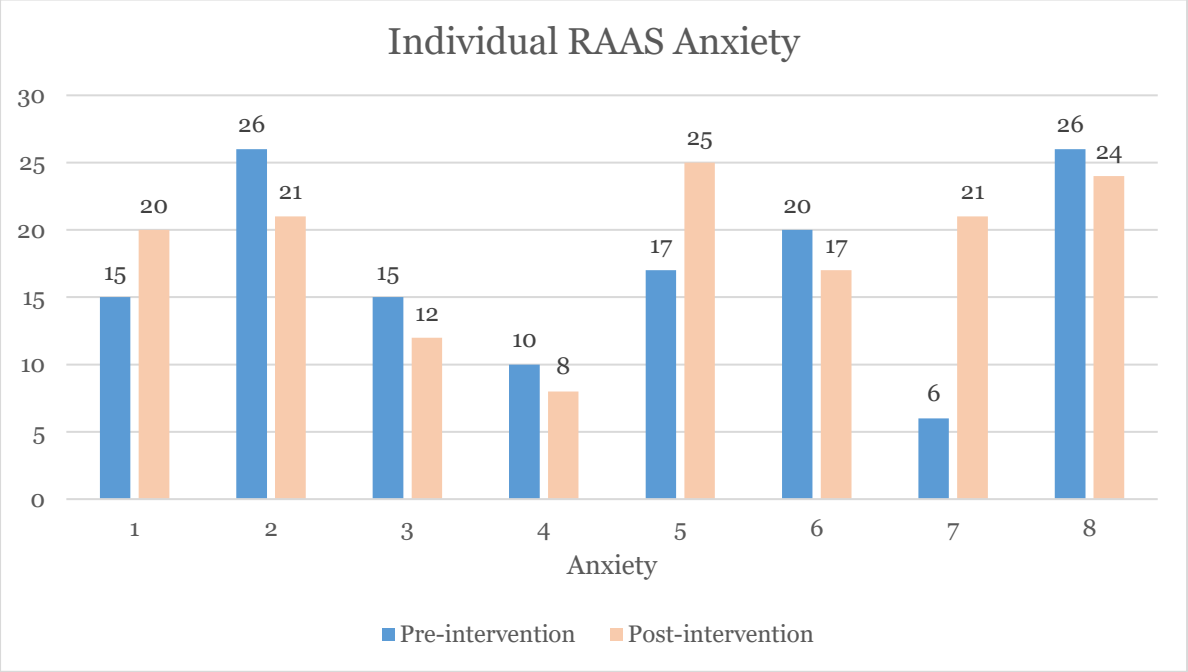
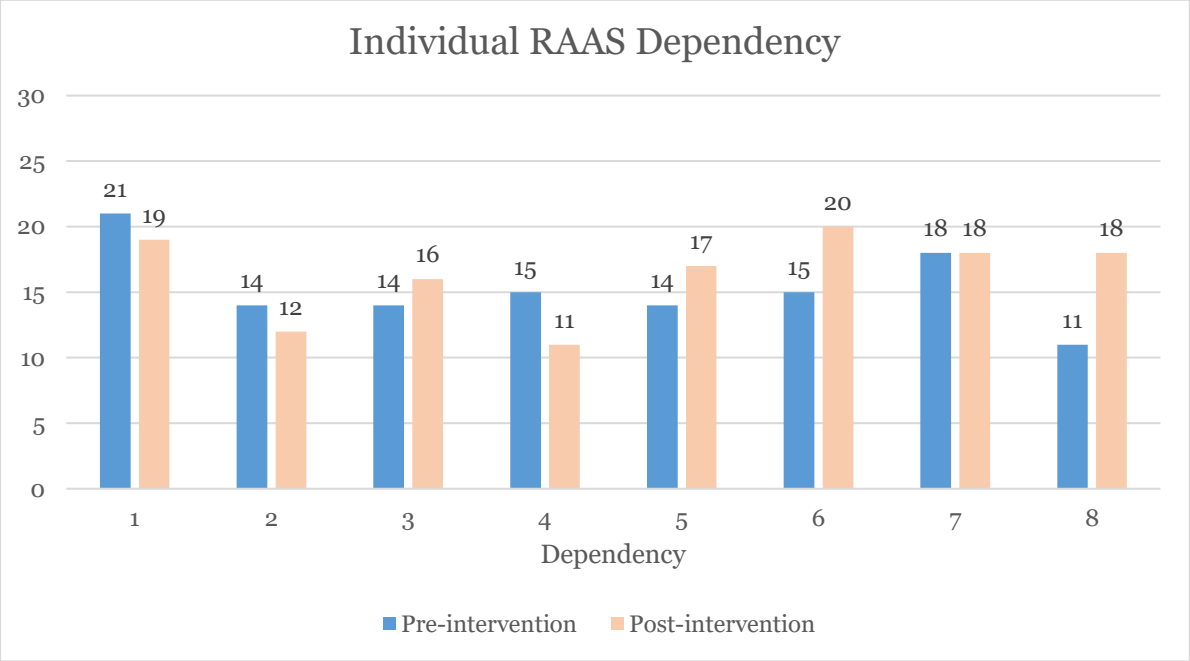


Figure 4. 144. *Pre and post individual* scores of *Revised Adult Attachment Scale (RAAS) Anxiety Subscale*



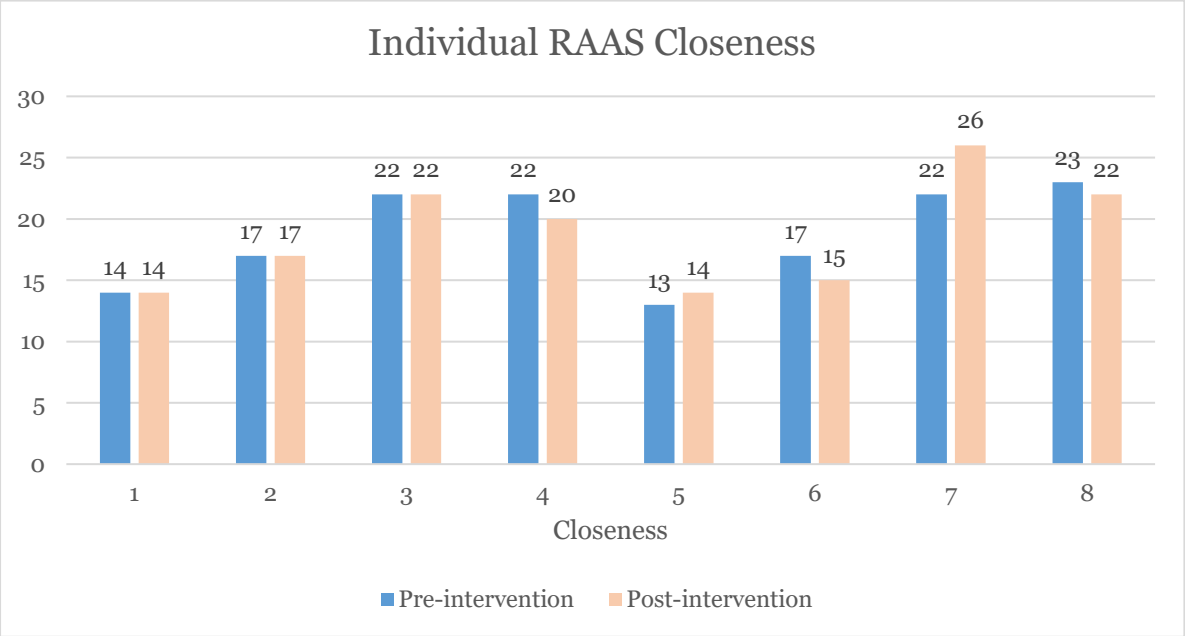
Five out of eight participants (62.5%) reported less anxiety meaning less fear of rejection having completed the intervention. Please see graph directly above for visual representation.

Figure 4. 145. *Pre and post individual* scores of *Revised Adult Attachment Scale (RAAS) Dependency Subscale*



Four out of eight participants (50%) endorsed greater comfort with closeness and intimacy in everyday life, having completed the intervention. Please see graph directly above for visual representation.

Figure 4. 146. *Pre and post individual scores of Revised Adult Attachment Scale (RAAS) Closeness Subscale*

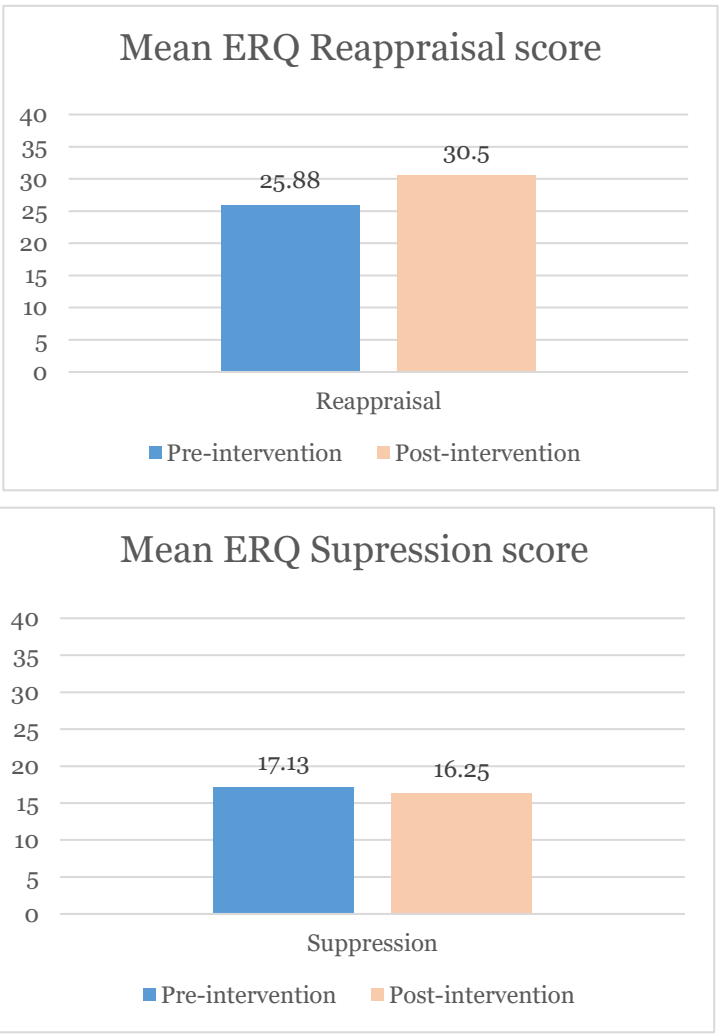


Just two out of eight participants (25%) reported greater comfort with closeness in everyday life after completing the intervention, as shown in the graph directly above.

Emotion Regulation Questionnaire (ERQ)

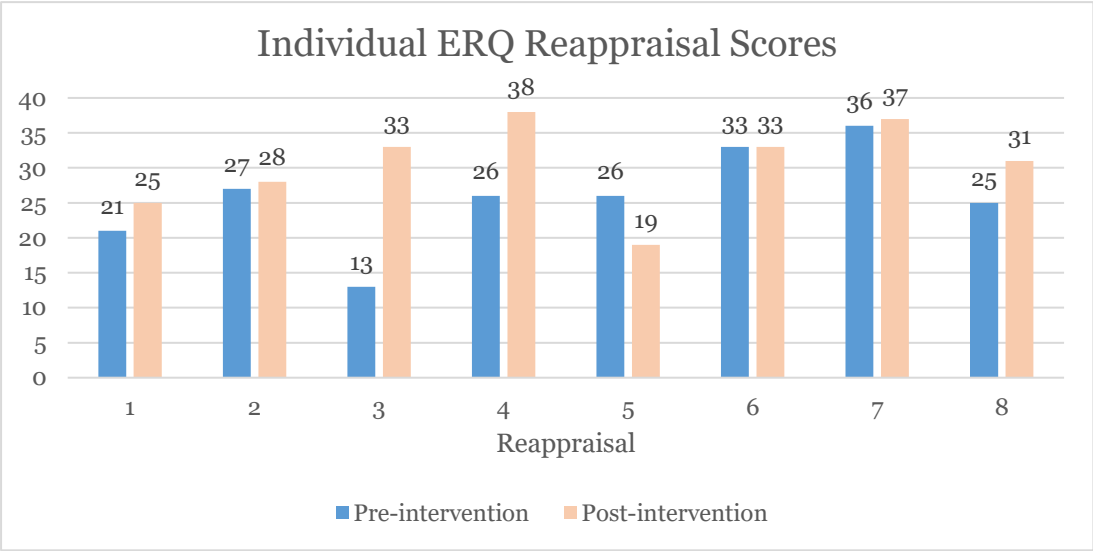
The mean score for reappraisal increased from 25.88 (SD= 7.02) at baseline to 30.50 (SD= 6.32) post-intervention. Expressive suppression, which describes the ability to control or suppress the urge to respond to emotional experiences, decreased from a mean of 17.13 (*SD*= 4.73) to 16.25 (*SD*= 6.32). Mean and individual scores for these subscales are displayed in graphs below.

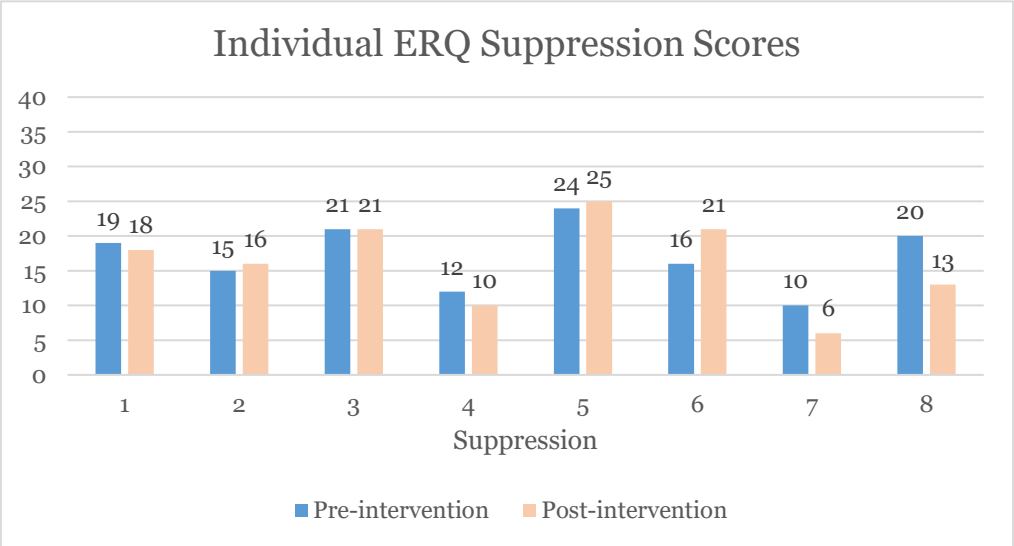
Figure 4. 147. *Pre and post mean scores of Emotion Regulation Questionnaire (ERQ) Reappraisal and Suppression subscales*



Six out of eight participants (75%) reported increased use of reappraisal as a strategy for managing difficult emotional experiences having completed the intervention, as shown in the graph below. Four out of eight participants (50%) reported less use of suppression as a coping strategy for difficult emotional experiences having completed the intervention, also shown in the graphs below.

Figure 4. 148. *Pre and post individual scores of Emotion Regulation Questionnaire* (ERQ) *Reappraisal and Suppression subscales*





4.23.4. Summary

Most measures in the battery of outcome measures indicate positive changes endorsed by most service users in the areas targeted by the programme: emotional expression, psychological flexibility and closeness and intimacy in relationships. The overall reductions in mental health symptomatology as measured by the DASS-21 suggest that the programme is having a positive impact on the mental health of older adult participants. 19 cycles of Sage have been completed up to 2023. This year saw the welcome introduction of the hybrid screen technology, which allowed for a far better online experience for service users who occasionally needed to attend remotely, usually for physical health reasons.

4.24. 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 practise (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. The programme was run all in person in 2023.

4.24.1. Descriptors

A total of eight people who were referred completed cycle six of the Trauma programme in 2023. Eight participants returned pre and post outcome measures. Six of the participants were female and two were male. Participant's ages ranged from 23 years to 59 years (M= 44.38, SD= 12.18). Pre-treatment completion of the Adverse Childhood Experience (ACEs) indicated that 7 out of 8 returned ACEs measures scored four and above, with two participants scoring 4; one participant scoring 5; two participants scoring 6 and two participants scoring 7. The higher the ACE score the more at risk the client is to chronic health problems, mental health difficulties, social difficulties, and substance misuse in adulthood.

4.24.2. Trauma Group Programme outcome measures

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

The PTSD Checklist is a 20-item self-report checklist of post-traumatic stress disorder (PTSD) symptoms based closely on the DSM-5 criteria (PCL-5; Lang & Stein, 2005). Service users rate each item from 0 – 'not at all', to four – 'extremely', to indicate the degree to which they have been impacted by that symptom over the past month. The

PCL has demonstrated strong psychometric properties. Estimates of internal consistency (Cronbach's alpha) range between 0.94 (Blanchard et al, 1996) to 0.97 (Weathers et al. 1993). Test-retest reliability has been reported as .96 at two to three days and 0.88 at one week (Blanchard et al.,1996; Ruggiero et al.,2003). Higher scores indicate higher experiencing of PTSD symptoms. A cut-off raw score of 38 indicates a provisional diagnosis of PTSD. This cut-off has high sensitivity (.78) and specificity (.98) (Cohen et al., 2015). When used to track symptoms over time, a minimum 10-point change represents clinically significant change.

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

The Dissociative Experiences Scale- Taxon (DES- T) (Bernstein and Putnam, 1986) is an 8- item self- report sub scale 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 1 – 'totally disagree', to 7 – 'totally agree'. The measure consists of three subscales measuring negative cognitions about self, negative cognitions about the world and self-blame. Higher scores indicate higher post-traumatic cognitions. This scale has been normed using three categories of individuals; a non-traumatised population, a traumatised population without PTSD and a traumatised population with PTSD. The median score for the non-traumatised group was 45.5, for the traumatised group without PTSD was 49 and for the traumatised group with PTSD the median score was 133.

- **Compassionate Engagement and Action Scales**

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

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

4.24.3. Results

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 57 participants would have been required to detect a medium effect size (Cohen's d=0.5). Therefore, for each measure individual results for the eight participants who returned both pre and post measures are given to reflect the outcome of the intervention.

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

There was a decrease in total PTSD scores for the PCL-5 checklist from pre-intervention (M = 47.63 SD = 15.43) to post-intervention (M = 24.5, SD= 16.49) This finding indicates that those who completed the trauma programme in 2023 had t reduction in PTSD symptoms post-intervention.

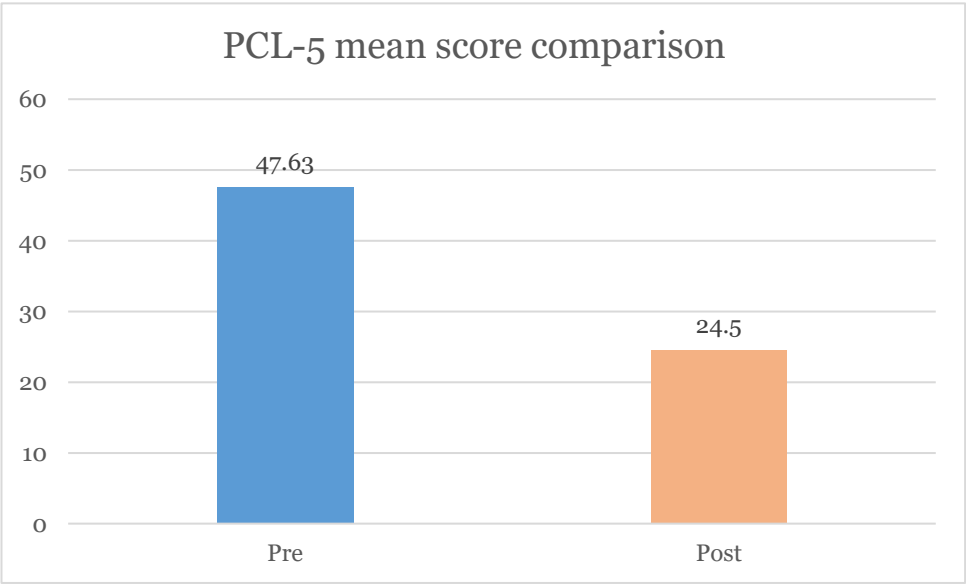
Due to the small sample size, changed in the PCL scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in PCL-5 scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The cut-off score indicating clinically meaningful improvement on the PCL-5 was 33. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and PCL-5 score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below PCL-5 cut-

off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased).

Table 4.20: *Results from Reliable Change Index (RCI) for the PCL-5 pre and post scores for each group member*

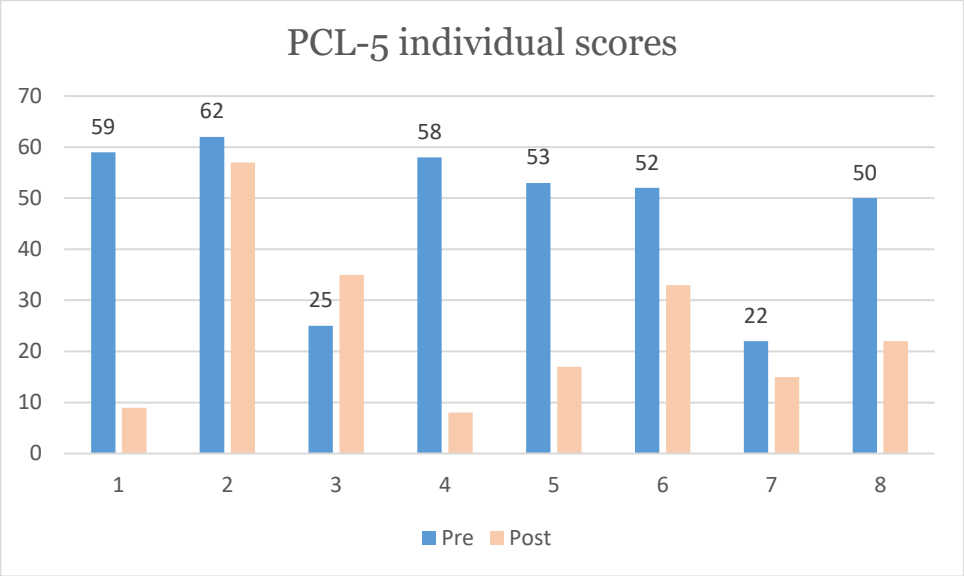
Participant	Pre score	Post score	RCI value	Category
1	59	9	-6.32	Clinically meaningful improvement
2	62	57	-0.63	Uncertain Change
3	25	35	1.26	Deterioration
4	58	8	-6.32	Clinically meaningful improvement
5	53	17	-4.55	Clinically meaningful improvement
6	52	33	-2.4	Reliable Improvement
7	22	15	-0.88	Uncertain change
8	50	22	-3.54	Clinically meaningful improvement

Figure 4. 149. *Pre and post mean scores of Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5)*



As can be seen from the below graph, further examination of the individual scores indicates that five out of eight participants (62.5%) demonstrated a clinically significant reduction in PCL scores from pre-intervention to post-intervention (10 points or greater). In addition, five participants (62.5 %) have moved from meeting criteria for a provisional diagnosis of PTSD pre-intervention (cut off score 33 or higher) to no longer meeting criteria post intervention.

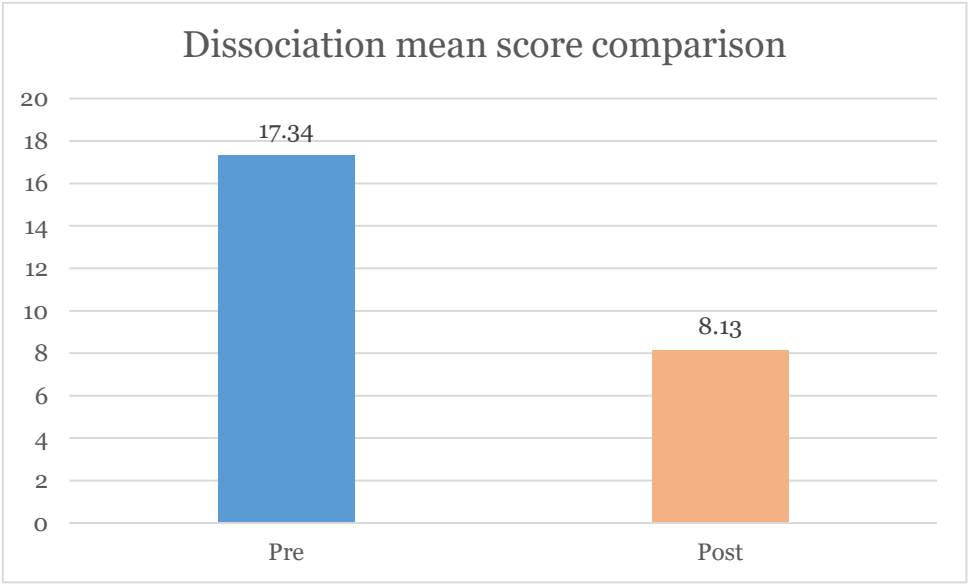
Figure 4. 150. *Pre and post individual scores of Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5)*



The Dissociative Experiences Scale-Taxon (DES- T)

The total dissociation mean scores for 2023 pre-intervention (M = 17.34; SD = 13.96) to post-intervention (M = 8.13; SD = 13.96). There shows a decrease in mean total dissociation scores from pre to post intervention (see graph below).

Figure 4. 151. *Pre and post mean scores of the Dissociative Experiences Scale- Taxon (DES- T)*

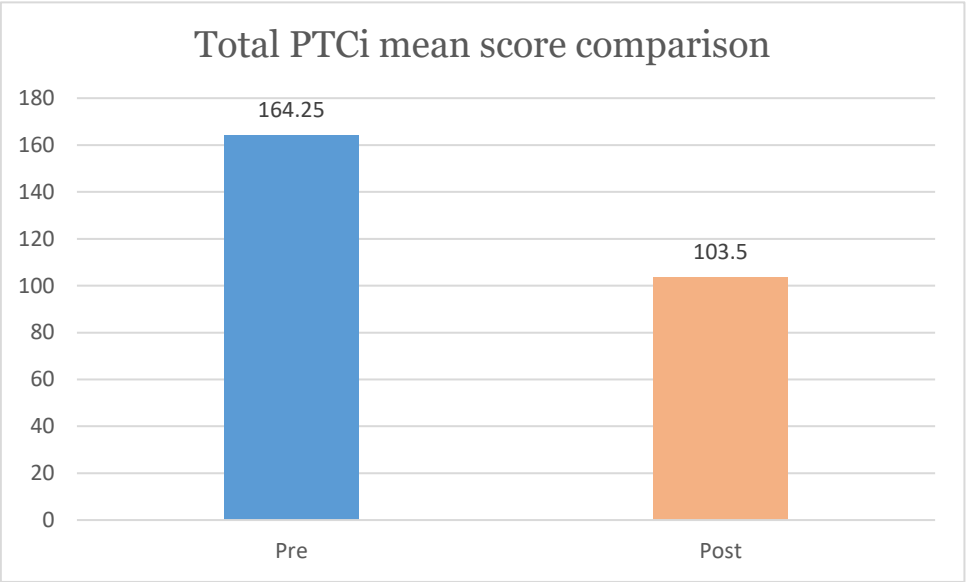


The Post Traumatic Cognitions Inventory (PTCI)

There was a decrease in total PTCI scores from pre-intervention (*M* = 164.25; *SD* = 29.22) to post-intervention (*M* = 103.5; *SD* = 35.43). This finding indicates that eight of out eight participants who completed the programme in 2023 had a reduction in post-traumatic cognition symptoms post-intervention (see table below).

Further examination of individual total PTCI scores indicates that six out of eight (75 %) participants scored 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. Three out of eight (37.5 %) participants yielded reduction in posttraumatic cognition symptoms and demonstrated a significant reduction in scores, no longer meeting this criteria post intervention following completion of the programme.

Figure 4. 152. *Pre and post mean scores of the Post Traumatic Cognitions Inventory (PTCI)*

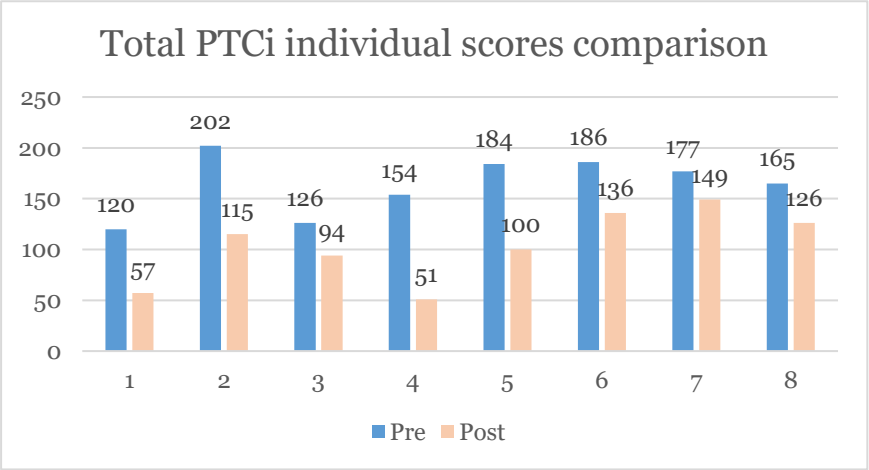


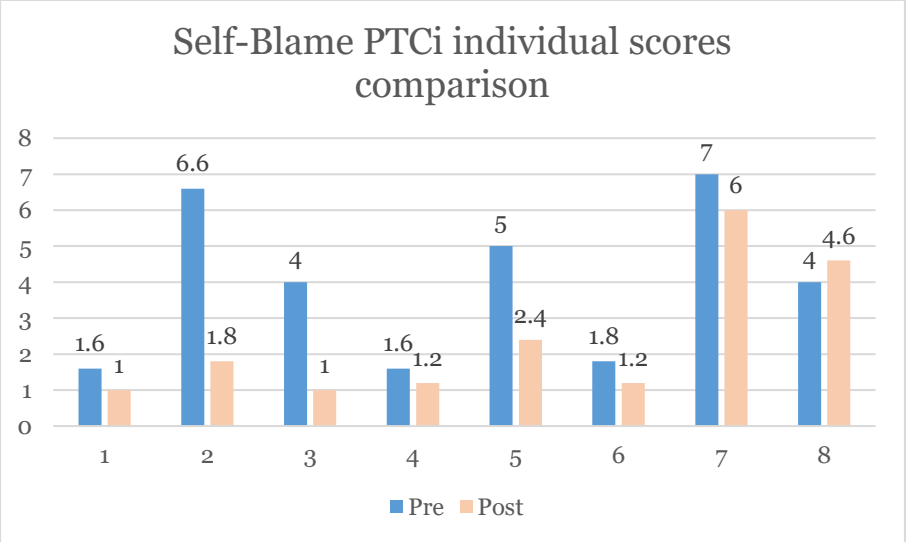
There was a decrease in Self Blame PTCI scores from pre-intervention (*M* = 3.95; *SD* = 2.17) to post-intervention (*M* = 2.4; *SD* = 1.89) This finding indicates that eight of out eight participants who completed the programme in 2023 had a reduction in post-traumatic cognition symptoms post-intervention (see table below).

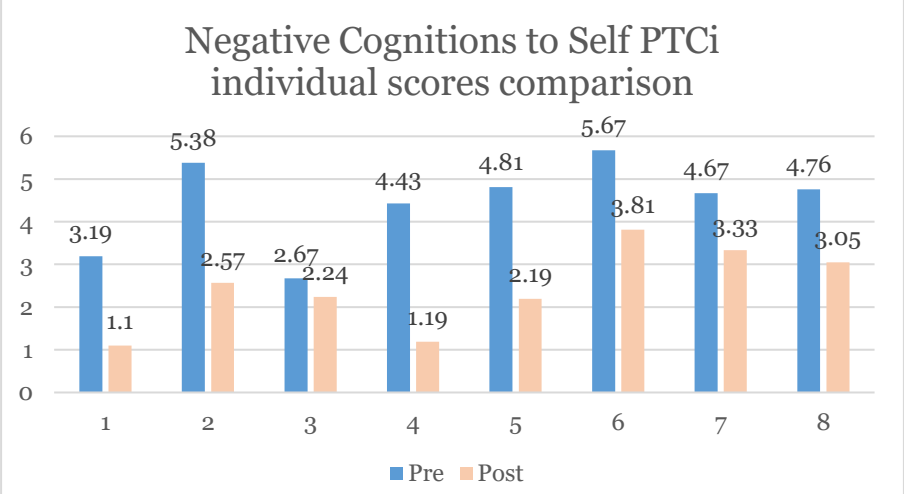
In addition, seven out of eight (87.5%) demonstrated reductions across the subscale 'self-blame', eight out of eight (100 %) demonstrated reductions across the subscale

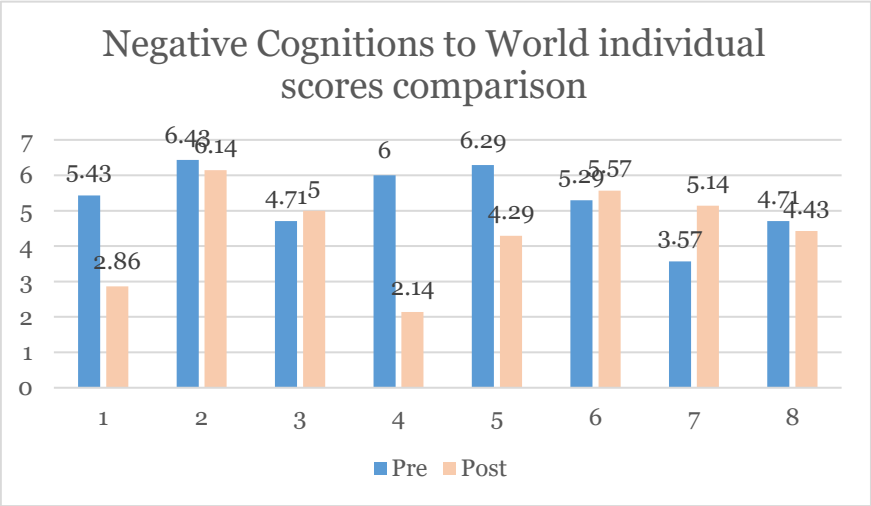
'negative cognitions about the self' and four out of eight (50 %) across the subscale 'negative cognitions about the world'. These findings indicate that participants who completed the trauma programme significantly reduced their PTSD symptoms associated with trauma related thoughts and beliefs (see graphs below).

Figure 4. 153. *Pre and post individual scores of the Post Traumatic Cognitions Inventory (PTCI) total and subscales*





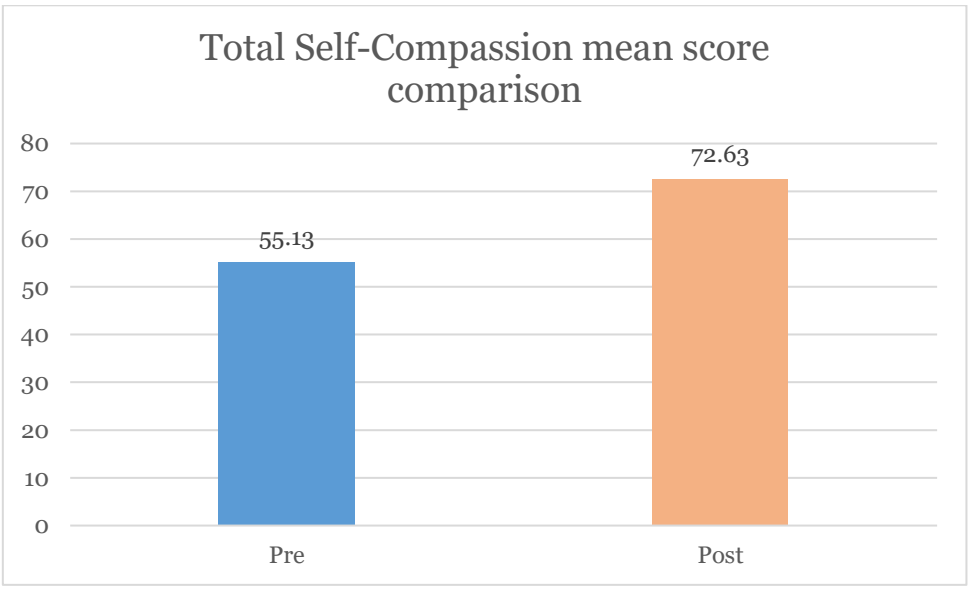




Compassionate Engagement and Action (CEA) Scales

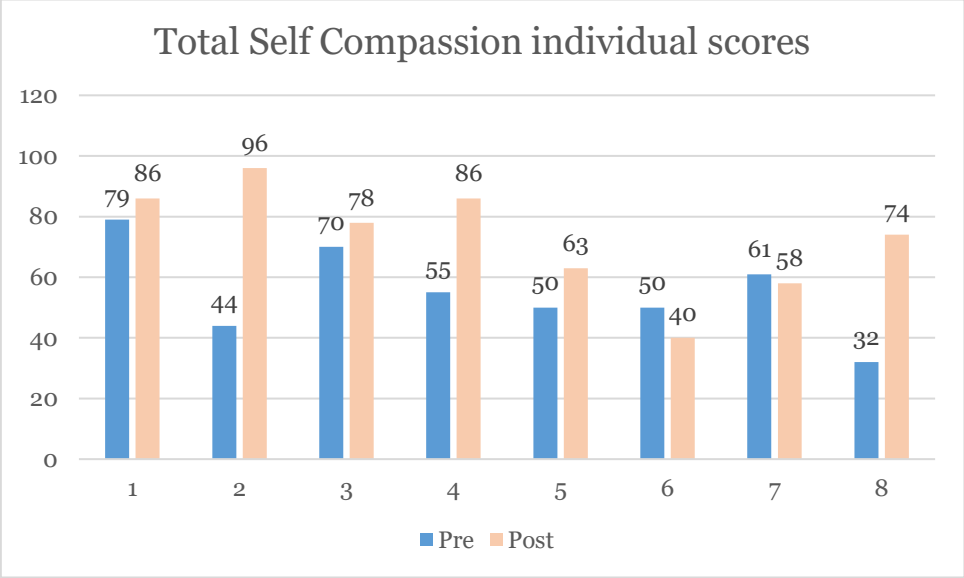
There was an increase in total self-compassion scores from pre-intervention (*M* = 55.13; *SD* = 14.82) to post-intervention (*M* = 72.63; *SD* = 18.15) (see graph below).

Figure 4. 154. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) self-compassion subscale*



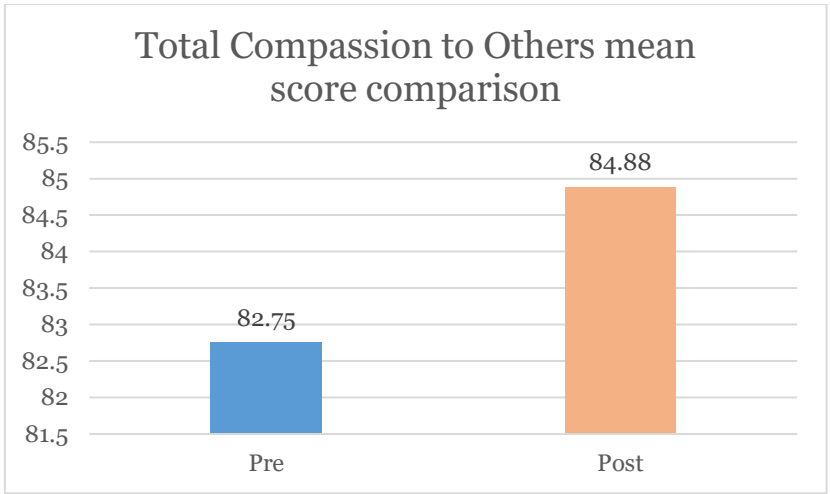
Further examination of the individual scores indicated that six out of eight participants (83.5%) demonstrated an improvement on the self-compassion subscale (see graph below).

Figure 4. 155. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) self-compassion subscale*



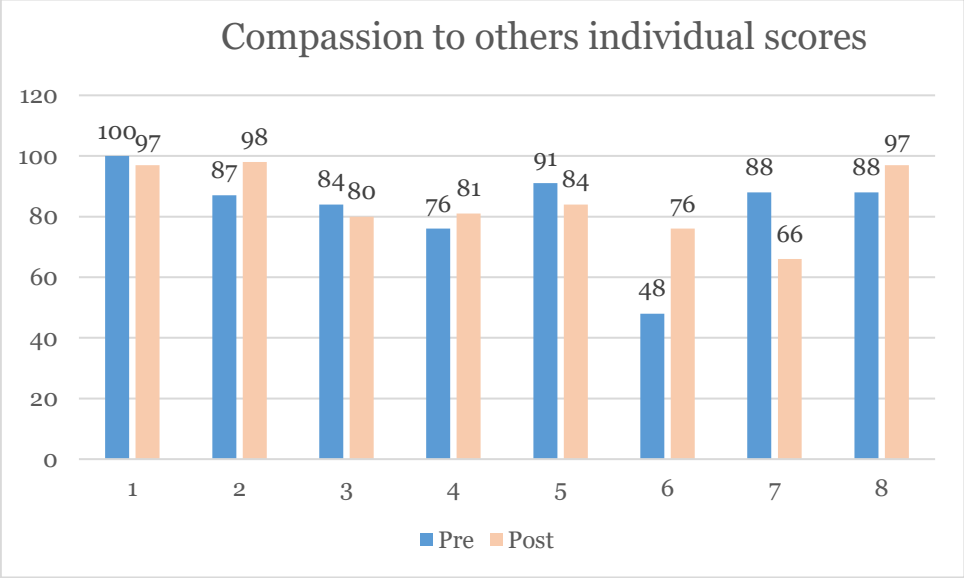
There was an increase in total compassion to others scores from pre-intervention (*M* = 82.75; *SD* =15.55) to post-intervention (*M* = 84.88; *SD* = 11.59) (see graph below).

Figure 4. 156. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) Compassion to others subscale*



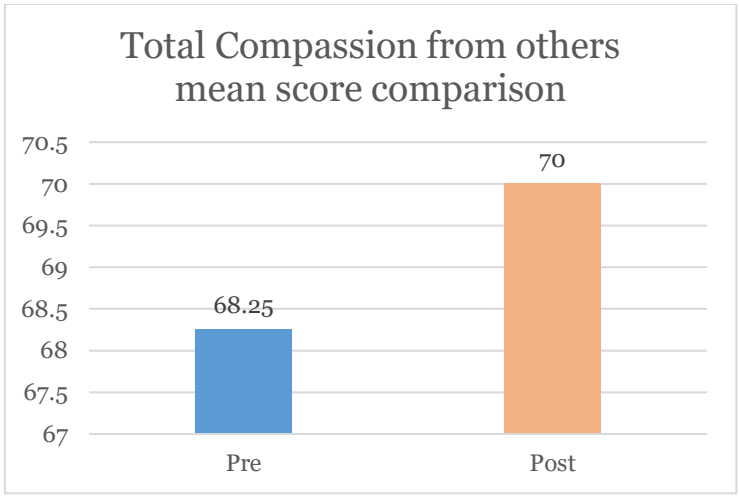
Further examination of individual scores indicate that four out of eight participants (50 %) demonstrated an increase in compassion to others. It should be noted that participants scored highly on these measures at baseline (57- 92), therefore, it was predicted that there would be minimal difference post-intervention.

Figure 4. 157. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) Compassion to others subscale*



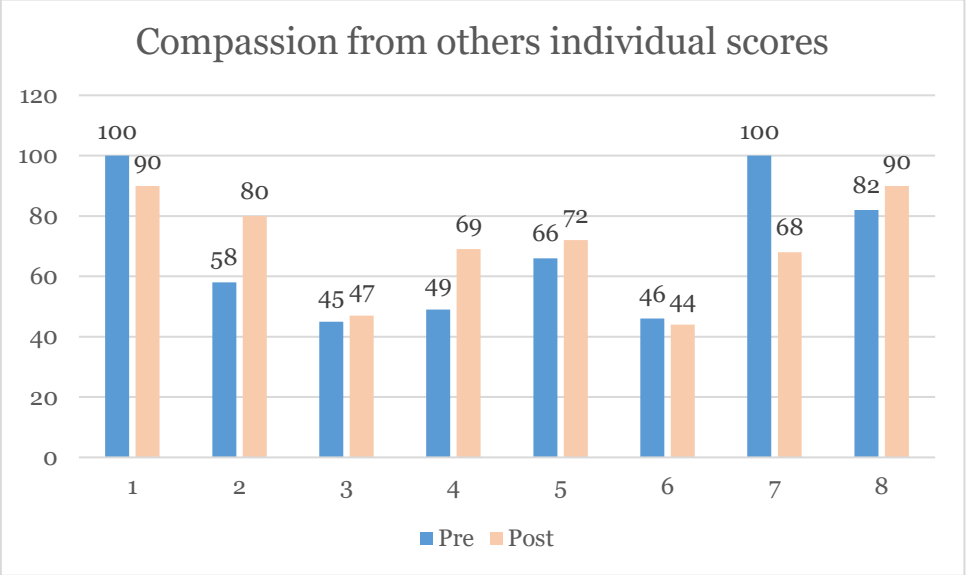
There was an increase in total compassion from others scores from pre-intervention (*M* = 68.25; *SD* =23.01) to post-intervention (*M* = 70.0; *SD* = 17.34) (see graph below).

Figure 4. 158. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) Compassion from others subscale*



Further exploration of individual scores indicates that five of eight participants (62.5 %) demonstrated an increase in perceived levels of compassion from others post-intervention.

Figure 4. 159. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) Compassion from others subscale*



4.20.4. Summary

The Trauma Programme is still a relatively new programme in the hospital delivered by the Psychology Department. The above results are for the programme's sixth 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 improvements in reducing PTSD symptoms post-intervention as demonstrated through findings from the PCL and PTCI measures. Another aim of the programme was to increase participant's capacity for compassion, and the results indicate there were improvements in self-compassion, compassion for others and receiving compassion from others. In conclusion, the 2023 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).

4.25. 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 12 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.

4.25.1. 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.

In line with the collaborative ethos of the unit, the HoNOSCA's were completed at admission and discharge by the young person (self-rated) and parent. Due to small sample size of clinician rated HoNOSCA's, statistical analyses were not able to be conducted and therefore not reported for 2023.

4.25.2. Results

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

Table 4.21: *HONSOCA Client and Parent rated paired samples t-tests results*

	Pre	**Post**	***n***	***t***	***df***	***p***	***d***
Client rated	19.88 SD = 8.11	12.01 SD = 7.24	72	7.7	71	**.000**	0.
Parent rated	17.98 SD = 7.78	12.56 SD = 7.62	72	6.06	71	**.000**	0.

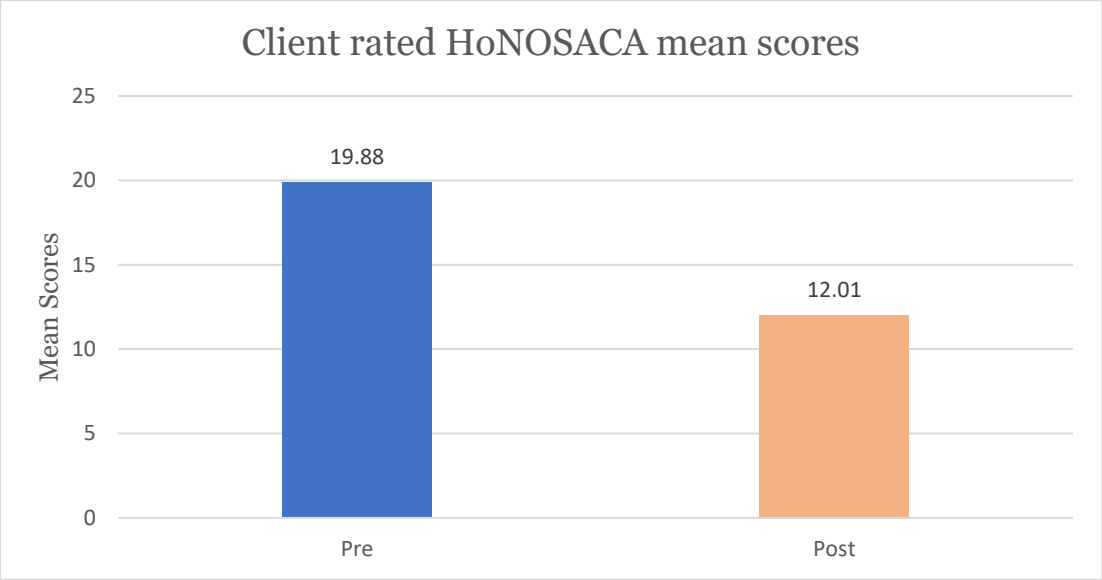
Pre and post scores on measures were available for 73 out of 88 service users (82%) who were admitted to and discharged from Willow Grove inpatient care in 2023. Analysis was run on pre and post data received.

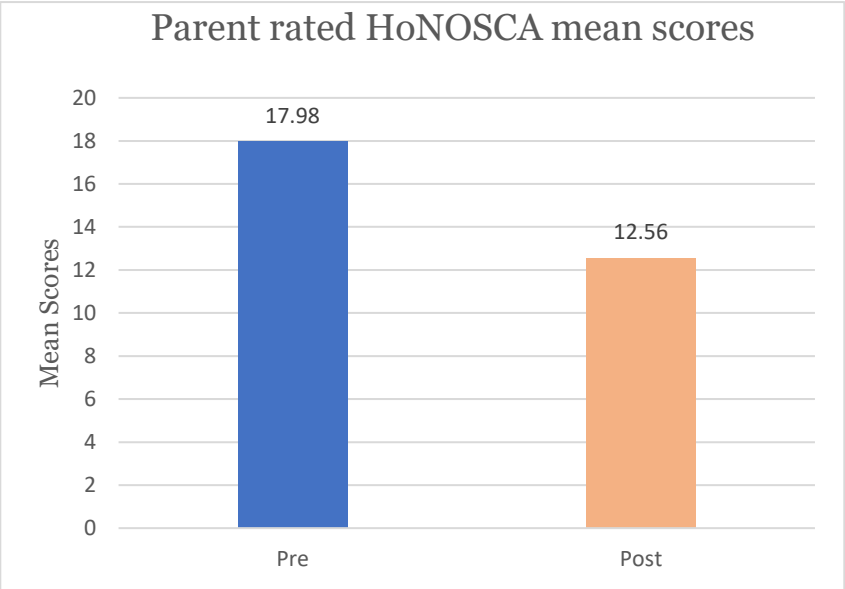
As illustrated in the table below, a significant decrease in total scores for the client self-rated HoNOSCA was apparent from pre-intervention (M = 19.88, SD = 8.11) to post-intervention (M = 12.01, SD = 7.24), n (73) = 7.7, p <. 0005 (two-tailed). The eta squared statistic (1.02) indicated a large effect size.

A significant decrease in total scores for the parent self- rated HoNOSCA was apparent from pre-intervention (M = 17.98, SD = 7.78) to post-intervention (M = 12.56, SD = 7.62), n=(73) = 6.78, p <. 0005 (two- tailed). The eta squared statistic (0.7) indicated a medium effect size.

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

Figure 4. 160. *Pre and post mean scores of Health of the Nation Outcome Scales for Children and Adolescents subscales*





4.25.3. 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.

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 2024.

SECTION FIVE
Measures of service user experience

5. Service User Experience Questionnaire

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 2023. The results of the Service User Experience Survey are collated every six months, 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. The data was collected data using the online survey tool, Survey Monkey and descriptive graphs were created using Microsoft Excel.

5.1.3. Data Collection

In accordance with SPMHS' aim to go paperless where possible, and to make it easy for service users to provide feedback, the use of printed versions of the surveys was phased out in January 2022. This change means all service users with an email address

on file receive an invitation to complete the survey online. Where service users have no email address on file, they receive a letter by post that indicates four options for how they can access the survey. This includes the option to receive a printed version of the survey by post if required.

5.2. Dean Clinics

In 2023, Dean Clinic appointments were delivered face-to-face and 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 informing them of how they could access the survey. 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 233 by email, 67 by QR Code and 48 onsite via paper or tablet device.

This is a considerable decrease from 779 responses received in 2022, but it is an increase from 318 achieved in 2021. The high response rate in 2022 was the result of a big drive by the Dean Clinic staff to increase the service user experience response rates. These efforts were continued in 2023, but service users provided direct feedback to staff that they had already completed the survey in relation to their Dean Clinic experience in 2022 and didn't feel it was necessary to complete another survey as there was no change in their experience.

Dean Clinic Survey Respondent Demographics

The majority of Dean Clinic survey responses in 2023 were from females (55.9%, n=194), aged between 61 and 80 years of age (52.9%, n=181) and who live in Leinster (73.2%, n=253). 46.2% (153) of respondents said they heard about the Dean Clinic while they were an inpatient.

Figure 5. 1. *Gender profile of Dean Clinic survey respondents*

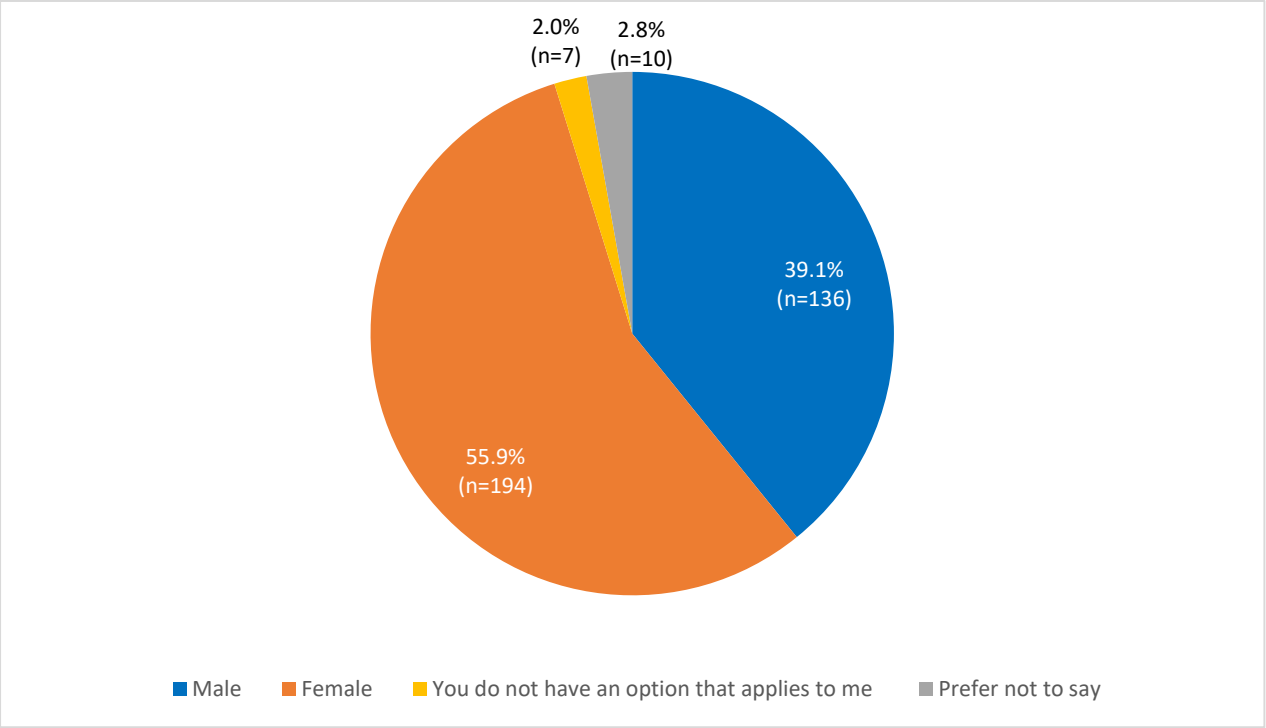


Figure 5. 2. *Age profile of Dean Clinic survey respondents*

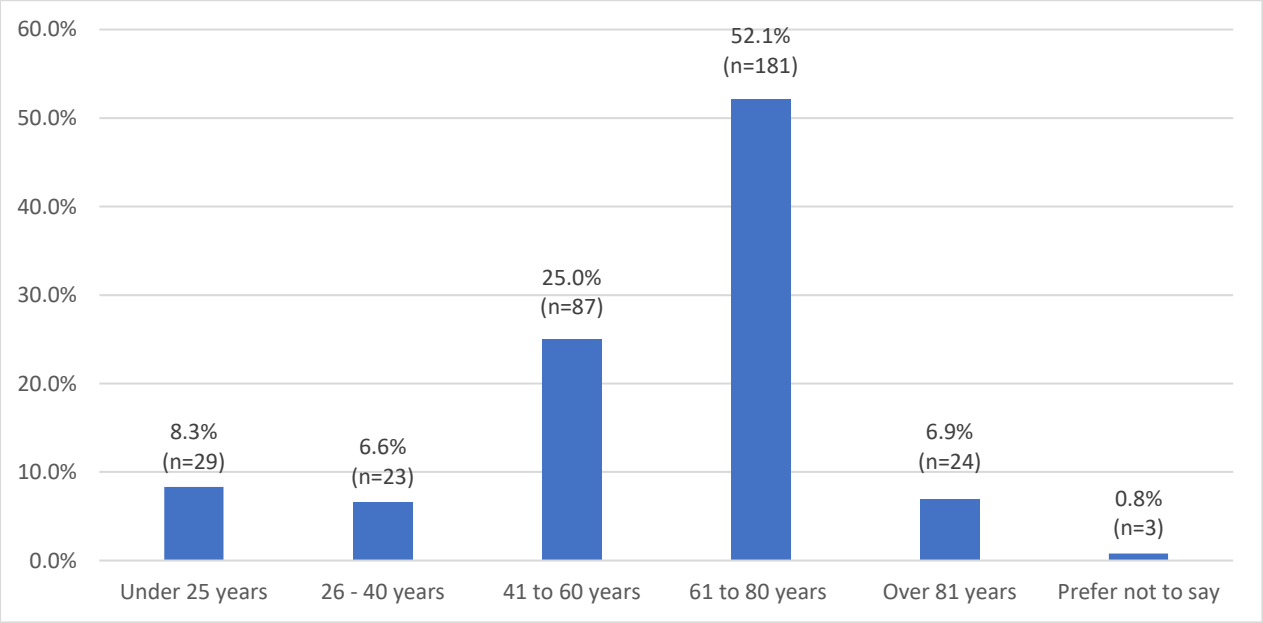


Figure 5. 3. *Location of Dean Clinic survey respondents*

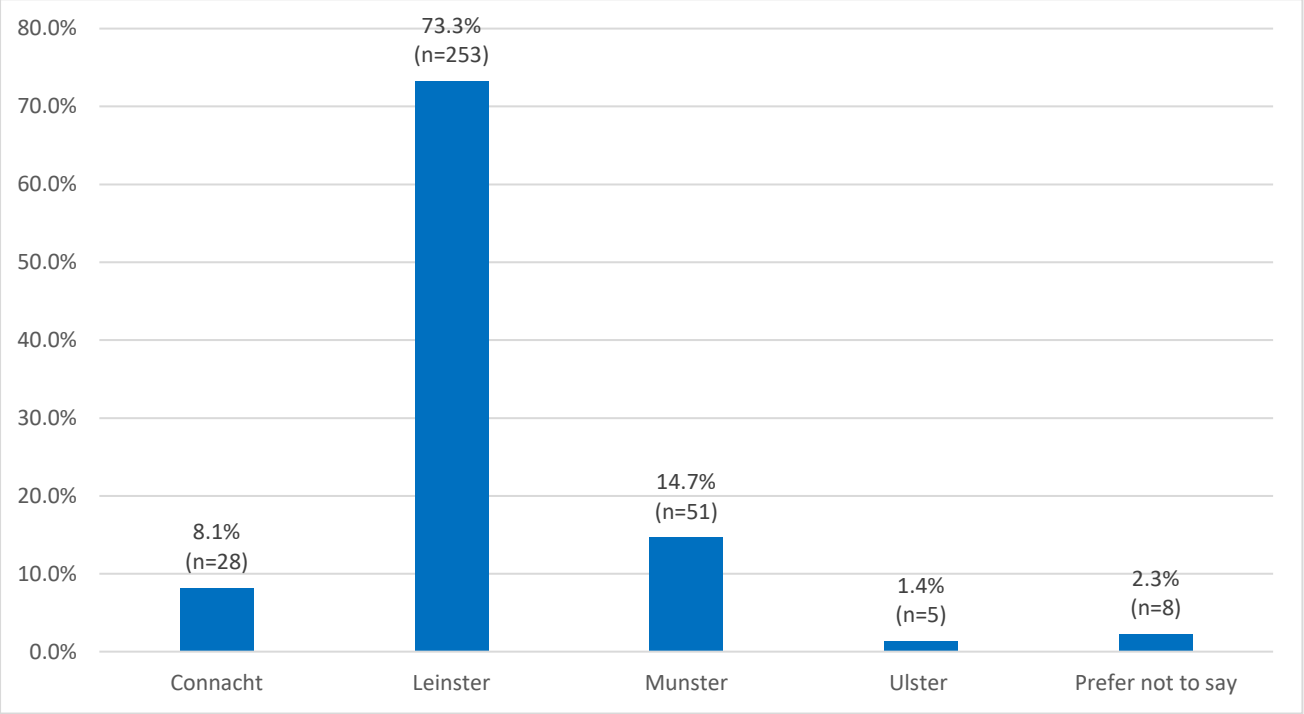


Figure 5. 4. *How respondents heard about Dean Clinic*

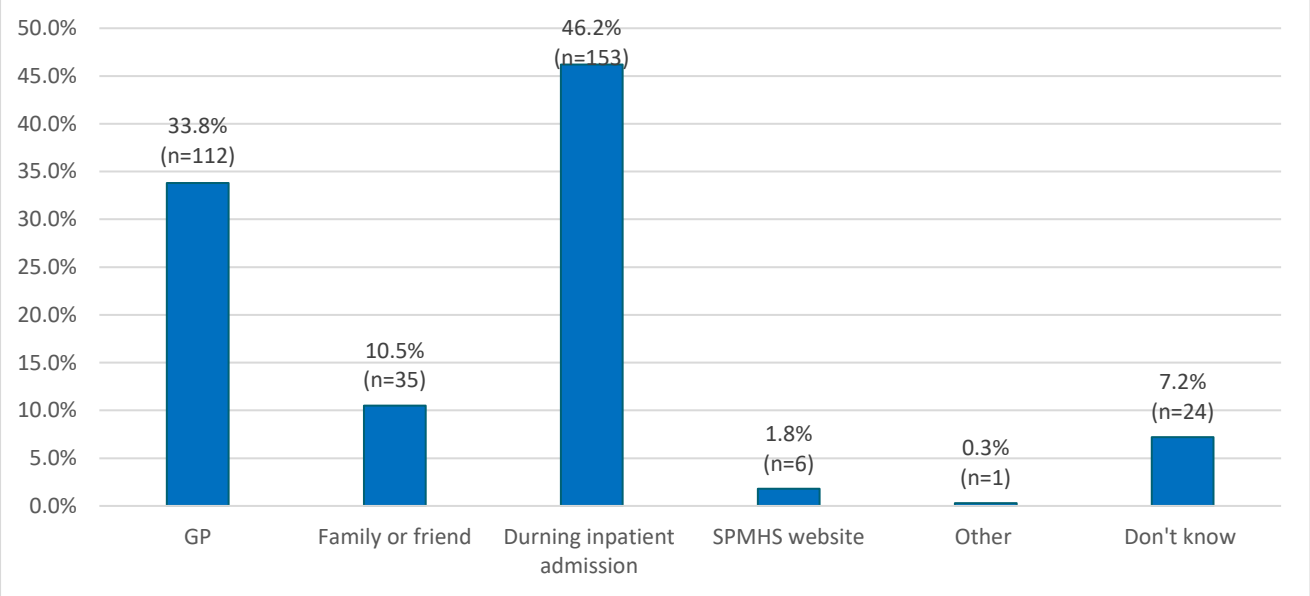
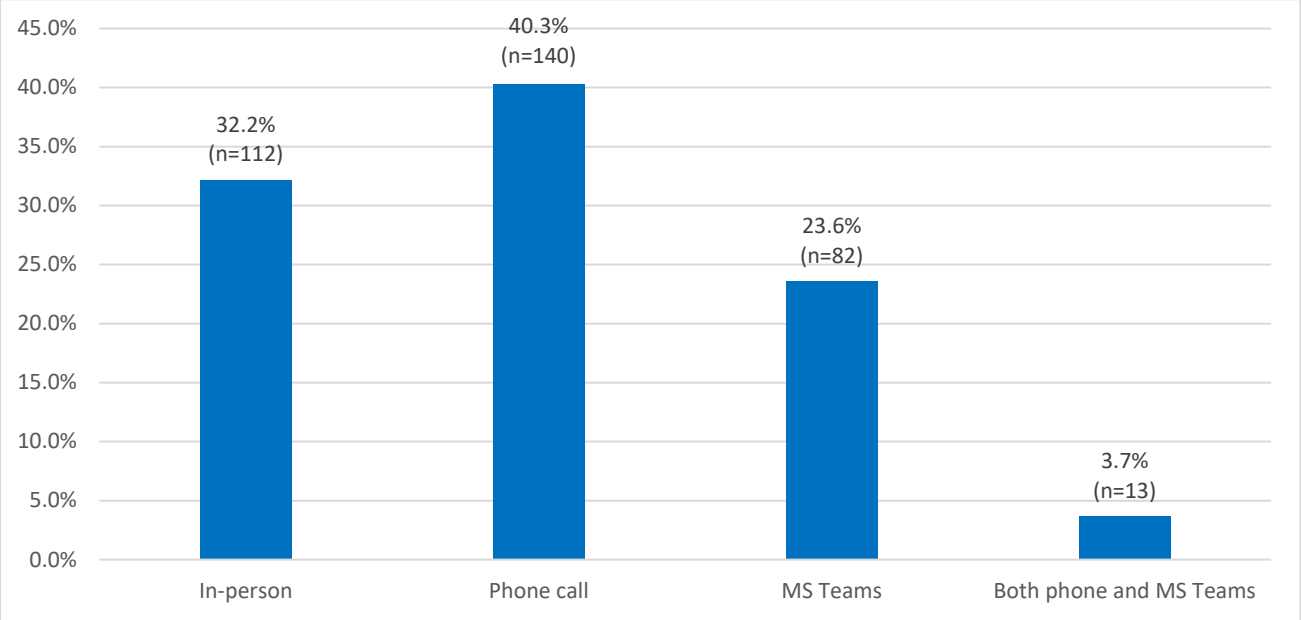


Figure 5. 5. *How respondents attended their most recent Dean Clinic appointment*



Dean Clinic in-person appointment feedback

The following section of this report details the feedback provided by 29.8% (n=104) of Dean Clinic survey respondents who attended their appointments in person between January and December 2023.

Experience of attending Dean Clinic appointment in-person

Dean Clinic survey respondents who attended their appointments in person were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their experience of the staff they encountered while attending their appointments.

Table 5.1. *Dean Clinic survey respondents experience of attending in person appointments.*

Please tell us about your experience of attending the Dean Clinic	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
It was convenient for me to access the Dean Clinic	47	45.6	46	44.6	6	5.8	3	2.9	1	0.9	**103**
I was welcomed in a friendly and professional manner by the Dean Clinic staff	82	78.8	19	18.2	1	0.9	2	1.9	0	0.0	**104**
I was shown where the facilities were in the Dean Clinic, such as the bathroom and waiting room	63	60.5	24	23.0	10	9.6	3	2.8	4	3.8	**104**

Table 5.2. *Dean Clinic survey respondents experience of staff while attending in person appointments*

Tell us about your experience of your Dean Clinic appointment	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I was treated with dignity and respect	86	82.6	14	13.4	2	1.9	1	0.9	1	0.9	**104**
My confidentiality was protected	74	73.2	23	22.7	3	2.9	0	0.0	1	0.9	**101**
My privacy was respected	72	72	25	25	2	2	0	0.0	1	1.0	**100**
I felt included in decisions about my treatment	73	70.8	23	22.3	5	4.8	1	0.9	1	0.9	**103**
I trusted my doctor or therapist or nurse	75	73.5	22	21.5	3	2.9	1	0.9	1	0.9	**102**
My appointment was value for money	47	47.0	26	26.0	17	17.0	5	5.0	5	5.0	**100**
I would recommend the Dean Clinic to family and friends	57	56.4	33	32.6	6	5.9	4	3.9	1	0.9	**101**

Table 5.3. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending Dean Clinic appointments in-person.*

How would you rate...?	...your care and treatment		...experience of SPMHS overall	
	n	% Of those who responded	n	% Of those who responded
1	1	1.0	1	1.0
2	1	1.0	2	2.0
3	0	0.0	1	1.0
4	1	1.0	0	0.0
5	1	1.0	2	2.0
6	4	4.0	3	3.0
7	7	7.0	6	6.0
8	14	14.1	15	15.0
9	24	24.2	22	22.0
10	46	46.4	48	48.0
No answer	5	-	5	-
1-4	3	3.5	4	4.0
5+	99	**96.5**	100	**96.0**
Total	104	100	104	100

Table 5.4. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending in person Dean Clinics appointments*

How would you rate...?	N	Mean (μ)
Your care and treatment	99	8.8
Overall experience of SPMHS	100	8.8

The average rating between one and 10 of care and treatment from 99 respondents who attend appointments in person was 8.8 out of 10. The average rating between one and 10 of overall experience of SPMHS from 100 respondents who attended appointments in person was 8.8 out of 10.

Dean Clinic remote appointment feedback

The following section of this report details the feedback provided by 62.1% (n=216) Dean Clinic survey respondents who attended their appointments remotely between January and December 2023.

Experience of attending Dean Clinic appointments remotely

Dean Clinic survey respondents were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their experience of accessing their Dean Clinic appointment remotely.

Devices used to attend Dean Clinic appointments remotely

The majority of Dean Clinic survey respondents used smartphones (49.5%, n=107), followed by laptops (23.1%, n=50). 16.6% (n=36) of respondents used a mobile phone without internet to attend their appointment remotely. 5.5% (n=12) used tablets and 5.0% (n=11) used personal computer (PC) to access their appointment remotely in 2023.

Figure 5. 6. *Devices used by respondents to attend their most recent Dean Clinic appointment*

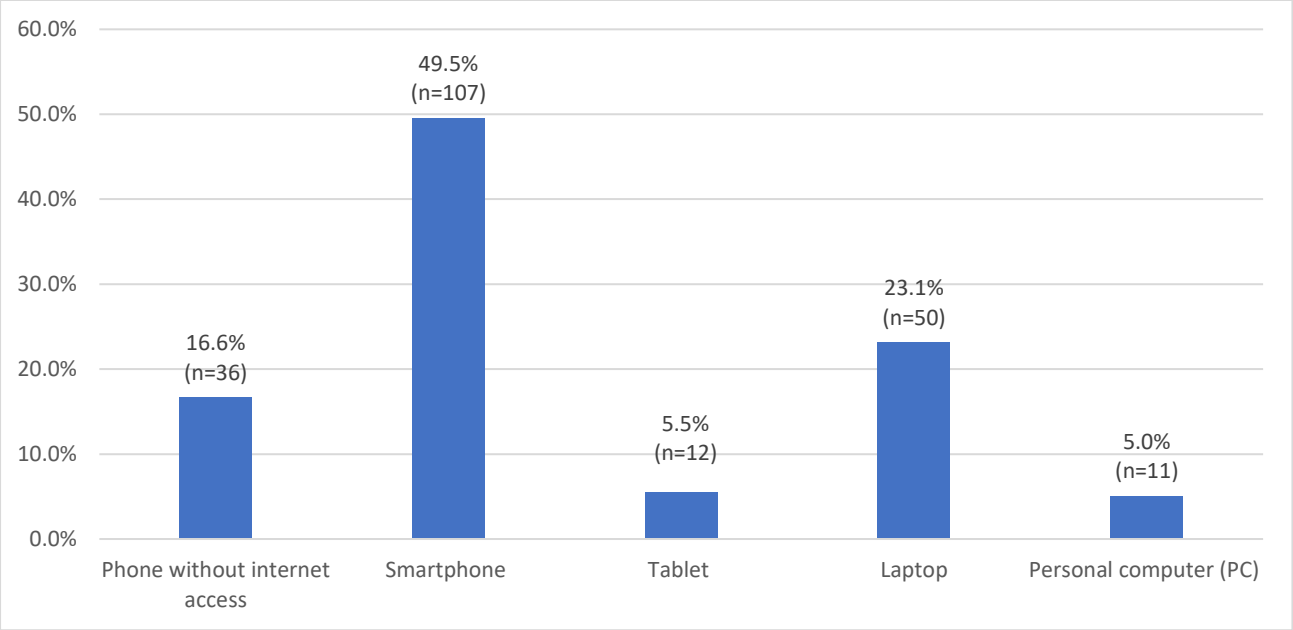


Figure 5. 7. *Dean Clinic respondents who contacted the SUITS service for IT support to access their remote appointment*

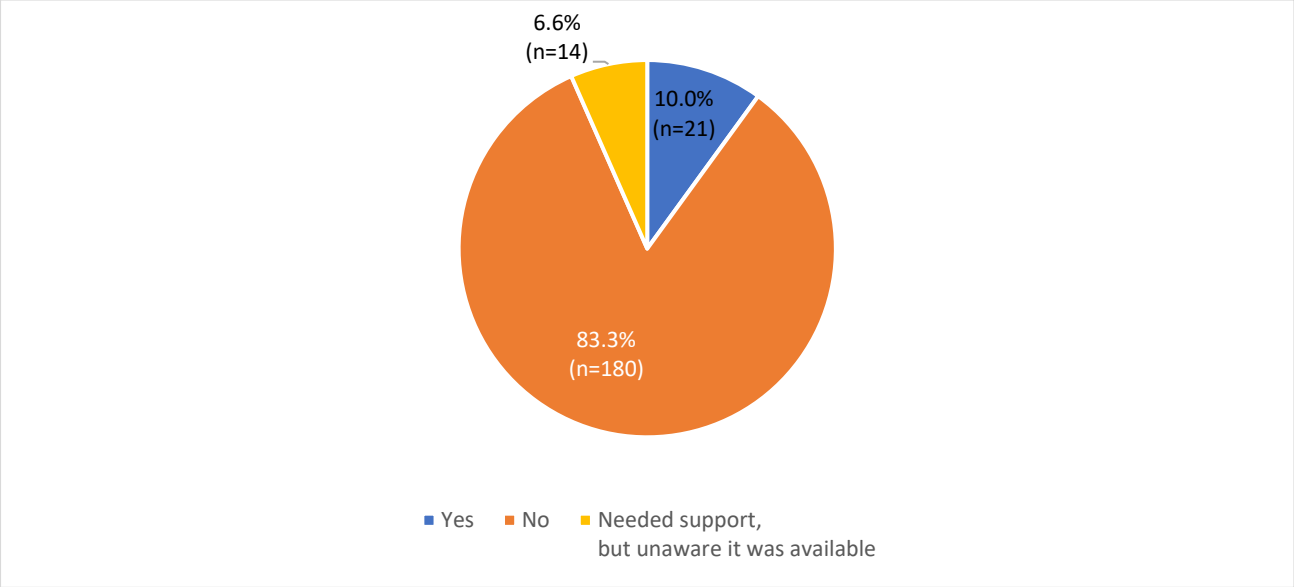


Table 5.5. *Dean Clinic survey respondents' rating of experience of contacting the SUITS service*

If you did contact the SUITS service	How would you rate the support they provided,	% Of those who responded
1	0	0
2	0	0
3	1	5.0
4	0	0.0
5	1	5.0
6	2	10.0
7	2	10.0
8	2	10.0
9	2	10.0
10	10	100.0
Number who answered	20	-
1-4	1	5.0%
5+	19	**95.0%**

9.2% (n=20) of Dean Clinic survey respondents who attended appointments remotely answered this question based on their experience of the SUITS service in 2023. This saw 95.0% (n=15) of respondents provide a rating of five out of 10 stars or higher. The average rating was 8.4 out of 10.

Table 5.6. *Dean Clinic survey respondents' experience of attending their appointment remotely*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
It was convenient for me to access my appointment remotely	83	43.0	69	35.7	20	10.3	7	3.6	14	7	**193**
It was clearly explained to me how to access my appointment using either phone or video	75	39.0	84	43.7	26	13.5	4	2.0	3	1.5	**192**
Attending my appointment remotely was a positive experience	67	34.7	70	36.2	19	9.8	22	11.4	15	7.7	**193**
I would consider the option of attending Dean Clinic appointments by phone or video in the future	68	35.2	65	33.6	20	10.3	23	11.9	17	8.8	**193**

Table 5.7. *Dean Clinic survey respondents' experience of staff while attending their appointment remotely*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I was treated with dignity and respect	134	68.7	46	23.5	10	5.1	3	1.5	2	1.0	**195**
My confidentiality was protected	123	63.7	56	29.0	12	6.2	1	0.5	1	0.5	**193**
My privacy was respected	120	63.4	55	29.1	11	5.8	2	1.0	1	0.5	**189**
I felt included in decisions about my treatment	112	58.3	48	25.0	20	10.4	9	4.6	3	1.5	**192**
I trusted my doctor or therapist or nurse	118	61.0	51	26.4	13	6.7	9	4.6	2	1.0	**193**
My appointment was value for money	80	41.2	43	22.1	31	15.9	19	9.7	21	10.8	**194**
I would recommend the Dean Clinic to family and friends	110	56.7	43	22.1	24	12.3	8	4.1	9	4.6	**194**

Table 5.8. *Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

How would you rate…?	…your care and treatment		…experience of SPMHS overall	
	n	% Of those who responded	n	% Of those who responded
1	5	2.6	4	20.1
2	3	1.5	3	1.6
3	4	2.1	10	5.3
4	8	4.2	5	2.6
5	16	8.4	13	6.9
6	5	2.6	8	4.2
7	14	7.3	18	9.5
8	30	15.7	20	10.6
9	23	12.1	25	13.3
10	82	43.1	82	43.6
No answer	26	-	28	
1-4	20	10.4	22	29.6
5+	170	89.6	166	70.4
Total	**216**	**100.00**	**216**	**100.00**

Table 5.9. *Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

How would you rate…?	N	Mean (μ)
Your care and treatment	**190**	**8.1**
Overall experience of SPMHS	**188**	**8.0**

The average rating between one and 10 of care and treatment from 190 respondents who attend appointments remotely was 8.1 out of 10. The average rating between one and 10 of overall experience of SPMHS from 188 respondents who attended appointments remotely was 8 out of 10.

5.3. Adult inpatient services

Service users discharged from inpatient and Homecare treatment between January and December 2023 were invited to complete either the inpatient Service User Experience Survey or the Homecare Service User Experience Survey.

Service users were provided with the option to complete the survey they felt was most relevant to the service they received for the majority of their care. It is necessary to provide service users with this option of surveys as it is not possible at present for the Service User Engagement Lead to determine if service users discharged have received only inpatient or Homecare services, or a combination of both.

219 responses were received to the inpatient Service User Experience Survey and 48 to the Homecare Service User Experience Survey. This is a total of 267 responses for this 12-month period.

5.3.1. Demographics

The majority of respondents to the inpatient survey in 2023 were female (52.2%, n=116), aged over 61 years (45.9%, n=62), and living in the Leinster region (70.5%, n=99).

Figure 5. 8. *Gender profile of inpatient survey respondents in 2023*

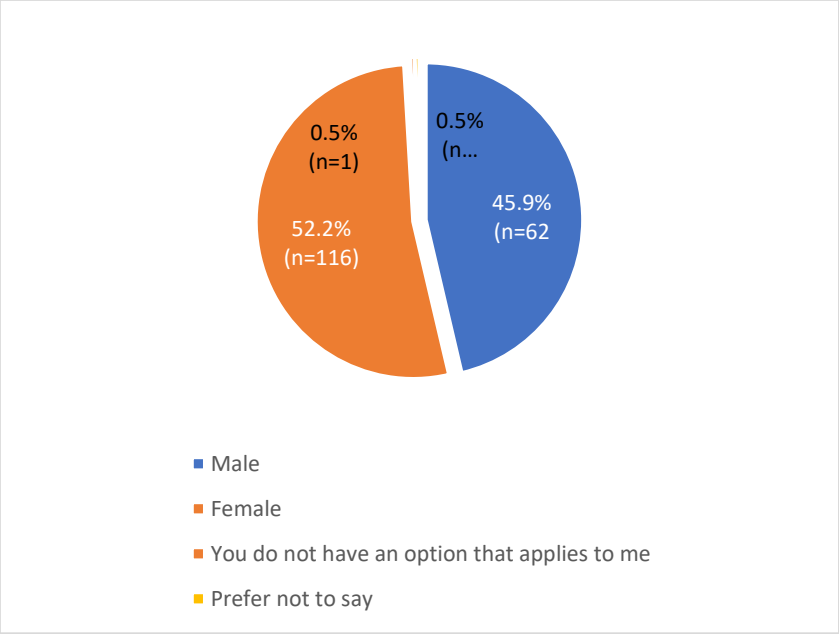


Figure 5.9. *Location of inpatient survey respondents in 2023*

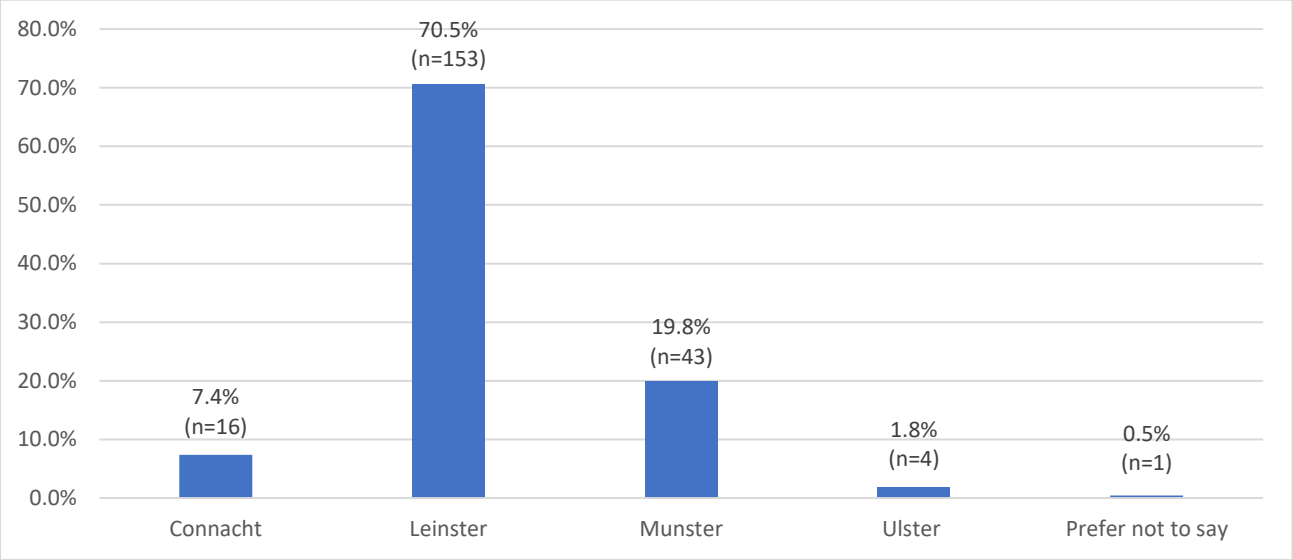


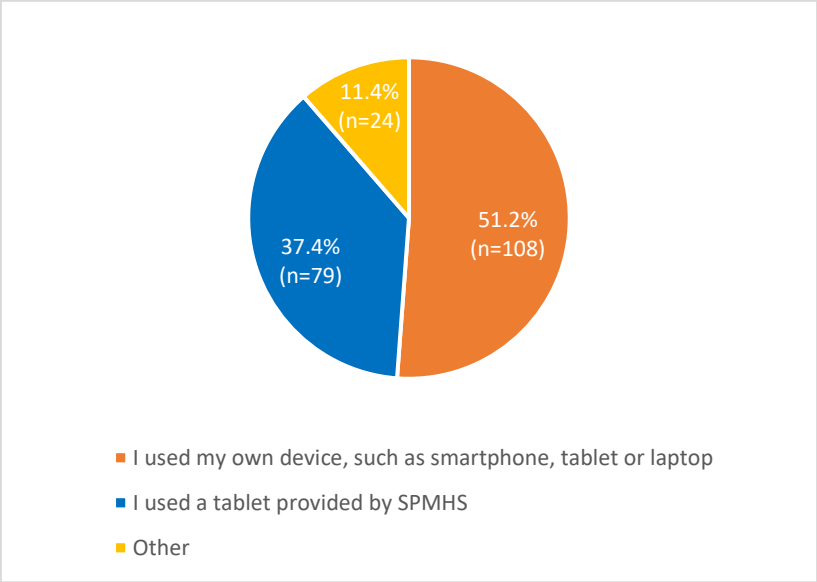
Table 5.10. *Respondents' opinions regarding their experience of admission to hospital in 2023*

Tell us about your experience of admission	Strongly agree		Agree		Disagree		Neither agree or disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
The admission process was explained to me by a member of staff	86	39.8	89	41.2	21	9.7	13	6.0	7	3.2	**216**
The ward routine, such as mealtimes and visiting arrangements, was explained to me by a member of staff	81	37.5	93	43.1	8	3.7	19	8.8	15	6.9	**216**
The activities available to me, and how to access them, was explained to me by a member of staff	58	26.8	75	34.7	34	15.7	32	14.8	17	7.8	**216**
Shortly after I was admitted, a member of staff explained how I would access appointments and activities remotely	53	24.7	79	36.9	31	14.5	32	14.9	19	8.8	**214**
I found inpatient activities easy to access	76	35.7	89	41.8	25	11.7	17	7.9	6	2.8	**213**

Accessing remote inpatient appointments and activities

A new question was added to the inpatient survey in January 2023 to gain a better understanding about the type of devices being used by inpatient survey respondents to access remote inpatient appointments and activities.

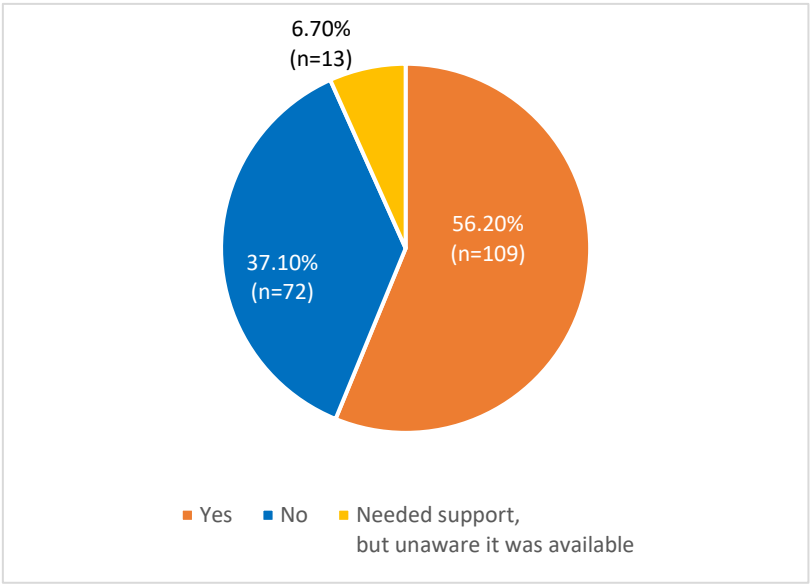
Figure 5.10. *Devices used by respondents to access remote appointments and activities during their inpatient admission*



IT Support

In January 2023 a new question was added to the Inpatient Service User Experience Survey to ascertain if survey respondents needed technical support, and if they did, if they then contacted the Service User IT Support (SUITS) service.

Figure 5.11. *Respondents who contacted the Service User IT Support (SUITS) service for support to access remote appointments and/or activities while they were an inpatient.*



Experience of SUITS Service for inpatient respondents

Inpatient survey respondents who contacted the SUITS service during their inpatient treatment were asked to rate their experience on a scale of one to 10, where one is poor, and 10 is excellent.

87.9% (n=117) of respondents provided a rating of 5 out of 10 or higher for their experience of the SUITS service between January and December 2023. The average rating was 8.2 out of 10.

Table 5.11. *Inpatient respondents' rating of experience of contacting the SUITS service*

If you did contact the SUITS service	**how would you rate the support they provided,**	**% Of those who responded**
Rating	**n**	**%**
1	7	8.3
2	3	2.3
3	5	3.8
4	1	0.8
5	11	8.3
6	0	0.0
7	6	4.5
8	12	9.0
9	17	12.8
10	71	53.4
Number who answered	133	-
1-4	16	12.1%
5+	117	87.9%

Hospital staff

Respondents to the inpatient survey were asked to rate their experience of the staff who cared for them using the options of poor, good, excellent, or 'not applicable'. The list of staff was increased in January 2023 to include catering staff in this section of the survey.

Table 5.12. *Overall, what was your experience of how the hospital staff looked after you while you were an inpatient in St Patrick's Mental Health Services?*

	Poor		Good		Excellent		Not applicable		Total
	n	%	n	%	n	%	n	%	n
Nursing staff	12	5.6	49	23.1	152	71.4	0	0	213
Consultant psychiatrist	29	13.6	39	18.3	141	66.2	5	2.3	214
Registrar	23	10.8	63	29.7	113	53.3	14	6.6	213
Key Worker	28	13.8	64	31.4	93	45.8	19	9.4	204
Psychologist	15	7.3	28	13.6	84	40.9	78	38.1	205
Occupational Therapist	14	7.0	49	24.7	59	29.8	77	38.8	199
Social Worker	16	8.0	36	18.1	59	29.6	89	44.7	200
Pharmacist	12	5.8	51	24.6	81	39.1	63	30.4	207
Healthcare Assistant	6	2.9	32	15.9	112	55.7	51	25.4	201
Household staff	4	1.9	48	23.2	143	68.8	13	6.3	208
Catering staff	9	4.4	55	26.8	140	67.9	2	0.9	206
Other (e.g. Counsellor, therapist etc)	7	3.5	25	12.6	67	33.6	100	50.3	199

Table 5.13. *Respondents' overall experience while an inpatient in St Patrick's Mental Health Services in 2023*

	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
The quality of food available was of a high standard	57	26.7	77	36.1	36	16.9	27	12.7	17	7.9	**214**
There was a good selection of food available	50	23.5	85	40.1	32	15.0	31	14.5	16	7.5	**214**
The daily activities provided were interesting and helpful	74	34.7	87	40.9	35	16.4	13	6.1	5	2.3	**214**
The weekend activities were interesting and helpful	30	14.4	67	32.1	58	27.7	38	18.1	17	8.1	**210**
The cleanliness in the hospital was of a high standard	120	56.3	61	28.5	20	9.4	11	5.2	2	0.9	**214**
My accommodation was of a high standard	79	37.6	78	37.1	25	11.9	21	9.5	8	3.8	**211**

Table 5.14. *Respondents' experiences of leaving the hospital*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
I was given notice of my discharge	106	49.5	71	33.8	15	7.0	12	5.6	11	5.1	**215**
I felt ready to be discharged	100	47.2	79	37.3	16	7.5	6	2.8	12	5.6	**213**
I was provided with details of the SPMHS Support and Information Service	75	35.4	64	30.2	29	13.7	27	12.7	18	8.5	**213**
I was provided with details about the day programmes available at SPMHS	65	30.5	60	28.2	37	17.4	36	16.9	16	7.5	**214**
I was provided with details of my follow-up appointments	81	38.2	70	33.0	22	10.4	21	9.9	19	8.9	**213**
Following my admission, I am confident that I would know what to do in the event of a possible future mental health crisis	92	43.4	67	31.6	21	9.9	18	8.5	15	7.1	**213**

Attitudes towards mental health

To better understand respondents' attitude towards mental health, a number of statements were added to the inpatient survey in January 2023. Respondents were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, strongly disagreed with, or disagreed with statements about their own perceptions when leaving hospital.

Table 5.15. *Respondents' attitudes towards mental health*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
a) I felt comfortable talking about my mental health prior to my inpatient admission	64	30.1	66	30.8	28	13.1	36	16.8	20	9.4	**214**
b) I would feel comfortable talking to family about my mental health following my inpatient admission	93	43.5	83	38.8	21	9.8	12	5.6	5	2.3	**214**
c) I would feel comfortable talking to friends about my mental health following my inpatient admission	73	34.3	88	41.3	25	11.7	21	9.8	6	2.8	**213**
d) I would feel comfortable talking to colleagues about my mental health following my inpatient admission	42	19.8	55	25.9	50	23.6	44	20.8	21	9.9	**212**

Table 5.16. *Recommending SPMHS to others*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
I would recommend St Patrick's Mental Health Services to others	121	56.3	51	23.7	13	6.1	13	6.1	17	7.9	**215**

Overall experience of inpatient care and treatment

Respondents to the inpatient survey are asked to rate on a scale of one to 10 their overall experience of the inpatient care and treatment they received while attending St Patrick's Hospital, where one is poor, and 10 is excellent.

The average rating between one and 10 of care and treatment from 212 inpatient survey respondents was 7.7 out of 10. The average rating between one and 10 of the overall experience of SPMHS from 212 inpatient survey respondents was 7.6 out of 10.

Table 5.17. *Inpatient respondents' ratings of care and treatment and overall experience of hospital for inpatients*

How would you rate...?	**...your care and treatment**		**... overall experience of SPMHS**	
	n	**% of those who responded**	**n**	**% of those who responded**
1	15	7.04	15	7.08
2	6	2.82	6	2.83
3	1	0.47	2	0.94
4	12	5.63	7	3.30
5	12	5.63	15	7.08
6	3	1.41	7	3.30
7	29	13.62	26	12.26
8	31	14.55	29	13.68
9	27	12.68	25	11.79
10	77	36.15	80	37.74
No answer	6	-	7	-
1-4	34	15.96%	45	21.23%
5+	179	84.04%	167	78.77%
Total	**219**	**-**	**219**	**-**

Table 5.18. *Inpatient respondents' ratings of care and treatment and overall experience of SPMHS*

How would you rate...?	**N**	**Mean (μ)**
Your overall care and treatment	213	7.7
Overall experience of SPMHS	212	7.6

5.4. Homecare Service User Experience Survey

This section provides an overview of the feedback received from 48 respondents to the Homecare survey between January and December 2023.

Homecare survey respondent demographics

The majority of Homecare survey respondents in 2023 were female (70.8%, n=34), aged between 41 and 60 years (52.1%, n=25), and who live in Leinster (72.9%, n=35).

Figure 5.12. *Gender profile of Homecare survey respondents in 2023*

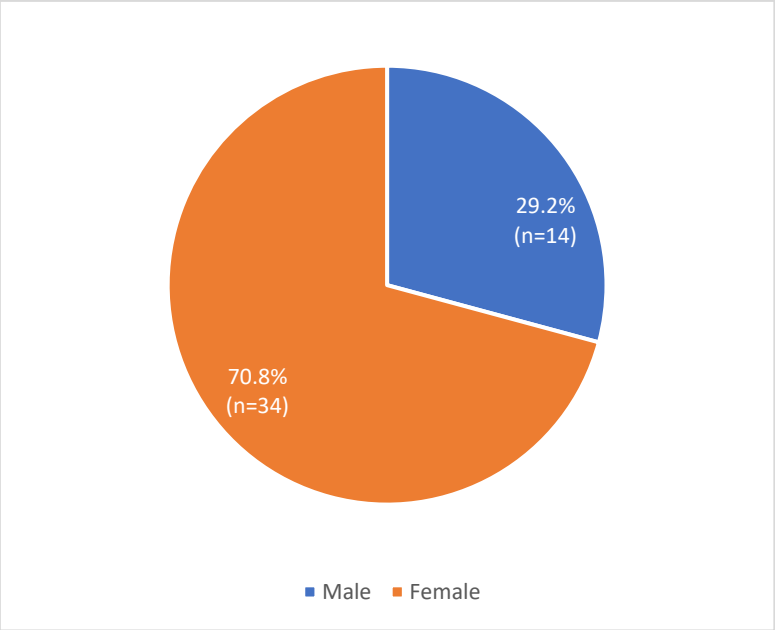


Figure 5.13. *Age profile of Homecare survey respondents in 2023*

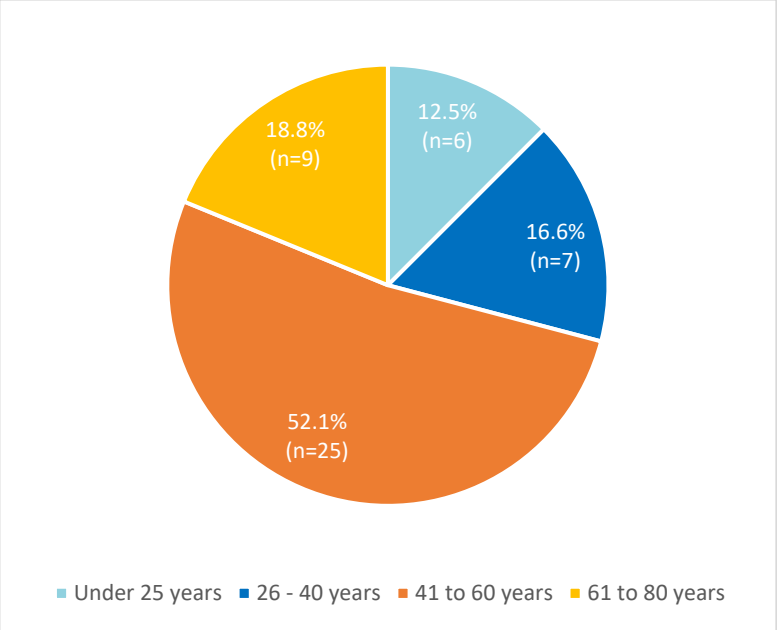
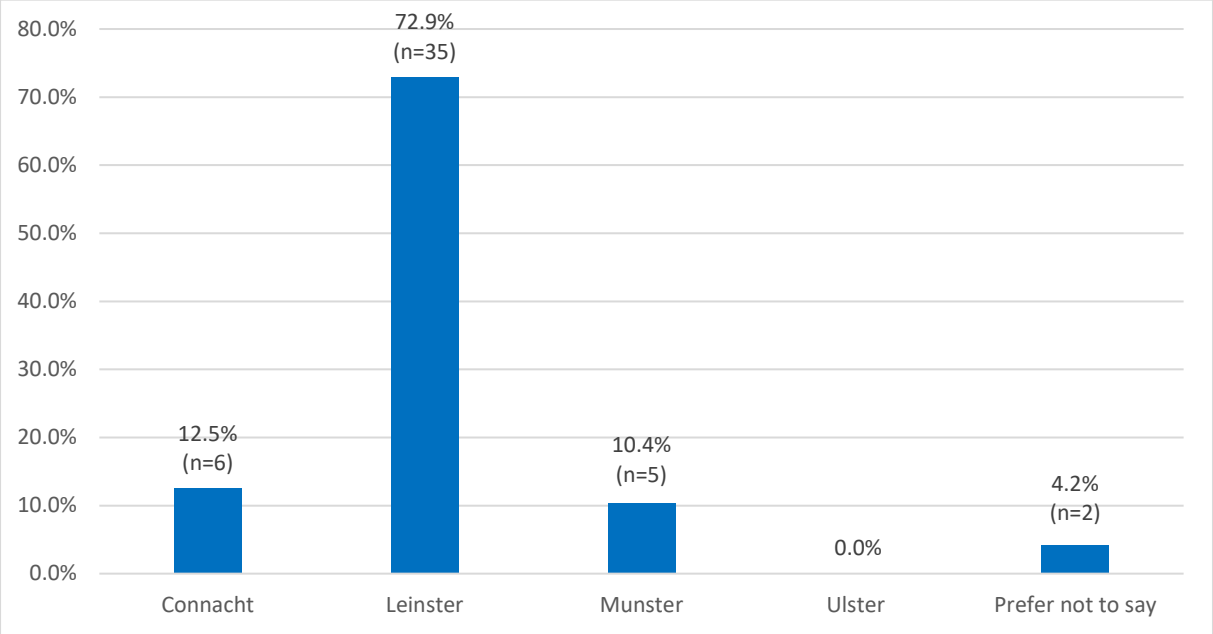


Figure 5.14. *Location of Homecare survey respondents in 2023*



Type of admission

In January 2023, a new question was added to the Homecare Service User Experience Survey. This asked respondents to indicate if their admission was Homecare only or if they had also been admitted as an inpatient. 52.2% (n=24) of Homecare survey respondents said their admission was Homecare only and 47.8% (n=22) said they were both an inpatient and on Homecare.

Figure 5.15. *How respondents accessed Homecare services*

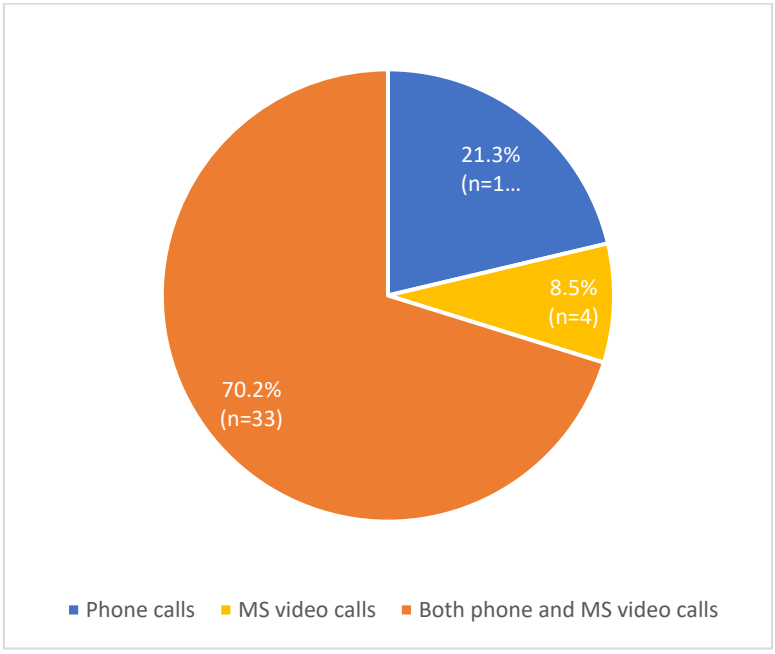
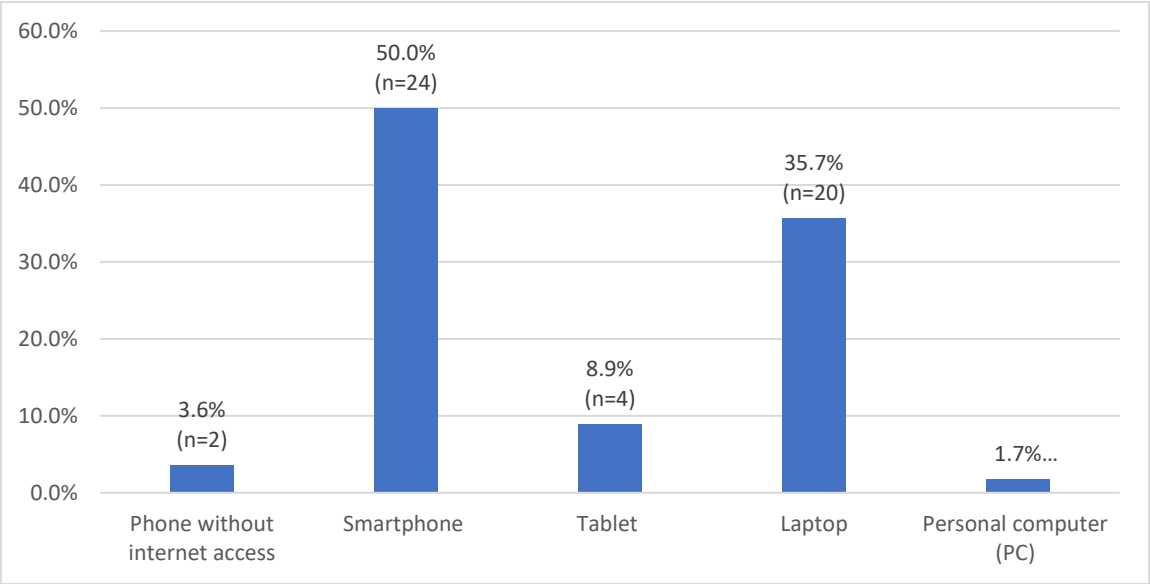


Figure 5.16. *Type of devices used by respondents to access Homecare appointment and activities.*



IT Support

Figure 5.17. *Respondents who accessed the SUITS service to access Homecare appointments and activities*

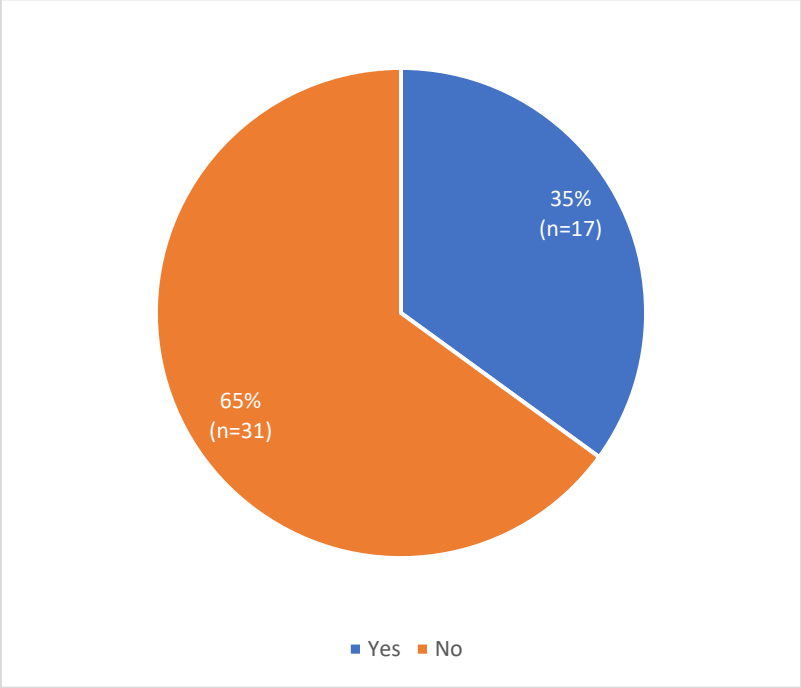


Table 5.19. *Homecare survey respondents' rating of experience of contacting the SUITS service.*

If you did contact the SUITS service	How would you rate the support they provided?	% of those who responded
Rating	**n**	**%**
1	0	0
2	0	0
3	0	0
4	1	6.2
5	1	6.2
6	2	12.5
7	1	6.2
8	1	6.2
9	3	18.7
10	7	43.7
Number who answered	16	-
1-4	1	6.3%
5+	15	**93.7%**

Table 5.20. *Homecare survey respondents' experience of beginning Homecare in 2023*

Tell us about your experience of beginning Homecare	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
How to access care and treatment while on Homecare was clearly explained to me	15	35.7	19	45.2	3	7.1	5	11.9	0	0	**42**
The activities available to me, and how to access them, were explained to me by a member of staff	13	35.1	12	32.4	5	13.5	5	13.5	2	5.4	**37**
I found Homecare services easy to access	18	43.9	17	41.4	3	7.3	3	7.3	0	0	**41**

Table 5.21. *Homecare survey respondents' experience of the care provided by staff while on Homecare*

	Poor		Good		Excellent		Not Applicable		Total
	n	%	n	%	n	%	n	%	n
Nursing staff	4	9.3	17	39.5	22	51.1	0	0	**43**
Consultant psychiatrist	5	11.9	11	26.1	25	59.5	1	2.3	**42**
Registrar	3	6.9	15	34.8	22	51.1	3	6.9	**43**
Key worker	4	9.7	7	17.0	22	53.6	8	19.5	**41**
Psychologist	3	7.1	3	7.1	21	50.0	15	35.7	**42**
Occupational Therapist	4	10.0	4	10.0	20	50.0	12	30.0	**40**
Social worker	3	7.3	3	7.3	13	31.7	22	53.6	**41**
Pharmacist	3	7.3	8	19.5	18	43.9	12	29.2	**41**
Healthcare Assistant	3	7.6	2	5.1	10	25.6	24	61.5	**39**
Other	3	7.6	2	5.1	13	33.3	21	53.8	**39**

Table 5.22. *Homecare survey respondents' experience of using technology*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I felt using MS Teams and/or telephone calls did not prevent me from being able to express myself when talking to my team	14	33.3	16	38.1	9	21.4	1	2.3	2	4.7	**42**
I felt using MS Teams and/or telephone calls did not stop me from feeling understood by my team	17	40.4	13	30.9	8	19.0	3	7.1	1	2.3	**42**
I had access to my prescription and medication	16	38.1	16	38.1	6	14.2	2	4.7	2	4.7	**42**
I received regular calls from my consultant	13	30.9	16	38.1	5	11.9	6	14.2	2	4.7	**42**
I received regular calls from nursing staff	28	68.2	11	26.8	1	2.4	1	2.4	0	0	**41**
I received regular calls from my key worker	12	29.2	6	14.6	9	21.9	7	17.0	7	17.0	**41**
I felt any issues I had were understood by my team	14	33.3	15	35.7	6	14.2	4	9.5	3	7.1	**42**
I felt any issues I had were addressed by my team	14	33.3	14	33.3	6	14.2	4	9.5	4	9.5	**42**

Table 5.23. *Homecare survey respondents' experience of leaving Homecare*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I was given notice of my discharge	19	45.2	11	26.1	8	19.0	1	2.3	3	7.1	**42**
I felt ready to leave Homecare	17	40.4	11	26.1	8	19.0	4	9.5	2	4.7	**42**
I was provided with details of the St Patrick's Mental Health Services Support and Information Service	15	37.5	9	22.5	9	22.5	4	10.0	3	7.5	**40**
I was provided with details about St Patricks' day services	14	34.1	13	31.7	6	14.6	4	9.7	4	9.7	**41**
I was provided with details of my follow-up appointments	15	35.7	15	35.7	5	11.9	5	11.9	2	4.7	**42**
I know what to do in the event of a further mental health crisis	15	35.7	14	33.3	4	9.5	4	9.5	5	4.7	**42**
I would consider the option of attending appointments with my SPMHS team by MS Teams or phone in the future	12	31.5	14	36.8	7	18.4	1	2.6	4	10.5	**38**

Table 5.24. *Homecare survey respondents' attitudes towards mental health*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I felt comfortable talking about my mental health to friends and family prior to my Homecare admission	11	31.4	11	31.4	4	11.4	7	20.0	2	5.7	**35**
I would feel comfortable talking to family about my mental health following my Homecare admission	12	34.2	16	45.7	4	11.4	3	8.5	0	0.0	**35**
I would feel comfortable talking to friends about my mental health following my Homecare admission	10	28.5	15	42.8	5	14.2	5	14.2	0	0.0	**35**
I would feel comfortable talking to colleagues about my mental health following my Homecare admission	6	17.1	4	11.4	10	28.5	9	25.7	6	17.1	**35**

Table 5.25. *Would respondents recommend St Patrick's Mental Health Services to others*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
I would recommend St Patrick's Mental Health Services to others	18	42.8	14	33.3	4	9.5	1	2.3	5	11.9	**42**

Overall experience of Homecare care and treatment

Respondents to the Homecare survey are asked to rate on a scale of one to 10 their overall experience of the care and treatment they received while on Homecare, where one is poor, and 10 is excellent.

Table 5.26. *Homecare respondents' ratings of care and treatment and overall experience of SPMHS*

How would you rate…?	…your care and treatment		… overall experience of SPMHS	
	n	% Of those who responded	n	% Of those who responded
1	4	9.3	5	11.9
2	1	2.3	1	2.3
3	0	0.0	0	0.0
4	7	16.2	3	7.1
5	0	0.0	2	4.7
6	1	2.3	1	2.3
7	8	18.6	10	23.8
8	4	9.3	3	7.1
9	5	11.6	4	9.5
10	13	30.2	13	30.9
No answer	5	-	6	-
1-4	12	27.8	9	21.3
5+	31	72.2	33	78.7
Total	**48**	**100**	**48**	**100**

Table 5.27. *Homecare respondents' ratings of care and treatment and overall experience of SPMHS*

How would you rate...?	N	Mean (μ)
Your care and treatment	43	7.1
Overall experience of SPMHS	42	7.0

The average rating between one and 10 of care and treatment from 43 Homecare survey respondents was 7.1 out of 10. The average rating between one and 10 of the overall experience of SPMHS from 100 Homecare survey respondents was 8.8 out of 10.

5.5. Day Programme 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.

5.5.1. Survey response rate

In 2023, 1,173 day programme service users were invited by email to complete the Day Programme Service User Experience Survey. A further 31 service users were invited by letter to complete this survey.

The Day Programme Service User Experience Survey received 145 responses in 2023. This is an increase from the 102 responses received in 2022. The response rate achieved in 2023 was 12% and this is a +42.4% increase on the response rate achieved in 2022.

Day Service programmes attended by survey respondents

Table 5.28. *Day service programmes attended by survey respondents*

Name of programme	n	%
Acceptance & Commitment Therapy (ACT)	18	13.5
Access to Recovery Programme	44	33.0
Aftercare	10	7.5
Anxiety Disorders Programme	20	15.0
*Bipolar Recovery Programme	4	3.0
Cognitive Behavioural Therapy (CBT)	2	1.5
*Compassion Focused Therapy	6	4.5
*Depression Recovery Programme	7	5.2
Dialectical Behavioural Therapy (DBT)	4	3.0
*Eating Disorder Programme	3	2.2
Formulation	0	0
*Group Radical Openness (GRO)	4	3.0
*Healthy Self-Esteem Programme	0	0
Mindfulness Based Stress Reduction (MBSR)	1	0.7
Pathways to Wellness Programme	5	3.7
*Psychology Skills Group	0	0
Recovery (WRAP®) Programme	5	3.7
Total	**133**	

Day Programmes Survey Respondent Demographics

The majority of day programme survey respondents in 2023 were female (65.2%, n=94), aged between 41 and 60 (43%, n=62) years of age and who live in the Leinster region (73.6%, n=106). The majority of feedback (33%, n=44) was provided by respondents who attended the *Access to Recovery* programme.

Figure 5.18. *Gender profile of day programme survey respondents in 2023*

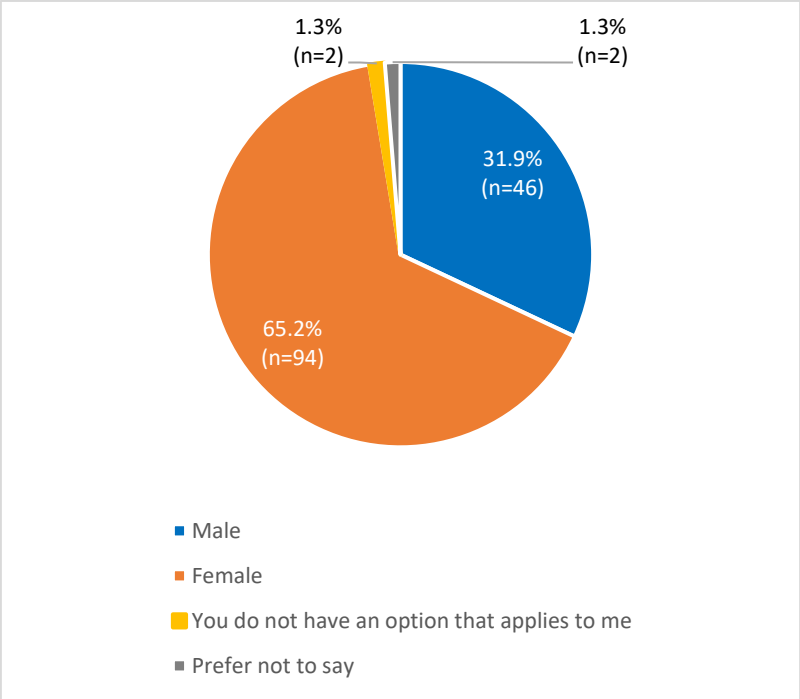


Figure 5.19. *Age profile of day programme survey respondents in 2023*

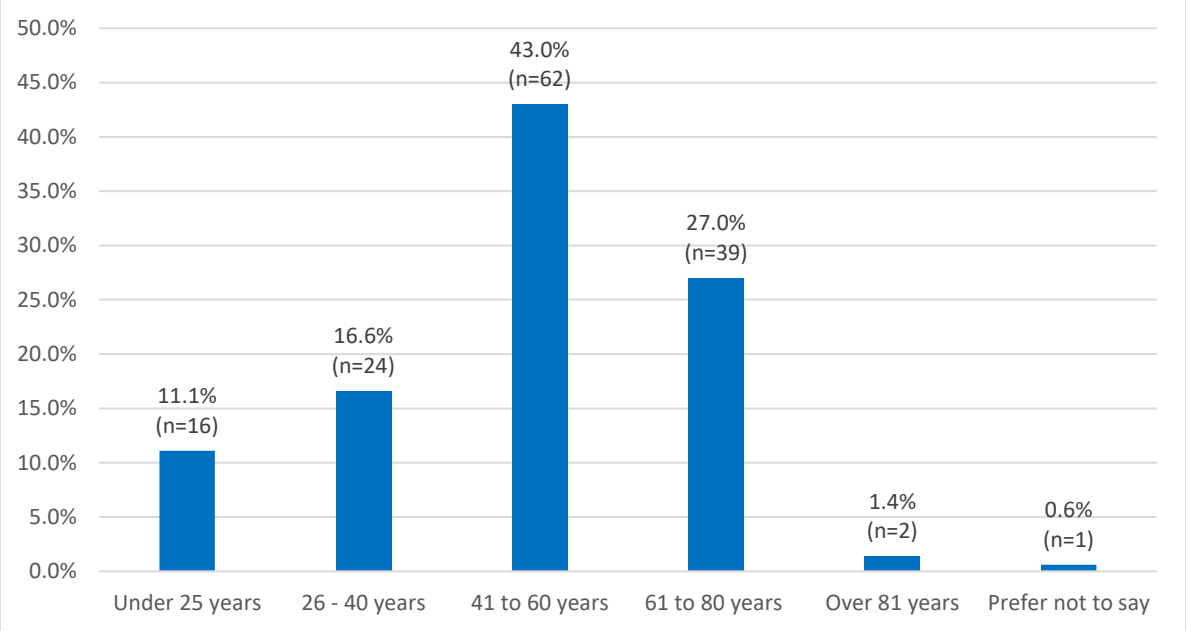


Figure 5.20. *Location of day programme survey respondents in 2023*

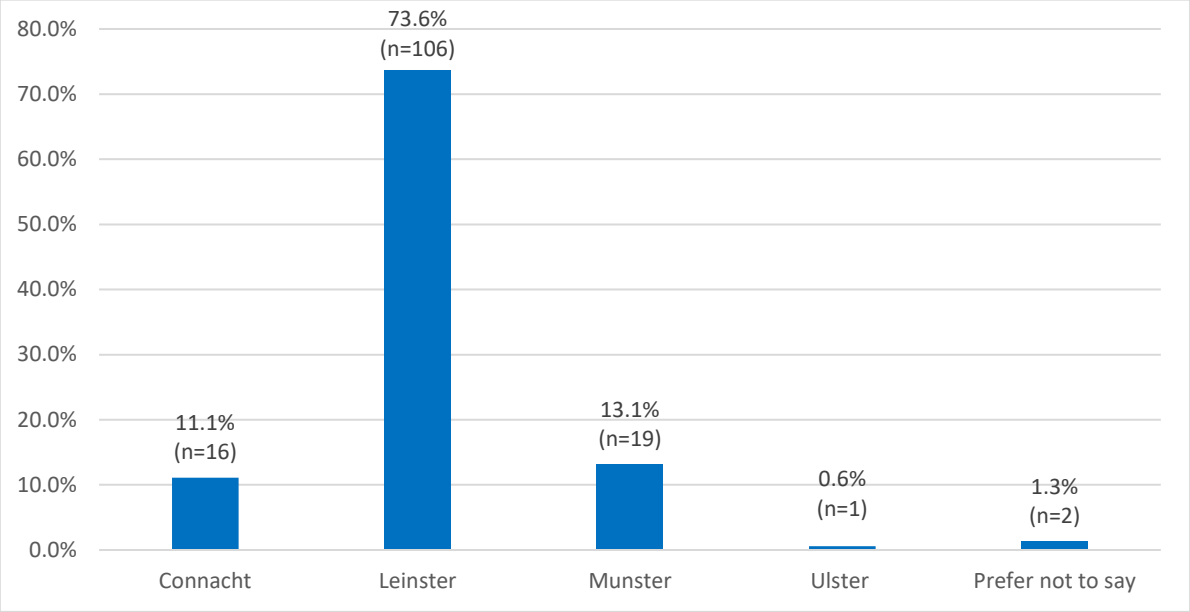


Figure 5.21. *How day programme survey respondents attending programmes in 2023*

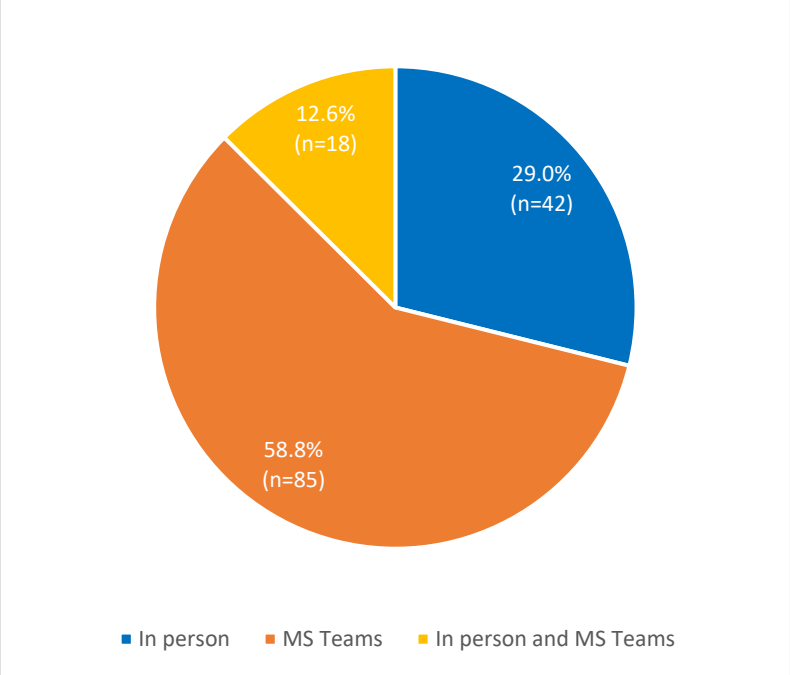


Figure 5.22. *Devices used by day programme survey respondents to attend programmes remotely in 2023*

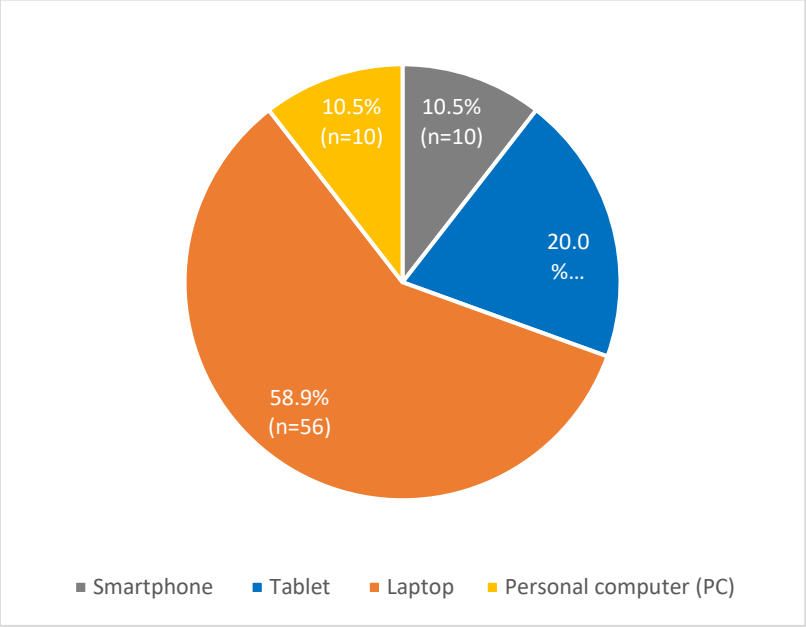


Figure 5.23. *Day programme survey respondents who contacted SUITS for support to attend programmes remotely in 2023*

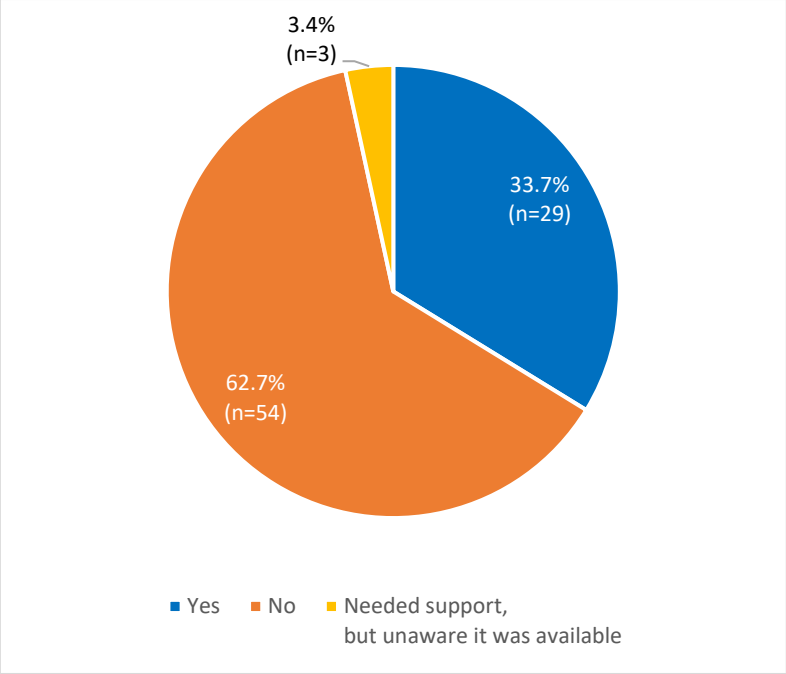


Table 5.29. *Day programme survey respondents' rating of experience of contacting the SUITS service*

If you did contact the SUITS service,	**how would you rate the support they provided,**	**% of those who responded**
Rating	**n**	**%**
1	**0**	**0.0**
2	**0**	**0.0**
3	**0**	**0.0**
4	**0**	**0.0**
5	**2**	**8.0**
6	**0**	**0.0**
7	**3**	**12.0**
8	**6**	**24.0**
9	**2**	**8.0**
10	**12**	**48.0**
Number who answered	**25**	**-**
1-4	**0**	**0.0**
5+	**25**	**100.00**

Experience of attending Day Programmes

Day programme survey respondents who completed all or some of their programmes remotely were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their experience of beginning their day programme remotely.

Table 5.30. *Day programme survey respondents' experience of beginning day programmes remotely in 2023*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
How to access my programme using MS Teams was clearly explained to me	47	49.4	38	40.0	8	8.4	2	2.1	0	0.0	**95**
Using MS Teams to access my programme was convenient	53	55.7	33	34.7	3	3.1	2	2.1	4	4.2	**95**
Using MS Teams to attend my programme was a positive experience	45	47.3	32	33.6	8	8.4	6	6.3	4	4.2	**95**
I would consider the option of attending programmes by MS Teams in the future	48	50.5	33	34.7	4	4.2	7	7.3	3	3.1	**95**

Table 5.31. *All day programme survey respondents' experience of their day programme in 2023*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
A member of staff explained clearly what would be happening in the programme	78	67.2	32	27.5	3	2.5	3	2.5	0	0.0	**116**
A member of staff explained the timetable to me when I started the programme	79	68.1	32	27.5	4	3.4	1	0.8	0	0.0	**116**
I trusted the members of my programme team	83	72.1	27	23.4	3	2.6	2	1.7	0	0.0	**115**
I was always treated with dignity and respect	90	78.9	20	17.5	1	0.8	2	1.7	1	0.8	**114**
Members of my programme team were courteous and respected me as an individual	92	80.0	20	17.3	1	0.8	2	1.7	0	0.0	**115**
Members of my programme team were knowledgeable and easy to understand	81	70.4	30	26.0	4	3.4	0	0.0	0	0.0	**115**

Table 5.32. *All day programme survey respondents' experience of finishing day programmes in 2023*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I knew in advance when the programme was due to finish	66	56.9	30	25.8	15	12.9	3	2.5	2	1.7	**116**
The programme met all of my expectations	51	43.9	50	43.1	6	5.1	8	6.9	1	0.8	**116**
I have been given details of the St Patrick's Mental Health Services Support and Information Service	45	38.7	31	26.7	22	18.9	18	15.5	0	0.0	**116**

Attitudes towards mental health having completed Day Programmes

To better understand if day programmes survey respondents' attitudes towards mental health changed following completion of their programme, the following statements were added to the day programmes survey in January 2023.

Respondents were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their own attitudes having finished their day programme.

Table 5.33: *Day programme survey respondents' attitudes towards mental health having completed day programmes in 2023*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I felt comfortable talking about my mental health to friends and family prior to completing this day programme	17	15.0	35	30.9	27	23.8	23	20.3	11	9.7	**113**
I would feel comfortable talking to family about my mental health having completed this day programme	28	25.0	50	44.6	22	19.6	8	7.1	4	3.5	**112**
I would feel comfortable talking to friends about my mental health having completed this day programme	25	22.1	42	37.1	27	23.8	12	10.6	7	6.1	**113**
I would feel comfortable talking to colleagues about my mental health having completed this day programme	12	10.6	18	15.9	47	41.5	23	20.3	13	11.5	**113**
Having completed my programme, I am confident that I would know what to do in the event of a possible future mental health crisis	46	40.3	48	42.1	15	13.1	4	3.5	1	0.8	**114**

Table 5.34. *Recommending SPMHS to others*

	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
I would recommend St Patrick's Mental Health Services to others	78	67.2	31	26.7	4	3.4	1	0.8	2	1.7	**116**

Table 5.35. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending day programmes in 2023*

How would you rate…?	**…your care and treatment**		**…experience of SPMHS overall**	
	n	**% of those who responded**	n	**% of those who responded**
1	1	0.9	1	0.9
2	0	0.0	3	2.6
3	2	1.8	1	0.9
4	1	0.8	2	1.7
5	6	5.2	3	2.6
6	4	3.5	3	2.6
7	7	6.2	7	6.1
8	15	13.2	19	16.5
9	24	21.1	20	17.4
10	54	47.3	56	48.7
No answer	31	-	30	-
1-4	4	3.5	7	6.1
5+	110	96.5	108	93.9

Table 5,36. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending day programmes in 2023.*

How would you rate…?	**N**	**Mean (μ)**
Your care and treatment	114	8.7
Overall experience of SPMHS	115	8.6

The average rating between one and 10 of care and treatment from 114 respondents who completed day programmes was 8.7 out of 10. The average rating between one and 10 of overall experience of SPMHS from 115 respondents who completed day programmes was 8.6 out of 10.

5.6. Willow Grove Adolescent Unit Service User Experience

5.6.1. Survey 2023

Willow Grove Adolescent Unit (WGAU) of SPMHS (previously described in this document). The unit provides inpatient and Homecare treatment for young people between the ages of 12 and 17 years who are experiencing mental health difficulties. It also has an associated outpatient Dean Clinic located in St Patricks University Hospital, Dublin, which offers assessment and treatment services for adolescents. The MDT are committed to ongoing quality improvement. This report presents the responses from the WGAU Service User Satisfaction Surveys received between January and December 2023.

5.6.2. Methodology

WGAU 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

Young people and their parents are invited to complete paper versions of the WGAU inpatient Service User Satisfaction Survey at the point of discharge. Young people and their parents/carers who were discharged from a Homecare are invited to complete the survey by email.

In 2023, 15 young people and 42 parents/carers completed the inpatient survey. The number of inpatient surveys returned by young people in 2023 decreased by 53.1% and the number of surveys completed by parents/carers decreased by 45.5% when compared with 2022, where responses were provided from 32 young people and 77 parents/carers.

The WGAU Homecare survey was completed by nine young people and five parents/carers in 2023. There were no survey responses to this survey available for 2022.

5.6.4. Survey design

The WGAU survey 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.

5.6.5. WGAU inpatient survey results

Quantitative responses

The median response (ie. the most common response) for each question is listed in table: 5.37. 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'.

Access

The statement in the access section of the survey that was rated 5 – 'very happy' by the majority of young people (53.8%, n=8) was with the waiting time to access the unit. This statement received the least number of 'very happy' responses (41.5%, n=17) from parents' in their version of the survey.

Environment

The statement in the environment section of the survey that was rated 5 – 'very happy' by the least number of young people (13.3%, n=2) was with the overall atmosphere (of feel) of the unit. This statement was rated 5 – 'very happy' by 78.1% (n=32) of parents.

Several comments from young people referred to the noise and lack of privacy in the unit. Several comments from parents refer to the lack of outdoor space, limited opportunities to exercise in the unit and the high cost of parking.

Care and treatment

61.9% (n=26) of parents said they were 'very happy' with the care and treatment their child received. 50% (n=20) rated 5 – 'very happy' that their child's stay was useful in addressing their mental health difficulty.

53.3% (n=8) of young people said they were 'very happy' with the care and treatment they received. 57.1% (n=8) rated 5 – 'very happy' that they were provided with the skills to manage their mental health.

Access to key workers/allocated nurse (66.7%, n=10) and the opportunity to attend discharge planning meetings (66.7%, n=10) both ranked 5 – 'very happy' by the majority of young people. The confidentiality of the service (85.4%, n=35) and the opportunity to attend discharge planning meetings both ranked 5 – 'very happy' by the majority of parents (75.6%, n=31).

Table 5.37. *Median responses to WGAU inpatient Service User Experience Survey*

How satisfied you were with the following aspects of the service:	Parents	Young people
Experience of accessing the service	5	5
Information received prior to admission	5	4
Information provided by St Patrick's website	4	4
The process of assessment and admission	5	4
The information given on admission	5	4
The environment and facilities	4	4
The overall atmosphere or feel of the unit	5	4
The cleanliness of the unit	5	5
The meals provided	4	4
Visiting arrangements	4	4
Safety arrangements on the unit	5	5
Experience of care and treatment	5	4
Access to group therapy	5	
Access to individual therapy	4	4
Access to leisure activities and outings	4	4
Access to a range of professionals	4	5
Access to key workers/allocated nurses	5	5
Access to educational supports	4	4
Access to an independent advocacy group	4	4
Your level of contact with the treatment team	4	4
Information received on treatment plan	4	4
Your involvement (young person)/your collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4	4
How you felt you were listened to/respected	5	4
Confidentiality of the service	5	4
Opportunity to attend discharge planning meeting	5	4
Weekend/mid-week therapeutic leave agreements	4	4
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	5	4
Provision of family support	4	5
Opportunity to attend parents support group	5	N/A
Opportunity to attend positive parenting course	4	N/A

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

5.7. WGAU Homecare survey results

Quantitative responses

As with the WGAU inpatient survey, the median response (ie 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'.

Access

Most statements in the access section of the Homecare survey received a median response of 4 – 'happy' by both young people and their parents. The exception to this was to statement that asked about the process of admission. This received a median response of 3 – 'mixed' from both young people and parents. The median response from parents to the statement that asked about the information given on admission was also 3 – 'mixed'.

Care and treatment

In the care and treatment section of the survey, the median response of 5 – 'very happy' was received from parents about the confidentiality of the service and the opportunity to attend discharge planning meetings. The median response from young people to these statements was both 4 – 'happy'.

When asked about their experience of care and treatment, the median response from both parents and young people was 4 – 'happy'.

The median response from parents when asked if they felt their child's Homecare admission useful in addressing their mental health difficulty, was 4 – 'happy'.

Young people provided a median response of 3 – 'mixed' to the statement that asked if they felt their Homecare provided them with the skills to manage their mental health.

Table 5.38: *Median responses to WGAU Homecare Service User Experience Survey*

Please tell us how satisfied you were with aspects of the service	**Parents**	**Young people**
Waiting time for admission to Homecare	4	4
The information you received prior to Homecare admission	4	4
The information provided by St Patrick's website	4	4
The process of assessment and admission	3	3
The information given on admission	3	4
Experience of care and treatment	4	4
Experience of daily contact calls	4	3
Access to group therapy	3	3
Access to individual therapy	3	4
Access to a range of professionals	2	4
Access to key workers/allocated nurses	4	4
Access to educational supports	4	3
Information received on treatment plan	4	3
Your level of contact with the treatment team	4	3
Your involvement (young person)/your collaboration (parent) in treatment plan	4	3
How you felt you were listened to/respected	4	3
Confidentiality of the service	5	4
Opportunity to attend discharge planning meeting	5	4
Information given to you to prepare for discharge	4	3
Having a service identified for follow up care	4	4
Access to family support	3	4
Was your child's Homecare admission useful in addressing their mental health difficulty?	4	N/A
Providing you with skills to manage mental health	N/A	3

5.8. Adolescent Dean Clinic

5.8.1 Surveys 2023

In 2023, Adolescent Dean Clinic appointments were delivered face-to-face and remotely by technology-enabled care. The Adolescent Dean Clinic gathers feedback from young people attending the service through the use of a Service User Experience Survey. The format of this survey is the same as the version used by adult service users.

The survey was sent by email to the parents/carers of young people who had attended Adolescent Dean Clinic appointments inviting them to ask the young people to complete the survey. Access to the survey was also displayed in the Adolescent Dean Clinic where young people attending appointments could access the survey using a QR code. In 2023, this survey was completed by 42 young people There were no survey responses to this survey available for 2022.

Adolescent Dean Clinic Survey Respondent Demographics

The majority of the adolescent Dean Clinic survey responses in 2023 were from females (65.2%, n=30), aged between 15 and 17 years of age (76.1%, n=35) and who live in Munster (67.4%, n=31). 60% (n=27) of respondents said they heard about the Dean Clinic adolescent service from their General Practitioner (GP).

Figure 5.24. *How respondents heard about Adolescent Dean Clinics*

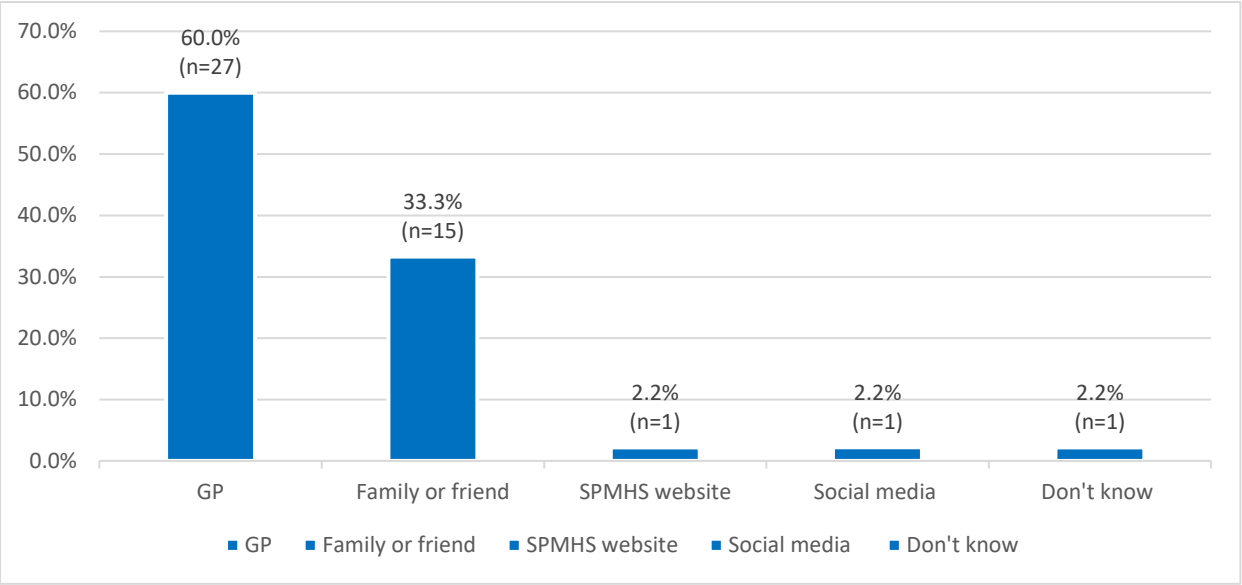
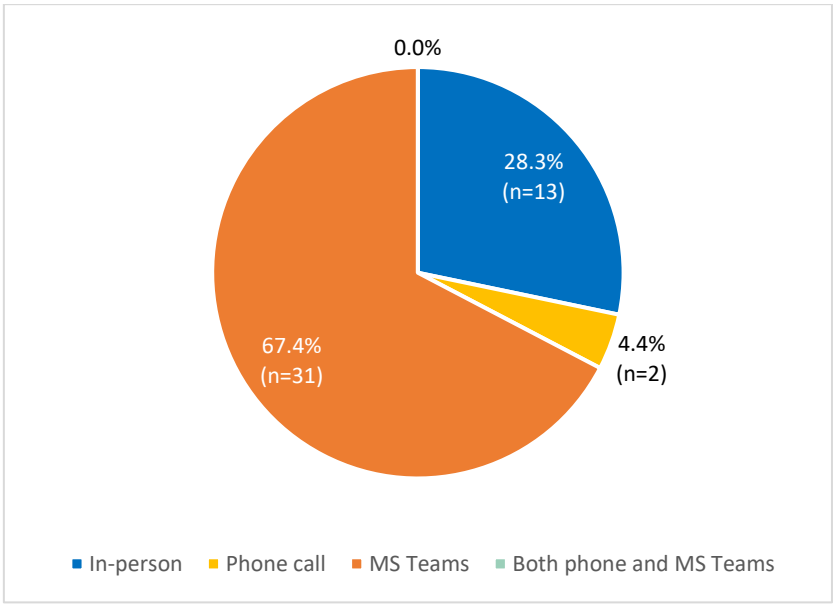


Figure 5.25. *How respondents attended their most recent Adolescent Dean Clinic appointment*



The majority of respondents (67.4%, n=31) attended their Adolescent Dean Clinic appointment by MS Teams in 2023. 28.3% (n=13) said they attended their Adolescent Dean Clinic appointments in person. 4.4% (n=2) of respondents said they accessed their appointment by phone calls, and none said they used both phone calls and MS Teams to attend their appointment.

Adolescent Dean Clinic in-person appointment feedback

The following section of this report details the feedback provided by 28.3% (n=13) of Adolescent Dean Clinic survey respondents who attended their appointments in person between January and December 2023.

Table 5.39. *Dean Clinic adolescent survey respondents experience of attending adolescent Dean Clinics in person*

Please tell us about your experience of attending the Adolescent Dean Clinic	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
The Adolescent Dean Clinic location was convenient for me to access the Dean Clinic	4	30.7	6	46.2	1	7.7	2	15.3	0	0.0	**13**
I was welcomed in a friendly and professional manner by the Adolescent Dean Clinic staff	8	61.5	5	38.5	0	0.0	0	0.0	0	0.0	**13**
I was shown where the facilities were in the Adolescent Dean Clinic, such as the bathroom and waiting room	3	23.1	4	30.7	4	30.7	1	7.7	1	7.7	**13**

Experience of staff during in person Adolescent Dean Clinic appointment

Table 5.40. *Adolescent Dean Clinic survey respondents experience of staff during their Dean Clinic in person appointment*

Tell us about your experience of your Adolescent Dean Clinic appointment	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I was treated with dignity and respect	8	61.5	5	38.5	0	0.0	0	0.0	0	0.0	**13**
My confidentiality was protected	7	53.8	5	38.5	0	0.0	1	7.7	0	0.0	**13**
My privacy was respected	6	46.2	7	53.8	0	0.0	0	0.0	0	0.0	**13**
I felt included in decisions about my treatment	6	46.2	5	38.5	1	7.7	1	7.7	0	0.0	**13**
I trusted my doctor or therapist or nurse	8	61.5	2	15.4	1	7.7	2	15.4	0	0.0	**13**
My appointment was value for money	4	30.7	1	7.7	6	46.2	1	7.7	1	7.7	**13**

I would recommend the Dean Clinic to family and friends	6	46.2	3	23.1	3	23.1	1	7.7	0	0.0	**13**

Table 5.41. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending Adolescent Dean Clinics in person*

How would you rate…?	**…your care and treatment**		**…experience of SPMHS overall**	
	n	**% of those who responded**	n	**% of those who responded**
1	0	0.0	0	0.0
2	0	0.0	0	0.0
3	0	0.0	1	7.7
4	2	15.4	1	7.7
5	2	15.4	2	15.4
6	0	0.0	0	0.0
7	0	0.0	0	0.0
8	3	23.1	4	30.8
9	3	23.1	3	23.1
10	3	23.1	2	15.4
No answer	0	-	0	-
1-4	2	15.4	2	15.4
5+	11	84.6	11	84.6
Total	**13**	**100**	**13**	**100**

Table 5.42. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending Adolescent Dean Clinics in person*

How would you rate...?	N	Mean (μ)
Your care and treatment	13	7.6
Overall experience of SPMHS	13	7.4

The average rating between one and 10 of care and treatment from 13 respondents who attended their appointments in person was 7.6 out of 10. The average rating between one and 10 of overall experience of SPMHS from 13 respondents who attended appointments in person was 7.4 out of 10.

Adolescent Dean Clinic remote appointment feedback

The following section of this report details the feedback provided by 69.6% (n=32) Adolescent Dean Clinic survey respondents who attended their appointments remotely in 2023.

Devices

The majority of Adolescent Dean Clinic survey respondents used laptops (56.3%, n=18) followed by tablets (21.8%, n=7, smartphones (15.6%, n=5), and 6.3% (n=2) used personal computer (PC) to access their appointment remotely in 2023.

Table 5.43. *Adolescent Dean Clinic survey respondents' experience of attending their appointment remotely*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
It was convenient for me to access my appointment remotely	15	51.7	14	48.3	0	0.0	0	0.0	0	0.0	**29**
It was clearly explained to me how to access my appointment using either phone or video	18	62.1	10	34.5	1	7.7	0	0.0	0	0.0	**29**
I felt using technology to attend my appointment was a positive experience	13	44.8	13	44.8	2	6.9	1	3.5	0	0.0	**29**
I would consider the option of attending Dean	12	41.4	11	37.9	4	13.8	2	6.9	0	0.0	**29**

Clinic appointments by phone or video in the future

Table 5.44. *Adolescent Dean Clinic survey respondents' experience of staff while attending their appointment remotely*

Please tell us about your experience of remotely accessing our services:	Strongly agree		Agree		Neither agree or disagree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	n	%	n
I was treated with dignity and respect	26	89.6	2	6.9	1	3.5	0	0.0	0	0.0	**29**
My confidentiality was protected	23	79.3	4	13.8	2	6.9	0	0.0	0	0.0	**29**
My privacy was respected	23	79.3	4	13.8	2	6.9	0	0.0	0	0.0	**29**
I felt included in decisions about my treatment	19	65.5	9	31.0	1	3.5	0	0.0	0	0.0	**29**
I trusted my doctor or therapist or nurse	21	72.4	7	24.1	1	3.5	0	0.0	0	0.0	**29**
My appointment was value for money	14	48.3	6	20.7	6	20.7	2	6.9	1	3.5	**29**
I would recommend the Dean Clinic to family and friends	19	65.5	9	31.0	0	0.0	1	3.5	0	0.0	**29**

Table 5.45. *Adolescent Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

How would you rate...?	...your care and treatment		...experience of SPMHS overall	
	n	% Of those who responded	n	% Of those who responded
1	0	0.0	0	0.0
2	0	0.0	0	0.0
3	0	0.0	0	0.0
4	1	3.6	1	3.6
5	0	0.0	0	0.0
6	0	0.0	0	0.0
7	0	0.0	1	3.5
8	4	14.3	4	14.3
9	10	35.7	10	35.7
10	13	46.4	12	42.8

No answer	1	-	1	-
1-4	1	3.6	1	3.6
5+	27	**96.4**	27	**96.4**
Total	28	100	28	100

Table 5.46. *Adolescent Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

How would you rate…?	N	Mean (μ)
Your care and treatment	28	9.1
Overall experience of SPMHS	28	9.0

The average rating between one and 10 of care and treatment from 28 respondents who attend Adolescent Dean Clinic appointments remotely was 9.1 out of 10. The average rating between one and 10 of overall experience of SPMHS from 28 respondents who attended their appointment remotely was 9.0 out of 10.

SECTION SIX

CONCLUSIONS

6.1. Conclusions

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

2. 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. In 2023, there was an increase in the number of the clinical programmes utilising 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 2023, 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 2023, significant improvements were made in the overall Service User Experience Survey response rates, through changes in processes, including increased focus on technology mediated surveys. The results presented in this annual outcomes report are reflective of the continued achievement of excellent levels of compliance on annual mental health commission inspection in 2023. The organisation delivered a full and comprehensive outcomes report in 2023, demonstrating the commitment of all SPMHS staff to continuously measure and improve our services. In keeping with efforts to expand the number of services incorporated in this report, two additional programmes were added to the *Outcomes Report* this year: The Building Healthy Self Esteem programme and Compassion-Focused therapy for Older 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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