St Patrick's
Mental Health Services

Outcomes Report 2017

Annual Review of St Patrick's Mental Health Services' Outcomes.

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SECTION 1

Introduction

1. Introduction

This report presents outcomes relating to clinical care, clinical governance processes, clinical programmes and service user satisfaction rates, within St Patrick's Mental Health Services (SPMHS). It is the seventh year that an outcomes report has been produced by SPMHS and is central to the organisation's promotion of excellence in mental health care. By measuring and publishing outcomes of the services we provide, we strive to understand what we do well and what we need to continue to improve. Wherever possible validated tools are utilised throughout this report and the choice of clinical outcome measures used is constantly under review, to ensure we are attaining the best possible standards of service delivery.

Leading healthcare providers around the world capture outcome measures related to care and treatment and make the results publicly available in order to enable service users, referrers and commissioners to make informed choices about what services they choose. Transparency informs staff of the outcomes of services they provide and advances a culture of accountability for the services being delivered. It provokes debate about what care and treatment should be provided and crucially how best to measure their efficacy. The approach of sharing treatment outcome results has also been used by the Mental Health Commission in Ireland (Mental Health Commission, 2012).

The 2017 Report is divided into 6 Sections. Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPMHS services are structured and how community, day-patient and inpatient services were accessed in 2017. SPMHS provides community and outpatient care through its Dean Clinic Community Mental Health Clinics and day-patient services through its Wellness & Recovery Centre. It provides inpatient care through its three approved centres, St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

Section 3 summarises the measures and outcomes of the organisation's Clinical Governance processes. Section 4 provides an analysis of clinical

outcomes for a range of clinical programmes and services. This information provides practice-based evidence of the efficacy of interventions and programmes delivered to service users during 2017, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

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

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

SECTION 2

Service Accessibility.

2. St Patrick's Mental Health Services

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our services are accessed in a number of ways. These include our community care accessed through our Dean Clinic network of community mental health clinics, our day-patient care accessed through our Wellness and Recovery Centre and our in-patient care accessed through our three approved centres. This Section provides information about how our services were accessed through these services in 2017.

2.1. Community Based Services (Dean Clinics)

Since 2009 a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the organisation. SPMHS operates a total of seven Adult Dean Clinics and two Adolescent Clinics. In 2017, free of charge multi-disciplinary mental health assessments continued to be offered through the Dean Clinic network to improve access for service users.

Adult Dean Clinic Services

2.1.1. Dean Clinic Referrals Volume

Seven Adult Dean Clinics have been established to date and provide multi-disciplinary mental health assessment and treatment for those who can best be supported and helped within a community setting and provision of continued care for those leaving the hospital's in-patient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community Mental Health Services, Day Services and Inpatient Care. The clinics encourage and facilitate early intervention which improves outcomes. In 2017, there was a total of 1,923 Adult Dean Clinic referrals received from General Practitioners. This compares with a total of 2,068 in 2016, representing a decrease of 7%. However, referrers are now sending more appropriate referrals, due to the increasing awareness among GP's of the services provided by SPMHS.

2.1.2. Dean Clinic Referral Source by Province

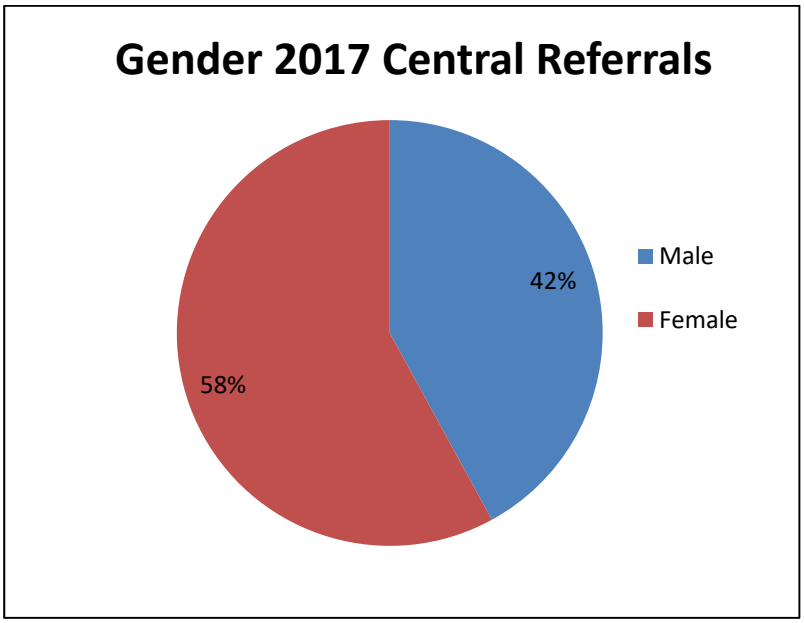
The following table illustrates the geographical spread of Dean Clinic Referrals by Province from 2013 to 2017. The highest referral volumes continued to be from Leinster in 2017 with 1251 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2013	1336	317	195	41	0
2014	1503	287	214	43	0
2015	1494	427	257	58	0
2016*	1320	444	243	45	16
2017*	1251	333	299	40	0

*This refers to Adult Services only. Adolescent Services are reported separately from 2016.

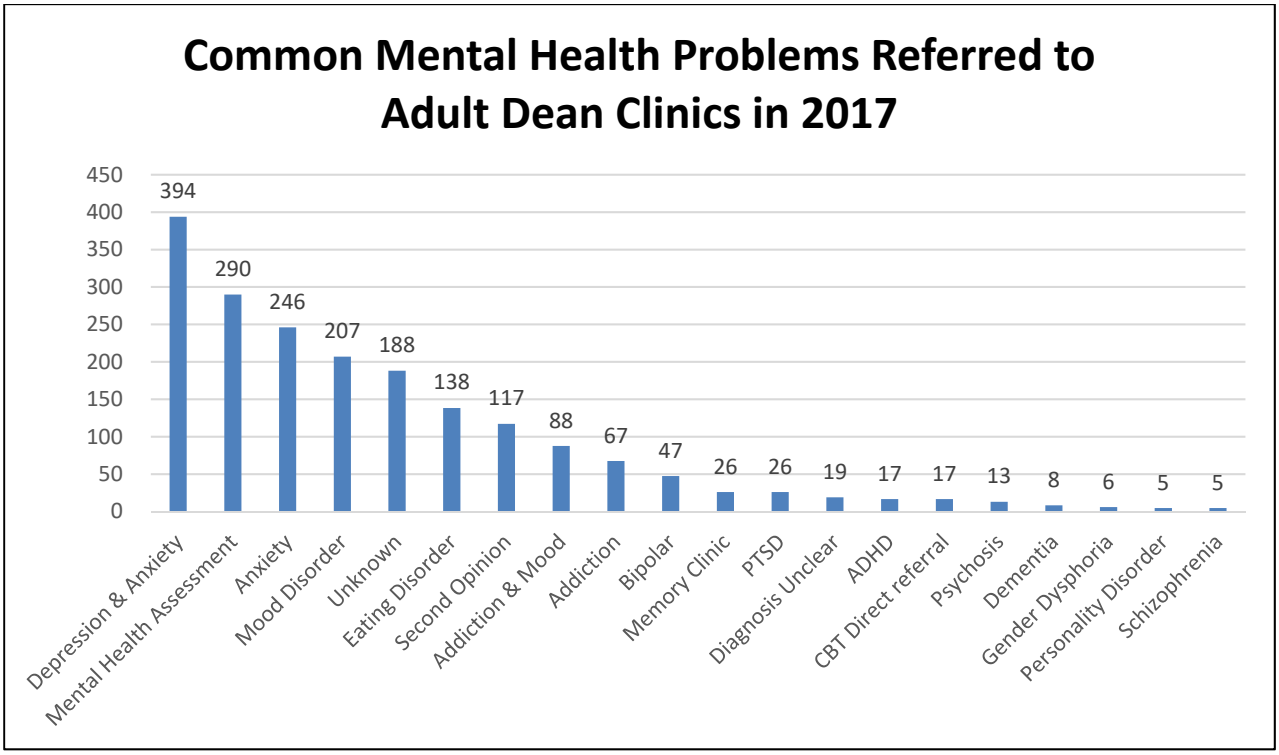
2.1.3. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic Adult referrals for 2017 was 58% female to 42% male.



2.1.4. Dean Clinic Referrals by Reason for Referral

The chart below documents the Common Mental Health Problems referred to the Dean Clinics throughout 2017 and shows Depression & Anxiety as the primary reason for referral.



2.1.5. Dean Clinic Activities (2010-2017)

2017 was a busy year clinically across all Dean Clinics. The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2010. Not all referrals resulted in an assessment, there are several reasons for this. In some cases, a decision is made not to progress with an assessment as the service user is already under the care of another service. Others do not attend their appointments and other service users have a more immediate need and are assessed for possible urgent admission to inpatient care.

Year	No. of Referrals	No. of Assessments
2010	692	573
2011	1376	924
2012	1759	1,398
2013	1889	1,422*
2014	2047	1,287*
2015	2236	1,461*
2016	2068**	1,204**
2017	1923**	1,128**

* From 2013 onwards, New Assessments include Assessments carried out by Associate Dean Consultant Psychiatrists.
** Excludes Adolescent Assessments from 2016, now reported separately.

A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Consultant Psychiatrist and other members of the multidisciplinary team. An individual care plan is agreed with the referred person following assessment which may involve follow-on community-based therapy, a referral to a day-patient programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the person to make a full recovery through the most appropriate treatment and care.

The following table summarises the total number of outpatient appointments or visits provided across Dean Clinics nationwide from 2010 to 2017.
Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager II Reviews, Clinical Nurse Specialist reviews, Nurse Reviews, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology, Psychotherapy. The decrease in the number of appointments is primarily due to two factors: an extreme weather event and an unforeseen reduction in capacity.

Year	Total No of Dean Clinic Appointments
2010	5,220
2011	7,952
2012	12,177
2013	12,826*
2014	13,541*
2015	16,142*
2016	15,017**
2017	14,465**

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

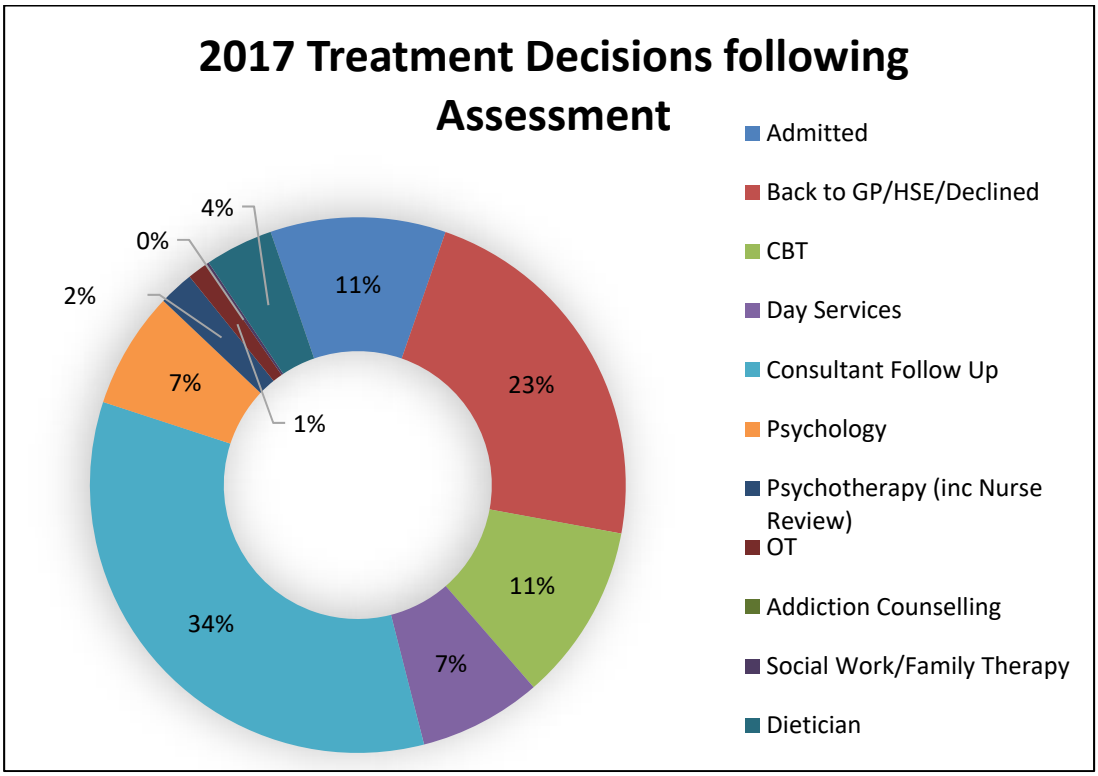
The table below summarises the number of first time inpatient admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2017.

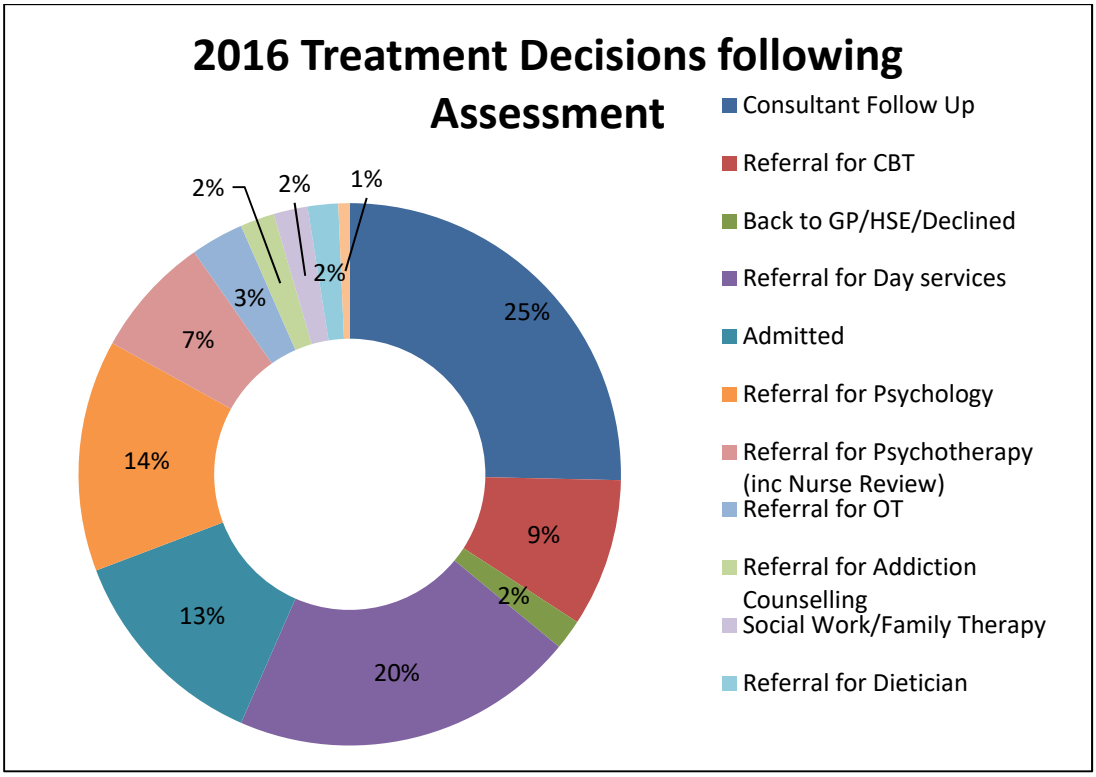
Year	First Admission
2011	150
2012	180
2013	225
2014	202
2015	235
2016	132*
2017	182*

*Excludes Adolescent Admissions from 2016

2.1.6 Dean Clinic: Outcome of Assessments

The two charts below summarise and compare the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics for 2016 and 2017.





Adolescent Dean Clinic Services

2.1.7 Dean Clinics Referral Volume

In 2017, there were a total of 614 referrals received for the Adolescent Service. The Adolescent Dean Clinics are based in Dublin and Cork.

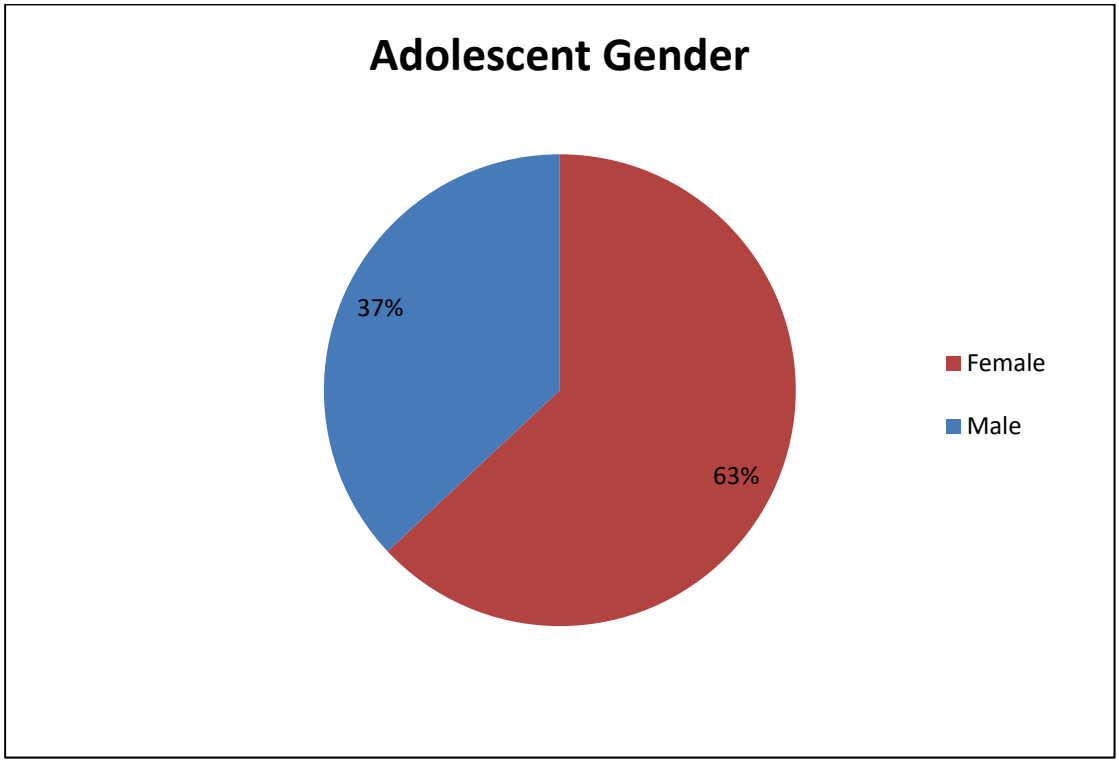
2.1.8 Dean Clinics Referral Source by Province

The following table illustrates the geographical spread of Adolescent Dean Clinic Referrals by Province for 2016 & 2017. The highest referral volume is from Leinster at 343 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2016	311	231	39	8	4
2017	343	232	23	16	0

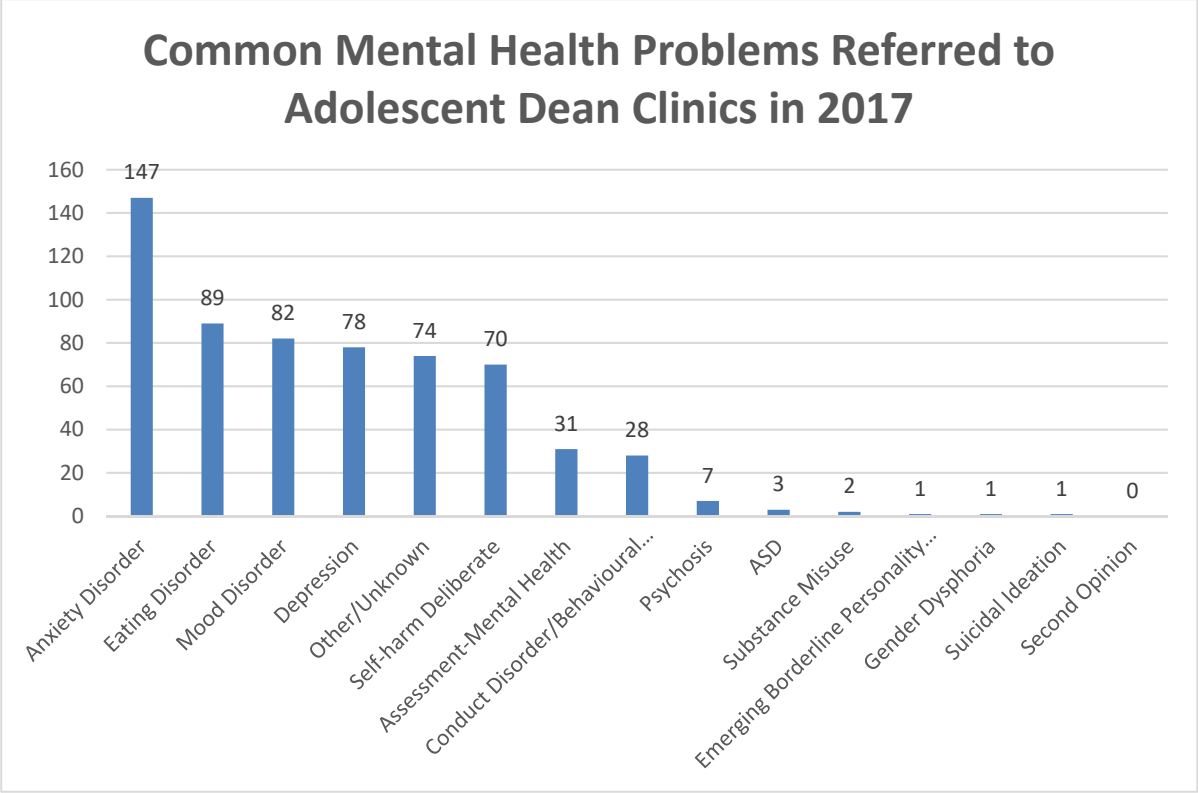
2.1.9 Dean Clinic Referrals by Gender

The Gender ratio of Dean Clinic Adolescent referrals for 2017 was 63% female to 37% male.



2.1.10 Common Mental Health Problems referred to Adolescent Dean Clinics

The chart below documents the Common Mental Health Problems referred to the Adolescent Dean Clinics throughout 2017 and shows Anxiety Disorders as the primary reason for referral.



2.1.11 Dean Clinic Activities

The table below summarises the number of Adolescent referrals and mental health assessments provided across the Adolescent Dean Clinics in 2017. Not all referrals result in an assessment, there are several reasons for this. In some cases, a decision is made not to progress with an assessment as the service user is already under the care of another service. Service users may not attend assessment appointments; decline the assessment offered and / or have a more immediate need and are referred for an admission assessment. In addition, service users may have been referred to a number of services and opt to take a local service. Parental consent is required prior to Adolescent assessments taking place.

Year	No. Of Referrals	No. Of Assessments
2016	593	201
2017	614	106

The reduction in Dean Clinic Adolescent assessments and appointments was due to an unforeseen reduction in capacity.

A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Consultant Psychiatrist and other members of the multidisciplinary team. An individual care plan is agreed with the referred adolescent and family following assessment. This may involve follow-on community-based therapy, a referral to a day-patient programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the young person to make a full recovery through the most appropriate treatment and care. The adolescent team provide family psycho-education to assist families in supporting the adolescents' recovery.

The following table summarises the total number of outpatient appointments or visits provided across Adolescent Dean Clinics nationwide in 2016 and 2017.

Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager Reviews, Clinical Nurse Specialist Reviews, Nurse Reviews, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology, Psychotherapy, Dietician service.

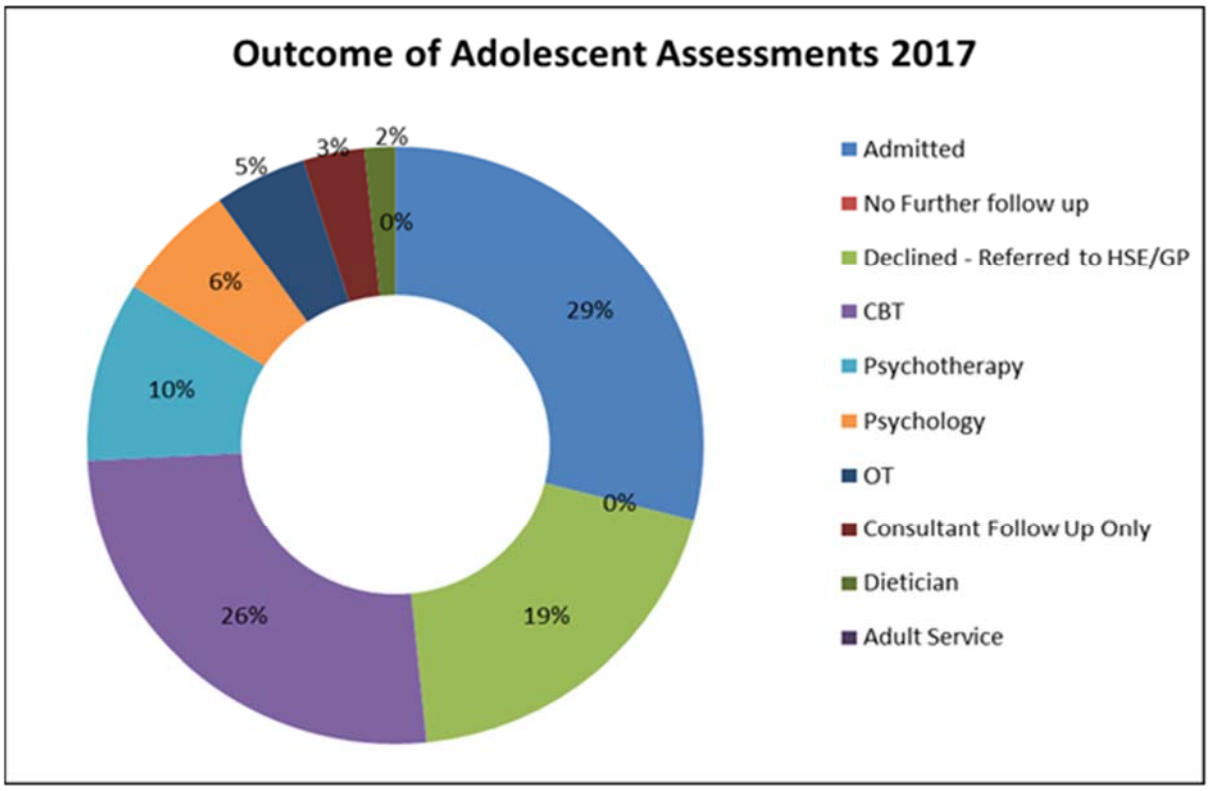
Year	Total No. Of Dean Clinic Adolescent Appointments
2016	1,944
2017	1,658

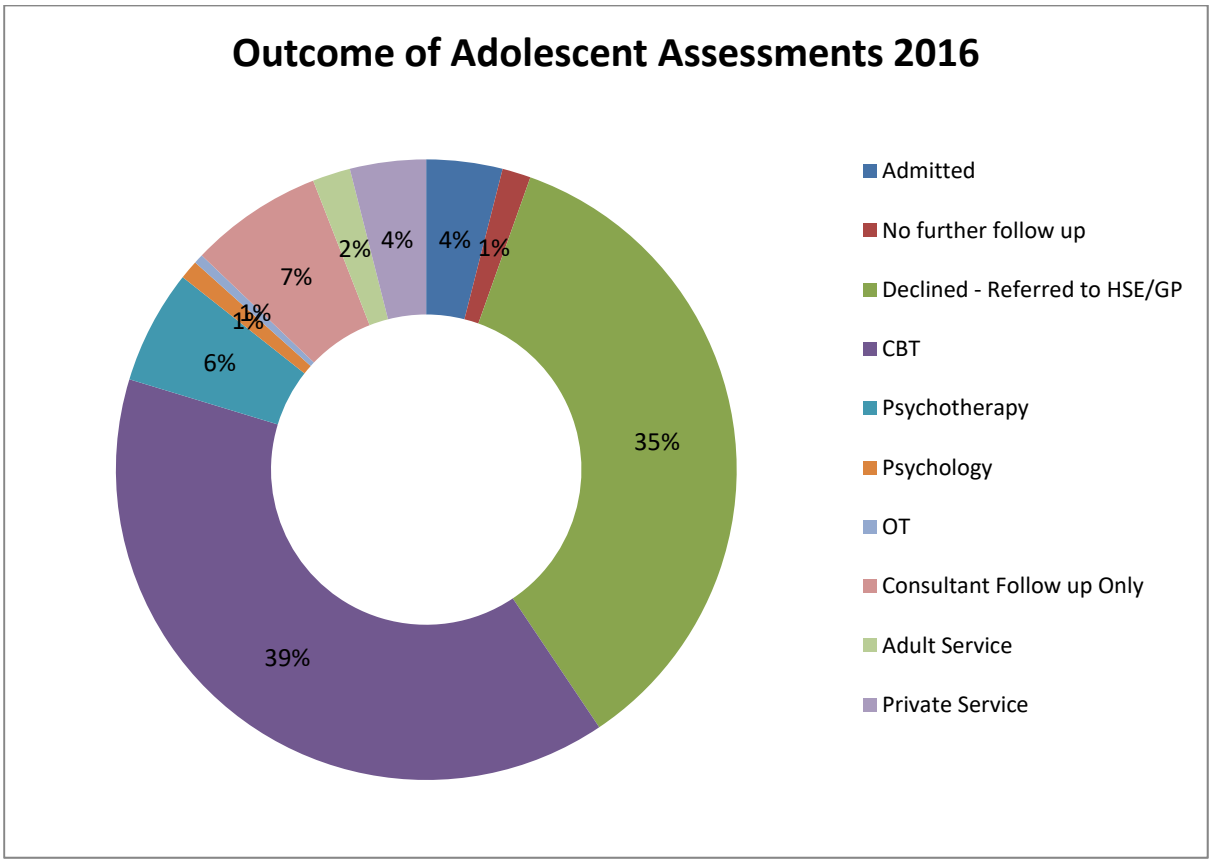
The total number of admissions to Willow Grove Adolescent Unit in 2017 was 85. The table below summarises the number of first time inpatient admissions to Willow Grove following an Adolescent Dean Clinic assessment in 2016 and 2017.

Year	First Admission
2016	68
2017	76

2.1.12 Dean Clinic: Outcome of Assessments

The chart below summarises the treatment decisions recorded in individual care plans following initial assessment in Adolescent Dean Clinics for 2016 and 2017.





2.2. SPMHS's Inpatient Care

SPMHS comprises of 3 separate approved centres including St Patrick's University Hospital (SPUH) with 241 inpatients beds, St Edmundsbury Hospital (SEH) with 52 inpatient beds and Willow Grove Adolescent Unit (WGAU) with 14 inpatient beds. In 2017, there were a total of 2,934 inpatient admissions across the organisation's 3 approved centres compared to 3,028 for 2016.

2.2.1. SPMHS Inpatient Admission Rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the 3 SPMHS approved centres; SPUH, SEH and WGAU for 2017.

The table below shows inpatient admission numbers and the percentage rates for Male and Female admissions. In 2017, 60.6% of admissions across all 3 Approved Centres were female, compared to 62.4% in 2016 and 60.4% in 2015.

No. of Admissions (% of Admissions) 2017				
	SEH	**SPUH**	**WGAU**	**Total**
Female	335 (70.4%)	1,384 (58.5%)	59 (63.4%)	1,778 (60.6%)
Male	141 (29.6%)	981 (41.5%)	34 (36.6%)	1,156 (39.4%)
Total	476 (100%)	2,365 (100%)	93 (100%)	2,934 (100%)

The table below shows the average age of service users admitted across the 3 Approved centres was 48.58 years in 2017. This compares to a figure of 50.45 years in 2016. The average age of adolescents admitted to WGAU was 15.49 years in 2017 as compared with 15.92 years in 2016. The average age of adults admitted to SEH was 55.51 years in 2017 & 54.87 years in 2016. Finally, the average age of adults admitted to SPUH was 49 years in 2017 compared with 50.66 years in 2016.

Average Age at Admission 2017					
	SEH	SPUH	Total Adult	WGAU	Total
Female	56.09	49.02	50.36	15.27	48.79
Male	54.09	48.97	49.54	15.87	48.28
Total	55.51	49.00	50.02	15.49	48.58

2.2.2. SPMHS Inpatient Length of Stay 2017

The following Tables present the 2017 average length of stay (LOS) for adult inpatients (over 18 years of age) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis and presentation of inpatient length of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2017 Adults	Number of Discharges	Percentage
Under 1 week	481	17%
1 -<2 weeks	238	8%
2-<4 weeks	551	20%
4-<5 weeks	279	10%
5-<6 weeks	326	12%
6-<7 weeks	236	8%
7-<8 weeks	175	6%
8-<9 weeks	124	4%
9-<10 weeks	101	4%
10-<11 weeks	85	3%
11 weeks -< 3 months	110	4%
3-<6 months	103	4%
6-12 months	2	0.1%
Total Number of Adult Discharges 2017	2811	100.00%

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

2017 WG	Number of Discharges	Percentage
Under 1 week	3	3%
1 -<2 weeks	2	2%
2-<4 weeks	11	12%
4-<5 weeks	7	8%
5-<6 weeks	9	10%
6-<7 weeks	19	20%
7-<8 weeks	8	9%
8-<9 weeks	9	10%
9-<10 weeks	3	3%
10-<11 weeks	5	5%
11 weeks -< 3 months	6	6%
3-<6 months	11	12%
Total Number of Adolescent Discharges 2017	93	100%

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpatients discharged in 2017)

The table below outlines the prevalence of diagnoses across SPMHS 3 Approved Centres during 2017 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 3 of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Edmundsbury Hospital combined. The data presented is based on all inpatients discharged from SPMHS in 2017.

SPMHS Analysis of Inpatient Primary ICD Diagnoses
(For all inpatients discharged in 2017)

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

ICD Codes: Admission & Discharge **For All Service Users Discharged in 2017**	SPUH Admissions		SPUH Discharges		SEH Admissions		SEH Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	49	2.1	44	1.9	1	0.2	1	0.2	50	1.8	45	1.6	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	386	16.5	406	17.4	27	5.7	27	5.7	413	14.7	433	15.4	0	0.0	0	0.0
F20-F29 Schizophrenia, schizotypal and delusional disorders	232	9.9	233	10.0	27	5.7	28	5.9	259	9.2	261	9.3	1	1.1	1	1.1
F30-F39 Mood [affective] disorders	1202	51.4	1181	50.5	314	66.5	314	66.5	1516	53.9	1495	53.2	39	41.9	33	35.5
F40-F48 Neurotic, stress-related and somatoform disorders	279	11.9	272	11.6	80	16.9	76	16.1	359	12.8	348	12.4	20	21.5	21	22.6
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	70	3.0	75	3.2	2	0.4	1	0.2	72	2.6	76	2.7	27	29.0	27	29.0
F60-F69 Disorders of adult personality and behaviour	117	5.0	121	5.2	19	4.0	22	4.7	136	4.8	143	5.1	2	2.2	6	6.5
F70-F79 Mental retardation	0	0.0	0.0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
F80-F89 Disorders of psychological development	4	0.2	5	0.2	0	0.0	0	0.0	4	0.1	5	0.2	2	2.2	2	2.2
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0	0.0	2	0.1	2	0.4	3	0.6	2	0.1	5	0.2	2	2.2	3	3.2
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
Totals	2339	100	2339	100	472	100	472	100	2811	100	2811	100	93	100	93	100

2.3. SPMHS's Day-patient: Wellness & Recovery Centre

The Wellness & Recovery Centre (WRC) was established in November 2008, following a reconfiguration of SPMHS Day Services. As well as providing a number of recovery-oriented programmes, the Centre provides service users with access to a range of specialist clinical programmes which are accessed as a step-down service following inpatient treatment or as a step-up service accessed from the Dean Clinics. Clinical programmes are delivered by specialist multi-disciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports and include the following:

1. Anxiety Programmes
2. Bipolar Disorder Programmes
3. Depression Programme
4. Addictions Programme
5. Eating Disorders Programme
6. Mental Health Support Programme (Pathways to Wellness)
7. Recovery Programme
8. Young Adult Programme
9. Psychosis Recovery Programme
10. Living Through Distress Programme
11. Radical Openness Programme
12. Compassion Focused Therapy
13. Living Through Psychosis
14. Mindfulness Based Stress Reduction
15. Psychology Skills Older Adults (SAGE)
16. Psychology Skills Adolescents
17. Compassion Focused Therapy for eating Disorders
18. Schema Therapy

The data below provides information on the types of services accessed by service users. In 2017, the WRC received a total of 2,096 day-programme referrals compared to a total of 1,943 for 2016, a year on year increase of 8%. 460 of the day programme referrals for 2017 came from Dean Clinics. This compares to a total of 510 day-programme referrals from Dean Clinics in 2016.

2.3.1. Day-Patient Referrals by Clinical Programme

The table below compares the total number of day programme referrals to each clinical programme for 2016 and 2017. In addition, day programme referrals received from the Dean Clinics are presented.

SPMHS Day Programmes	Total Day Patient Referrals from Dean Clinics 2016	Total Day Patient Referrals from Dean Clinics 2017	Total Day Patient Referrals 2016	Total Day Patient Referrals 2017
St.Edmundsbury Services	62	82	247	354
Depression Programme	71	47	324	272
Recovery Programme	57	32	228	200
Anxiety Programme	83	89	198	194
Links to Wellbeing	8	32	35	160
Alcohol Stepdown	0	0	112	139
Compassion Focused Therapy	23	25	103	118
Living Through Distress	18	17	107	104
Radical Openness	20	14	111	84
Mindfulness	67	36	115	78
Pathways to Wellness	11	7	37	74
Psychology Skills for Older Adults	21	13	60	62
Living Through Psychosis	13	7	76	61
Eating Disorder Programme	24	13	41	60
Bipolar Programme	13	24	68	49
CFT Eating Disorders	2	10	17	35
Schema Therapy	1	1	28	17
Psychology Skills for Adolescents	7	9	9	12
Young Adult programme	5	1	9	12
Driving Assessments	1	0	9	8
Psychosis Programme	3	1	9	3
Total	**510**	**460**	**1943**	**2096**

2.3.2. Day-patient Referrals by Gender

Of all referrals to day services in 2017, 1,317 (62.8%) were female and 779 (37.2%) male. This compares to 1,188 (61%) female and 757 (39%) male in 2016.

2.3.3 Day-patient Referrals from Dean Clinics

In 2017, a total of 460 day-patient referrals were made from Dean Clinics, representing 22% of the total referrals to Day Programmes.

In 2016 a total of 510 day-patient referrals were received from Dean Clinics representing 26.24% of the total referrals to Day Programmes.

2.3.4. Day-patient Attendances for Clinical Programmes 2016-2017

In 2017, 1,329 commenced day-patients commenced day programmes, compared to 1,213, in 2016. These registrations represented a total of 14,150 (2017) and 13,085 (2016) half day attendances respectively. Therefore in 2016 each registered day service user attended on average 10.78 half days while in 2017 each registered day service user attended on average 10.64 half days.

Day Patient Attendances at Clinical Programmes

SPMHS Day Programmes	Total Day Patient registrations 2016	Total Day Patient registrations 2017	Total Day Patient Attendances 2016	Total Day Patient Attendances 2017
Depression Programme	110	137	1412	1616
Access to Recovery	0	124		1558
Eating Disorder	30	48	871	1290
Recovery Programme	151	79	2375	1135
Anxiety Programme	86	86	1027	1032
Alcohol Stepdown	123	141	860	1030
Radical Openness	45	73	1000	922
Living Through Distress	70	64	717	769
Pathways to Wellness	25	43	388	742
Acceptance and commitment Therapy	86	130	617	660
Compassion Focus Therapy	63	41	666	458
Psychology Skills Older Adults	37	30	267	346
Schema Therapy	20	15	215	335
CFT Eating Disorders	10	22	245	307
Living Through Psychosis	51	44	339	291
Mindfulness	84	36	438	280
Mindfulness	35	45	198	233
Healthy Self Esteem	22	24	216	230
Bipolar Programme	38	39	206	185
Psychology Skills Adolescents	13	11	207	173
Radical Openness	12	12	193	142
Mood Management	17	26	78	116
Roles in Transition	31	28	101	90
Young Adult programme	7	3	96	34
Psychosis Programme	5	7	16	29
Driving Assessments	10	5	10	7
Links to Wellbeing	18	0	123	0
	1213	1329	13085	14150

SECTION 3

Clinical Governance

3. Clinical Governance & 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.

The table below provides a summary of key clinical governance measures, between 2013 and 2017.

3.1 Clinical Governance Measures Summary

Governance Measure	2013	2014	2015	2016	2017
Clinical Audits	19	10	16	26	20
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	635	627	666	860	818
Number of Incidents An event or ciscumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	2098	2227	2423	2601	2594
Root Cause Analyses & Focused Reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	6	11	9	3	8
Number of Section 23's – Involuntary detention of a voluntary service user A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the Approved Centre (SPUH) - where the person indicates an intention to discharge from the Approved Centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	107	107	92	84	73
% 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.	37 % (40)	43% (46)	44% (41)	48% (41)	47% (34)
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.	46	52	39	60	61
% of Section 14's which progress to Involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	76% (35)	80% (42)	87% (34)	88% (53)	90% (55)
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.	21	13	19	18	47
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	33	37	18	15	20
Number of Section 60 – Medication Reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of 3 months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	15	11	10	4	12
Number of Section 19 – Appeal to Circuit Court A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness.	6	2	2	0	3
Number of Tribunals held	96	91	63	72	86
Mental Health Commission Reporting – Number of ECT Programme's (Signed off) in 2016	129	143	103	142	132
Mental Health Commission Reporting – Number of Physical Restraint Episodes (Including WGAU)	219	129	178	174	204

3.2. Clinical Audits

This section summarises briefly the clinical audit activity for St. Patrick's Mental Health Services in 2017. 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 taking action to bring practice in line with these standards. A complete clinical audit cycle involves re-measurement of previously audited practice to confirm improvements and make further improvements if needed.

3.2.1. Overview of Clinical Audit Activity

The table below demonstrates the breakdown of projects by type undertaken in 2017 including those facilitated by clinical staff at local level and those carried out throughout the organization 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 of change pre and post inpatient treatment** To measure the CGI /CGAS outcomes for service users pre and post admission .	Clinical Governance Committee	Yearly audit completed
2.	**Individual Care Plan Key Worker System** Ensure compliance with the Mental Health Commission standards and local policies at St. Patrick's University Hospital, St. Edmundsbury Hospital and Willow Grove Adolescent Unit.	Clinical Governance Committee	Four re-audits completed in 2017.
3.	**Audits of compliance with the Regulations for approved centres** To ensure compliance with the Mental Health Commission guidelines and rules of practice.	Departmental Audits	Baseline audits and re-audits completed in 2017.
4.	**Clozapine initiation pathway re-audit** To ensure that Clozapine (Clozaril ®) is prescribed according to guidelines in Hospital and too ensure adherence to the Clozaril ® Patient Monitoring Service (CPMS) guidelines and the SPMHS Clozapine Initiation Pathway.	Clinical Governance Committee	Re-audit completed in 2017.
5.	**Re-audit on the use of Agomelatine in SPMHS** To ensure the sufficient monitoring of service users prescribed agomelatine to detect possible side effects.	Clinical Governance Committee	Re-audit completed in 2017.
6.	**ECT Processes** To assess consistency and appropriateness of the ECT documentation in accordance with the MHC guidelines.	Clinical Governance Committee	Re-audit completed.
7.	**Adherence to the organisations protocol on falls risk prevention interventions** Ensure that service users identified as medium or high risk of fall or with fall episode are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Re-audit completed.

No.	Audit Title	Audit Lead	Status at year end
8.	**Is ECG routinely performed on admission?** To assess whether ECG is routinely performed on admission to St. Patricks University Hospital and St. Edmundsbury Hospital.	Clinical Governance Committee	Baseline audit completed.
9.	**Follow up of abnormal laboratory test results** To ensure that critical and notifiable laboratory test results are correctly communicated, documented and reviewed.	Clinical Governance Committee	Re-audit completed.
10.	**Infection Control Audits** Theses audits measure the implementation of policies and procedures relating to infection control.	Infection Control Committee	These are yearly routine audits. Audits scheduled for 2017 were completed.
11.	**Nursing Metrics** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit.
12.	**Prescribing for substance misuse: alcohol detoxification** To assess adherence to best practice standards derived from the NICE clinical guidelines on alcohol-use disorders (NICE CG100, 2010 and CG115, 2011).	Clinical Governance Committee	Re-audit completed.
13.	**Prescribing high dose and combined antipsychotics on adult psychiatric wards (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE Schizophrenia Guideline, 2014.	Clinical Governance Committee	Re-audit completed.

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

No.	Audit Title	Audit Lead	Status at year end
14.	**Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE Guideline on Violence and aggression: short-term management in mental health, health and community settings - NICE NG10 (2015).	Clinical Governance Committee	Baseline audit completed.
15.	**Review compliance with documentation of last menstrual period for patients of child bearing potential on admission to SPUH** To review documentation on admission of LMP in clinical examination section and, if necessary, put in place measures to improve adherence to LMP documentation.	Multidisciplinary Team	Full audit cycle completed.
16.	**Correct adherence to benzodiazepine and hypnotic withdrawal schedule** Measure adherence to the standard benzodiazepine and hypnotic detoxification schedules and the safety recommendations as stated in the SPMHS hospital guidelines and to implement changes to improve adherence to the guidelines.	Multidisciplinary Team	Full audit cycle completed.
17.	**Pre-lithium commencement therapy treatments checks** To ensure that Lithium therapy is efficacious and monitored effectively.	Multidisciplinary Team	Full audit cycle completed.
18.	**CBT Formulation in the Depression Programme- Access for All** To ensure quality of discharge formulation.	Multidisciplinary Team	Full audit cycle completed.

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

No.	Audit Title	Audit Lead	Status at year end
19.	**An audit of effective monitoring of Cardiovascular risk factors in inpatients with Bipolar Affective Disorder.** To establish if we are monitoring physical and cardiovascular health parameters in inpatients with a diagnosis of Bipolar Affective Disorder in accordance with NICE guidelines.	Multidisciplinary Team	Baseline audit completed.
20.	**Use of DEXA scanning in an adolescent inpatient unit and management of the results.** To ensure that all patients who fit criteria for DEXA scan are referred for same. To ensure that patients with low bone mineral density are appropriately managed.	Multidisciplinary Team	Baseline audit completed.

3.2.2. Key Audit Outcomes for 2017

- The findings showed a satisfactory level of performance of completion of the Clozapine Initiation Pathway, pre-treatment physical health checks, including ECG and the on-going monitoring of adverse effect of the treatment.
- The analysis of the data collected on the use of Agomelatine in SPMHS showed that over a half of the service users admitted for inpatient treatment and who were prescribed this drug prior to admission were discontinued this treatment prior to discharge from in-patient care. This is good practice as this non-formulary medicine is associated with possible side effects.
- A Clinical Audit Programme for audits of compliance with the Regulations for approved centres is continued and all Departments are actively involved.
- The findings from the re-audit on prescribing for alcohol detoxification suggest that in most key metrics SPMHS, for both the specialist and general adult services, is exceeding the comparable benchmark data provided by UK Trusts for the purpose of the POMH-UK baseline audit. Patients are being assessed for risk of alcohol withdrawal on admission, examined for sequelae of alcohol use, appropriately prescribed a benzodiazepine and thiamine, monitored closely during alcohol detox, and investigated for potential alcohol related complications.
- The data from the POMH-UK audit on prescribing high dose and combined antipsychotics showed that a small proportion of eligible patients who were on antipsychotic medication were prescribed a high dose antipsychotic therapy (HDAT). Among fifty-seven Trusts participating in the 2017 audit SPMHS had the second lowest proportion of service users prescribed HDAT. A relatively small proportion of inappropriate polypharmacy in comparison to the other Trusts was showed. The SPMHS were identified as the service with the highest compliance with the standard on incorporating HDAT into care plans. The safety monitoring of HDAT was also excellent.
- The baseline POMH-UK rapid tranquillisation audit looked at prescribing patterns for the management of an episode of acutely-disturbed behaviour. The SPMHS data analysis identified a small proportion of service users receiving intramuscular medication for rapid tranquillisation; the vast majority of the service users were administered oral medication. Prompt debriefs following the episodes of rapid tranquilization with service users

involved were held. SPMHS was the highest scored service among 57 Trusts participated in this audit. The SPMHS had, among 11 other Trusts, full compliance with the standard on assessment of the mental and behavioural state of the service user following the period of rapid tranquilization.

SECTION 4

Clinical Outcomes

4. Clinical Outcomes

Clinical outcome measurement has been in place in St Patrick's Mental Health Services since 2011 and is a priority for the service, embedded within clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2015 outcome measurement expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing shift towards an organisational culture that recognises the value of intergrated outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important Considerations for Interpretation of Outcomes.

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

- The data reported in this chapter represent pre and post programme measurements.
- Pre and post measurement is 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 Wilcoxin Signed Rank test is used. **Statistical significance** indicates the extent to which the difference from pre to post is due to chance or not. Typically the level of significance is set at $p > 0.05$ which means that there is only a 5% probability that the difference is due to chance and therefore it is likely that there is a difference. Statistical significance provides no information about the magnitude, clinical or practical importance of the difference. It is possible that a very small or unimportant effect can turn out to be

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

- **Statistically non-significant findings** suggest that the change from pre and post is not big enough to be anything other than chance but does not necessarily mean that there is no effect. Non-significant findings may result from small sample size, the sensitivity of the measure being used or the time point of the measurement. As such non-significant findings are not unimportant; rather they provide useful information and an invitation to investigate further.
- **Practical significance** indicates *how much* change there is. One indicator of practical significance is effect size. **Effect size** is a standardized 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 behavioral 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 or not a treatment was effective enough to change whether or not a patient met the criteria for a clinical diagnosis at the end of treatment. It is possible for a treatment to produce a significant difference and medium to large effect sizes but not to demonstrate a positive change in the service user's level of functioning.

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for Inpatient Care 2017

4.2.1. Objective

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

Following admission each service user's level of functioning and illness severity is evaluated by a clinician or multidisciplinary team (MDT) either between admission and the first MDT meeting or at a first MDT meeting. This is referred to as the CGIS or 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 Clinical Global Impressions Scale (CGI) is a standard, widely used mental health assessment tool. The complete CGI scale consists of three different global measures designed to rate the effectiveness of a particular treatment: the CGI-Severity (CGIS) that is used to establish the severity of psychopathology at point of assessment; the CGI-Change or Improvement (CGIC) which compares the service user baseline condition to her/his current condition following care, treatment or intervention; the efficacy index that compare the service user's baseline condition to a ratio of current therapeutic benefit and severity of side effects. Out of these three measures the CGIS and the CGIC are used frequently in clinical and research settings.

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

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

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

4.2.1.2. Data Collection Strategy

This report used data extracted from the Patient Administration System (PAS) which provided details on the St. Patrick's University (SPUH) and St. Edmundsbury (SEH) Hospital admissions and admissions to the Willow Grove Adolescent Unit (WG).

A random representative sample was chosen from admissions to SPUH and SEH. The chosen sample size was minimum of 400 cases. Then the cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases for each ward within the services.

An electronic database of CGAS scores recorded for admissions generated by the Willow Grove MDT provided CGAS data for the Adolescent sample. All WGAU inpatient admissions were included for the CGAS adolescent dataset.

The anonymised dataset collected for each selected case included the following variables:

- Service user age and gender,
- Admission ICD code (primary and additional),
- Date of admission,
- Admission ward,
- Re-admission rate,
- Date of discharge,

- Baseline assessment scale score (CGIS or CGAS respectively)– recorded on the Individual Care Plan on or before the first MDT meeting,
- Date recorded against the baseline score,
- Final assessment scale score (CGIC or CGAS respectively)– recorded on the MDT meeting care plan review document,
- Date recorded against the final score.

4.2.2. Sample Description

		TOTAL ADULT SERVICE	WGAU
Sample size		329	84
Admissions	1st admission	39%	87%
	Re-admission	61%	13%
Average age ± standard deviation		51±17	15 ± 1
Gender breakdown	Female	57%	67%
	Male	43%	33%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

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

		TOTAL ADULT SERVICE			WGAU		
ICD-10 Admission Diagnosis Category		**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
F30-F39	Mood disorders	58%	53%	58%	51%	39%	39%
F40-F48	Neurotic, stress-related and somatoform disorders	14%	15%	13%	13%	24%	21%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	12%	17%	14%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	7%	7%	1%	5%	1%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	3%	2%	1%	30%	26%	30%
F00-F09	Organic, including symptomatic, mental disorders	1%	0%	1%	0%	1%	0%
F60-F69	Disorders of adult personality and behaviour	6%	4%	5%	4%	1%	4%
F80-F89	Disorders of psychological development	0%	0%	0.3%	0%	0%	2%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0.3%	0%	0%	0%	3%	2%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *Total adult service*

CGIS -Baseline measure of severity of illness		2015	2016	2017
		TOTAL	TOTAL	TOTAL
1	Normal, not at all ill	0%	0%	0%
2	Borderline mentally ill	0%	0%	1%
3	Mildly ill	9%	10%	9%
4	Moderately ill	30%	30%	40%
5	Markedly ill	30%	30%	32%
6	Severely ill	18%	15%	9%
7	Extremely ill	0%	2%	1%
	Not scored	12%	13%	8%

Table: *Total adult service*

CGIC – Final Global improvement or change score		2015	2016	2017
		Total	Total	Total
1	Very Much improved	13%	13%	15%
2	Much Improved	49%	37%	45%
3	Minimally Improved	16%	15%	15%
4	No Change	6%	5%	5%
5	Minimally Worse	0%	0%	0%
6	Much Worse	0%	0%	0%
7	Very Much Worse	0%	0%	0%
	Not scored	16%	31%	20%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		**2015**		**2016**		**2017**	
		Baseline	**Final**	**Baseline**	**Final**	**Baseline**	**Final**
100-91	Superior functioning	0%	0%	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	0%	0%	0%
80-71	No more than a slight impairment in functioning	0%	0%	0%	0%	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	12%	0%	45%	0%	26%
60-51	Variable functioning with sporadic difficulties	33%	68%	24%	38%	7%	68%
50-41	Moderate degree of interference in functioning	55%	10%	61%	8%	56%	2%
40-31	Major impairment to functioning in several areas	6%	0%	12%	4%	36%	2%
30-21	Unable to function in almost all areas	0%	0%	4%	0%	1%	1%
20-11	Needs considerable supervision	0%	0%	0%	0%	0%	0%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	6%	10%	0%	5%	0%	0%
Mean ±SD		49±5	57±4	45±7	59±7	41±6	57±6
Median		50	57	45	59	42	58
Wilcoxon Signed Ranks Test:		Z=-5.983, p<.001		Z=-5.485, p<.001		Z=-7.841, 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 7 days following admission;

Exception: Short admission;

Target level of performance: 100%.

Audit Standard No. 2: Final score is taken within at least 7 days prior to discharge;

Exception: Short admission, unplanned discharge;

Target level of performance: 100%

4.2.4.2. Results

	TOTAL ADULT SERVICE			WGAU		
	2015	2016	2017	2015	2016	2017
Baseline Assessment Scale Score						
% of admission notes with recorded baseline scores	88%	87%	92%	94%	100%	100%
% compliance with clinical audit standard No. 1	67%	84%	85%	72%	99%	100%
Final Assessment Scale Score						
% of admission notes with recorded final scores	84%	69%	80%	90%	95%	100%
% compliance with clinical audit standard No. 2	81%	83%	85%	80%	95%	100%

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Mental Health Services discharges for 2017.

2. A female to male ratio was for adult service user's 1.3:1 for adults and WGAU 2:1 for adolescents.

3. Among the adults, there was a further increase in the number of service users who were admitted for the first time, in comparison to 2015 and 2016. In the 2017 sample, 1st admissions accounted for 39% of adult service users.

4. 2017 analysis of the primary ICD-10 codes showed for the adult population the most frequent reasons for admission to be mood disorders followed by behavioural disorders due to psychoactive substance use and neurotic, stress related, somatoform disorders.

5. In 2017 the breakdown of baseline clinical global improvement scores on admission shows that 40% of SPUH and SEH service users were moderately ill. Another 32% were markedly ill. 9% were severely ill. 1% of service users were extremely ill on admission.

6. There has been 12% increase in the percentage of service users rated as having moderate and markedly severity of illness on admission in comparison to 2014 - 2016 data. At the same time there has been 6% decrease in the percentage of service users who were dated as severely ill on admission.

7. Based on a sample of 262 (total cases with discharge CGI score documented) 94% of the sample were rated with an overall improvement (1 - very much improved (19%), 2 - much improved (57%) and 3 - minimally improved (18%)). This percentage of sample rated with an overall improvement is similar to those percentages observed between 2014 and 2016.

8. The majority (56%) of Willow Grove Adolescent Unit service users were scored as having a moderate degree of interference in functioning on admission. Baseline CGAS scores recorded for the population admitted to WGAU in 2017 revealed a 24% increase in the percentage of young people being admitted with major impairment of functioning in comparison to 2016 data.

9. Overall improvement rates for Willow Grove Adolescent Unit was 95% which gives a 7% increase in comparison to 2016 data. Of the sample 2.5 %

were found to have no change and this referred to short admissions. Another 2.5% were found to have dis-improved following in-patient treatment.

10. The audit shows improvement in recording the baseline and final assessment scales scores in adult and adolescent population.

4.3. Acceptance & Commitment Therapy Programme

Acceptance and Commitment Therapy (ACT) is an evidence-based psychotherapy which 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 Edmundsbury Hospital in 2010, runs recurrently over an 8-week period, for one half-day per week. During the eight-week programme, participants engage in a range of experiential exercises to help them develop the six core processes of ACT; mindfulness, thought defusion, acceptance, perspective taking, values and committed action. Participants are given three CDs to accompany the experiential exercises covered in session which assists in integrating ACT processes into their daily lives. The essential aim of this programme is to help people connect with what matters most to them and develop skills to help overcome the obstacles that get in the way of living a value guided life. The programme aims to foster a key shift in terms of helping people to look at their lives in terms of workability; what helps them move closer towards who and where they want to be, and what brings them further away. This programme is primarily facilitated by an experienced counselling psychologist who also trains other clinicians in the ACT approach.

4.3.1. Descriptors

In 2017, data were available for a total of 64 participants. Both pre and post measures were available for 44 of those completing the programme,

representing 68.75% of the sample. The remaining participants chose not to complete one or both sets of measures.

4.3.2. ACT Outcome Measures

The following programme measures were used:

• Acceptance & Action Questionaire II

The Acceptance and Action Questionnaire (AAQ II: Bond et al., 2011) is a 10 item measure of experiential avoidance or the tendency to avoid unwanted internal experiences – the opposite of which is psychological flexibility. Service users are asked to rate statements on a seven point likert scale from 1 "Never True" to 7 "Always true". Scores range from 1 to 70 with higher scores indicating greater psychological flexibility/less experiential avoidance. The AAQ II has good validity, reliability (Cronbach's alpha is .84 (.78 - .88)), and 3- 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 hypothesized to underlie depression and examines changes in: activation, avoidance/rumination, work/school impairment, and social impairment. The BADS consists of 25 questions; each rated on a seven point scale from 0 "not at all" to 6 "completely". Scores range from 0 to 150 with higher scores representing increased behavioural activation. Mean scores for a non-clinical sample of undergraduate students were 110.51 (*SD* = 21.04) (Kanter et al., 2007) and for a community sample with elevated depressive symptoms the mean was 69.83 (SD =20.15) (Kanter, Rusch, Busch & Sedivy, 2009). The measure has good internal consistency (Cronbach's α ranging from .76 - .87), adequate test-retest reliability (Cronbach's α ranging from .60 - .76), and good construct and predictive validity (Kanter et al., 2007).

• Five Facet Mindfulness Questionnaire

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life,

including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity- to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 "never or very rarely true" to 5 "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 practice mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practice 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 5-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 9-point Likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in functioning. In a study including participants with Obsessive Compulsive Disorder or Depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Marks, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

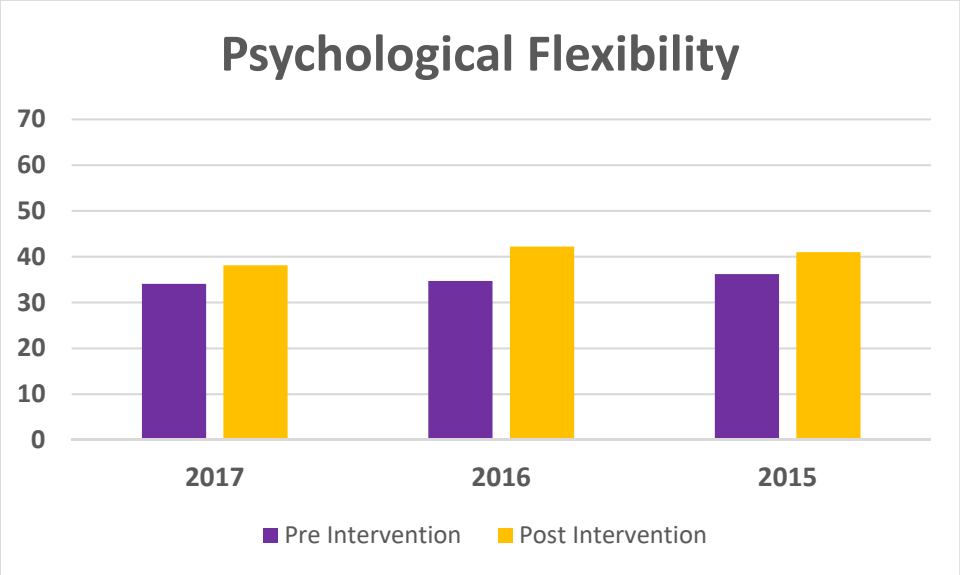
The Self-Compassion Scale

The Self-Compassion Scale (SCS) is a twenty-six 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 5 point Likert scale, from 1 Almost Never to 5 Almost Always.

4.3.3. Results

Acceptance & Action Questionnaire-II

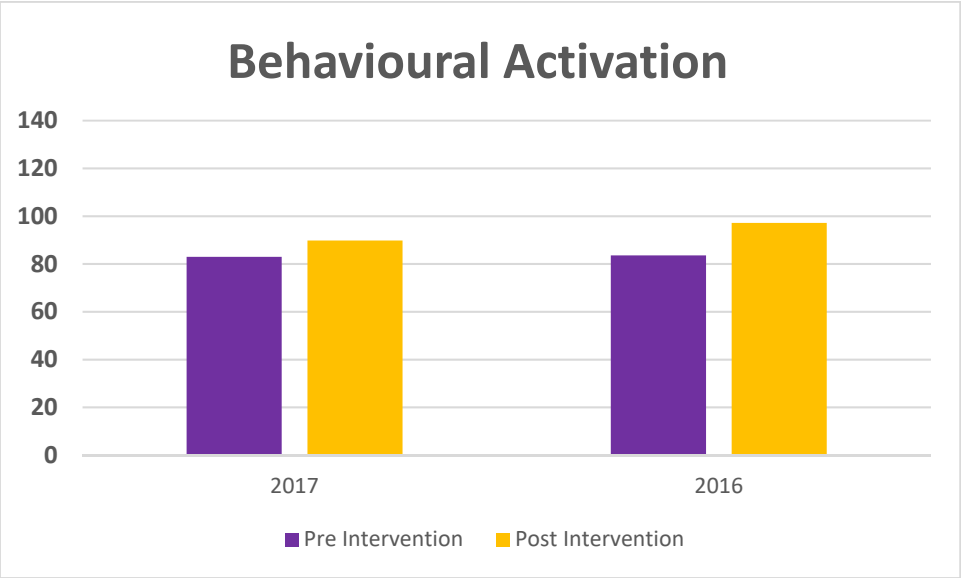
Graph: Psychological Flexibility as measured by the AAQ-II



Total scores on the AAQ-II showed a statistically significant increase, t (41) = 3.91, p < .05, which indicates greater psychological flexibility post programme. An effect size (d) of .44, indicates a small effect size. Pre and Post mean scores on the AAQ-II were similar to those reported in previous years.

Behavioural Activation for Depression Scale (BADS)

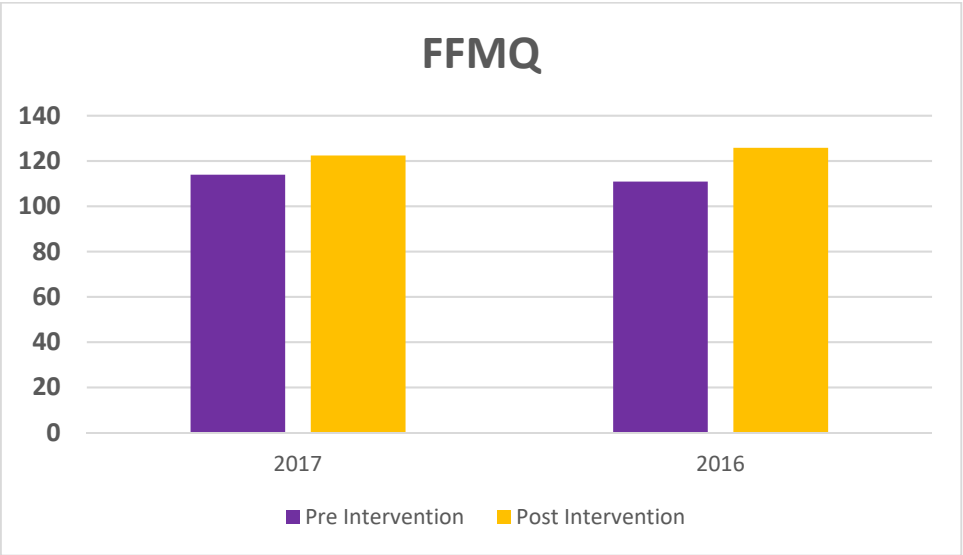
Graph: Behavioural Activation as measured by the BADS



Mean BADS scores increased significantly from (M = 83, SD =24.9) to (M = 89.8, SD = 24.1) indicating greater behavioural activation, t (41) = 2.13, p < .05, representing a small effect size (d = 0.3). The percentage of those completing the programme with scores below 70 (the mean reported by Kanter et al. (2009) for a sample with elevated depressive symptoms) reduced from 47.6% to 19% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

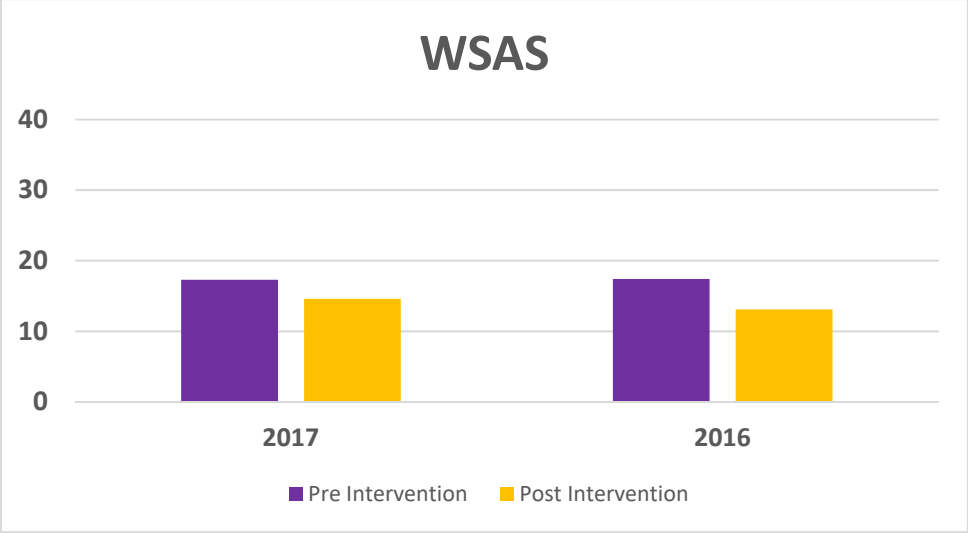
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (39) = 3.28 , $p < .05$, from pre (M = 113.9, SD = 22.0) to post (M =122.4, SD = 21.8) indicating greater levels of overall mindfulness, with a small effect size observed (Cohen's d =.38). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

Work and Social Adjustment Scale (WSAS)

Graph: Total Work and Social Adjustment Scale Scores



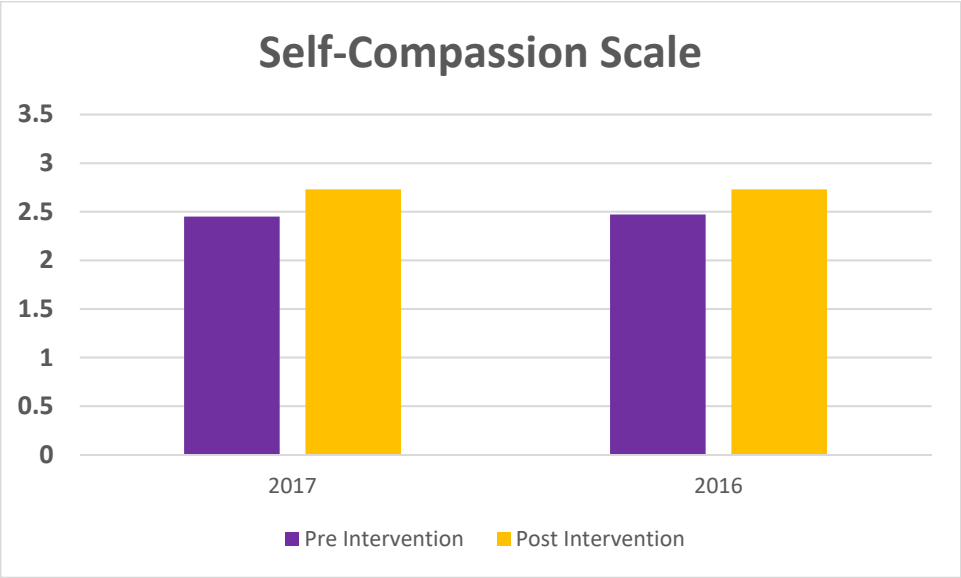
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (42) = 2.67, p <.05, from 17.34 (SD = 7.9) to 14.67 (SD =8.8), indicating less functional impairment. The effect size of Cohen's d =.31 indicates a small effect.

The scores on both pre and post means are within the range which indicates significant functional impairment but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 18.6% of those who completed the programme had scores below 10 when they started the programme, while 27.9% had scores below 10 on completion of the programme.

These findings are in line with the 2016 and 2015 outcomes reports that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

Self-Compassion Scale

Graph: Total scores on Self-Compassion Scale



Total SCS scores increased significantly, t (41) = 4.17, $p < .05$, from pre (M = 2.45, SD = .6) to post (M = 2.73, SD = .59) indicating higher overall levels of self-compassion post intervention. A medium effect size was observed (Cohen's d = .50). Self-compassion is measured in six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts.

4.3.4. Summary

People who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. Comparisons show consistent results across 2017, 2016 and 2015. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of

mindfulness. This also allows for the potential comparison with published research.

4.4. Alcohol and Chemical Dependency Programme.

The Alcohol and Chemical Dependence (ACDP) Programme is designed to help individuals with alcohol and/or chemical dependence/abuse to achieve abstinence by enabling them to develop an increased awareness of the implications and consequences of their drinking/drug taking. The 'staged' recovery programme is delivered by Psychiatrists, Addiction Counsellors, Ward based nursing staff, with input from other disciplines including Psychology, Social Work and Occupational Therapy and includes:

- In-patient, residential service for four weeks
- Twelve week Step-Down programme
- Aftercare

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

1. The service user is over the age of 18 years.
2. The service user is believed to be experiencing alcohol and/or chemical dependence/abuse.
3. The service user has the cognitive and physical capability to engage in the activities of the programme such as psycho-education, group therapy and addiction counselling.
4. The service user is not intoxicated and is safely detoxified.
5. The service user's mental state will not impede their participation on the programme.

4.4.1 Alcohol and Chemical Dependency Programme Outcome Measures

•Leeds Dependency Questionnaire (LDQ)

The Leeds Dependence Questionnaire (LDQ; Raistrick et al., 1994) is a 10-item questionnaire, designed to screen psychological dependence 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 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

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

4.4.2. Descriptors

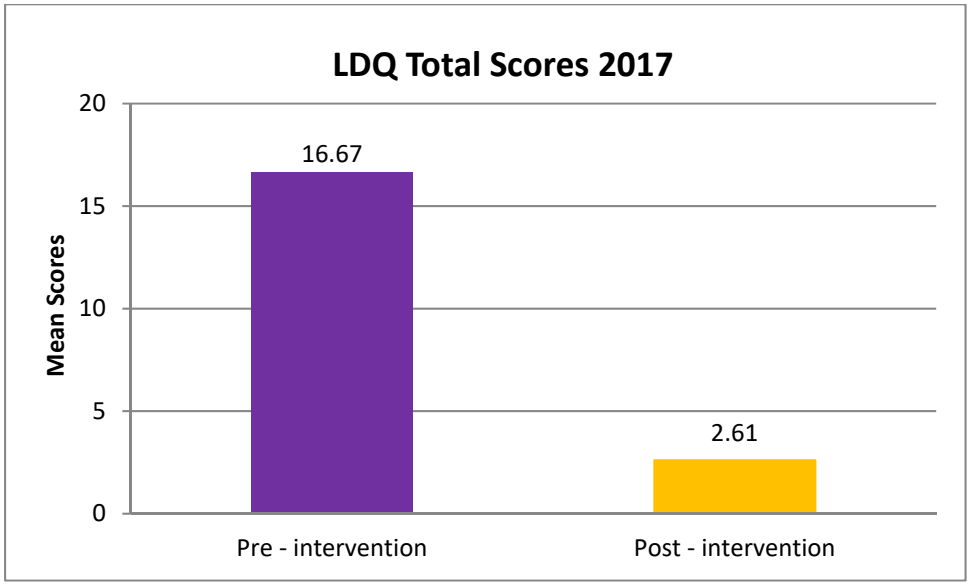
A total of 214 participants attended the full or modified programme in 2017, of whom, 113 participants completed the full programme. Pre and post data were available for 83 service users, which represents a 73.5% response rate. Of those that completed the programme, 46% of participants were male and 54% were female.

4.4.3 Results

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post programme participation. Following completion of the programme, a Wilcoxon Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, $z=7.33$, $p<.001$, with a large effect size ($r=.57$). The mean score on the total LDQ scores decreased from pre-programme to post-programme, as depicted in the graph below.

Leeds Dependency Questionnaire (LDQ)

Graph: Total scores on Leeds Dependency Questionnaire



4.4.4 Summary

Following completion of the Alcohol and Chemical Dependency programme, significant and large reductions in psychological markers of substance and/or alcohol dependency were observed.

These results suggest that the introduction of the LDQ as a measure to evaluate this programme has been successful and will continue to be used as the primary outcome measure in 2018. It is important to note that the response rate has increased by 23% since 2016. In light of this, response rates are expected to improve further in 2018 as a result of post measures being administered as part of the exit interview.

4.5. Anxiety Disorders Programme

The Anxiety Disorders Programme provides a clinical intervention programme for service users with primary anxiety disorders. The Anxiety Programme provides group and individual intervention and support based on the cognitive behaviour 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 5-week programme and includes group-based psycho-education and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based therapy, through behaviour workshops, which aid experiential goal work, fine tune therapeutic goals and identify possible obstacles, in order to address an individual's specific anxiety difficulties (FFMQ & 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 provides a structured 8-week programme which is also based on a CBT approach focusing on shifting core beliefs, emotional processing and regulation, and increased exposure work.

Service users typically attend Level 2 following discharge from hospital as an inpatient.

A separate Obsessive Compulsive Disorder (OCD) strand of the Anxiety Programme provides a tailored and focussed service for those with OCD. This incorporates tasks such as challenging the meanings of obsessions and more tailored goal work.

4.5.1. Anxiety Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2017. All service users attending the Anxiety Programme complete (or are rated on) the following measures, before starting the programme, after completing level one of the programme and again after completing level two (if they have attended this level).

- **Beck Anxiety Inventory**

The Beck Anxiety Inventory (BAI: Beck & Steer, 1993) is a 21-item multiple-choice self-report inventory that measures the severity of anxiety in adults and adolescents. The respondent is asked to rate how much each of the 21 symptoms has bothered him/her in the past week. The symptoms are rated on a four-point scale, ranging from "not at all" (0) to "severely" (3). The BAI scores range from 0 - 63 and scores can be interpreted in relation to four qualitative categories: minimal level anxiety (0-7), mild anxiety (8-15), moderate anxiety (16-25) and severe anxiety (26-63). The instrument has excellent internal consistency (α= .92) and high test–retest reliability (r = .75) (Beck & Steer, 1990).

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a 21-item questionnaire developed to measure the intensity, severity, and depth of depression symptoms in patients with psychiatric diagnoses. Individual questions on the BDI assess mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia,

fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores range from 0 – 63, where higher scores indicate, increased depressive symptoms. Scores can be interpreted in four qualitative categories: minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

- **Fear Questionnaire**

The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items which measure the extent to which potentially anxiety provoking situations are avoided using a 9-point Likert scale ranging from 0 "Would not avoid" to 8 "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. It was designed specifically to measure the severity of OCD regardless of the type of obsessions and compulsions. The Y-BOCS enables the clinician to rate the severity of the obsessions and compulsions separately e.g. (five items assess obsessions and five items assess compulsions) which enables the clinician to discern between the severity of obsessions and compulsions as well as have a global score of severity and response by adding the two separate scores.

Obsessions and compulsions are each assessed on a 5-point scale ranging from 0 "no symptoms" to 4 "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; Extreme: 32 – 40. 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".

- **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 5-point 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, 5-point Likert scale, with responses ranging from 0 'Almost never' to 4 'Almost all the time'. Previous research has suggested that this scale's psychometric reliability is good (alpha=.92; Gilbert et al., 2009). This instrument was administered at time points, pre and post level 2.

- **Social Phobia Inventory (SPIN)**

The Social Phobia Inventory (SPIN; Connors et al., 2000) is a 17-item questionnaire developed by the Psychiatry and Behavioural Sciences Department at Duke University**.** The Social Phobia Inventory (SPIN) provides a patient-rated assessment of the three clinically important symptom domains of social phobia (Fear, Avoidance and Physiological Symptoms), with the practical advantages of brevity, simplicity and ease of

scoring. The SPIN 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 correlates significantly with other self-reported measures of agoraphobia (Mobility Inventory and Fear Questionnaire). This instrument was administered at time points, pre and post level 2.

4.5.2. Descriptors

Data were available for 82 people who completed the programme in 2017, of which 42 (51.2%) were female and 40 (48.8%) were male. Programme attendees ranged in age from 19 to 83 with an average age of 43 years (*SD* = 18.2). 48.8% of participants were in employment, 4.9% were working from home, 15.8% were unemployed, 17.1% were students, and 11.0% were retired, with the remaining percentage selecting "Disability" or "other". 50% of programme attendees were single, 31.1% were married, 7.3% were separated or divorced, 4.9% were in a long- term relationship and cohabiting, 2.4% were in a relationship and 1.2% were widowed. 51.2% of participants had achieved a 3rd level degree, 25.6% had a non-degree 3rd level education, 11% had completed their Leaving Certificate and 12.2% left school before their leaving certificate. Post data were collected after Level 1 and Level 2 of the anxiety programme.

There were seven primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (48.8%), followed by Social Phobia/Anxiety (17.1%), Generalised Anxiety Disorder (11.0%), Agoraphobia (with/without panic) and Panic Disorder (18.3%), Specific Phobia and Health Anxiety (4.8%). The table below shows the percentage of people with each diagnosis over the past 4 years.

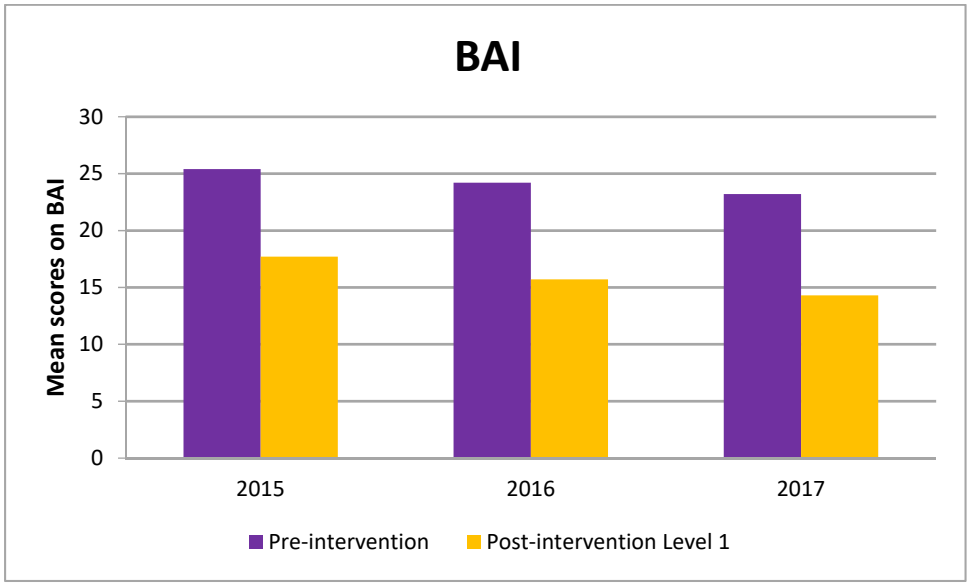
The majority of individuals with a diagnosis of OCD (n = 29) attended the OCD specific strand of the anxiety programme Level 1.

	2014		2015		2016		2017	
	N	%	N	%	N	%	N	%
Obsessive Compulsive Disorder	40	45.0	44	42.1	29	40.3	40	48.8
Generalised Anxiety Disorer	15	16.9	13	13.3	13	18.1	9	11.0%
Social Phobia/Anxiety	18	20.2	21	21.4	16	22.2	14	17.1%
Panic Disorder	9	10.1	11	11.1	7	9.7	6	7.3
Agorophobia	5	5.6	11	11.1	2	2.8	9	11.0%
Health Anxiety	1	1.1	1	1	3	4.2	2	2.4%
Specific Phobia	1	1.1	-	-	2	2.8	2	2.4%

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved from the higher end of the moderate (*M* = 23.22, *SD* = 14.32) to the lower end of the moderate (*M* = 10.95, *SD* = 9.29) range on the measure. Changes were

statistically significant, z = 6.72, p < .001, and reflect a large effect size (r = 0.53). At the pre measurement time point, 69.1% had anxiety scores in the severe and moderate ranges, this dropped to 30.9% by the end of Level 1. See the table below for how these scores redistributed into the other categories.

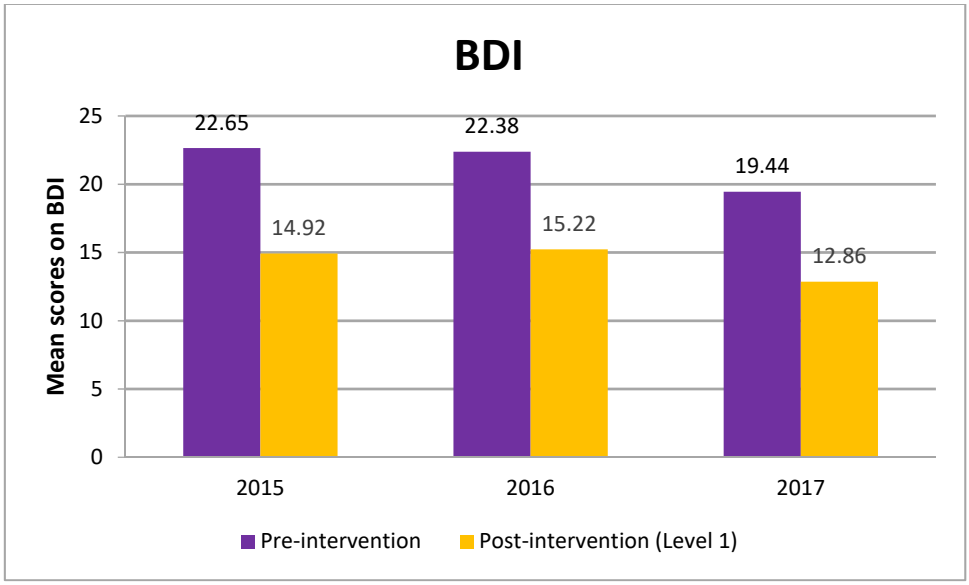
% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	12.7	38.0	28.8	62.5
Mild	16.5	30.4	23.7	20
Moderate	45.6	22.8	27.5	10
Severe	25.3	8.9	20	7.5
Totals	**100**	**100**	**100**	**100**

These results are broken down into the four main diagnostic subgroups in the table below.

BAI	n	Pre Mean	Post Mean	T value	df	Sig.
Agoraphobic	8	24.13	15.63	2.32	7	.053
Social Phobia	15	32.21	21.57	8.30	13	.000
Panic Disorder	6	30.50	18.00	1.72	5	.147
GAD	9	21.55	11.11	4.19	8	.003
OCD	29	22.86	15.89	3.51	28	.002

Beck Depression Inventory (BDI)

Graph: Beck Depression Inventory Scores



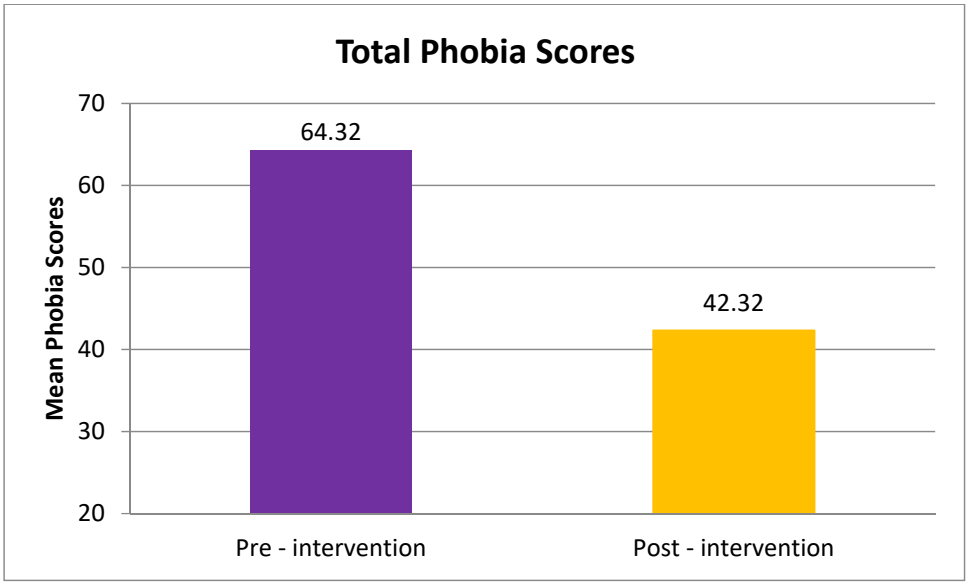
Mean scores on the Beck Depression Inventory were in the moderate range pre-intervention (M = 19.44, SD = 9.60) and showed a statistically significant drop to within the mild range post-intervention, (M = 12.86, SD =8.84), t (80) = 6.16, p < .001, which represented a large effect size (d =.68). While 45.1% were classified as having moderate and severe depression before the programme, 18.3% were classified as such by the end (See the table above).

A comparison of change across the five main diagnostic categories is available in the table below.

BDI	N	Pre Mean	Post Mean	T value	df	Sig.
Social Phobia	14	21.91	9.0	5.29	11	.000
Panic Disorder	6	21.50	17.16	1.08	5	.330
GAD	9	13.9	13.7	.12	9	.904
OCD	40	19.02	12.05	5.38	37	.000
Agoraphobic	9	19.75	10.75	8.16	7	.000

The Fear Questionnaire

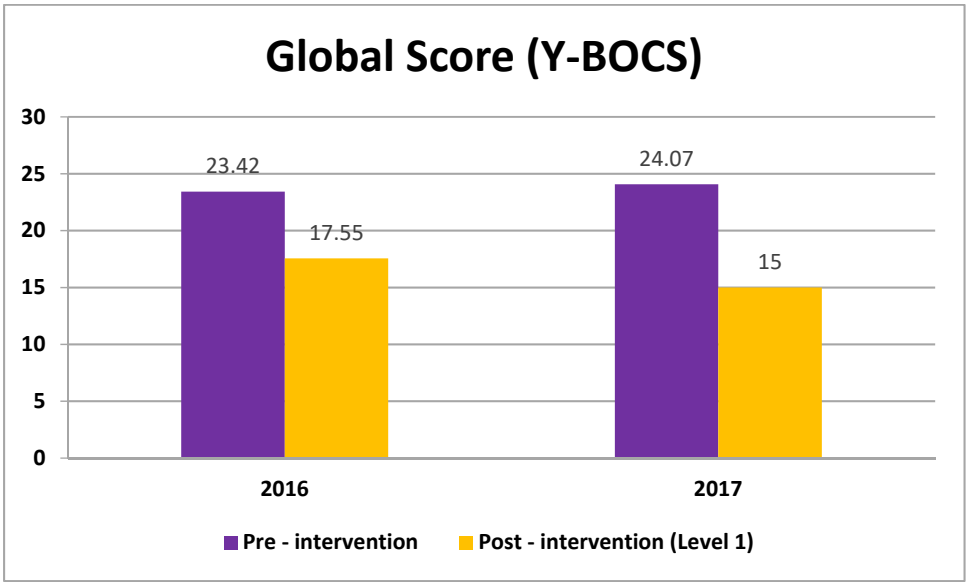
Graph: Fear Questionnaire Total Phobia Scores



A Wilcoxon Signed Rank test revealed a statistically significant difference between pre and post level 1 Total Phobia scores, $z = 6.52$, $p < .001$. The mean phobia score decreased from 64.32 (SD= 28.76) to 41.32 (SD=26.01), and represented a large effect size (r = .51).

The Yale Brown Obsessive Compulsive Scale

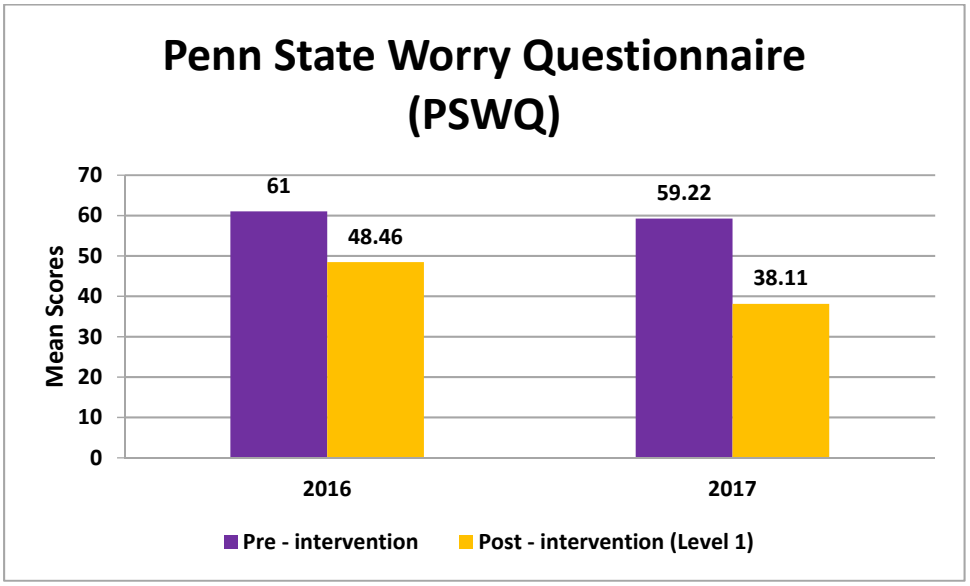
Graph: Yale Brown Obsessive Compulsive Scale



For those with OCD (n = 43), global (Y-BOCS) scores dropped significantly from 24.07 (*SD* = 6.69) to 15.00 (*SD* = 7.88), *t* (42) = 7.42, *p* <.001, (Cohen's *d* = 1.13), indicating an overall reduction in the severity of OCD symptoms with a large effect size.

Penn State Worry Questionnaire (PSWQ)

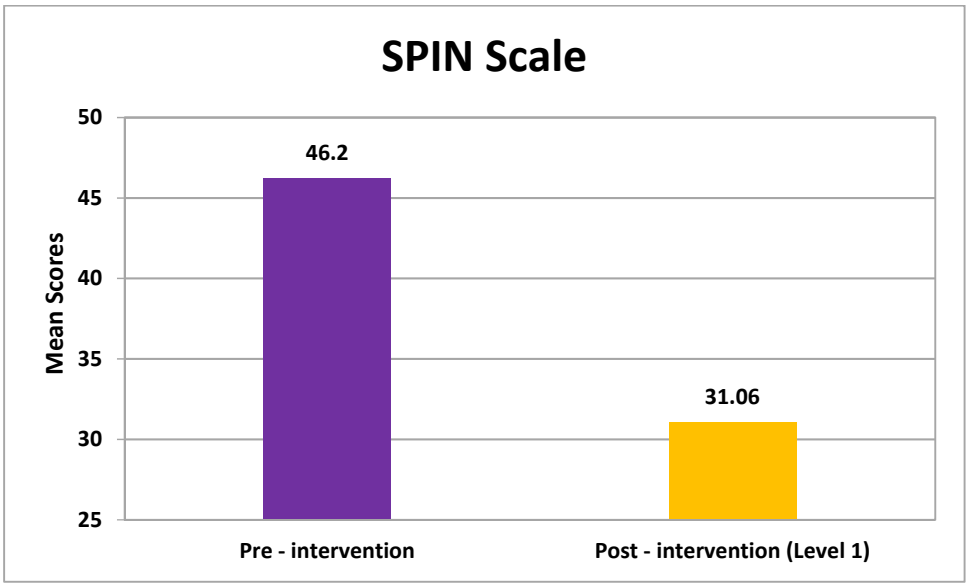
Graph: Penn State Worry Questionnaire



Participants' scores on the Penn State Worry Questionnaire dropped from 59.22 (SD = 14.29) to 38.11 (SD = 9.69), t (8) = 5.25, p < .000, which reflects a large effect size (Cohen's *d*= 1.75).

Social Phobia Inventory (SPIN)

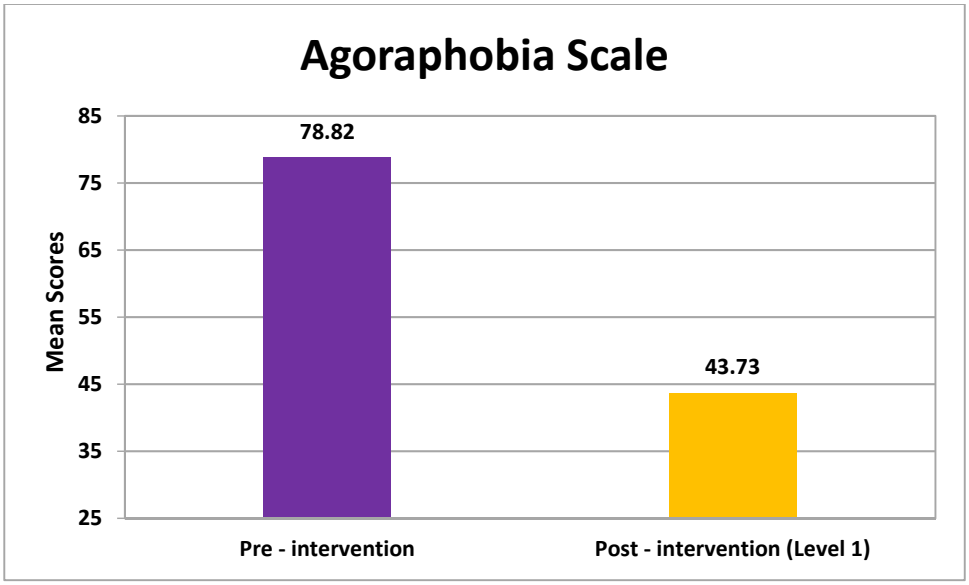
Graph: SPIN Scale



A statistically significant reduction in the Social Phobia Inventory (SPIN) scores were observed, t (14) = 6.47, p<.001, from pre- intervention (M = 46.20, SD = 7.96) to post level 1 intervention (M = 31.06, SD = 12.01), reflecting a large effect size (Cohen's *d* = 1.67).

The Agoraphobia Scale

Graph: The Agoraphobia Scale

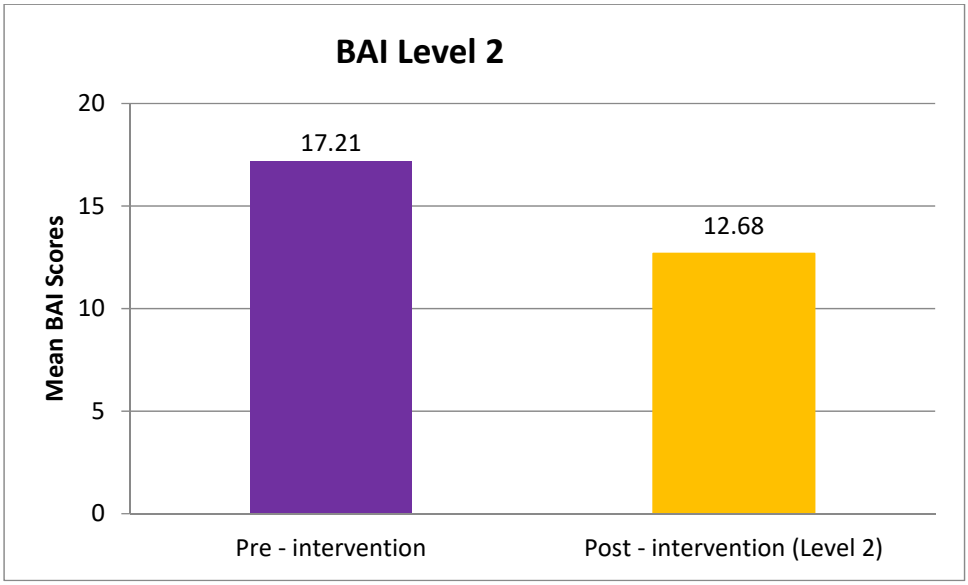


A statistically significant reduction in mean scores on the Agoraphobia Scale was observed, t (10) = 4.06, p < .01, from pre intervention (M = 78.82, SD = 21.91) to post level 1 intervention (M = 43.73, SD = 22.57), reflecting a large effect size (Cohen's *d* = 1.22)

4.5.4. Level 2 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores

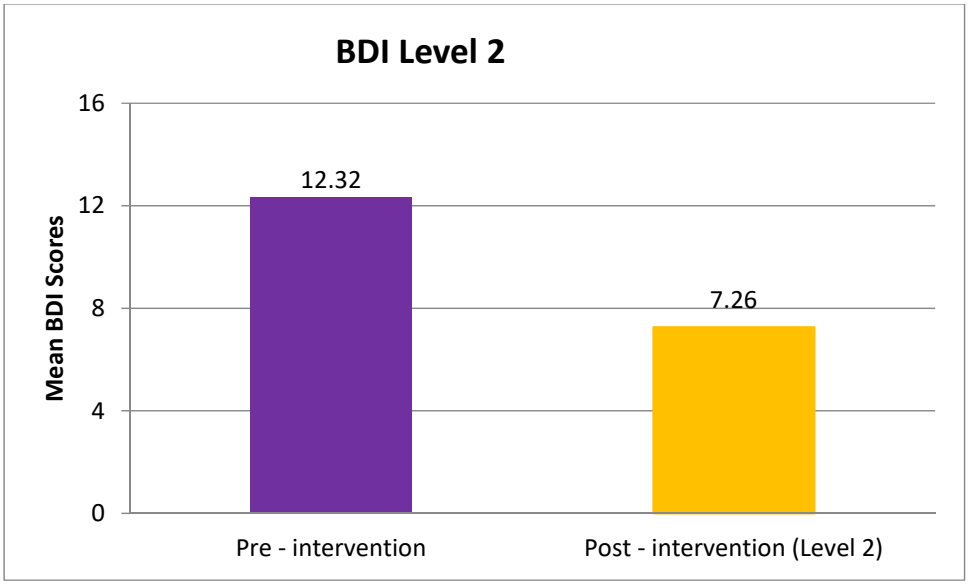


Pre and post level 2 scores on the Beck Anxiety Inventory (shown in the graph above) suggest that the mean scores for those who completed the programme decreased from M= 17.21 (SD=6.45) pre intervention to M=12.68 (SD=9.01) post intervention. Changes were statistically significant, $t(18) = 2.65$, $p < .05$, and reflect a medium effect size ($d = .61$). At the pre measurement time point, 42.1% had anxiety scores in the severe and moderate ranges, this dropped to 21.0% by the end of Level 2 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	10.5%	42.1%	47.4%	84.2%
Mild	47.4%	36.8%	42.1%	10.5%
Moderate	42.1%	15.8%	10.4%	5.3%
Severe	0%	5.3%	0%	0%
Totals	**100**	**100**	**100**	**100**

Beck Depression Inventory (BDI)

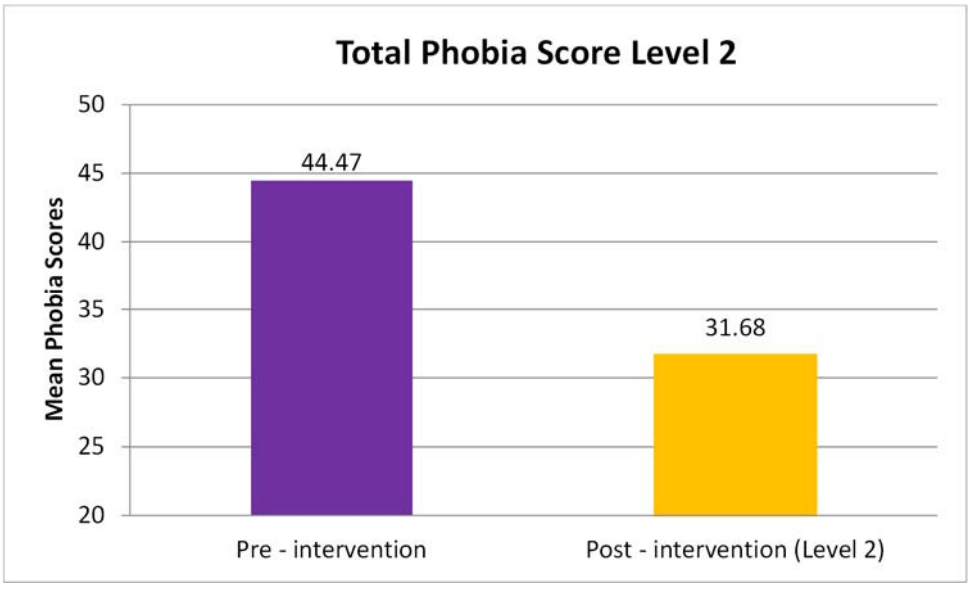
Graph: Beck Depression Inventory Total Scores



Average depression scores for those who completed the level 2 programme (indicated on the graph above) were in the minimal range pre-intervention (M = 12.32, SD = 6.06) and and showed a statistically significant drop to the lower minimal range post-intervention, (M = 7.26, SD =6.04), t (18) = 3.84, p < .001, which represented a large effect size (d =.87).

The Fear Questionnaire

Graph: The Fear Questionnaire

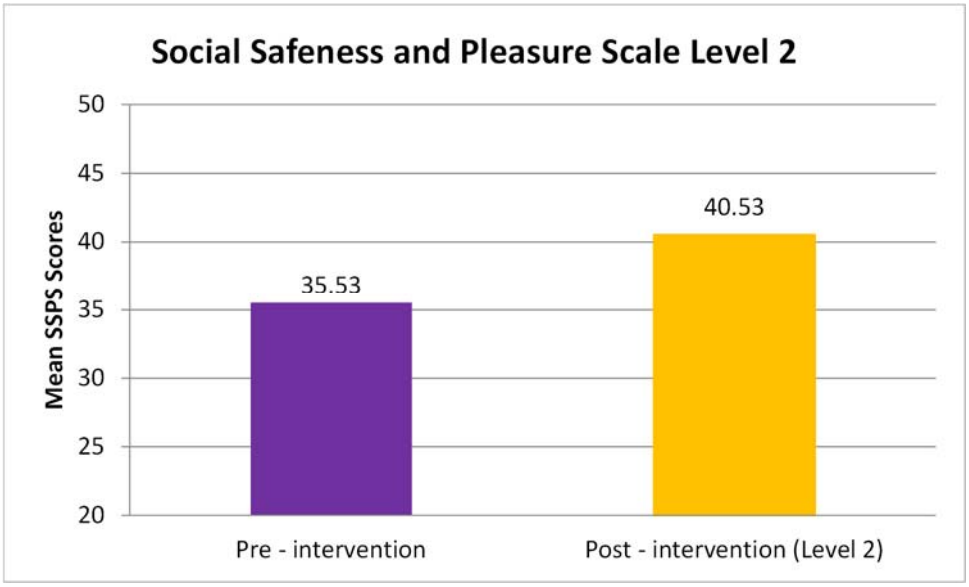


Total Phobia Scores dropped from a mean of 44.47 (*SD* = 14.02) to 31.68 (*SD* =20.98) post level 2. This reduction was statistically significant, t (18) = 3.06, $p < .01$ with a medium effect size; (*d*= .70).

The Social Safeness and Pleasure Scale

Participant's scores on the Social Safeness and Pleasure Scale changed from a mean of 35.53 (SD= 6.89) pre level 2 intervention to 40.53 (SD=8.76) post intervention. This increase was statistically significant t (18) = 4.57, $p < .001$, with a large effect size; (d= 1.04)

Graph: The Social Safeness and Pleasure Scale



4.5.5. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2017 suggested significant reductions in anxiety and depression symptoms, OCD symptoms, and reductions in pathological worrying and social anxiety. The majority of effect sizes observed were within the large range as shown on the table below.

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

Instrument	Effect Size
BAI	.53 (r)
BDI	.68 (Cohen's *d*)
Fear Questionnaire	.51 (r)
Y-BOCS (Global Score)	1.13 (Cohen's *d*)
Penn State Worry Questionnaire	1.75 (Cohen's *d*)
Social Phobia Inventory	1.67 (Cohen's *d*)
Agoraphobia Scale	1.22 (Cohen's *d*)

Note: 'Cohen's d' or 'r' is reported depending on parametric or non-parametric test

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the anxiety programme in 2017 suggested further decreases in anxiety and depression symptoms. These reductions were also statistically significant with the majority of effect sizes also observed within the large range.

Changes in scores for most measures have been consistently positive across the data since 2011, following both Level 1 and Level 2. It should be noted that the differences in results between years may be attributable to changes in sample size.

4.6. Compassion Focused Therapy

CFT was developed by Professor Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Leaviss & Uttley, 2014). Compassion Focused Therapy (CFT) draws on evolutionary psychology, neuroscience, attachment theory, cognitive behaviour therapy and mindfulness and compassion practices. CFT recognises the importance of being able to engage with our own suffering in a compassionate way, and helps people to respond to distress and challenging emotions (Kolts, 2016).

Research has demonstrated the importance of self-compassion for psychological functioning (Neff & Germer, 2017). Jazaeir et al (2012), identified compassion as a predictor of psychological health and wellbeing

and found that it was associated with fewer negative feelings and stress as well as more positive feelings and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014), suggested CFT as a particularly helpful intervention for clients experiencing high shame and criticism. Research has found that CFT is associated with reductions in depression, anxiety, shame, and self-criticism and increased ability to self soothe in response to emotional distress (Lucre & Corten, 2012). Research conducted on the CFT group in St. Patrick's Mental Health Services demonstrated that group CFT was effective in reducing symptoms of mental ill health for service users who attended the group. These improvements were associated with improvements in self-criticism and fears of self-compassion (Cuppage, Baird, Gibson, Booth & Hevey, 2017). Research was also recently carried out at St. Patricks Mental Health Services to investigate subjective bodily changes associated with attending a trans-diagnostic CFT group (Mernagh, et al. 2017). Results suggest that service users who attended a CFT group developed an increase in mind-body attunement. That is, they became more trusting of their bodies as a source of important information about their emotions and were more readily able to self-regulate their emotions by becoming aware of physical sensations in the body.

The Compassion Focused Therapy group commenced in St Patrick's University Hospital in February 2014, and in St Edmundsbury Hospital in July 2014. Groups are facilitated by the Psychology Department.

4.6.1. Compassion Focused Therapy Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the Compassion Focused Therapy Programme in 2017.

All service users attending the CFT Programme are invited to complete the following measures, before starting the programme and again after completion. These measures have been selected because studies have shown them to be reliable and valid (Derogatis & Melisartos, 1983: Lovibond & Lovibond, 1995: Derogatis & Fitzpatrick, 2004: Gilbert et al., 2011: Gilbert et al, 2015), in other words, they provide a good measure of the intended outcome of the CFT programme.

From April 2017, the CFT team at St Patrick's University Hospital replaced the Brief Symptom Inventory (BSI) with a measure known as the Depression Anxiety and Stress Scales (DASS-21). The CFT team noted that the BSI may have been too general to fully capture the changes made by group members who attended the CFT group.

The Compassionate Engagement and Action Scales (CEAS) first became available from 2016. The CEAS was developed to "measure the extent to which people are motivated to engage with suffering and to take wise action to alleviate it" (Gilbert et al., 2017). This measure was introduced with the beginning of a new CFT cycle in April 2017.

- **Brief Symptom Inventory**

The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item measure of psychological distress experienced by service users within the previous week. Each item is rated on a 5 - point scale of distress from 0 ("Not at all") to 4 ("Extremely"). Higher scores are indicative of greater psychological difficulty. This measure was used from January 2017 to April 2017.

- **Depression Anxiety and Stress Scales**

The Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995) is a 21 item Likert scale that measures the three related states of depression, anxiety and stress. Each item is rated on a 4 - point scale from 0 ("Did not apply to me at all") to 4 ("Applied to me very much or most of the time"). Higher scores are indicative of greater psychological difficulty. This measure was introduced in April 2017 and has replaced the Brief Symptom Inventory.

- **Fears of Self-Compassion**

The Fears of Self-Compassion Scale (FSCS; Gilbert, McEwan, Matos & Rivis, 2011) consists of three sub-scales measuring; *Fear of compassion for self* (e.g. "I fear that if I am too compassionate towards myself, bad things will happen"), *Fear of compassion from others* (e.g. "I try to keep my distance from others even if I know they are kind) and *Fear of compassion for others* (e.g. "Being too compassionate makes people soft and easy to take advantage of"). The scale consists of 38 items in total, each rated on a five point scale

from 0 (“Don’t agree at all”) to 4 (“Completely agree”). Higher scores are indicative of greater fears of self-compassion.

From January to April 2017, a subscale of The FSCS was used to measure *fear of compassion for self*. This subscale contains 15 items. From April to December 2017, the complete 38 item scale was used to measure scores on all three subscales; *Fear of compassion for self, Fear of compassion from others and Fear of compassion for others.*

- **Social Safeness and Pleasure Scale**

This 11-item scale (Gilbert et al., 2008) measures the extent to which people perceive their social world as safe. The items relate to how comfortable they are in relationships and how pleasurable they find interactions with others. This measure was used from January 2017 to April 2017.

- **Compassionate Engagement and Action Scales**

The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring *compassion to the self*, *compassion to the other* and *compassion experienced from the other* (Gilbert et al., 2015). Each scale consists of 13 items, which generate an engagement (i.e. motivation to care for well-being, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and nonjudgmental) and an action sub scale (i.e. directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10 point Likert scale (*1 =never* to *10 = always*). High scores indicate high compassion. This measure was introduced in April 2017. A longer version of the Fears of Self Compassion Scale was also introduced from April 2017.

4.6.2. Descriptors

There were pre and post data available for 36 participants who completed the programme either at St Patrick’s University Hospital or at St Edmundsbury Hospital in 2017. This represents approximately 54% of those who completed the programme in 2017. Of these 36 service users, 31 (86%) were female and 5 (14%) were male. Programme attendees ranged in age from 19 to 77 years

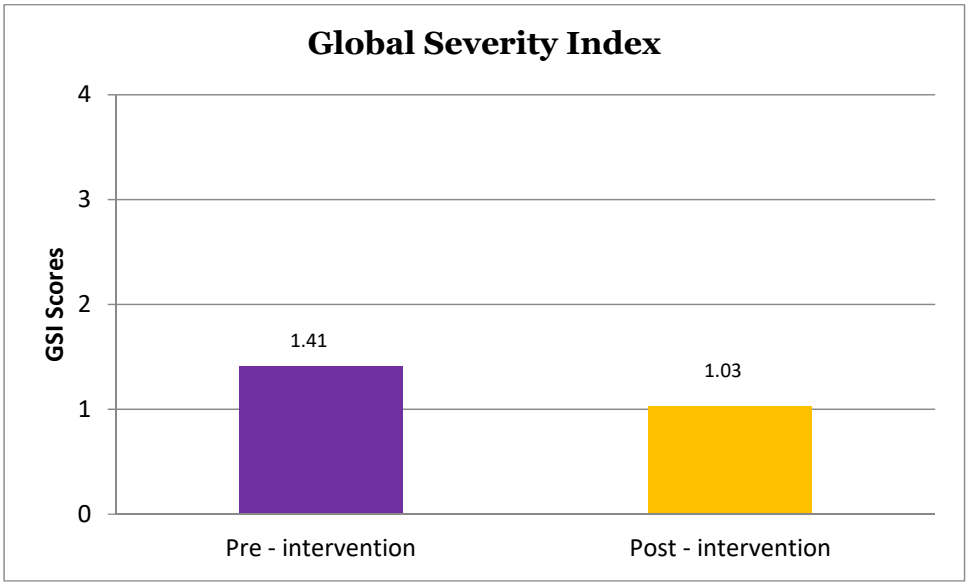
with an average age of 42.92 years. One additional cycle of the CFT Programme began in 2017 but will not be completed until 2018. Data for those who started a cycle in 2017 but finished in 2018 will be included in next year's report

4.6.3. Results

As mentioned above, a number of the measurement tools changed in April 2017, including the Brief Symptom Inventory (BSI), the Social Safeness and Pleasure Scale (SSPS), the Depression Anxiety and Stress Scales (DASS) and the Compassionate Engagement and Action Scales (CEAS). A longer version of the Fears of Self Compassion Scales (FSCS) was also introduced in April 2017. As such, the following results should be considered in terms of the changes that were made.

Brief Symptom Inventory

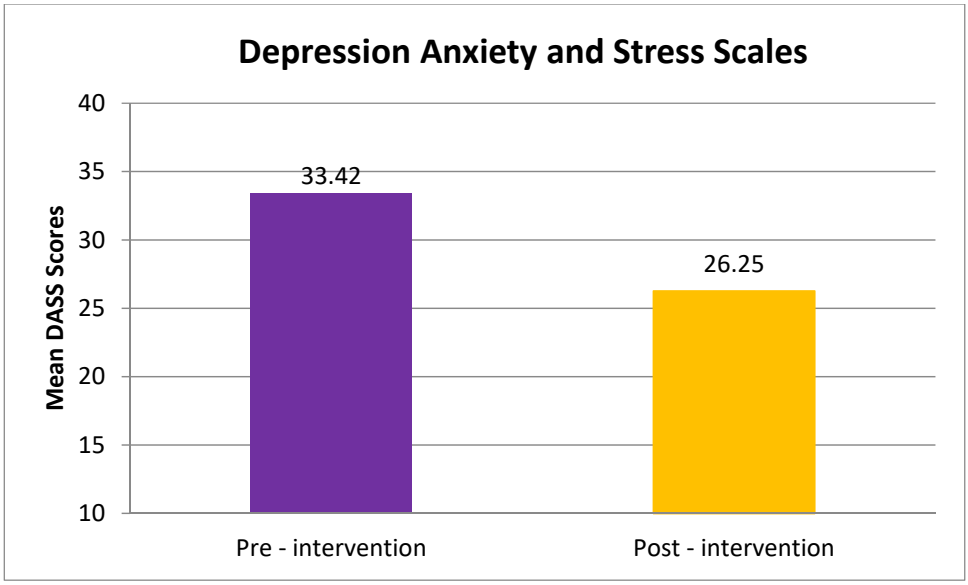
Graph: Brief Symptom Inventory GSI Scores



A significant decrease in psychological distress as measured by the Brief Symptom Inventory was observed in service users who completed the Compassion Focused Therapy programme between January and April 2017, where t (19) = 3.68, p<.01. A large effect size was observed (*d* = .80).

Depression Anxiety and Stress Scales (DASS)

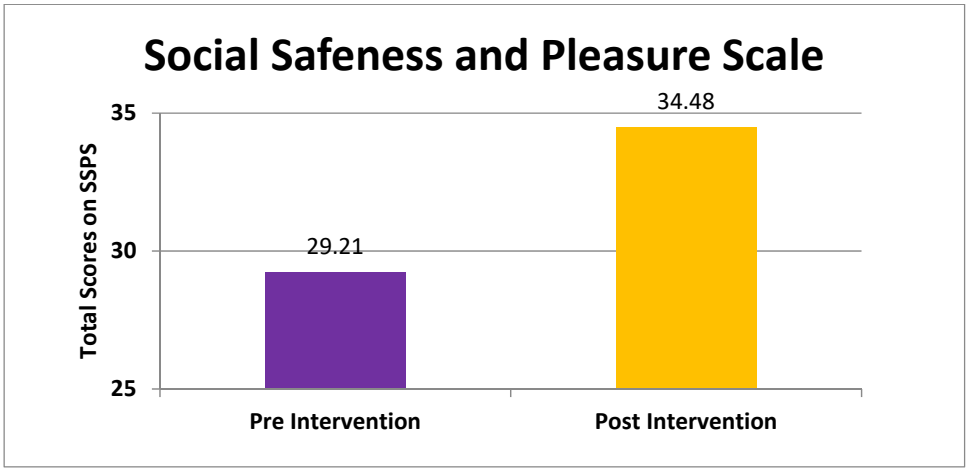
Graph: Depression Anxiety and Stress Scores



A significant decrease in psychological difficulty as measured by the Depression Anxiety and Stress (DASS[21]) Inventory was observed in service users who completed the Compassion Focused Therapy programme between April and December 2017, where t (11) = 2.76, p<.05. A large effect size was observed (*d* = .80).

Social Safeness and Pleasure Scale (SSPS)

Graph: Social Safeness and Pleasure Scale (SSPS) Scores

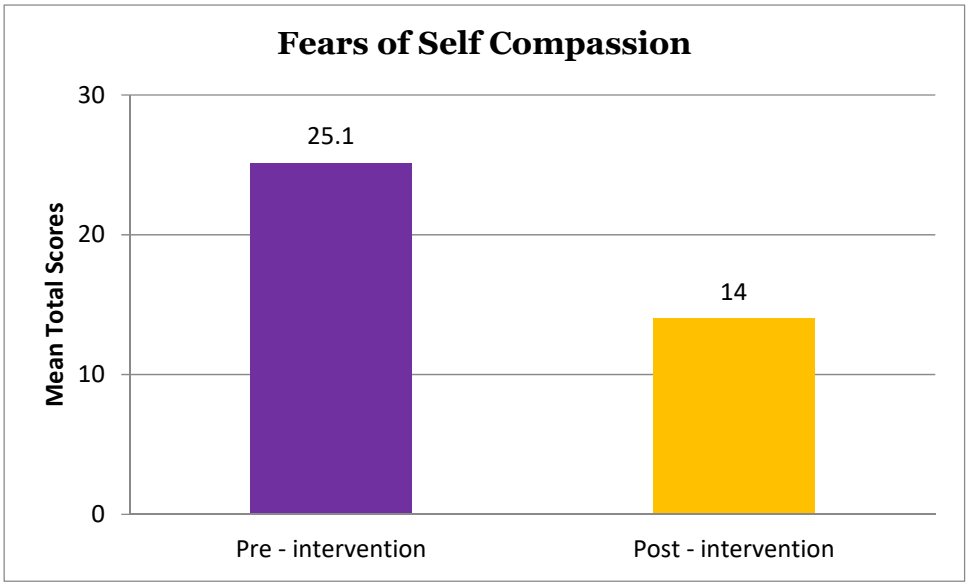


Significant increases were observed from pre to post intervention on the Social Safeness and Pleasure Scale, whereby t (21) = 2.55, p<.05, with a medium effect size (*d* = .54). These findings suggest that following completion of the programme, service user's perception of how comfortable they were in interpersonal relationships and of how pleasurable they found interactions with others had improved.

4.6.3.2 The Fears of Self-Compassion Scale

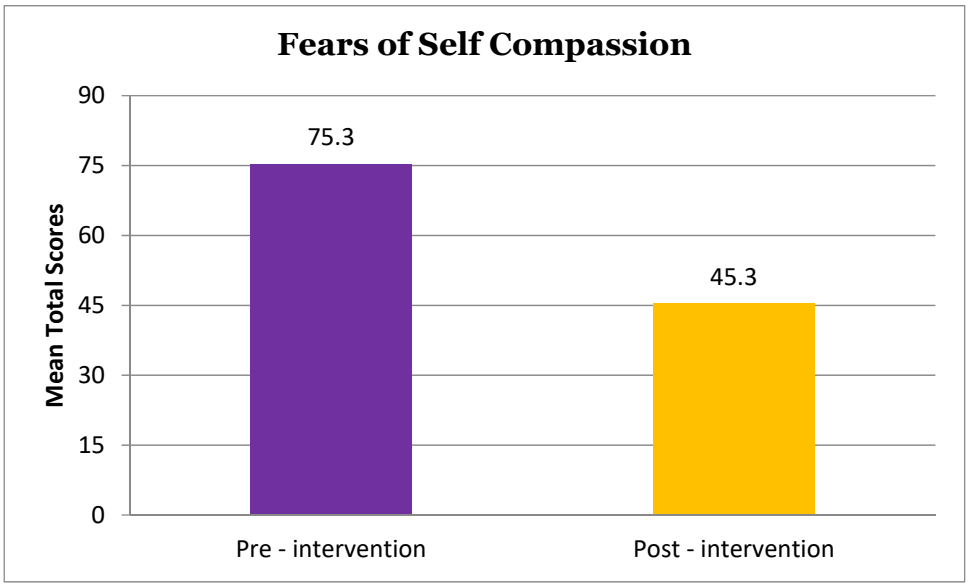
From January to April 2017, the Fears of Self Compassion scale included 15 items related to expressing kindness and compassion towards the self. From April to December 2017, the Fears of Self Compassion scale was updated to include 38 items relating to expressing kindness and compassion towards self, expressing compassion for others, and responding to compassion from others.

Graph: The Fears of Self-Compassion Scale



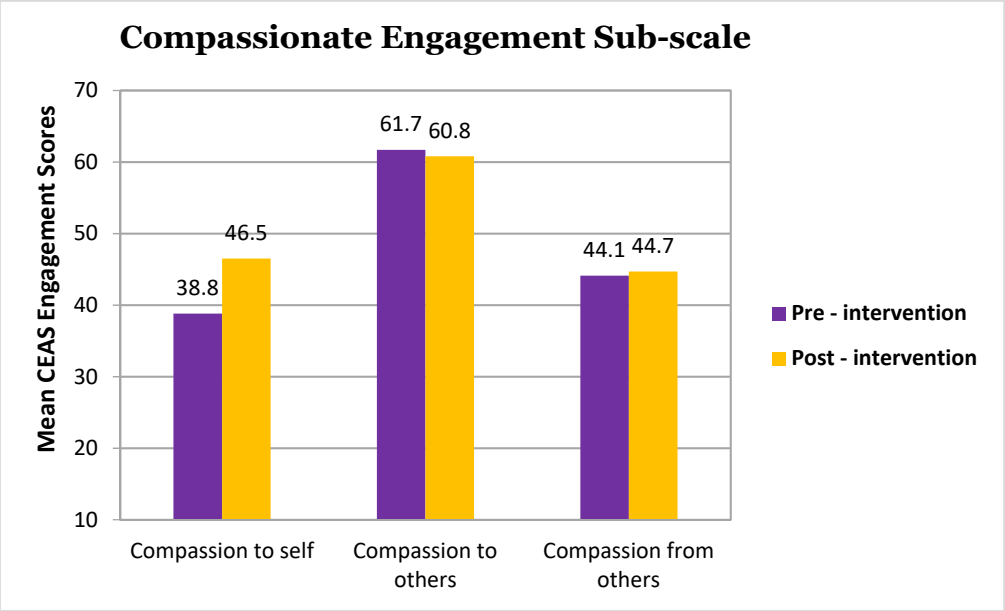
A significant decrease in fears of self-compassion was observed in service users who had completed the CFT programme between January to April 2017. A Wilcoxin Signed Rank Test revealed a statistically significant reduction in total Fears of self-compassion (expressing kindness and compassion towards the self), z=3.41, p<.01, with a large effect size (r=.62).

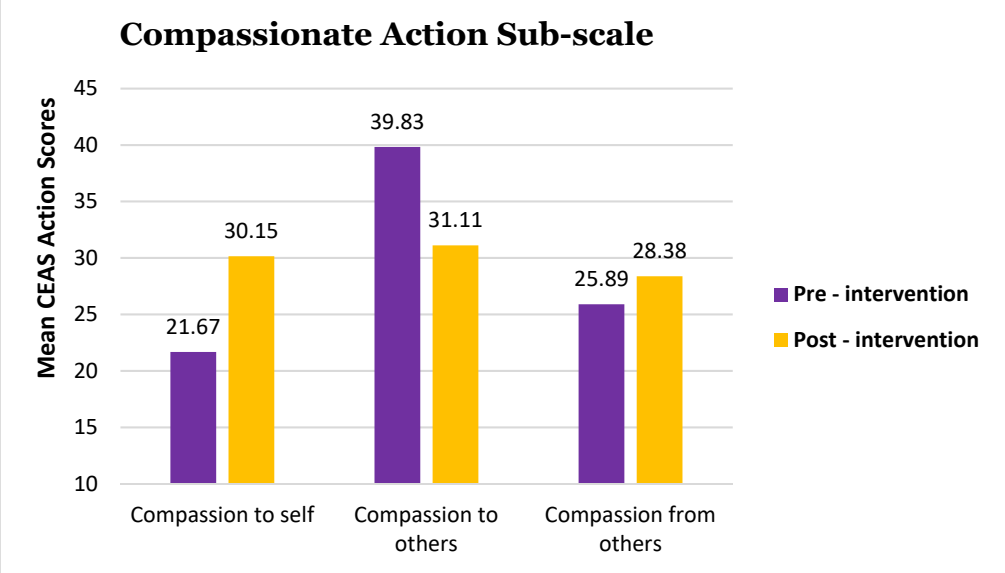
Graph: The Fears of Self-Compassion Scale



A statistically significant reduction in total Fears of self- compassion (expressing kindness and compassion towards self, expressing compassion for others, and responding to compassion from others) was also found between April- December 2017 using the 35 item scale, $z=3.11$, $p<.01$, with a large effect size ($r=.64$). These findings suggest that fears of developing and having self- compassion decreased from pre to post programme participation.

4.6.3.2 Compassionate Engagement and Action Scale





Significant increases were observed from pre- to post- intervention on the Compassionate to Self-Scale; t (17) = 3.44, p< .01, with a large effect size (*d* = .81) and a significant decrease was observed from pre- to post intervention on the Compassion to Others Scale; t (17) = -3.53, p< .01, with a large effect size (*d*= .83). There was no significant difference from pre to post test on the Compassion From Others Scale; t (17) = .62, p= .54. These findings suggest that on completion of the programme, service users compassion for themselves increased. The decrease in compassion towards others would be consistent with the findings that many service users who enter this

programme tend to show compassion to others before considering their own needs (Mernagh et al., 2017).

4.6.4. Summary

The Compassion Focused Therapy programme started in SPMHS in 2014. Since it began seventeen cycles of the group have been facilitated.

Anecdotal feedback from clients who attended these groups has been largely positive, with clients reporting noticeable improvements in their lives. This feedback has been supported statistically by the findings of this report; specifically by the reduction of symptoms of psychological distress as measured by the BSI and the DASS-21 following completion of the group.

Fears of self-compassion were found to significantly decrease, while service user self-perceptions of their ability to feel safe in and draw on their relationships for support significantly increased following completion of the group.

The CFT group delivery format is currently under review in an effort to ensure a high quality service that meets service users' needs.

4.7. Depression Recovery Programme

The Depression Recovery Service offers a group-based stepped care treatment programme in line with international best practice guidelines. The programme has 2 levels:

Level A (Activating Recovery) is a group based programme, facilitated two days per week for three weeks. The group includes twelve to fourteen individuals and is open to inpatients and day patients. It focuses on Behavioural Activation, Education about Depression, Building Personal Resources and an Introduction to WRAP (Wellness Recovery Action Plan).

Level B (Building Recovery - CBT and Compassion Focused Therapy Workshops) is a twelve week programme. For the first four weeks the programme aims to introduce the concepts of CBT (Cognitive Behavioural Therapy) and Compassion Focused Therapy. Workshops have been designed

as a means of exploring the thought mood connection, the development of the vicious cycle and how to unravel them. The following eight weeks are based on a closed Psychotherapy Programme that runs one day a week. This area of the programme utilises Cognitive Behavioural Therapy, Compassion Focused Therapy and Mindfulness.

4.7.1. Depression Recovery Programme Outcome Measures

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses. For a full description please refer to section 4.5.1. of this report.

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

The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic tool for common mental disorders. The PHQ-9 is the depression component, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It is commonly used to monitor the severity of depression and response to treatment. Reliability and validity of the tool have indicated it has sound psychometric properties. Internal consistency of the PHQ-9 has been shown to be high and studies of the measure have produced Cronbach alphas of .86 and .89 (Kroenke and Spitzer, 2001). PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent the cut-off points for mild, moderate, moderately severe and severe depression, respectively.

4.7.2. Descriptors

Paired data were available for 118 participants who completed the programme in 2017, 60 males and 58 females.

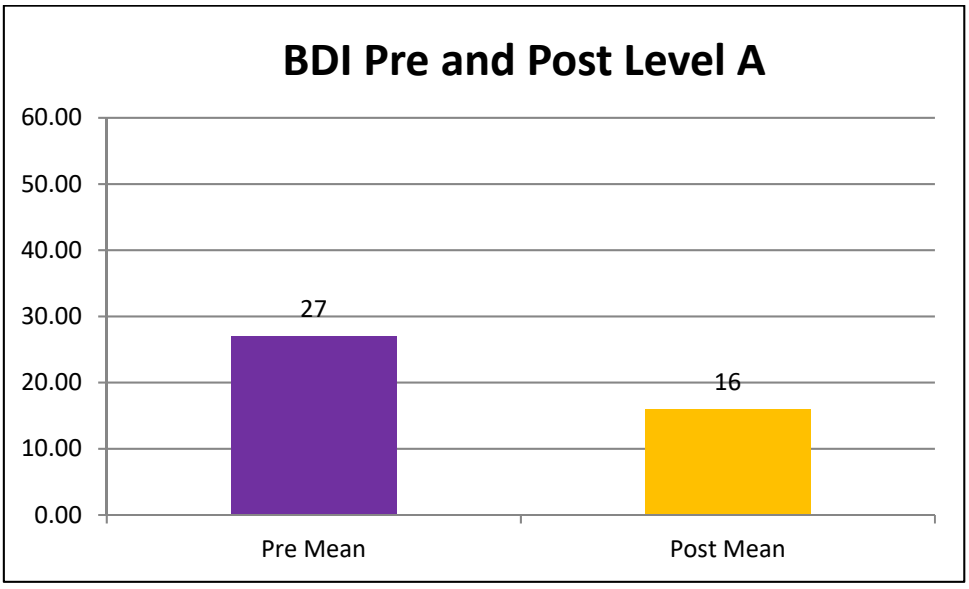
4.7.3. Results

Pre Level A and Post Level A

Beck Depression Inventory (BDI)

Comparison of service user scores on the BDI from pre and post level A indicated that on average service users moved from the moderate range (*Md* = 27) to the mild range (*Md* = 16) on the measure (see graph below). A Wilcoxin Signed Rank test revealed that the reduction was statistically significant, z= -8.19, p = .000, with a medium effect size (Cohen's *r* = 0.4). This indicates a significant decrease in depressive symptoms post intervention.

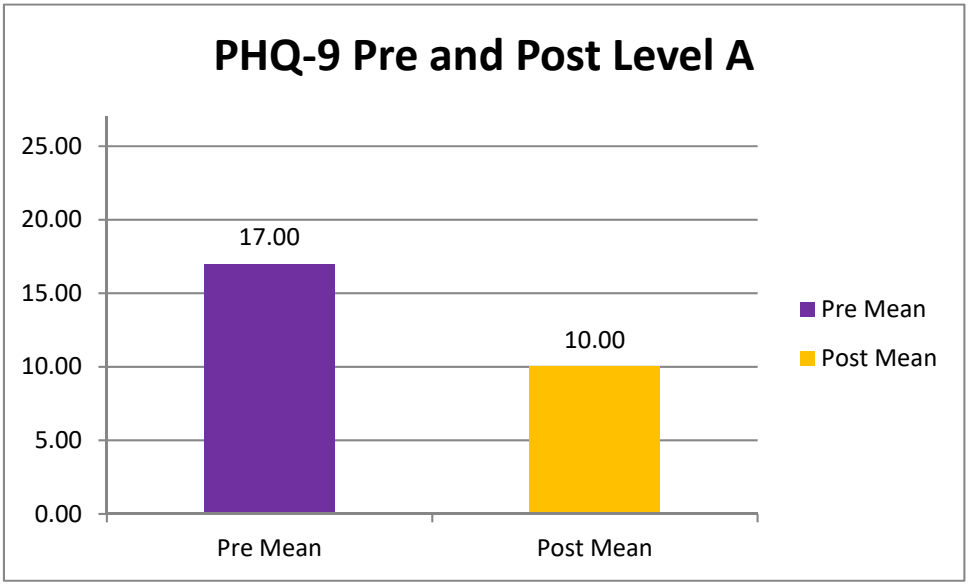
Graph: Beck Depression Inventory Total Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of service user scores on the, pre and post Level A indicated that, on average, those who completed rated themselves in the moderately severe range (*Md* = 17) prior to the intervention and in mild to moderate range (*Md* = 10) following intervention. This reduction in mean scores is statistically significant, A Wilcoxin Signed Rank test revealed z= -7.5, p = .000, with a medium effect size (Cohen's *r* = 0.40).

Graph: Patient Health Questionnaire-9 Scores



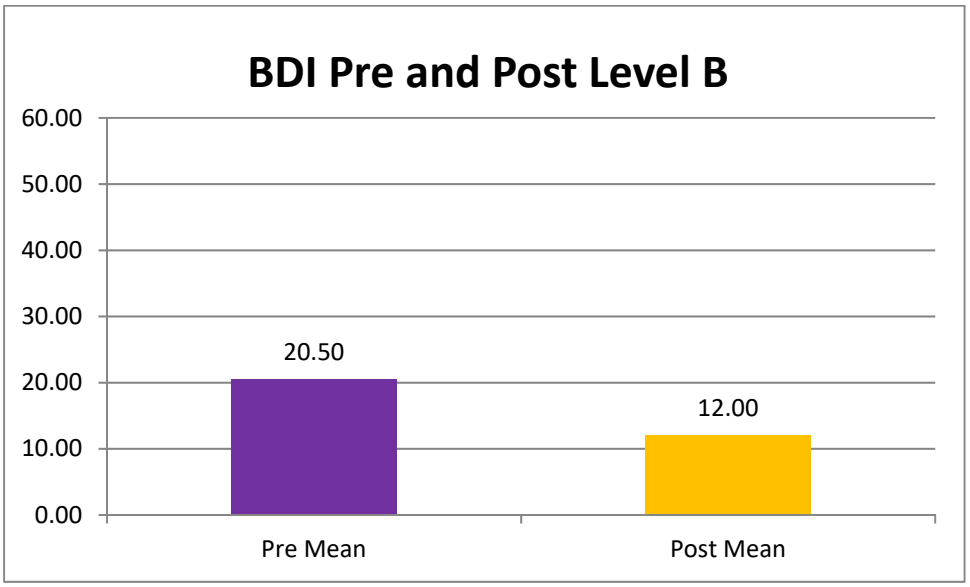
Pre Level B and Post Level B

Prior to 2016, data was analysed from pre Level A to post Level B. However feedback from the clinical team in 2016 highlighted that the time between completing level A to commencing level B can vary significantly. There can be lengthy gaps in commencing level B due to the service user's choice and personnel circumstances, such as fitting around work, family commitments or study. As a result it was decided to analysed the data from pre level B to post level B instead.

Beck Depression Inventory (BDI)

Pre and post scores on the Beck Depression Inventory (see graph below) demonstrate that the average score for people who completed Level B of the Depression Programme moved from the moderate range pre Level B (M = 20.5) to the mild range (*M* = 12). This reduction in the mean score is statistically significant, $t(24) = 3.7$ $p < .05$, with a small effect size (Cohen's $d = 0.4$).

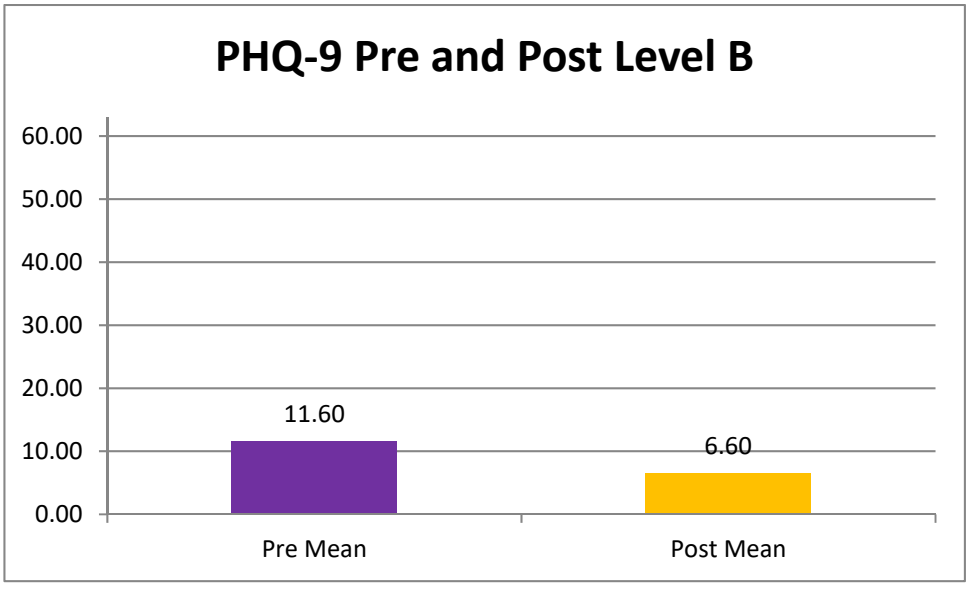
Graph: Beck Depression Inventory Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, indicated that, on average, those who completed Level B rated themselves in the moderate range (*M 11.6*) prior to Level B and moved to the mild range (M = 6.6) following Level B. This reduction in the mean score is statistically significant, $t(24) = 3.7$ $p < .05$, with a small effect size (Cohen's d = 0.4).

Graph: Patient Health Questionnaire-9 Scores



4.7.4. Summary

This is the fourth year the depression programme has been included in the SPMHS outcomes report. Two well established outcome measures were used to investigate the programme's effectiveness at reducing symptoms of depression. Both measures showed significant reductions in service users' mean scores following completion of the programme.

These results provide evidence to suggest that, on average, people who complete the programme experience a significant reduction in symptoms associated with depression at each level of the programme. In future years the programme will consider including more demographic information on patients who complete the programme (e.g. age). Model-specific outcomes such as "compassion" or understanding and implementation of CBT skills may also be measured. This may help provide further evidence that the programme is effective and operating by its hypothesised mechanism.

4.8. Dual Diagnosis Programme

The Dual Diagnosis Programme is designed for adults who are currently abusing (clients must meet the criteria for dependence) or dependent on alcohol or chemical substances, and in addition, have a co-morbid diagnosis of a mental health difficulty such as depression, anxiety or bipolar disorder (Axis 1 disorder, DSM-V).

The aim of this programme is not only to enable clients to achieve abstinence and recovery in relation to substance use, but also to facilitate awareness, understanding and provide practical support and knowledge in relation to their mental health difficulties.

It aims to assist the client in the recovery process by providing a bio-psychosocial support structure and the therapeutic environment necessary to foster their recovery. This includes a combination of group and 1:1 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 is a staged recovery programme, delivered by Psychiatrists, Addiction Counsellors, Ward based nursing staff, with input from other disciplines including Psychology, Social Work and Occupational Therapy and includes:

- Initial detoxification and assessment by a multidisciplinary team
- In-patient, residential service for approximately four weeks (longer if required)
- 12 week Stepdown programme (not always required, pending treatment pathway)
- Aftercare follow-up for 12 months

The programme includes the following elements:

- **Individual multi-disciplinary assessment:** This facilitates the development of an individual treatment care plan for each service user.
- ***Psycho-education lectures:*** A number of lectures are delivered weekly with a focus on providing education on substance misuse and recovery, as well as approaches for managing mental health issues e.g. CBT, and Mindfulness. There is also a weekly family and patient lecture, facilitated by Addiction Counsellors, providing information on substance misuse and recovery to clients and their families.
- ***Goal setting and change plan*:** This group is facilitated by therapists and encourages participants to put plans and structure in place for time spent outside of the hospital.
- ***Mental health groups:*** This is a psycho-educational group focussing on Mental Health related topics such as Depression, Anxiety and Recovery.
- ***Role play groups:*** This group aims to allow clients to actively practice drink/drug refusal skills, to learn how to communicate about mental health, and to manage relapse in mood and substance misuse. The group creates opportunities to role play real life scenarios that may have been relevant to the client or may be relavant in the future.
- ***Recovery plan:*** This group facilitates and supports clients in developing and presenting an individual recovery plan. It covers topics such as Professional Monitoring, Community Support groups, Daily

inventories, Triggers, Physical care, problem solving, Relaxation, spiritual care, Balance Living, family/friends, work balance etc.

- ***Reflection group:*** This group provides a safe place to support clients through the process of change; an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- ***Relapse prevention and management groups:*** This group focuses on developing successful relapse prevention and management strategies.

4.8.1. Dual Diagnosis Outcome Measures

Leeds Dependency Questionnaire (LDQ)

The Leeds Dependence Questionnaire (LDQ; Raistrick et al., 1994) is a 10-item questionnaire, designed to screen for mild to severe psychological dependence to a variety of different substances, including alcohol and opiates. This measure was completed by service users pre and post programme participation.

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence, the 10 items map on to the ICD-10 and DSM-IV criteria for substance dependence which include: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Kelly, Magill, Slaymaker & Kahler, 2010).

Items are scored on a 4-point scale from 0 "Never" to 3 "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).

4.8.2. Descriptors

214 participants attended the full or modified programme in 2017, of whom 102 completed the full programme. Pre and post data were available for 88 participants, with an even number of males and females. This data represents approximately 86.3% of those participants who completed the programme in 2017. This means that findings presented may not be representative of all participants who completed the programme and these findings need to be interpreted in light of this.

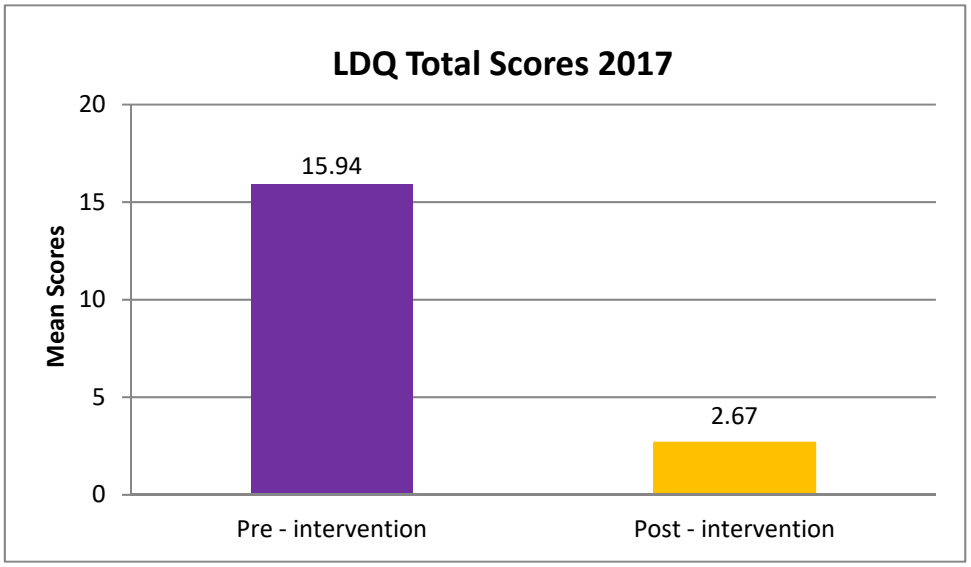
4.8.3. Results

Leeds Dependency Questionnaire

A Wilcoxin Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, $z=7.47$, $p<.001$, with a large effect size ($r=.56$).

The mean score on the total LDQ decreased from pre-programme to post-programme, as depicted in the graph below.

Graph: Leeds Dependency Questionnaire Scores



4.8.4. Summary

Following completion of the Dual Diagnosis programme, significant and large reductions in psychological markers of alcohol/substance dependency were observed. These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and its use will continue in 2018.

4.9. Eating Disorder Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the treatment needs of people with Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. 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 cognitive behaviour therapy (CBT) treatment model which is applied throughout inpatient, day patient 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 or follow-up outpatient care. Inpatient care consists of a variety of interventions including:

- Stabilisation of Weight
- Medical Treatment of physical complications where present
- Meal supervision and support
- Nutritional assessment and treatment
- Dietetics group: discuss nutrition, meal planning, shopping, food portions, etc.
- Methods to improve self-assertiveness and self-esteem
- Enhancement of self-awareness
- Body image group
- Occupational therapy groups: Weekly groups addressing lifestyle balance, stress management, and social, leisure and self-care needs. A weekly cookery session is also included in the programme.

- Family support
- 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 and Psychology MDT members, including:

- Occupational therapy groups
- Goal setting groups
- Cooking groups
- Body-image, self-esteem and relaxation/self-reflection 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 Dietician reviews, along with CBT sessions, in order to support service users in their recovery.

4.9.1. EDP Outcome Measures

The following measures have been chosen to capture eating disorder severity and co morbidity, 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, Gideon, 2016). 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.

Twenty-seven items contribute to a Global score and four subscales including: Restraint, Eating Concern, Weight Concern, and Shape Concern. Items from each subscale are summed and averaged with the global score generated by summing and averaging the subscale scores (resulting scores range from 0 – 6 for each subscale and the global score). Higher scores suggest greater psychopathology. Evidence in support of the reliability and validity of the measure comes from a number of studies (e.g. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

	Binge Eating Disorder Sample (n=52)	Control group of UK school girls (n=808)	Anorexia Nervosa Sample at Time 1	Anorexia Nervosa Sample at Time 2
Restraint	2.5 (1.5)	1.4 (1.5)	3.1 (1.9)	3.0 (1.9)
Eating Concern	3.4 (1.4)	1.0 (1.0)	2.2 (1.7)	1.8 (1.4)
Weight Concern	4.1 (1.1)	1.8 (1.7)	2.6 (1.7)	2.2 (1.8)
Shape Concern	4.8 (1.1)	2.2 (1.7)	3.4 (1.9)	3.0 (2.6)

1. Wilfley et al, 1997; *N = 6 Males & N= 46 females; Mean age= 45.4 years (SD=9.1).*

2. Carter et al, 2001; *All female; Mean age = 13.4 years (SD=0.5, range=12-14 years); Items rated based on a 14 day period rather than a 28 day period and question wording simplified due to age of subjects.*

3. Passi et al, 2003; *All female; Mean age = 15.8 years (SD=1.5). Time two data: patients completed the EDE-Q for a second time. The interview version of the EDE was administered between the two questionnaire versions.*

- **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 3 components of self-esteem: (1) performance self-esteem, social self-esteem, and appearance self-esteem. All items are answered using a 5-point scale (1= not at all, 2= a little bit, 3= somewhat, 4= very much, 5= extremely).

4.9.2. Descriptors

Data was available for a total of 35 service users attending the EDP as an inpatient in 2017 and 14 attending as a day-patient.

As there may be multiple entry points to the programme data was collected at 4 points

1. Inpatient admission
2. Inpatient Discharge
3. Daypatient Admission
4. Daypatient discharge

Due to these multiple timepoints data was grouped and analysed according to inpatient and day-patient categories. Results are presented in two separate sections as follows.

1. Inpatient outcomes: Time point 1 – inpatient admission, Time point 2 – inpatient discharge
   and
2. Daypatient outcomes: Time point 1 – daypatient admission, Time point 2 – daypatient discharge

4.9.3. 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 inpatient admission (m=3.27) and inpatient discharge (m = 2.7)

All subscales of the EDE-Q showed decreases in symptomatology by time point 2, inpatient discharge.

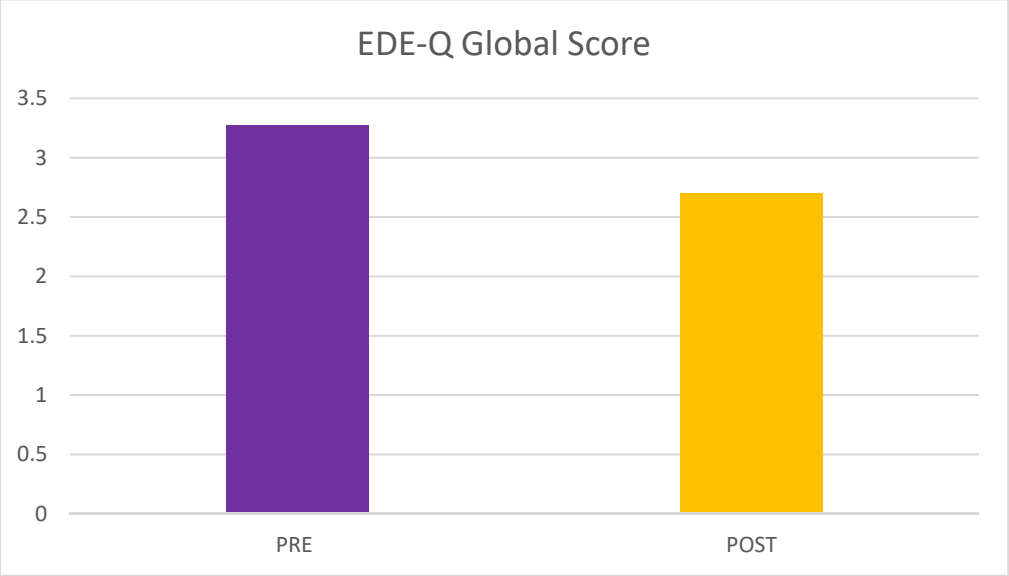
Of these, three subscales showed statistically significant change. These were restraint, eating concern and weight concern.

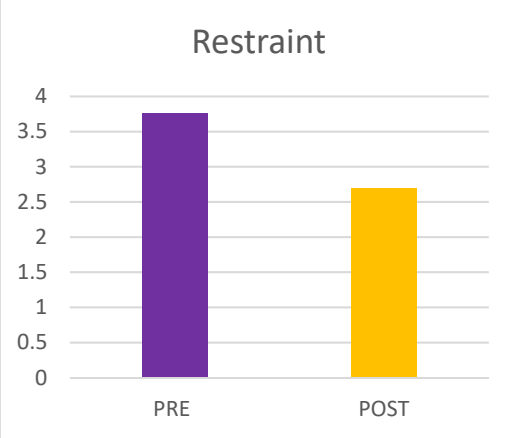
Symptomatology on the restraint subscale decreased from (M= 3.76) to (M=2.45). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(10) = 2.1$, $p < .05$, reflecting a medium effect size ($d = 0.6$)

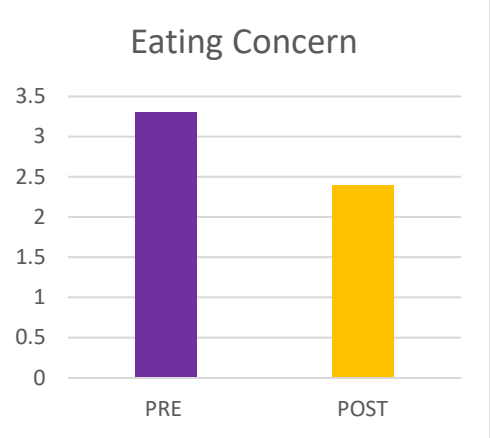
Symptomatology on the eating subscale decreased from (M = 3.3) to (M = 2.4). Paired sample t-tests indicated that this was a statistically significant change, whereby t(5) = 2.6, p < 0.5, reflecting a medium effect size (d=0.7)

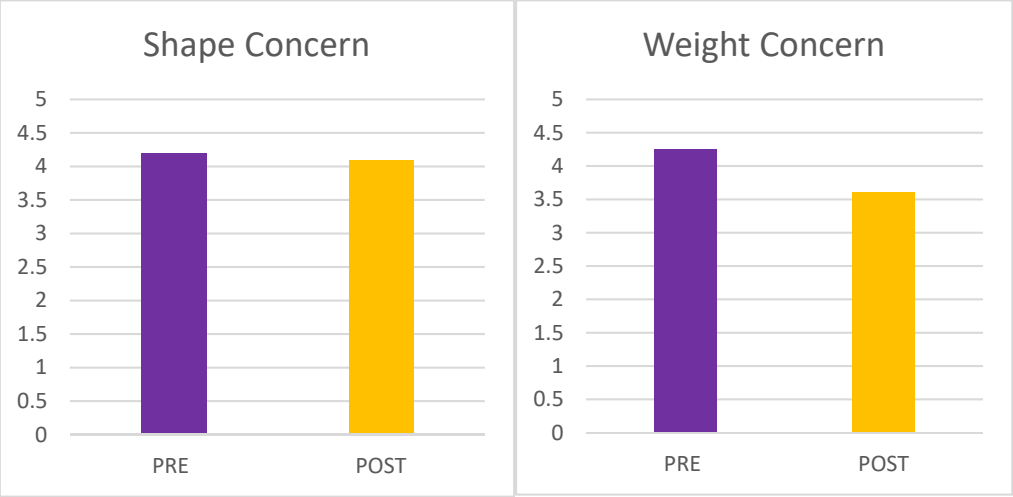
Symptomatology on the weight concern subscale decreased from (M = 4.25) to (M = 3.6). Paired sample t-tests indicated that this was a statistically significant change, whereby t(11) – 2.7, p < .05, reflecting a medium effect size (d = 0.5)

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









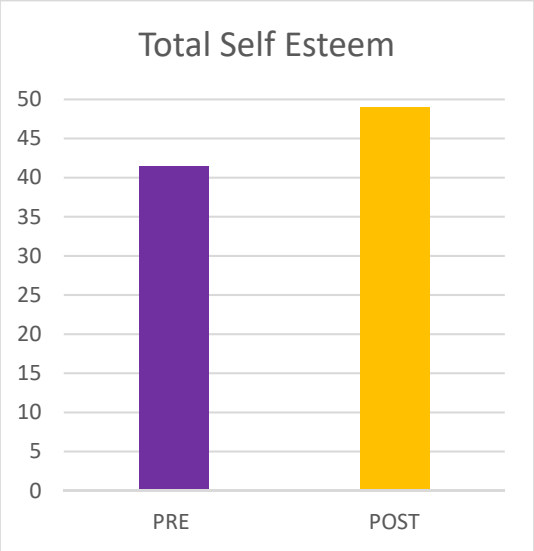
State Self Esteem Scale (SSES)

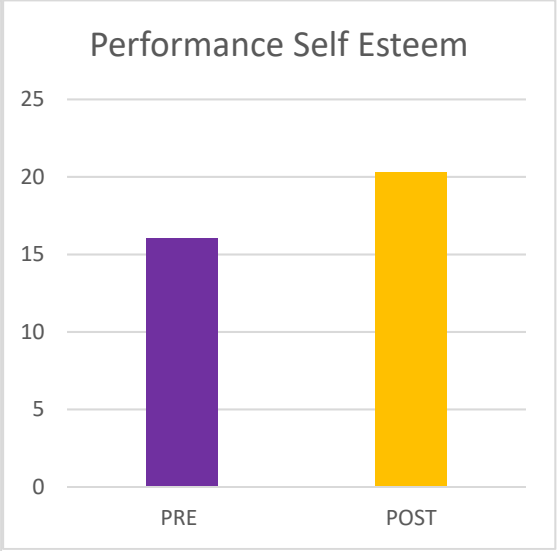
On the SSES patients with measures at both timepoints showed increased overall self-esteem as well as increases across the 3 subscales (Performance Self Esteem, Appearance Self Esteem and Social Self Esteem. At time 2 (inpatient discharge) mean score across all scales had increased suggesting improvements across all domains.

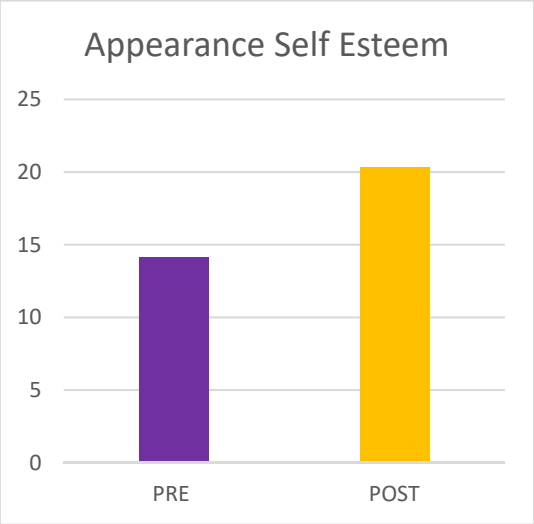
While the results indicate increased average means across all domains, only the subscales Performance Self Esteem and Social Self Esteem were statistically significant.

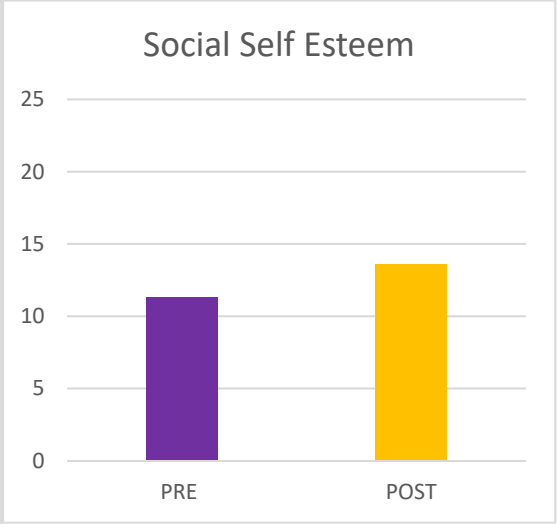
Performance self-esteem increased from pre-intervention (M=16) to post intervention (M=20). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(8) = 2.6$, $p < .05$, reflecting a large effect size ($d = 0.8$)

Social Self Esteem increased from pre-intervention (M = 14) to post intervention (M = 15). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(8) = 0.67$, $p < .05$, reflecting a small effect size ($d = 0.1$)









Day patient Results

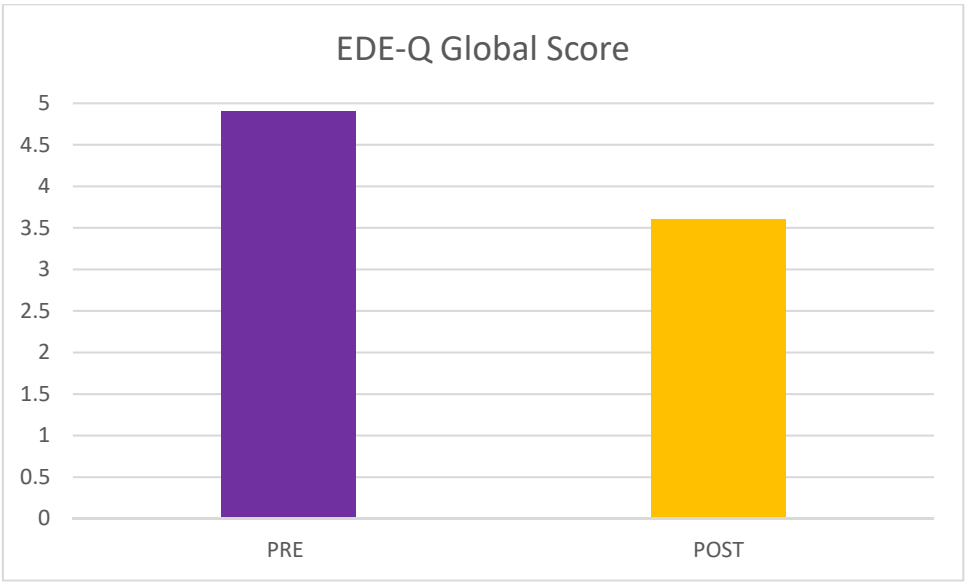
Eating Disorders Examination – Questionnaire (EDE-Q)

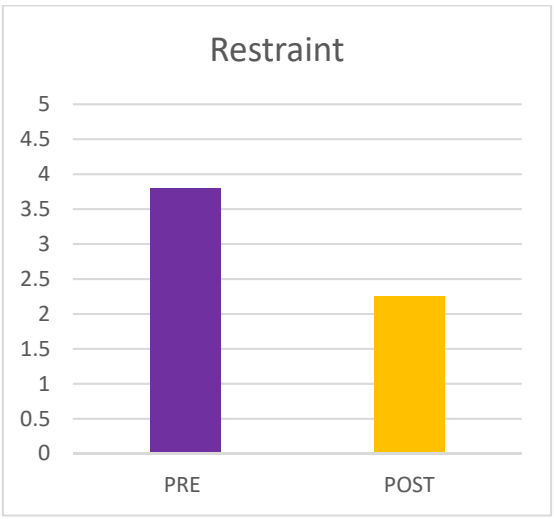
A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed on all subscales for the day-patient data. The total score on the EDE-Q showed decreased symptomatology between day patient admission (M = 4.9) and day-patient discharge (M = 4.6) however this was not statistically significant.

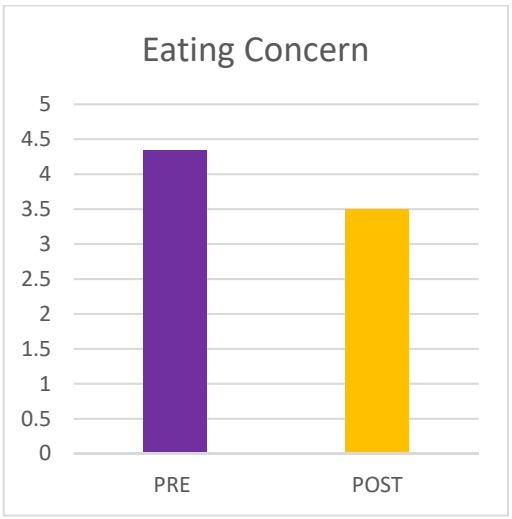
Similarly all subscales of the EDE-Q showed decreases in symptomatology at time point two. With statistically significant change observed in one of the subscales, this was restraint.

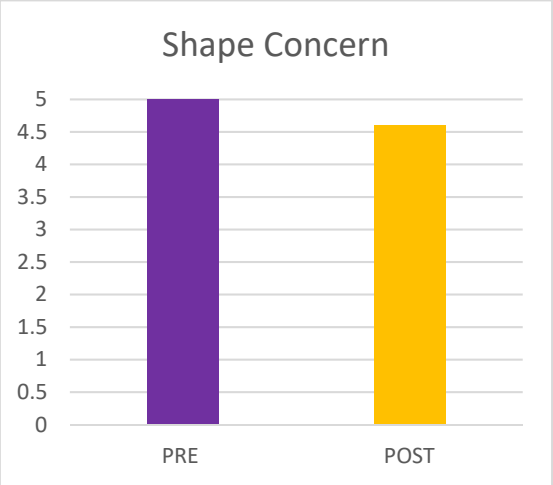
Symptomatology for the restraint subscale decreased from day patient admission (M = 3.8) to day patient discharge (M = 2.25). Paired sample t-tests indicated that this was statistically significant, t(3) = 4.7, p < 0.5. This had a large effect size (d = 0.9)

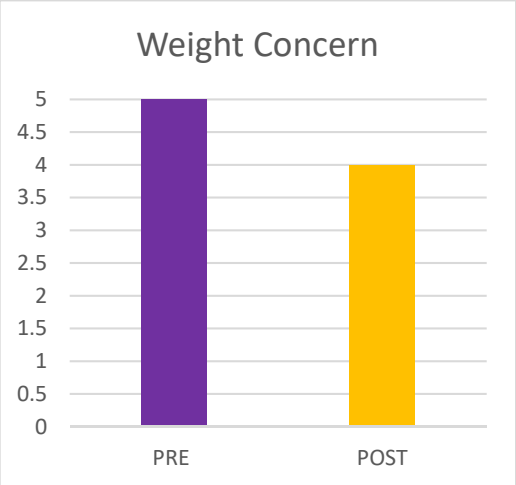
The failure to observe statistical differences in some of the scores may be due to many factors and it is not possible to determine these in this report.







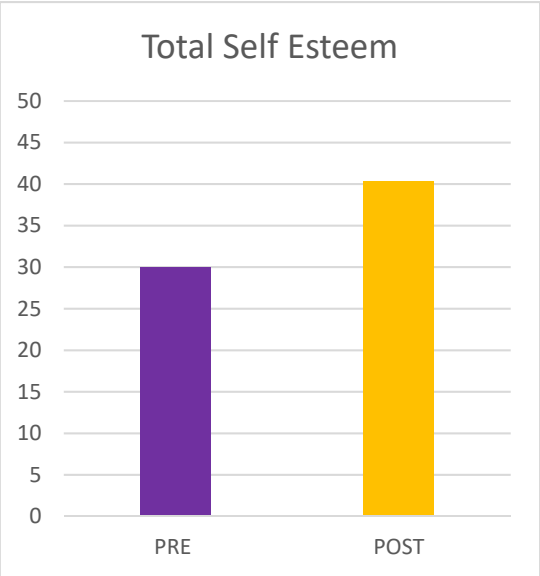




State Self Esteem Scale (SSES)

On the SSES patients with measures at both timepoints showed increased overall self-esteem as well as increases across the 3 subscales (Performance Self Esteem, Appearance Self Esteem and Social Self Esteem. At time two (daypatient discharge) mean score across all scales had increased suggesting improvements across all domains.

While the results indicate increased average means across all domains none of these were statistically significant.



4.9.4. Summary

The overall results indicate a trend that service users, both at inpatient and day-patient level of treatment, are moving towards less symptomatology as measured by the Eating Disorder examination questionnaire (EDE-Q) and improvements in self-esteem across a range of domains as measures by the state self-esteem questionnaire. While not all results presented were found to be statistically significant, they are indicative that the aims of the programme are being met. The team have therefore maintained the current outcome measures for use in 2018.

4.10. Living Through Distress Programme

Living Through Distress (LTD) is a Dialectical Behaviour Therapy (DBT) informed, group-based intervention. The programme aims to teach emotional regulation, distress tolerance, mindfulness and interpersonal effectiveness skills for individuals with problems of emotional under-control who frequently present with self-harmful behaviours. Linehan (1993a) proposed that emotional dysregulation underlies much maladaptive coping behaviour. Research suggests that behaviours such as deliberate self-harm (DSH) may function as emotion regulation strategies (Chapman et al., 2006).

Linehan's bio-social theory posits that difficulties with emotional under-control are disorders of self-regulation arising from a skills deficit. Emotional regulation difficulties result from biological irregularities combined with certain dysfunctional environments, as well as from the interaction between

them over time (Linehan, 1993a). Dialectical Behaviour Therapy informed interventions are described in a Cochrane review (2009) as effective evidence-based interventions for DSH behaviours, emotional under-control difficulties and Borderline Personality Disorder.

Skills which aid patients to regulate their emotions are at the core of LTD. LTD focuses on both change and acceptance skills. The content is informed by Linehan's skills-based group intervention and has been modified to meet the needs of the organisation, based on clinical research on the efficacy of the group.

Level 1 of the programme provides 18 skill-group sessions, three times a week for 6 weeks. These sessions focus on teaching mindfulness, distress tolerance and introducing emotion regulation skills. Following these 18 sessions, the programme has introduced a 16-week Level 2 intervention for those who complete Level 1. Level 2 is now exclusively a day patient programme and is focused on the concept of *'building a life worth living'* and facilitating patients in generalising their use of skills beyond the hospital setting. These 16 sessions aim to address emotion regulation and interpersonal effectiveness in more depth.

The department has undertaken research relating to the programme since its commencement and the measures being used have changed over time and continue to evolve. Previous research conducted with LTD attendees has demonstrated that participants show significant reductions in reported deliberate self-harmful behaviours and increases in distress tolerance skills (Looney & Doyle, 2008). In another study, those who attended LTD showed greater improvements in DSH, anxiety, mindfulness, and aspects of emotion regulation than people receiving treatment as usual. Further analysis showed that group process/therapeutic alliance and changes in emotion regulation were related to reductions in DSH (Gibson, 2011).

4.10.1. Living Through Distress Programme Outcome Measures

- **Difficulties in Emotion Regulation Scale**

  The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dysregulation. It comprises six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 "almost never" to 5 "almost always". Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability ($\alpha = .93$), construct and predictive validity, and test-retest reliability in an article which described the development of this scale.

- **Distress Tolerance Scale**

  The Distress Tolerance Scale (DTS; Simons & Gaher, 2005) is a 15-item measure of levels of distress and readiness to tolerate distress. The DTS comprises of 4 subscales assessing tolerance, absorption, appraisal and regulation. Respondents are asked to rate each statement on a 5-point scale from 1 "Strongly Agree" to 5 "Strongly Disagree". Higher total scores on the DTS scale indicate greater distress tolerance.

- **Cognitive and Affective Mindfulness Scale-Revised**

  The Cognitive and Affective Mindfulness Scale-Revised (CAMS-R; Feldman et al. 2007) was administered for the first time in 2015 to replace the Five-facet mindfulness questionnaire (FFMQ; Baer et al., 2006). Mindfulness as measured by the CAMS-R is unique in two ways, firstly, it is understood as the willingness and ability to be mindful rather than as a mindfulness experience and secondly, it is particularly related to psychological distress (Bergomi et al., 2012). The new measure was deemed more accessible to users as it captures their mindfulness experience in a shorter measure and additionally it is particularly relevant for use in clinical studies (Bergomi et al., 2012).

4.10.2. Descriptors

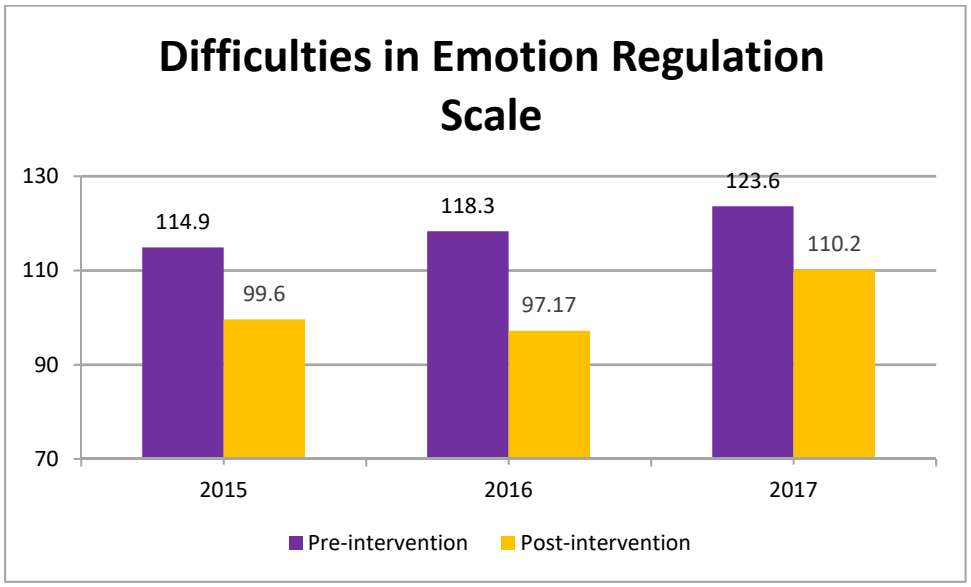
Pre and post data were available for 43 participants who completed the programme in 2017. Of those who had pre and post data, 90.7% were female and 9.3% were male. LTD attendees ranged in age from 18 to 67 years, with an average age of 30.30 (*SD* = 12.5). Their highest level of educational attainment ranged from Junior Certificate (11.6%), to Leaving Certificate (39.5%), to non-degree 3rd level qualification (16.3%), to 3rd level degree (21.0%) to postgraduate qualification (11.6%). Those who attended the group's current employment status was also recorded. 2.3% worked in the home, 4.6% were in part-time employment, 23.3% were in full-time employment, 23.3% were unemployed, 7.0% were retired, 25.6% were students and 13.9% chose other.

4.10.3. Results

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 123.6 (*SD* = 23.1) on the DERS pre to 110.2 (*SD* = 18.7) post completion of the programme, t (41) = 3.02, $p < .01$. This change represented a medium effect size (Cohen's d = .47). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

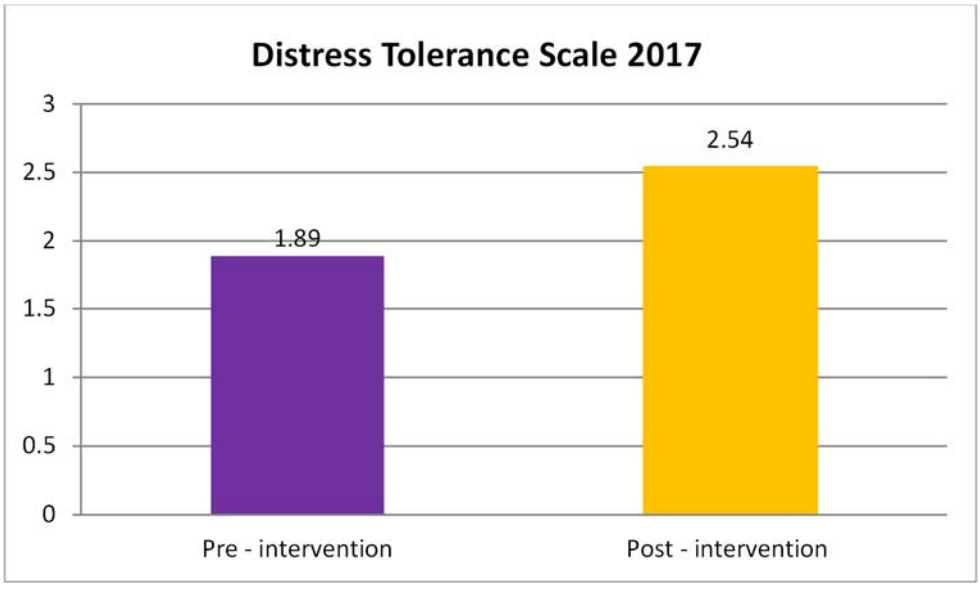


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 1.89 (*SD* = .54) before the programme on the DTS to 2.54 (*SD* = .75) after completing the programme, $z = 4.48$, $p < .001$, representing a large effect size (r = .49).

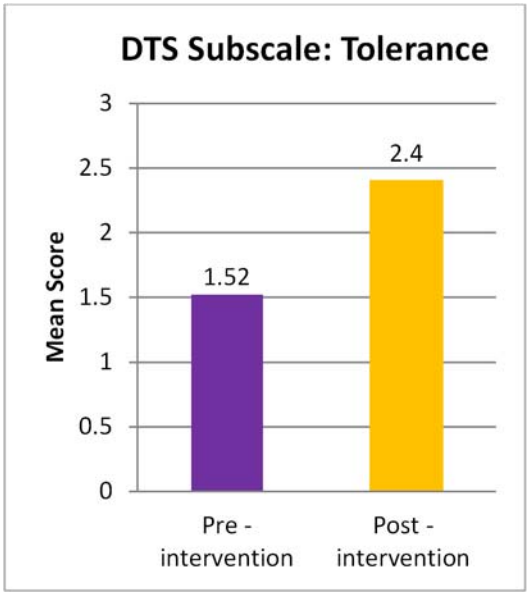
Graph: Distress Tolerance Scale Total Scores

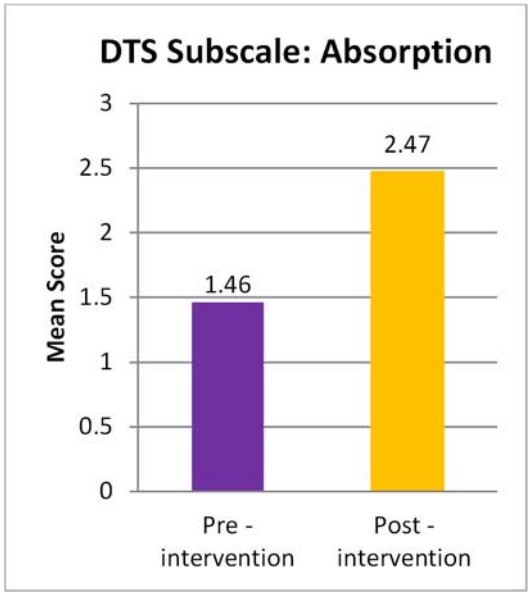


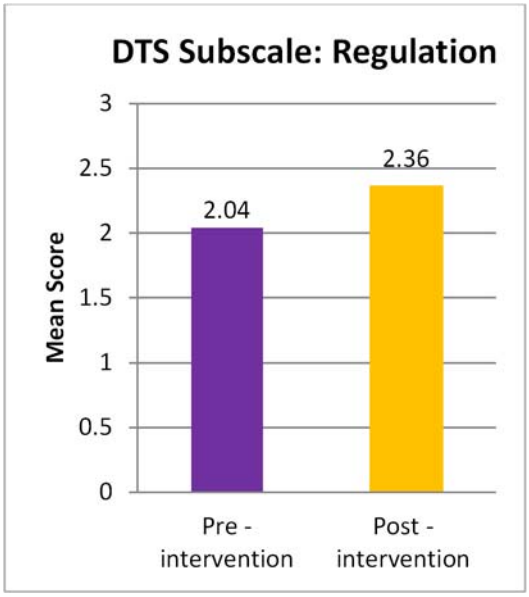
Note: Higher scores indicate increased ability to tolerate distress

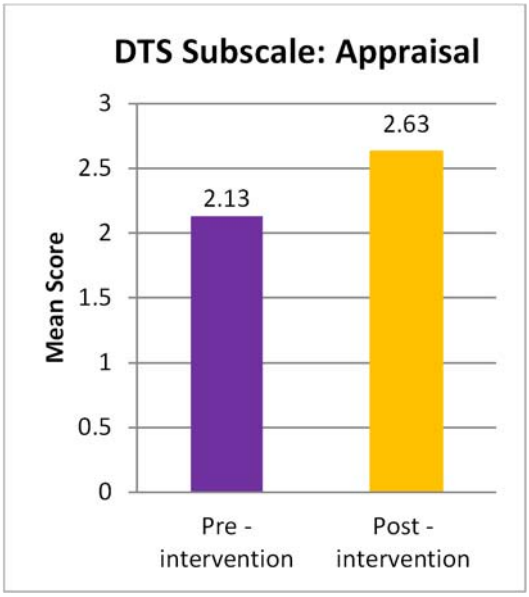
The DTS comprises of 4 subscales assessing tolerance, absorption, appraisal and regulation. There were statistically significant differences identified between pre and post intervention on the tolerance and absorption subscales. There was a change in the intended direction on the regulation and appraisal subscales; however, this change was not statistically significant. These results indicate that participants' distress tolerance increased post-programme as expected. The differences between pre and post intervention subscale scores are represented in the graphs below.

Graph: Distress Tolerance Scale Sub-scales





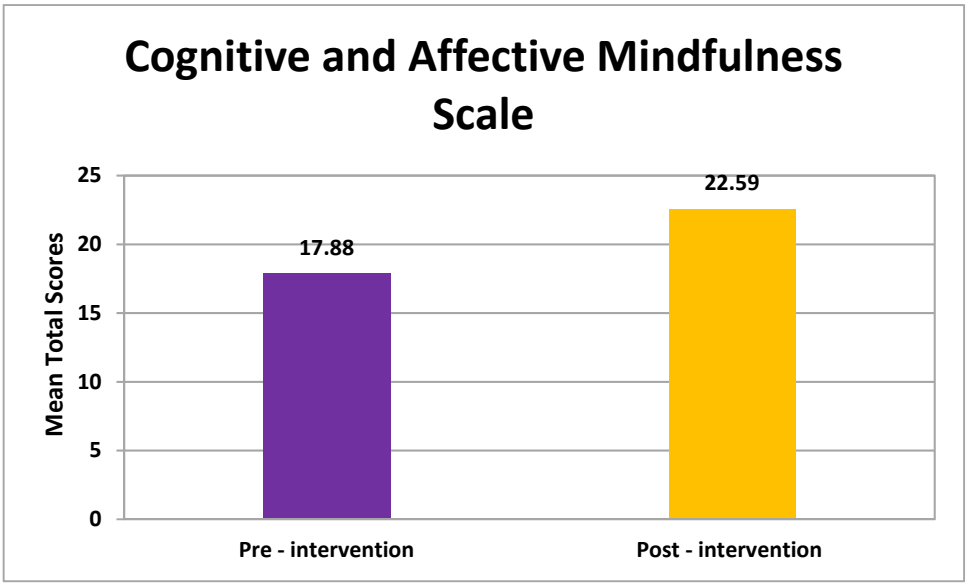




Cognitive and Affective Mindfulness Scale

Participants also had greater mindful qualities post intervention moving from a mean score of 17.9 (*SD* = 3.22) before the programme on the CAMS-R to 22.6 (*SD* = 4.98) after completing the programme, $z = 4.80$, $p < .001$, representing a large effect size (r= .52)

Graph: Cognitive and Affective Mindfulness Scale Total Scores



4.10.4. Summary

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

Outcome measures for the programme are expected to remain the same for the coming year. There is ongoing research on this programme to look at emotional over and under control and functioning in relationship, which includes participants from both the LTD and Radical Openness groups. Radical Openness is a dialectical behaviour therapy (DBT) style group for service users with an over-controlled personality style. All the data for this project has been collected and it is currently being written up. New research

will commence this year that aims to explore possible barriers to skill acquisition.

4.11. Living through Psychosis Programme

Living through Psychosis (LTP) is a psychology group intervention that addresses the primary issue of emotional dysregulation which is understood to be a significant vulnerability and co-morbidity factor in psychosis. The programme aims to provide emotional regulation, distress tolerance and mindfulness skills for individuals with psychosis (Psychosis, Schizophrenia, Schizo-affective Disorder, Acute psychotic episode and Bipolar affective disorder) to maintain gains made in hospital and to reduce the likelihood of relapse and to support patients to return to social and occupational recovery goals.

LTP has been developed in line with established models of cognitive behavioural therapy for psychosis which promotes normalising and coping with both positive and negative symptoms. These models have been enhanced by incorporating skills that focus on emotion regulation. Given that each patient is impacted uniquely by psychosis a formulation based approach further informs the content of the programme.

The programme provides teaching on eight skills which have been found to be important factors to better cope with symptoms. Additionally the programme provides a safe environment where the personal impact of psychosis can be explored. Following these eight sessions, each LTP group member is offered a level 2 intervention. This is a longer intervention and combines well established models of cognitive behavioural therapy with an emerging evidence base of Compassion focused therapy.

4.11.1 Living Through Psychosis Programme Outcome Measures

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

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dys-regulation, comprising six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 "almost never" to 5 "almost always". Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability ($\alpha = .93$), construct and predictive validity, and test-retest reliability in the development study.

- **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 7- point Likert scale, from 0 'strongly disagree' to 6 'strongly agree'. Total scale scores range from 0 to 96.

The SMQ was included in a study by Baer et al. (2006) exploring the psychometric properties of five mindfulness questionnaires. The SMQ was internally reliable (a=.85) and significantly positively correlated with mindfulness measures, as well as with measures of emotional experience, self-compassion, psychological symptoms, and dissociation

4.11.2. Descriptors

Data were available for 20 people who completed the programme in 2017, of whom 8 (40%) were female and 12 were male (60%). Programme attendees ranged in age from 19 to 68 years with a mean age of 40.25 (SD=15.58). The

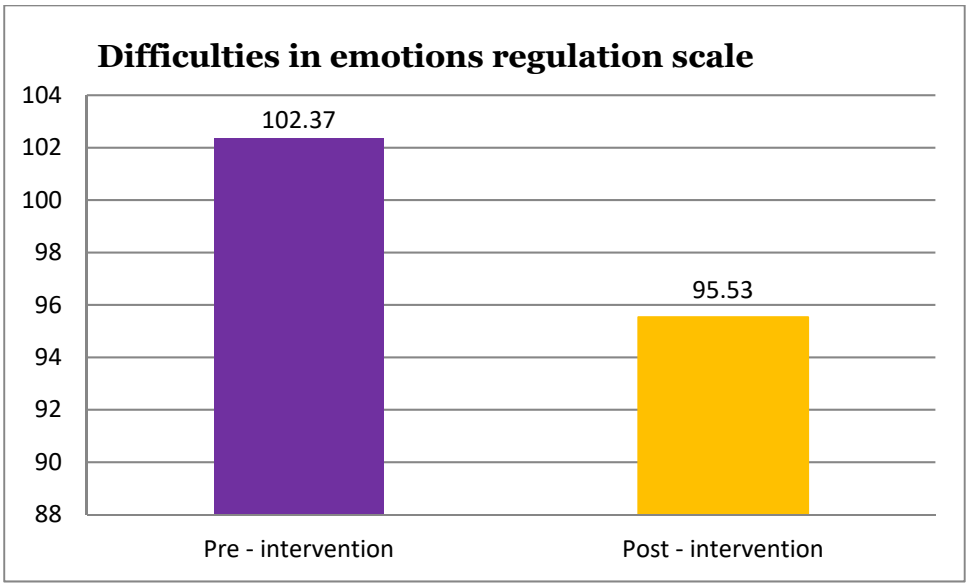
mean age of onset was 29.68 years, with a range from 17-51 years. Of note 6 (30%) were first episode psychosis patients. Of those who attended 25% were employed, 60% were unemployed, 10% were retired and 5% were currently in education courses. Their levels of education ranged from Junior Certificate (5%), Leaving Certificate (25%), Apprenticeship (5%), Undergraduate (30%) to Postgraduate (35%).

4.11.3. Results

Difficulties in Emotion Regulation Scale

Participants experienced a decrease in difficulties regulating emotions moving from an average score of 102.37 (*SD* = 27.32) on the DERS to 95.53 (*SD* = 23.53) post completion of the programme, however, this change was not statistically significant, *t* (17) =1.10, p= .28. See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

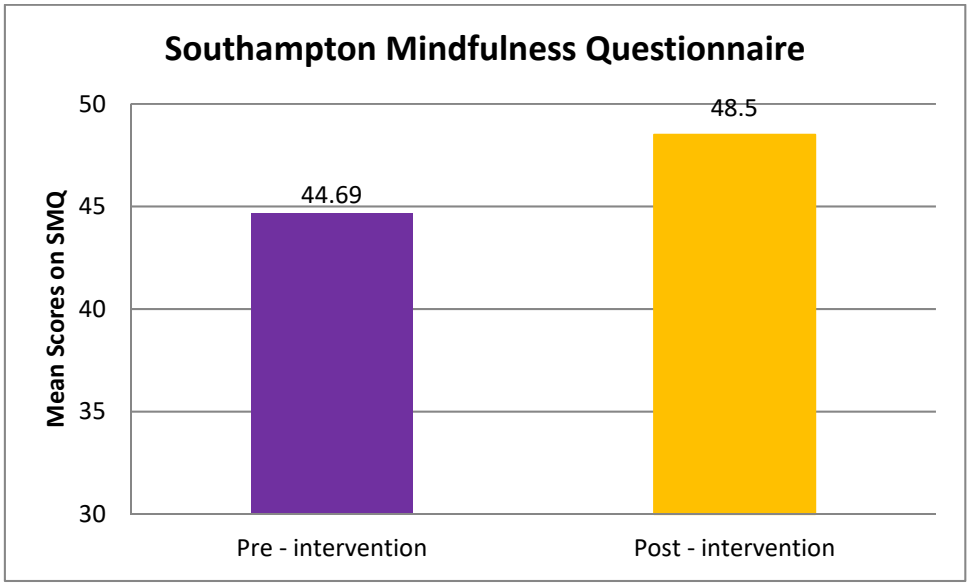


Note: Higher scores indicate greater difficulties with emotion regulation

In terms of the degree to which individuals mindfully responded to distressing thoughts and images; there was an increase from an average score of 44.69 (SD = 16.72) to 48.50 (SD = 18.48) on the SMQ from pre- to post

intervention. However, there was no statistically significant change identified t (17) = 1.57, p= .14.

The Southampton Mindfulness Questionnaire (SMQ)



4.11.4. Summary

The Living Through Psychosis programme continues to promote a service that engages the patient actively in their recovery. The programme draws on current research findings to determine key areas to target in psychological recovery. The findings presented above demonstrate that skills such as emotion regulation can be learnt during recovery from psychosis and that it can lead to improvements in many factors related to positive recovery. The programme continues to aim towards being a central part of care planning for each person in this cohort.

This year all graduates of the programme were given the option of attending a level 2 programme which extends over 16 sessions. This is a pilot project and will be evaluated and reviewed in 2018.

4.12. Mindfulness Programme

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

4.12.1. Mindfulness Programme Outcome Measures

- **Five Facet Mindfulness Questionnaire**

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five specific facets of mindfulness: observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 “never or very rarely true” to 5 “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).

4.12.2. Descriptors

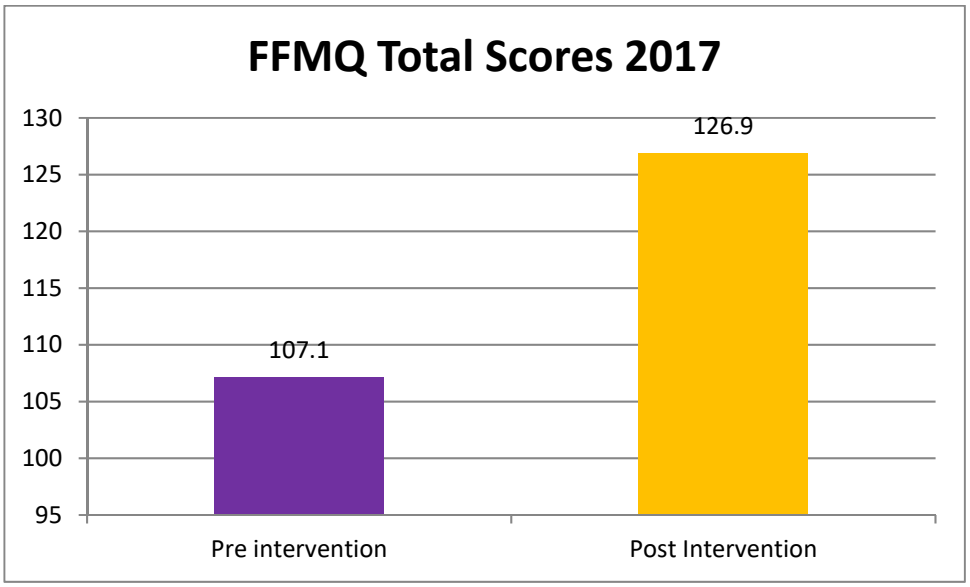
The Mindfulness Programme was delivered in St Patrick’s University Hospital and St Edmundsbury Hospital. For the purpose of this report the data from both centres has been collated, analysed and reported on together.

Data was collected on 64 participants, 22 males (34.8%) and 42 females (65.6%). Participants age ranged from 19 to 76 years old (mean = 47 years).

4.12.3. Results

Five Fact Mindfulness Scale (FFMQ)

Graph: Five Facet Mindfulness Scale Total Scores



An examination of the combined data from across both sites revealed a significant increase in total scores on the FFMQ from pre intervention (M=107; SD=19.1) to post intervention (M=126.9; SD=19.2). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (41) = -5.6, p<.005, with a large effect size (Cohen's *d* = 1.03). These results suggest that, on average, service users who completed the outcome measure showed an increase in their tendency to be mindful in daily life.

Statistically significant increases were reported on all subscales, with a large effect size for the "observing" domain (Cohen's *d* =0.8). Medium effect sizes were reported on "describing" (Cohen's *d* = 0.5), "acting with awareness" (Cohen's *d* =0.6), "non-judgement of inner experience" (Cohen's *d* = 0.6) and "non-reactivity to inner experience (Cohen's *d* = 0.6).

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

FFMQ	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*P value*	*Cohen's d*
Observe	23.9 (6.5)	30.1 (8.3)	4.7	46	.000	0.8
Describe	25.4 (6.8)	27.7 (10)	3.3	45	.002	0.5
Awareness	20.1 (4.6)	22.8 (4.8)	3.5	44	.001	0.6
Non-Judgement	20.4 (5.9)	24 (6)	4.3	44	.000	0.6
Non-Reactivity	19 (5.5)	22 (4.5)	3.1	45	.003	0.6

4.12.4. Summary

In line with the 2016 report, results for 2017 suggest that the programme continues to be successful in helping service users' develop their capacity for mindfulness in daily life. The analysis revealed significant change with a large effect size apparent for changes on the measure overall. Medium effect sizes were reported for most of the subscales, with the "observing" domain reporting a large effect size.

4.13. Psychology Skills Group for Adolescents

Due to the small numbers in the Psychology Skills Group for Adolescents the outcome measures from when the group began in 2015 to 2017 are analysed together so that the data from these measures can provide us with meaningful feedback in relation to the effectiveness of the group.

The Psychology Skills Group is a psychological group therapy that aims to provide young people who are experiencing a range of mental health difficulties with new ways of coping. The group is centred on learning a mixture of skills from Dialectical Behavioural Therapy (DBT) for adolescents and Radical Openness. The group invites parents or caregivers to attend the group alongside their young person to help support them in learning and

practicing new coping skills. The group runs for one afternoon per week for 20 weeks. The structure of the group features five modules each containing four sessions.

4.13.1 Psychology Skills for Adolescents Measures

Child Behaviour Checklist (CBCL)

The CBCL is a measure which is completed by parents or caregivers to provide an indication of behavioural and emotional problems experienced by young people aged 6-18 years. It consists of 113 questions, scored on a three-point Likert scale (0=absent, 1= occurs sometimes, 2=occurs often). The measure consists of a number of sub-scales, categorised as anxious/depressed, withdrawn/depressed, somatic complaints, thought problems, attention problems, rule-breaking behaviour and aggressive behaviour. These sub-scales are grouped into two composite scales, which assess internalising behaviours and externalising behaviours. Achenbach and Rescorla (2000) found that the measure has excellent test-retest reliability and internal consistency.

Difficulties in Emotion Regulation Scale (DERS)

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dysregulation, comprising six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 “almost never” to 5 “almost always”. Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability ($\alpha = .93$), construct and predictive validity, and test-retest reliability in the development study.

DBT Ways of Coping Checklist (DBTWCCL)

Both parents and young people completed this measure pre and post intervention. The DBTWCCL measures DBT skills use. It comprises two sub-scales, one which assesses coping using DBT skills, the DBT Skills Subscale (DSS), and one which assesses coping using dysfunctional means, the

Dysfunctional Coping Subscale (DCS). The measure consists of 59 items scored on a 4-point scale, from 0 "never used" to 3 "regularly used". Higher scores indicate on the DSS indicate greater use of DBT skills, while higher scores on the DCS indicate higher levels of unhelpful coping behaviours. Neacsiu, Rizvi, Vitaliano, Lynch and Linehan (2010) found that the measure has excellent test-retest reliability, internal consistency and content validity.

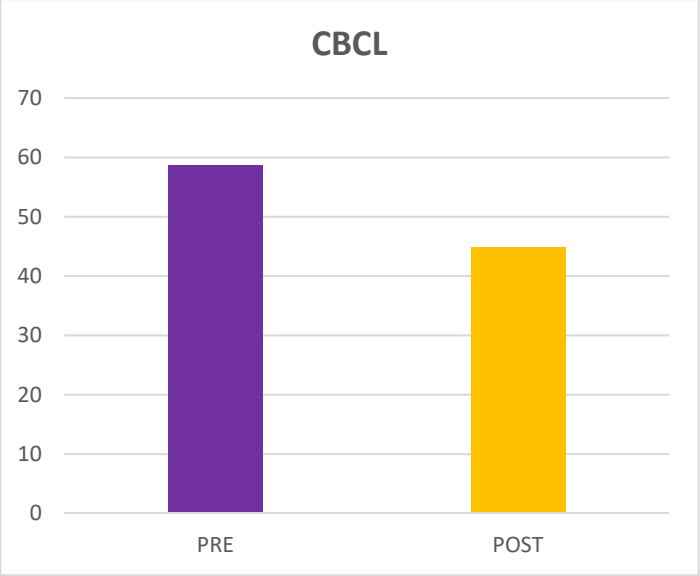
4.13.2. Descriptors

78 service users took part in the Psychology skills group for adolescents; 27 young people and 51 parents. The average age of young people attending was 16 years.

4.13.3 Results

Child Behaviour Checklist (CBCL)

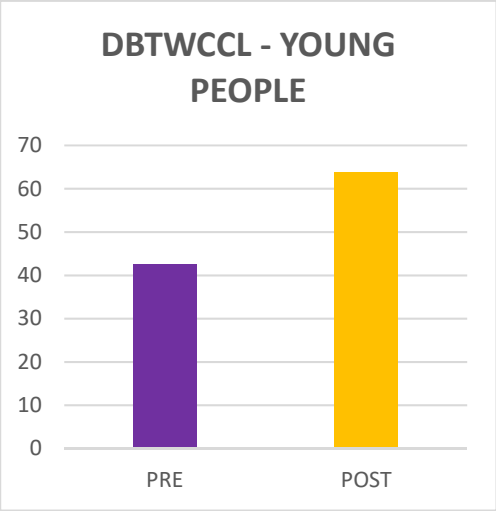
This measure is completed by caregivers only. Total problem scores on the CBCL as completed by the young person's caregivers decreased from pre-intervention (M = 58.64) to post intervention (M = 44.95). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(21) = 2.3$, $p < .05$, reflecting a medium effect size ($d = 0.5$).

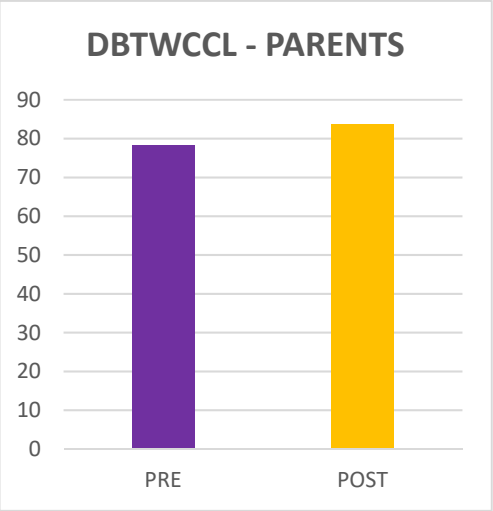


DBT Ways of Coping Checklist (DBTWCCL)

For young people, total DBT skill use increased from pre-intervention (M=42.55) to post intervention (M=63.82). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(11) = 4.2$, $p < .05$, reflecting a large effect size ($d = 0.9$).

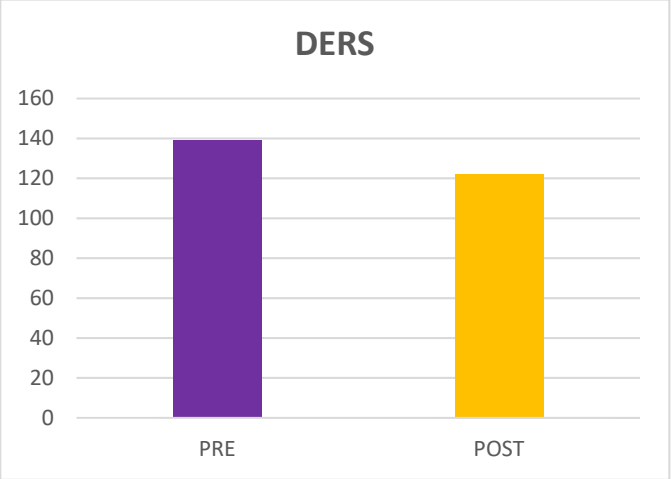
Parents showed a similar trend with DBT skill use increasing from pre-intervention (M=78.17) to post intervention (M=83.8), however this change was not statistically significant.





Difficulties in Emotion Regulation Scale (DERS)

This measure is completed by young people only. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=138.9) to post intervention (M=121.9). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(10) = 2.5$, $p < .05$, reflecting a large effect size ($d = 0.9$).



4.13.4. Summary

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

The findings presented provide a meaningful insight into the effectiveness of the programme. The results indicate that by attending the group, young people developed an increased capacity to tolerate distress and to manage difficult emotions. Young people who completed the group also evidenced an increase in the use of DBT skills when coping. Parents and caregivers reported a decrease in young peoples' externalising behaviours, such as physical aggression and rule-breaking, and a decrease in internalising behaviours, such as low mood and anxiety.

4.14. Radical Openness Programme

The Radical Openness (RO) Programme is a therapeutic group delivered by the Psychology Department. The programme is based on an adaptation of DBT for "emotional over-control", developed by Tom Lynch (Lynch, 2018; Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007; Lynch and Cheavens, 2008). The programme is for those who have developed an emotionally over-controlled style of coping. This includes inhibiting emotional experience and expression, maintaining aloof and distant relationships and having rigid rule governed behaviour.

The Radical Openness programme aims to enhance participants' ability to 1) experience and express emotion 2) develop more fulfilling relationships and 3) be more open to what life can offer. The group is underpinned by a model that suggests that behavioural over-control, psychological rigidity, and emotional constriction can underlie difficulties such as recurrent depression, obsessive-compulsive characteristics and restrictive eating difficulties. Radical Openness is offered over a five month period, twice a week for eleven weeks and then once a week for four weeks.

4.14.1. Radical Openness Programme Outcome Measures

- **Brief symptom Inventory**

The Brief Symptom Inventory (BSI; Derogatis, 1983) is a 53-item measure of symptoms that cause service users' to experience psychological distress within the previous week. Psychometric evaluations (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004) have shown that the BSI is a reliable and valid measure. It has good test-retest reliability and internal consistency, and it shows high convergence with comparable scales on the SCL-90-R and MMPI. Service users rate each symptom on a scale of 0 'Not at all' to 4 'Extremely'. The Global Severity Index score, which is used in this report, is the best indicator of current distress levels.

- **The Social Connectedness Scale-Revised**

The SCS-R (Lee & Robins, 1995) is a fifteen-item self-report scale that was designed to assess an individual's subjective sense of social connectedness to their social world. Increased scores reflect higher social connectedness. Each item is rated on a 6 point Likert scale, from 1 Strongly Disagree to 6 Strongly Agree.

- **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. The DTS comprises of 4 subscales assessing tolerance, absorption, appraisal and regulation. Respondents are asked to rate each statement on a 5-point scale from 1 "Strongly Agree" to 5 "Strongly Disagree". Higher total scores on the DTS scale indicate greater distress tolerance.

4.14.2. Descriptors

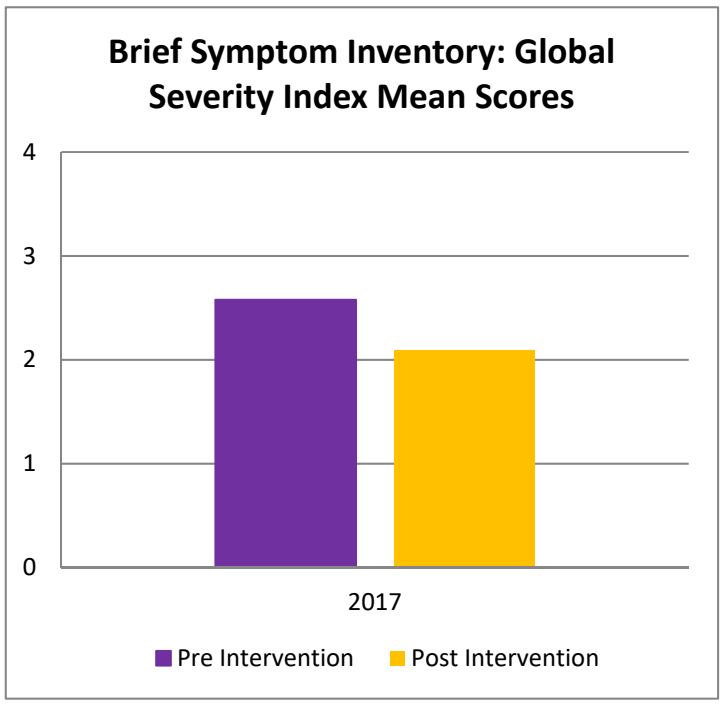
A total of 40 people completed RO programmes in 2017. Pre and post data were available for 23 people representing 57.5%. Where gender data was available, 33.3% were female and 36.4% were male and they ranged in age from 18 to 70 years (M=38.5; SD=15.34).

4.14.3. Results

Brief Symptom Inventory

A significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale on the Brief Symptom Inventory (BSI), whereby t(22)= 3.09, p<.05, reflecting a medium effect size (*d*= .68).

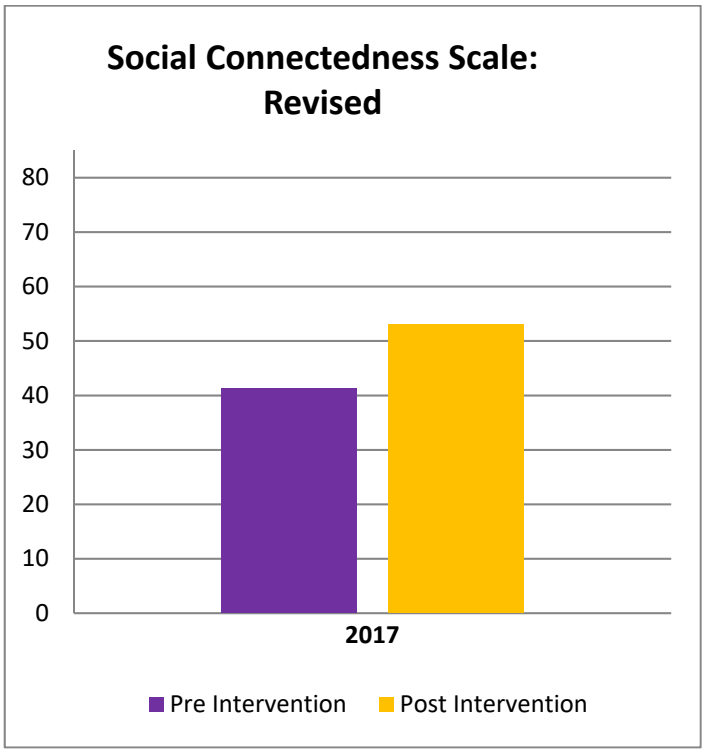
Graph: Brief Symptom Inventory Global Severity Index



Social Connectedness Scale: Revised

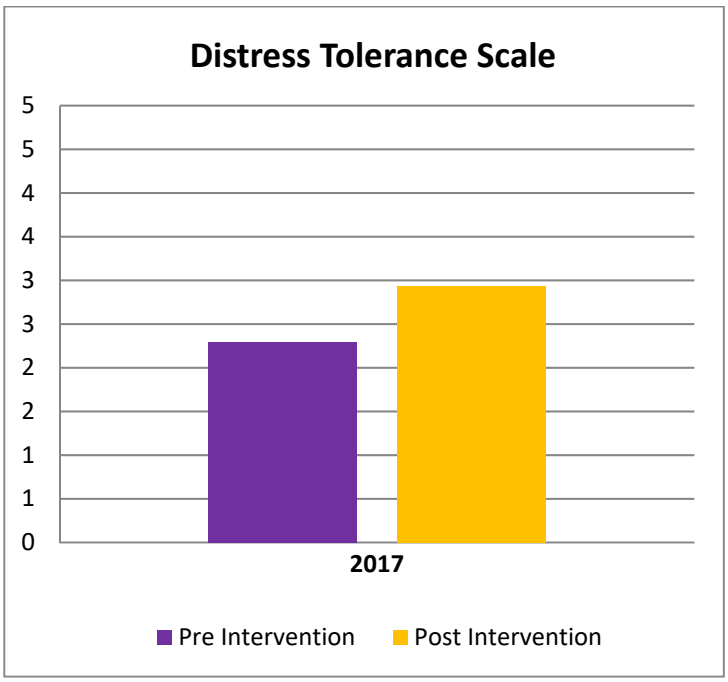
A significant change was also observed on the SCS-R, whereby t (22) = 3.16, p< .05, reflecting a large effect size (Cohen's *d*=0.8), suggesting that after the programme participants felt more connected to their social world.

Graph: Social Connectedness Scale: Revised



Distress Tolerance Scale

A significant change was also observed on the DTS, whereby t (14) = 2.34, p< .05, reflecting a medium effect size (Cohen's *d*=0.69), suggesting that after the programme participants were better able to tolerate their distress.



Graph: Social Connectedness Scale: Revised

Table 1: *Results from paired samples t-tests for measures pre and post Radical Openness intervention.*

Scale	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
BSI	2.57 (0.7)	2.09 (0.7)	3.09	22	.005	0.7
SCS-R	41.3 (12.9)	53 (17.3)	3.16	22	.005	0.8
DTS	2.29 (0.7)	2.93 (1.1)	2.34	14	.03	0.69

BSI=Brief Symptom Inventory, SCS-R=Social Connectedness Scale-Revised & DTS = Distress Tolerance Scale

4.14.4. Summary

The Radical Openness programme teaches skills that provide new ways of coping for individuals who find it difficult to lessen their emotional control. This is a targeted approach for service users who are often underserved in mental health care. In 2017 service users who completed Radical Openness showed reductions in psychological distress as measured by mental ill health symptoms as well as emotional avoidance (i.e. avoiding the internal experience of emotion) and increases in social connectedness. These findings were consistent with previous years.

Services users who have completed the programme report better insight into their emotional over-control and the costs this can have in their lives. This is supported by the significant improvements in ability to tolerate distress and in social connectedness as found in this report.

There is ongoing research on this programme being undertaken by a doctoral student in Clinical Psychology, which is looking at the interpersonal profiles of over and under controlled individuals. This involves a comparison of profiles of those individuals referred to Radical Openness and Living through Distress. The study will also explore group differences that may help develop the current programmes to ensure they effectively meet the needs of service users.

4.15. Psychosis Recovery Programme

The psychosis recovery programme is an intensive three-week programme catering for both inpatients and day patients. It aims to provide education around psychosis, recovery and specific cognitive behavioural therapy (CBT) skills to help participants cope with distressing symptoms. In particular, groups focus on recovery strategies, practical information about psychosis, social support, staying well, effective use of medication, CBT techniques, building resilience, and occupational therapy. The programme is delivered by members of a multi-disciplinary team (MDT) which includes a Consultant Psychiatrist, Clinical Nurse Specialist, Clinical Psychologist, Occupational Therapist and a Pharmacist.

4.15.1. Psychosis Programme Outcome Measures

- **Recovery Assessment Scale**

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. The RAS is a 41-item survey rated on a 5-point scale from 1 “Strongly Disagree” to 5 “Strongly Agree”. Twenty four 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 burden in completion of measures for this programme, which had previously resulted in low response rates.

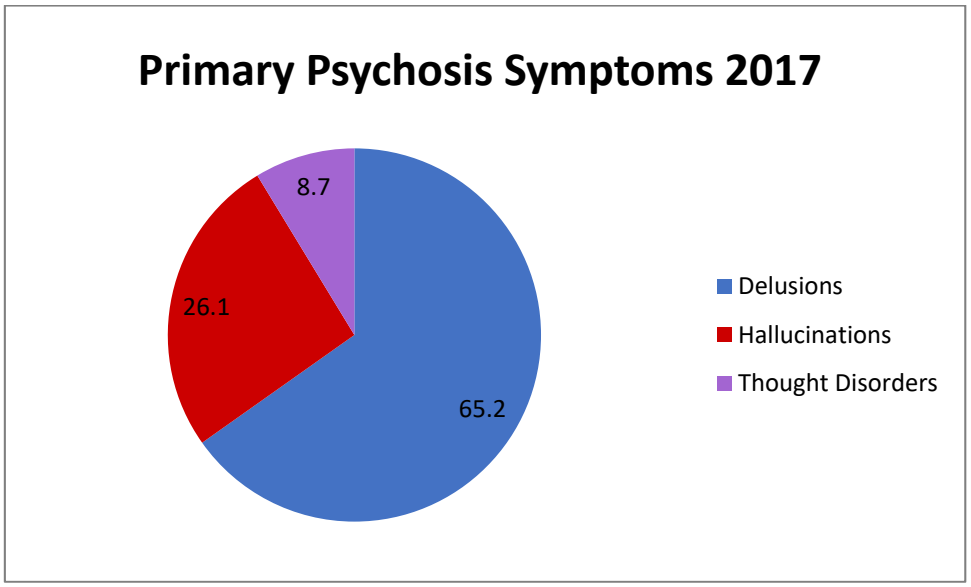
4.15.2. Descriptors

In 2017 pre and post RAS and DAI scores were available for 23 participants. The average age of psychosis programme participants was 38.19 years (ranging from 21 to 61 years) with a slightly higher number of females (n=13) than males (n=10). 60.8% were single, 26.1% married, and 13.1% were separated or divorced. 43.5% were in employment, 21.7% were unemployed, 21.7% were students, 4.4% were receiving disability allowance, and a further 8.8% either worked from home or preferred not to say. Over one quarter had attained a third level degree. 30.4% had completed the leaving certificate, with another 26.1% having a non-degree third level qualification. The remaining 4.4% had left school before the leaving certificate. The majority lived with family (82.6%) followed by living alone (13.0%). 4.4% were living with friends, or cohabiting. The majority of service users reported their ethnicity as white Irish (96.6%). Comparing 2016 to 2017, services users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

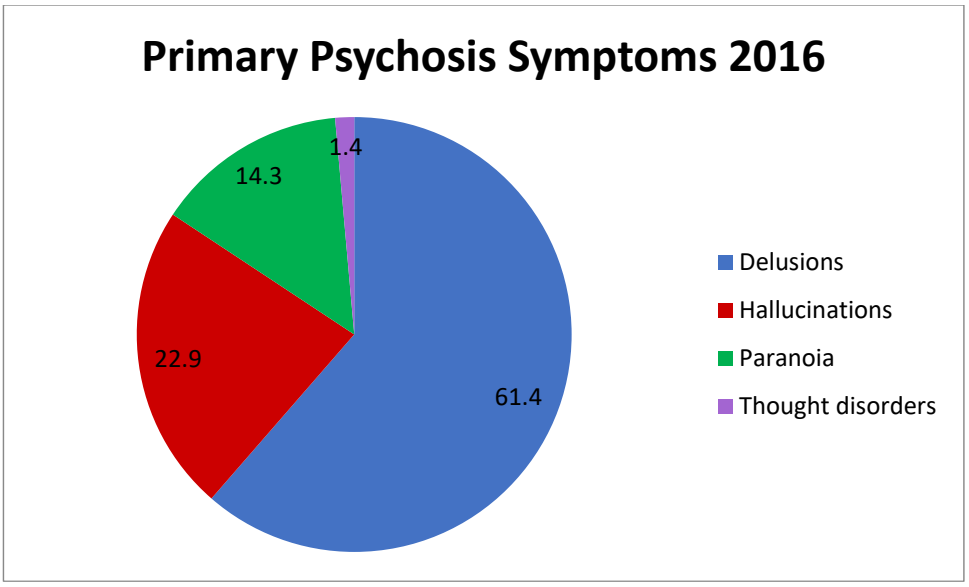
There were similar trends identified in the primary psychosis experience reported for service users in 2016 and 2017. In 2016 the primary reported symptoms were delusions, followed by hallucinations, and paranoia. In 2017 the primary reported symptoms were delusions (65.2%), followed by

hallucinations (26.1%), and thought disorders (8.7%). See the figures below for reported primary psychosis symptoms in 2016 and 2017. The average attendance per client in 2017 was 17.9 sessions. Participants are permitted to attend multiple cycles of the programme.

Graph: Primary Psychosis Symptoms 2017



Graph: Primary Psychosis Symptoms 2016



4.15.3. Results

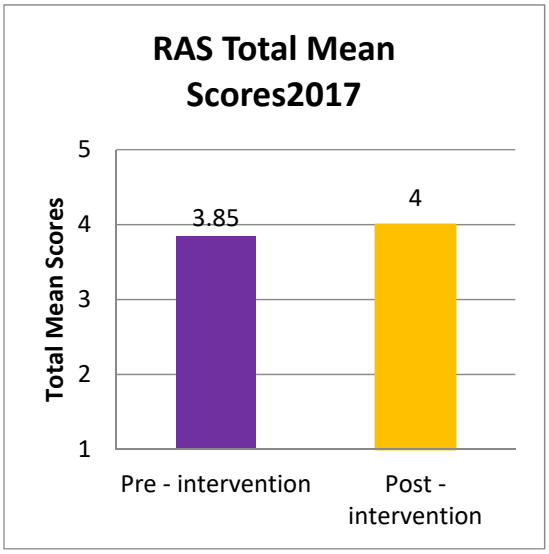
Recovery Assessment Scale

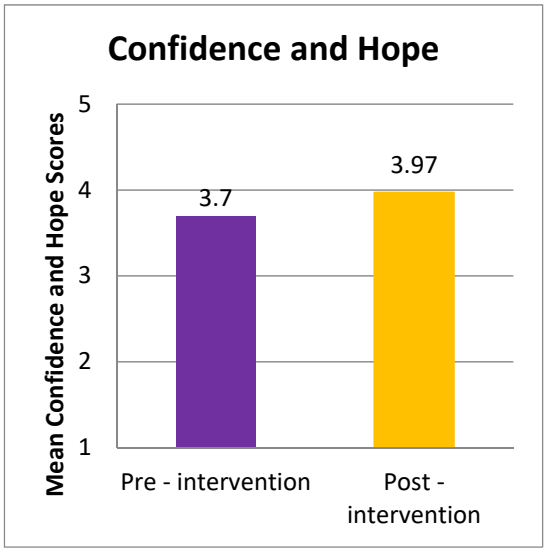
A Wilcoxon Signed Rank test identified no statistically significant difference in mean total scores for the RAS from pre- intervention (M=3.85; SD=.77) to post intervention (M=4.00; SD=.87). This indicates that the RAS measure failed to demonstrate an overall change in coping ability and quality life following completion of the programme. However, looking at the RAS sub-scale scores, significantly higher scores were identified post intervention for users on the 'Goal and Success Orientation' subscale, $z=2.68$, $p<.05$. The difference between pre- and post- intervention means on the 'Ability to rely on others' 'Confidence and Hope', 'Willingness to ask for help', and 'No domination by symptoms' subscales were not statistically significant. See the table below for test statistics and figures for differences in pre- and post-intervention means and graphs on the following page for visual representations.

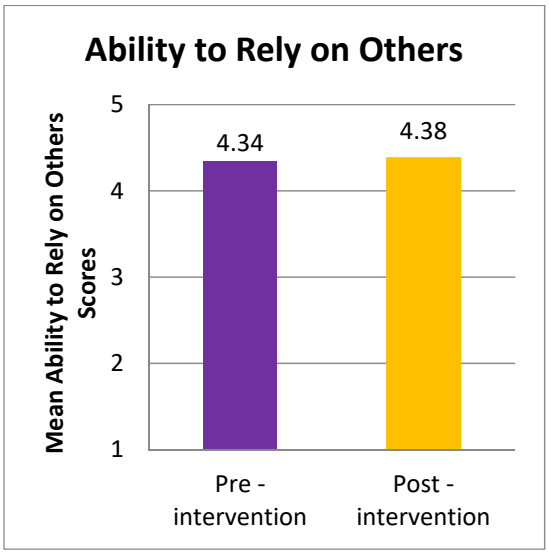
RAS	Pre Mean	Post Mean	*z*	*p*	Cohen's *d*
Mean Total	3.85 (.77)	4.00 (.87)	1.12	.26	.23
Confidence and Hope	3.70 (1.03)	3.97 (.91)	1.43	.15	.29
Willingness to ask for Help	4.10 (.78)	4.12 (.73)	.15	.87	.03
Goal/ Success Orientation	3.92 (.85)	4.32 (.78)	2.68	.01	.56
Ability to Rely on Others	4.34 (.67)	4.38 (.58)	.28	.77	.06
No Domination by Symptoms	3.19 (1.24) (.95)	3.44 (1.03)	1.28	.19	.27

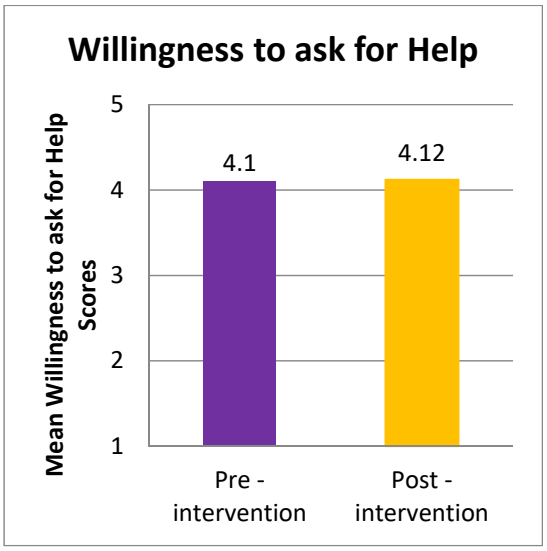
*Table: *Results from Wilcoxon Signed Rank tests and Paired Sample T Tests for the RAS pre and post scores* RAS = Recovery Assessment Scale.

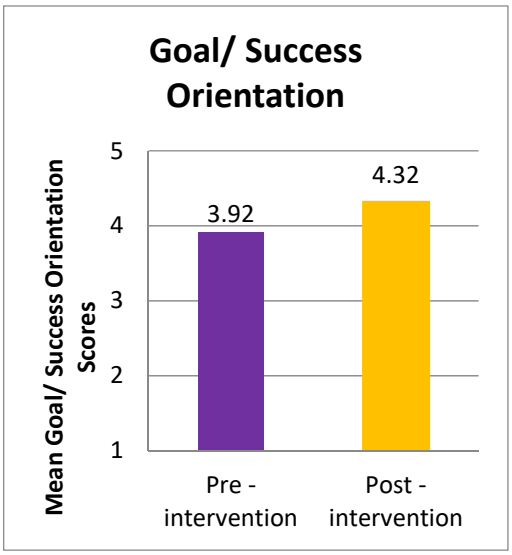
Graphs: Recovery Assessment Scale sub-scales

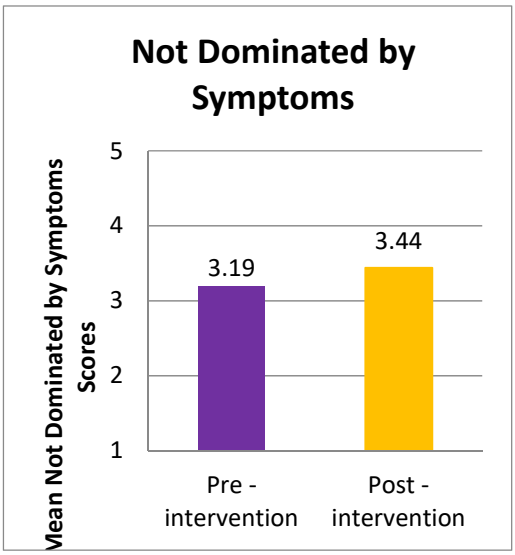






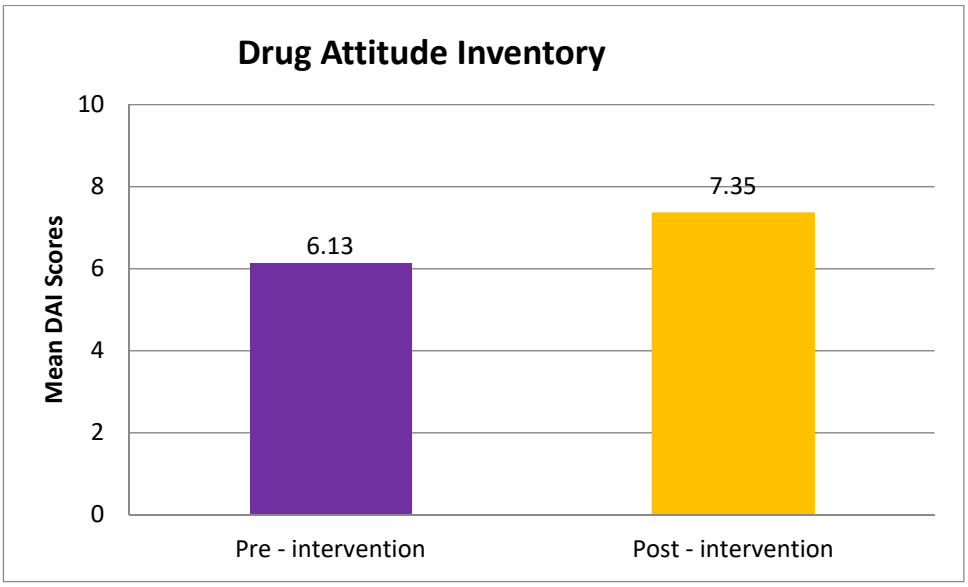






Drug Attitude Inventory

A Wilcoxin Signed Rank test identified a statistically significant increase in mean scores on the DAI-10 from pre- intervention (M=6.13 SD=2.70) to post intervention (M=7.35; SD=2.60) $z=2.4$, $p<.05$, with a medium effect size (Cohen's *d*: .49). This indicates that service users who completed the measures reported more positive views towards medication after completing the programme.



4.15.4. Summary

Outcomes for the psychosis programme were captured for the first time in 2012 and analysis of data from the programme has consistently suggested benefits for service users since this time. Average total scores on the RAS and DAI have been consistently shown to increase post intervention, suggesting the Psychosis Recovery Programme is helpful in supporting service users' recovery and in encouraging more positive views towards medication.

Programme staff explained that service user's inability to complete the measures accurately at the pre time point due to the acute nature of their illness has resulted in significant amount of lost data. Programme staff will be proactive in encouraging completion of measures accurately in order to increase response rates in 2018.

4.16. Recovery Programme

The recovery programme is a structured 12-day programme based on the Wellness and Recovery Action Plan (WRAP) approach designed by Mary Ellen Copeland of the Copeland Centre (1992). The WRAP approach focuses on assisting service users who have experienced mental health problems to regain hope, personal responsibility through education, self-advocacy, and support. The recovery model emphasises the centrality of the personal

experience of the individual and the importance of mobilising the person's own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. The Recovery Programme at St Patrick's Mental Health Services (SPMHS) is delivered through the Wellness and Recovery Centre for day-patients.

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

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

4.16.1. Recovery Programme Outcome Measures

• Recovery Assessment Scale

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

In 2015, it was decided to make a minor adjustment to the reporting of the RAS figures in this outcomes report. The change involved moving from reporting total scores to reporting mean scores, which makes the data more

meaningful to the reader, whereby it is easier to draw comparisons across the subscales on the RAS.

4.16.2. Descriptors

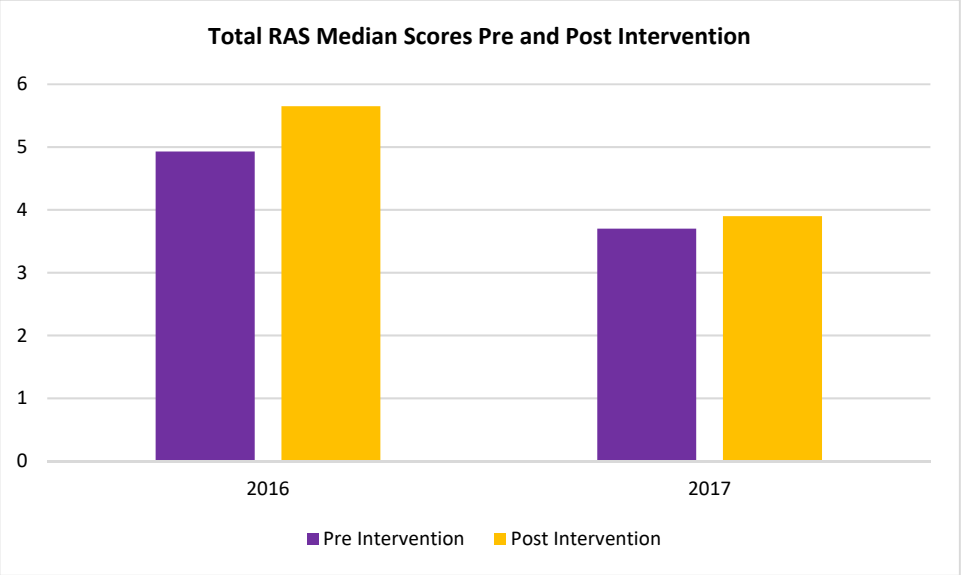
62 service users took part in the Recovery Programme in 2017. Pre and post data were available for 46 participants which represents 74% of those who attended in 2017. The average age of participants was 52 years and 65.2% were female.

4.16.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre-measurement (Md = 3.7) to post measurement (Md = 3.9) indicating greater overall recovery. A Wilcoxin Signed Rank Test revealed this increase was statistically significant, z = 3.85 , p < .005, and represented a medium effect (d = 0.67).

Graph: Recovery Assessment Scale: Median Scores



The figures below show pre and post scores on each of the five subscales: 'Personal Confidence and Hope', 'Willingness to ask for Help', 'Ability to rely

on others', 'Not dominated by Symptoms' and 'Goal and Success Orientation'. A series of t-tests and Wilcoxin Signed rank tests were run in order to compare pre and post scores, mean and median scores, standard deviations, z values, *p* values and effect sizes for each of the subscales. Significant change was seen across all subscales as can be seen in the tables below.

Table 1: Mean scores on RAS (t-tests)

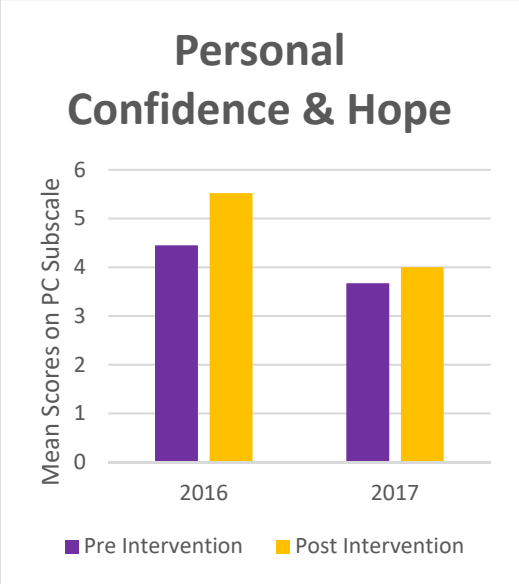
RAS	Pre *Mean (SD)*	Post *Mean (SD)*	*T value*	*P*	*Cohen's d*
Personal confidence	3.51 (0.67)	4.03 (0.42)	5.71	.000	0.92
Willingness To Ask For Help	3.46 (0.7)	3.85 (0.5)	3.65	.001	0.64

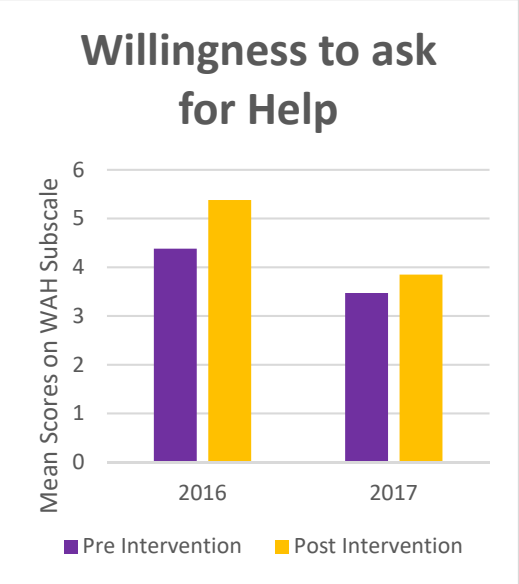
Table 2: Median scores on RAS (Wilcoxin Signed rank tests)

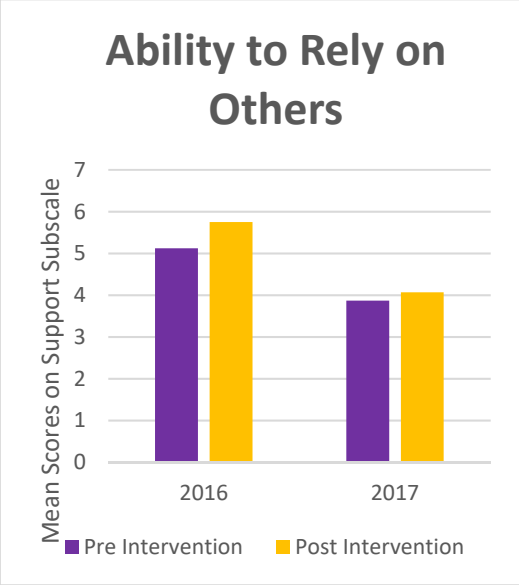
RAS	Pre *Median*	Post *Median*	*Z value*	*P*	*Cohen's r*
Ability To Rely On Others	3.75	4.00	3.02	.002	0.2
Not Dominated By Symptoms	3.67	4.0	3.47	.001	0.3
Goal and Success Orientation	3.8	4.0	4.28	.000	0.5

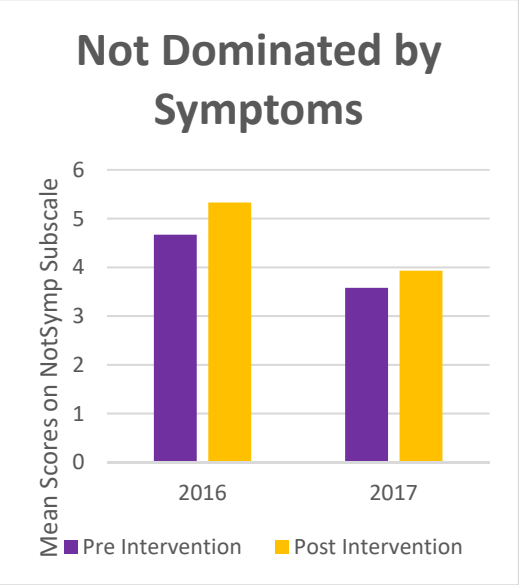
Scores on each of the 5 subscales improved significantly from pre to post measurement (see the graphs below).

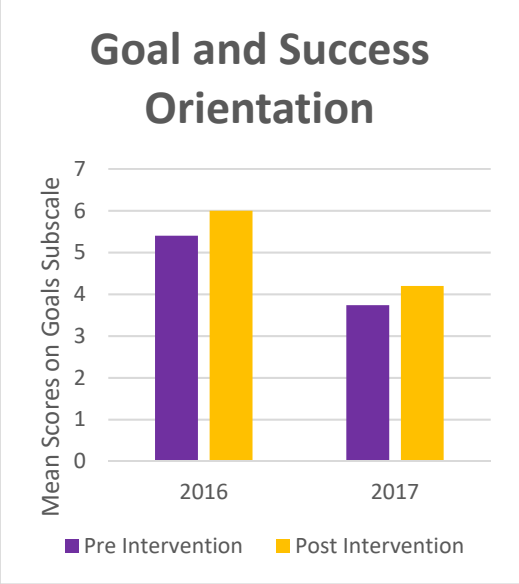
Graphs: Recovery Assessment Scale sub-scale







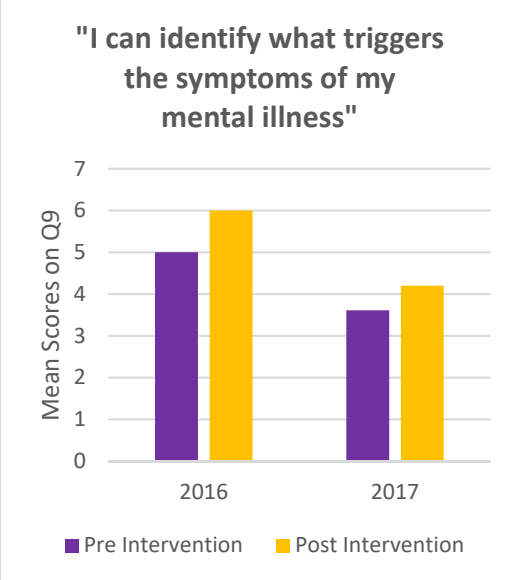


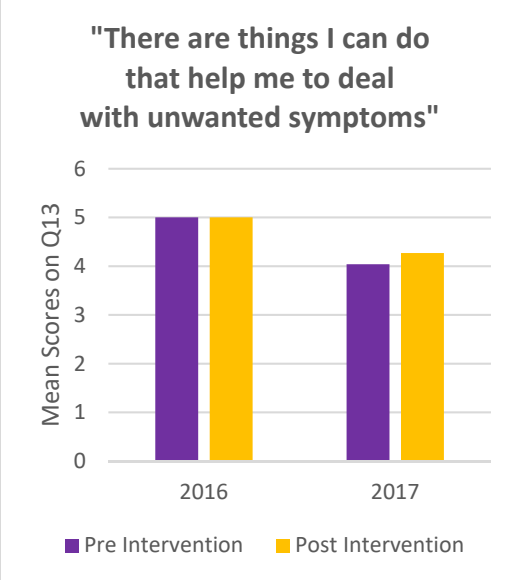


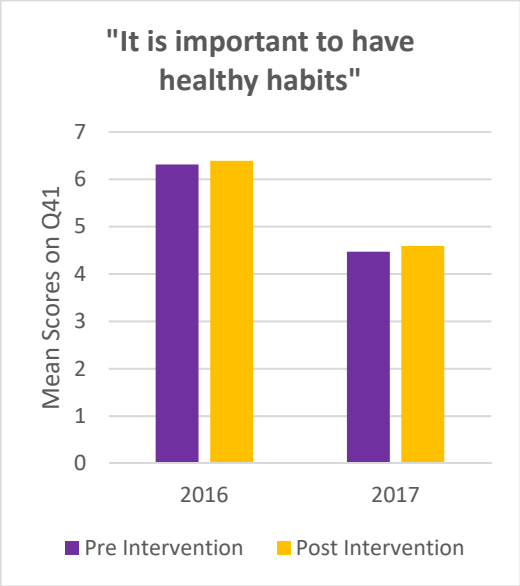
From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 “I can identify what triggers the symptoms of my mental illness”, item 13 “There are things I can do that help me deal with unwanted symptoms” and item 41 “It is important to have healthy habits”.

A series of Wilcoxin Signed Rank tests were run and scores improved significantly, $p<0.05$, from pre to post measurement (see the following graphs) for items 9 and 13. Item 41 showed improved scores at post measurement however these were not statistically significant, $P>0.05$. Items 9 and 13 evidenced a medium effect sizes, $r = 0.4$ and 0.31 respectively. While item 41 had a small effect size, $r = 0.1$.

Graph: Recovery Assessment Scale Questions 9, 13, 41







4.16.4. Summary

Completion rates for 2017 were good with 74% completing measures pre and post intervention. The findings presented provide a meaningful insight into the effectiveness of the programme. Careful consideration has been given to the retention of the RAS as the primary outcome measure for the Recovery Programme. While there is no "gold standard" measure of recovery, the RAS has strong support for its psychometric properties. The RAS was found to meet a number of criteria set out by Burgess, Pirkis, Coombs and Rosen (2010), in their assessment of existing recovery measures including; measuring domains related to personal recovery, is brief, takes a service user perspective, is suitable for routine use, has been scientifically scrutinised, and demonstrates sound psychometric properties.

In summary, those who completed the programme showed significant improvements on the total RAS scale and on each of the 5 subscales. These improvements all demonstrated medium to large effect sizes. In addition, two of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements at post intervention, with medium effect sizes.

4.17. Willow Grove Outcome Measures

Willow Grove is the inpatient adolescent service associated with St Patrick's Mental Health Services. The 14 bed unit opened in April 2010 and aims to provide evidence based treatment in a safe and comfortable environment to young people between the ages of 13 and 17 years who are experiencing mental health difficulties. The Unit is an approved centre accepting voluntary and involuntary admissions.

The team consists of medical and nursing personnel together with Clinical psychologists, Cognitive behavioural therapists, Social worker/Family therapist, Occupational therapist, Registered Advanced Nurse Practitioner and teaching staff.

The unit offers an intensive structured clinical programme designed to assist and support young people and their families to manage and alleviate mental health difficulties. These difficulties include:

- Mood Disorders
- Anxiety Disorders
- Psychosis
- Eating Disorders

Our Treatment Approach

Care is delivered from a multidisciplinary perspective. The unit provides a group programme in addition to individual therapy and treatment focuses on skills to assist and maintain recovery and promote personal development. Groups include Psychotherapy, Self Esteem, Assertiveness, Life skills, Communication Skills, WRAP Group, Advocacy, Music, Drama, Gym, and activity/creative groups. Education is also a central component of the programme and tailored for individual needs.

4.17.1 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 (3-18 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 multi-disciplinary team 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, nonorganic somatic symptoms, emotional symptoms, peer relationships, self-care, family relationships and school attendance. All scales are scored on a 0-4 point rating from “no problems” to “severe problems”. Higher scores are indicative of greater severity.

While the clinician rated HoNOSCA is the principal measurement tool, self-rated (HoNOSCA-SR) and parental rated versions of the HoNOSCA have also been developed to facilitate a more collaborative assessment. While the HoNOSCA has been found to correlate adequately with other measures of child psychopathology (Bilenberg, 2003; Yates et al., 1999), there appears to be little research investigating the relationship between clinician, parental and self-rated scores. Correlations between clinician rated and self-reported total scores were found to be poor in a study by Gowers, Levine, Bailey-Rogers, Shore & Burhouse (2002). In line with the collaborative ethos of the unit, the HoNOSCA’s were completed at admission and discharge by the young person (self-rated), multi-disciplinary team (clinicians) and parent.

4.17.2. Descriptors

There were data available for 48 patients who were admitted in 2017. Of those, 16 (33.3%) were male and 32 (66.7%) were female. The age ranged from 12- 17 years, with a mean of 16.06 (SD=1.5).

4.17.3. Results

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

Table 1: Paired Samples T Test

	Pre	Post	*t*	*df*	p	*d*
Client Rated	23.0 (10.0)	16.28 (9.63)	5.64	42	.000	.86

Table 2: Wilcoxon Signed Rank Test

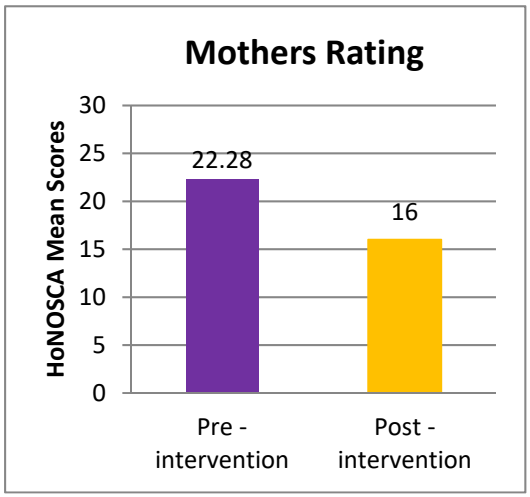
	Pre	Post	*z*	p	*r*
Clinician Rated	12.95 (5.60)	8.10 (3.87)	5.31	.000	.60
Mother Rated	22.28 (9.0)	16.0 (8.92)	4.01	.000	.51
Father Rated	19.02 (9.43)	12.91 (9.19)	3.32	.001	.50

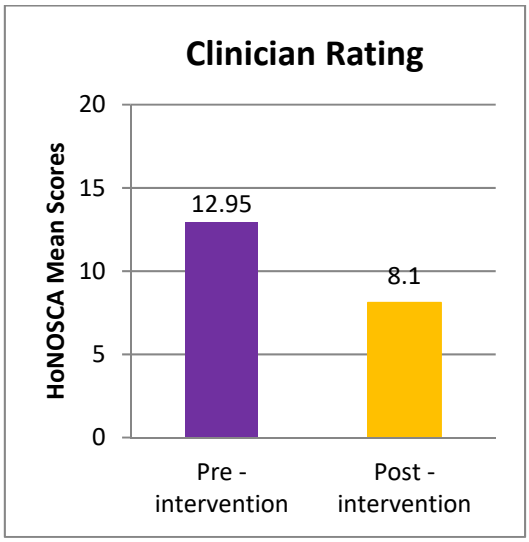
In order for the analysis to be run, each participant had to have a pre and a post score on the measure. Hence, the completion rates reported are not representative of all the data in the sample, but rather relate solely to the complete data, which can be analysed in this way.

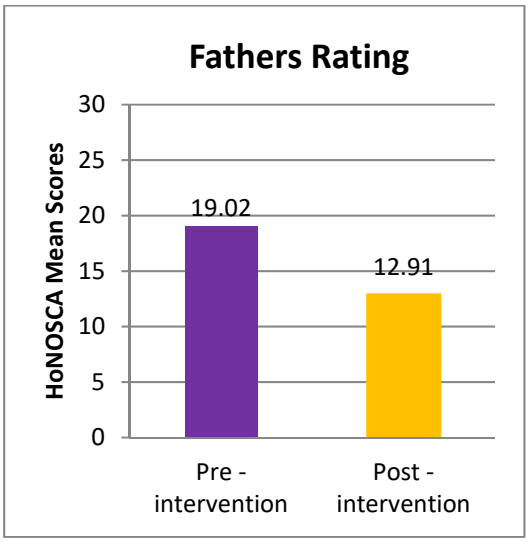
A significant decrease between total scores for the self-rated HoNOSCA was apparent at the post intervention time point ($t(42) = 5.64$ $p = <.01$), reflecting a large effect size (Cohen's d: .86). A Wilcoxon Signed Rank test also revealed a statistically significant decrease in Clinician's rated HoNOSCA scores at the post intervention time point ($z = 5.31$, $p < .01$), with a large effect size ($r = .60$)

A significant decrease in total scores was also identified post intervention on mother's rated HoNOSCA (z=4.01, p <.01), which had a large effect size(r=.51); and on father's rated HoNOSCA (z=3.32, p <.01), which had a large effect size (r=.50).

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







4.17.4. Summary

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

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

The MDT is actively considering ways that data collection at discharge could be improved. It is of note that the response rates on the HoNOSCA in 2017 were higher than the previous year. It is anticipated that response rates will continue to improve in 2018 and that it will be possible to conduct further analysis on the data to identify the breakdown of the pertinent presenting problems.

The measure has been commended in the literature for its ease of access for adolescents (Levine, Bailey-Rogers, Shore & Burhouse, 2002) and clinicians (Jaffa, 2000). It is expected to continue to serve as the primary outcome measure for 2018.

SECTION 5

Measures of Service User Satisfaction

5.1 Service User Satisfaction Questionnaires

5.1.1 Introduction

St Patrick's Mental Health Service is committed to listening to and acting upon the views of those who use and engage with its service. In order to enhance communication between service users and providers, a Service User Satisfaction Survey was developed and is distributed to service users who attend the Dean Clinics, Inpatient, and Day Programme services. This report outlines the views of a portion of Dean Clinic, Inpatient, and Day Programme service users from January to December 2017. The results of the service user satisfaction survey are collated for the first six months of each year and for each full year, to provide management and the board of governors' valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

5.1.2 Survey design

The report is structured to reflect the design of the survey, whereby responses of each survey question are depicted in graph and/or table form. The Inpatient survey was initially created based on the Picker Institute National Inpatient Survey for Mental Health Services in the UK. Subsequent adaptations were made to include topics which appear to be of importance to service users (as identified by previous service user complaints) and to service providers (e.g. service users' perception of stigma after receiving mental health care). The Dean Clinic and Day Programme surveys were subsequently adapted from the Inpatient survey and tailored to collect data regarding the respective services.

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

5.1.3 Data collection

The three surveys for the Dean Clinics, Inpatient, and Day Programmes were continually distributed from January to December 2017, in order to gather information about service users' journey through St Patrick's Mental Health Services, thus engaging a system in which service users can offer feedback and take an active role in the provision of their care. Since March 2016, the Service User Satisfaction Surveys for the Dean Clinics, Inpatient and Day Programmes are also available online, in order to increase accessibility. The employment of the Service User's Satisfaction Survey is part of a larger quality improvement process undertaken by St Patrick's Mental Health Services. Data collection across SPMHS is continually facilitated as a key strategic objective to improve services.

Dean Clinics

Dean Clinic administration staff gave all attendees an opportunity to complete the questionnaire and return it in person or by post to St Patrick's Mental Health Services or to complete the survey online. All service users were given an opportunity to complete the questionnaire with the exception of those attending a first appointment or assessment, and those whom Dean Clinic administration staff felt may have been too unwell to complete the questionnaire.

Inpatient Adult Services

All service users discharged between January and December 2017 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online.

Day Programme Services

Programme coordinators in St Patrick's Mental Health Services invited all services users finishing a programme to complete a copy of the questionnaire and return it in person, by post to St Patrick's Mental Health Services or to complete the survey online.

5.1.4.1 Dean Clinic (Community Services)

Percentage of surveys received from Dean Clinics:

Dean Clinic	n	%
St Patrick's	9	16.9
Sandyford	2	3.8
Capel Street	12	22.6
Donaghmede	3	5.6
Galway	2	3.8
Lucan Adolescent	3	5.6
Cork	0	0
Lucan Adult	19	35.8
No Answer	3	5.6
Total	53	100

Service User Responses

How long did you wait for a first appointment?

Percentage of respondents who endorsed each first appointment waiting time frame

1st Appt. Waiting Time	n	%
<1 week	5	9.4
<2 weeks	4	7.5
<1 month	8	15.1
<2 months	6	11.3
>2 months	5	9.4
>4 months	23	43.4
No Answer	2	3.8
Total	53	100

Were you seen at your appointment time?

15.1 % of respondents reported being seen on time, 20.8 % of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic and 11.3% of respondents reported a half hour wait for their appointment on arrival to the clinic. Cumulatively 47.2% of respondents were seen within half an hour of their appointment time.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	8	15.1
Seen within 15 minutes	11	20.8
Seen within a half hour	6	11.3
Seen within hour	3	5.7
Seen within over 2 hours	23	43.4
No Answer	2	3.8
Total	53	100

Tell us about your experience of assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

Experience of assessment/therapy/review?	Yes		No		Don't Know		No Answer	
	n	%	N	%	n	%	n	%
Did a member of the clinic staff greet you?	27	50.9	24	45.2	0	0	2	3.8
Did a member of the clinic staff explain clearly what would be happening?	21	39.6	26	49.1	1	1.9	5	9.4
Were you told about the services available to you to assist you in looking after your mental health?	18	33.9	28	52.8	2	3.8	5	9.4

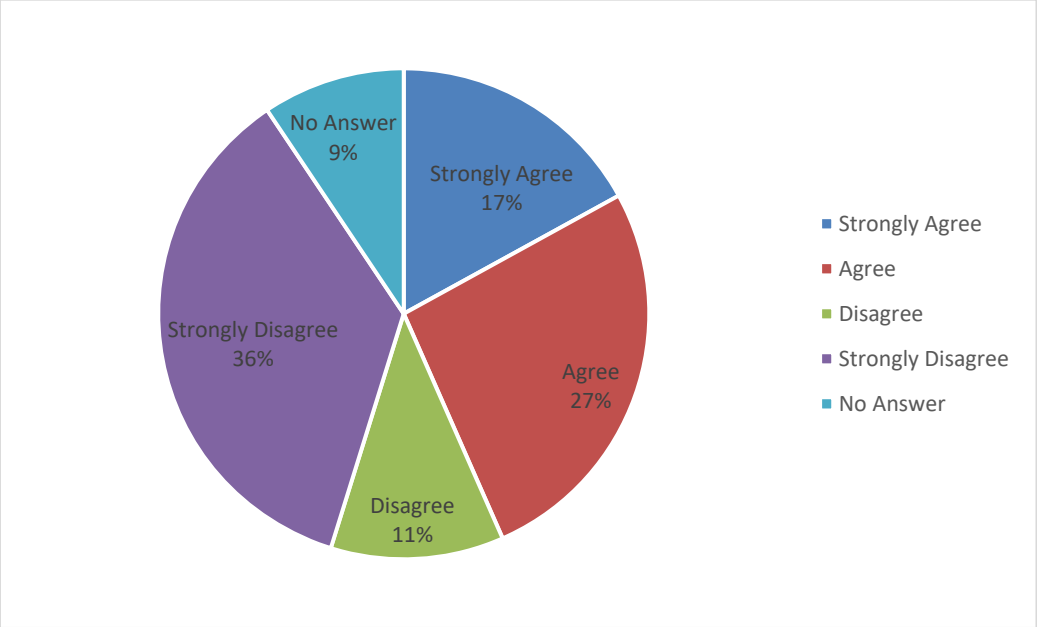
Tell us about your experience of care and treatment at the clinic following assessment

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

Respondents experience of care and treatment at the Clinic following assessment

Experience of Care & Treatment following your assessment?	Agree		Neither Agree or Disagree		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Treated as an individual	28	52.8	1	1.9	21	39.6	1	1.9	2	3.8
Treated with dignity & respect	28	52.8	0	0	22	41.5	0	0	3	5.7
Confidentiality was protected	24	45.3	2	3.8	24	45.3	0	0	3	5.7
Privacy was respected	24	45.3	1	1.9	25	47.2	0	0	3	5.7
Staff were courteous	27	50.9	0	0	23	43.4	0	0	3	5.7
Felt included in decisions about my treatment	24	45.3	2	3.8	25	47.2	0	0	2	3.8
Trusted my doctor/therapist/nurse	26	49	1	1.9	24	45.3	0	0	2	3.8
Appointments were flexible	23	43.4	4	7.5	24	45.3	0	0	2	3.8

In your opinion was the service you received value for money?



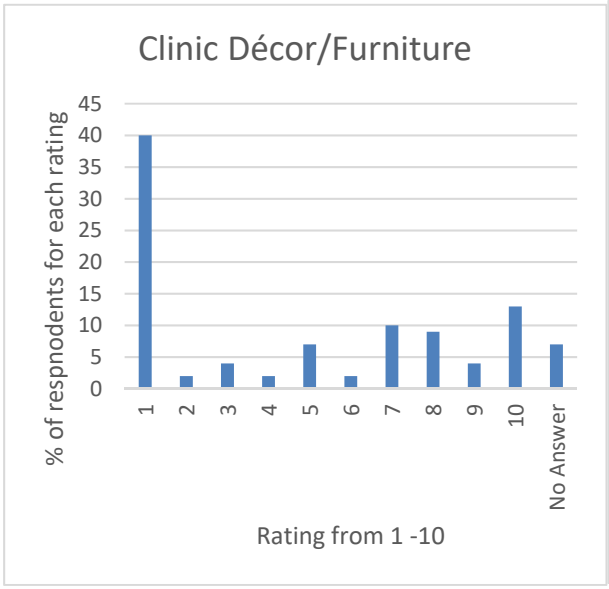
How would you rate the Dean Clinic facilities?

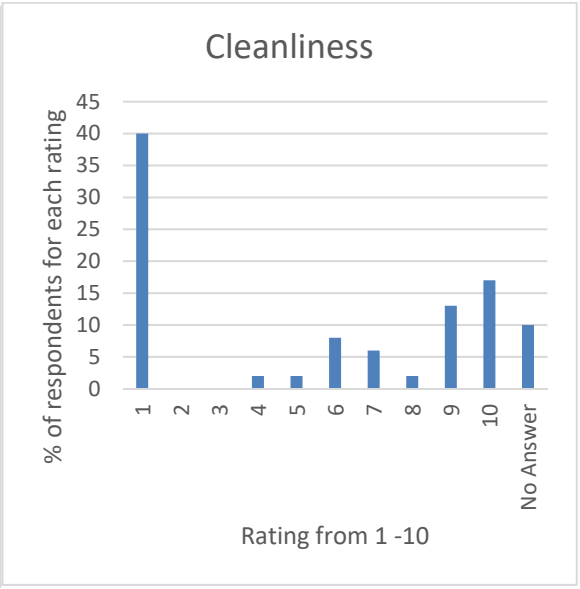
Respondents were asked to rate Dean Clinic facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that

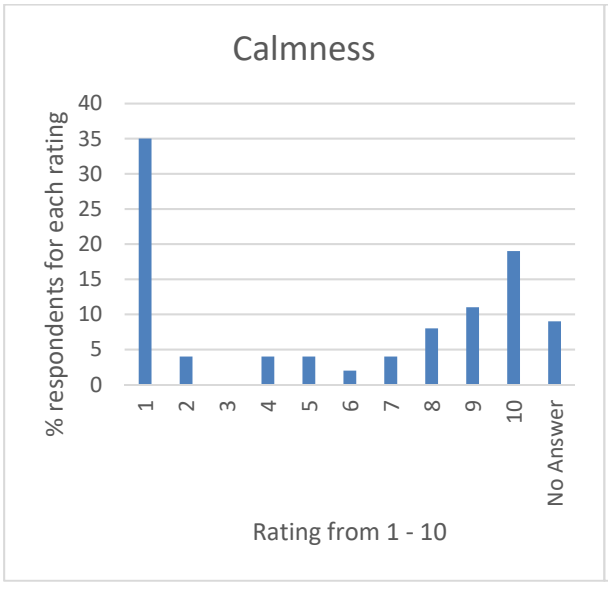
respondents held moderately positive opinions of the Dean Clinic facilities, with all means ranging close to a middle rating of 5. Furthermore the standard deviation was below 4 across all four areas showing small variation between responses.

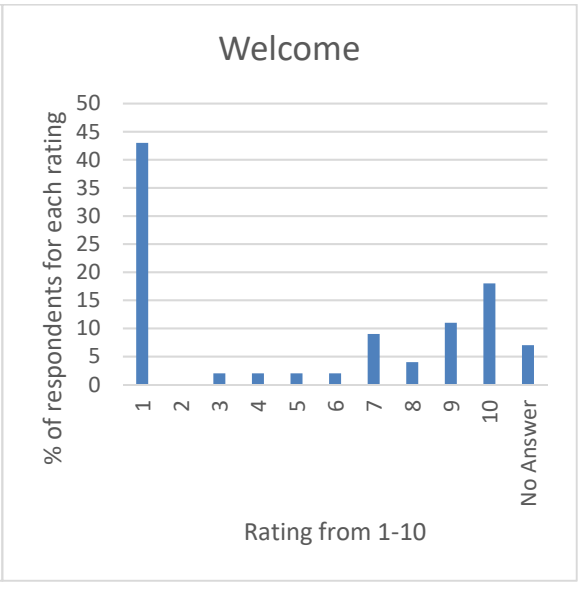
Respondents' scores of Dean Clinic facilities

Rate the following in relation to the Clinic…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	50	4.62	3.5
Cleanliness of Clinic	47	5.02	3.8
Calmness of environment	48	5.15	3.8
Welcome environment	49	4.82	3.9









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

Service users who completed and returned the Service User Satisfaction Survey between January and December demonstrated a medium level of satisfaction with the care they received. Service users rated their care and treatment at the Dean Clinic on a scale of 1 to 10; showing a mean score of 5 (N=50; SD=3.9). Respondents also indicated a medium level of satisfaction with the overall Dean Clinic service, with a mean also of 5 (N=50; SD=3.9).

23 respondents gave a low rating of "1" for care & treatment and the dean clinic overall. Of these 23 responses, 20 responses were completed online. The language, themes, focus and style of open ended responses were extremely similar across these 20 surveys. This may indicate that the same person completed multiple negative surveys, leading to negatively skewed results.

Table: *Respondents' ratings of: a) Care & Treatment b) The Overall Dean Clinic*

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	%	n	%
1	23	43	23	43
2	0	0	0	0
3	0	0	0	0
4	0	0	0	0
5	0	0	0	0
6	1	1.9	1	1.9
7	5	9.4	6	11.3
8	7	13.2	6	11.3
9	5	9.5	5	9.5
10	9	17	9	17
No Answer	3	6	3	6
1-5	23	43	23	43
6-10	27	51	27	51
Total	53	100	53	100

Table: *Respondents' ratings of: a) Care & Treatment b) The Overall Dean Clinic*

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	50	5.1	3.9
Overall, the Dean Clinic	50	5.0	3.9

Further Service User Views

Dean clinic respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the users' experiences. Not all respondents answer these questions. Please find below a sample of answers

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

Positive Comments include:

- *My first appointment at the dean clinic was so good. Everyone I met were so professional and friendly and really nice to encounter*
- *Getting appointments quickly if you are not well*
- *The opportunity to apply for reduced fees was a major support as a student unemployed and help relieve financial stress when looking for support and having to travel for appointment. The text reminders are an excellent service.*

Comments to learn from include:

- *I find the surroundings of clinic very dreary.*
- *It needs to be clearer to me as to what is a available to outpatients.*
- *Getting appointments quickly if you are not well*

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

- *Care by doctor very satisfactory*
- *The team were extremely reassuring, welcoming and professional especially as I was attending for the first time and was nervous*
- *Non-judgemental environment. Actively listened to my story and provided me with an actionable plan to continue my recovery.*
- *The registrar was excellent*
- *Friendliness, courtesy, kindness*

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

- *Improvement required in in time span returning calls*
- *Consider services outside the prime business day.*
- *Reducing the waiting time should be made a priority.*
- *Appointment letters need to be updated to include how long/how much time you need to allow for the appointment*
- *Appointment letter should include information around assessment process*

5.1.4.2 Adult Inpatient Services

Demographics

Service users discharged between January and December 2017 from adult inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online. 2809 discharges were processed in 2017, with a total of 263 (9.3%) surveys being returned to St Patrick's Mental Health Services (SPMHS), Adult Inpatient services.

Table: *Number of adult inpatient surveys returned and discharges in 2017*

Month	Surveys Returned	Discharges
January	5	184
February	6	207
March	25	262
April	14	232
May	32	247
June	27	266
July	28	229
August	4	233
September	24	229
October	50	214
November	33	234
December	15	272
Total	263	2809

Service User Responses

"Can you recall how long you waited for an admission to hospital?"

The most common waiting timeframes reported by respondents were between '1 – 3 days' (27.4%), and 'less than 1 day' '1-3 days' (22.8%), (see table below).

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

Waiting Time	n	%
<1 day	60	22.8
1-3 days	72	27.4
4-7 days	51	19.4
1-2 weeks	42	16
3-4 weeks	27	10.3
Don't know	6	2.3
No answer	5	1.8
Total	263	100.0

"When you came to the hospital for assessment/admission how long did you have to wait before you were seen by a member of staff?"

The most common waiting time frame reported by respondents was less than 1 hour, with 55.1% of respondents reporting this time period (see table below).

Table: *How long respondents waited to be seen by staff at admission.*

Waiting Time	n	%
<1 hr	145	55.1
1-2 hrs	51	19.4
2-3 hrs	20	7.6
3-4 hrs	12	4.6
>4 hrs	22	8.4
Don't know	3	1.1
No answer	10	3.8
Total	263	100.0

"Please tell us how long it took from your arrival in admissions to your arrival on the ward?"

The most common waiting time frames reported by respondents were '1-2 hrs' (27.4%) and ''2-3 hrs' (24%) (see table below).

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

Waiting Time	n	%
<1 hr	27	10.3
1-2 hrs	72	27.4
2-3 hrs	63	24
3-4 hrs	39	14.8
>4 hrs	46	17.5
Don't know	10	3.8
No answer	6	2.2
Total	263	100.0

"Tell us about your experience of admission."

Table: *Respondents' opinions regarding their experience of admission to Hospital*

Tell us about your experience of admission.	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
When you came to the Hospital did a member of the assessment unit greet you?	196	74.5	48	18.3	17	6.5	2	0.7
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	172	65.4	60	22.8	24	9.1	7	2.7
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	181	68.8	65	24.7	9	3.5	8	3
Were you given written information about the Hospital and the services provided?	178	67.7	60	22.8	15	5.7	10	3.8

"In relation to your care plan, can you tell us the following…"

In relation to your care plan…	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
I understand what a care plan is	195	74.1	10	3.8	32	12.2	4	1.5	22	8.4
I was involved in the development of my care plan	118	44.9	33	12.5	75	28.5	13	4.9	24	9.2
I was offered a copy of my care plan	107	40.7	16	6.1	99	37.6	14	5.3	27	10.3
I was involved in the review of my care plan	118	44.9	27	10.3	78	29.7	10	3.8	30	11.3
There was a focus on recovery in the care and treatment offered	177	67.3	17	6.5	39	14.8	5	1.9	25	9.5
My care plan is key to my recovery	142	54.0	45	17.1	46	17.5	9	3.4	21	8.0

Service users' perceptions regarding their understanding, involvement and engagement in their care plan has been a significant focus for the organisation over recent years. The concept of a care plan isn't familiar for many service users, particularly those being admitted for the first time. There has been on-going work at multidisciplinary team level to inform service users and facilitate their involvement and engagement in their care planning process. Education and information regarding care planning, key working, recovery focus and multidisciplinary teams has also been on-going on an organisational level through a regular morning lecture and information booklets provided to all service users' on inpatient admission. This on-going focus has produced positive results, for example, as can be seen above 74.1 % reported that they understood what a care plan is.

"During my stay in hospital I was given enough time with the following health professionals..."

	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Consultant Psychiatrist	175	66.5	24	9.1	48	18.3	2	0.8	14	**5.3**
Registrar	132	50.2	51	19.4	46	17.5	3	1.1	31	11.8
Key Worker	106	40.3	29	11	84	31.9	7	2.7	37	14.1
Nursing Staff	176	66.9	20	7.6	37	14.1	3	1.1	27	10.3
Psychologist	67	25.5	29	11	93	35.4	14	5.3	60	22.8
Occupational Therapist	93	35.4	39	14.8	64	24.3	17	6.5	50	19
Social Worker	57	21.7	41	15.6	69	26.2	23	8.7	73	27.8
Pharmacist	58	22.1	36	13.7	73	27.8	24	9.1	72	27.3
Other	56	21.3	29	11.0	49	18.6	21	8.0	108	41.1

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

Waiting Time	n	%
<1 week	30	11.4
1-2 weeks	31	11.8
2-3 weeks	21	8
>3 weeks	59	22.4
Not on programme	4	1.5
No Answer	118	44.9
Total	263	100.0

Tell us about your care...

Table: *Respondents' experiences of the team during their in-patient stay*

Experience of the team that worked with you	Strongly Agree		Agree		Disagree		Strongly Disagree		No answer	
	n	%	n	%	n	%	n	%	n	%
Trusted the team members	137	52.1	48	18.3	17	6.5	23	8.7	38	14.4
Treated with dignity and respect	137	52.1	51	19.4	18	6.8	22	8.4	35	13.3
Protected my confidentiality	152	57.8	46	17.5	9	3.4	20	7.6	36	13.7
Respected my privacy	146	55.5	56	21.3	8	3.0	20	7.6	33	12.6
Were courteous	139	52.9	55	20.9	9	3.4	22	8.4	38	14.4
Felt included when my team discussed medical issues at my beside / in my room	140	53.2	51	19.4	17	6.5	15	5.7	40	15.2
Respected me as an individual	140	53.2	55	20.9	10	3.8	22	8.4	36	13.7

Tell us about your experience of discharge...

Table: *Respondents' perceived involvement in discharge*

Experience of Discharge from Hospital	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you discuss and agree your discharge with your treating team?	193	73.4	35	13.3	6	2.3	29	11
Do you think you were given enough notice of your discharge from hospital?	194	73.8	39	14.8	3	1.1	27	10.3
Do you have a discharge plan?	161	61.2	62	23.6	8	3.0	32	12.2
Do you know what to do in the event of a further mental health crisis?	178	67.7	48	18.3	9	3.4	28	10.6

Tell us about your experience of hospital activities…

Tell us about your experience of hospital activities	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you attend any of the activities during the day?	204	77.6	29	11	1	0.4	29	11
Did you attend any of the activities in the evenings and at weekends?	172	65.4	59	22.4	1	0.4	31	11.8
Was there a range of activities that you could get involved in?	195	74.1	33	12.5	4	1.5	31	11.9
At the weekend were there enough activities available for you?	110	41.8	102	38.8	12	4.6	39	14.8

The majority of respondents felt that there was a range of activities they could get involved in (74.1%). However, 38.8% indicated that there were not enough activities available in the hospital at weekends.

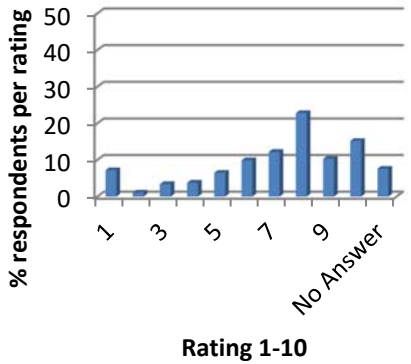
Tell us about your experience of hospital facilities…

A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with all means above 6. In particular, the service in ward dining areas (8.33) and Cleanliness of ward areas (8.24) received high scores as well. The standard deviation across most areas was close to 3 indicating that there was significant variation in responses.

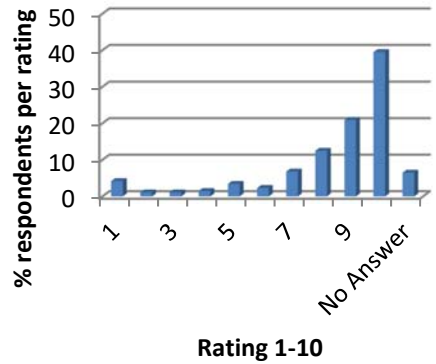
Table: *Respondents' scores of Hospital facilities*

Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	243	6.91	2.6
Food on Ward	245	6.51	2.9
Service in ward dining areas	246	8.33	2.4
Cleanliness of ward areas	246	8.24	2.7
Cleanliness of Communal areas	237	8.05	2.9
Hospital Facilities	246	7.13	2.9
Garden Spaces	229	7.82	2.7

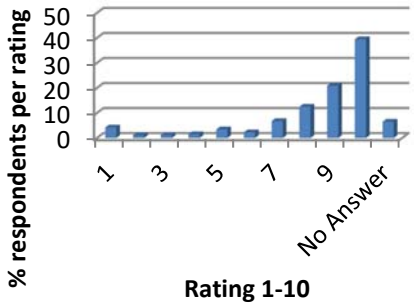
Décor/ Furniture



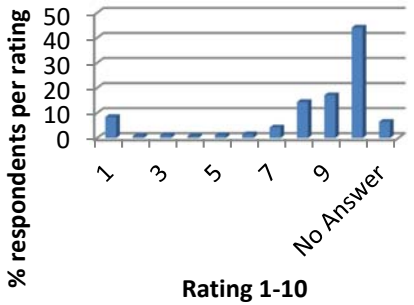
Food on Ward



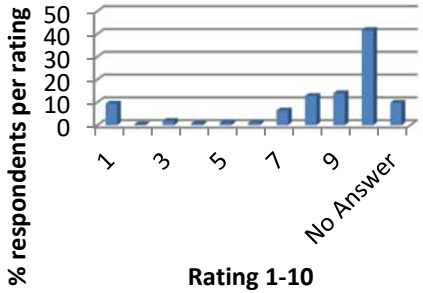
Service in dining areas



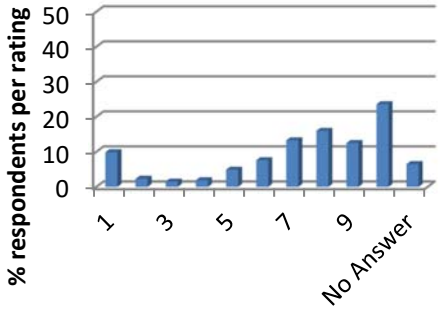
Cleanliness of ward area



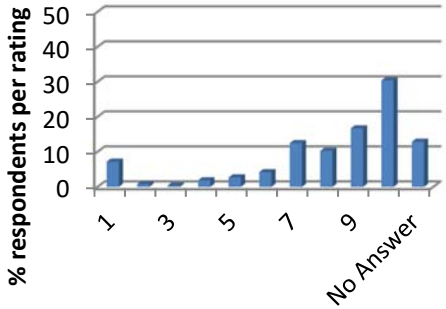
Cleanliness of communal areas



Hospital Facilities



Garden Spaces



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

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would disclose to others that they received support from St Patrick's Mental Health Service. The majority of respondents felt they had more positive views towards mental health difficulties in general (68.4%) and towards their own mental health difficulties (70%) and felt that they would share with others that they received support from SPMHS (59.3%).

Table: *Experiences of stigma*

Tell us about your views and perceptions regarding mental illness following your stay…	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Are your views regarding mental illness in general more positive than they were?	180	68.4	37	14.2	18	6.8	28	10.6
Are your views regarding your own mental illness more positive than they were?	184	70	38	14.4	14	5.3	27	10.3
Will you tell people that you have stayed in St Patrick's Hospital?	156	59.3	45	17.1	35	13.3	27	10.3

Overall views of St Patrick's Mental Health Services

Service users who completed and returned the Service User Satisfaction Survey demonstrated a high level of satisfaction with the care they received, rating their care and treatment in Hospital on a scale of 1 to 10, with a mean of 7.6 (N=242; SD=2.8). Respondents also demonstrated a high level of satisfaction with the Hospital overall, rating the Hospital on a scale of 1 to 10, with a mean of 7.8 (N=246; SD=2.7).

Table: *Respondents' ratings of care and treatment and overall experience of Hospital*

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	%	n	%
1	24	9.1	24	9.1
2	2	0.8	1	0.4
3	6	2.3	1	0.4
4	2	0.8	4	1.5
5	9	3.4	7	2.7
6	13	4.9	13	4.9
7	20	7.6	20	7.6
8	52	19.8	47	17.9
9	46	17.5	58	22.1
10	68	25.9	71	27
No Answer	21	8	17	6.5
1-5	43	16.4	37	14
6-10	199	75.6	209	79.5
Total	263	100.0	263	100.0

Table: *Respondents' ratings of care and treatment and overall experience of Hospital*

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	242	7.6	2.8
The Hospital	246	7.8	2.7

Further Service User Views

Inpatient respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the service users' experiences. Not all respondents answered these questions. Please find below a sample of answers:

Q: Is there anything else you would like to tell us about your experiences of being in Hospital please do so here.

Positive Comments include:

- *The nursing staff were amazing and were very good outlets to talk to during my stay!*
- *The quality of the nursing staff who were available to talk anytime*
- *I felt really involved in my progress and care*
- *I found my consultant to be very understanding of my illness and also a pleasure to deal with.*
- *I was in the grip of a severe depression, my stay in Saint Pats gave me time, space and directed care, so that I could recover. My stay here was the most significant factor in my recovery from a severe depression*

Comments to learn from include:

- *Room on door of staff room beside ward kept banging for a few hours the first two nights I was in.*
- *Felt as though the weekly views/ opinion card I filled in were not reviewed at MDTs as when i brought up the points after the MDT, it seemed as if it was MDT members first time hearing it.*
- *Weekend activities could be more structured*
- *Showers in temple are desperate-Water only hot for a short period in day.*
- *Wifi keeps dropping out .*

Q: Was there anything particularly good about your care?

- *I was always shown respect and compassion*
- *I found the nurses were excellent they were always available to talk and give advice.*
- *My key worker was excellent and spoke to me regularly and liased with the team for me*
- *Great list of activities to get myself motivated on the road to recovery*
- *In general, the nursing staff and medical teams are excellent as are the series of lectures hosted daily*

- *Baking class, yoga, clinical psychology*
- *The focus on care by the entire team on the ward, throughout the hospital was amazing. Everyone is clearly focussed and dedicated. I can place my trust in their abilities and knowledge*
- *Psychiatrist and team working with me, listening to how I was feeling and dedicated time to ensure quality of my life improved.*
- *Cleaning staff on ward were friendly and worked hard, also catering*
- *Activities. Music sessions. Bingo, walks.*
- *Psychiatrist and psychologist very respectful, listened to my opinions, were open to healthy discussions where we had difference of opinions.*
- *The care is tailored to each individual*
- *Excellent support*
- *Care and compassion of the ward nurses, psychiatrist, psychologist, OT activities, compansionship of fellow patients*
- *Multidisciplinary holistic approach and including me in care plan and discharge plans very beneficial*

Q: What could we improve?

- *Cleanliness of bathrooms. both the shared ones on the ward and the public bathrooms downstairs*
- *Dispensation of medication is a frustratingly slow process whereby you can be queuing*
- *In special care and dean swift there should be an enclosed room for tv as the noise is dreadful*
- *vegetarian food bland*
- *Opening times of activities often clashed with lectures, groups. The gym is fantastic. Would be great to be open all day*

5.1.4.3 Day Services

St Patrick's Mental Health Services offer mental health programmes through the Day Service's Wellness and Recovery Centre. A range of programmes are offered which aim to support recovery from mental ill-health, and promote positive mental health.

Day Services Service User Satisfaction Survey Response Rate

Month	Surveys Distributed/ people discharged	Surveys Returned
January	113	16
February	157	20
March	187	7
April	185	15
May	195	4
June	78	13
July	52	0
August	89	4
September	150	0
October	381	5
November	421	0
December	134	0
Total	2142	84

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Recovery	13	8.6%
Mindfulness	56	36.8%
Other	37	24.3%
Depression	9	5.9%
St Edmundsbury	17	11.2%
Bipolar	3	2.0%
Eating Disorder	1	0.6%
No answer	0	0%
Anxiety	7	4.6%
Radical Openness	4	2.6%
Living Through Distress	2	1.3%
Alcohol Step Down	0	0%
Young adult	2	1.3%
Pathways to Wellness	1	0.7%

The "Other" programmes included in the table above, include; Compassion Focused Therapy, ACT, Roles in Transition, healthy self-esteem and WRAP.

85.2% of respondents reported living in Leinster.

Province	n	%
Leinster	69	85.2%
Connaught	5	6.2%
Munster	3	3.7%
Ulster	3	3.7%
Don't want to say	0	0%
Missing	1	1.2%
Total	81	100%

The majority of respondents had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. 43.2% had experienced an in-patient stay and 42% had attended as an outpatient at the Dean Clinic.

Service	n	%
Dean Clinic	34	42.0%
In-patient stay	35	43.2%
In-patient day programme	17	21.0%
Other day programme	18	22.2%
Not applicable	5	6.2%
Associate Dean consultation	13	16.1%
No answer	5	6.2%

Service User Responses

The service users' perceptions of the time they waited for communication from a member of the programme staff, following their referral.

'After you were referred how long did you wait for communication from a member of the programme staff?'

Wait time	n	%
Less than 1 day	8	9.9%
1-3 days	20	24.7%
4-7 days	17	21.7%
1-2 weeks	17	21.7%
2-4 weeks	10	12.3%
More than 4 weeks	7	8.6%
No answer provided	1	1.2%

Service Users were asked about their experience of beginning the programme. The majority agreed that they were greeted by staff when first coming to the hospital, and that the structure and organisation of the programme was clearly explained to them before commencement. See table below for further details of respondents' experiences of beginning a programme.

Tell us about your experience of starting a programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
When you came to the hospital did a member of Day Services greet you?	64	79%	8	9.9%	8	9.9%	1	1.2%
When you came to hospital did a member of Day Services explain clearly what would be happening?	71	87.6%	5	6.2%	4	5.0%	1	1.2%
When you commenced the programme did a member of staff explain the timetable?	76	93.8%	3	3.7%	1	1.2%	1	1.2%
Were you given a written copy of the timetable and other relevant information?	73	90.1%	6	7.4%	1	1.2%	1	1.2%

Respondents also generally reported an informed ending to the programme, with 98.7% of valid responses agreeing that they knew when the programme was to end. Over 80% of respondents felt that the programme met their expectations and felt that they know what to do in the event of a further mental health crisis. The majority of respondents reported that they had received information regarding the organisation's support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Did you know in advance when the programme was due to end?	81	100%	0	0%	0	0%	0	0%
Did the programme meet all your expectations?	70	84.4%	7	8.6%	4	5.0%	0	0%
Have you been given details of the hospital's support and information service?	65	80.3%	9	11.1%	3	3.7%	4	4.9%
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	70	86.4%	7	8.6%	3	3.7%	1	1.2%

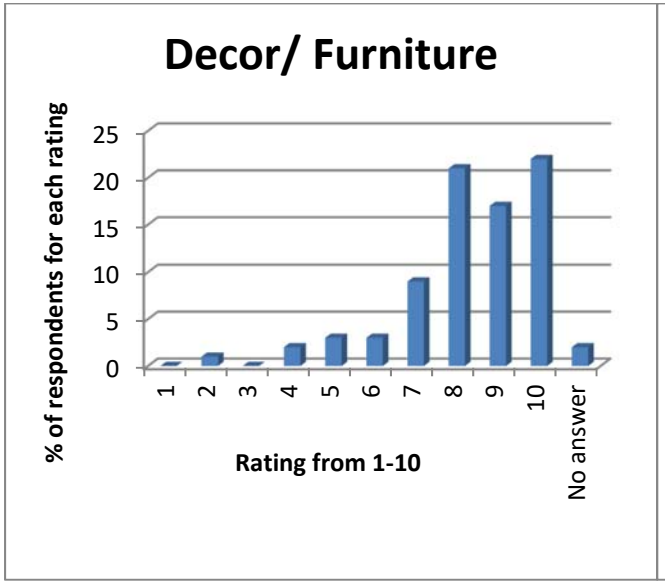
The Service User Satisfaction Questionnaire also asks for service users' experiences of stigma after having attended St Patrick's.

Tell us about your experience of stigma following your attendance at St Patrick's.

As you are prepared to leave the programme...	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Do you feel that your views regarding mental ill-health in general are more positive than they were?	73	90.1%	5	6.2%	3	3.7%	0	0%
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	73	90.1%	3	3.7%	3	3.7%	2	2.5%
Will you tell people that you have attended St Patrick's	54	66.7%	10	12.3%	16	19.7%	1	1.2%

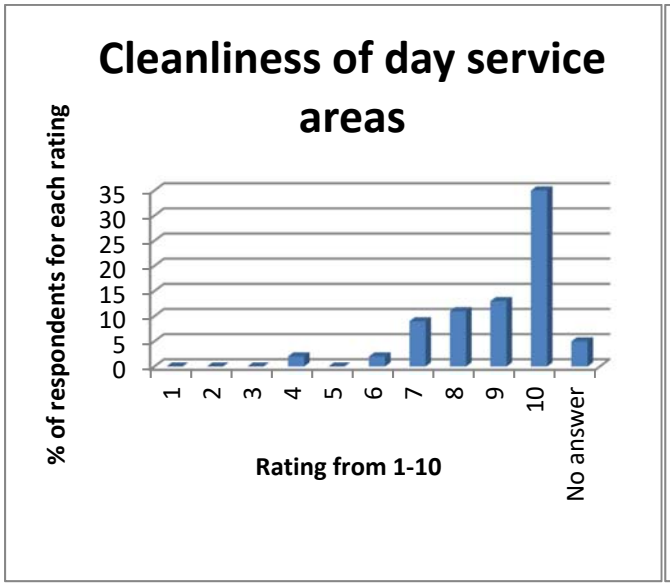
How would you rate the Day Services Facilities?

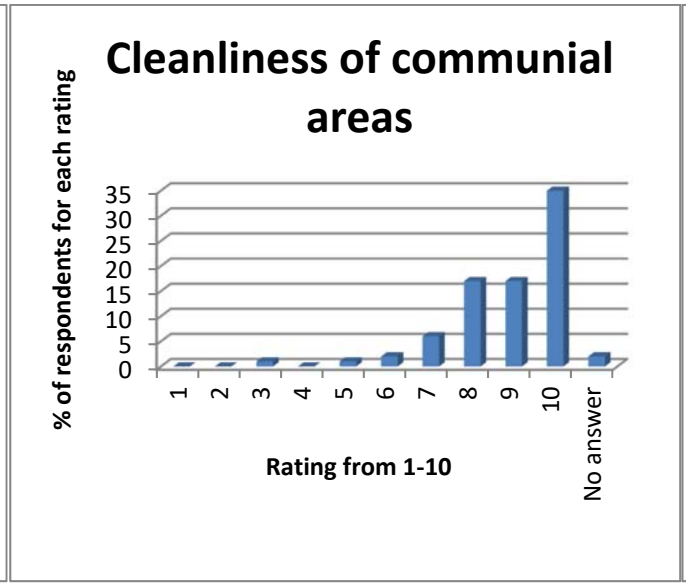
Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of 1 to 10. For each of the facilities, the most endorsed scores were 8, 9 and 10. (Please see the following graphical depictions).

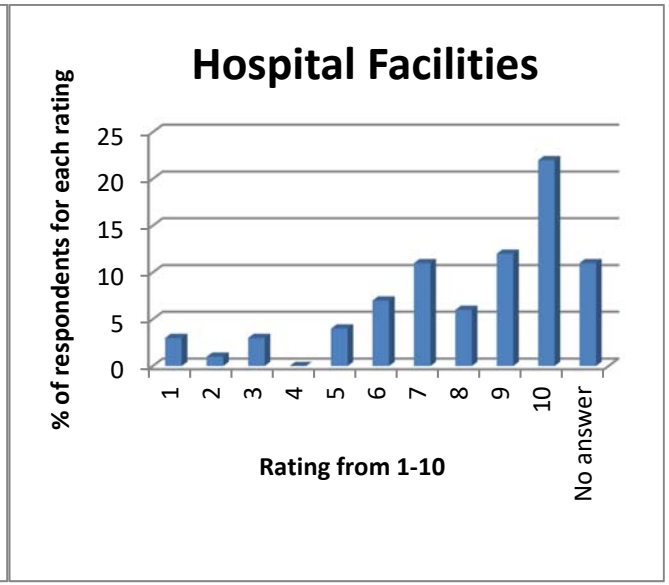

Decor/ Furniture
% of respondents for each rating
25
20
15
10
5
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10


Food/ Restaurant Facilities
% of respondents for each rating
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10


Parking
% of respondents for each rating
16
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10


Cleanliness of day service areas
% of respondents for each rating
35
30
25
20
15
10
5
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10


Cleanliness of communial areas
% of respondents for each rating
35
30
25
20
15
10
5
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10


Hospital Facilities
% of respondents for each rating
25
20
15
10
5
0
1
2
3
4
5
6
7
8
9
10
No answer
Rating from 1-10

Respondents were also asked to rate their care and treatment, and St Patrick's Mental Health Day Services overall, on a scale of 1 to 10.

Overall, on a scale of 1-10, how would you rate your care and treatment in St Patrick's Mental Health Day Services?

Score	n	%
1	0	0%
2	0	0%
3	0	0%
4	0	0%
5	0	0%
6	1	1.2%
7	8	10.0%
8	20	24.7%
9	13	16.1%
10	39	48.1%
No answer		0%
1-5	0	0%
6-10	81	100%

100% rated their care and treatment between 6 and 10.

Overall, on a scale of 1-10, how would you rate St Patrick's Mental Health Day Services?

Score	n	%
1	0	0%
2	0	0%
3	0	0%
4	1	1.2%
5	1	1.2%
6	3	3.7%
7	6	7.41%
8	18	22.22%
9	13	16.05%
10	39	41.2%
No answer		0%
1-5	2	2.47%
6-10	79	97.53%

97.53% rated the St Patrick's Mental Health Day Services overall, between 6 and 10.

Further Service User Views

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

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

Positive comments include:

- *I am very grateful for the referral. The course suggested by the consultant was appropriate at this point in my ongoing recovery/ management*
- *I really enjoyed my course. I even did the midfullness again*
- *Very positive experience. I felt the staff have a very real understanding of what patients experience. Also very good at interpreting what we are trying to say about our feelings and experiences*
- *Very good interaction between all who attended*
- *The staff are excellent*
- *The facilitors were very efficient, attentive and respectful. They provided very useful and comprehensive notes that can be used again if I feel I am slipping back*
- *Before I attended St Pats I was very negative. Apart from getting stabilizers on med, I learned how to develop positively through cultural activities*
- *Excellent overall. A very positive experience*
  I felt that the staff were so kind, they were there for you at any time, when you are low, they were there

- *The wide spectrum of people attending made me feel less of a freak, that difficulties can and do happen to people from all ages, backgrounds and social status and that we are all perfectly 'normal'*
- *Very positive experience. Good rapport with other group members and with the course facilitator*
- *A wonderful welcoming environment full of smiles and pleasent support*
- *Very relaxed and friendly team leaders. Had the service users best interest in mind*
- *I enjoyed the mindfullness programme and will continue to put to use in everyday life*
- *It was so enriching to share my experiences with the rest of the group"I felt that I was in a really comfortable, safe environment*
- *I have found that the WRAP programme has really saved me. Its the best thing I have ever done in St Pats*
- *I wasnt sure if it would help me, but I'm so glad it did. I got a lot from it and the others on the programme. I am definitely leaving with a more positive outlook*
- *I was very surprised at the hospital in general. I had thought that the hospital would be depressing, or a general feeling of saddness, in fact it was the opposite. The bright walls, the paintings on the walls. I noticed some patients and they looked the same as non- patients. I found all the staff very friendly and helpful*

Comments to learn from include:

- *Day services are very strictly run and run for too long*
- *Have more evening classes, allowing people to come after work*
- *some confusion on start day as person registry not working, and no substitute available. Unsure where to meet group*
- *A lot of time was given to patients talking, I would have prefered if the facilitators had moved the conversation on more quickly*

- *The service is great, but it would be better if the WRAP programmes were available in Cork/ Donegal because people are under pressure to get up from the country*
- *Maybe a Connections area in Cork and other counties*

Q: Was there anything particularly good about your care in Day Services?

- *The facilitation skills and humanity of the staff was incredible and very important to me and my experience*
- *The staff are very friendly, approachable, capable and understanding*
- *The people I met as leaders were very good. Also, the people who attended helped to make it very enjoyable*
- *Genuine concern of day services staff towards each patient*
- *Relaxing and good psychotherapy*
- *The friendliness and comforting care of the staff, knowing that aftercare is available*
- *Good course, well put together. Hand-outs very helpful*
- *The support of the group members*
  The very positive attitude and general support
- *Sharing experiences with people in your group*
- *Being in the lovely surroundings, the garden, roses and gym equipment*
- *Lunch being available. Mutual respect of group and leaders. Some leaders opening up a little with their lives, more humane and made me feel normal*
- *The staff are fantastic- very courteous, friendly and helpful*
- *Feeling the way I was when I went there. I am feeling much better, it was hard work and I felt so upset many times, but the staff were there to help me*
- *Gave me the skills to manage the triggers that escalate my mood changes*
- *Having team leaders who have direct experience of mental health and therefore can fully get the illness from the patient's side. The positivity of all members of the team and their interest in me as a person and service user*
- *Instructor was very good and energetic. People opened up and there was never judgement*

- *The continued support while your getting used to being at home again*
- *Respect and dignity was in abundance*
- *Networking with other participants. The variety and quality of the facilitators.*
- *The have been fantastic. They could not have been more helpful, kind, understanding and considerate. I liked the way therapists use their own personal examples during group discussions*
- *Learning about the healthy way to work with food, buying food and overcoming my fears*

Q: What could we improve about your experience of Day Service?

- *Improve quality of the written materials provided on the mindfulness course*
- *Day service patients at St. Edmunsbury should be allowed to pay for a dinner in the canteen*
- *Need for more facilitators*
- *Number of courses available to GP referral patients*
- *More plants throughout the hospital would brighten the environment*
- *I found the canteen staff incredibly rude and unwelcoming*
- *Timing of courses, more evening classes would be great*
- *More courses available by GP referral*
- *Mindfullness course could be 10 weeks rather than 8. This was felt by us all, as it is about re-inforcing new ways*
- *I would like to know more about other programmes offered to me, perhaps before I leave today that will be shared*
- *More after- care please*
- *More healthy food options in the canteen*
- *A wider selection of vegetarian food options*
- *More structure, handouts, more examples of things we had to do*
- *Follow up mindfulness course*
- *I felt the sessions were dominated by an attendent and would have liked the group facilitators to handle this better*

- *As I am coming to group straight from work, perhaps something more substantial than biscuits could be provided e.g. sandwich*
- *More comfort in green room, better pictures, more flowers and plants. It would be useful if text appointments could be sent by text or email instead of calling*
- *Better time keeping, punctual start and finishing times*
- *For WRAP, if the handouts from all the presenters could be organised and placed in our folders with labels and dividers rather than getting pages every day and mixing up the social work handouts with OCC therapy handouts*
- *To suggest that the patient should recap a course occasionally*
- *In the restaurant in St Pats, I would love if the staff there could be a bit more mindful of how they treat people- just a simple smile or hello*
- *More time in the gym - a longer time would be of great benefit*

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2017

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

The multi-disciplinary team are committed to on-going quality improvement. This report presents the responses from the survey which was distributed to young people and parents/carers following an inpatient stay in the Willow Grove Adolescent Unit in 2017.

5.2.1. Methodology

Willow Grove is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (Q.N.I.C.), 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 Q.N.I.C.

5.2.2 Respondents

Parents and young people were asked to complete this measure on the day of discharge. 69 young people and 89 parents/carers completed the questionnaire. Response rates for service users were 75.5%. As surveys were anonymous and some service users may have only one parent/carer, this response rate could not be calculated. The number of surveys returned by young people and parents/carers were up 6.7% and 23.2% respectively in 2017 compared with the previous year.

5.2.3 Survey Design

The questionnaire asked young people a set of questions which gather information on their experiences of access to services, the environment and facilities, the therapeutic services offered, the ability of the service to help young people and parents 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 1 'Very unhappy' to 5 'Very happy'. The young person's questionnaire also included a 5 point Likert scale ranging from 1 'Very poor' to 5 'Very good', printed with corresponding smiley faces to help young people to understand the response options.

5.2.4. Results

Quantitative Responses

The median response (i.e. the most common response) for each question is listed in the table below. In order to be concise, the median response for the young people and their parents/carers are presented in a single table. As a consequence the questions are presented generically. The questionnaires that were given to the young person and parent/carer were worded slightly differently in order to frame the question as to whether it was directed to the young person or to their parent/carer. For example; '*your experience of the care and treatment you received*' compared to '*your experience of the care and treatment your child received*'.

Overall the young people and the parents who answered the survey appeared pleased or very pleased with the service. The majority of median responses for young people were a 4 'Good' (84.4%), followed by 5 'Very good' (6.25%) and 3 'Average' (9.38%). For the parents/carers, the most common response across questions was 5 'Very happy' (63.67%), followed by 4 'Happy' (33.3%).

The least positive answers given by service users were in relation to information about the service and meals provided, where parents/ caregivers rated these more favourably. Service users rated 5 'very happy' on items including safety of the unit and confidentiality of the service, while parents/ caregivers rated 5 'very happy' on the cleanliness and appearance of the unit, the safety and atmosphere of the unit, access to professionals, and the provision of family support.

Please tell us how satisfied you were with aspects of our service	Median rating	
	Young person	Parent/ Carer
Experience of accessing the service	4	5
Information received prior to admission	3	5
Information provided by St Patricks website	4	4
The process of assessment and admission	4	5
The information given on admission	4	4
The environment and facilities	4	5
The overall atmosphere (or feel) of the unit	4	5
The cleanliness/ appearance of the unit	4	5
The meals provided	3	4
Visiting arrangements	4	4
Safety arrangements on the unit	5	5
Experience of care and treatment	4	5
Access to group therapy	5	5
Access to individual therapy	5	5
Access to leisure activities and outings	5	5
Access to a range of professionals	5	5
Access to key workers/allocated nurse	5	5
Access to educational support	4	5
Access to an independent advocacy group	4	4
Your level of contact with the treatment team	4	5
Information received on treatment plan	4	4
Your involvement (young person)/ collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4	4
How you felt you were listened to/ respected	4	5
Confidentiality of service	5	5
Opportunity to attend discharge planning meeting	4	5
Your preparation for discharge	4	N/A
Weekend/midweek therapeutic leave arrangements	4	5
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	4	5
Provision of family support	4	5
Opportunity to attend parents support group	N/A	4
Opportunity to attend Positive Parenting Course	N/A	4
Was your child's stay helpful in addressing mental health difficulty?	N/A	5
Providing you with Skills to manage your mental health	4	N/A

Table: *Median responses to Willow Grove Service User Satisfaction Questionnaire*

Further Service User Views

The Willow Grove Service User satisfaction survey respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the users' experiences. Not all respondents answered these questions. Please find below a sample of answers provided by both young people and their parents/caregivers.

Q: What did you like best about the unit?

Young people:

- *The other young people*
- *The nursing staff and key workers*
- *The atmosphere and the support from the staff and other young people*
- *Feeling of safety and normality*
- *The bright colours, bean bags and communal spaces available*
- *Friendly and kind staff*
- *Meeting other young people who I could relate to*
- *Group therapy and outings*
- *I was kept busy with things to do. It was a good distraction*

Parents/ caregivers:

- *The wonderful empathic and supportive people*
- *The responsibility was taken off me when I was at my lowest point of caring for my child*
- *Secure, caring environment*
- *The colourful appearance of the units.; I found it very welcoming and relaxing*
- *Good atmosphere among staff and young people. Very scheduled routine each day. Own bedrooms which were lovely and modern*

- *Positive atmosphere, openness and team approach. Felt really listened to and supported no matter which member of staff was on duty*
- *Nursing staff and key workers were very kind and helpful*
- *Teacher was excellent and communicated very well with faculty*
- *I felt that my input and opinions were respected and listened to*

Q: What did you dislike about the unit?

Young people

- *Lack of access to gym and outdoors*
- *Sometimes we weren't told about the appointments we had*
- *Restrictions, feels a bit like school at times*
- *Some of the groups were not available during my stay*
- *I would have liked more group therapy*
- *Sometimes felt like I wasn't listened to/taken seriously by some of the nurses*
- *No therapy for the last four weeks*
- *Not enough quite spaces*
- *The snacks and food choices were very boring*
- *Activities were repetitive and childish*
- *Being woken up early and the structured environment*
- *Restrictions at night*

Parents/ caregivers

- *Location and lack of family support*
- *Very rigid on rules regarding weight gain. Maintenance weight plan set out by dietician not shared to staff and parents - necessitated weekend stay by child which should not have happened*
- *Short notice to attend meetings-overnight leave*
- *I found at times I was not so involved in how my daughter was getting on. In hindsight I did not need to be-she got on fine- but I worried at the time*

- *One weekend of leave for my daughter was very difficult she felt very low and wished to return to unit early and was denied this early return*
- *The lack of opportunity to meet with team for review. The limited one on one therapy available for my child*
- *The vegetarian menu seemed a bit limited*
- *Difficulty with linking with therapists, although they were very helpful*
- *Parents support group or skills group would be beneficial from early onset of admissions*
- *The food, too much biscuits, sugary stuff, I'm surprised there's not more focus on more nutritious food snacks e.g. nuts, juice*

Is there anything you would change about the unit?

Young people

- *Easier access to gym*
- *Open to the family room for patients to use as well as lounge*
- *The physical contact rule, with consent allowed*
- *Different groups for older patients*
- *More food options*
- *Netflix instead of old DVD's*
- *More therapists*
- *Visiting gym and stay up later*
- *Being able to hug someone if they need it or want one*
- *Have a better art room*
- *It was very triggering to be in an environment with people who were restricting eating. More support for those trying to get better when being around this environment*

Parents/ caregivers

- *No, very happy with the unit*
- *Identify the goals for her plan and then evaluate progress on a weekly basis*
- *Ensure voice of parents is heard going into the weekly meeting and results and plan of actions are clearly communicated back to parent*

- *More openness by dietician by talking to parents*
- *Improve the website*
- *I would like more support around issues such as food and better options for healthy and varied menus*
- *Maybe more info on care of child/ young person in how they are doing throughout their stay*
- *I think my son would have benefited from more individual support around behaviours associated with eating*
- *Have better access to family support*
- *Would have liked more goal focused group, e.g. stress management, self-esteem, mindfulness and body image groups*
- *Parenting course would have been helpful*

SECTION 6

Conclusions

6.1. Conclusions

1. The SPMHS outcomes report is now in the 7th year and the 2017 report builds on the previous reports from 2011 onwards. Service evaluation, outcome measurement, clinical audit and service user experience surveys continue to be used routinely in the context of improving the quality of service delivery.

2. Service user experience survey results indicate the service user experience of SPMHS services continued to be positive overall.

3. The clinical staff delivering the programmes and services continue to identify the appropriate validated clinical outcome measures and utilise them as a routine part of clinical service delivery. Clinical outcome measurement is now an established practice within SPMHS, with clinical staff driving ways to expand or improve the way we measure outcomes and utilise them to maintain and improve services.

4. Clinical outcomes data was added for the Psychology Skills Group for Adolescents, a psychological group therapy that aims to provide young people who are experiencing a range of mental health difficulties with new ways of coping. The outcomes presented indicate that by attending the group, young people developed an increased capacity to tolerate distress and to manage difficult emotions.
   Work was also commenced in 2017, to establish further additional outcome measures to determine the efficacy of more services in 2018.

5. The scope of audit across the organisation was further strengthened in 2017, consistent with the requirements of the Mental Health Commission's 2017 revisions to the Judgement Support Framework.

6. Strengths: SPMHS continues to lead by example in providing such a detailed insight into service accessibility, efficacy of clinical programmes and service user satisfaction. Reporting this breadth of routinely collected clinical outcomes, demonstrates a willingness to constantly re-evaluate the efficacy of our clinical programmes/services, in an open and transparent way. Well established in this report, is a detailed service user satisfaction survey encompassing all service delivery within SPMHS, reinforcing the organisation's commitment for service user centred care and treatment.

7. Challenges: whilst we have continued with our expansion of services included within this report, as yet we do not have all areas of service delivery included. Efforts to benchmark the results of this report remain very difficult, as no other organisation within Ireland produces a comparable report. In order to best capture the efficacy of clinical programmes and services, there have been changes in the outcome measures used, which can create difficulties when comparing

results to previous reports. The repo;rt's clinical outcome results cannot be solely attributed to the service or intervention being measured and are not developed to the standard of randomised control trials.
The relatively low service user experience survey response rate remains a significant challenge for SPMHS and ways to improve these rates will be further explored in 2018. A number of negative responses for the Dean Clinic service user experience survey were recieved. It is however worth noting, that significant structural improvements are being implemented in 2018, to address some weaknesses in Dean Clinic service delivery. Most notably the Dublin Dean Clinics are being centralised to 1 location and a prompt assessment of needs has been introduced. This new prompt assessment is delivered by a Registered Mental health Nurse via telecommunications, in order to give early assessment to those newly referred for outpatient services, to ensure the service user is directed on the correct care pathway.

SECTION 7

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