St Patrick's
Mental Health Services

# Outcomes Report 2024

**Annual review of St Patrick's Mental Health Services' Outcomes**

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# SECTION ONE

# Introduction

## 1. Introduction

This report presents outcomes relating to clinical care, clinical governance processes, clinical programmes, and service user experiences within St Patrick's Mental Health Services (SPMHS). It is the fourteenth year that an outcomes report has been produced by SPMHS and this report is central to the organisation's promotion of excellence in mental healthcare. By measuring and publishing outcomes of the services we provide, we continually strive to understand what we do well and what we need to continue to improve. Wherever possible, validated tools are utilised throughout this report and the choice of clinical outcome measures used is consistently reviewed to ensure we are attaining the best possible standards of service delivery. The completion and publication of this report demonstrates the commitment of all SPMHS staff to continuously measure and improve our services.

Leading healthcare providers around the world capture outcome measures related to care and treatment and make the results publicly available to enable service users, referrers, and commissioners to make informed choices about what services they choose. Transparency informs staff of the outcomes of services they provide and advances a culture of accountability for the services being delivered. It prompts debate about what care and treatment should be provided and crucially, how best to measure their efficacy. Sharing treatment outcome results is also consistent with the standards of the Mental Health Commission in Ireland (Mental Health Commission, 2023).

Since 2020, some of SPMHS services have been available through remote participation via audio-visual technology. Remote delivery of care is offered across a range of SPMHS services, based on a service user's assessment of needs. Technology-enabled care has not replaced inpatient admission, or other in-person care delivery where needed. For the purpose of this report the term 'in-person' admission is used when referring to our inpatient services where the service user is physically present in the hospital. This is to distinguish it from our Homecare service, which offers all the elements of inpatient services, but provided remotely in the

service users' own home. This involves the highest levels of one-to-one mental health support, delivered remotely through daily or more frequent contact over videocall and other technological channels.

The 2024 report is divided into seven sections. **Section one** provides an introduction and summary of the report's contents.

**Section two** outlines information regarding how SPMHS services are structured and how community clinics, day programme and inpatient services were accessed in 2024. SPMHS provides community care through its Dean Clinic community mental health clinics and day programme services through its Wellness and Recovery Centre (WRC). It provides in-person inpatient care through its three approved centres: St Patrick's University Hospital (SPUH), St Patrick's Lucan (SPL) and Willow Grove Adolescent Unit (WGAU).

**Section three** summarises the measures and outcomes of the organisation's clinical governance processes.

**Section four** provides an analysis of clinical outcomes for a range of clinical programmes and services. This information provides practice-based evidence of the efficacy of interventions and programmes delivered to service users during 2024, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

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

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

**Section seven** provides a reference list.

# SECTION TWO

# Service Accessibility

## 2. St Patrick's Mental Health Services

SPMHS is the largest independent, not-for-profit mental health service provider in Ireland. Our services are accessed in a number of ways, including community care accessed through our Dean Clinic network, day programme care accessed through our Wellness and Recovery Centre. Our inpatient care is accessed through three approved centres and our Homecare service provided remotely in the service users' own home. In addition, a free-of-charge Prompt Assessment of Needs (PAON) was introduced in December 2017 through the Referral and Assessment service (R&A) and aims to improve access for service users. The PAON service is delivered through technology for example telephone/audio visual technology, which ensures that the assessment is delivered at a time that suits the service user in their own home, greatly increasing accessibility. This section provides information about how services were accessed through these services in 2024.

### 2.1. Prompt Assessment of Needs (PAON)

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

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

#### 2.1.1. Outcomes of PAON Assessments

The table 2.1 provides the number and percentages of adult PAON assessments completed and the outcome of each PAON in 2023 and 2024. These results identify the immediate outcome of the PAON assessment.

Table 2.1. *Outcomes of PAON Assessments 2023-2024*

| | 2023 | % | 2024 | % |
|---|---|---|---|---|
| **Dean Clinic referral** | 793 | 86.5% | 770 | 83% |
| **Discharge*** | 14 | 1.5% | 15 | 2% |
| **Admission referral** | 110 | 12% | 136 | 15% |
| **Total** | **917** | **100%** | **921** | **100%** |

*A discharge occurred when the service user did not receive further services from SPMHS because the service user declined an offer of service or SPMHS did not have appropriate services to offer the service user at that time.

# Adult Dean Clinic Services

## 2.2.1. Dean Clinic Referrals Volume

The four Adult Dean Clinics provide multidisciplinary mental health assessments and treatment for those who can best be supported and helped within a community-based setting and provision of continued care for those leaving the hospital's inpatient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community-based Mental Health Services, Day Services, and Inpatient Care. The clinics encourage and facilitate early intervention which improves outcomes. In 2024, a total of 1,169 Adult Dean Clinic referrals were received from the centralised Referral and Assessment Service (R&A). This presents a decrease of 2% comparing with 1,193 referrals received in 2023. This decrease is due to the centralised R&A service assessing and forwarding referrals to the most suitable service thus decreasing the number of referrals to the Dean clinics.

## 2.2.2. Dean Clinic Referral Source by Province

Table 2.2 illustrates the geographical spread of Dean Clinic Referrals by province from 2022 to 2024. The highest referral volumes continued to be from Leinster in 2024 with 836 referrals, with referrals from Munster increasing by 6.7%.

Table 2.2. *Dean Clinic Referrals by Province from 2022 to 2024*

| Year | Leinster | Munster | Connaught | Ulster |
|---|---|---|---|---|
| **2022** | 1,021 | 217 | 143 | 40 |
| **2023** | 864 | 164 | 134 | 31 |
| **2024** | 836 | 175 | 131 | 27 |

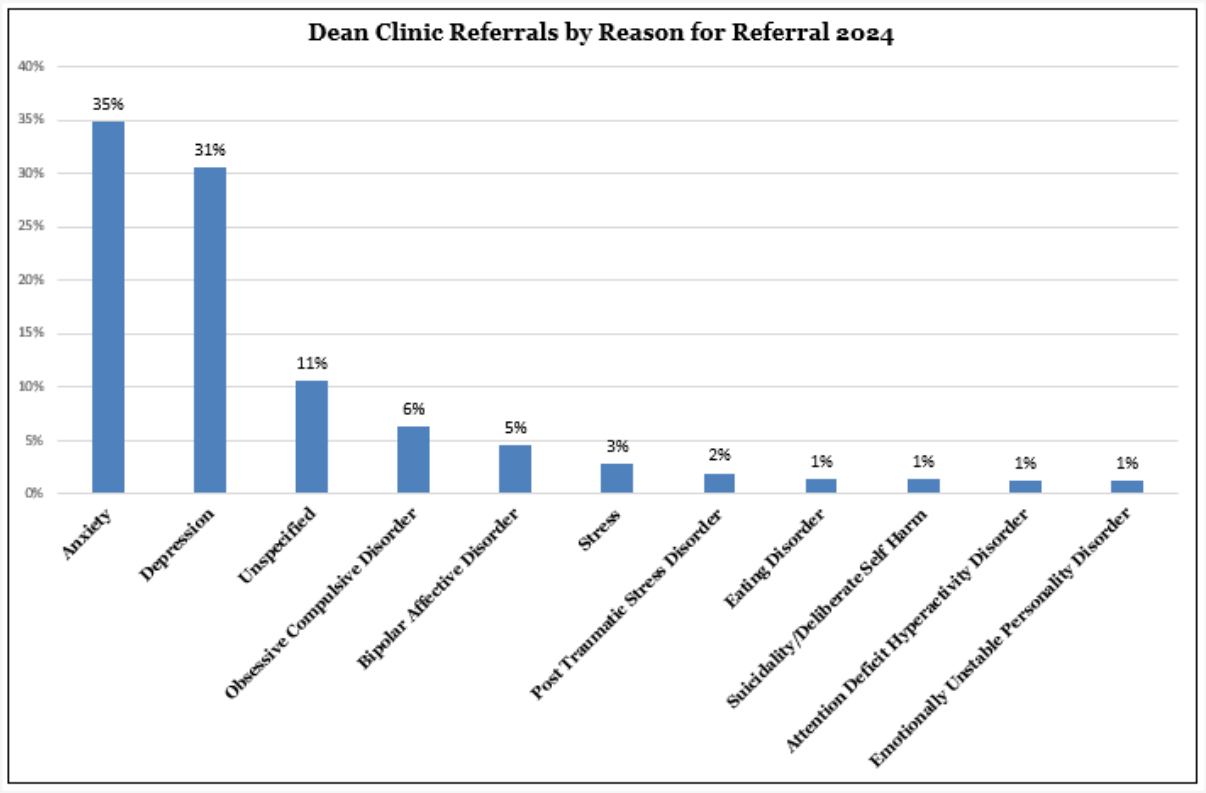
### 2.2.3. Dean Clinic Referrals by Gender

The female to male ratio of Dean Clinic Adult referrals for 2024 was 1:0.8. Male referrals increased by 4% in comparison to 2022 – potentially indicating that more men are seeking mental health support. Male referrals increased by 1% in comparison to 2023 – potentially indicating that more men seeking mental health support.

### 2.2.4. Dean Clinic Referrals by Reason for Referral

Table 2.1 shows the reasons for referral to the Dean Clinics in 2024, as identified by the referrer. It shows Depression and Anxiety as the most common reasons for referral, with 11% presenting with complaints unspecified by the referrer.

Figure 2.1. *Dean Clinic Referrals by Reason for Referrals in 2024*




## 2.2.5. Dean Clinic Activities

Table 2.3 below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2022. In 2024, 21% of referrals proceeded to have a mental health assessment – an 8.6% decrease from 2023. The main reason for this reduction is the increase in service users referred for assessment opting for an Assessment Homecare Admission (AHA), a three-day comprehensive assessment provided remotely in the service users' own home. Additionally, some service users have a more immediate need and are assessed for possible admission to inpatient care or are referred for a homecare service admission. This is evidenced in the 22.2% increase of first-time admissions. In some cases, a decision is made not to progress with an assessment as the service user is already under the care of another service. Others do not attend appointments and 47.2% of referrals suitable for assessment had to be declined as there was no capacity to assess them - this is 5% less than referrals declined in 2023. Table 2.3 summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2022.

Table 2.3. *A summary of the number of referrals and mental health assessments provided in the adult Dean Clinics from 2022 - 2024.*

| Year | No. of Referrals | No. of Assessments |
|---|---|---|
| **2022** | 1,421 | 262 |
| **2023** | 1,193 | 354 |
| **2024** | 1,169* | 246 |

*248 of these adults referred for Dean Clinic assessment did not recieve PAON assessments. The reasons that these 248 service users did not receive a PAON include: They were internal Dean referrals for young people transitioning into SPMHS adult services, they had been under the care of another mental health service in the previous three years or the service user declined PAON assessment.

A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Consultant Psychiatrist and members of the multidisciplinary team. An individual care plan is agreed with the referred person following assessment which may involve follow-on community-based therapy, a referral to a day-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.

Table 2.4 summarises the total number of outpatient appointments that were offered across Dean Clinics nationwide from 2022 to 2024. Appointments include

- Consultant Reviews,
- Clinical Nurse Manager II Reviews,
- Clinical Nurse Specialist Reviews,
- Cognitive Behavioural Therapy,
- Occupational Therapy,
- Social Work and Psychology.

There was a 3.2% increase in adult Dean clinic appointments in 2024. The “Did not Attend” (DNA) rate was 4.6, a slight reduction of 0.8% in comparison to 2023. This is

8.4% below the national DNA rate of 13% for outpatient appointments in the Health Service Executive (HSE).

Table 2.4. *Adult Dean Clinic appointments from 2022 - 2024.*

| Year | Adult Dean Clinic Appointments |
|---|---|
| **2022** | 13,876 |
| **2023** | 14,028 |
| **2024** | 14,476 |

Table 2.5 summarises the number of first-time inpatient admissions to SPMHS from an initial Dean clinic referral or following a Dean Clinic assessment for the period 2022 to 2024. There was an increase of 22.2% in first time admissions from the Dean clinics in 2024. This increase was potentially due to improvements made to the triaging process of referrals and the introduction of Assessment Homecare Admissions in the Dean clinics. The ability to transition to a Homecare service admission provided an acceptable alternative for service users who otherwise may have declined an in-person inpatient admission.

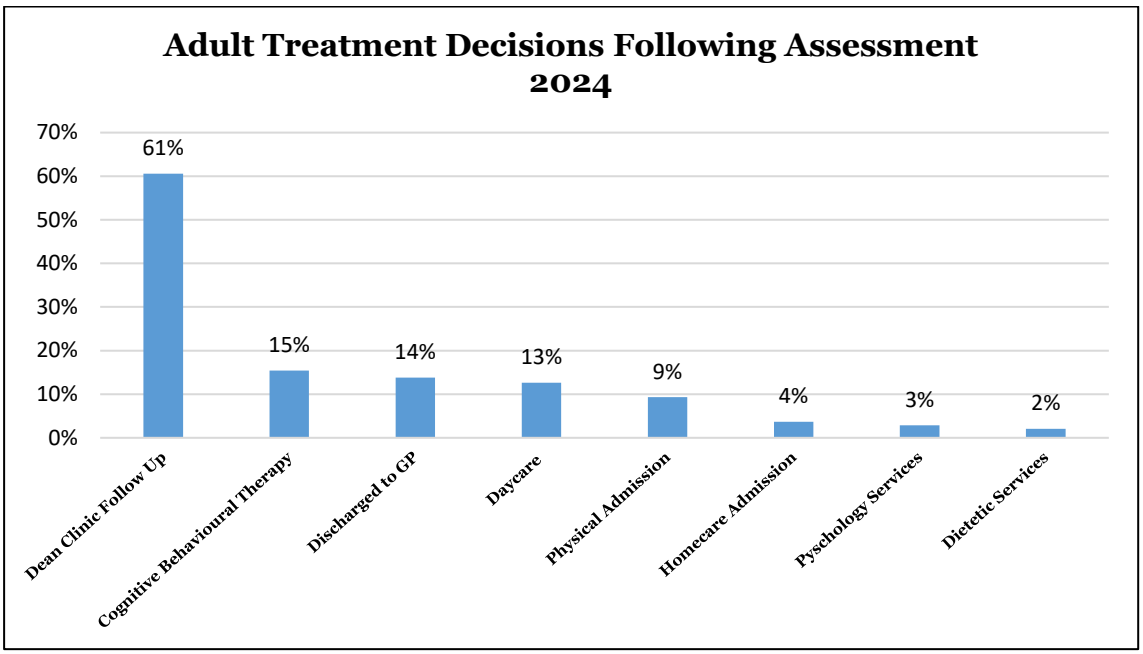
*Table 2.5. First time inpatient admissions from an initial Dean Clinic referral.*

| Year | First Admission |
|---|---|
| **2022** | 187 |
| **2023** | 212 |
| **2024** | 259 |

### 2.2.6 Dean Clinic: Outcome of Assessments

Figure 2.2 summarises and compares the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics 2024.

Figure 2.2. *Adult Dean Clinic Treatment Decisions following Dean clinic assessments.*




### 2.2.7 Adolescent Dean Clinics

The two Adolescent Dean Clinics are based in Dublin and Cork. In 2024, there were a total of 958 referrals received for the Adolescent Service, a marginal decrease of 1.4% from 2023. A total of 232 Adolescent Prompt Assessment of Needs (PAON's) were completed in 2024 which was on par with 2023.

Referrals to the Adolescent Service are centrally received and reviewed by the Willow Grove Adolescent Unit (WGAU) clinical team. All 958 referrals were assessed to determine if inpatient admission, the Homecare service, or the Dean clinics would be the best service to meet their needs.

In 2024, 718 (74.9%) of the 958 referrals received by the Adolescent service were declined or discharged prior to admission or Dean Clinic assessment. Of these, 505 (52.7%) were discharged prior to admission or Dean Clinic assessment, 1.6% less than 2023. The main reasons for declining the referrals were due to the Adolescent service being at capacity and not being able to offer prompt admission or a Dean Clinic assessment within an appropriate time frame to meet their urgent needs. The other main reason for declining referrals to the Adolescent service was that we did not have the appropriate service to meet the young person's needs. The clinical team

made recommendations for alternative treatment options in these cases. The referral refusal rate is 2.3% below the HSE CAMHS (Child and Adolescent Mental Health Services) referral-refusal rate of 55% and 1.3% less than the United Kingdom's (UK) National Health Service's (NHS) average referral-refusal rate of 54%.

The balance of the referrals received by the Adolescent service that were discharged prior to admission or Dean clinic assessment, 213 (22%) were discharged for several reasons such as the young person not meeting required age parameters, the young person/ parents declining services offered, the young person being admitted to another service or the young person residing outside Ireland.

### 2.2.8 Adolescent Referral Source by Province

Table 2.6 illustrates the geographical spread of Adolescent Referrals by Province from 2022. The highest referral volume is from Leinster.

Table 2.6. *Adolescent Service Referrals by Province*

| Year | Leinster | Munster | Connaught | Ulster | Other |
|---|---|---|---|---|---|
| **2022** | 695 | 291 | 44 | 15 | 0 |
| **2023** | 603 | 286 | 58 | 25 | 0 |
| **2024** | 574 | 317 | 48 | 17 | 2 |

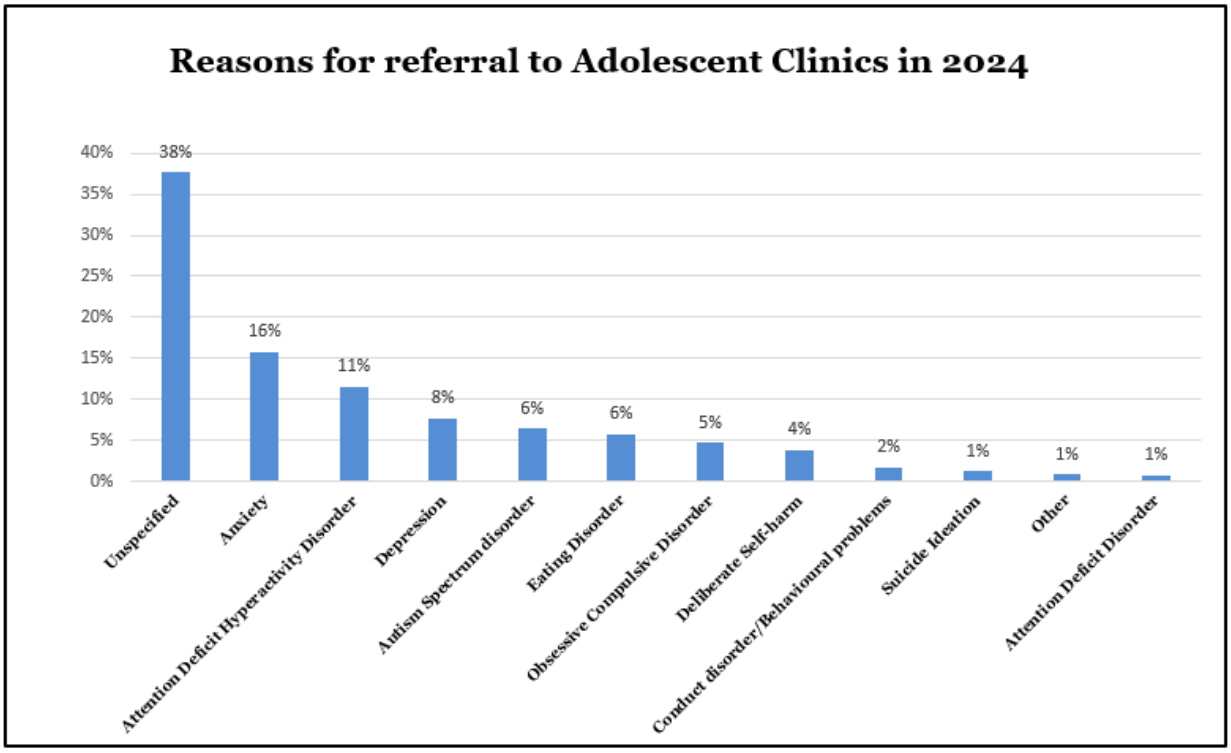
### 2.2.9 Dean Clinic Referrals by Gender

The female to male ratio of Dean Clinic Adolescent referrals for 2024 was 1:0.6. There was a 1% increase in male referrals in comparison to 2023.

### 2.2.10 Reasons for referral to Adolescent Dean Clinics

Figure 2.3 reflects a sample of the reasons for referrals to the Adolescent Dean Clinics throughout 2024 by General Practitioners, HSE CAMH services, private consultants, HSE adult mental health inpatient services and independent mental health services. The primary reasons for referral were Anxiety, Depression and Attention Deficit Hyperactivity Disorder (ADHD), with 38% presenting complaint being unspecified by the referrer.

Figure 2.3 *Reasons for referral to the Adolescent Dean clinics in 2024*




## 2.2.11 Dean Clinic Activities

Table 2.7 summarises the total number of referrals received by the Adolescent service, the number of referrals sent to the Adolescent Dean Clinics and the number of Adolescent mental health assessments provided across the Dean Clinics since 2022.

In 2024, 702 referrals were forwarded to the Adolescent Dean Clinics presenting an increase of 115.3% in comparison to the number of referrals in 2023. In part, this increase reflects improvements in the data collection process of triaged referrals and accurately captures the referral pathways during the triage process.

As mentioned in paragraph 2.2.7 not all referrals result in an assessment due to service users already being under the care of another service; non-attendance of assessment appointments; declining the assessment offered and / or may be referred for an admission assessment. The increased capacity of the Homecare service increased accessibility to the service by creating an acceptable alternative to in-person admissions for young people and their parents; and negated the waiting

times for a Dean Clinic assessment. In addition, service users may have been referred to several services and opted to take a local service. Parental consent is required prior to Adolescent assessments taking place. Table 2.7 provides a summary of the number of referrals received and the number of assessments completed in 2024.

Table 2.7 *A summary of the number of referrals and mental health assessments provided in the adolescent Dean Clinics from 2022 - 2024.*

| Year | No. of Referrals to Adolescent Dean Clinics | No. of Assessments in the Dean Clinics |
|---|---|---|
| **2022** | 394 | 109 |
| **2023** | 326 | 120 |
| **2024** | 702 | 91 |

There was an 24.2% decrease in the Adolescent Dean Clinic assessments in 2024. This decrease was due to unplanned clinician leave in 2024 which reduced assessment capacity in the clinic for several months. The mental health assessment involves a comprehensive evaluation of the young persons' mental state carried out by members of the multidisciplinary team. An individual care plan is agreed with the referred young person and family following assessment. This may involve follow-on community-based therapy, a referral to a day-patient programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the young person to make a full recovery through the most appropriate treatment and care. The adolescent team provide family psychoeducation to assist families in supporting the adolescents' recovery.

The total number of Adolescent Dean Clinic appointments offered in 2024 by the Adolescent Dean Clinics nationwide decreased by 20% in comparison to 2023. The reductions in appointments offered was due to unplanned clinician leave. The "Did Not Attend" (DNA) rate was 1.3%, which is 4.1% below the national DNA rate of 5.4% for CAMHS appointments in Ireland. The number of appointments offered is summarized in table 2.8. Appointments include Consultant Reviews, Clinical Nurse Manager Reviews, Nurse Practitioner appointments, Cognitive Behavioural Therapy,

Occupational Therapy, Social Work, Psychology, and Dietetic services. Table 2.8 shows the number of Adolescent Dean clinic appointments from 2022 – 2024.

Table 2.8. *The number of Adolescent Dean Clinic appointments from 2022 – 2024*

| Year | Total No. of Adolescent Dean Clinic Appointments |
|---|---|
| **2022** | 2,233 |
| **2023** | 2,200 |
| **2024** | 1,759 |

The total number of admissions to WGAU included 50 inpatient admissions and 88 Homecare admissions in 2024. This represents a decrease of 3.5% in the combined number of inpatient and Homecare admissions. The combined number of inpatient and Homecare first-time admissions was 83, which was a decrease of 3.5% in comparison to 2023. The reduction in admissions can be attributed to the reduction of assessments in the Dean Clinic due to the unexpected reduction in referring capacity from referrers for example waiting times to access Child and Adolescent Mental Health services (CAMHS) and vacant consultant posts in CAMHS potentially reducing referrals from being sent to the adolescent services and unplanned clinician leave in the Adolescent Dean Clinic. Table 2.9 summarises the number of first-time inpatient admissions to WGAU from 2022.

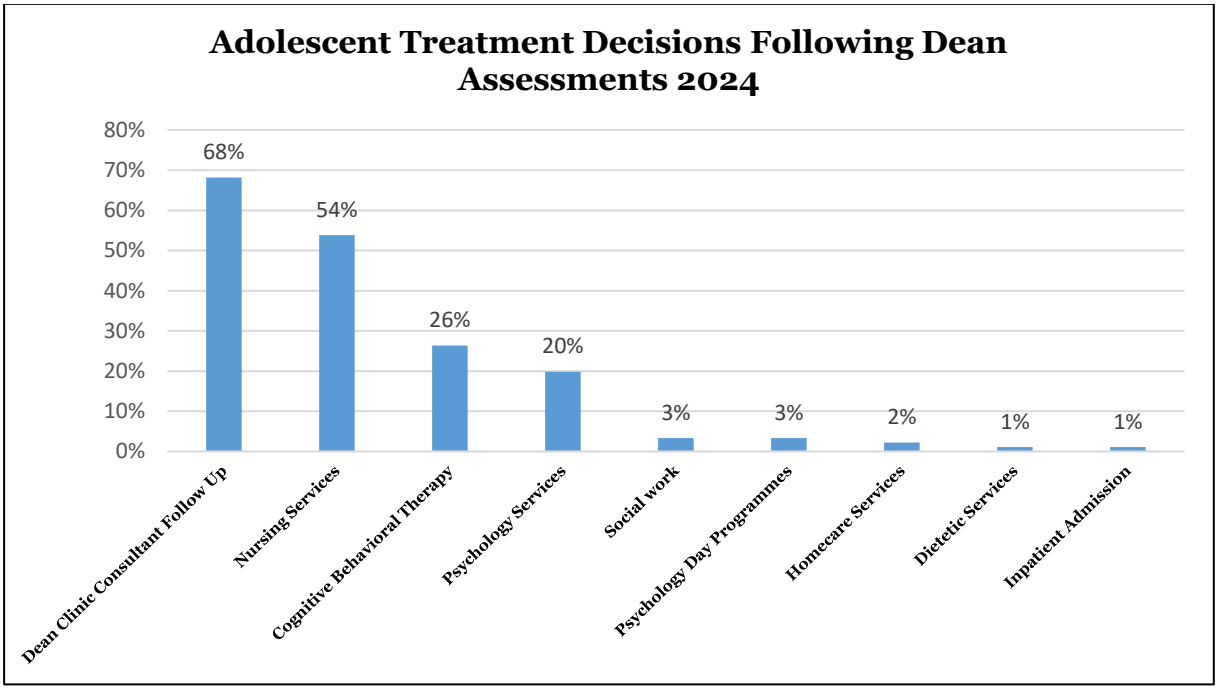
Table 2.9. *First-time inpatient admissions to WGAU from 2022 – 2024*

| Year | First Admission |
|---|---|
| **2022** | 92 |
| **2023** | 86 |
| **2024** | 83 |

### 2.2.12 Dean Clinic: Outcome of Assessments

Figure 2.4 summarises the treatment decisions recorded from individual care plans following initial assessment in Adolescent Dean Clinics in 2024. There was a 16% increase in referrals to the adolescent Dean clinic nursing team and a 6% increase to cognitive behavioural psychotherapy, a 4% increase to individual psychology sessions, a 3% increase in referrals to social work. However, that was a 17% reduction of referrals to the adolescent psychology day programs.

Figure 2.4. *Adolescent Treatment Decision Following Dean Assessments 2024*




## 2.3. SPMHS' In-person Inpatient Care and Homecare Services

SPMHS in-person inpatient care is provided in St Patrick's University Hospital (SPUH) with 208 in-person inpatient beds, St Patrick's Lucan (SPL) which contains 52 inpatient beds and Willow Grove Adolescent Unit (WGAU) with 14 in-person inpatient beds. In addition to its in-person inpatient care, SPMHS also provides Homecare services first introduced in March 2020 to both Adult and WGAU service users. The Homecare service offers all the elements of in-person inpatient care, involves the highest levels of one-to-one mental health support, but is delivered remotely through frequent contact daily over videocall and other technological channels.

### 2.3.1. SPMHS' In-person Inpatient and Homecare Admission Rates

The following information includes gender ratios, age and length of stay (LOS) distributions across Adult and WGAU in-person inpatient and Homecare services for 2024. In 2024, 62.0% of admissions across in-person inpatient and Homecare services were female, this compared to 59.2% in 2023.

Table 2.10. *No. of Total Admissions (% of Total Admissions) 2024*

| Gender | Adult In-person Inpatient | Adult Homecare | WGAU In-person Inpatient | WGAU Homecare | Total |
|---|---|---|---|---|---|
| **Female** | 1,390 (61.2%) | 506 (63.5%) | 39 (78.0%) | 52 (59.8%) | 1,987 (62.0%) |
| **Male** | 881 (38.8%) | 291 (36.5%) | 11 (22.0%) | 35 (40.2%) | 1,218 (38.0%) |
| **Total** | **2,271 (100%)** | **797 (100%)** | **50 (100%)** | **87 (100%)** | **3,205 (100%)** |

Table 2.11 shows the numbers and percentages of admission care/treatment days delivered in 2024, providing a synopsis of the inpatient in-person care days and the Homecare service days.

Table 2.11. *No. (%) of Inpatient In-person and Homecare Admission Days 2024*

| | Total Adult | Total WGAU | Total |
|---|---|---|---|
| **Homecare admission days** | 18,748 (18.1%) | 3,139 (56.7%) | 21,887 (20.0%) |
| **In-person Inpatient admission days** | 84,945 (81.9%) | 2,401 (43.3%) | 87,346 (80.0%) |
| **Total admission days** | **103,693** | **5,540** | **109,233** |

Table 2.12 shows the average age of service users admitted across all services was 48.49 in 2024 (2023 - 48.14 years). The average age of adults admitted was 50.32 years in 2024 and was 49.95 years in 2023. The average age of adolescents admitted to WGAU in-person inpatient and Homecare Services was 15.27 years in 2024 and was 15.40 years in 2023.

Table 2.12. *Average Age at Admission (ALL) 2024*

| Gender | Adult In-person Inpatient | Adult Homecare | WGAU In-person Inpatient | Adolescent Homecare | Total |
|---|---|---|---|---|---|
| **Female** | 51.92 | 45.89 | 15.27 | 14.90 | 48.91 |
| **Male** | 50.08 | 44.64 | 16.00 | 15.46 | 47.88 |
| **Gender total** | **51.14** | **45.44** | **15.41** | **15.16** | **48.49** |

### 2.3.2. SPMHS Inpatient Length of Stay 2024

Tables 2.13 to 2.18 present the 2024 average length of stay (LOS) for adult in-person inpatient and Homecare service discharges (18 years of age and over) and Adolescent in-person inpatient and Homecare service discharges (under 18 years of age). The analysis and presentation of length of stay for these discharges was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under one week up to five years.

Table 2.13. *SPMHS length of stay (LOS) for 2024 Adult Discharges*

| 2024 Adults | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 665 | 21.8% |
| **1 -<2 weeks** | 286 | 9.4% |
| **2-<4 weeks** | 551 | 18.0% |
| **4-<5 weeks** | 269 | 8.8% |
| **5-<6 weeks** | 259 | 8.5% |
| **6-<7 weeks** | 217 | 7.1% |
| **7-<8 weeks** | 219 | 7.2% |
| **8-<9 weeks** | 123 | 4.0% |
| **9-<10 weeks** | 107 | 3.5% |
| **10-<11 weeks** | 78 | 2.6% |
| **11 weeks -< 3 months** | 139 | 4.5% |
| **3-<6 months** | 139 | 4.5% |
| **6 + months** | 5 | 0.2% |
| **Total number of adult discharges 2024** | **3,057** | **100.00%** |

Table 2.14. *SPMHS length of stay (LOS) for 2024 Adult In-person Inpatient Discharges*

| 2024 Adult In-person Inpatients | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 463 | **21.8%** |
| **1 -<2 weeks** | 144 | 9.4% |
| **2-<4 weeks** | 352 | **18.0%** |
| **4-<5 weeks** | 195 | 8.8% |
| **5-<6 weeks** | 219 | **8.5%** |
| **6-<7 weeks** | 180 | 7.1% |
| **7-<8 weeks** | 186 | **7.2%** |
| **8-<9 weeks** | 105 | 4.0% |
| **9-<10 weeks** | 84 | **3.5%** |
| **10-<11 weeks** | 70 | 2.6% |
| **11 weeks -< 3 months** | 118 | **4.5%** |
| **3-<6 months** | 130 | 4.5% |
| **6 + months** | 5 | 0.2% |
| **Total number of adult In-person Inpatient discharges 2024** | **2,251** | **100.00%** |

Table 2.15. *SPMHS length of stay (LOS) for 2024 Adult Homecare Discharges*

| 2024 Adult Homecare Service Users | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 202 | 25.1% |
| **1 -<2 weeks** | 142 | 17.6% |
| **2-<4 weeks** | 199 | 24.7% |
| **4-<5 weeks** | 74 | 9.2% |
| **5-<6 weeks** | 40 | 5.0% |
| **6-<7 weeks** | 37 | 4.6% |
| **7-<8 weeks** | 33 | 4.1% |
| **8-<9 weeks** | 18 | 2.2% |
| **9-<10 weeks** | 23 | 2.9% |
| **10-<11 weeks** | 8 | 1.0% |
| **11 weeks -< 3 months** | 21 | 2.6% |
| **3-<6 months** | 9 | 1.1% |
| **Total number of adult Homecare discharges 2024** | **806** | **100.00%** |

Table 2.16. *SPMHS length of stay (LOS) for 2024 Adolescent (WGAU) discharges*

| 2024 Adolescents | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 9 | 6.5% |
| **1 -<2 weeks** | 14 | 10.1% |
| **2-<4 weeks** | 27 | 19.4% |
| **4-<5 weeks** | 12 | 8.6% |
| **5-<6 weeks** | 16 | 11.5% |
| **6-<7 weeks** | 11 | 7.9% |
| **7-<8 weeks** | 17 | 12.2% |
| **8-<9 weeks** | 9 | 6.5% |
| **9-<10 weeks** | 7 | 5.0% |
| **10-<11 weeks** | 4 | 2.9% |
| **11 weeks -< 3 months** | 5 | 3.6% |
| **3-<6 months** | 8 | 5.8% |
| **Total number of WGAU discharges 2024** | **139** | **100%** |

Table 2.17. *SPMHS length of stay (LOS) for 2024 WGAU In-person Inpatient Discharges*

| 2024 Adolescents | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 2 | 3.8% |
| **1 -<2 weeks** | 2 | 3.8% |
| **2-<4 weeks** | 12 | 23.1% |
| **4-<5 weeks** | 2 | 3.8% |
| **5-<6 weeks** | 4 | 7.7% |
| **6-<7 weeks** | 4 | 7.7% |
| **7-<8 weeks** | 6 | 11.5% |
| **8-<9 weeks** | 6 | 11.5% |
| **9-<10 weeks** | 4 | 7.7% |
| **10-<11 weeks** | 3 | 5.8% |
| **11 weeks -< 3 months** | 2 | 3.8% |
| **3-<6 months** | 5 | 9.6% |
| **Total number of 2024WGAU In-person Inpatient discharges** | **52** | **100%** |

Table 2.18. *SPMHS length of stay (LOS) for 2024 WGAU Homecare Discharges*

| 2024 Adolescents | Number of discharges | Percentage |
|---|---|---|
| **Under 1 week** | 7 | 8.0% |
| **1 -<2 weeks** | 12 | 13.8% |
| **2-<4 weeks** | 15 | 17.2% |
| **4-<5 weeks** | 10 | 11.5% |
| **5-<6 weeks** | 12 | 13.8% |
| **6-<7 weeks** | 7 | 8.0% |
| **7-<8 weeks** | 11 | 12.6% |
| **8-<9 weeks** | 3 | 3.4% |
| **9-<10 weeks** | 3 | 3.4% |
| **10-<11 weeks** | 1 | 1.1% |
| **11 weeks -< 3 months** | 3 | 3.4% |
| **3-<6 months** | 3 | 3.4% |
| **Total number of 2024 WGAU Homecare Discharges** | **87** | **100%** |

### 2.3.3. SPMHS Analysis of Primary ICD Diagnoses for all In-person Inpatient and Homecare Discharges in 2024

Tables 2.19 and 2.20 outline the prevalence of diagnoses across SPMHS In-person inpatient and Homecare settings during 2024 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded on admission and at the point of discharge are presented for all SPMHS in-person inpatient and Homecare settings. The data presented is based on all in-person inpatient and Homecare discharges from SPMHS in 2024.

Table 2.19. *SPMHS analysis of inpatient Primary ICD Diagnoses*
*(For all In-person Inpatients discharged in 2024)*

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

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

| **ICD Codes: Physical Admission & Discharge**<br>**For All Physical Service Users Discharged in 2024** | **SPUH In-person Admissions** | | **SPUH In-person Discharges** | | **SPL In-person Admissions** | | **SPL In-person Discharges** | | **Total Adult In-person Admissions** | | **Total Adult In-person Discharges** | | **WGAU In-person Admissions** | | **WGAU In-person Discharges** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| **F00-F09** Organic, including symptomatic, mental disorders | 25 | 1.3 | 30 | 1.6 | 0 | 0.0 | 0 | 0.0 | 25 | 1.1 | 30 | 1.3 | 0.0 | 0.0 | 0 | 0.0 |
| **F10-F19** Mental and behavioural disorders due to psychoactive substance use | 288 | 15.4 | 323 | 17.3 | 19 | 5.0 | 19 | 5.0 | 307 | 13.6 | 342 | 15.2 | 0.0 | 0.0 | 0 | 0.0 |
| **F20-F29** Schizophrenia, schizotypal and delusional disorders | 118 | 6.3 | 119 | 6.4 | 13 | 3.4 | 13 | 3.4 | 131 | 5.8 | 132 | 5.9 | 0.0 | 0.0 | 1 | 1.9 |
| **F30-F39** Mood [affective] disorders | 831 | 44.5 | 758 | 40.6 | 179 | 46.9 | 185 | 48.4 | 1010 | 44.9 | 943 | 41.9 | 6.0 | 11.5 | 6 | 11.5 |
| **F40-F48** Neurotic, stress-related and somatoform disorders | 417 | 22.3 | 386 | 20.7 | 133 | 34.8 | 122 | 31.9 | 550 | 24.4 | 508 | 22.6 | 21.0 | 40.4 | 23 | 44.2 |
| **F50-F59** Behavioural syndromes associated with physiological disturbances and physical factors | 57 | 3.0 | 63 | 3.4 | 2 | 0.5 | 1 | 0.3 | 59 | 2.6 | 64 | 2.8 | 10.0 | 19.2 | 10 | 19.2 |
| **F60-F69** Disorders of adult personality and behaviour | 130 | 7.0 | 163 | 8.7 | 36 | 9.4 | 40 | 10.5 | 166 | 7.4 | 203 | 9.0 | 1.0 | 1.9 | 6 | 11.5 |
| **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 | 1 | 0.1 | 20 | 1.1 | 0 | 0.0 | 1 | 0.3 | 1 | 0.0 | 21 | 0.9 | 1.0 | 1.9 | 1 | 1.9 |
| **F90-F98** Behavioural and emotional disorders with onset usually occurring in childhood and adolescence | 2 | 0.1 | 7 | 0.4 | 0 | 0.0 | 1 | 0.3 | 2 | 0.1 | 8 | 0.4 | 13.0 | 25.0 | 5 | 9.6 |
| **F99-F99** Unspecified | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0.0 | 0.0 | 0 | 0.0 |
| **Totals** | **1869** | **100.0** | **1869** | **100.0** | **382** | **100.0** | **382** | **100.0** | **2251** | **100.0** | **2251** | **100.0** | **52** | **100.0** | **52** | **100.0** |

Table 2.20. *SPMHS analysis of inpatient Primary ICD Diagnoses (For all Homecare Service Users discharged in 2024)*

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

| **ICD Codes: Homecare Admission & Discharge For All Homecare Service Users Discharged in 2024** | Adult Homecare Admissions | | Adult Homecare Discharges | | Willow Grove Homecare Admissions | | Willow Grove Homecare Discharges | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % |
| **F00-F09** Organic, including symptomatic, mental disorders | 1 | 0.1 | 1 | 0.1 | 0.0 | 0.0 | 0 | 0.0 |
| **F10-F19** Mental and behavioural disorders due to psychoactive substance use | 26 | 3.2 | 26 | 3.2 | 0.0 | 0.0 | 0 | 0.0 |
| **F20-F29** Schizophrenia, schizotypal and delusional disorders | 28 | 3.5 | 26 | 3.2 | 0.0 | 0.0 | 0 | 0.0 |
| **F30-F39** Mood [affective] disorders | 332 | 41.1 | 330 | 40.9 | 7.0 | 8.0 | 5 | 5.7 |
| **F40-F48** Neurotic, stress-related and somatoform disorders | 306 | 37.9 | 300 | 37.2 | 59.0 | 67.0 | 54 | 61.4 |
| **F50-F59** Behavioural syndromes associated with physiological disturbances and physical factors | 9 | 1.1 | 7 | 0.9 | 9.0 | 10.2 | 9 | 10.2 |
| **F60-F69** Disorders of adult personality and behaviour | 80 | 9.9 | 96 | 11.9 | 3.0 | 3.4 | 3 | 3.4 |
| **F70-F79** Mental retardation | 0 | 0.0 | 0 | 0.0 | 0.0 | 0.0 | 0 | 0.0 |
| **F80-F89** Disorders of psychological development | 7 | 0.9 | 7 | 0.9 | 0.0 | 0.0 | 1 | 1.1 |
| **F90-F98** Behavioural and emotional disorders with onset usually occurring in childhood and adolescence | 17 | 2.1 | 13 | 1.6 | 10.0 | 11.4 | 16 | 18.2 |
| **F99-F99** Unspecified | 1 | 0.1 | 1 | 0.1 | 0.0 | 0.0 | 0 | 0.0 |
| **Totals** | 807 | 100.0 | 807 | 100.0 | 88 | 100.0 | 88 | 100 |

## 2.4. SPMHS' Day Programme: Wellness and Recovery Centre

The Wellness and Recovery Centre (WRC) provides service users with access to a range of specialist clinical programmes which are available as a step-down service following inpatient or homecare treatment or as a step-up service accessed from the Dean Clinics. It also provides a number of recovery-oriented programmes. Throughout 2024, many day programmes continued to be delivered entirely or in part, via technology-enabled care. Programme delivery was further enhanced through the introduction of hybrid technology which supports a blend of onsite and remote

delivery. This was particularly useful at times of illness and adverse weather conditions, which otherwise would have prevented service users attending in person. Clinical programmes are delivered by specialist multidisciplinary teams and focus primarily on disorder-specific interventions, psychoeducation and supports, and fall into the following broad categories;

- Cognitive Behavioural Therapy (CBT) based programmes
- Psychology programmes
- Addiction services
- Eating disorder services
- Recovery focused programmes

### 2.4.1. Day programme referrals by clinical programme

Table 2.21 compares the total number of day programme referrals to each clinical programme for 2023 and 2024. Referrals come from a number of sources, including SPMHS multidisciplinary teams, Dean Clinics, GPs, and external mental health services.

In 2024, the WRC received a total of 2,146 referrals compared to a total of 2,205 for 2023, a year-on-year decrease of 2.7%. Of the day programme referrals for 2024; 25.25% were received from Dean Clinics. This compares to a total of 19% referrals received from Dean Clinics in 2023 but is consistent with previous years.

Most day programme referrals (69%) are created internally by the service users' multidisciplinary team. The remainder are referred from GPs, external consultants and HSE community services.

Table 2.21. *Individual day programme referrals for 2023 and 2024*

| SPMHS Day Programmes | Total day programme referrals 2023 | Total day programme referrals 2024 |
|---|---|---|
| **Access to Recovery** | 189 | 192 |
| **Acceptance Commitment Therapy** | 305 | 301 |
| **Addictions Programmes** | 244 | 273 |
| **Anxiety Programme** | 206 | 147 |
| **Bipolar Programme** | 94 | 59 |
| **Building Strength and Resilience** | 38 | 41 |
| **Cognitive Behaviour Therapy for Adolescents** | 5 | 0 |
| **Coping for Older Adults** | 0 | 3 |
| **Compassion-Focused Therapy (CFT)** | 151 | 127 |
| **CFT - Eating Disorders** | 24 | 13 |
| **Dialectical Behaviour Therapy** | 90 | 150 |
| **Depression Programme (incl BHSE)** | 135 | 108 |
| **Eating Disorders Assessment Prog (new)** | 0 | 14 |
| **Eating Disorders Programme** | 84 | 91 |
| **Emotion Focused Therapy YA** | 30 | 35 |
| **Formulation Group Therapy** | 84 | 126 |
| **Group Radical Openness** | 82 | 70 |
| **CFT-Psychosis** | 26 | 26 |
| **Mild Cognitive Impairment (new)** | 0 | 18 |
| **Mindfulness (MBSR)** | 50 | 33 |
| **Pathways to Wellness** | 83 | 82 |
| **Psychology Skills Group for Adolescents** | 24 | 15 |
| **Recovery Programme** | 170 | 119 |
| **SABE Adolescents & Families** | 29 | 23 |
| **Psychological Therapy for Older Adults** | 18 | 23 |
| **Schema Group Therapy** | 15 | 35 |
| **Trauma Group Therapy** | 29 | 22 |
| **Total** | **2,205** | **2,146** |

### 2.4.2 Day programme referrals by gender

Of all referrals to day services in 2024, 1,366 (63.65%) were female, 780 (36.68%) were male, a slight (1%) increase in male referrals and associated reduction in female referrals compared to 2023.

### 2.4.3 Day programme attendances for clinical programmes 2023-2024

In 2024, of the 2,146 referrals to a day programme, 1,331 commenced day programmes. This compares to 2,205 referrals and 1,651 commencing a programme in 2023. These registrations represented a total of 18,679 (2023) and 18,720 (2024) half day attendances respectively. Therefore, in 2023 each registered day service user attended on average 10.66 half days while in 2024 each registered day service user attended on average 14 half days.

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

| SPMHS Day Programmes | Total day programme registrations 2023 | Total day programme registrations 2024 | Total day programme attendances 2023 | Total day programme attendances 2024 |
|---|---|---|---|---|
| **Access to Recovery** | 139 | 103 | 1340 | 1265 |
| **Acceptance Commitment Therapy** | 235 | 179 | 1829 | 1849 |
| **Addictions Programmes** | 221 | 244 | 2173 | 2448 |
| **Anxiety Programme** | 145 | 94 | 1239 | 871 |
| **Bipolar Programme** | 55 | 21 | 520 | 382 |
| **Building Strength and Resilience** | 20 | 12 | 106 | 68 |
| **Cognitive Behaviour Therapy Adolescents** | 5 | 0 | 13 | 0 |
| **COAP** | 0 | 4 | 0 | 11 |
| **Compassion-Focused Therapy** | 142 | 78 | 1097 | 1325 |
| **CFT Eating Disorders** | 20 | 9 | 235 | 202 |
| **Dialectical Behaviour Therapy** | 84 | 75 | 1523 | 1766 |
| **Depression Programme (incl BHSE)** | 92 | 57 | 875 | 717 |
| **Eating disorders Assessment prog (new)** | 0 | 17 | 0 | 40 |
| **Eating Disorders Programme** | 49 | 75 | 2137 | 1951 |
| **Emotion Focused Therapy YA** | 21 | 13 | 244 | 203 |
| **Formulation Group Therapy** | 66 | 53 | 460 | 531 |
| **Group Radical Openness** | 53 | 59 | 1335 | 1337 |
| **Living Through Psychosis (CFT-P)** | 18 | 16 | 97 | 169 |
| **Mild Cognitive Impairment (new)** | 0 | 15 | 0 | 72 |
| **Mindfulness (MBSR)** | 49 | 4 | 208 | 47 |
| **Pathways to Wellness** | 84 | 77 | 1593 | 1631 |
| **Psychology Skills Group for Adolescents** | 24 | 13 | 199 | 148 |
| **Recovery Programme** | 68 | 71 | 681 | 981 |
| **SABE Adolescents & Families** | 7 | 5 | 26 | 14 |
| **SAGE** | 21 | 11 | 217 | 160 |
| **Schema Group Therapy** | 19 | 9 | 198 | 136 |
| **Trauma Group Therapy** | 14 | 20 | 334 | 396 |
| **Total** | **1,651** | **1,334** | **18,679** | **18,720** |

Table 2.22. *Day programme attendances at clinical programmes 2023 and 2024*

# SECTION THREE

# Clinical Governance

## 3. Clinical Governance measures and quality management

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

## 3.1. Clinical Governance measures summary

| Governance Measure | 2022 | 2023 | 2024 |
|---|---|---|---|
| **Clinical audits** | | | |
| **Number of complaints**<br>Total including all complaints, comments and suggestions received and processed throughout the entire year. | **733** | **816** | **663** |
| **Number of incidents**<br>An event or crcumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event. | **2,139** | **2,239** | **2,024** |
| **Root cause analyses and focused reviews commenced**<br>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** | **6** | **4** |
| **Number of Section 23's – Involuntary detention of a voluntary service user**<br>A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the approved centre (SPUH) - where the person indicates an intention to discharge from the approved centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the centre to detain a voluntary person for a period not exceeding 24 hours for assessment. | **64** | **51** | **33** |
| **% Section 23s which progress to involuntary admission (Section 24 - Form 13 Admissions)**<br>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. | **52% (33)** | **53% (27)** | **75% (24)** |
| **Number of Section 14's – Involuntary admissions**<br>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. | **19** | **19** | **10** |
| **% of Section 14s which progress to involuntary admission (Section 15 - Form 6 Admissions)**<br>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. | **84% (16)** | **73% (14)** | **100% (10)** |
| **Number of Section 20/21 - Transfers**<br>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. | **40** | **41** | **42** |
| **Assisted Admissions**<br>The number of instances where assisted admissions services were required to assist in the transportation of a service user | **14** | **16** | **13** |
| **Number of Section 60 – Medication reviews**<br>Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of three months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist. | **7** | **7** | **10** |
| **Number of Section 19 – Appeal to Circuit Court**<br>A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness. | **0** | **0** | **0** |

| | | | |
|---|---|---|---|
| **Number of Tribunals held** | **42** | **52** | **43** |
| **Number of ECT Programme's completed within the year** | **125** | **146** | **169** |
| **Number of Physical Restraint Episodes (SPUH and SPL and WGAU)** | **121** | **75** | **41** |

## 3.2. Clinical audits

This section summarises clinical audit activity for St Patrick's Mental Health Services in 2024. Clinical audit is an integral part of clinical governance. Its main purpose is to improve the quality of care provided to service users and the resulting outcomes. The clinical audit process is a cycle which involves measurement of the quality of care and services against agreed and proven standards for high quality, and, where necessary, taking action to bring practice in line with these standards. A complete clinical audit cycle involves remeasurement of previously audited practice to confirm improvements and make further improvements if needed.

### 3.2.1. Overview of clinical audit activity 2024

The following table demonstrates the breakdown of projects by type undertaken in 2024, including those facilitated by clinical staff at local level, and those carried out throughout the organisation led by various committees.

| No. | Audit title | Audit lead | Status at year end |
|---|---|---|---|
| 1. | **The Clinical Global Impression (CGI) and Children's Global Assessment Scale (CGAS) level of change pre and post-inpatient treatment**<br>To measure the CGI/CGAS outcomes for service users pre and post-admission. | Clinical Governance Committee | Annual audit completed |
| 2. | **Admission protocol**<br>To improve compliance with the admission protocol for adult service users being admitted for physical admission.<br>To change practice if standards on admission protocols are not being met to ensure that the initial care plan is appropriate, and the treatment chosen and implemented on admission is provided in timely manner. | Postgraduate Training Audit Committee | Re-audit completed |
| 3. | **Adherence to the organisations protocol on falls risk prevention interventions**<br>Ensure that service users identified as medium or high risk of fall are managed appropriately to reduce any future fall incidents and to increase service users' safety. | Falls Committee | Bimonthly audits completed |
| 4. | **Monitoring of service users prescribed lithium maintenance therapy in Dean Clinics**<br>To ensure that the lithium therapy is efficacious and monitored effectively.<br>To increase the safety of service users prescribed lithium.<br>To ensure that a service user is effectively educated about the lithium therapy including potential side effects and benefits.<br>To assess compliance with local policy. | Clinical Governance Committee | Baseline audit completed |
| 5. | **ECT processes**To ensure the highest quality of clinical governance through ensuring compliance with Mental Health Commission guidelines, code of practice and rules. | Clinical Governance Committee | Re-audit completed |
| 6. | **The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services (audit facilitated by Prescribing Observatory for Mental Health-UK*)** | Clinical Governance Committee | Baseline audit completed |

| No. | Audit title | Audit lead | Status at year end |
|---|---|---|---|
| | To assess adherence to best practice standards and benchmark the results with the UK Trusts. | | |
| 7. | **Use of medicines with anticholinergic (antimuscarinic) properties in population of service users aged 65 and over following in-patient or home care**<br><br>To assess and review current practice of prescribing medication with anticholinergic (antimuscarinic) properties among service users aged 65 and over. | Clinical Governance Committee | Baseline audit completed |
| 8. | **Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour (audit facilitated by Prescribing Observatory for Mental Health-UK*)**<br><br>To assess adherence to best practice standards and benchmark the results with the UK Trusts. | Clinical Governance Committee | Re-audit completed |
| 9. | **Audits of compliance with the regulations for approved centres**<br>To ensure the highest quality of clinical governance through ensuring compliance with Mental Health Commission guidelines, code of practice and rules. | Departmental Audits | Baseline audits and re-audits completed in 2024 |
| 10. | **Nursing Metrics**<br>To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice. | Nursing Department | This is a monthly routine audit. |

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

### 3.2.2. Key audit outcomes for 2024

- A Clinical Audit Programme for audits of compliance with regulations for approved centres was continued in 2024. The findings confirmed that all clinical and non-clinical staff have been committed to maintaining good practice and to provide the highest standards of quality care and treatment.

- SPMHS benchmarked its practice with UK Mental Health Services by taking part in two POMH-UK audits.

- The baseline audit report on the use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services published by the POMH-UK for SPMHS led to an internal audit with an extended population consisting of service users aged over 65 and receiving either as an inpatient or on Homecare. On foot of the internal audit findings, an information campaign was initiated to raise awareness amongst the clinicians on the anticholinergic properties of psychotropic medication and importance of assessing anticholinergic burden.

- SPMHS took part in the Prescribing Observatory for Mental Health (POMH-UK) second re-audit on rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour. The rate of administered medication for each of the episodes of acutely disturbed behaviour calculated for SPMHS compares favourably to the total UK national sample.

- The clinical audit on monitoring of service users attending Dean Clinics and prescribed lithium maintenance treatment indicated a need to strengthen the practice of ongoing physical health monitoring.

- A further re-audit on admission protocols was completed by a group of non-consultant hospital doctors. The aim was to reinforce hight compliance levels with the standards.

- A comprehensive audit of ECT processes confirmed high compliance with the Mental Health Commission Code of Practice on ECT standards and SPMHS internal standards.

# SECTION FOUR

# Clinical Outcomes

Clinical outcome measurement has been in place in SPMHS since 2011 and is a priority for the service, embedded within clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. This report reflects a continuing shift towards an organisational culture that recognises the value of integrated outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

## 4.1. Important considerations for interpretation of outcomes

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

- The data reported in this chapter represent pre and post-programme measurements.
- Pre and post-programme measurement are carried out at the start and finish of programmes but other elements of care, simultaneous interventions, time, medications etc. may also play a part (any effects cannot be solely attributable to clinical programme intervention).
- Where appropriate to the analysis of outcomes, paired sample t-tests are used to determine if, across the sample, post-scores are statistically significantly different from pre-scores. Where a t-test is not appropriate (due to sample size), the Reliable Change Index (RCI) is used. The RCI should be interpreted with caution because it can be influenced by measurement variability, but it is useful for small sample sizes as it provides a standardised way to assess individual change in a way that accounts for reliability.
- **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, for example, small changes on a depression measure can be statistically significant, but not clinically or practically meaningful.

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

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

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

**Clinical significance** refers to whether a treatment was effective enough to change whether a patient met the criteria for a clinical diagnosis at the end of treatment. It is

possible for a treatment to produce a significant difference and medium to large effect sizes but not to demonstrate a positive change in the service user's level of functioning.

## 4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for care 2024

### 4.2.1. Objective

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

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

#### 4.2.1.1. Background

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

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

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

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

#### 4.2.1.2. Data collection strategy

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

A random sample was chosen from admissions to SPUH and SPL. The chosen sample size was 327 cases. Then the cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases for each ward within the services.

All WGAU admissions were included for CGAS adolescent dataset.

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

- Service user age and gender
- Admission ICD code (primary and additional)

- Date of admission
- Admission ward
- Re-admission rate
- Date of discharge
- Baseline assessment scale score (CGIS or CGAS respectively)– recorded on the individual care plan on or before the first MDT meeting
- Date recorded against the baseline score
- Final assessment scale score (CGIC or CGAS respectively) recorded on the MDT meeting care plan review document
- Date recorded against the final score.

### 4.2.2. Sample description

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

| | | TOTAL ADULT SERVICE | WGAU |
|---|---|---|---|
| **Sample size** | | **327** | **96** |
| **Admissions** | First admission | 46% | 82% |
| | Re-admission | 54% | 18% |
| **Average age ± standard deviation** | | 51±19 | 15±1 |
| **Gender** | Female | 57% | 67% |
| | Male | 43% | 33% |

### 4.2.2.1. ICD-10 admission diagnosis

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

| | | TOTAL ADULT SERVICE | | | WGAU | | |
|---|---|---|---|---|---|---|---|
| **ICD-10 Admission diagnosis category** | | **2022** | **2023** | **2024** | **2022** | **2023** | **2024** |
| **F30-F39** | Mood disorders | 45% | 39% | 42% | 17% | 20% | 9% |
| **F40-F48** | Neurotic, stress-related and somatoform disorders | 27% | 32% | 26% | 35% | 52% | 60% |
| **F10-F19** | Mental and behavioural disorders due to psychoactive substance use | 12% | 12% | 15% | 0% | 0% | 0% |
| **F20-F29** | Schizophrenia, schizotypal and delusional disorders | 4% | 5% | 4% | 0% | 0% | 0% |
| **F50-F59** | Behavioural syndromes associated with physiological disturbances and physical factors | 3% | 4% | 2% | 15% | 13% | 11% |
| **F00-F09** | Organic, including symptomatic, mental disorders | 2% | 1% | 2% | 0% | 0% | 0% |
| **F60-F69** | Disorders of adult personality and behaviour | 8% | 8% | 8% | 0% | 1% | 1% |
| **F80-F89** | Disorders of psychological development | 0% | 0% | 0% | 6% | 2% | 1% |
| **F90-F98** | Behavioural and emotional disorders with onset usually occurring in childhood and adolescence | 0% | 0.3% | 0.6% | 28% | 12% | 17% |

### 4.2.3. Baseline and final assessment scale scores

Table 4.3. *Total adult service*

| CGIS - Baseline measure of severity of illness | | 2022 Total | 2023 Total | 2024 Total |
|---|---|---|---|---|
| **1** | Normal, not at all ill | 0% | 2% | 0% |
| **2** | Borderline mentally ill | 1% | 2% | 2% |
| **3** | Mildly ill | 14% | 13% | 9% |
| **4** | Moderately ill | 34% | 37% | 46% |
| **5** | Markedly ill | 25% | 21% | 22% |
| **6** | Severely ill | 14% | 14% | 17% |
| **7** | Extremely ill | 0% | 1% | 1% |
| | Not scored | 11% | 12% | 2% |

Table 4.4. *Total adult service*

| CGIC – Final global improvement or change score | | 2022 Total | 2023 Total | 2024 Total |
|---|---|---|---|---|
| **1** | Very much improved | 5% | 4% | 6% |
| **2** | Much improved | 41% | 42% | 50% |
| **3** | Minimally improved | 29% | 28% | 29% |
| **4** | No change | 8% | 8% | 5% |
| **5** | Minimally worse | 0% | 1% | 0% |
| **6** | Much worse | 0% | 0% | 0% |
| **7** | Very much worse | 0% | 0% | 0% |
| | Not scored | 15% | 17% | 9% |

Table 4.5. *Willow Grove Adolescent Unit*

| Children's Global Assessment Scale | | 2022 | | 2023 | | 2024 | |
|---|---|---|---|---|---|---|---|
| | | **Baseline** | **Final** | **Baseline** | **Final** | **Baseline** | **Final** |
| **100-91** | Superior functioning | 0% | 0% | 0% | 0% | 0% | 1% |
| **90-81** | Good functioning | 0% | 1% | 0% | 2% | 0% | 3% |
| **80-71** | No more than a slight impairment in functioning | 1% | 2% | 2% | 13% | 0% | 14% |
| **70-61** | Some difficulty in a single area, but generally functioning pretty well | 2% | 20% | 7% | 27% | 8% | 21% |
| **60-51** | Variable functioning with sporadic difficulties | 12% | 31% | 14% | 22% | 27% | 34% |
| **50-41** | Moderate degree of interference in functioning | 40% | 31% | 38% | 26% | 34% | 21% |
| **40-31** | Major impairment to functioning in several areas | 35% | 11% | 24% | 8% | 25% | 5% |
| **30-21** | Unable to function in almost all areas | 10% | 2% | 14% | 0% | 5% | 0% |
| **20-11** | Needs considerable supervision | 0% | 0% | 0% | 0% | 0% | 0% |
| **10-1** | Needs constant supervision | 0% | 0% | 0% | 0% | 0% | 0% |
| | Not scored | 0% | 3% | 0% | 1% | 0% | 1% |
| **Mean ±SD** | | 41±9 | 52±11 | 43±11 | 57±12 | 45±10 | 58±12 |
| **Median** | | 41 | 52 | 41 | 58 | 44 | 57 |
| **Wilcoxon Signed Ranks Test:** | | Z= -7.745, p<.001 | | Z= -7.605, p<.001 | | Z=-7.356, p<.001 | |

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

### 4.2.4.1. Clinical audit standards

**Audit Standard no. 1:** Baseline score is taken within at least seven days following admission:

Exception: Short admission

Target level of performance: 100%

**Audit Standard no. 2:** Final score is taken within at least seven days prior to discharge:

Exception: Short admission, unplanned discharge

Target level of performance: 100%

### 4.2.4.2. Results

Table 4.6. *Results of clinical audits*

| | TOTAL ADULT SERVICE | | | WGAU | | |
|---|---|---|---|---|---|---|
| | **2022** | **2023** | **2024** | **2022** | **2023** | **2024** |
| **Baseline assessment scale score** | | | | | | |
| **% of admission notes with recorded baseline scores** | 89% | 88% | 98% | 100% | 100% | 100% |
| **% compliance with clinical audit standard no. 1** | 86% | 78% | 84% | 98% | 100% | 100% |
| **Final assessment scale score** | | | | | | |
| **% of admission notes with recorded final scores** | 85% | 83% | 91% | 97% | 99% | 99% |
| **% compliance with clinical audit standard no. 2** | 94% | 85% | 90% | 95% | 99% | 100% |

## 4.2.5. Summary of findings

- A sample was chosen out of a dataset of St. Patrick's Mental Health Services discharges for 2024.
- A female to male ratio was 1.3:1 for adults and WGAU 2.0:1 for adolescents.
- In the 2024 sample, 1st admissions accounted for 46% of adult service users and 82% of adolescent service users.
- 2024 analysis of the primary ICD-10 codes showed for the adults' population the most frequent reasons for admission were mood disorders followed by neurotic, stress related, somatoform disorders and behavioural disorders due to psychoactive substance use.

- In 2024, 46% of SPUH, SPL and the Homecare service users were moderately ill. Another 22% were markedly ill. 17% were severely ill.
- Based on a sample of 299 (total cases with discharge CGI score documented) 94% of the sample were rated with an overall improvement (1 - very much improved (7%), 2 - much improved (55%) and 3 - minimally improved (32%)). This percentage of sample rated with an overall improvement increased in comparison to observed in the 2023 data set where 89% overall improvement was observed.
- 2024 analysis of the primary ICD-10 codes showed for the adolescent population the most frequent reasons for admission were neurotic, stress related, somatoform disorders followed by behavioural and emotional disorders with onset usually occurring in childhood and adolescence.
- In 2024, 34% of Willow Grove Adolescent Unit service users were scored as having a moderate degree of interference in functioning on admission and another 25% had major impairment in functioning in several areas. 5% was unable to function in almost all areas.
- Overall improvement rate for Willow Grove Adolescent Unit was 85%.
- The audit shows an increase in the rates of the recorded baseline and final assessment scale scores in the adult cohort. The calculated compliance with the standards increased for adults and for adolescents.

## 4.3. Alcohol and Chemical Dependency Programme

The Alcohol and Chemical Dependence Programme (ACDP) is designed to support individuals with alcohol and/or chemical dependence or abuse to achieve abstinence by enabling them to develop an increased awareness of the implications and consequences of their drinking or drug-taking. The ‘staged’ recovery programme is delivered by psychiatrists, addiction counsellors and ward-based nursing staff, with input from other disciplines including psychology, social work and occupational therapy.

The programme includes:

- Inpatient residential service for four weeks
- 12-week step-down programme
- Aftercare
- The programme caters for adults who are currently abusing or dependent on alcohol or chemical substances.

Referral criteria include:

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

### 4.3.1. Descriptors

In 2024, 101 participants completed the full programme and returned pre and post data. 50.5% of participants were male and 49.5% were female.

### 4.3.2. Alcohol and Chemical Dependency Programme Outcome Measures

- **Leeds Dependence Questionnaire (LDQ)**

The Leeds Dependence Questionnaire (LDQ) (Raistrick et al 1994) is a 10-item questionnaire designed to screen psychological dependency to a variety of different substances. The LDQ was designed to be sensitive to change over time and to range from mild to severe dependence (Raistrick 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, et al., 2010).

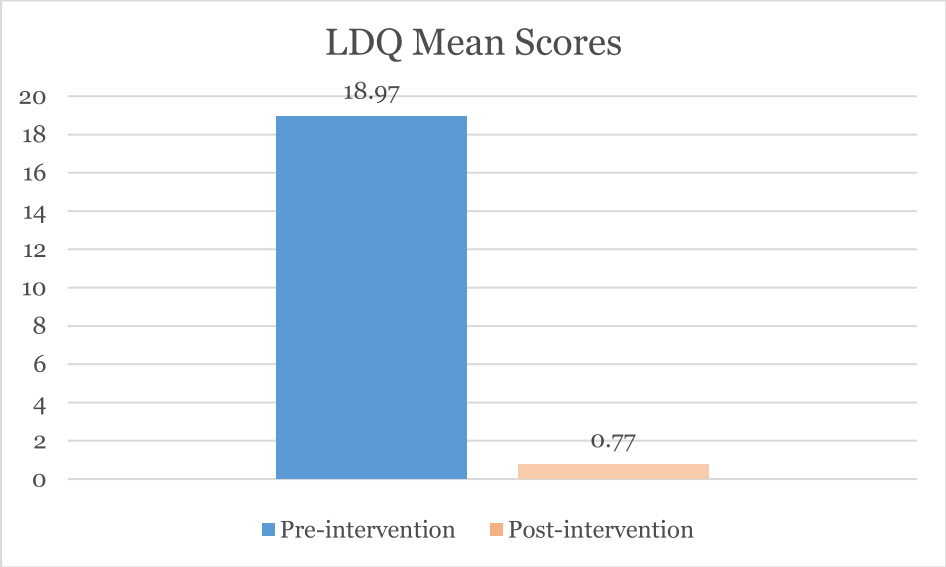
Items are scored on a four-point scale from zero – 'never', to three – 'nearly always', with higher total scores (maximum score of 30) indicating greater dependence.

Analysis of the measure has shown it to have high internal consistency (alpha = .88), good test-retest reliability (r = 95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003), and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Toberet al., 2000).

### 4.3.3. Results

This measure was completed by service users pre- and post-programme participation. Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre- to post-programme participation. A paired samples t-test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, $t$ (99) = 25.12, $p < 0.001$, with a large effect size ($d$ = 2.51). The mean score on the total LDQ scores decreased from pre-intervention ($M$ = 18.97, SD = 7.34) to post-intervention ($M$ = 0.77, $SD$ = 1.73), as depicted in Figure 4.1.

Figure 4.1. *Leeds Dependence Questionnaire scores from pre- to post-intervention*




### 4.3.4. Summary

Significant and large reductions in psychological markers of substance and/or alcohol dependency were observed, following completion of the Alcohol and Chemical Dependency Programme. These findings are in line with previous research and literature which regard the LDQ as a suitable tool for the evaluation of interventions for adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

## 4.4. Dual Diagnosis Programme

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

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

The programme aims to assist the service user in the recovery process, by providing a bio-psychosocial support structure and the therapeutic environment necessary to foster their recovery. This includes a combination of group and one-to-one support to help in the transition from complex mental health and addiction issues to a more sustainable and healthy life in sobriety.

The Dual Diagnosis Programme is a staged recovery programme and is delivered by psychiatrists, addiction counsellors and ward-based nursing staff, with input from other disciplines including psychology, social work and occupational therapy. It includes:

- Initial detoxification and assessment by MDT
- Inpatient residential service for approximately four weeks (longer if required)
- 12-week step-down programme (not always required, pending treatment pathway)
- Aftercare for 12 months.

The programme includes the following elements:

- **Individual multidisciplinary assessment:** This facilitates the development of an individual treatment care plan for each person.
- **Psychoeducation lectures:** A number of lectures are delivered weekly, with a focus on providing education on substance misuse and recovery, as well as approaches for managing mental health issues such asCBT and mindfulness. There is also a weekly family and service user lecture, facilitated by addiction counsellors, providing information on substance misuse and recovery to service users and their families.
- **Goal-setting and change plan:** This group is facilitated by therapists and encourages participants to put plans and structure in place for time spent outside of the hospital.
- **Mental health groups:** This is a psychoeducational group focusing on mental health-related topics such as depression, anxiety and recovery.
- **Recovery plan:** This group facilitates and supports participants in developing and presenting an individual recovery plan. It covers topics such as professional

monitoring, community support groups, daily inventories, triggers, physical care, problem-solving, relaxation, spiritual care, balance living, family/friends and work balance etc.

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

### 4.4.1. Descriptors

92 individuals with complete data were included in this analysis. These participants attended and completed the full or modified programme in 2024. Of these, 56.5% were male and 43.5% female. The age of participants ranged from 20 to 77, with a mean age of 47.17 (SD = 14.50).

### 4.4.2. Dual Diagnosis Programme Outcome Measures

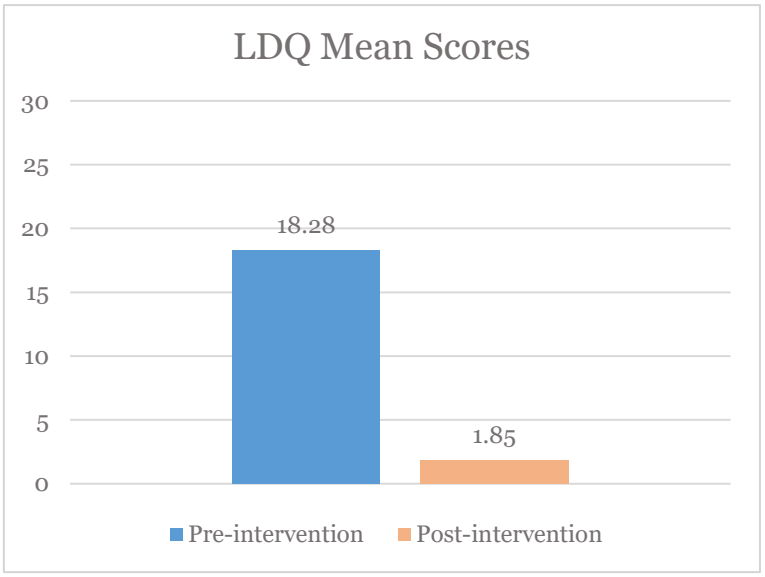
- **Leeds Dependence Questionnaire (LDQ):** see page 48

### 4.4.3. Results

#### Leeds Dependence Questionnaire

A paired samples t -test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, $t$ (91) = 19.95, $p$ < .001, with a large effect size ($d$ = 2.08). The mean score on the total LDQ decreased from 18.28 (SD=8.01) pre-programme to 1.85 (SD=2.08) post-programme, as depicted in the Figure 4.2.

Figure 4.2. *Leeds Dependence Questionnaires scores from pre- to post-intervention*




### 4.4.4. Summary

Large and significant reductions in the psychological markers of alcohol and chemical dependency, as measured by the Leeds Dependence Questionnaire, were observed for individuals who took part in the Dual Diagnosis Programme. These findings are in line with previous research and literature which regard the LDQ as a suitable tool for the evaluation of interventions for adults with substance dependency (Tober et al., 2000).

## 4.5. Acceptance and Commitment Therapy Programme

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

The ACT programme, which was implemented in St Patrick's Mental Health Services in 2010, runs recurrently over a twelve-week period for one half-day per week. During the twelve-week programme, participants engage in a range of experiential exercises to

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

### 4.5.1. Descriptors

In 2024, 68 individuals completed pre and post-measures, including 42 females (61.8%) and 26 males (38.2%). The age of participants completing the programme ranged from 18 to 74 (mean age of 51.25).

### 4.5.2. ACT Programme outcomes measures

- **Acceptance and Action Questionaire II**

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

- **Behavioural Activation for Depression Scale (BADS)**

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

- **Five Facet Mindfulness Questionnaire (FFMQ)**

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five facets of mindfulness; observing, describing, acting with awareness, non-reactivity to inner experience and non-judging of inner experience. The measure consists of 39 items which are responded to on a five-point rating scale ranging from one – 'never or very rarely true', to five 'very often or always true'. Scores range from 39 to 195, with higher scores suggesting higher levels of mindfulness. In a study of non-clinical samples participants who regularly practise mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practise mindfulness had a mean of 138.9 (*SD* = 19.2) (Lykins & Baer, 2009). The measure evidences good reliability (alpha co-efficient ranging from .72 to .92 for each facet) (Baer et al, 2006). Evidence for construct validity comes from analysis of data from samples with mindfulness meditation and no mindfulness meditation experience (Baer et al, 2006).

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

The Work and Social Adjustment Scale (WSAS) is a brief five-item service user self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private

leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a nine-point Likert scale from zero – 'not at all', to eight – 'very severely'. Total scores for the measure can range from zero to 40, with higher scores indicating greater impairment in functioning. 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 service users with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt et al., 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change. Its psychometric properties have been well established across different psychopathologies. Its internal consistency, convergent/divergent validity and test–retest reliability are excellent, Cronbach's alpha measure of internal scale consistency ranged from 0.70 to 0.94. Test-retest correlation was 0.73. As an outcome measure, it is highly sensitive to treatment change in a wide range of conditions such as obsessive–compulsive disorder (OCD), bipolar disorder, phobic disorders, anxiety and depression.

- **The Self-Compassion Scale (SCS)**

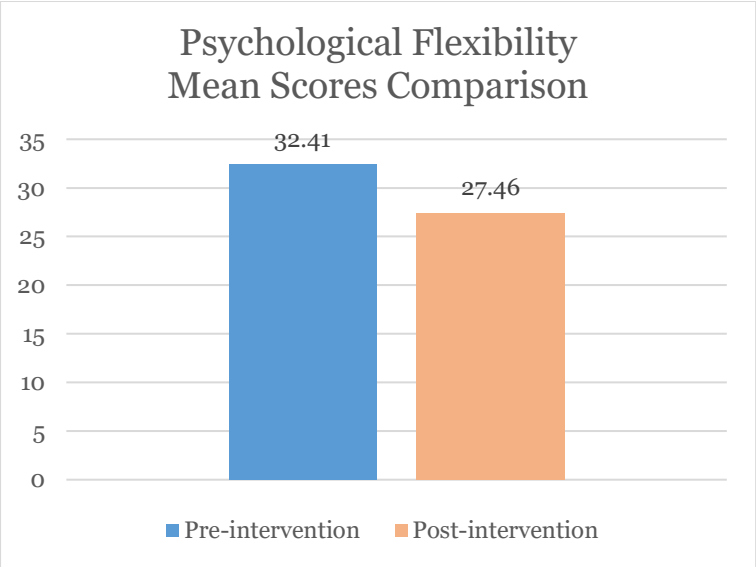
The Self-Compassion Scale (SCS) is a 26-item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; self-kindness, self-judgement, humanity, isolation, mindfulness and identification or over-identification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

### 4.5.3. Results

#### Acceptance and Action Questionnaire-II (AAQ-II)

Mean scores on the AAQ-II decreased significantly from ($M$ = 32.41, $SD$ = 8.68) to ($M$ = 27.46, $SD$ = 8.51) indicating greater psychological flexibility post-intervention, $t$ (67) = 5.242, $p$ <.001, with a medium effect size (Cohen's $d$ = 0.64) (see Figure 4.3).

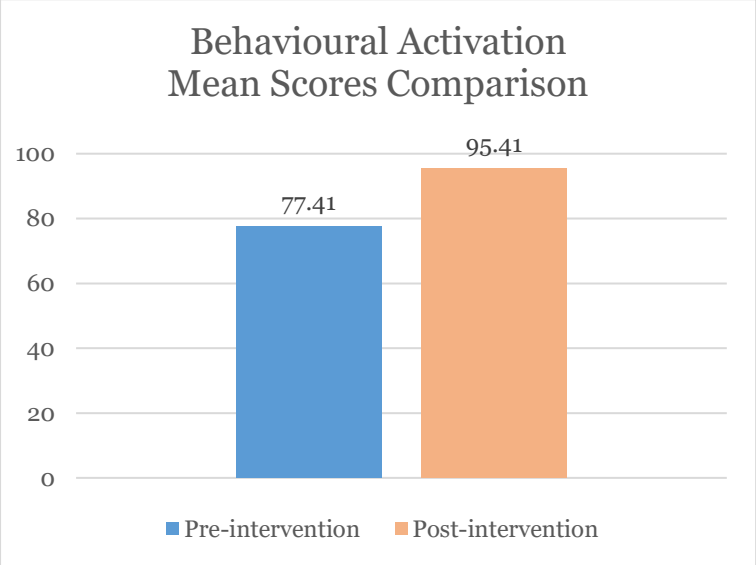
Figure 4.3. *Total mean psychological flexibility (AAQ-II) scores*




### Behavioural Activation for Depression Scale (BADS)

Mean BADS scores increased significantly from pre-intervention ($M$ = 77.41, $SD$ = 23.73) to post-intervention ($M$ = 95.41, $SD$ = 22.89) indicating greater behavioural activation, $t$ (67) = -6.62, $p$ < .001, with a large effect size (Cohen's $d$ = -0.80) (see Figure 4.4).

Figure 4.4. *Total mean behavioural activation (BADS) scores*

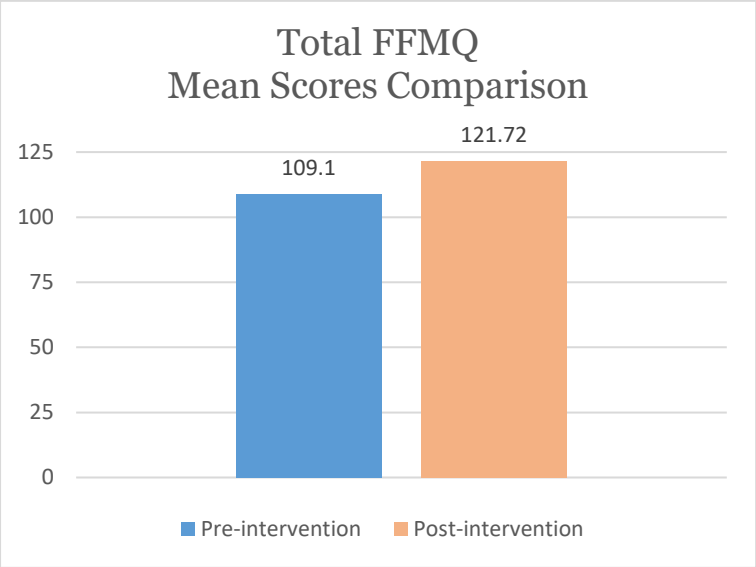



### Five Facet Mindfulness Questionnaire (FFMQ)

Total mean FFMQ scores increased significantly from pre-intervention ($M$ = 109.10, $SD$ = 20.56) to post-intervention ($M$ = 121.72, $SD$ = 23.83), indicating greater levels of overall

mindfulness, $t$ (67) = -5.64, $p$ < .001, with a medium effect size observed (Cohen's $d$ = -0.68). Mindfulness is defined in this context as observing, describing, acting with awareness, non-reactivity to inner experience and non-judging of inner experience (see Figure 4.5).

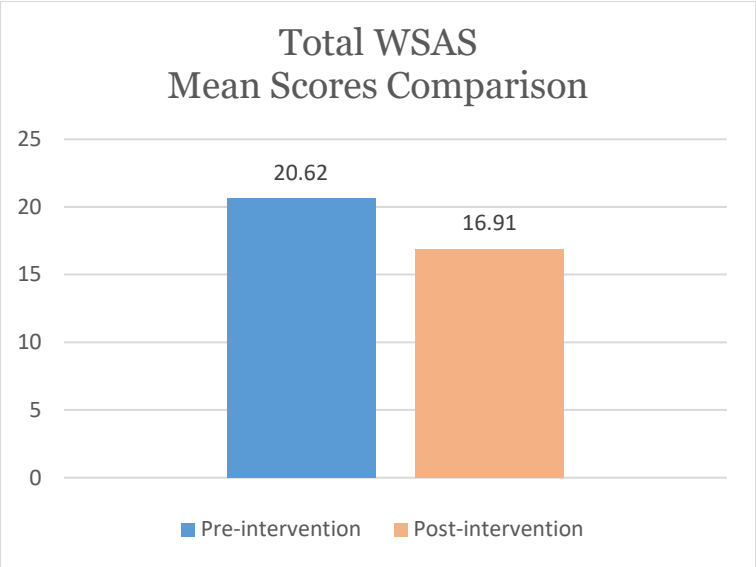
Figure 4.5. *Total Mean FFMQ scores pre and post-intervention*




### Work and Social Adjustment Scale (WSAS)

The total WSAS scale score was used to assess functioning pre and post the ACT programme in comparison to previous year. Mean scores decreased significantly, $t$ (67) = 3.61, $p$ = <.001, from pre-intervention ($M$= 20.62; $SD$ = 8.51) to post-intervention ($M$= 16.91; $SD$ =7.74), with a small to medium effect size observed (Cohen's $d$ = 0.44). This finding indicates that those who completed the ACT programme indicated significantly less functional impairment post-intervention (see Figure 4.6).

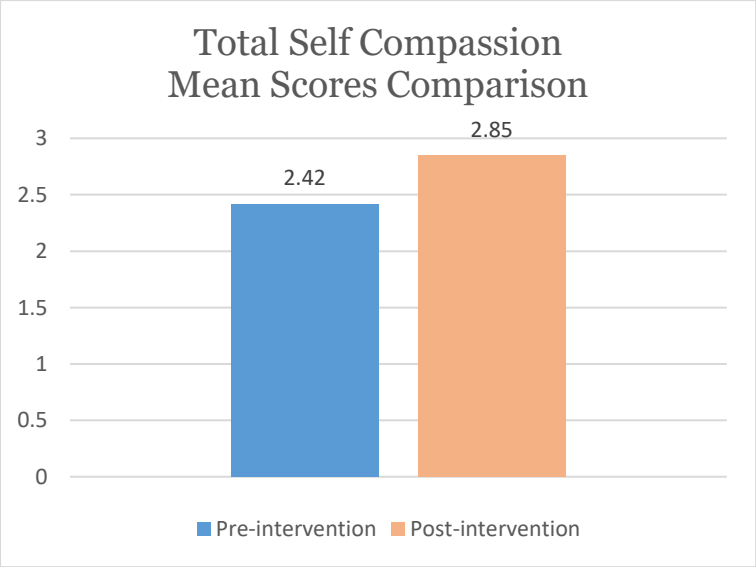
Figure 4.6. *Total Work and Social Adjustment Scale (WSAS) scores*




### Self-Compassion Scale (SCS)

Total SCS scores increased significantly, $t$ (67) = -5.87, $p$ < .001, from pre ($M$ = 2.42, $SD$ = 0.64) to post ($M$ = 2.85, $SD$ = 0.75) indicating higher overall levels of self-compassion post-intervention. A medium to large effect size was observed (Cohen's $d$ =-0.72) (see Figure 4.7). Self-compassion is measured in six domains: self-kindness, self-judgement, humanity, isolation, mindfulness and identification or 'over-identification' (see Figure 4.7).

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



### 4.5.5. Summary

In 2024, service users who completed the ACT programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation, self-compassion and functioning as measured by the available psychometrics. These outcomes are consistent with findings from previous years, reflecting a sustained pattern of improvement amongst service users who complete the programme. Data from the past 10 years indicate a continued trend of measurable benefits for service users, reinforcing the programme's effectiveness.

## 4.6. Anxiety Disorders Programme

The Anxiety Disorders Programme provides a clinical intervention programme for service users with primary anxiety disorders. The Anxiety Programme provides both group and individual intervention and support based on the cognitive behavioural therapy (CBT) model. CBT has been found to be efficacious for adult anxiety disorders (Butler, Chapman, Forman & Beck, 2006; Hofmann & Smits, 2008; Olantunji, Cisler & Deacon, 2010). All programme facilitators have received training in both CBT and mindfulness.

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

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

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

### 4.6.1. Descriptors

Data was available for 105 people who completed the programme in 2024, in which 54 (51.43%) were male and 51 (48.7%) were female. Programme attendees ranged in age from 18 to 78 (*M* = 42.82; *SD* = 14.03). Pre and post data were collected after Level 1 and Level 2 of the anxiety programme. 91 service users availed of Level 1 and 14 attended Level 2 of the anxiety programme.

OCD accounted for the largest subgroup (60.8%), followed by GAD (12.16%) and social phobia/ anxiety (12/16%), panic disorder (5.41%) and health anxiety (5.41%), agoraphobia (with/without panic) (2.7%), and specific phobia (1.35%).

Table 4.7 below shows the percentage of people with each diagnosis over the past three years.

Table 4.7. *Percentage of diagnoses for 2022, 2023 and 2024.*

| | **2022** | | **2023** | | **2024** | |
|---|---|---|---|---|---|---|
| | **N** | **%** | **N** | **%** | **N** | **%** |
| OCD | 54 | 46.6 | 35 | 43.2 | 45 | 60.8 |
| GAD | 18 | 15.5 | 17 | 21 | 9 | 12.6 |
| Social Phobia/Anxiety | 21 | 18.1 | 9 | 11.1 | 9 | 12.6 |
| Panic Disorder | 7 | 6.0 | 3 | 3.7 | 4 | 5.41 |
| Health Anxiety | 0 | 0 | 6 | 7.4 | 4 | 5.41 |
| Agoraphobia | 13 | 11.2 | 6 | 7.4 | 2 | 2.7 |
| Specific Phobia | 3 | 2.6 | 4 | 4.9 | 1 | 1.35 |

### 4.6.2. Anxiety Disorders Programme outcome measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2024. All service users attending the Anxiety Programme complete (or are rated on) the following measures: before starting the programme, after completing Level 1 of the programme and again after completing Level 2 (if they have attended this level).

- **Fear Questionnaire (FQ)**

The Fear Questionnaire (FQ) (Marks & Matthews, 1979) consists of 23 items that measure the extent to which potentially anxiety-provoking situations are avoided using a nine-point Likert scale ranging from zero – 'would not avoid', to eight – 'always avoid'. Four scores can be obtained from the Fear Questionnaire: main phobia level of avoidance, total phobia score, global phobia rating and associated anxiety and depression. For the purposes of this analysis the total phobia score was used. This measure has been found to be psychometrically sound with good discriminant validity and internal consistencies from .71 to .83 (Oei, Moylan, & Evans, 1991).

- **Yale Brown Obsessive Compulsive Scale (Y-BOCS)**

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

Obsessions and compulsions are each assessed on a five-point Likert scale ranging from zero – 'no symptoms', to four – 'severe symptoms', measuring the following: time spent engaging with obsessions and/or compulsions; the level of distress; the ability to

resist and level of control over obsessions and compulsions. Scores are rated across five levels: sub-clinical (0-7), mild (8-14), moderate (16-23), severe (24-31), and extreme (32-40).

- **Penn State Worry Questionnaire (PSWQ)**

The Penn State Worry Questionnaire (PSWQ) (Meyer, Miller, Metzger, & Borkovec, 1990) is designed to capture the generality, excessiveness, and uncontrollability of pathological worry. The PSWQ allows clinicians to identify individuals with generalised anxiety disorder (GAD) who present for treatment for anxiety disorders (Fresco et al, 2003).

The PSWQ is a 16-item self-report measure. Participants are asked to rate worries on a five-point Likert scale ranging from 'not at all typical of me', to 'very typical of me', capturing the generality, excessiveness and uncontrollability of pathological worry. Total scores range from 16 to 80, with higher scores indicating greater worry. The reliability and validity of the PSWQ has been widely researched, positively correlating with other self-report measures of worry and aggregate peer ratings showing it to be of sound psychometric properties.

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

The Social Safeness and Pleasure Scale (SSPS) (Gilbert et al., 2009), aims to measure service users' feelings of safety, warmth, acceptance and belonging within their social world. The measure is a brief 11-item, five-point Likert scale, with responses ranging from zero – 'almost never', to four – 'almost all the time'. Previous research has suggested that this scale's psychometric reliability is good (α =.92; Gilbert et al., 2009). This instrument was administered at two-time points, pre and post Level 2.

- **Social Phobia Inventory (SPIN)**

The Social Phobia Inventory (SPIN) (Connor et al, 2000) is a 17-item questionnaire developed by the Psychiatry and Behavioural Sciences Department at Duke University**.** The Social Phobia Inventory (SPIN) provides a patient-rated assessment of the three clinically important symptom domains of social phobia (fear, avoidance and physiological symptoms), with the practical advantages of brevity, simplicity and ease of scoring. The SPIN, which demonstrates solid psychometric properties, can be used

as a valid measure of severity of social phobia symptoms and is sensitive to the reduction in symptoms over time.

- **The Agoraphobia Scale**

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

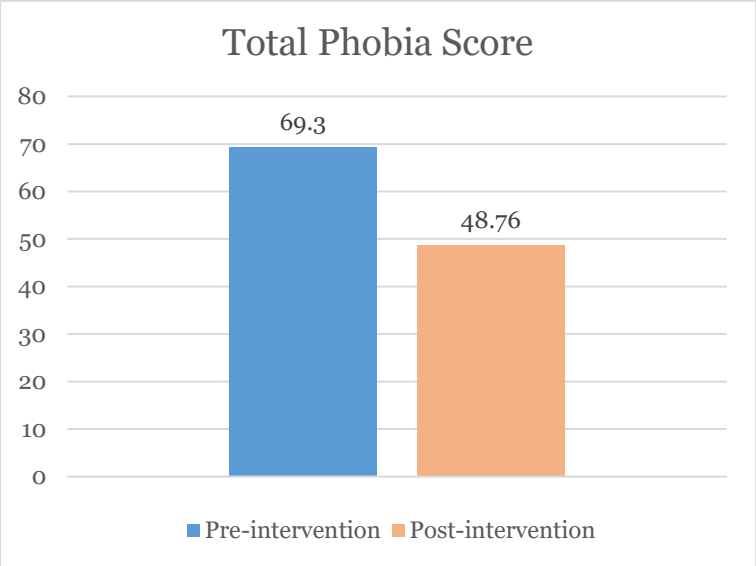
- **The Work and Social Adjustment Scale (WSAS):** See page 55

### Level 1 results

### The Fear Questionnaire (FQ)

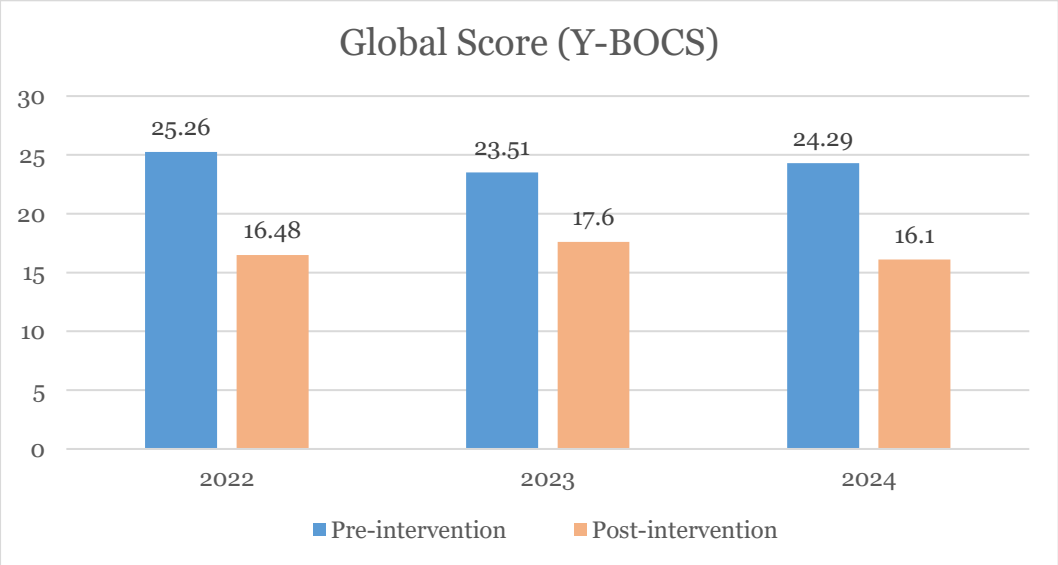
Analysis using a paired sample t-test revealed a statistically significant change between pre and post-intervention at Level 1 on the Total Phobia scores within the Fear Questionnaire, $t$ (85) = 10.95, $p$ < .001. The mean Total Phobia score decreased from 69.30 ($SD$ = 25.01) to 48.76 ($SD$ = 23.11), with a large effect size observed (Cohen's $d$= 1.18) (see Figure 4.8).

Figure 4.8. *Fear Questionnaire mean Total Phobia scores pre and post-intervention for 2024.*




**The Yale Brown Obsessive Compulsive Scale (Y-BOCS)**

Figure 4.9. *Yale Brown Obsessive Compulsive Scale mean total scores pre and post-intervention for 2022, 2023 and 2024.*

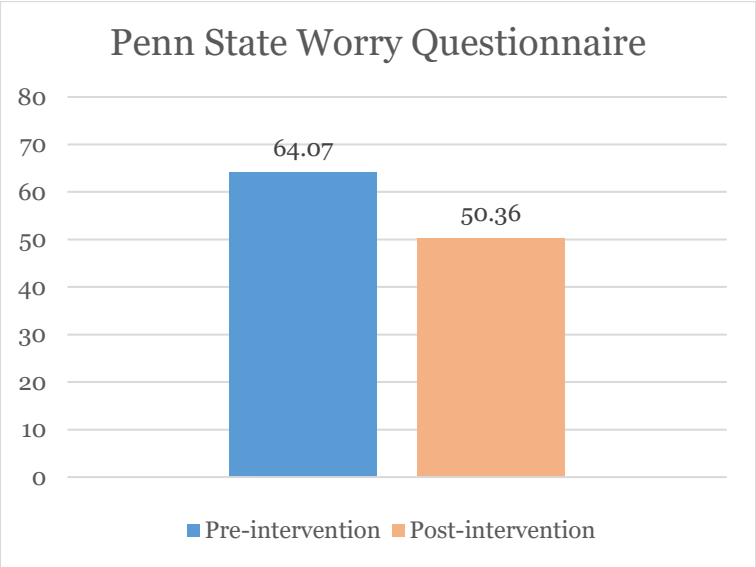



OCD symptomatology as measured by the Y-BOCS reduced from pre intervention to post-intervention. Analysis using a t-test indicated that scores on this measure decreased significantly, $t$ (41) = 8.52, $p$ <.001, with the total mean score changing from 24.29 ($SD$ = 6.92) to 16.10 ($SD$ = 6.24). This indicates an overall significant reduction in

the severity of OCD symptoms post-intervention with a large effect size (Cohen's *d* = 1.32) (see Figure 4.9).

### Penn State Worry Questionnaire (PSWQ)

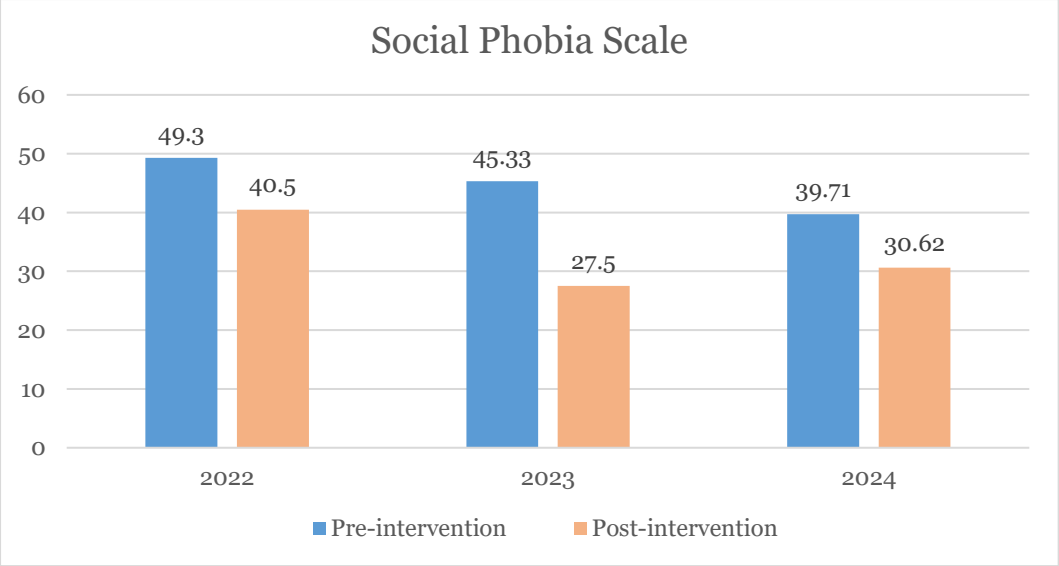
Figure 4.10. *Penn State Worry Questionnaire mean scores pre and post-intervention for 2024.*




Analysis of service user scores on the Penn State Worry Questionnaire, using a paired sample t-test, indicated a statistically significantly change in scores, *t* (13) = 7.39, p < .001, between pre-intervention (*M*= 64.07, SD = 10.03) and post-intervention (*M*= 50.36, SD = 8.55). This change reflected a large effect size (Cohen's *d*= 1.98) (see Figure 4.10).

### Social Phobia Inventory (SPIN)

Figure 4.11. *Social Phobia Inventory mean scores pre and post intervention in 2022, 2023 and 2024.*

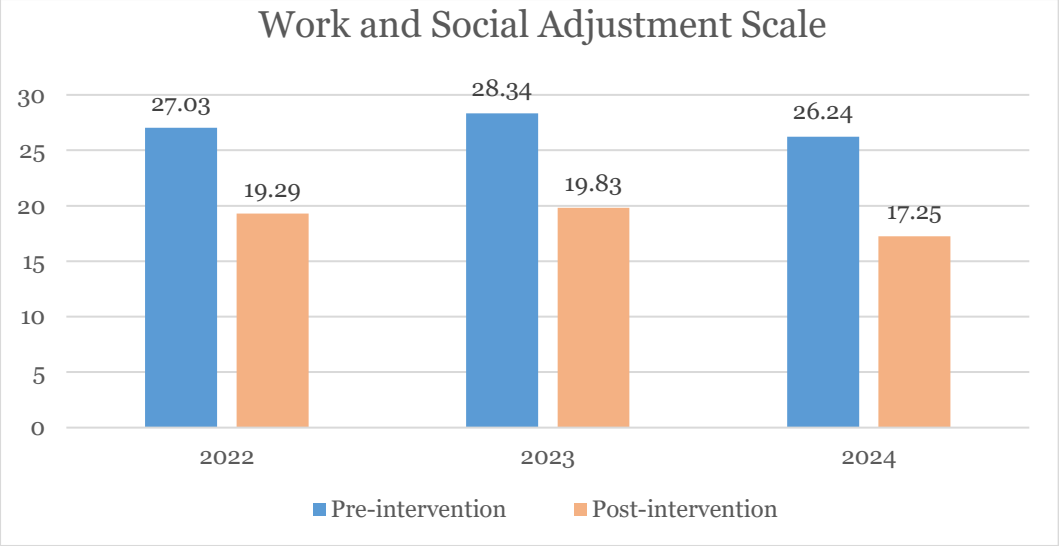



Analysis of the SPIN using a paired sample t-test indicated a statistically significant reduction in service users scores, $t$ (20) = 6.11, $p < .001$, from pre-intervention ($M$= 39.71, SD = 15.15) to post-intervention ($M$= 30.62, $SD$ = 15.93). This reflected a large effect size (Cohen's $d$= 1.33) (see Figure 4.11).

### Work and Social Adjustment Scale (WSAS)

Analysis of the WSAS using a t-test indicated that there was a statistically significant reduction in mean scores observed, $t$ (88) = 11.06, $p < .001$, from pre-intervention ($M$ = 26.24, $SD$ = 9.65) to post-intervention ($M$ = 17.25, $SD$ = 8.71) at Level 1. This result reflected a large effect size (Cohen's $d$ = 1.17) (see Figure 4.12).

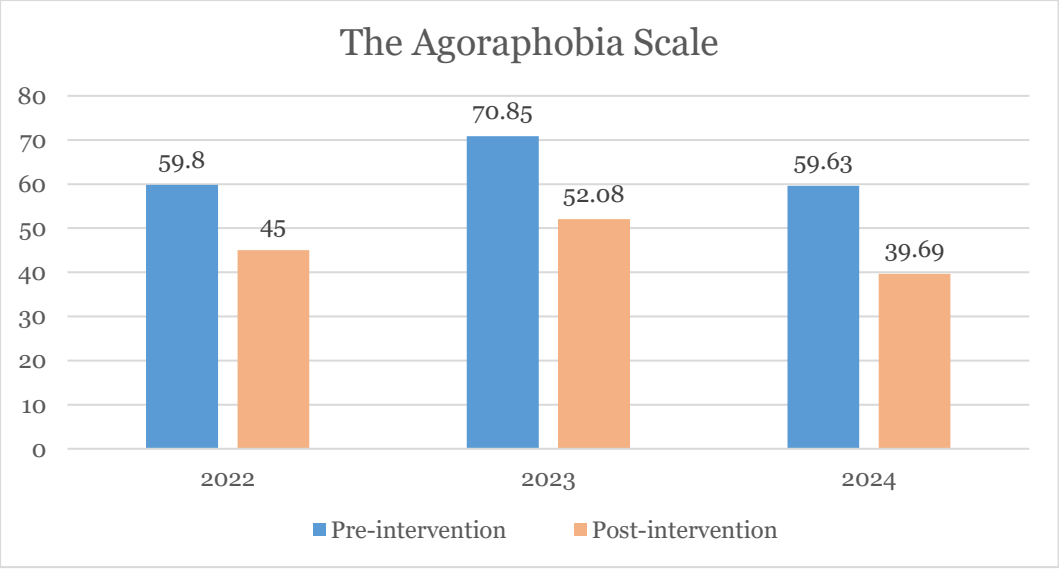
Figure 4.12. *Work and Social Adjustment Scale Group mean score pre and post-intervention for 2022, 2023 and 2024.*




### The Agoraphobia Scale

Scores on the Agoraphobia Scale reduced from pre-intervention (*M*= 59.63, *SD* = 26.94) to post-intervention (*M*= 39.69, *SD* = 23.89). Analysis of the Agoraphobia Scale using a paired samples t-test indicated that this result did represent a statistically significant reduction in mean total scores, *t* (15) = 5.63, p < .001. A large effect size was observed (Cohen's *d*= 1.41) (see Figure 4.13).

Figure 4.13. *The Agoraphobia Scale mean scores pre and post-intervention for 2022, 2023 and 2024*



### Level 2 results

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 14 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

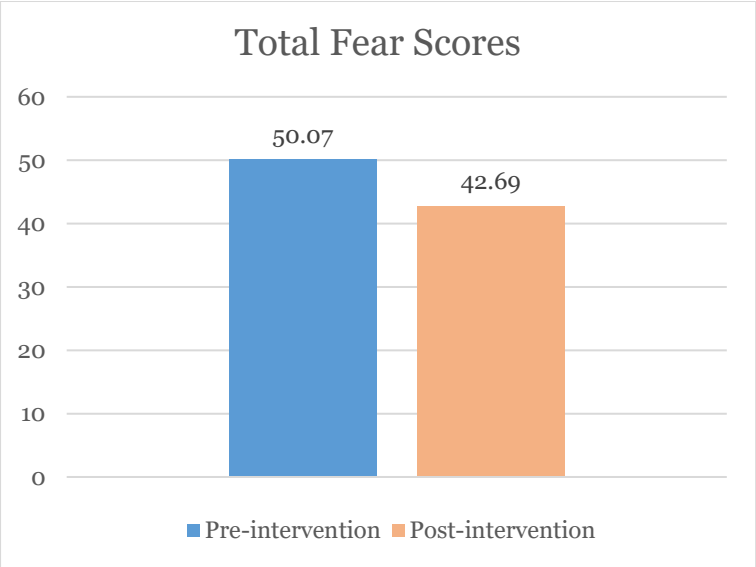
### The Fear Questionnaire (FQ)

Due to the small sample size, changes in the FQ scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in FQ scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values equal to or larger than 1.96. The cut-off score indicating clinically meaningful improvement on the FQ was 38. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and FQ score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below FQ cut-off score), "no reliable change" (did not pass RCI criterion) or "reliable deterioration" (passed RCI criterion but symptom score increased). One participant (7.69%) reported clinically significant improvement, eleven participants reported uncertain change (84.62%), and one participant (7.69%) reported reliable deterioration (see table 4.8).

Table 4.8. *Results from Reliable Change Index (RCI) for the FQ pre and post scores for each group member.*

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 96 | 131 | 2.57 | Reliable deterioration |
| 2 | 40 | 39 | -0.07 | Uncertain change |
| 3 | 62 | 34 | -2.06 | Reliable improvement |
| 4 | 34 | 23 | -0.81 | Uncertain change |
| 5 | 39 | 24 | -1.10 | Uncertain change |
| 6 | 22 | 22 | 0.00 | Uncertain change |
| 7 | 18 | 12 | -0.44 | Uncertain change |
| 8 | 88 | 84 | -0.29 | Uncertain change |
| 9 | 60 | 38 | -1.62 | Uncertain change |
| 10 | 41 | 30 | -0.81 | Uncertain change |
| 11 | 37 | 21 | -1.17 | Uncertain change |
| 12 | 74 | 61 | -0.95 | Uncertain change |
| 13 | 53 | 36 | -1.25 | Uncertain change |

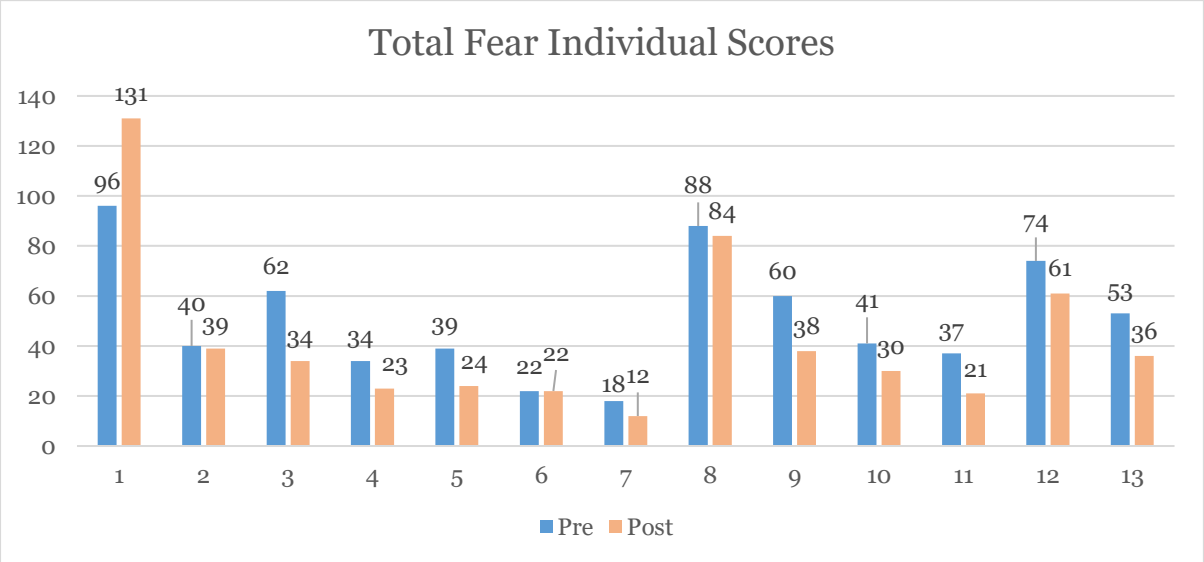
Figure 4.14. *The Fear Questionnaire, Mean Symptom pre and post-intervention*




Comparison of service user mean scores on the Fear Questionnaire indicated a decrease in scores from pre-intervention (*M* = 50.07; *SD* = 23.36) to post-intervention (*M* = 42.69; *SD* = 32.58) (see Figure 4.14).

Further examination of the individual scores indicates that 10 out of 13 (76.92%) participants showed a reduction in total scores from pre-intervention to post-intervention (see Figure 4.15).

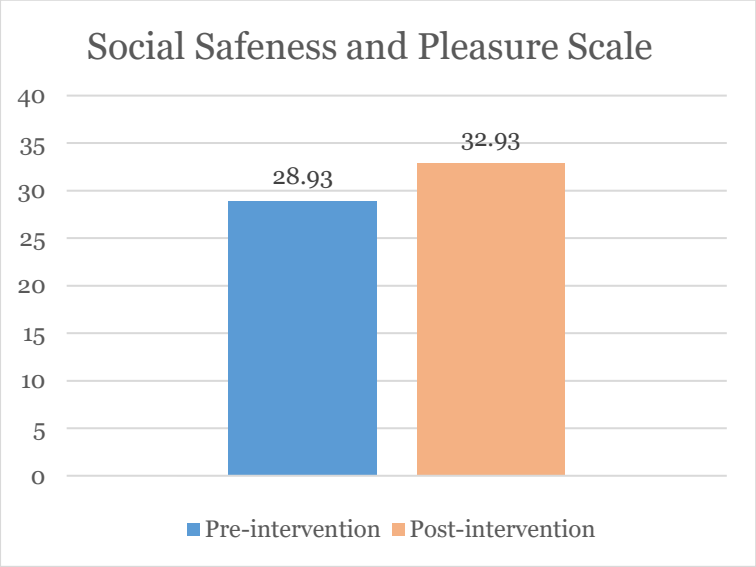
Figure 4.15. *Pre and post individual scores of the Fear Questionnaire.*



### The Social Safeness and Pleasure Scale (SSPS)

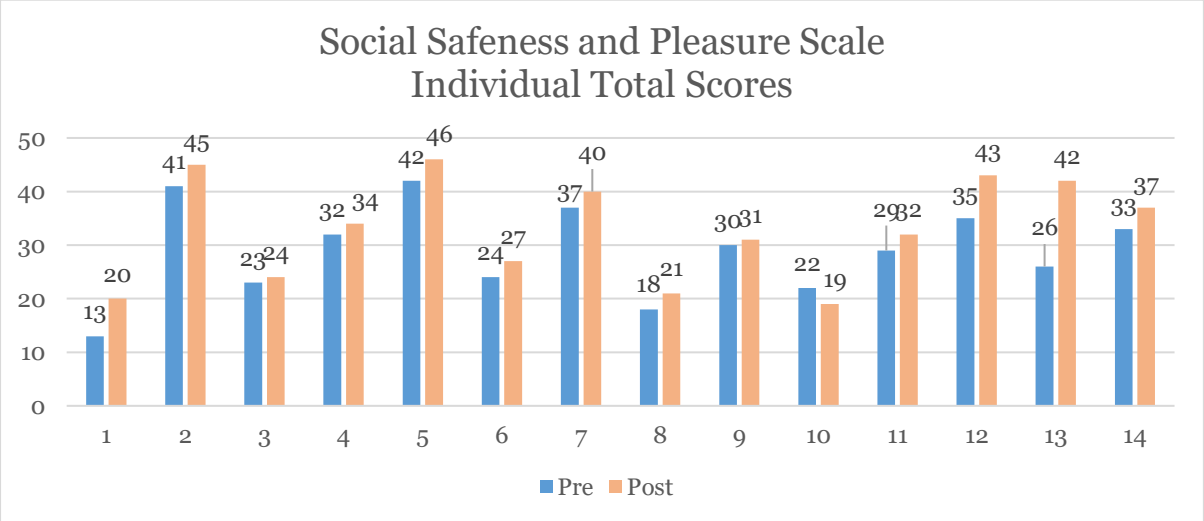
Comparison of service user mean scores on the Social Safeness and Pleasure Scale indicated an increase in scores from pre-intervention (*M* = 28.93; *SD* = 8.48) to post-intervention (*M* = 32.93; *SD* = 9.57) (see Figure 4.16).

Figure 4.16. *The Social Safeness and Pleasure Scale mean scores pre and post-intervention*




Further examination of the individual scores indicates that 13 out of 14 (92.86%) participants showed a reduction in the Social Safeness and Pleasure Scale total scores from pre-intervention to post-intervention (see Figure 4.17).

Figure 4.17. *Pre and post individual scores of the Social Safeness and Pleasure Scale.*



### 4.6.3. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2024 suggested significant reductions in anxiety and depression symptoms, OCD symptoms and reductions in pathological worrying and social anxiety; in line with previous years.

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the Anxiety Disorders Programme in 2024 suggest further increases in feelings of safety, warmth, acceptance and belonging within their social world.

Changes in scores for most measures have been consistently positive across the data since 2011, following both Level 1 and Level 2, indicating that the Anxiety Disorders programme continues to be a reliable and effective support to those who have completed the programme.

## 4.7. Bipolar Recovery Programme

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

There are three elements to the Bipolar Recovery Programme. Of note, in previous years, the programme also included the Bipolar Seminar Series. However, the content of the seminar series has now been incorporated into the other elements of the programme to more effectively deliver this content.

### Bipolar Programme Workshop

The Bipolar Programme Workshop takes place while the service user is an inpatient in SPMHS or receiving care through our Homecare service. This single-session workshop

is a chance for the service user to develop an initial understanding of bipolar disorder, the signs and symptoms, the phases of recovery, the triggers, and the treatment options available.

### Bipolar Recovery Programme

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

### Bipolar Aftercare Programme

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

### 4.7.1. Descriptors

Paired data were available for 14 service users who completed the programme in 2024: 9 females (64.3%) and 5 male (35.7%). The age profile of participants ranged from 22 to 81 years, with the average age being 52.79 years.

### 4.7.2. Bipolar Recovery Programme Outcome Measures

- **The Work and Social Adjustment Scale (WSAS):** see page 55
- **The Goldberg Mania Scale**

The Goldberg Mania Scale is a self-administered questionnaire designed to measure the severity of manic thinking and behavior. This tool was designed by Dr Ivan K Goldberg, MD and this tool *is not* designed to diagnose any psychiatric disorder. It is only intended to measure the severity of manic symptoms. The test is made up of

eighteen questions. The higher the number, the more severe the mania. If you take the questionnaire again weekly or monthly, changes of five or more points between tests may be significant. This questionnaire is only valid for people aged 18 or older and where symptoms have caused distress and/or interfered with functioning in one or more important areas of life such as home, work, school, or interpersonal relationships.

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

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

The Quick Inventory of Depression Symptomatology (QIDS) (Rush et al., 2003) is a 16-item measure used to assess the severity of depression symptoms. The items cover the nine diagnostic domains of depression as identified in the DSMS-IV: sad mood, concentration, self-criticism, suicidal ideation, interest, energy/fatigue, sleep disturbance and decrease or increase in appetite. It utilises a four-point rating scale, with a score of zero = none, one = mild, two = moderate, three = severe and, four = very severe. Total scores range from 0 - 27. The QIDS has been found to have high internal consistency with a Cronbach's alpha of 0.83. The QIDS is based on the 30-item IDS questionnaire, for which it has good concurrent validity (Ware et al, 1996). The IDS is shown to have comparative sensitivity and specificity to the IDS the HRSD (Rush et al. 1996, 2000, 2003, in press), BDI (Rush et al. 1996), MADRS and SCL-90 (Corruble et al. 1996).

### 4.7.3. Results

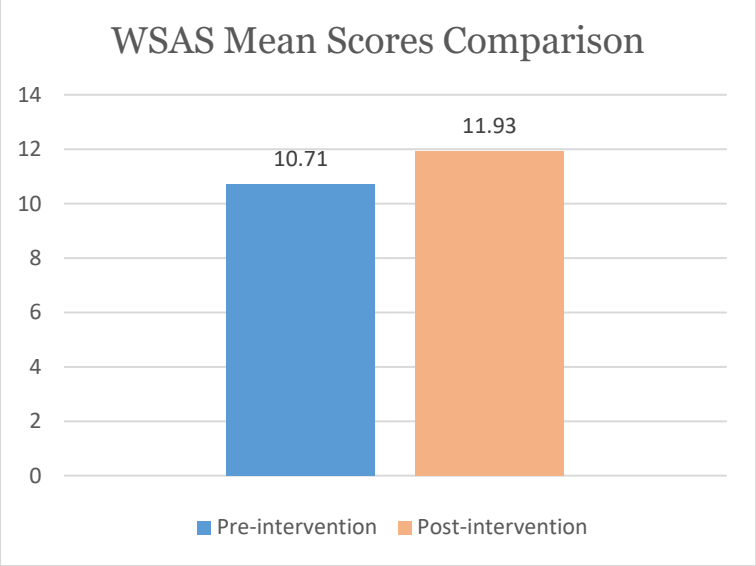
Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been

required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 14 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

### The Work and Social Adjustment Scale (WSAS)

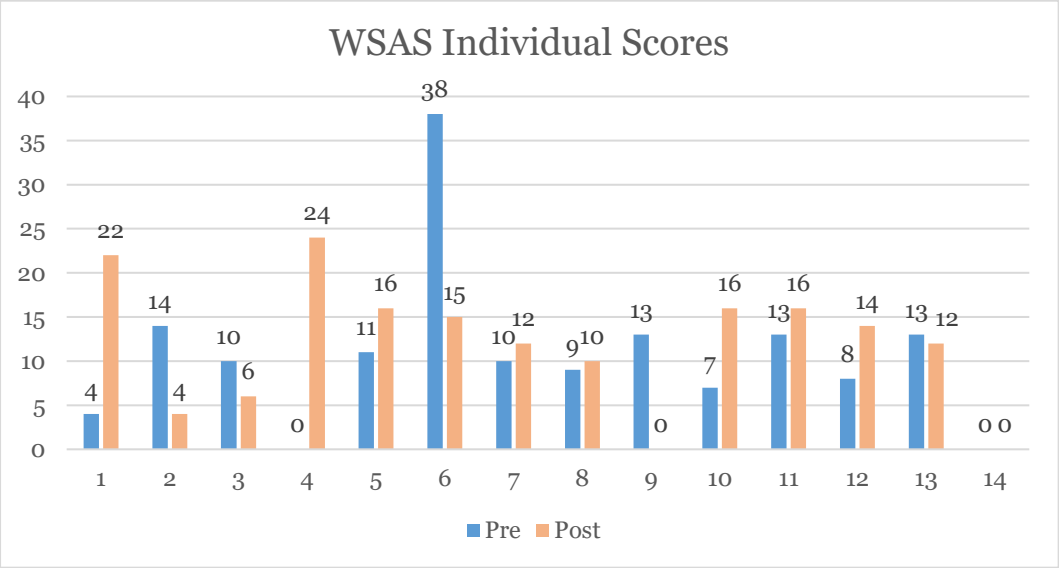
Comparison of service user mean scores on the WSAS indicated an increase in impairment functioning from pre-intervention (M = 10.71, SD = 9.08) to post intervention (11.93, SD = 7.32).

Figure 4.18. *Total mean scores pre and post-inervention of the Work and Social Adjustment Scale (WSAS).*




As can be seen from Figure 4.19, further examination of the individual scores indicates that five out of fourteen participants (35.71%) demonstrated a reduction in WSAS scores from pre-intervention to post-intervention. Eight out of fourteen (57.14%) participants demonstrated an increase in WSAS scores, and one participant demonstrated no change in scores (7.14%).

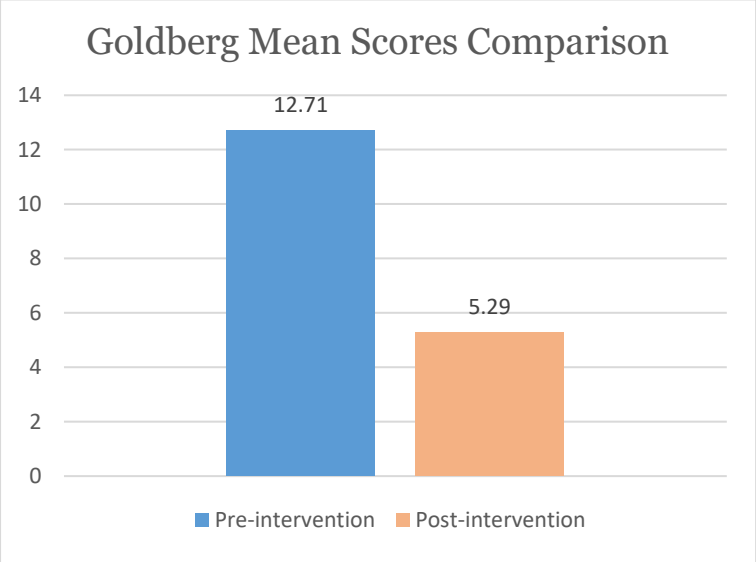
Figure 4.19. *Pre and post individual scores of the Work and Social Adjustment Scale (WSAS).*




### The Goldberg Mania Scale

There was a decrease in total scores for the Goldberg Mania Scale from pre-intervention (*M* = 12.71, *SD* = 10.3) to post-intervention (*M* = 5.29, *SD*= 7.57). This finding indicates that those who completed the bipolar programme in 2024 had a reduction in mania symptoms post-intervention (see Figure 4.20).

Figure 4.20. *Total Goldberg Mania Scale mean scores pre and post-inervention*



Due to the small sample size, changes in the Goldberg scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in Goldberg scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values equal to or larger than 1.96. The critical change score indicating clinically meaningful improvement on the Goldberg was a change of 14.58 points. Participants were classified as "reliable improvement" (passed RCI criterion), "uncertain change" (did not pass RCI criterion) or "reliable deterioration" (passed RCI criterion but symptom score increased). Results from the RCI demonstrated that four out fourteen participants (28.57%) demonstrated reliable improvement and ten out of fourteen participants (71.43%) demonstrated uncertain change (see table 4.9).

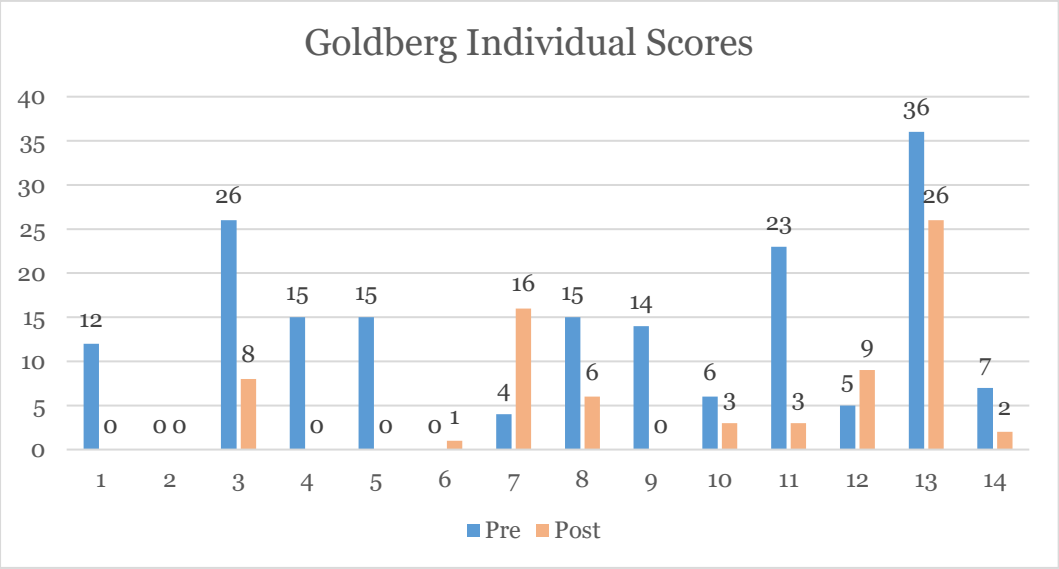
Table 4.9. *Results from Reliable Change Index (RCI) for the Goldberg Mania Scale pre and post scores for each group member.*

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 12 | 0 | -1.61 | Uncertain change |
| 2 | 0 | 0 | 0.00 | Uncertain change |
| 3 | 26 | 8 | -2.42 | Reliable improvement |
| 4 | 15 | 0 | -2.02 | Reliable improvement |
| 5 | 15 | 0 | -2.02 | Reliable improvement |
| 6 | 0 | 1 | 0.13 | Uncertain change |
| 7 | 4 | 16 | 1.61 | Uncertain change |
| 8 | 15 | 6 | -1.21 | Uncertain change |
| 9 | 14 | 0 | -1.88 | Uncertain change |
| 10 | 6 | 3 | -0.40 | Uncertain change |
| 11 | 23 | 3 | -2.69 | Reliable improvement |
| 12 | 5 | 9 | 0.54 | Uncertain change |

| | | | | |
|---|---|---|---|---|
| 13 | 36 | 26 | -1.34 | Uncertain change |
| 14 | 7 | 2 | -0.67 | Uncertain change |

As can be seen from Figure 4.21, further examination of the individual scores indicates that ten out of fourteen participants (71.43%) demonstrated a reduction in Goldberg scores from pre-intervention to post-intervention. Three out of fourteen participants (21.43%) demonstrated an increase in Goldberg scores, and one participant (7.14%) demonstrated no change in scores from pre-intervention to post-intervention.

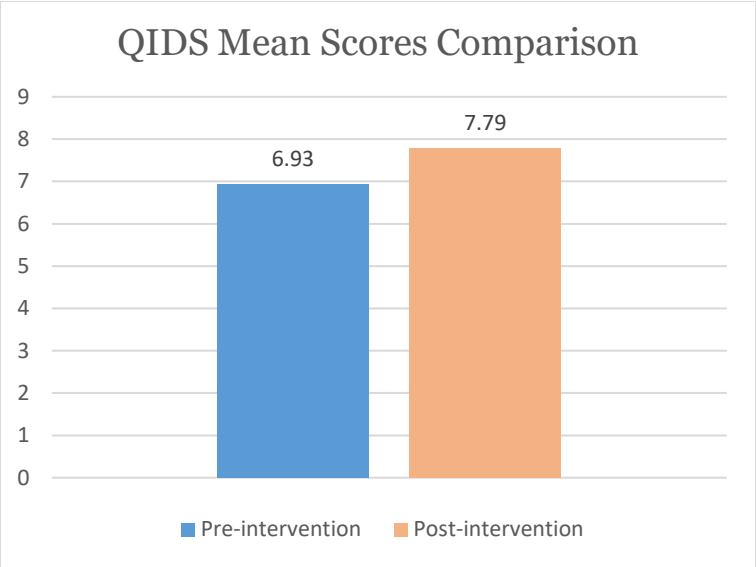
Figure 4.21. *Pre and post individual scores of Goldberg Mania Scale.*




### Quick Inventory of Depression Symptomatology (QIDS)

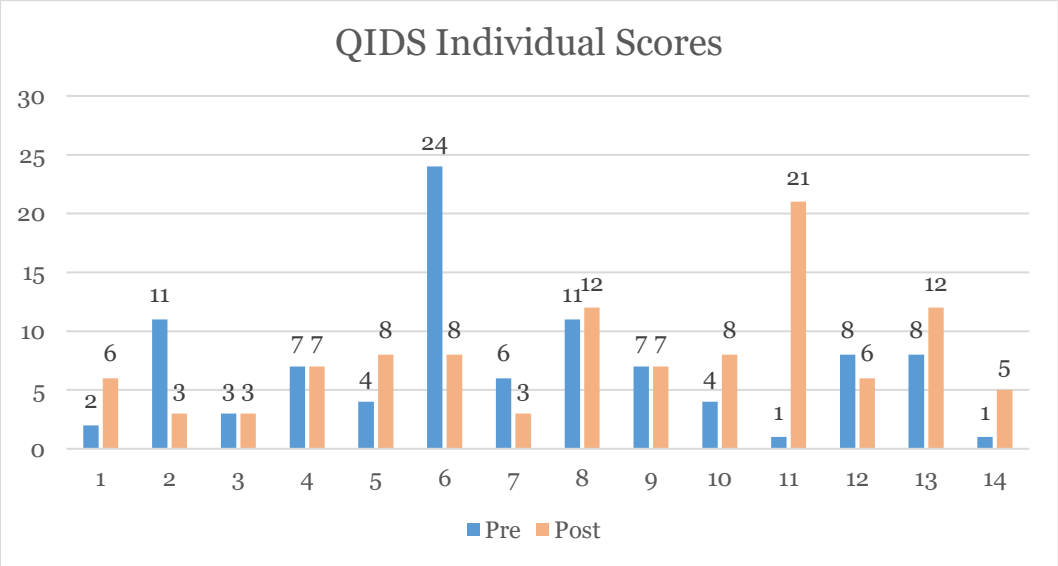
Comparison of service user mean scores on the QIDS indicated an increase of depression severity scores from pre-intervention ($M$ = 6.93, $SD$ = 5.92) to post-intervention ($M$ = 7.79, $SD$ = 4.76) (see Figure 4.22).

Figure 4.22. *Total QIDS mean scores pre and post-inervention*




As can be seen from Figure 4.23, further examination of the individual scores indicates that four out of fourteen participants (28.57%) demonstrated a reduction in QIDS scores from pre-intervention to post-intervention. Seven out of fourteen participants (50%) demonstrated an increase in scores, and three out of fourteen participants (21.43%) demonstrated no chance in scores pre-intervention to post-intervention.

Figure 4.23. *Pre and post individual scores of the Quick Inventory of Depression Symptomatology (QIDS).*



### 4.7.4. Summary

This is the third year the bipolar programme has been included in the SPMHS Outcomes Report. The aim of the programme is to improve overall functioning and reduce the severity of bipolar symptoms such as mania and depression. In 2024, of those who completed the programme, 14 people completed outcome measures. Three measures were used to assess the efficacy of the programme; the WSAS, which examines functioning impairment; the Goldberg Mania Scale which examines mania symptoms and the QIDS which assesses depression symptoms. The findings indicate that those who completed the programme in 2024 yielded overall reductions in their functioning impairment on the Goldberg Mania Scale.

Increases in mean scores on the WSAS and QIDs may be due to outliers seen in individual scores below. Additionally, individuals referred to the programme can further decompensate rapidly and additionally, and a number of service users experienced higher symptoms of mania in the 2024 report compared to reports from previous years. In light of these findings, the programme is currently under review.

## 4.8. Building Healthy Self-Esteem Programme

The Building Healthy Self-Esteem (BHSE) Programme is designed to help individuals build healthy self-esteem using cognitive behavioural therapy. The course is aimed for service users with low self-esteem. This can be a debilitating phenomenon often leading to, or exacerbating, anxiety and/ or depression. CBT can help the individual address their low self-esteem and develop a more positive attitude towards themselves, whereby the individual acts in an accepting, respectful and trusting manner towards themselves. The group is facilitated by a team of mental health professionals, including a cognitive behavioural therapist and nurses with expertise in cognitive psychotherapy, compassion- focused therapy and mindfulness-based stress reduction. The programme runs for a half day a week for 10 weeks over Microsoft Teams.

### 4.8.1. Descriptors

Complete pre and post-outcome data were available for 9 people. The decrease in participant numbers for the programme from the 2023 to 2024 report was largely due to the transition to a new data collection system at the beginning of the year. This issue was resolved in later cycles of the programme. Six participants (66.7%) were female and three (33.3%) were male. Participants ages ranged from 27 to 72 years with an average age of 53.33 years old.

### 4.8.2. Building Healthy Self-Esteem Programme outcome measures

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

The Rosenberg Self Esteem Scale (RSES) is a ten-item scale that measures self-esteem on a four-point Likert-type scale — from strongly agree, to strongly disagree. The RSES is one of the most widely used measures of self-esteem (Sinclair et al., 2010). Self-esteem is not a singular construct and has been divided equally to measure two 5-item facets; self-competence and self-liking. The minimum total score is 0 and the maximum is 30, with higher scores representing higher self-esteem. To interpret the RSES, scores of 0-14 indicate low self-esteem, scores of 15-25 are within normal range, and scores above 25 indicate high self-esteem. The scale has good predictive validity, as well as internal consistency and test–retest reliability (Schmitt & Allik, 2005; Torrey, Mueser, McHugo, & Drake, 2000).

- **The Generalised Anxiety Disorder-7 (GAD-7)**

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

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

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

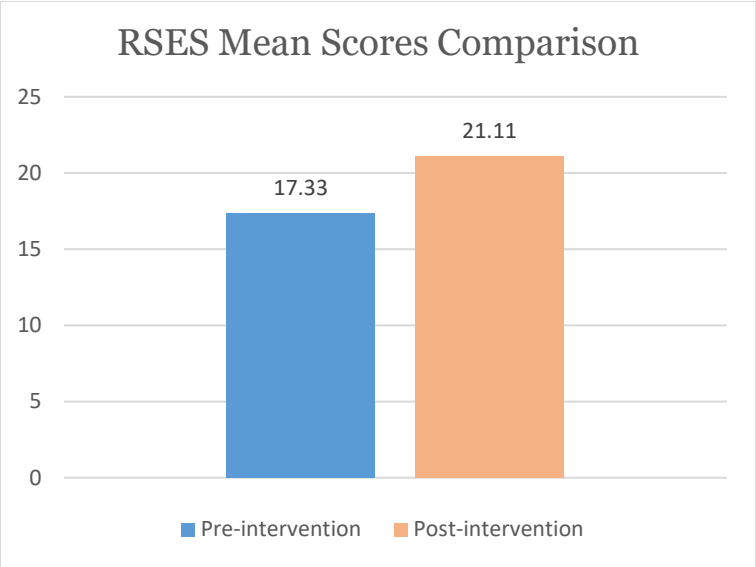
appetite, and other possible symptoms of depression. It assesses how often service user has “been bothered by any of the following problems” in the past two weeks. Scores are calculated based on how frequently a person experiences these feelings and aims to predict the presence and severity of depression. Scores represent: 0-5 = mild, 6-10 = moderate, 11-15 = moderately severe anxiety, 15-21 = moderately severe and 15-21 = severe depression.

### 4.8.3. Results

#### The Rosenberg Self Esteem (RSES) Questionnaire

There was an increase in total Self Esteem scores for the RSES from pre- intervention (*M* = 17.33 *SD* = 4.39) to post-intervention (*M* = 21.11, *SD* = 4.31). This finding indicates that those who completed the BHSE programme in 2024 had an increase in their self-esteem post-intervention (see Figure 4.24).

Figure 4.24. *Pre and post mean scores of the Rosenberg Self Esteem Scale (RSES).*



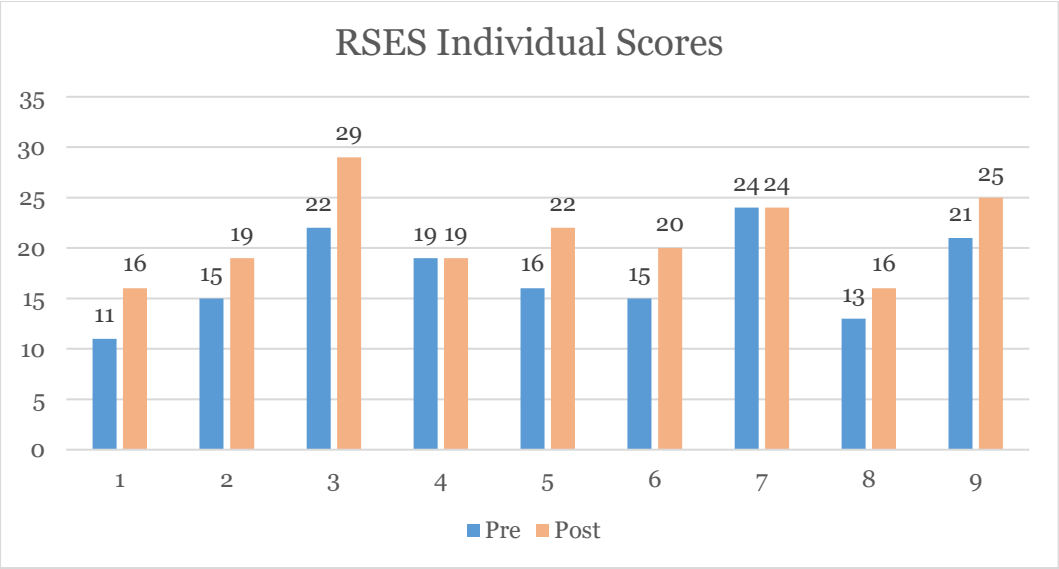

Due to the small sample size, changes in the RSES scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in RSES scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values larger than or equal to 1.96. The RCI critical change score was 4.21. Participants were classified as “reliable improvement” (passed RCI criterion and symptom score increased), “uncertain change” (did not pass RCI criterion) or “deterioration” (passed RCI criterion but symptom score decreased) (see table 4.10 below).

Table 4.10. *Results from Reliable Change Index (RCI) for the RSES pre and post scores for each group member.*

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 11 | 16 | 2.33 | Reliable improvement |
| 2 | 15 | 19 | 1.86 | Uncertain change |
| 3 | 22 | 29 | 3.26 | Reliable improvement |
| 4 | 19 | 19 | 0.00 | No change |
| 5 | 16 | 22 | 2.79 | Reliable improvement |
| 6 | 15 | 20 | 2.33 | Reliable improvement |
| 7 | 24 | 24 | 0.00 | No change |
| 8 | 13 | 16 | 1.40 | Uncertain change |
| 9 | 21 | 25 | 1.86 | Uncertain change |

Further examination of the individual scores indicates that seven out of nine participants (77.78%) demonstrated an increase in RSES scores from pre-intervention to post-intervention. In addition, two out of nine (22.22%) participants moved from the low self-esteem to normal self-esteem range of the scale; and two out of nine (22.22%) moved from the normal self-esteem to high self-esteem range (see Figure 4.25).

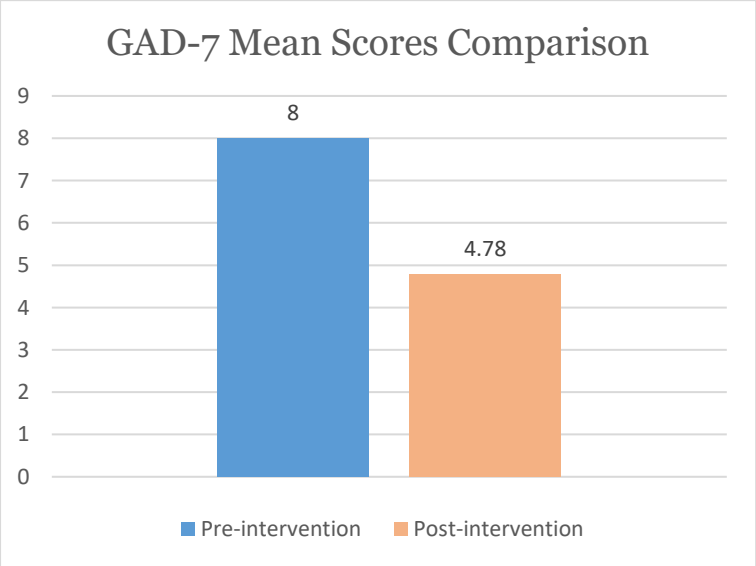
Figure 4.25. *Pre and post individual scores of the Rosenberg Self-Esteem Scale (RSES).*




### The Generalised Anxiety Disorder-7 (GAD-7)

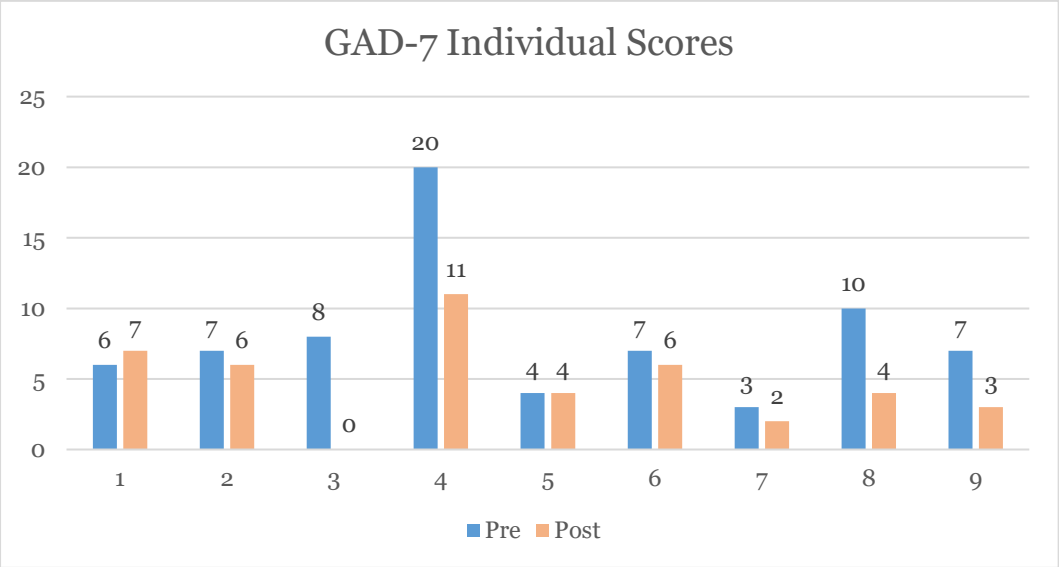
There was a decrease in total scores for the GAD-7 from pre-intervention (*M* = 8 *SD* = 4.95) to post-intervention (*M* = 4.78, *SD* = 3.19). This finding indicates that those who completed the BHSE programme in 2024 had a decrease in symptoms related to anxiety (see Figure 4.26).

Figure 4.26. *Pre and post mean scores of the Generalised Anxiety Disorder-7 (GAD-7) Scale.*



Further examination of the individual scores indicates that seven out of nine participants (77.78%) demonstrated a decrease in GAD-7 scores from pre-intervention to post-intervention (see Figure 4.27).

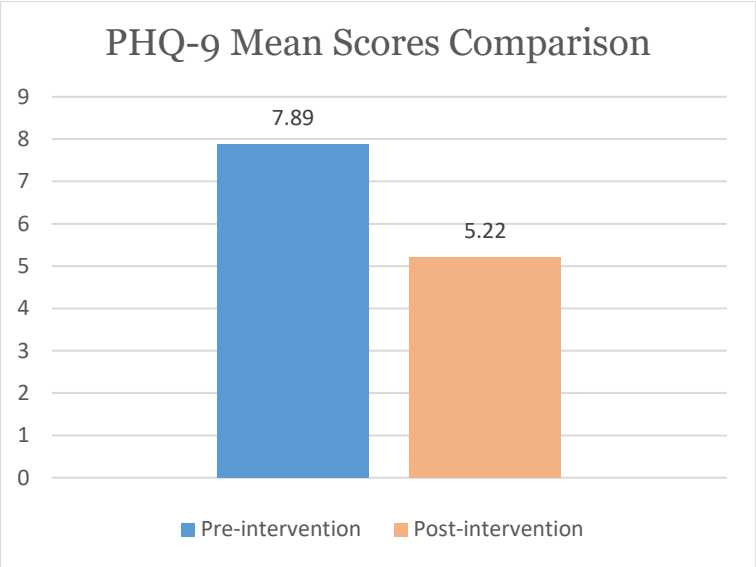
Figure 4.27. *Pre and post individual scores of the Generalised Anxiety Disorder-7 (GAD-7) Scale.*




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

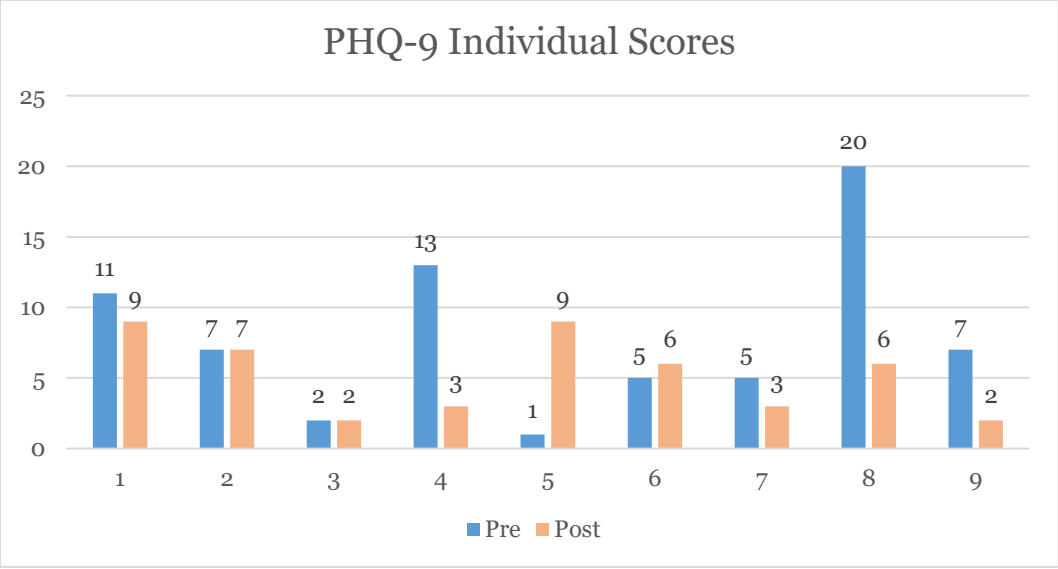
There was a decrease in total scores for the PHQ-9 from pre-intervention (*M* = 7.89 *SD* = 5.95) to post-intervention (*M* = 5.22, *SD* = 2.82). This finding indicates that those who completed the BHSE programme in 2024 had a decrease in symptoms related to depression (see Figure 4.28).

Figure 4.28. *Pre and post mean scores of the Patient Health Questionnaire-9 (PHQ-9).*




Further examination of the individual scores indicates that five out of nine participants (55.56%) demonstrated a decrease in PHQ-9 scores from pre-intervention to post-intervention (see Figure 4.29).

Figure 4.29. *Pre and post individual scores of the Patient Health Questionnaire-9 (PHQ-9).*




## Summary

The Building Healthy Self-Esteem Programme has been run in St Patrick's Mental Health Services for three years. The results of the programme show that there were

reductions in both symptoms related to depression and severity of depressive symptoms reduced, and post-intervention there was an increase in their self-esteem.

## 4.9. Compassion-Focused Therapy Programme

Compassion-Focused Therapy (CFT) was developed by Prof Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Gilbert, 2009; Leaviss & Uttley, 2014). It is an integrative, multi-modal approach that draws on evolutionary psychology, neuroscience, attachment theory, cognitive behaviour therapy, mindfulness, and compassion-focused practices. CFT recognises the importance of being able to engage with our suffering in a compassionate way and helps people to respond to distress and challenging emotions (Kolts, 2016).

Research has demonstrated the importance of self-compassion for psychological functioning (Neff & Germer, 2017). Jazaeir et al. (2012) identified compassion as a predictor of psychological health and wellbeing and found that it was associated with fewer negative feelings and stress, as well as more positive feelings and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for service users experiencing high shame and criticism. Research has found that CFT is associated with reductions in depression, anxiety, shame and self-criticism, and increased ability to self-soothe in response to emotional distress (Lucre & Corten, 2012).

Research conducted in SPMHS demonstrated that group CFT was effective in reducing symptoms of mental ill health for service users who attended the group. These findings were associated with improvements in self-criticism and fears of self-compassion (Cuppage, Baird, Gibson, Booth & Hevey, 2017). A further research study carried out at SPMHS investigated subjective bodily changes associated with attending a transdiagnostic CFT group (Mernagh, Baird & Guerin, 2020). Results suggest that service users who attended the CFT group developed an increase in mind-body attunement. That is, they developed their capacity to listen to, and trust, their own bodily sensations as a source of important information about their emotions, as well as to regulate their emotions through responding to associated physical sensations with increased compassion and understanding.

The Compassion-Focused Therapy (CFT) programme commenced in SPMHS in 2014 and is facilitated by the psychology department. In 2022, the CFT programme implemented a new structure including a Level 1 Introduction to CFT Psychoeducation Group, followed by a Level 2 Therapy Group aimed to reduce the waiting times for service users wishing to access the CFT group. As this effectively reduced waiting times, the CFT programme returned to its original structure of combined psychoeducation and therapy within the 18-session model CFT group. It was felt that the combined structure was the best fit for the needs of the current service users and staff group. Eight cycles of the CFT programme ran in 2024.

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

### Descriptors

Pre and post data was available for 48 individuals who completed the CFT programme in SPMHS in 2024. 37.5% of these were female (N = 18) and 62.5% were male (N = 30). Programme attendees ranged in age from 20 to 69 years old with a mean age of 43 (*M* =42.56, *SD*= 12.54).

### Outcome Measures

All service users attending the CFT Programme in SPMHS are invited to complete the following measures before starting the programme, and again after completion. These measures were selected on the basis of their use in published international scientific

research relating to compassion-focused therapy and having established reliability and validity (Lovibond & Lovibond, 1995; Gilbert et al, 2011; Gilbert et al, 2014).

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

The Depression Anxiety and Stress Scales (DASS-21) is a 21-item questionnaire that measures the three related states of depression, anxiety and stress (Lovibond & Lovibond, 1995). Each item is rated on a four-point Likert scale from zero – 'did not apply to me at all', to four – 'applied to me very much or most of the time'. Higher scores are indicative of greater psychological difficulty. Each of the three DASS-21 scales contain seven items, divided into sub-scales with similar content. Each item comprises a statement and four short response options to reflect severity. They are scored from zero – 'did not apply to me at all', to three – 'applied to me very much, or most of the time'.

The Depression Scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The Anxiety Scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal and being easily upset/agitated, irritable/over-reactive and impatient. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by non-clinical populations and clinical populations are essentially differences of degree. Cronbach alphas were .84 for the Anxiety Scale, .95 for the Depression Scale and .83 for the Stress Scale.

- **Fears of Compassion (FCS)**

The Fears of Compassion Scale (FCS) consists of three subscales measuring: fear of compassion for self (for example "I fear that if I am too compassionate towards myself bad things will happen"); fear of compassion from others (for example "I try to keep my distance from others even I know they are kind); and fear of compassion for others (for example "being too compassionate makes people soft and easy to take advantage of") (Gilbert, McEwan, Matos & Rivis, 2011). The scale consists of 38 items in total, each

rated on a five-point Likert scale from zero – 'don't agree at all', to four – 'completely agree'. Higher scores are indicative of greater fears of self-compassion. Cronbach alphas were .89 for the fear of compassion for others scale, .89 for the fear of compassion from others scale, and .86 for the fear of compassion to self scale.

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

The FSCRS was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004). This scale was developed to measure self-criticism and the ability to self-reassure. It is a 22-item scale that measures different ways people think and feel about themselves when things go wrong for them. The items make up three components, there are two forms of self-criticalness: inadequate self ("I am easily disappointed with myself"); and hated self ("I have become so angry with myself that I want to hurt or injury myself"), and one form to self-reassure ("I am able to remind myself of positive things about myself"). The responses are given on a five-point Likert scale ranging from zero – 'not at all like me, to four – 'extremely like me'. Cronbach alphas were .89 for the inadequate self scale, .89 for the hated self scale, and .85 for the reassured self scale.

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

The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to self, compassion to others and compassion experienced from others (Gilbert et al, 2017). Each scale consists of 13 items which generate an engagement subscale (such as motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgmental) and an action sub-scale (such as directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10-point Likert scale; one – 'never', to 10 – 'always'. High scores indicate high compassion. Cronbach alphas were .67 for compassion to self, .71 for compassion to others and .72 for compassion to others.

## Results

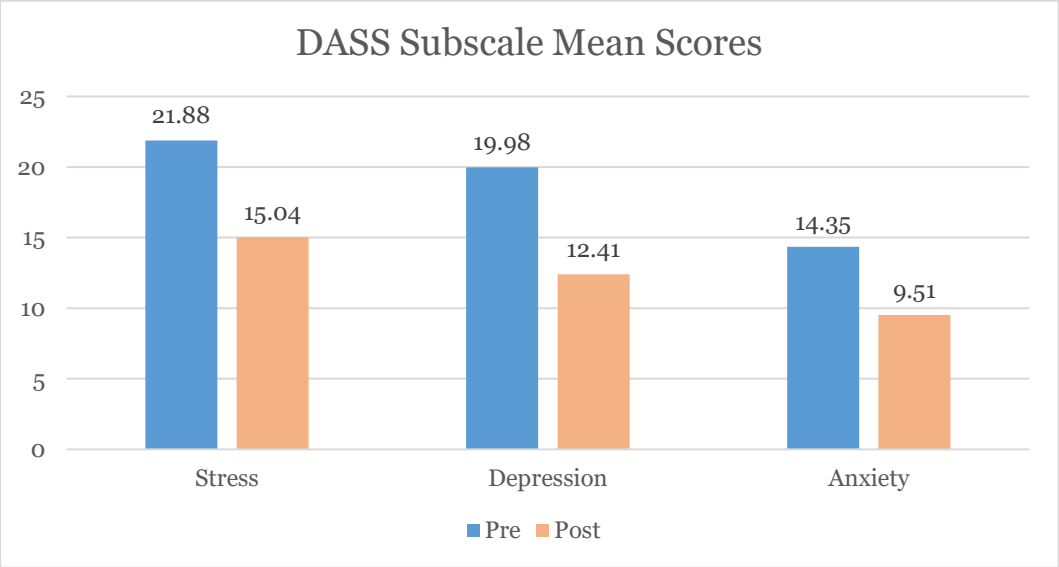
### Depression Anxiety and Stress Scales (DASS)

Analysis of the DASS Stress scores from the CFT therapy programme indicated that there was a significant decrease in reported stress, $t$ (47) = 4.50, $p$ < .001 representing a medium effect size *(d* = 0.65*)*. Participants mean scores decreased from 21.88 (*SD* = 11.38) at pre-intervention to 15.04 (*SD* = 8.79) after completing the programme.

Analysis of the DASS Depression scores from the CFT therapy programme indicated that there was a significant decrease in reported depressive symptoms, $t$ (47) = 4.55, $p$ <.001, with a medium effect size ($d$ = .66). Participants' mean scores decreased from 19.98 (*SD* = 11.86) at pre-intervention to 12.41 (*SD* = 9.59) after completing the programme.

Analysis of the DASS Anxiety subscale mean scores showed that levels of anxiety decreased significantly from 14.35 (*SD* = 9.63) at pre-intervention to 9.51 (*SD* = 8.43), following engagement in the programme, $t$ (47) = 3.60, $p$ < .001. This decrease demonstrated a medium effect size of $d$ = .52.

Figure 30. *DASS - Depression, Anxiety and Stress Subscale Mean Scores pre and post intervention.*




### The Fears of Compassion Scale (FCS)

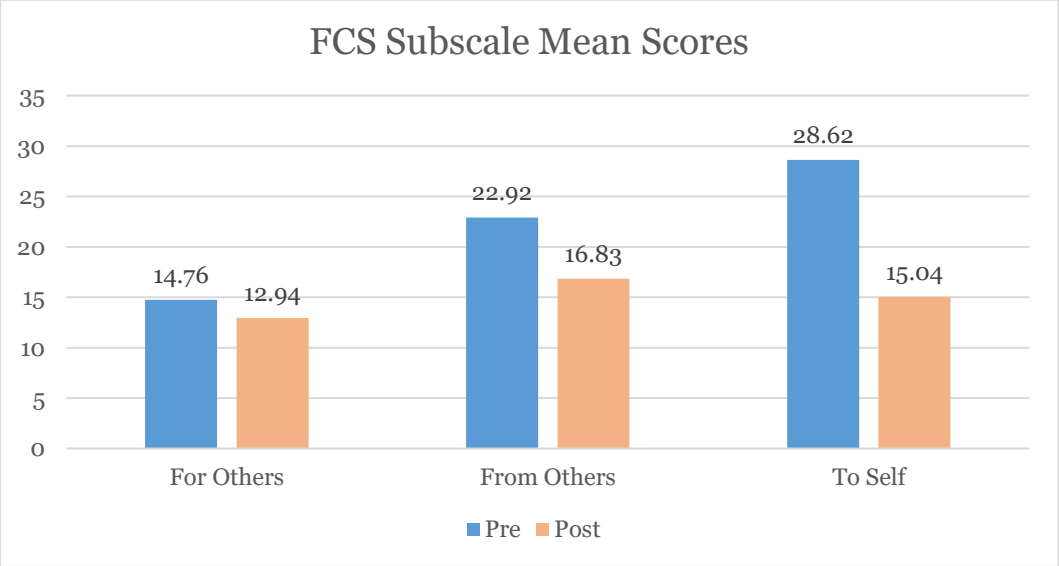
The FCS is divided into three scales: fear of expressing compassion for others, fear of responding to compassion from others, and fear of expressing kindness and compassion towards self. Mean scores on the subscales are presented below.

Mean scores on the fear of expressing compassion for others scale fell from 14.76 (*SD* = 7.54) at pre-intervention to 12.94 (*SD* = 7.38) at post-intervention. However, this reduction was not found to be statistically significant, $p = 0.053$.

A paired samples t-test demonstrated a statistically significant reduction in reported fear of responding to compassion from others, $t(47) = 3.83$, $p < 0.001$, representing a medium effect size ($d = .55$). Mean scores fell from 22.92 (*SD* = 12.77) at pre-intervention to 16.83 (*SD* = 10.78) at post intervention.

A paired samples t-test demonstrated a statistically significant reduction in fears of expressing kindness and compassion towards self, $t(47) = 6.82$, $p < 0.001$, representing a large effect size ($d = .98$). At pre-intervention, participants mean scores were 28.62 (*SD* = 13.56), compared to 15.04 (*SD* = 10.34) at post-intervention.

Figure 4.31. *Fears of Compassion Subscale Mean Scores pre and post intervention.*



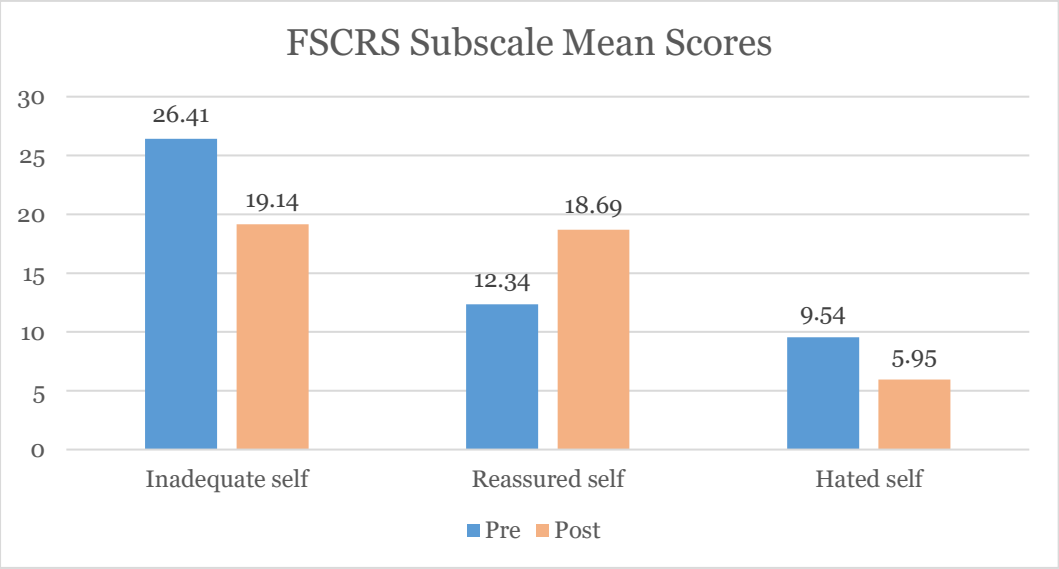

### The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Mean scores on the FSCRS 'inadequate self' subscale showed a significant decrease following engagement with the therapy programme, $t(47) = 5.55$, $p < .001$. Mean scores fell from 26.41 (*SD* = 6.33) at pre-intervention to 19.14 (*SD* = 7.58) at post-intervention, demonstrating a large effect size, ($d = 0.80$). Decreases in scores indicate reduced feelings of inadequacy.

Mean scores on the FSCRS 'reassured self' subscale showed a significant increase following engagement with the programme $t$ (47) = -5.80, $p$ < .001. Mean scores rose from 12.34 (*SD* = 6.22) at pre-intervention to 18.69 (*SD* = 7.30) at post-intervention, demonstrating a large effect size, ($d$ = -0.84). Increases in scores indicate increased feelings of reassurance in self.

Mean scores on the FSCRS 'hated self' subscale showed a significant decrease following engagement with the programme, $t$ (47) = 4.84, $p$ < 0.001. Mean scores fell from 9.54 (*SD* = 4.47) at pre-intervention to 5.95 (*SD* = 4.22) at post-intervention, demonstrating a medium effect size, ($d$ = .70). Decreases in scores indicate reduced feelings of self-hatred.

Figure 4.32. *FSCRS Subscale Mean Scores pre and post intervention.*




### Compassionate Engagement and Action Scale (CEAS)

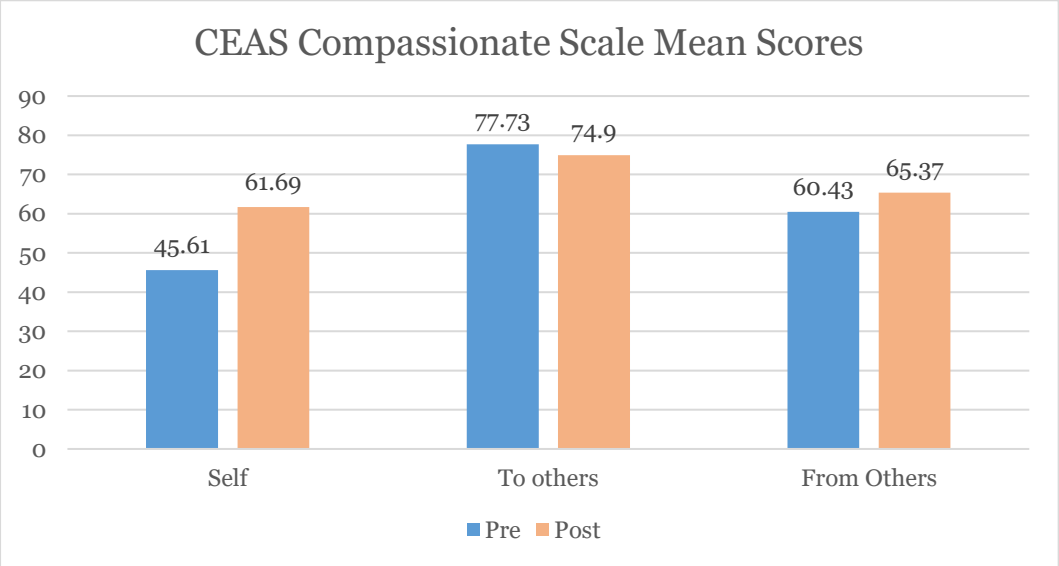
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores, and scores on the engagement and action subscales are reported below.

Significant increases were reported on the overall Compassion to Self-Scale from pre-intervention (*M* = 45.61, *SD* = 10.12) to post-intervention (*M* = 61.69, *SD* = 11.52), $t$ (47) = -8.46, $p$ <.001, with a large effect size (Cohen's $d$ = -1.22). These findings illustrate that participants' self-directed compassion increased from pre- to post-intervention.

Mean scores on the Compassion to Others-Scale increased from pre-intervention (*M* = 77.73, *SD* = 14.74) to post-intervention (*M* = 74.90, *SD* = 11.03). However, this increase was not statistically significant, *p* = 0.052.

Significant increases were reported on the overall Compassion from Others Scale from pre-intervention (*M* = 60.43, *SD* = 16.05) to post-intervention (*M* = 65.37, *SD* = 11.30), *t* (47) = -2.75, *p* = 0.008, with a large effect size (Cohen's *d* = -1.22). These findings illustrate that participants' compassion from others increased from pre- to post-intervention.

Figure 4.33. *CEAS Compassionate Scale Mean Scores pre and post intervention.*



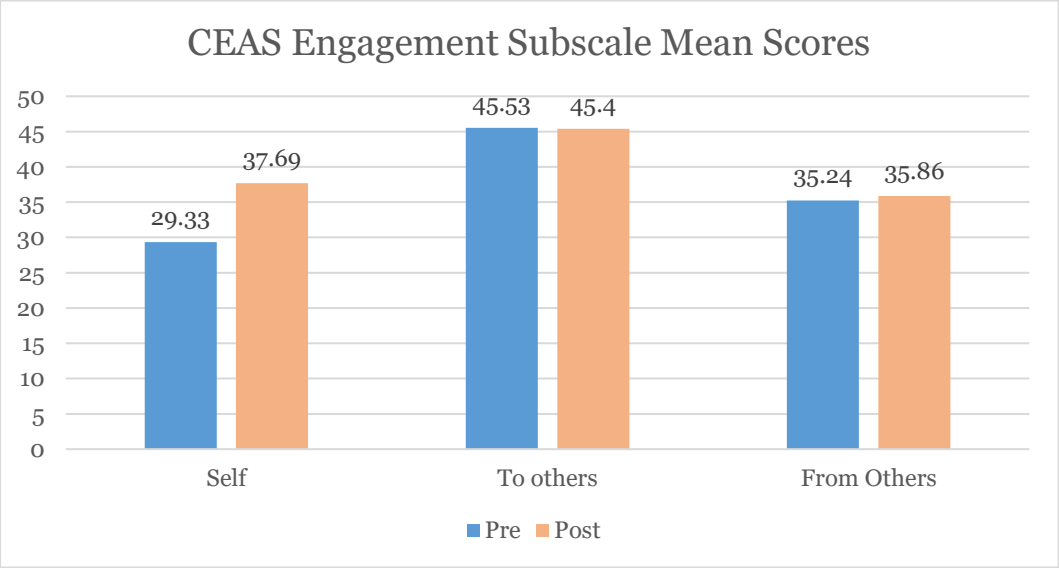

Within the Compassionate Engagement sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (*M* = 29.33, *SD* = 6.28) to post-intervention (*M* = 37.69, *SD* = 6.42), *t*(47) = -7.21, *p* < .001, with a large effect size (*d* = -1.04).

Mean scores was increased significantly on the Compassion to Others subscale within the Compassion Engagement subscales. Participant mean scores decreased marginally from pre-intervention (*M* = 45.53, *SD* = 9.23) to post-intervention (*M* = 45.40, *SD* = 6.85). However, this decrease was not statistically significant, *p* = 0.90.

An increase in mean scores was observed on the Compassion from Others subscale within the Compassionate Engagement sub-scales. Scores on this subscale slightly increased from 35.24 (*SD* = 9.67) pre intervention to 35.86 (*SD* = 9.54). However, this increase was not statistically significant, *p* = 0.63.

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

Figure 4.34. *CEAS Compassionate Engagement Subscale Mean Scores pre and post intervention.*

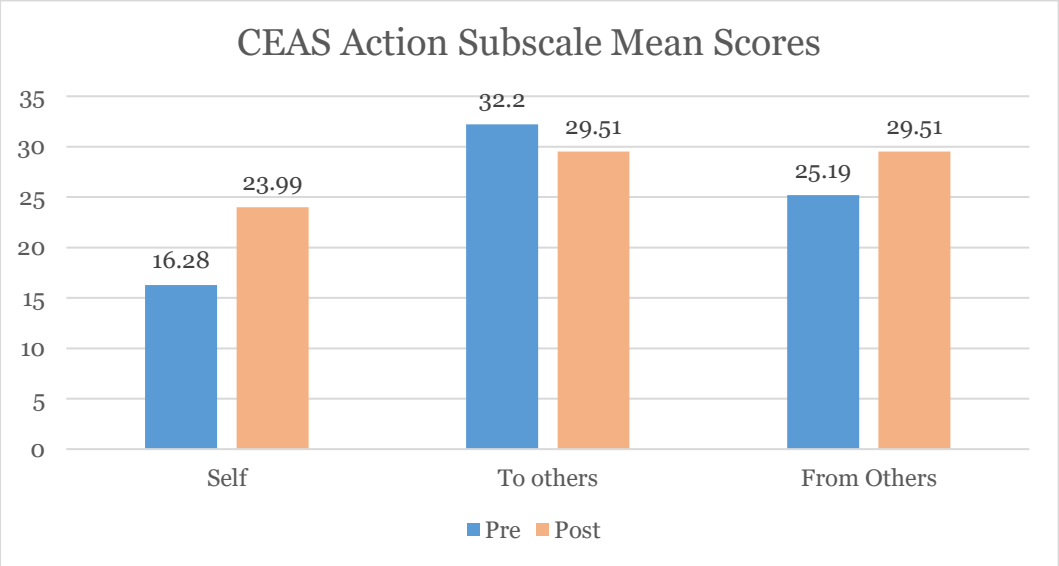



Within the Compassionate Action sub-scales, a statistically significant increase in mean scores was observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (*M* = 16.28, *SD* = 6.36) to post-intervention (*M* = 23.99, *SD* = 5.77), *t*(47) = -7.15, *p* < .001, with a large effect size (*d* = 1.03).

A decrease in mean scores was observed on the Compassion to Others subscale within the Compassion Action subscales. Participant mean scores decreased from pre-intervention (*M* = 32.20, *SD* = 6.26) to post-intervention (*M* = 29.51, *SD* = 5.68), *t*(47) = 3.06, *p* = 0.004, with a small effect size (*d* = 0.44).

An increase in mean scores was observed on the Compassion from Others subscale within the Compassionate Action subscales. Scores on this subscale increased from 25.19 (*SD* = 7.42) pre intervention to 29.51 (*SD* = 5.68), $t(47) = -3.56$, $p < .001$, with a medium effect size ($d = -0.51$).

Figure 4.35. *CEAS Compassionate Action Subscale Mean Scores pre and post intervention.*




### 4.8.6. Summary

The Compassion-Focused Therapy Programme started in SPMHS in 2014. Each year, the programme has evolved and continued to receive positive outcomes. Effect size calculations for data from the CFT groups in 2024 demonstrated mostly medium to large effect sizes for significant results on outcome measures, with the exception of one significant result demonstrating a small effect size. These results demonstrate meaningful reductions in symptoms of depression, anxiety and stress for service users after completing the programme. Significant changes were also noted in relation to people's openness to compassion, with a decrease in fears associated with receiving compassion from others and offering compassion to oneself. The data demonstrated that after completion of the CFT programme the impact of their inner critic had changed and service users reported that feelings of inadequacy had significantly reduced and there was an improvement in their ability to reassure themselves.

Results from outcome measures and anecdotal feedback from service users who attended these groups are consistently positive. Service users report noticeable improvements in their lives due to reductions in levels of self-criticism and increased ability to engage with compassion.  CFT continues to be an effective, well-received group-based psychological intervention to SPMHS service users.

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

Compassion-Focused Therapy (CFT) was developed by Prof Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Gilbert, 2009; Leaviss & Uttley, 2014). It is an integrative, multi-modal approach that draws on evolutionary psychology, neuroscience, attachment theory, cognitive behaviour therapy, mindfulness, and compassion-focused practices. CFT recognises the importance of being able to engage with our suffering in a compassionate way and helps people to respond to distress and challenging emotions (Kolts, 2016).

Research has demonstrated the importance of self-compassion for psychological functioning (Neff & Germer, 2017). Jazaeir et al. (2012) identified compassion as a predictor of psychological health and wellbeing and found that it was associated with fewer negative feelings and stress, as well as more positive feelings and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for service users experiencing high shame and criticism. Research has found that CFT is associated with reductions in depression, anxiety, shame and self-criticism, and increased ability to self-soothe in response to emotional distress (Lucre & Corten, 2012).

Research conducted in SPMHS demonstrated that group CFT was effective in reducing symptoms of mental ill health for service users who attended the group. These findings were associated with improvements in self-criticism and fears of self-compassion (Cuppage, Baird, Gibson, Booth & Hevey, 2017). A further research study carried out at SPMHS investigated subjective bodily changes associated with attending a transdiagnostic CFT group (Mernagh, Baird & Guerin, 2020). Results suggest that

service users who attended the CFT group developed an increase in mind-body attunement. That is, they developed their capacity to listen to, and trust, their own bodily sensations as a source of important information about their emotions, as well as to regulate their emotions through responding to associated physical sensations with increased compassion and understanding.

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

In 2024, the CFT-OA programme completed its second and third cycles since its inception. The second cycle ran from October 2023 to March 2024, followed by the third cycle from July to December 2024. In order to respond to challenges in filling the second cycle of CFT-OA, we decided to add additional group sessions, using an open group format to allow us more time to recruit for the group. The additional group session presented the CFT-OA team with a unique opportunity to provide group members with additional support and space to make sense of their mental health difficulties and self-critic. Group members provided positive feedback about this longer group format and so we decided to permanently increase the size of the CFT-OA group from 16 group sessions to 18 groups sessions. The new 18 group session format runs over 20-weeks to facilitate individual reflection sessions at the halfway point in group. These individual reflection sessions provide the group member with an opportunity to reflect on their experience of the group before completing the remaining group sessions. Group members are also invited to attend a final review appointment at the end of group, which serves as an opportunity to further reflect on their experiences of doing group therapy and think about appropriate next steps following

the CFT-OA group. The CFT-OA continues to take place in-person, in St Patricks University Hospital and uses a closed group format.

### 4.9.1. Descriptors for CFT Older Adults Group

Thirteen service users completed CFT-OA in 2024, although 1 service user chose not to complete the outcome measures. As a result, twelve service users are included in the following demographic data. The age of service users ranged from 61 to 84 years old (M = 69.5, SD = 5.65). Seven (58.33%) of the service users were female, and five (41.67%) were male. Pre and post data on the outcomes measures below was available for all twelve service users. Due to the small sample size available, the statistical significance of these differences could not be determined. Instead, descriptive statistics are presented for pre and post intervention mean scores, as well as individual service user scores are presented below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

### 4.9.2. CFT Older Adults Outcome Measures

The Functions of Self-Criticising/Attacking Scale (FSCS) was removed from the measures collected at pre- and post-intervention in 2024 to reduce the burden on participants. No other changes were made to the outcome measures used to evaluate the CFT-OA group. Please see a description of the outcome measures used below.

- **The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS):** see page 92
- **Depression Anxiety and Stress Scale (DASS-21):** see page 92
- **Compassionate Engagement and Action Scales (CEAS):** see page 92

### 4.9.3. Results for CFT Older Adults Group

#### Depression, Anxiety and Stress Scale (DASS 21)

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

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

The mean for the 'DASS-21 Total' score decreased from pre-intervention (M= 48.17, SD= 31.71) to post-intervention (M =33.67, SD = 24.8), see Figure 4.36. Analysis of individual total scores showed that total DASS-21 scores decreased for six out of twelve (50%) of service users, as illustrated in the Figure 4.37.

Figure 4.36. *Pre and Post Group Mean Scores for the DASS-21 Total Score*.

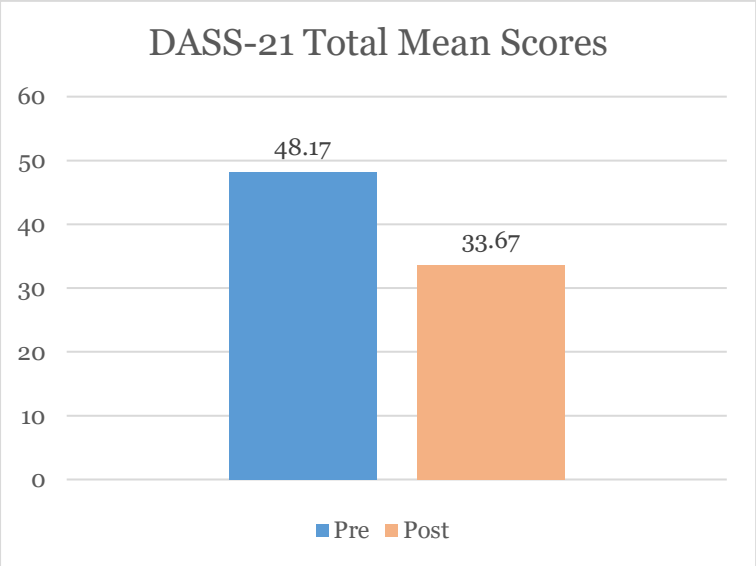
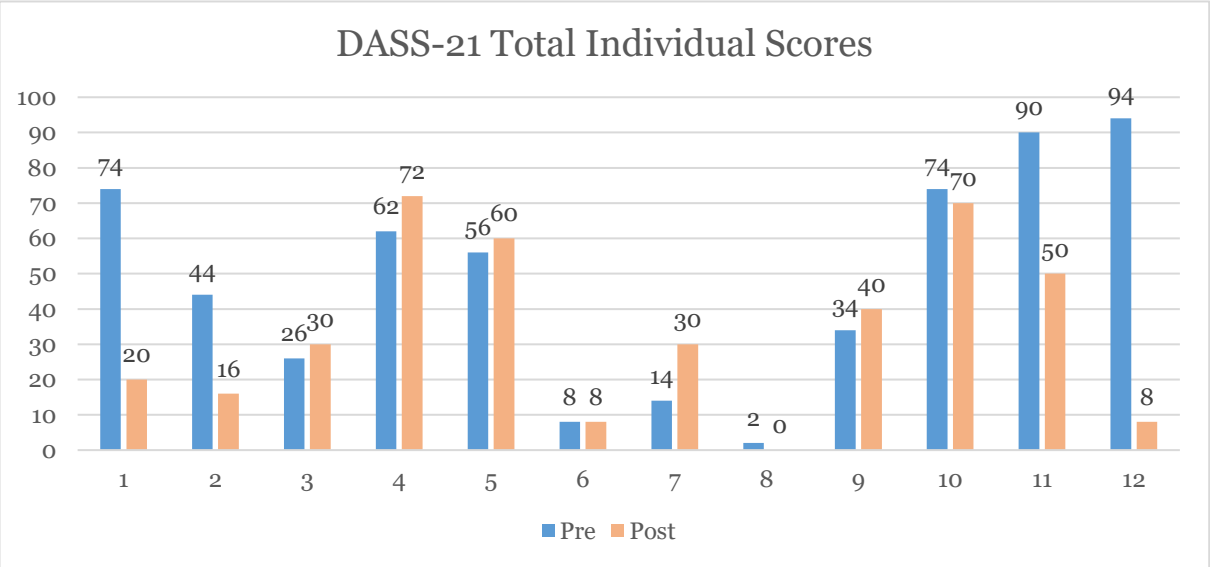
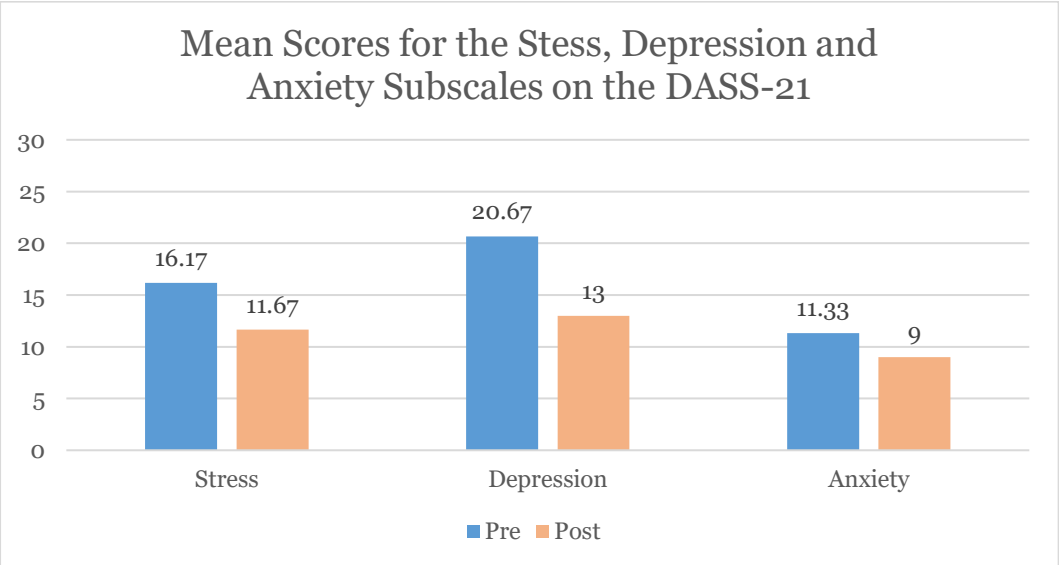


Figure 4.37. *Pre and Post Group Scores for the DASS-21 Total Score for each individual group member.*




The pre and post group mean scores for each of the DASS-21 subscales were also calculated, please see Figure 4.38 for visual representation of this.

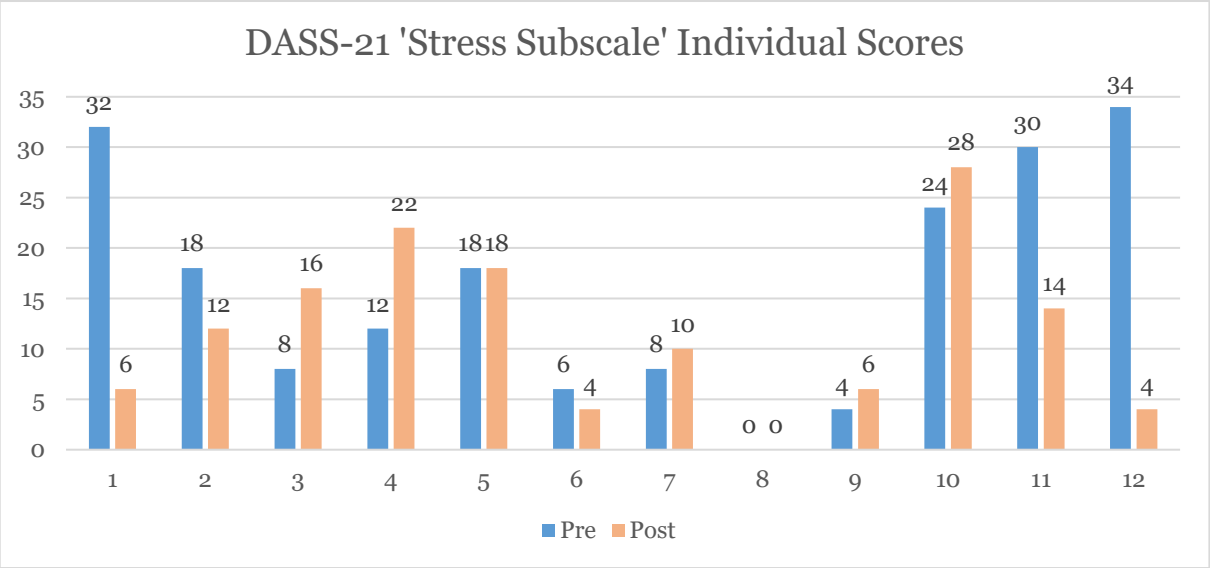
Figure 4.38. *Pre and Post Group Mean Scores for the 'Stress Subscale', the 'Depression Subscale' and the 'Anxiety Subscale' Score on the DASS-21.*




As illustrated in Figure 4.38, the mean scores on the DASS-21 'Stress Subscale' decreased from pre-intervention (M = 16.17, SD = 11.65) to post-intervention (M = 11.67, SD = 8.3). Scores on this subscale increased or remained unchanged for seven

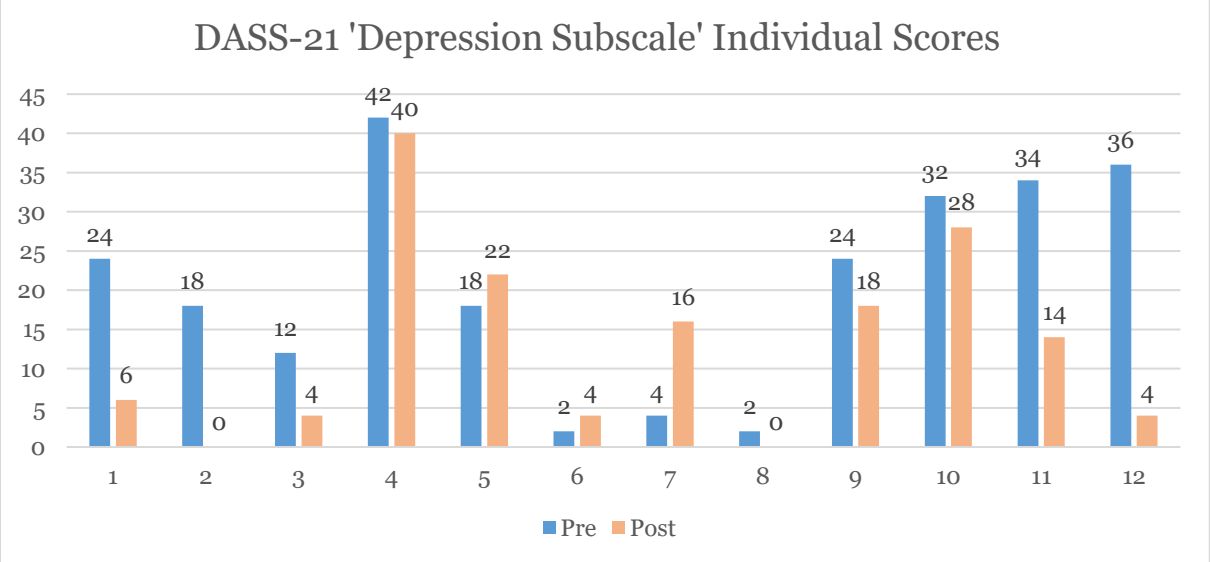
out of twelve service users (58.33%), while decreasing for five (41.67%) service users, see Figure 4.39.

Figure 4.39. *Pre and Post Group Scores for the 'Stress Subscale' for each individual group member.*



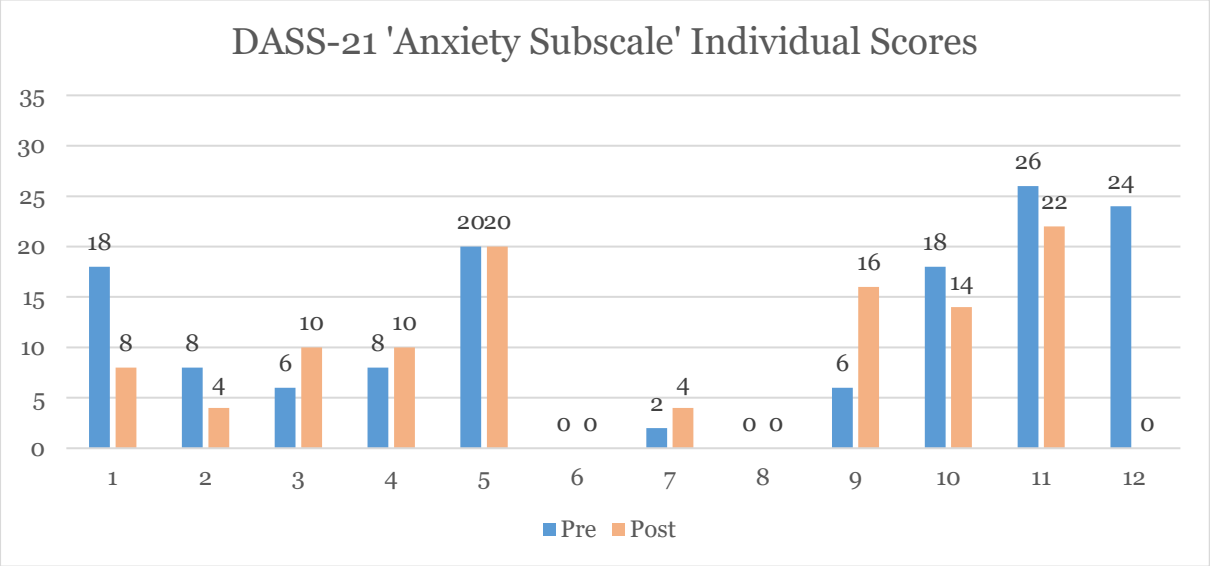

The mean scores on the DASS-21 'Depression Subscale' decreased from pre-intervention (M = 20.67, SD = 13.76) to post-intervention (M = 13, SD = 12.43), see Figure 4.38. Similarly, analysis of individual scores found a decrease in scores for nine out of twelve (75%) service users on this subscale as illustrated on Figure 4.40.

Figure 4.40. *Pre and Post Group Scores for the 'Depression Subscale' for each individual group member.*



The mean scores on the DASS-21 'Anxiety Subscale' decreased from pre-intervention (M = 11.33, SD = 9.35) to post-intervention (M = 9, SD = 7.75), see Figure 4.38. As illustrated in Figure 4.41, scores on this subscale decreased for five of twelve (41.67%) service users. Scores on this subscale increased for four of twelve (33.33%) service users and remained unchanged for three (25%) of twelve service users.

Figure 4.41. *Pre and Post Group Scores for the 'Anxiety Subscale' for each individual group member.*




Due to the small sample size available, the statistical significance of these differences could not be determined. Changes in total DASS-21 scores were analysed using the Reliable Change Index (RCI) for each group member. In order to ensure that changes in DASS scores were not attributable to chance or measurement error a RCI was calculated for each group member using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than or equal to 1.96. The cut-off score indicating clinically meaningful improvement on the DASS-21 for this sample was calculated to be 30. Group members were classified as "clinically meaningful improvement" (passed RCI criterion and DASS score decreased to below cut-off score), "reliable improvement" (passed RCI criterion but the score did not decrease below DASS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in table 4.11, three group members (25%) reported clinically

significant improvement, one participant (8.33%) reported reliable improvement and the remaining eight participants (66.67%) reported uncertain change.

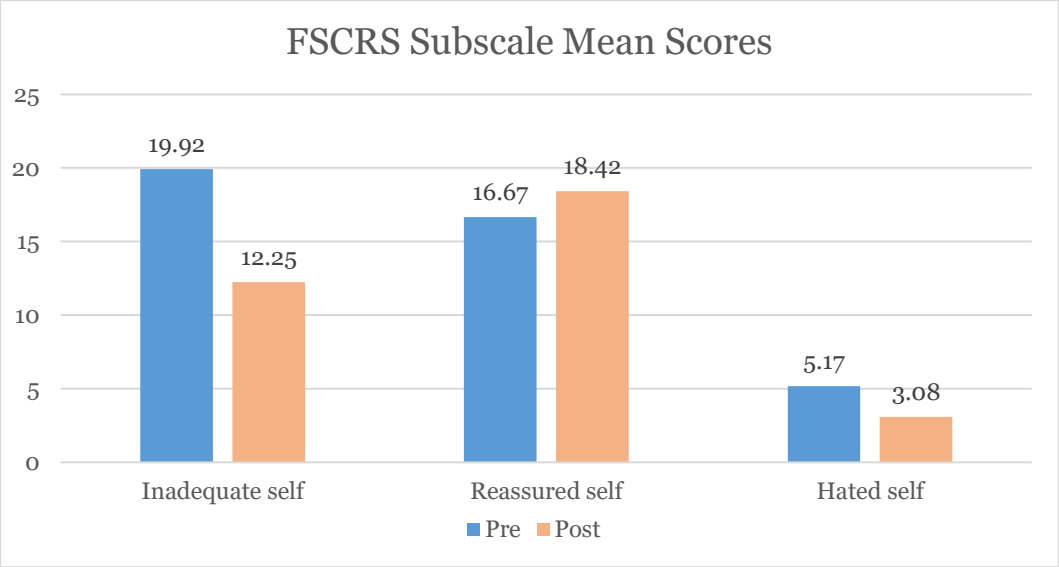
Table 4.11. *Results from Reliable Change Index (RCI) for the Depression Anxiety and Stress Scale (DASS-21) pre and post scores*

| Group Member | Pre-Score | Post Score | RCI Value | Category |
|---|---|---|---|---|
| 1 | 74 | 20 | -4.28 | Clinically Significant Improvement |
| 2 | 44 | 16 | -2.22 | Clinically Significant Improvement |
| 3 | 26 | 30 | 0.32 | Uncertain Change |
| 4 | 62 | 72 | 0.79 | Uncertain Change |
| 5 | 56 | 60 | 0.32 | Uncertain Change |
| 6 | 8 | 8 | 0.00 | Uncertain Change |
| 7 | 14 | 30 | 1.27 | Uncertain Change |
| 8 | 2 | 0 | -0.16 | Uncertain Change |
| 9 | 34 | 40 | 0.48 | Uncertain Change |
| 10 | 74 | 70 | -0.32 | Uncertain Change |
| 11 | 90 | 50 | -3.17 | Reliable Improvement |
| 12 | 94 | 8 | -6.82 | Clinically Significant Improvement |

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

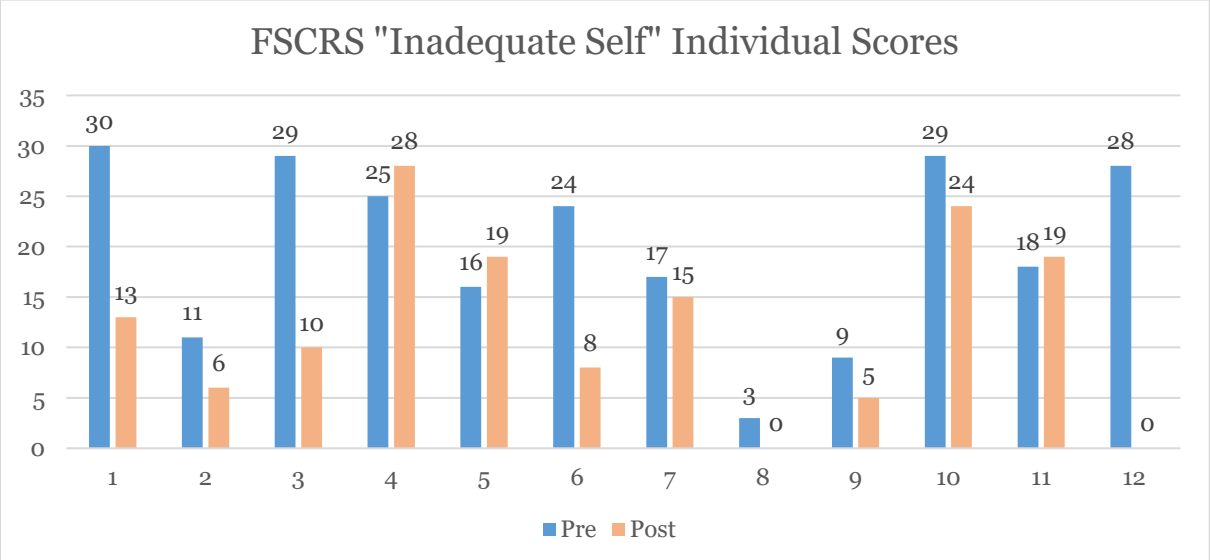
The pre and post group mean scores for each of the 'Inadequate Self', 'Reassured Self' and 'Hated Self' scales on the FSCRS were calculated, please see Figure 4.42.

Figure 4.42. *Pre and Post Mean scores for the 'Inadequate Self', 'Reassured Self' and 'Hated Self' scales on the FSCRS.*




As illustrated in Figure 4.42, the mean scores on the FSCRS 'Inadequate Self' subscale decreased from pre-intervention (M = 19.92, SD = 8.98) to post-intervention (M = 12.25, SD = 9.05). Analysis of individual scores showed that scores on this subscale decreased for nine out of the twelve (75%) service users, see Figure 4.43.

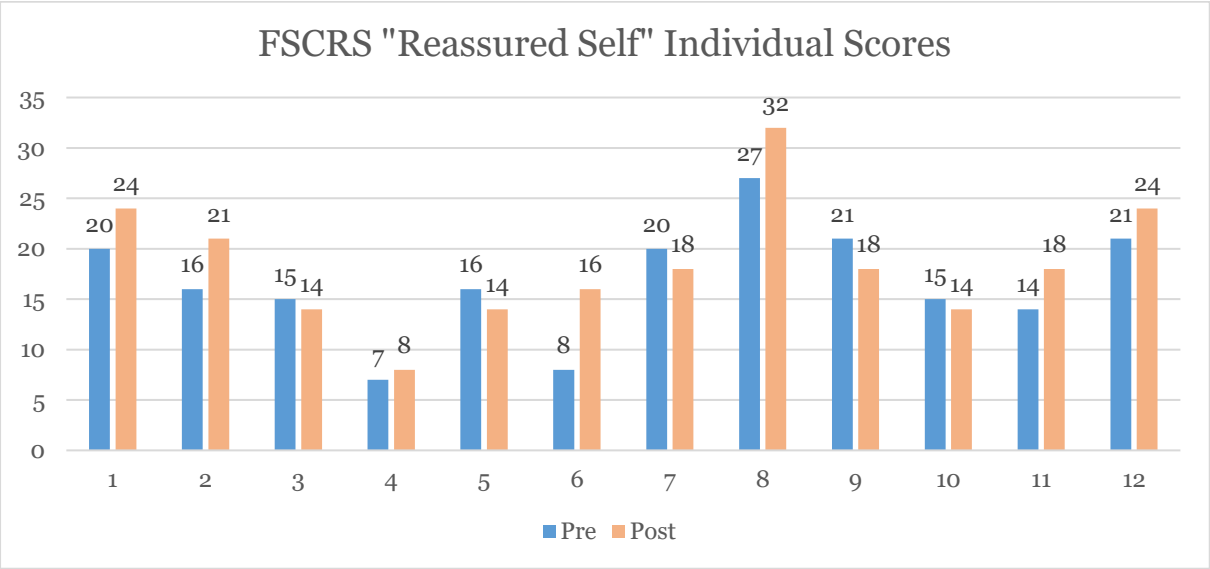
Figure 4.43. *Pre and Post Score for the 'Inadequate Self' subscale for each individual group member on the FSCRS.*




The mean scores on the FSCRS 'Reassured Self' subscale increased slightly from pre-intervention (M = 16.67, SD = 5.63) to post-intervention (M = 18.42, SD = 6.23), see

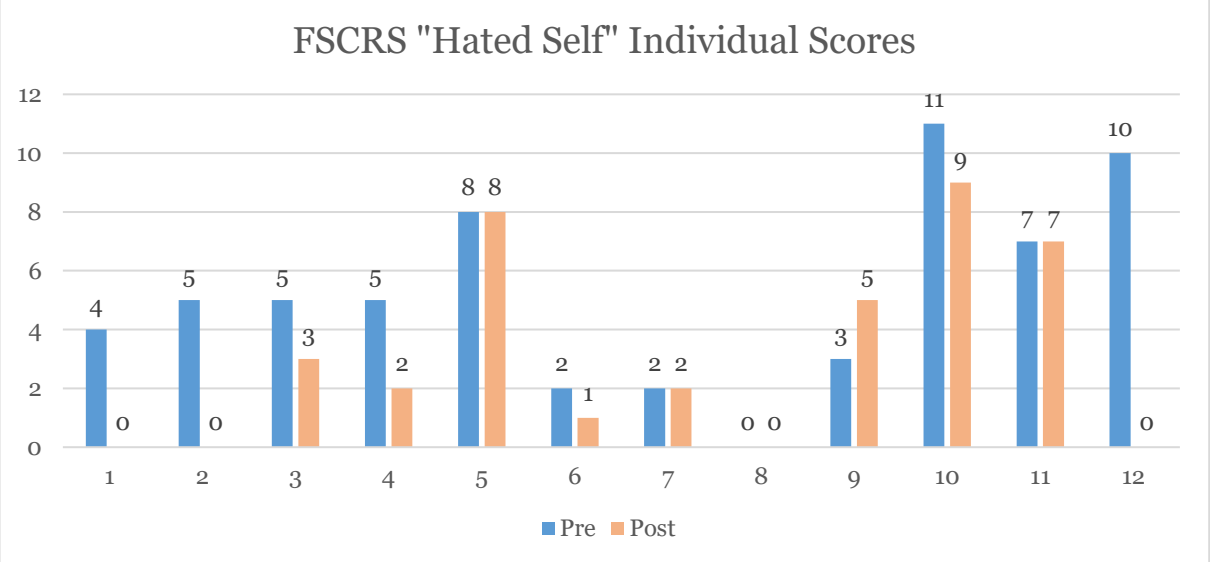
Figure 4.42. Individual scores increased for seven out of twelve service users (58.33%) on this subscale, see Figure 4.44.

Figure 4.44. *Pre and Post Score for the 'Reassured Self' subscale for each individual group member on the FSCRS.*




The mean scores on the FSCRS 'Hated Self' subscale decreased from pre-intervention (M = 5.17, SD = 3.33) to post-intervention (M = 3.08, SD = 3.34), see Figure 4.42. As illustrated in Figure 4.45, individual scores decreased or remained unchanged for eleven out of twelve (91.67%) service users on this subscale.

Figure 4.45. *Pre and Post Scores for the 'Hated Self' subscale for each individual group member on the FSCRS.*



### Compassionate Engagement and Action Scale (CEAS)

The results obtained on the 'Compassion to Self' scale, the 'Compassion to Others' scale and the 'Compassion experienced from Others' scale, as well as the results obtained on the 'Engagement' and 'Action' subscales of the CEAS are outlined below. As illustrated on Figure 4.46, the mean scores increased on the 'Compassion to Self Scale' from pre-intervention *(M* = 54.33, *SD* = 13.53) to post-intervention (*M* = 68.25, *SD* = 13). Individual scores increased for eleven out of twelve (91.67%) service users on this scale, see Figure 4.47.

Figure 4.46. *Pre and Post Mean scores for the Compassion to Self' scale, the 'Compassion to Others' scale and the 'Compassion experienced from Others' scale on the CEAS.*

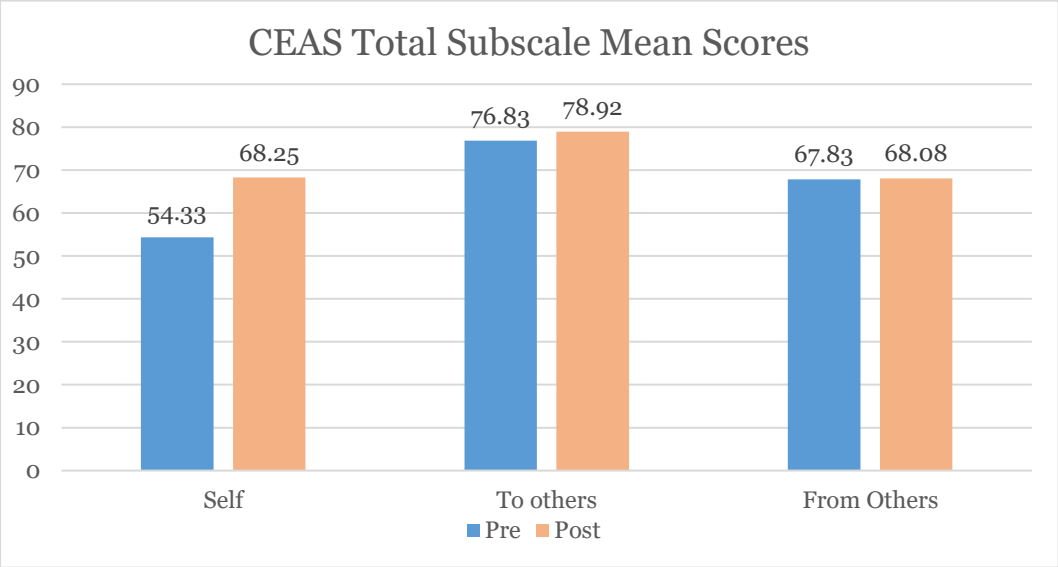
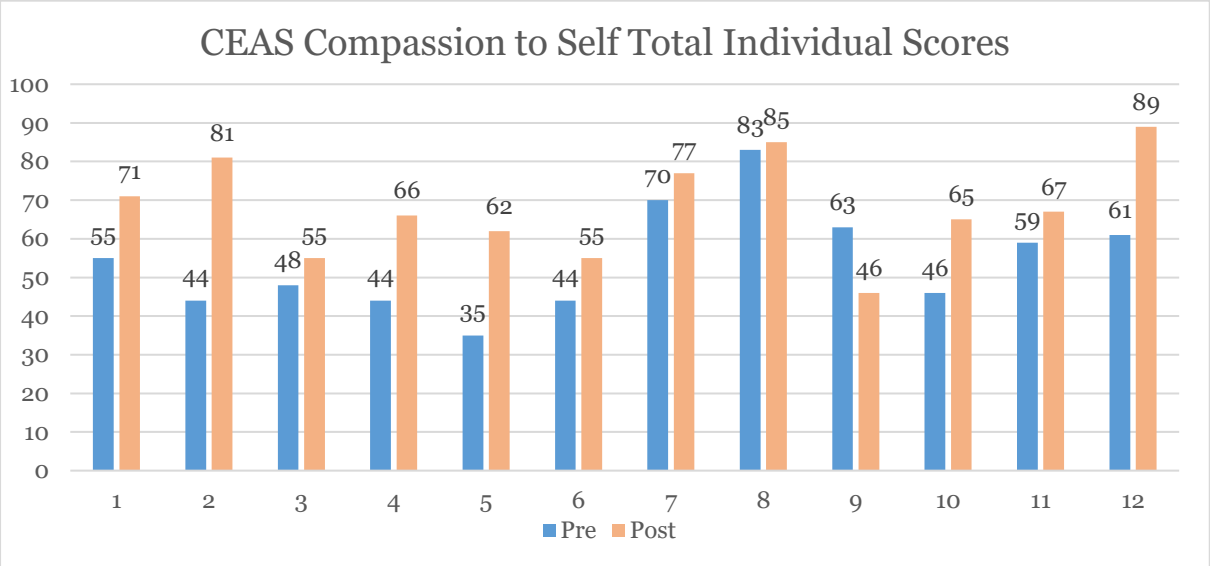
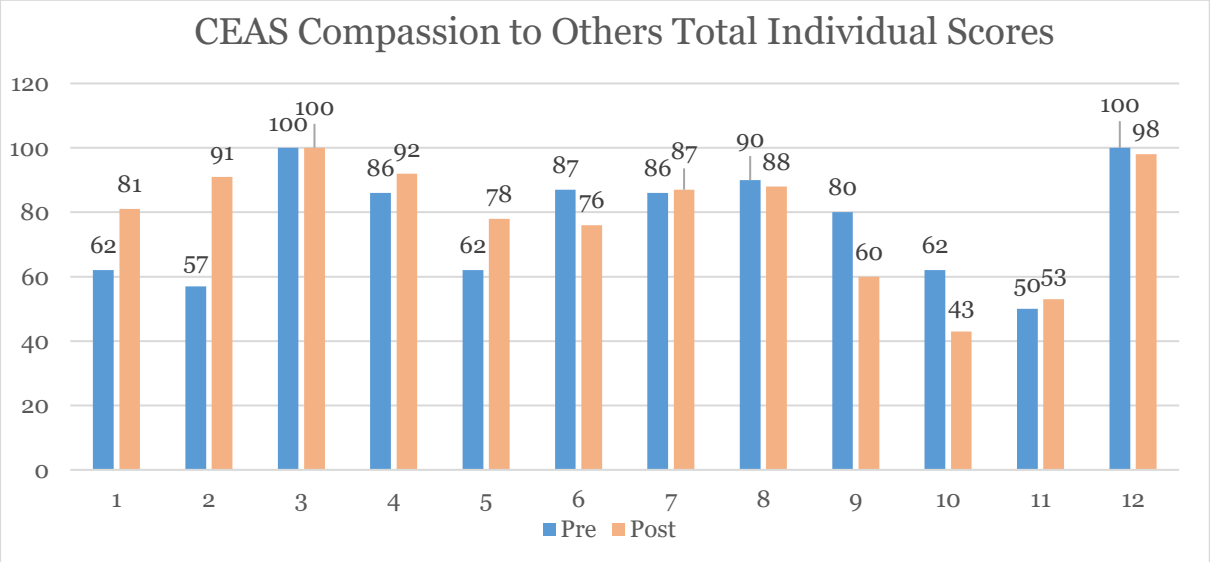


Figure 4.47. *Pre and Post Scores for the 'Compassion to Self' scale for each individual group member on the CEAS.*




The mean scores on the 'Compassion to Others Scale' were observed to increase from pre-intervention (*M* = 76.83, *SD* = 17.32) to post-intervention (*M* = 78.92, *SD* = 18.12), see Figure 4.46. Individual scores increased for six out of twelve (50%) service users on this scale, see Figure 4.48.

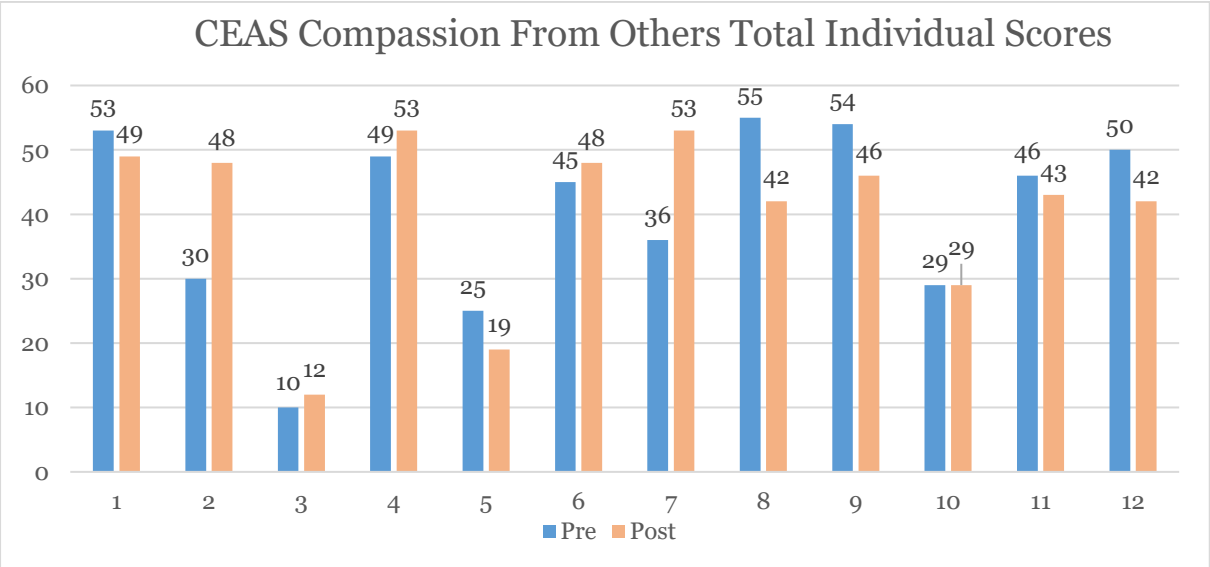
Figure 4.48. *Pre and Post Scores for the 'Compassion to Other' scale for each individual group member on the CEAS.*




The mean scores on the 'Compassion Experienced from Others Scale' increased from pre (*M* = 67.83, *SD* = 23.57) to post-intervention (*M* = 68.08, *SD* = 23.12), see Figure 4.46.

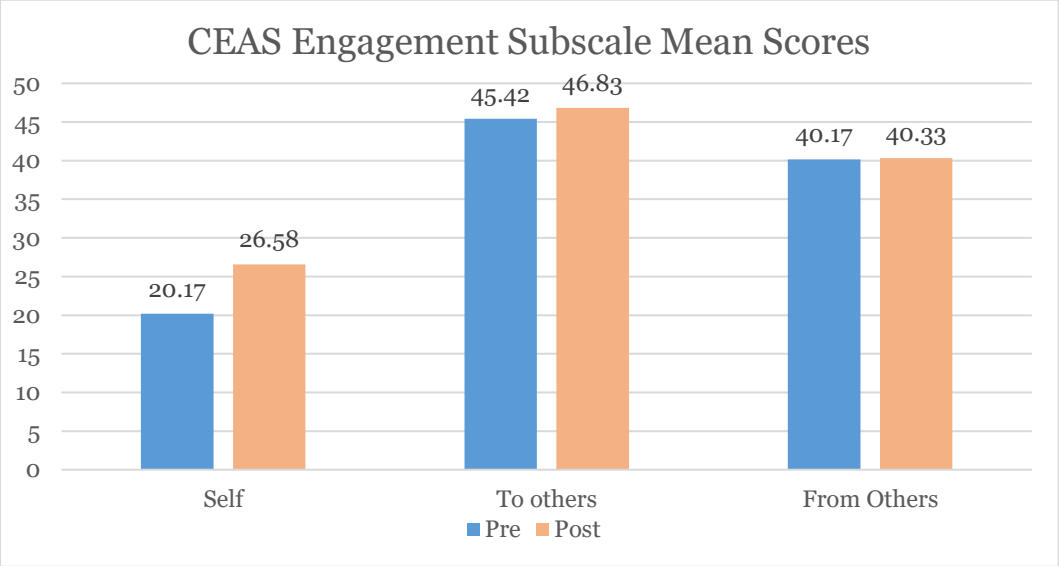
As illustrated in Figure 4.49, individual scores decreased or remained unchanged for seven out of twelve (58.33%) service users on this scale.

Figure 4.49. *Pre and Post Scores for the 'Compassion Experienced from Other' scale for each individual group member on the CEAS.*



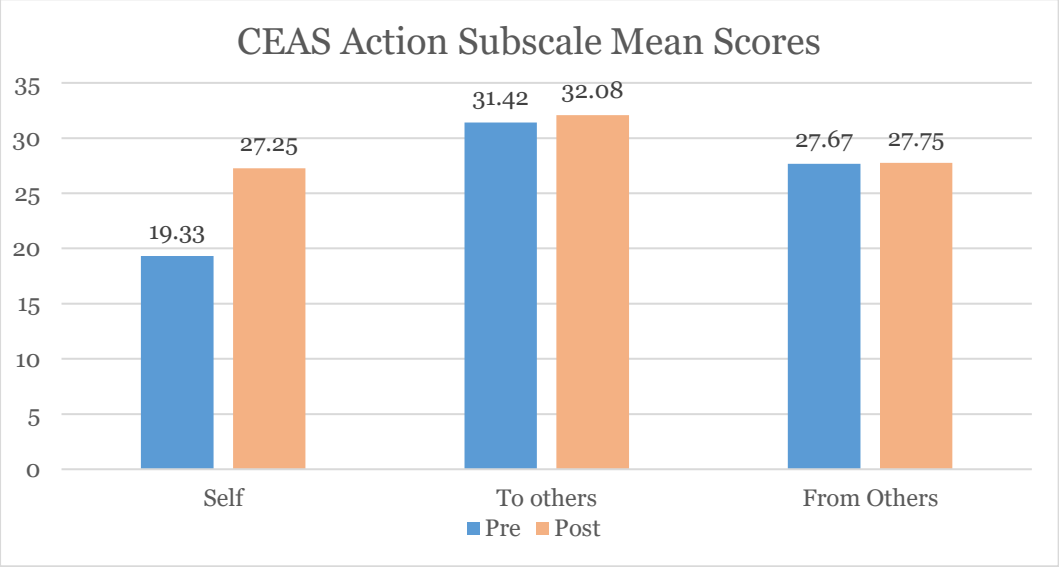

Within the 'Engagement' sub-scales, an increase in mean scores was observed on the Compassion to Self subscale. Group member mean scores increased from pre-intervention (*M* = 20.17, *SD* = 6.25) to post-intervention (*M* = 26.58, *SD* = 5.16). There was an increase observed on the Compassion to Others subscale within the Engagement scales, with group member mean scores of (*M* = 45.42, *SD* = 11.36) at pre-intervention and (*M* = 46.83, *SD* = 11.13) at post-intervention. The group members' mean scores on the Compassion from Others subscale remained relatively stable within the Engagement scales, with pre-intervention scores of (M = 40.17, SD = 14.12) and post-intervention scores of (M = 40.33, SD = 13.3). Please see Figure 4.50.

Figure 4.50. *Pre and post mean scores for 'Compassion to Self', 'Compassion to Others' and 'Compassion Experienced from Others' within the Engagement Subscale of the CEAS.*




Within the Action sub-scales, group member mean scores on the Compassion to Self subscale increased from pre-intervention (*M* = 19.33, *SD* = 8.37) to post-intervention (*M* = 27.25, *SD* = 7.77). There was an increase in mean scores observed on the Compassion to Others subscale within the Compassionate engagement scales, with group member mean scores of (*M* = 31.42, *SD* = 6.58) at pre-intervention and (*M* = 32.08, *SD* = 7.34) at post-intervention. The group members' mean scores on the Compassion from Others subscale remained relatively stable within the Compassionate Action scales, with pre-intervention scores of (M = 27.67, SD = 10.05) and post-intervention scores of (M = 27.75, SD = 10.15). Please see Figure 4.51.

Figure 4.51. *Pre and post mean scores for Compassion to Self, Compassion to Others and Compassion Experienced from Others scales within the Action Subscale of the CEAS.*




## Summary

In 2024, the CFT-OA programme completed its second and third cycles since its inception. The second cycle ran from October 2023 to March 2024, followed by the third cycle from July to December 2024. The CFT-OA group is a compassion focused group therapy programme specifically designed for older adult service users. It aims to reduce self-criticism and enhance self-compassion amongst its group members.

Analysis of the pre and post mean scores on these outcome measures showed trends towards positive changes in the areas targeted by the programme: including reductions in levels of self-criticism as measured by the FSCRS, increases in levels of compassion to self and compassion from others as measures by the CEAS and overall levels of distress as measured by the DASS-21. Pre and post mean scores on the CEAS also show trends towards increases in observed levels of compassionate 'Engagement' (such as motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgement) and compassionate 'Action' (such as directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Due to the small

sample size available, the statistical significance of these differences could not be determined; however, the trends observed on these outcome measures suggest that the CFT-OA programme is meeting it's aims in seeking to reduce the levels self-criticism experienced by older adult group members and cultivate greater compassion amongst these individuals.

## 4.10. Compassion-Focused Therapy for Eating Disorders

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

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

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

CFT is underpinned by evolutionary theory and the neuroscience of emotion, thus scientifically explaining the application of compassion to promote mental health (Mullen, Dowling, Doyle, & O'Reilly, 2019). A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for service users experiencing high levels of shame and self-criticism, which are more common amongst people experiencing eating disorders than any other mental health population (Pinto Gouveia, Ferreira & Duarte, 2014). A recent randomized control trial demonstrated that CFT-E is effective for reducing eating disorders, is as effective as CBT-E and maintained better outcomes than CBT-E for those with childhood trauma (Vrabel et al., 2024).

CFT categorises emotions by their functions for:

- Alert to threat and activation of defence behaviours

- Incentivisation of seeking behaviour
- Allow for rest and digest (Gilbert, 2014)

These have been named the threat, drive and soothing systems respectively. The CFT-E model suggests that people who experience eating disorders have learned to regulate their experience of threat through their drive system, with little access to their healthy soothing system (Goss & Allan, 2014). For example, experiences of threat such as shame and self-criticism can be managed through the drive of goal-directed food restriction or accessing soothing through food. Research indicates that food restriction stems from experiences of threat which are overly responded to by the drive system through excessive dieting which becomes reinforced through feelings of pride (Kelly & Tasca, 2016). Bingeing behaviour is regulated by the soothing system through dissociation from negative emotions and an increase in pleasurable sensation and soothing affect (Goss & Allan, 2014).

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

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

The format of the programme incorporates psychoeducation for service users and their family members; skill building and therapeutic elements. The programme is delivered by psychologists and one assistant psychologist. In total, there are 30 half day group sessions for group participants and one evening session for family and friends.

### 4.10.1. Descriptors

Seven out of nine participants completed the CFT-E programme in 2024, and 12 cycles of CFT-E have run since it began. Demographic information is included for all seven participants. Most of the programme was completed face to face with four hybrid sessions due to service user request. The programme welcomes participants with a

range of eating disorder symptoms and diagnoses. Six of the seven participants were female, with one male participant in the programme. Participants ranged in age from 20 to 52 years with a mean age of 35.29. Pre and post-outcome data was available all seven participants on all measures. Missing Value Analysis (MVA) was carried out to examine the type of missingness within the data. Where data was found to be Missing Completely at Random by Little's test (Cheng & Evanston, 2013) the Expectation Maximisation method was applied before any total scores were computed or analyses carried out.

### 4.10.2. Compassion-Focused Therapy for Eating Disorders Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the CFT-E programme in 2024. All service users attending the CFT-E programme are invited to complete the measures listed below at assessment for the programme and again upon completion.

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

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

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

The responses are designed to be averaged by the practitioner to produce a mean score to indicate the level of current psychological global distress (from healthy to severe). The scoring range of the CORE-OM is between zero and four, with four being the highest level of severity. The CORE Outcome Measure (CORE-OM) was conceived as a non-

proprietary measure of psychological distress. Crucially, it was informed by feedback from practitioners as to what they considered to be important to include (Barkham et al, 2010). Since its development, the CORE-OM has been validated with samples from the general population, NHS primary and secondary care and in older adults. Furthermore, analyses of over 2,000 responses show good reliability and convergent validity against longer and less general measures; small gender effects, large clinical/non-clinical differences and good sensitivity to change (Palmieri et al, 2009).

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

The Eating Disorder Examination Questionnaire (EDE-Q: Fairburn and Beglin, 1994) is a well-established self-report instrument that investigates eating disorder behaviours and attitudes. It is a 36-item self-report questionnaire that measures change in eating disorder symptoms over the course of treatment. It is considered the 'gold standard' measure of eating disorder psychopathology and is designed to assess past month cognitive sub-scales related to eating disorders; restraint, eating concern, shape concern and weight concern, as well as behavioural symptoms related to these concerns (for example frequency of binge-eating, vomiting, use of laxatives or diuretics and over-exercise).

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

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

The EDE-Q reports good internal consistency and with the exception of some of the eating disorder behaviours, test-retest reliability has been reported to be fairly strong for both men and women.

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

The Functions of Self-Criticising/Attacking Scale (FSCS) was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004) to measure the functions of self-criticism; why people think they self-criticise and self-attack. Factor analysis suggests two very different functions for being self-critical; one is to try and improve the self and stop the self from making mistakes (self-correction) and the other involves expressing anger and wanting to harm the self (self-persecution). It is a 21-item scale measuring both these factors. The responses are given on a five-point Likert scale ranging from zer0 – 'not at all like me', to four – 'extremely like me'.

- **The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS):** see page 91
- **The Compassionate Engagement and Action Scales (CEAS):** see page 92

### 4.10.3. Results

As mentioned above, the statistical significance of changes in mean scores could not be calculated due to the small sample size. For this reason, participants' individual pre and post measure scores are reported below, as it is most appropriate to look to these scores.

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

Participants total scores decreased from a mean of 5.18 (*SD* = 2.23) on the CORE-OM at pre-intervention to 1.21 (*SD* = 1.06) post-intervention. All seven participants reported a decrease in individual total CORE-OM scores as shown in Figure 4.52.

Figure 4.51. *CORE-OM Total Mean Scores*

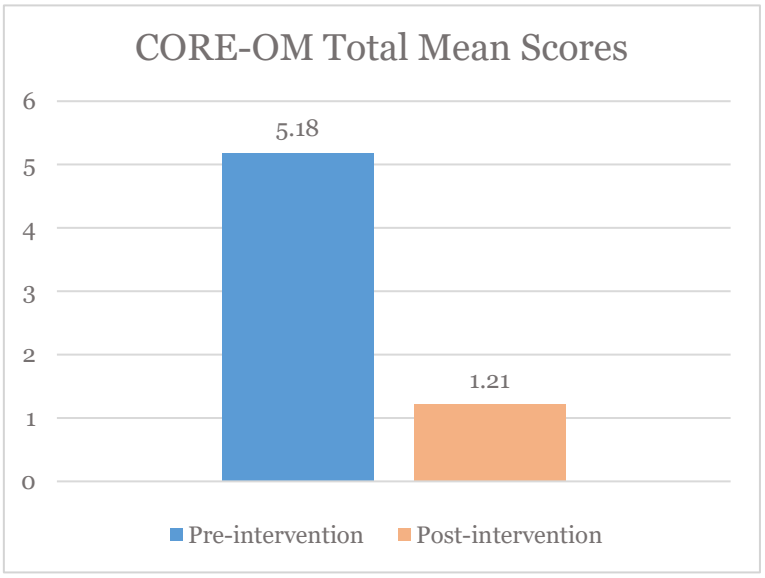
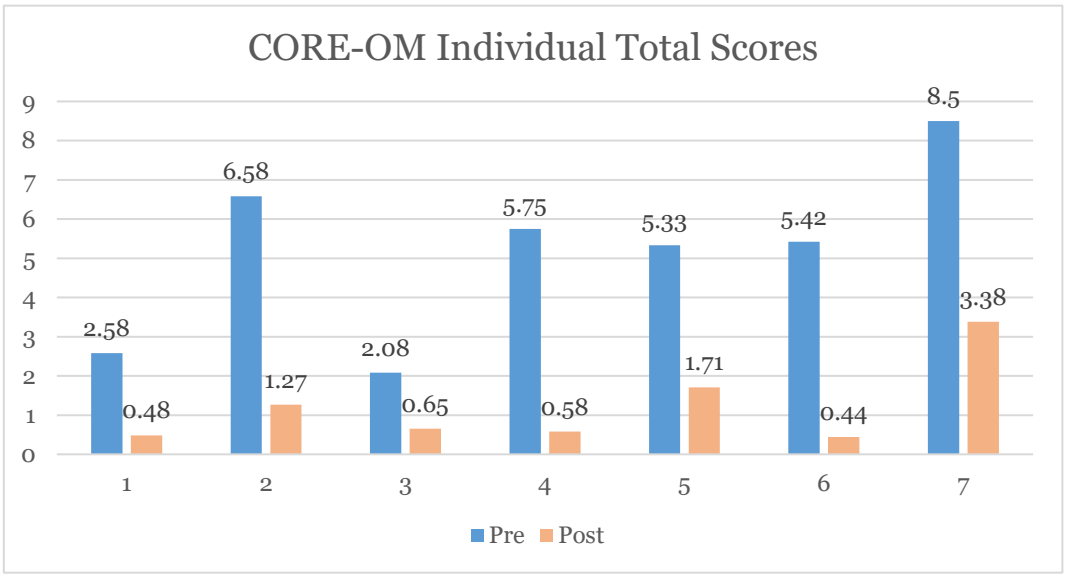
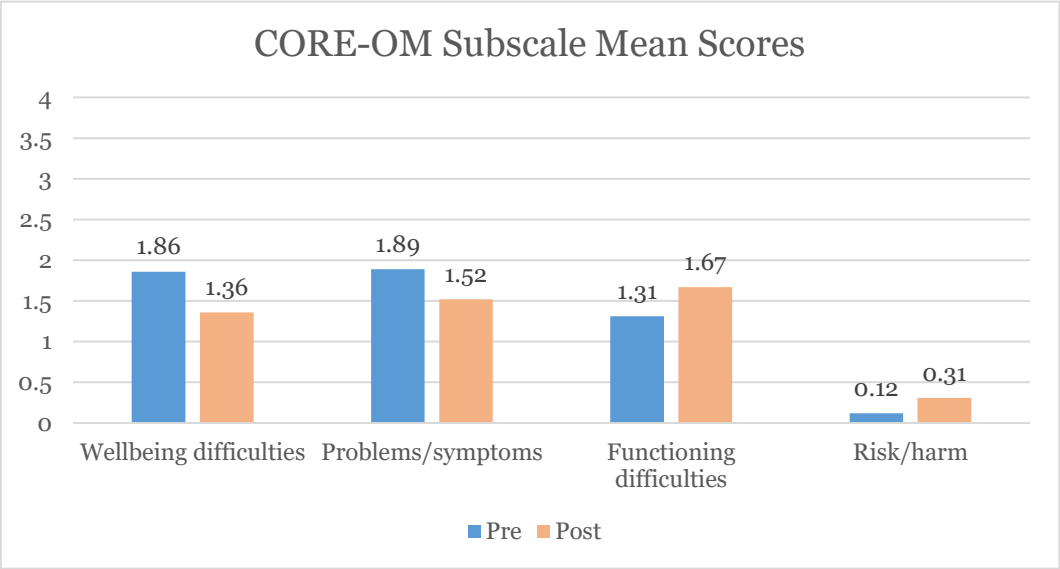



Figure 4.52. *CORE-OM Total Individual Scores*




Mean scores on the subjective wellbeing subscale decreased from 1.86 (*SD* = 0.85) at pre-intervention to 1.36 (*SD* = 1.07) at post-intervention. Mean scores on the problems/symptom's domain decreased from 1.89 (*SD* = 0.84) at pre-intervention to 1.52 (*SD* = 0.79) at post-intervention. Mean scores on the functioning subscale increased from 1.31 (*SD* = 0.53) at pre-intervention to 1.67 (*SD* = 2.03) at post-intervention. Mean scores on the risk/harm subscale remained relatively unchanged, at 0.12 (*SD* = 0.16) at pre-intervention to 0.31 (*SD* = 0.49) at post-intervention.

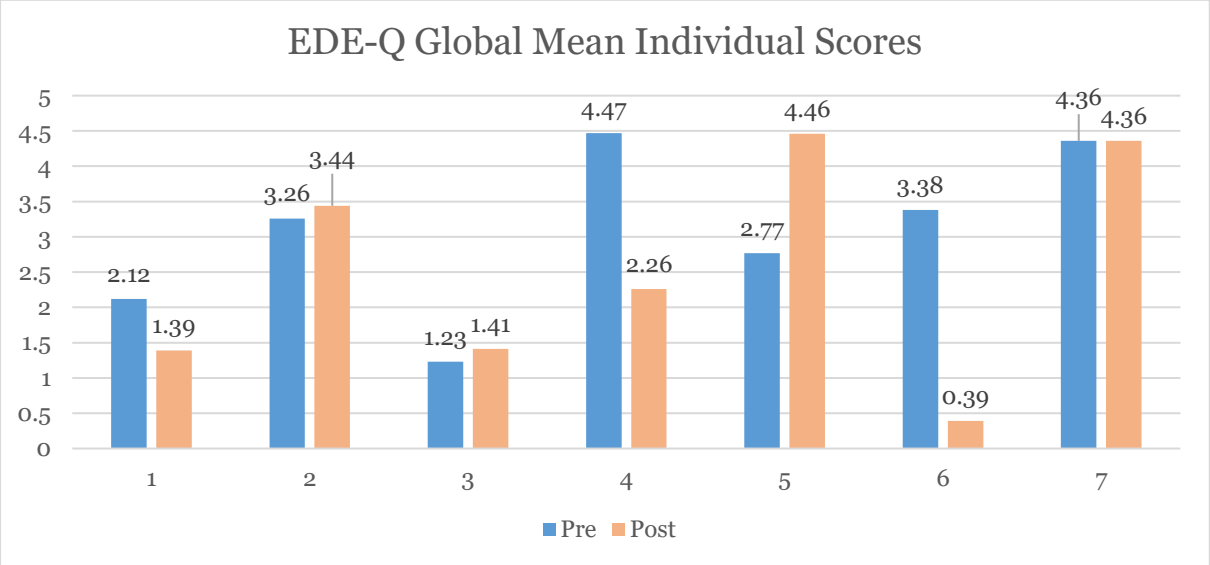
Figure 4.53. *CORE-OM Subscale Mean Scores*




## Eating Disorder Examination Questionnaire (EDE-Q)

The mean global score on the EDE-Q decreased between pre-intervention (*M* = 3.08, *SD* = 1.16) and post-intervention (*M* = 2.53, *SD* = 1.59).

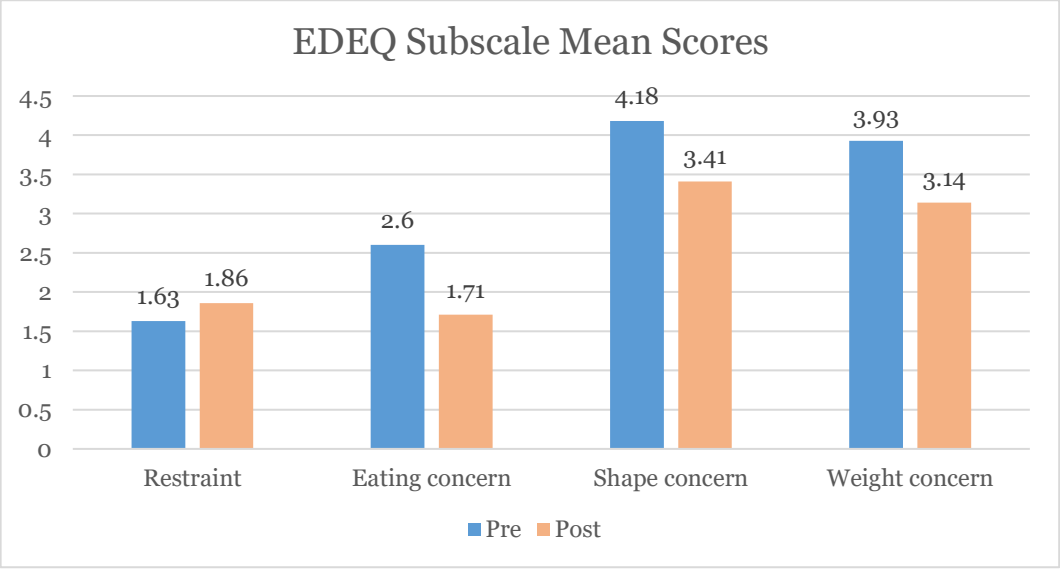
Figure 4.54. *EDE-Q Global Mean Individual Scores*




There are four sub-scales measured within the EDE-Q, which are restraint, eating concern, shape concern and weight concern. Mean scores on restraint were found to increase from 1.63 (*SD* = 1.10) at pre-intervention to 1.86 (*SD* = 1.54) at post-intervention. Mean scores on the eating concern subscale showed a decrease from

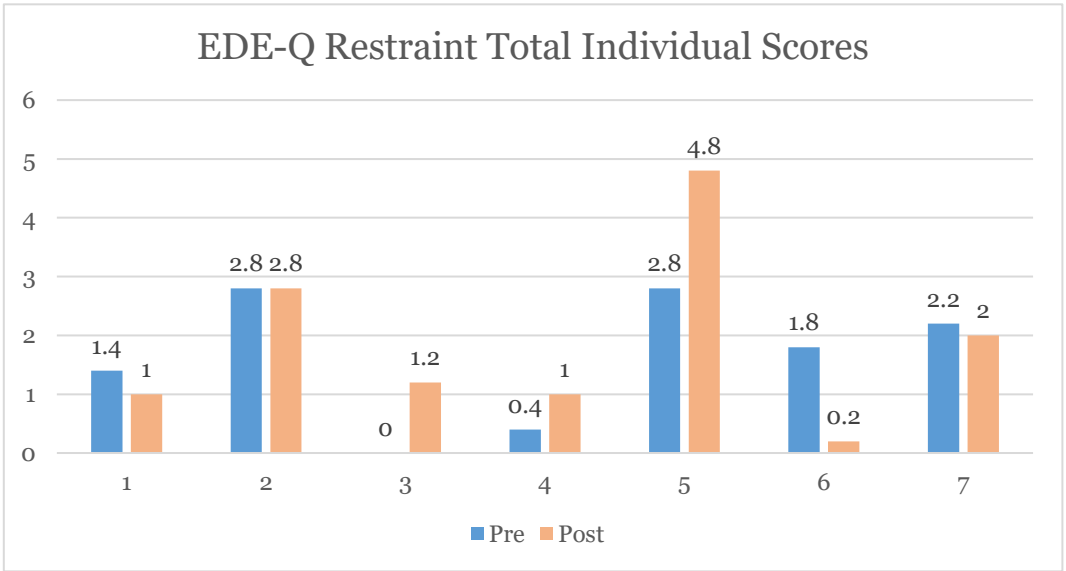
2.60 (*SD* = 1.73) to 1.71 (*SD* = 1.52). Scores on the preoccupation with shape subscale also decreased from 4.18 (*SD* = 1.49) to 3.41 (*SD* = 1.8). Scores on the preoccupation with weight subscale similarly decreased from 3.93 (*SD* = 1.46) to 3.14 (*SD* = 2.00).

Figure 4.55. *EDEQ Subscale Mean Scores*



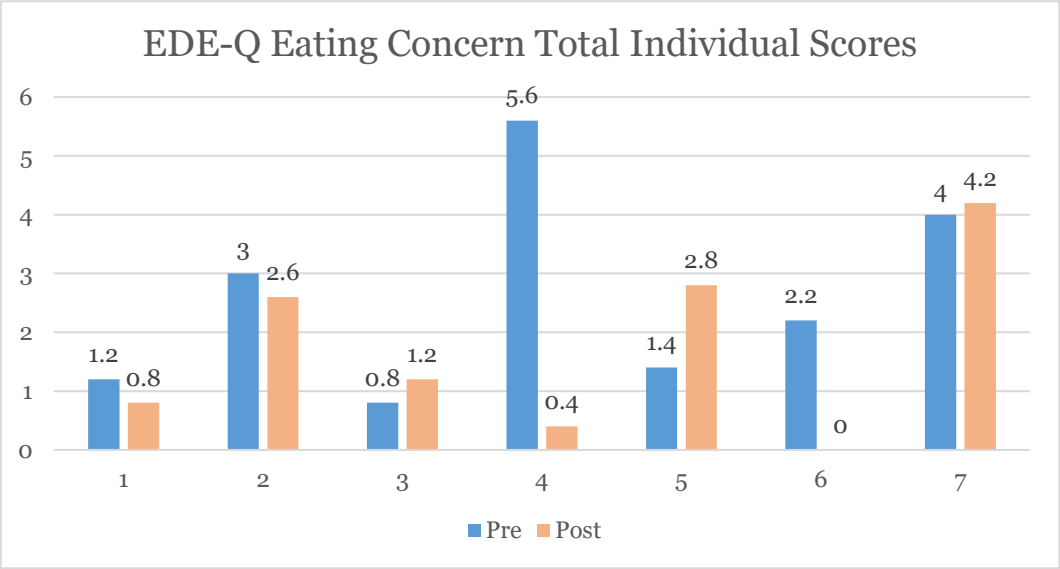

Individual scores on the restraint subscale, as shown in Figure 4.56, demonstrate that three participants reported a decrease in scores on this subscale, one participant reported no change, and two participants reported an increase in scores.

Figure 4.56. *EDEQ Restraint Total Individual Scores*



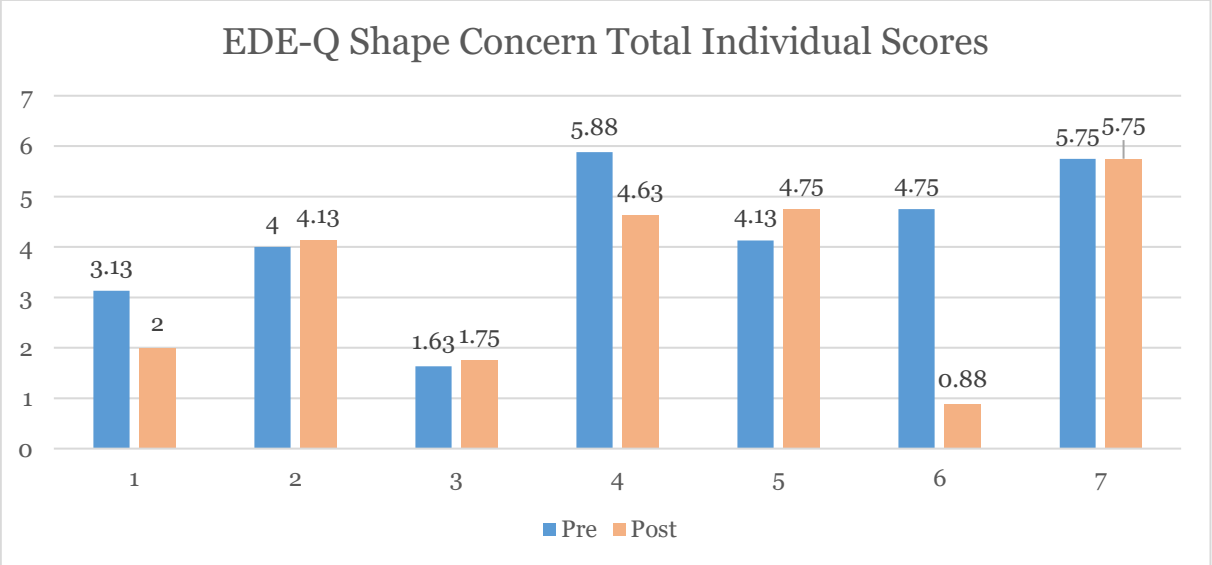
Individual scores on the eating concern subscale, as shown in Figure 4.57, demonstrate that four participants reported a decrease in scores on this subscale, and three participants reported an increase in scores.

Figure 4.57. *EDEQ Eating Concern Total Individual Scores*



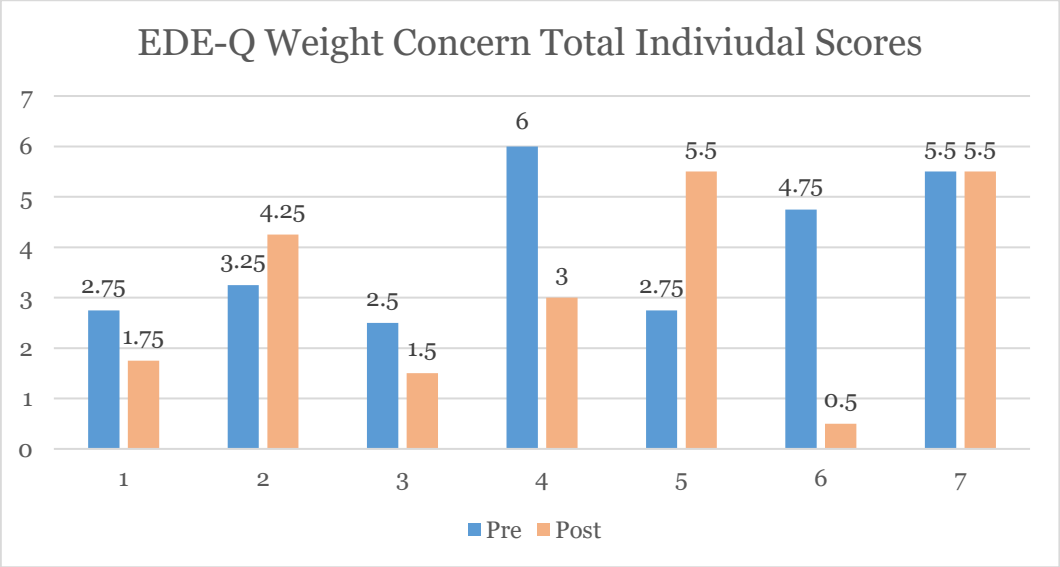

Individual scores on the shape concern subscale, as shown in Figure 4.58, demonstrate that three participants reported a decrease in scores on this subscale, one participant reported no change, and two participants reported an increase in scores.

Figure 4.58. *EDEQ Shape Concern Total Individual Scores*



Individual scores on the weight concern subscale, as shown in Figure 4.59, demonstrate that four participants reported a decrease in scores on this subscale, one participant reported no change, and two participants reported an increase in scores.

Figure 4.59. *EDEQ Weight Concern Total Individual Scores*




Due to the small sample size, changes in total EDE-Q scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in EDE-Q scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than or equal to 1.96. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and EDE-Q score decreased to below cut-off score of 2.1), "reliable improvement" (passed RCI criterion but the score did not decrease below EDE-Q cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in table 4.12, one participant (14.29%) reported clinically meaningful change, one participant (14.29%) reported reliable improvement, four participants (57.14%) reported uncertain change while one participant (14.29%) reported reliable deterioration.

Table 4.12. *Results from Reliable Change Index (RCI) for EDE-Q pre and post scores.*

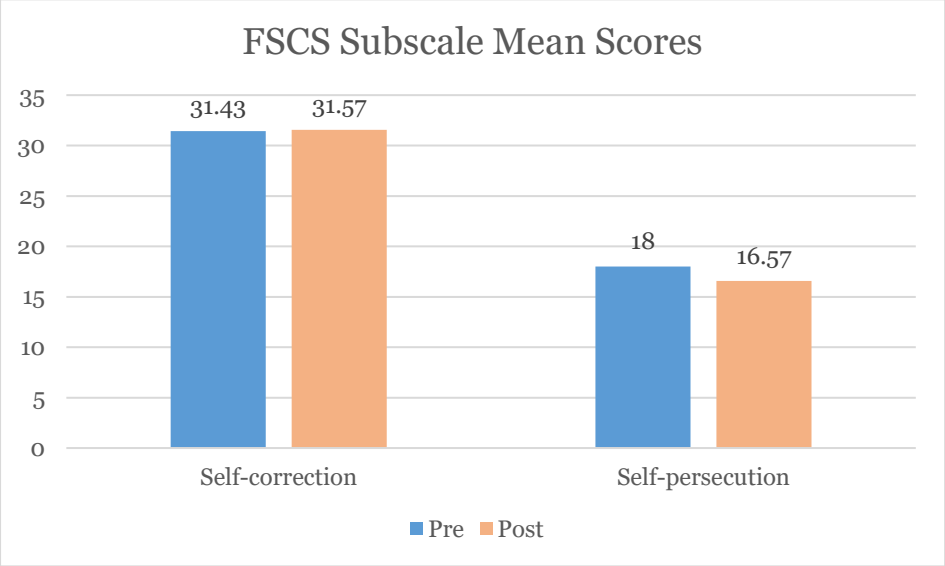
EDE-Q = Eating Disorder Examination Questionnaire

| Participant | Pre-Score | Post Score | RCI Value | Category |
|---|---|---|---|---|
| 1 | 2.12 | 1.39 | -1.01 | Uncertain Change |
| 2 | 3.26 | 3.44 | 0.25 | Uncertain Change |
| 3 | 1.23 | 1.41 | 0.25 | Uncertain Change |
| 4 | 4.47 | 2.26 | -3.04 | Reliable Improvement |
| 5 | 2.77 | 4.46 | 2.33 | Reliable Deterioration |
| 6 | 3.38 | .39 | -4.12 | Clinically Meaningful Change |
| 7 | 4.36 | 4.36 | 0.00 | Uncertain Change |

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

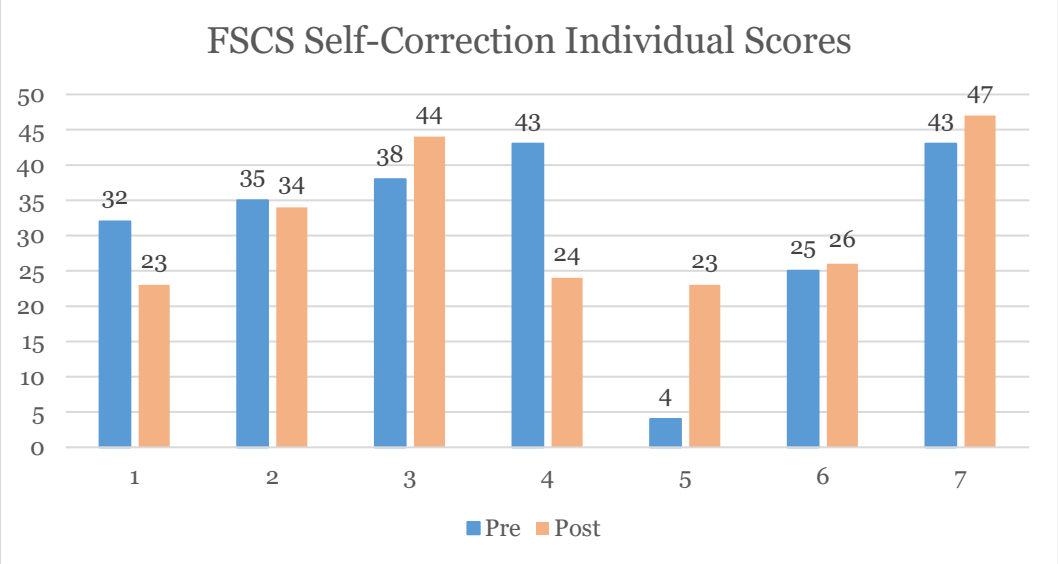
The FSCS is divided into two sub-scales, measuring the function of self-criticising/attacking in terms of self-correction and self-persecution. Total scores on the self-persecution subscale decreased from 18.00 (*SD* = 10.83) to 16.57 (*SD* = 8.16). Levels of self-correction increased from pre-intervention (*M* = 31.43, *SD* = 13.65) to post-intervention (*M* = 31.57, *SD* = 10.28).

Figure 4.60. *FSCS Subscale Mean Scores*



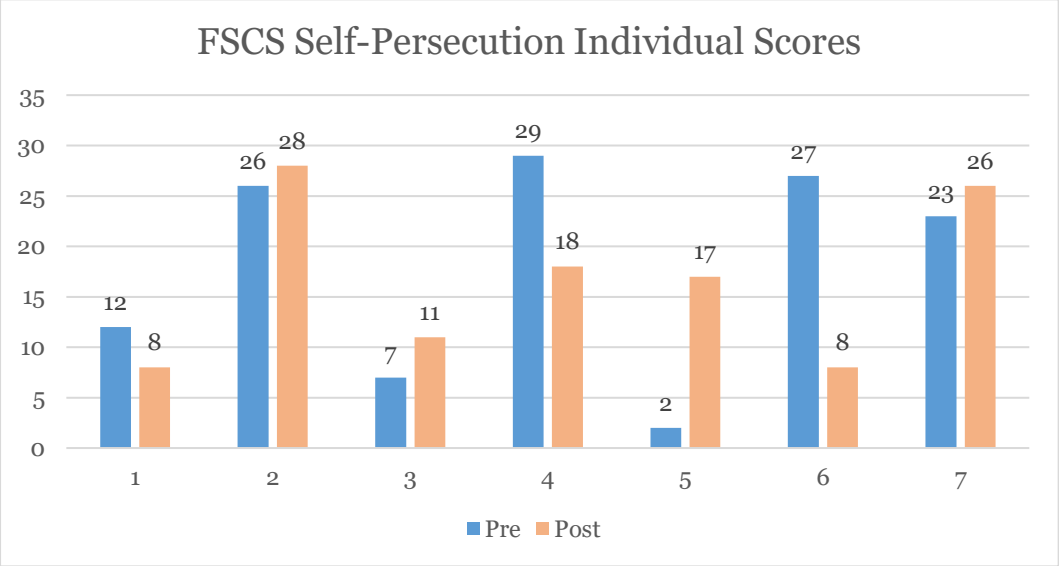

Individual scores on the FSCS Self-Correction subscale, as shown in Figure 4.61, demonstrate that three participants reported a decrease in scores on this subscale, and four participants reported an increase in scores.

Figure 4.61. *FSCS Self Correction Individual Scores*




Individual scores on the FSCS Self-Persecution subscale, as shown in Figure 4.62, demonstrate that three participants reported a decrease in scores on this subscale, and four participants reported an increase in scores.

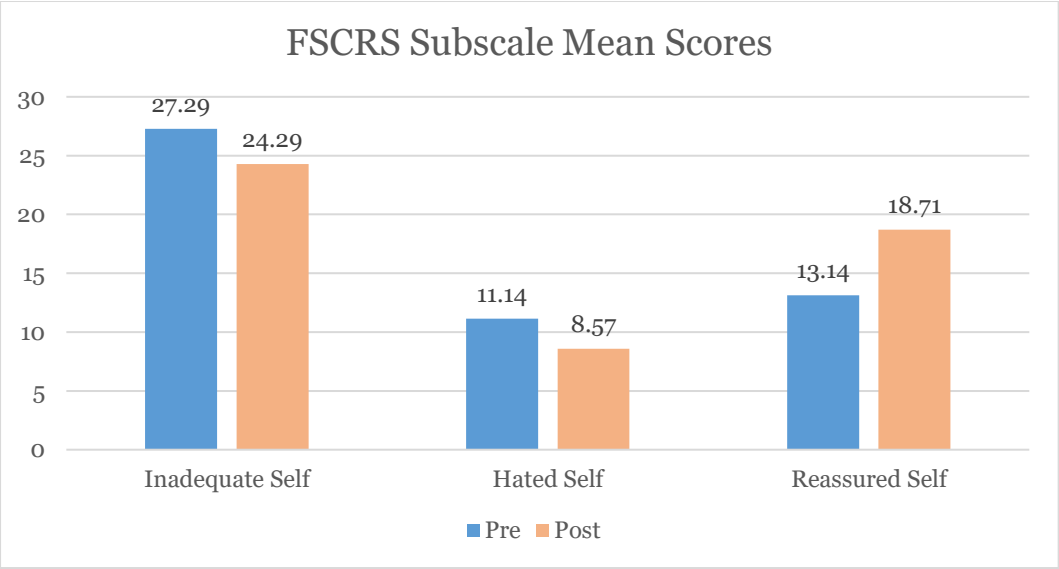
Figure 4.62. *FSCS Self-Persecution Individual Scores*




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

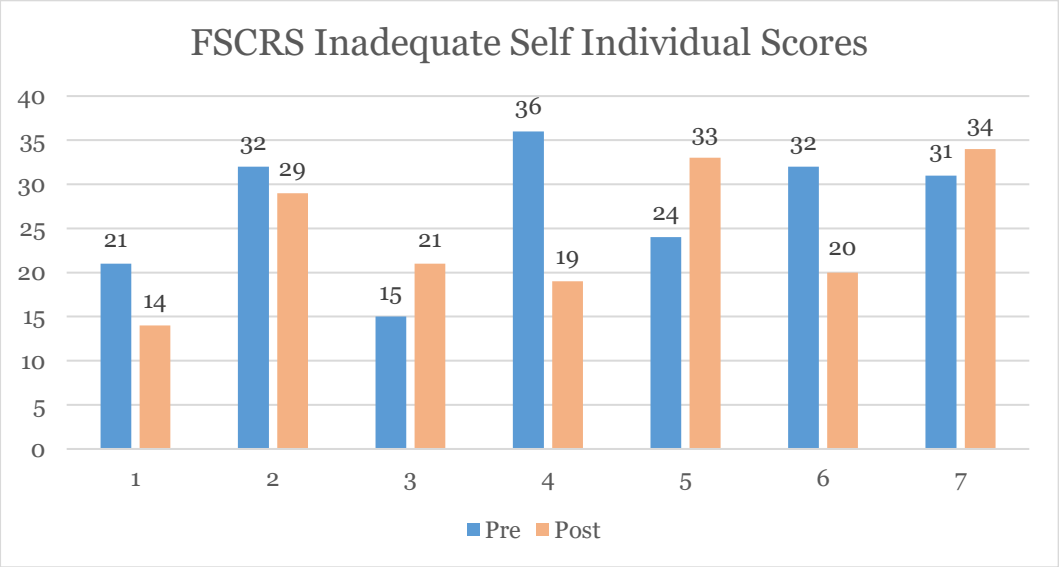
Mean scores on the FSCRS 'inadequate self' sub-scale decreased from pre (*M* = 27.29, *SD* = 7.48) to post-intervention (*M* = 24.29, *SD* = 7.70). A reduction in mean scores on the 'hated self' sub-scale was observed from pre (*M* = 11.14, *SD* = 6.96) to post-intervention (*M* = 8.57, *SD* = 4.93). Mean scores on the 'reassured self' sub-scale increased from pre-intervention (*M* = 13.14, *SD* = 6.74) to post-intervention (*M* = 18.71, *SD* = 6.50).

Figure 4.63. *FSCRS Mean Subscale Scores*



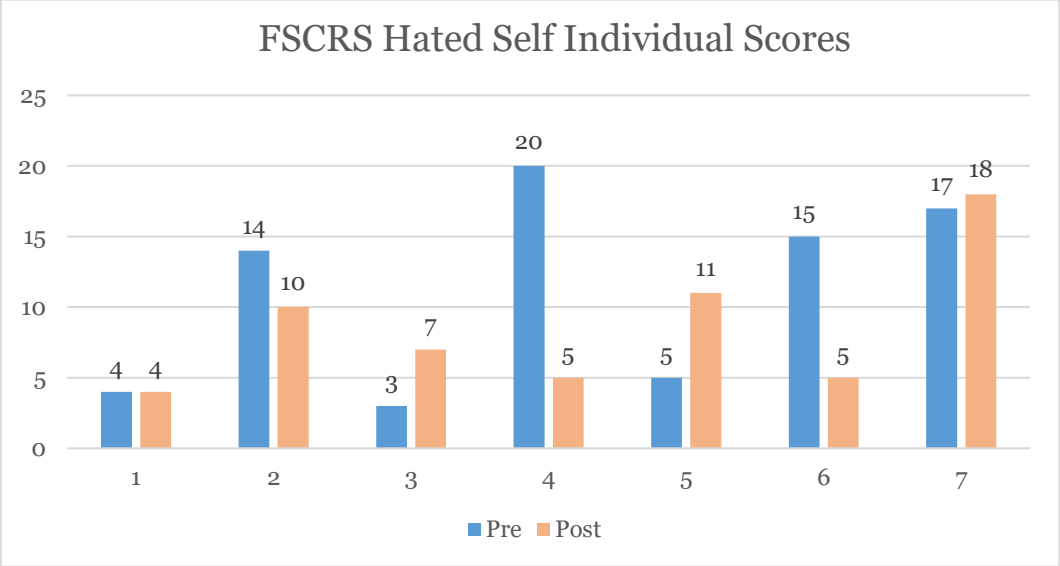

As shown in Figure 4.64, individual scores on the FSCRS Inadequate Self subscale demonstrate that four participants reported a decrease in scores on this subscale, and three participants reported an increase in scores.

Figure 4.64. *FSCRS Inadequate Self Individual Scores*



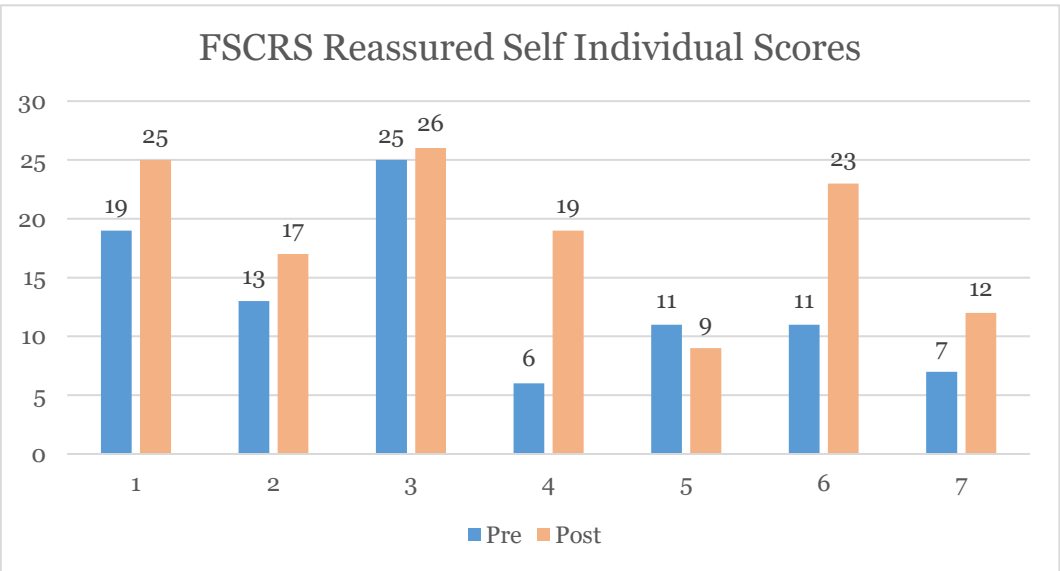

As shown in Figure 4.65, individual scores on the FSCRS Hated Self subscale demonstrate that three participants reported a decrease in scores on this subscale, one participant reported no change, and three participants reported an increase in scores.

Figure 4.65. *FSCRS Hated Self Individual Scores*




As shown in Figure 4.66, individual scores on the FSCRS Reassured Self subscale demonstrate that six participants reported an increase in scores on this subscale, while one participant reported a decrease in scores.

Figure 4.66. *FSCRS Reassured Self Individual Scores*




### Compassionate Engagement and Action Scale (CEAS)

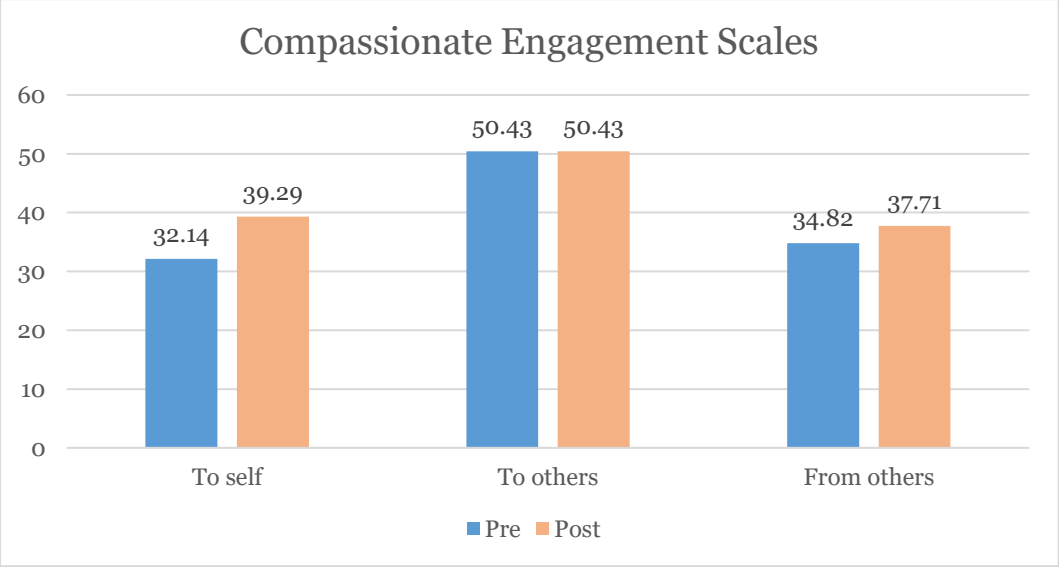
The CEAS is divided into three scales ‘Compassion to Self’, ‘Compassion to Others’ and ‘Compassion from Others’. Overall scores and scores on the engagement and action subscales are reported below.

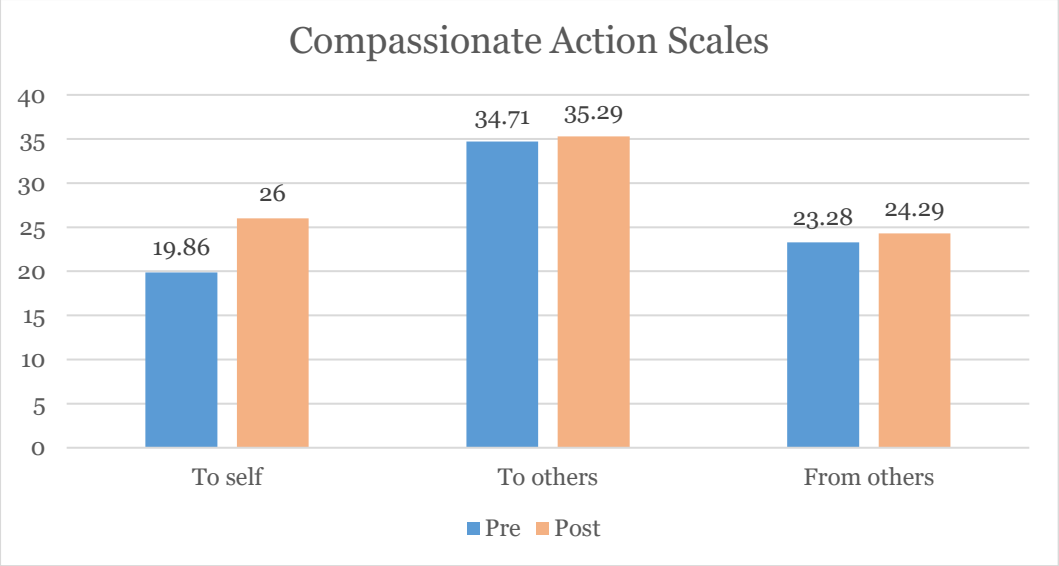
Mean scores on the Compassion to Self Engagement scale increased from pre-intervention *(M* = 32.14, *SD* = 10.24) to post-intervention (*M* = 39.29, *SD* = 6.34). Mean scores also increased on the Compassion to Self Action scale, with scores increasing from 19.86 (*SD* = 7.58) at pre-intervention to 26.00 (*SD* = 6.06) at post-intervention. The total mean score for self-compassion also increased from 52.00 (*SD* = 17.07) to 65.29 (SD = 11.76).

Mean scores for the Compassion to Others Engagement scale remained unchanged from pre-intervention (*M* = 50.43, *SD* = 5.44) to post-intervention (*M*= 50.43, *SD* = 2.44). There was an increase in mean scores from the Compassion to Others Action scale from pre-intervention (*M* = 34.71, *SD* = 3.35) to post-intervention (*M* = 35.29, *SD* = 3.82). Overall mean scores on the Compassion to Others subscale increased from (M = 85.14, *SD* = 8.75), to (M= 85.71, *SD* = 5.62).

Mean scores on the Compassion from Others Engagement Scale increased from pre-intervention (*M* = 34.82, *SD* = 8.85) to post-intervention (*M* = 37.71, *SD* = 7.76). Mean scores on the Compassion from Others Action Scale increased with a pre-intervention mean of 23.28 (*SD* = 6.13) to a post-intervention mean of 24.29 (*SD* = 8.62). The total mean scores on the Compassion from Others subscale increased, from 58.10 (*SD* = 14.70) at pre-intervention to 62.00 (*SD* = 15.91) at post-intervention.

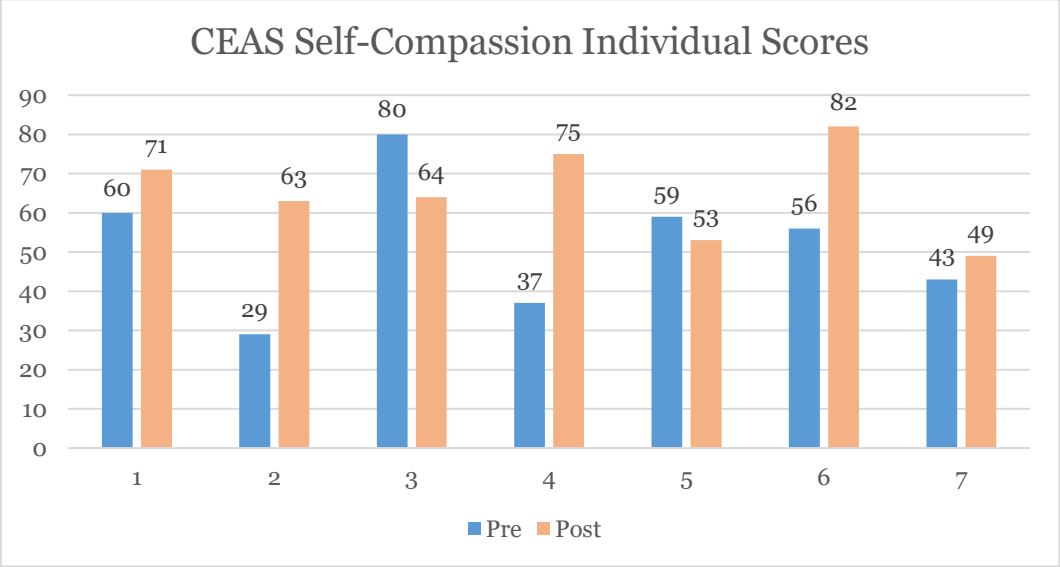
Figure 4.67. *CEAS Engagement and Action Scales Mean Scores*





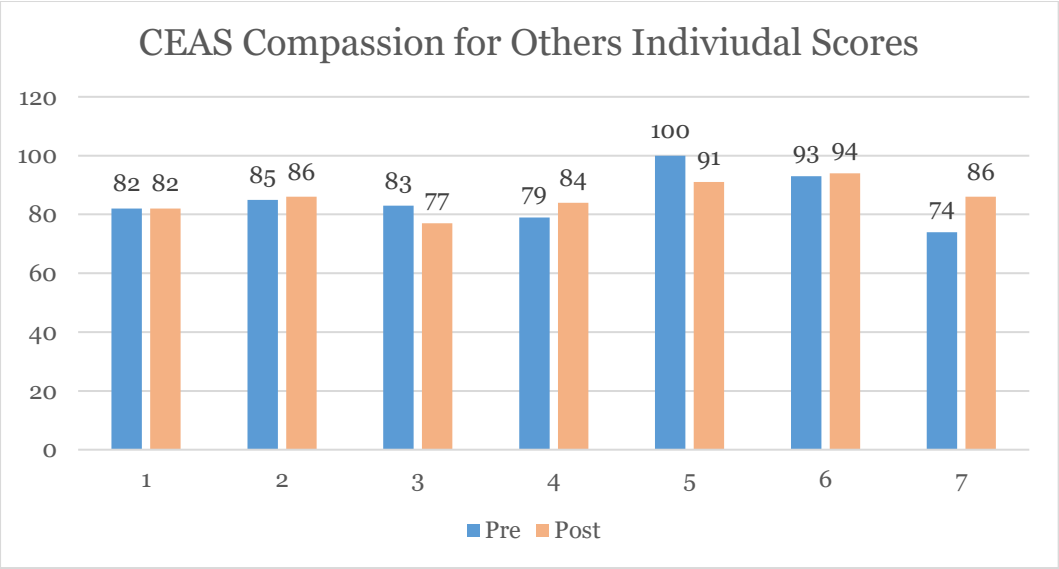

As shown in Figure 4.68, individual scores on the CEAS Self-Compassion subscale demonstrate that five participants reported an increase in scores on this subscale, while two participants reported a decrease in scores.

Figure 4.68. *CEAS Self-Compassion Individual Scores*



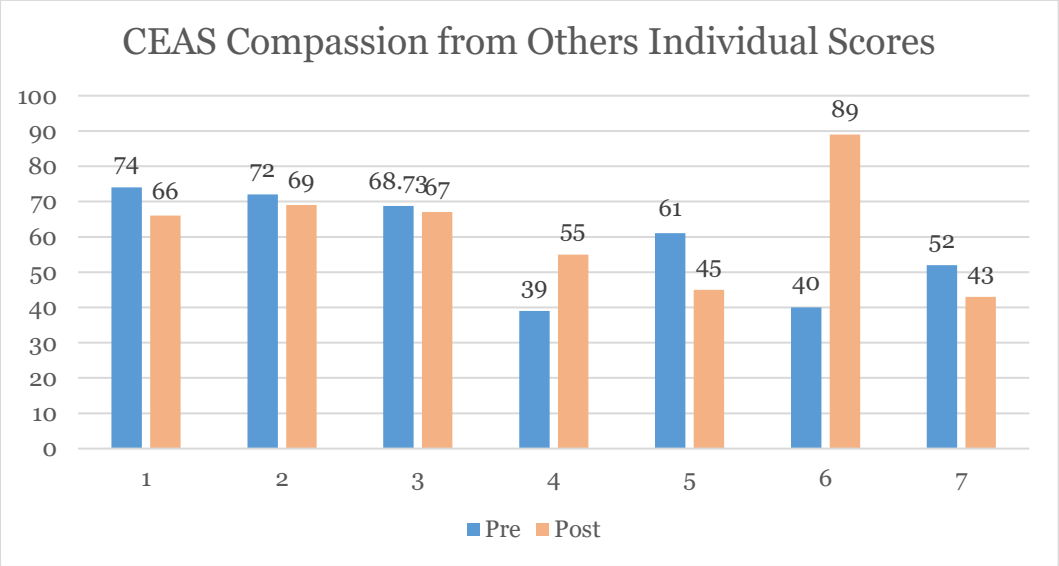

As shown in Figure 4.69, individual scores on the CEAS Compassion for Others subscale demonstrate that four participants reported an increase in scores on this subscale, one participant reported no change, while two participants reported a decrease in scores.

Figure 4.69. *CEAS Compassion for Others Individual Scores*




As shown in Figure 4.70, individual scores on the CEAS Compassion from Others subscale demonstrate that two participants reported an increase in scores on this subscale, while five participants reported a decrease in scores.

Figure 4.70. *CEAS Compassion from Others Individual Scores*




### 4.10.4. Summary

Since CFT-E began in SPMHS in 2015, 12 cycles have been facilitated and the most recent cycle completed in 2024 was delivered in mainly a face-to-face format with four

hybrid sessions due to service user request. The programme receives referrals from within the hospital and from external referrers. The outcomes report above illustrates the efficacy of the CFT-E programme; Participants reported a reduction in eating disorder symptoms, self-hatred, feelings of inadequacy with an increase in self reassurance and self-compassion. The programme is meetings its aims in reducing eating disorder symptoms and improving service users' relationship with themselves. As this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs, the results must be interpreted with caution.

## 4.11. Depression Recovery Programme

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

### Depression Recovery Programme

The Depression Recovery Programme is a 10-week psychotherapy group programme which combines approaches from Cognitive Behavioural Therapy (CBT), Compassion-Focused Therapy (CFT) and Mindfulness-Based Stress Reduction (MBSR). Sessions are led by cognitive behavioral psychotherapists and nurses with expertise in depression, group therapy, CFT, and mindfulness.

### Depression Recovery Aftercare

Following programme review, and in line with service user feedback, the Depression Recovery Aftercare programme was extended in January 2024 to two years rather than the previous one year. It is a group that meets for a half day once a month. It focuses on building on and maintaining the change made through the Depression Recovery Programme. The group is run by two accredited CBT therapists, and continues to apply the approaches of CBT, CFT and MBSR.

### 4.11.1. Descriptors

Paired data were available for 19 service users who completed the programme in 2024: 10 females (52.6%) and 9 males (47.4%). The age profile of participants ranged from 29 to 77 years of age (*M* = 56 *SD* = 12.49).

### 4.11.2. Depression Recovery Programme outcome measures

- **Quick Inventory of Depression Symptomatology (QIDS):** see page 132
- **The Work and Social Adjustment Scale (WSAS):** see page 135

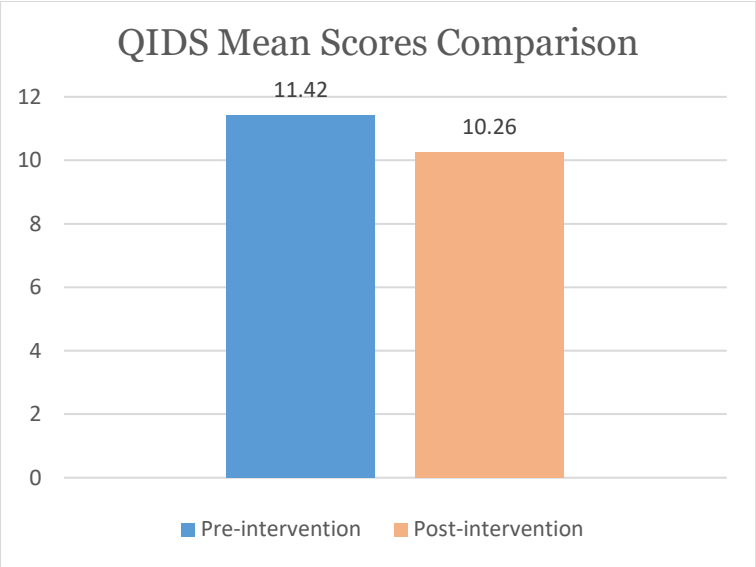
### 4.11.3. Results

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 19 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

#### Quick Inventory of Depression Symptomatology (QIDS)

Comparison of service user scores on the QIDS indicated a reduction of depression severity scores from pre-intervention (*M* = 11.42, *SD* = 5.06) to post-intervention (*M* = 10.26, *SD* = 5.43) (see Figure 4.71).

Figure 4.71. *Pre and post-group mean scores for the QIDS*




Due to the small sample size, changes in the QIDS scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in QIDS scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values equal to or larger than 1.96. The critical score change score indicating clinically meaningful improvement on the QIDS was a change of 5.78 points. Participants were classified as “reliable improvement” (passed RCI criterion), “no reliable change” (did not pass RCI criterion) or “reliable deterioration” (passed RCI criterion but symptom score increased).

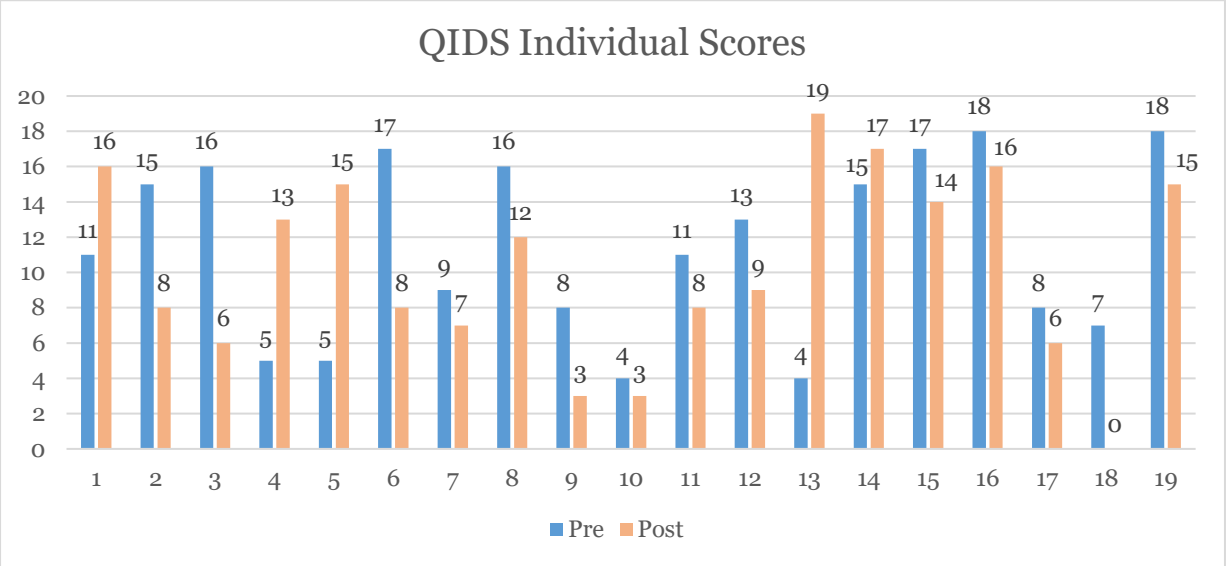
Results for the reliable change index indicated that four participants (33.33%) reported reliable improvement, twelve participants (63.18%) reported uncertain change, and three participants (25%) reported reliable deterioration (see table 4.13).

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

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 11 | 16 | 1.69 | Uncertain change |
| 2 | 15 | 8 | -2.37 | Reliable improvement |
| 3 | 16 | 6 | -3.39 | Reliable improvement |
| 4 | 5 | 13 | 2.71 | Reliable deterioration |
| 5 | 5 | 15 | 3.39 | Reliable deterioration |
| 6 | 17 | 8 | -3.05 | Reliable improvement |
| 7 | 9 | 7 | -0.68 | Uncertain change |
| 8 | 16 | 12 | -1.36 | Uncertain change |
| 9 | 8 | 3 | -1.69 | Uncertain change |
| 10 | 4 | 3 | -0.34 | Uncertain change |
| 11 | 11 | 8 | -1.02 | Uncertain change |
| 12 | 13 | 9 | -1.36 | Uncertain change |
| 13 | 4 | 19 | 5.08 | Reliable deterioration |
| 14 | 15 | 17 | 0.68 | Uncertain change |
| 15 | 17 | 14 | -1.02 | Uncertain change |
| 16 | 18 | 16 | -0.68 | Uncertain change |
| 17 | 8 | 6 | -0.68 | Uncertain change |
| 18 | 7 | 0 | -2.37 | Reliable improvement |
| 19 | 18 | 15 | -1.02 | Uncertain change |

Further examination of the individual scores indicates that 14 out of 19 participants (73.68%) demonstrated a reduction in QIDS scores from pre-intervention to post-intervention (see Figure 4.72).

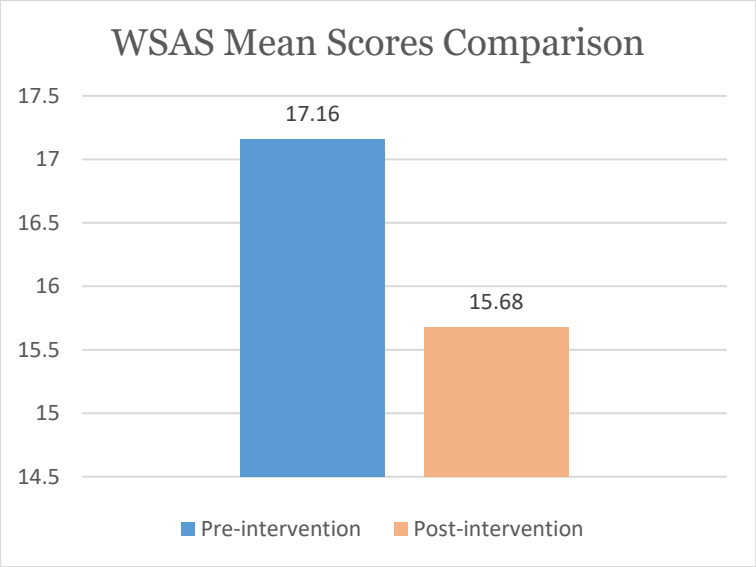
Figure 4.72. *Pre and post individual scores of the QIDS.*




### The Work and Social Adjustment Scale (WSAS)

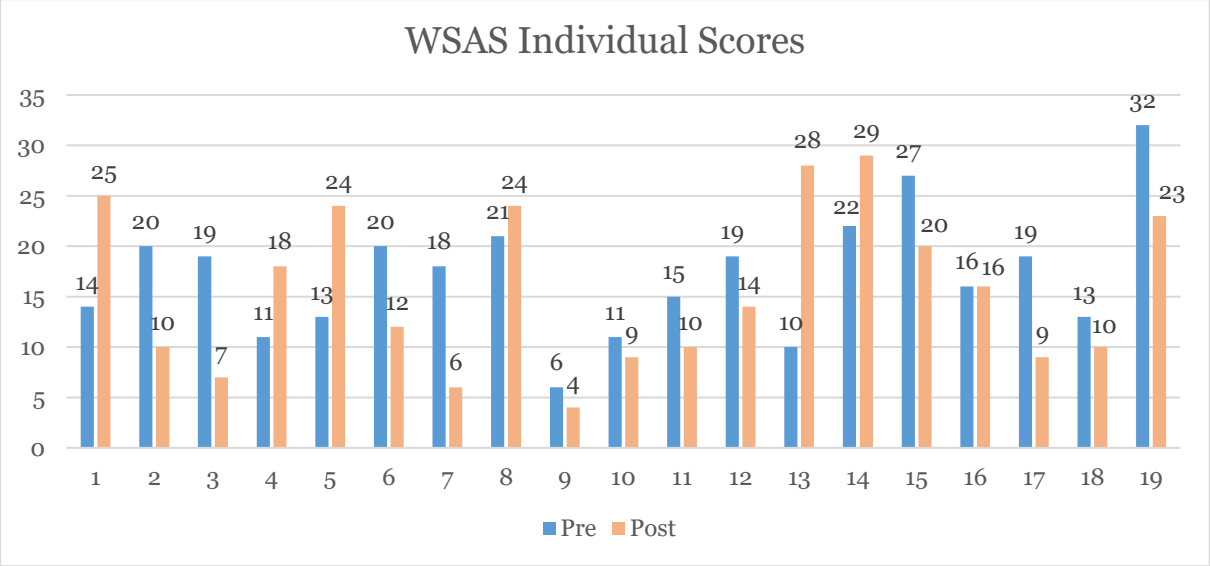
Comparison of service user scores on the WSAS indicated a reduction of severity scores from pre-intervention ($M$ = 17.16, $SD$ = 6.17) to post-intervention ($M$ = 15.68 $SD$ = 7.96) (see Figure 4.73).

Figure 4.73. *Pre and post-group mean scores for the WSAS*



Further examination of the individual scores indicates that 12 out of 19 participants (63.16%) demonstrated a reduction in QIDS scores from pre-intervention to post-intervention (see Figure 4.74).

Figure 4.74. *Pre and post individual scores of the WSAS.*




### 4.11.4. Summary

This is the tenth year the Depression Recovery Programme has been included in the SPMHS *Outcomes Report*. This is the second year the the Work and Social Adjustment Scale (WSAS) which measures functioning impairment has been measured pre and post-intervention. This is fifth year the QIDS has been used to capture the profile of group attendees and investigate the programme's effectiveness at reducing symptoms of depression. These results provide evidence to suggest that overall, people who complete the programme experience a reduction in symptoms associated with depression, and their functioning impairment.

## 4.12. Eating Disorders Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the needs of people with anorexia nervosa, bulimia nervosa, binge eating disorder and Other Specified Feeding and Eating Disorders (OSFED). The objective of the programme is to address the physical, psychological and social issues arising as a result of an

eating disorder in an attempt to resolve and overcome many of the struggles associated with it. The programme is a multidisciplinary programme with an emphasis on a CBT treatment model which is applied throughout inpatient, day programme and outpatient treatment stages, as needed by the service user. The programme is structured into three stages. Initially service users are assessed at the Dean Clinic. The typical care pathway then involves inpatient care, day care and follow-up outpatient care. Treatment can also be provided in a standalone capacity as an inpatient, a day care service user or an outpatient.

Inpatient care consists of a variety of interventions including:

- Stabilisation of weight
- Medical treatment of physical complications where present.
- Meal supervision.
- Nutritional assessment and treatment.
- Dietetics group: discuss nutrition, meal planning, shopping, food portions, etc.
- Care planning, goal-setting and personal development.
- Occupational therapy groups: weekly groups addressing lifestyle balance, stress management and social, leisure and self-care needs. A weekly cookery session is also included in the programme.
- Family support and education individual psychotherapy.
- Psychology groups for compassionate mind training which aims to help participants begin to understand, engage with and alleviate their distress.

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

- Occupational therapy groups
- Goal-setting and care planning

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

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

### 4.12.1. Descriptors

Data was available for a total of 14 service users attending the EDP as an inpatient in 2024. Inpatient data was collected at two points, inpatient admission, and discharge. Data was available for 6 service users who attended EDP as a day service user in 2024. Day service user data was collected at either inpatient discharge or day service user admission as a pre-intervention measure, and then day service user discharge as their post-intervention measure. 12 service users completed outcome measures for both the inpatient and day service programmes.

### 4.12.2. EDP Outcome Measures

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

- **Eating Disorder Examination – Questionnaire (EDE-Q) –** see page 116
- **State Self-Esteem Scale (SSES) –** see page 140

The State Self-Esteem Scale is a 20-item scale that measures a participant's self-esteem at a given point in time. The 20 items are subdivided into three components of self-esteem: performance self-esteem, social self-esteem and appearance self-

esteem.  All items are answered using a five-point scale (one = not at all, two = a little bit, three = somewhat, four = very much, five = extremely).

Higher scores indicate higher levels of self-esteem.

### 4.12.3. Results

## Inpatient Results

### Eating Disorders Examination Questionnaire (EDE-Q)

A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed. The total Global score on the EDE-Q showed decreased symptomatology between pre-treatment (*M* = 3.95) and post-treatment (*M* = 2.41). A pairwise sample t-test indicated this was a statistically significant change *t(*25) = 6.31, *p*<0.001, with a large effect size, *d* = 1.23.

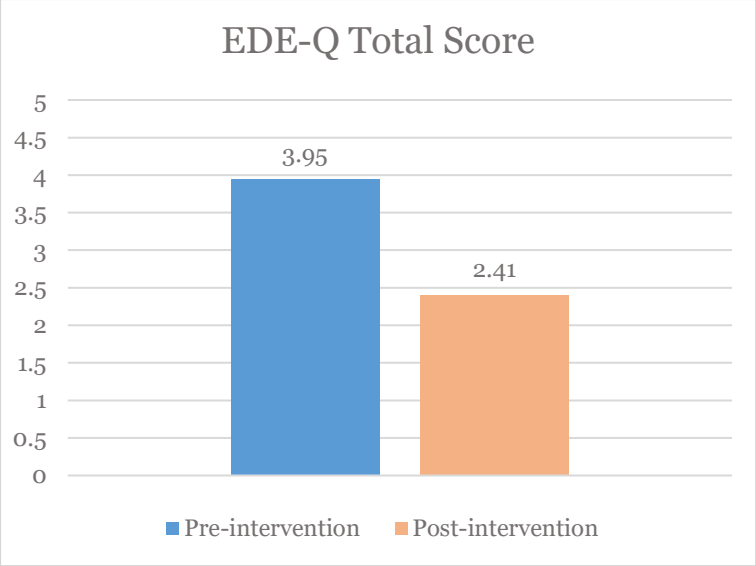
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restraint sub-scale significantly decreased from pre-treatment (*M*= 3.33) to post-treatment (*M* = 1.22), *t(*25)= 6.48, *p*<0.001, with a large effect size of *d* = 1.27.

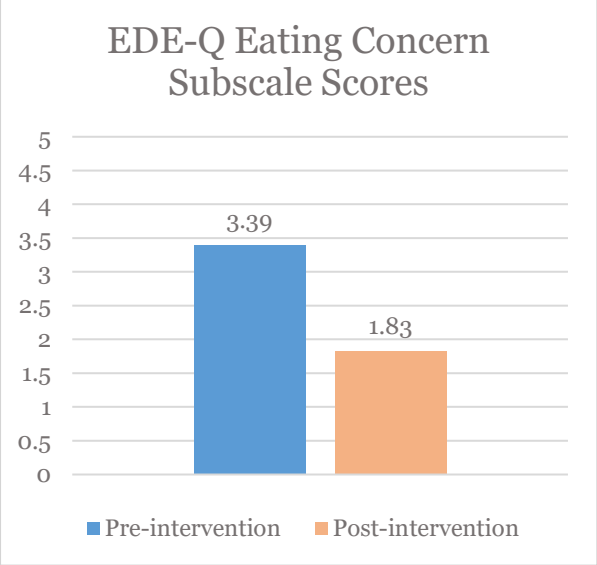
Secondly, symptomatology on the eating concern sub-scale significantly decreased from pre-treatment (*M*= 3.39) to post-treatment (*M* = 1.83), *t(*25)= 7.05, *p*<0.001, with a large effect size, *d* = 1.38.

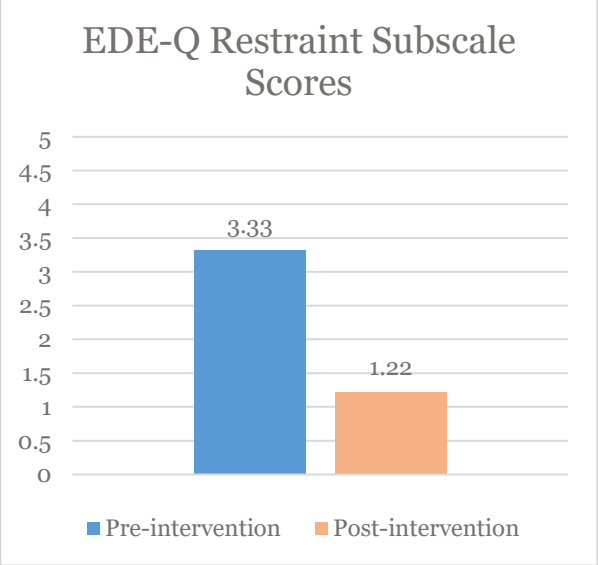
Additionally, symptomatology on the shape concern sub-scale significantly decreased from pre-treatment (*M*= 4.74) to post-treatment (*M* = 3.56), *t(*25)= 3.98,  *p* <0.001, with a medium effect size, *d* = *0*.78.

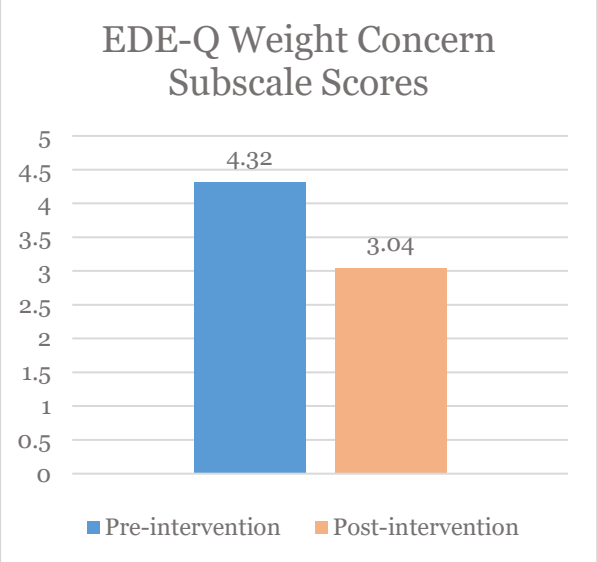
Finally, symptomatology on the weight concern sub-scale significantly decreased from pre-treatment (*M*= 4.32) to post-treatment (*M* = 3.04), *t(*25)= 3.79, *p* <0.001, with a large effect size, *d* = 1.24.

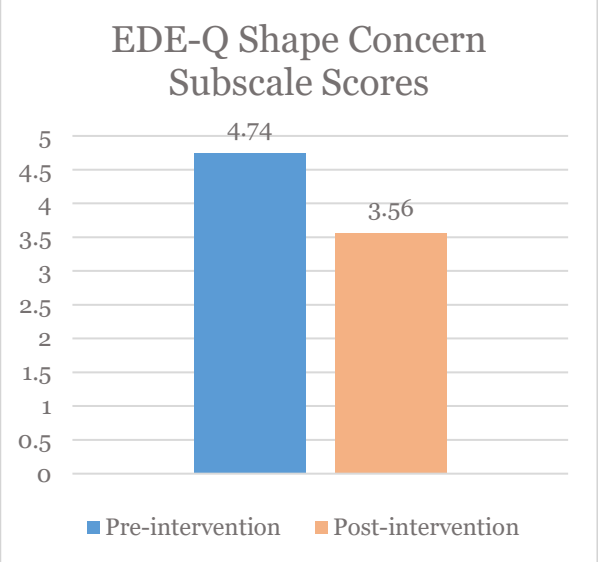
Figure 4.75. *Pre and Post Group Mean Scores for the EDE-Q total and sub-scale scores*


EDE-Q Total Score
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.95
2.41
Pre-intervention
Post-intervention


EDE-Q Eating Concern Subscale Scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.39
1.83
Pre-intervention
Post-intervention


EDE-Q Restraint Subscale Scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.33
1.22
Pre-intervention
Post-intervention


EDE-Q Weight Concern Subscale Scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.32
3.04
Pre-intervention
Post-intervention


EDE-Q Shape Concern Subscale Scores
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.74
3.56
Pre-intervention
Post-intervention

### State Self-Esteem Scale (SSES)

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

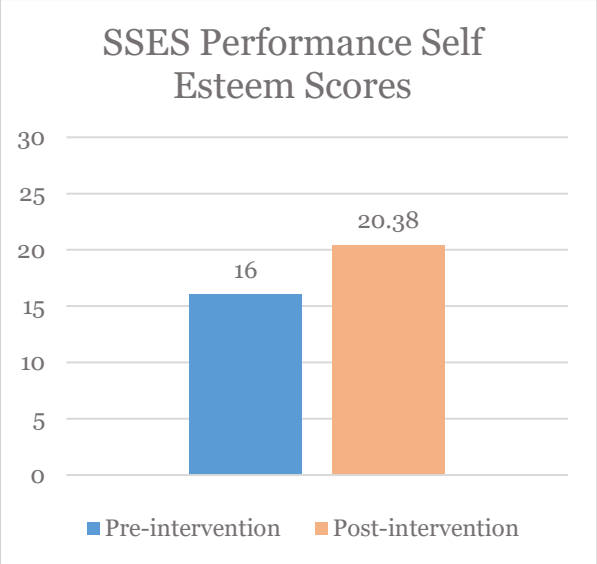
The total score on the SESS showed an increase between pre-treatment (*M*=49.03) and post-treatment (*M*=61.23). A pairwise sample t-test indicated this was a statistically significant change, *t* (25) = -3.95, *p* <0.001, with a medium to large effect size *d*= 0.77.

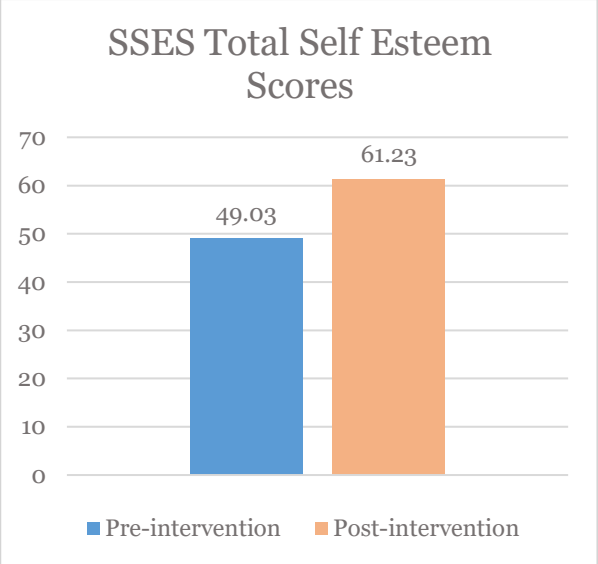
The performance self-esteem score on the SESS showed an increase between pre-treatment (*M*=16.00) and post-treatment (*M*=20.38). A pairwise sample t-test indicated this was a statistically significant change, *t (*25*)* = -3.35, *p* <0.001, with a medium effect size *d*= 0.66

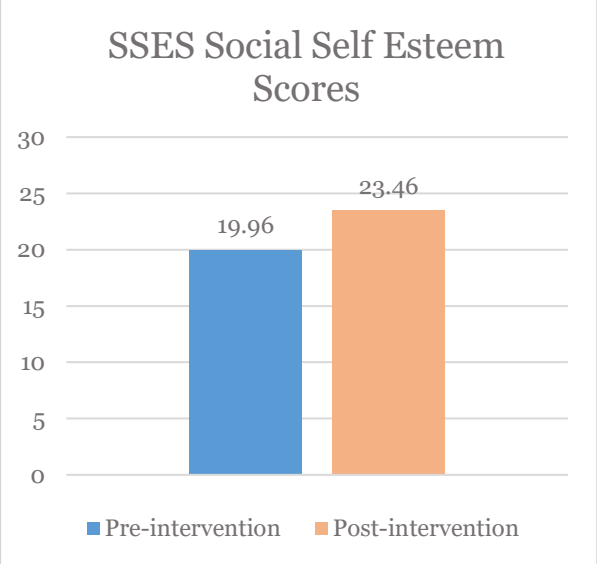
The social self-esteem score on the SESS showed an increase between pre-treatment (*M*=19.96) and post-treatment (*M*=23.46). A pairwise sample t-test indicated this was statistically significant, *t(*25)= -3.83, *p* <0.001, with a medium to large effect size of *d* = 0.75.

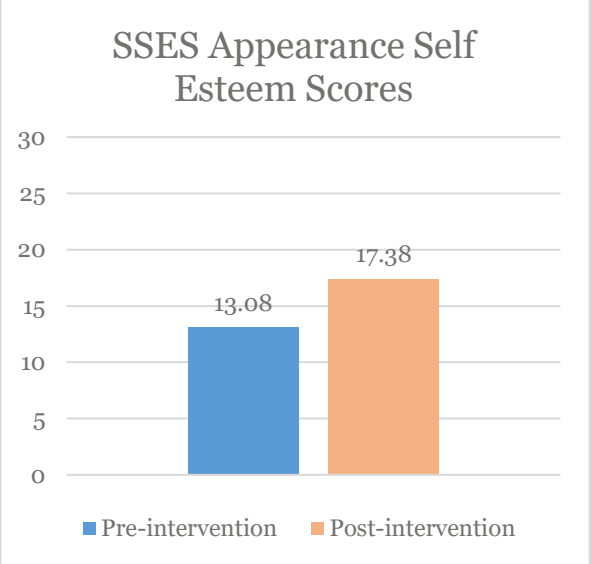
The appearance self-esteem score on the SESS showed an increase between pre-treatment (*M*=13.08) and post-treatment (*M*=17.38). A pairwise sample t-test indicated this was a statistically significant change, *t(*25)= -4.25, *p* <0.001, with a large effect size *d*=0.83

Figure 4.76. *Pre and Post Group Mean Scores for the State Self Esteem Scale total and subscale scores*




## 4.12.4. Day Programme Service User Results

### Eating Disorders Examination Questionnaire (EDE-Q)

A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed. The total score on the EDE-Q showed decreased symptomatology between pre-treatment ($M$ = 3.02) and post-treatment ($M$ = 2.68). However, a pairwise sample t-test indicated this was not a statistically significant change $t(17) = 1.42$, $p = 0.17$.

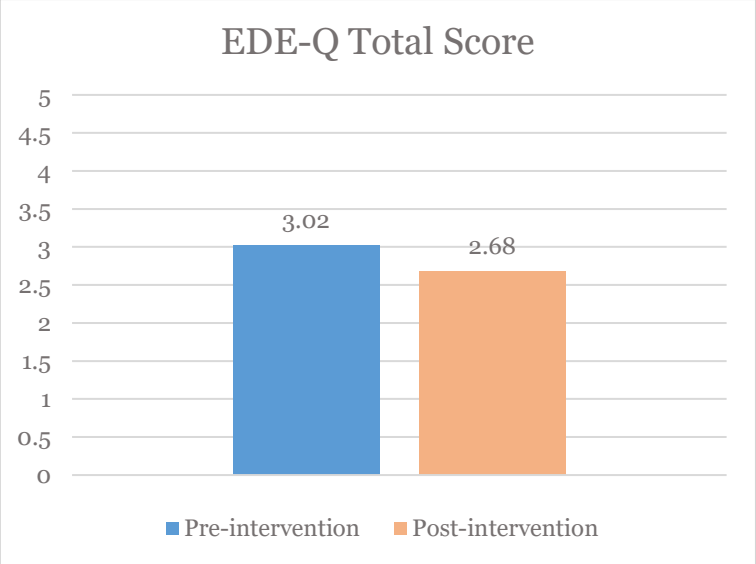
Symptomatology on the restraint sub-scale decreased from pre-treatment (*M*= 1.91) to post-treatment (*M* = 1.49), although this difference was not found to be statistically significant, t(17)= 2.22, *p* = 0.24.

Symptomatology on the eating concern sub-scale decreased from pre-treatment (*M*= 2.37) to post-treatment (*M* = 2.24), although this difference was not found to be statistically significant, *t*(17) = 0.44, *p* = 0.67.

Additionally, symptomatology on the shape concern sub-scale decreased from pre-treatment (*M*= 4.35) to post-treatment (*M* = 3.84), although this difference was not statistically significant, *t(*17)= 1.81, *p* = 0.09.

Finally, symptomatology on the weight concern sub-scale decreased from pre-treatment (*M*= 3.47) to post-treatment (*M* = 3.14), but again this was not statistically significant, *t(*17)= 1.30, *p* = 0.21.

Figure 4.77. *Pre and Post Group Mean Scores for the EDE-Q Global and subscale scores.*




### State Self-Esteem Scale (SSES)

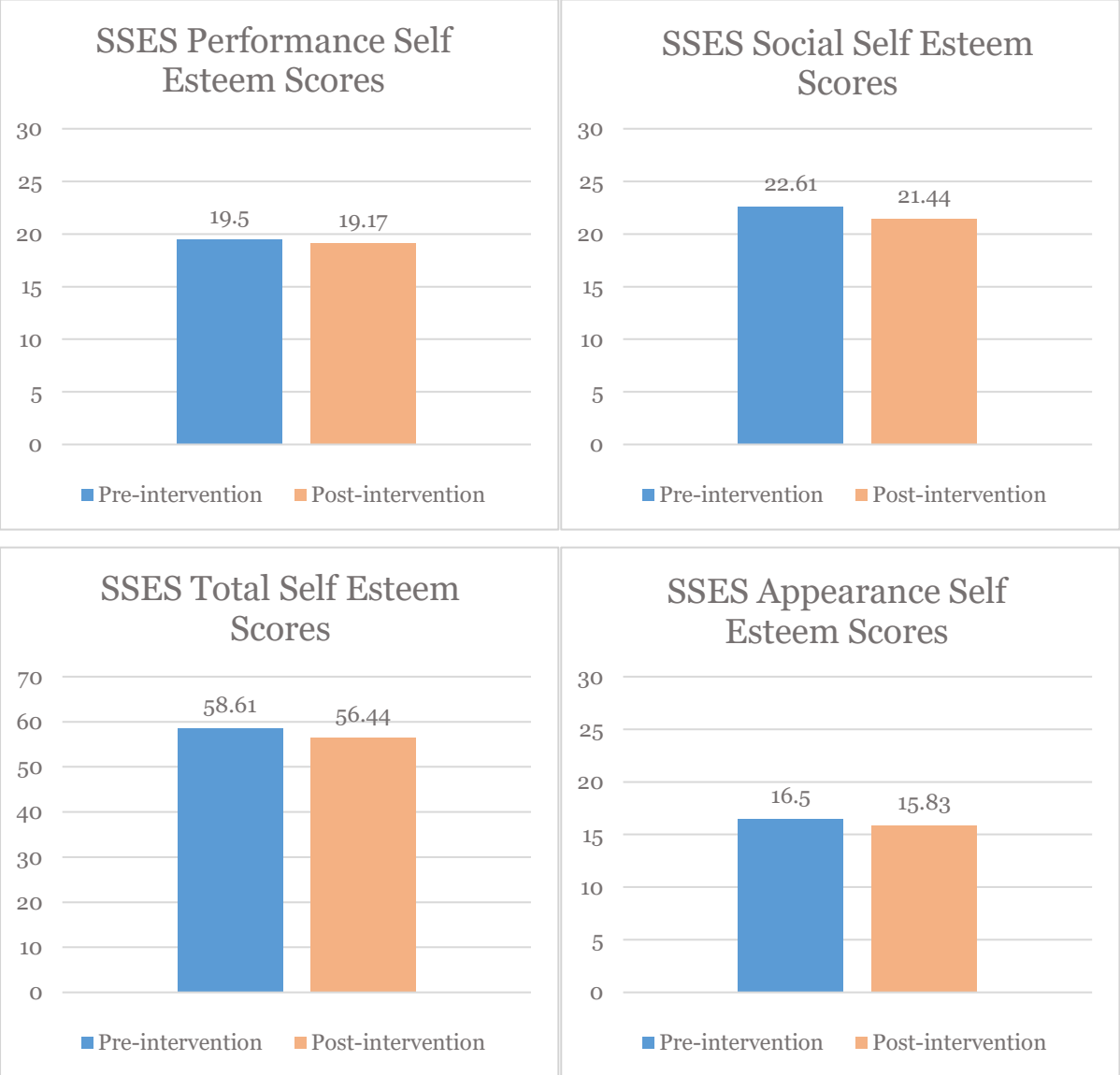
The total score on the SESS showed a slight decrease between pre-treatment (*M*=58.61) and post-treatment (*M*=56.44). A paired samples t-test indicated this was not a statistically significant change, *t* (17) = 0.72, *p* = 0.48.

The performance self-esteem score on the SESS showed a slight increase between pre-treatment (*M*=19.50) and post-treatment (*M*=19.17). A paired samples t-test indicated this was not a statistically significant change, *t* (17) = 0.20, *p* = 0.84.

The social self-esteem score on the SESS showed slight decrease between pre-treatment (*M*=22.61) and post-treatment (*M*=21.44). A pairwise sample t-test indicated this was not a statistically significant change, *t* (17) = 1.15, *p* = 0.27.

The appearance self-esteem score on the SESS showed slight decrease between pre-treatment (*M*=16.50) and post-treatment (*M*=15.83). A paired samples t-test indicated this was not a statistically significant change, *t* (17) = 0.86, *p* = 0.40.

Figure 4.78. *Pre and Post Group Mean Scores for the State Self-Esteem scale total and subscale scores.*




### 4.12.5. Summary

The findings presented provide insight into the effectiveness of the programme. Analysis of the data collected via outcome measures indicate that, on average, those who attend the Eating Disorder Programme as an inpatient experienced a significant reduction in eating disorder symptomology as measured by the EDE-Q, as well as

significant improvements in self-esteem across a range of domains as measured by the SSES. This is indicative of the aims of the programme and reflects promising service user outcomes on completion of the Eating Disorders Programme. Smaller improvements were observed for those who took part in the Day Programme. One likely explanation for this finding is that those who had taken part in the inpatient programme beforehand may have already made gains and thus may have already met their goals in terms of eating disorder symptoms and self-esteem, leaving less scope for their scores to change. Overall, the Eating Disorder Programme has been demonstrated as an effective intervention for eating disorder behaviours and issues of self-esteem.

Whilst the number of outcomes measures collected for individuals completing the inpatient programme were comparable to those gathered in 2023, there was a decline in the number of pre and post measures collected for individuals completing the day services programme. However, there were an increased number of measures collected for those who completed both programmes in succession. The EDP team are confident that the number of day programme pre and post outcome measures collected will improve during 2025 following changes to the process for collection of outcome measures. In 2024, the EDP programme began to utilise a secure service user electronic portal (*Your Portal*), to send clinical outcome measures for completion by consenting service users attending the programme. Service users can now complete the outcome measures via the secure portal, which are instantly accessible for review by the clinical staff delivering the programme. It is anticipated this change will result in an increase in the number of pre and post outcome measures completed by service users attending the EDP programme in 2025 as it continues to be used.

## 4.13. Emotion-Focused Therapy for Young Adults Programme

The Emotion-Focused Therapy for Young Adults (EFT-YA) programme proposes that the young adult population commonly describe finding themselves stuck at specific developmental points in their lives. These may take the form of vocational crisis (dropping out of college or repeatedly losing employment opportunities), systemic issues (difficulty in achieving psychological individuation and autonomy from family of origin), stuck in unhelpful patterns of behaviour (disorganised

attachment/interpersonal difficulties), maladaptive coping strategies, difficulty in achieving developmental milestones (perception of being 'left behind' by 'more successful' peers). It is postulated that this sense of 'stuckness' is mirrored in the internal psychological processing issues experienced by the young adult. It suggests that a fear of/reluctance/inability to access and tolerate the affect associated with core pain leads the young person to engage in emotional and behavioural avoidance strategies which are successful to the extent that they frustrate effective and meaningful processing of this pain. The young person then finds themselves in a state of undifferentiated Global Distress, characterised by secondary emotional experiencing, such as rejecting anger, anxiety, hopelessness, agitation and so on. This state can be triggered by current and historic triggers which may be internal and external and is complicated by problematic self-treatment (excessive self-criticism, shame and fear). By accessing the core pain and by identifying the associated needs, the young adult can move beyond global distress and begin to access the necessary compassion and protective anger required to support them in their journey towards relief from their pain and a towards a sense of agency/empowerment.

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

**Underlying principles/philosophy:**

"EFT's theory of psychopathology places emotions at the centre of dysfunction/ function. Emotions are fulfilling many functions. They inform us as to whether our needs are being met, they communicate to others about our internal world, and they

set the goals for our rational pursuits (Greenberg, 2011). In terms of psychopathology, EFT sees service users as either, not fully availing of the adaptive information embedded in their emotional experience (for example *sadness tells me what I miss*) or, and more typically, as experiencing chronic, painful, and maladaptive emotions generated through complex memory-based emotional schematic processes (Greenberg, 2016)." (Timulak and Keogh, 2020)

### Efficacy/ Effectiveness of EFT-YA

Emotion-Focused Therapy (EFT) is an empirically supported therapy (Greenberg, 2011; Greenberg and Watson, 2005; Greenberg and Watson, 2006) with roots in the person-centred, gestalt, experiential and existential therapies (Rogers, 1957, Gendlin, 1996; Elliott, Watson, Goldman & Greenberg, 2004). It has evolved gradually over twenty-five years through a systematic program of psychotherapy research and in its current incarnation, incorporates elements of contemporary cognitive and emotion theory (Greenberg, 2011). The evolution of EFT is directly attributable to its origins in a research-based investigation of change processes in psychotherapy (Greenberg, 1979; 1984; Rice & Greenberg, 1984) in tandem with a curiosity regarding the role of emotion (Greenberg & Safran, 1987).

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

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

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

EFT-YA is a 20-week programme. Prior to commencing group, each participant has two individual sessions to help them orient to the model and begin the process of engaging with their emotional processing style. This is essential to support the individuals future engagement with group (Thompson & Girz, 2020). In 2024, the EFT-YA programme length was increased from 14 to 20 sessions. The clinical rationale for the increase in sessions was to support the development of group cohesion over a longer time period. Group cohesion is an active agent of therapeutic change in EFT-YA. The change in structure length further allows for service users to engage in two sessions of 'chair-work' each, to support the resolution of idiosyncratic processing difficulties in the group setting.

### 4.13.1. Descriptors

A total of 13 people completed EFT- YA in 2024. Complete pre and post outcome data were available for 10 people, representing a 76.92% total completion rate. Of 10 participants 8 (80%) were female and 2 (10%) were male. Participants ages ranged from 20 to 25 years (*M* = 22.40; *SD* 1.71).

Missing Value Analysis (MVA) was carried out to examine the type of 'missingness' within the data. Where data was found to be Missing Completely at Random by Little's test (Cheng & Evanston, 2013) the Expectation Maximisation method was applied before any total scores were computed or analyses carried out.

### 4.13.2. Emotion-Focused Therapy for Young Adults Programme outcome measures

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

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dysregulation. It comprises six domains: non-acceptance of emotions;

inability to engage in goal-directed behaviours when distressed; impulse control; emotional awareness; emotion regulation strategies; and emotional clarity. The measure consists of 36 items scored on a five-point Likert scale from one – 'almost never', to five – 'almost always'. Total scale scores range from 36 to 180, with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability (α = .93), construct and predictive validity, and test-retest reliability in an article which described the development of this scale.

- **The Generalised Anxiety Disorder-7:** see page 82
- **The Patient Health Questionnaire-9 (PHQ-9):** see page 82
- **The Clinical Outcomes in Routine Evaluation - outcome measure (CORE-OM):** see page 116

### 4.13.3. Results

Results were examined and compared in greater detail including overall mean, individual and programme cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 10 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

#### The Difficulties in Emotion Regulation Scale (DERS)

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

improvement on the DERS was 94. Participants were classified as “clinically meaningful improvement” (passed RCI criterion and DERS score decreased to below cut-off score), “reliable improvement” (passed RCI criterion but the score did not decrease below DERS cut-off score), “uncertain change” (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased).

Results for the reliable change index indicated that four participants (40%) reported clinically meaningful improvement, one participant (10%) reported reliable improvement, three participants (30%) reported uncertain change, and two participants (20%) reported reliable deterioration (see table 4.14).

Table 4.14. *Results from Reliable Change Index (RCI) for the DERS pre and post scores for each group member*

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 103 | 87 | -4.13 | Clinically meaningful improvement |
| 2 | 86 | 81 | -1.29 | Uncertain change |
| 3 | 92 | 85 | -1.81 | Uncertain change |
| 4 | 91 | 97 | 1.55 | Uncertain change |
| 5 | 105 | 90 | -3.87 | Clinically meaningful improvement |
| 6 | 102 | 79 | -5.94 | Clinically meaningful improvement |
| 7 | 86 | 70 | -4.13 | Reliable improvement |
| 8 | 92 | 100 | 2.07 | Reliable deterioration |
| 9 | 99 | 107 | 2.07 | Reliable deterioration |
| 10 | 112 | 88 | -6.20 | Clinically meaningful improvement |

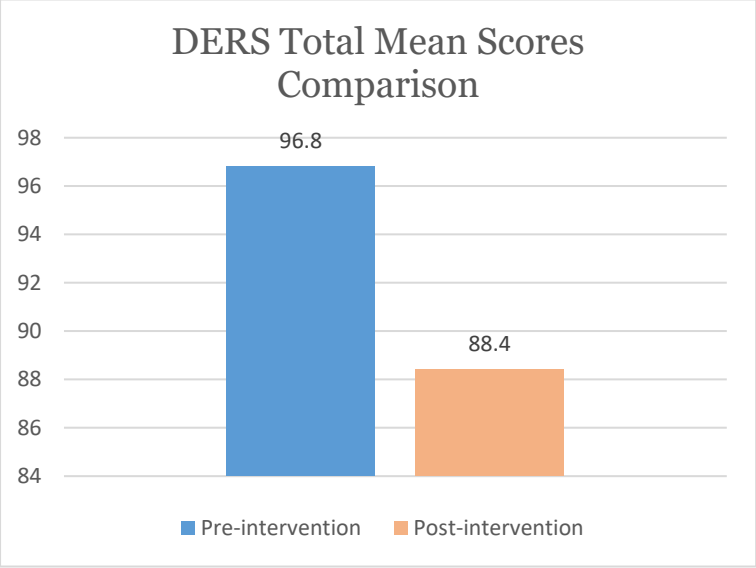
Comparison of service user mean scores on the DERS indicated a decrease in scores from pre-intervention ($M$ = 96.80 $SD$ = 8.70) to post-intervention ($M$ = 88.40 $SD$ = 10.81).

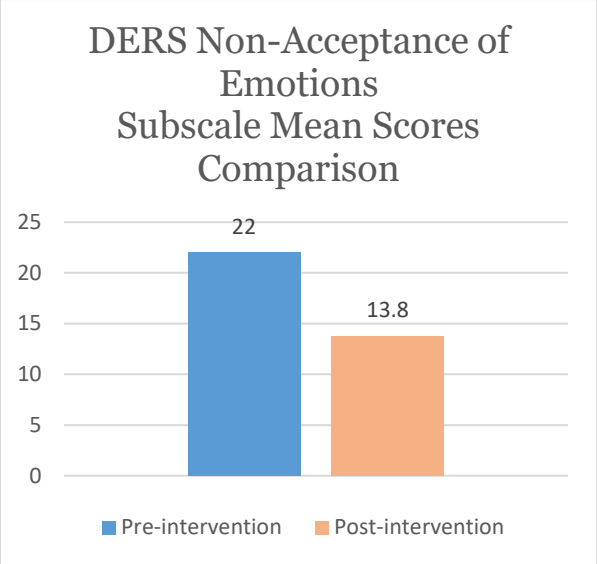
There were reductions in mean scores for five out of six of the DERS sub-scales. There was a reduction in the DERS sub-scale Non-Acceptance of Emotions scores from pre-intervention (*M* = 22; *SD* = 5.38) to post-intervention (*M* = 13.8; *SD* = 3.68). There was a reduction in the DERS sub-scale Impulse Control from pre-intervention (*M* = 18.3; *SD* = 3.95) to post-intervention (*M* = 12.5; *SD* = 3.06). There was a reduction in the DERS sub-scale Emotional Awareness from pre-intervention (*M* = 18.7; *SD* = 3.27) to post-intervention (*M* = 14; *SD* = 2.75). There was a reduction in the DERS sub-scale Emotional Regulation Strategies from pre-intervention (*M* = 30; *SD* = 5.01) to post-intervention (*M* = 20.2 *SD* = 4.49). There was a reduction in the DERS sub-scale Inability to Engage in Goal-Directed Behaviours when Distressed from pre-intervention (M = 18.2; SD = 1.99) to post-intervention (M = 16.3; SD = 2.67).

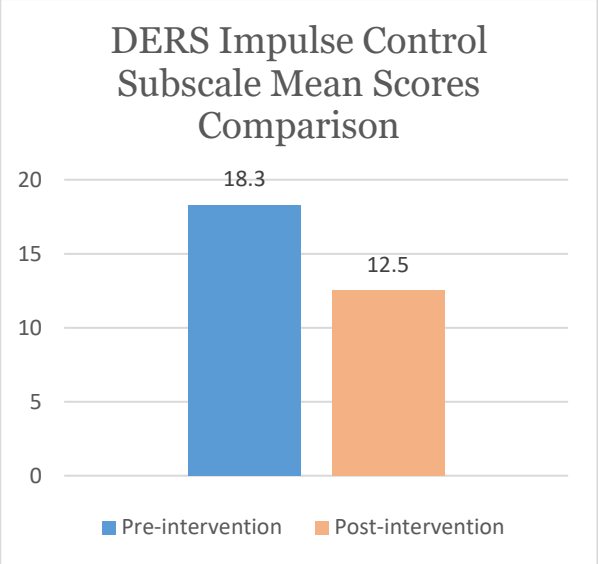
There was no change in pre and post-intervention scores for DERS subscale Emotional Clarity from pre-intervention (*M* = 11.6; *SD* = 2.07) to post-intervention (*M* = 11.6; *SD* = 2.07).

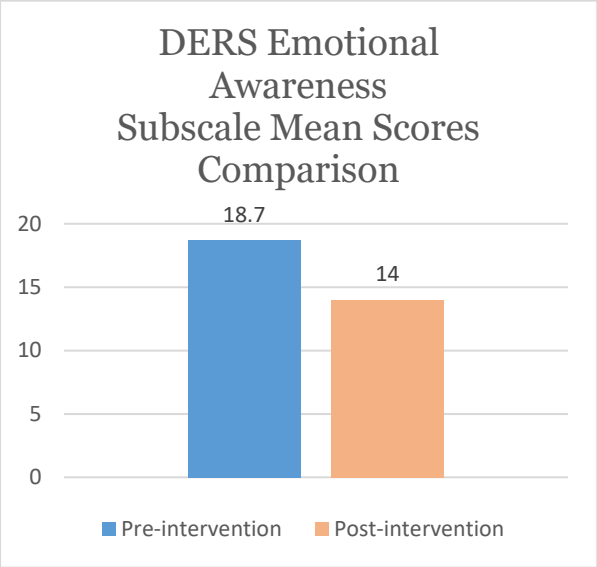
These findings indicate that those who completed the EFT-YA programme in 2024 increased their capacity for emotional regulation as well as yielded improvements in impulse control and emotional awareness (see Figure 4.78).

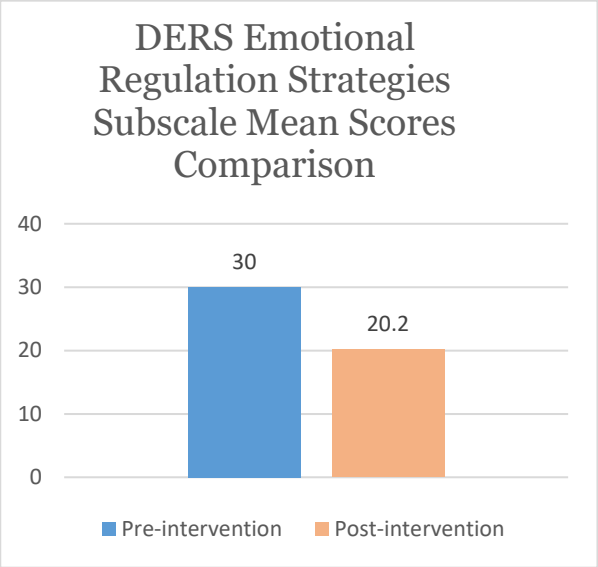
Figure 4.78. *Pre and post-group mean scores for the Difficulties in Emotion Regulation Scale (DERS) total and subscale scores.*

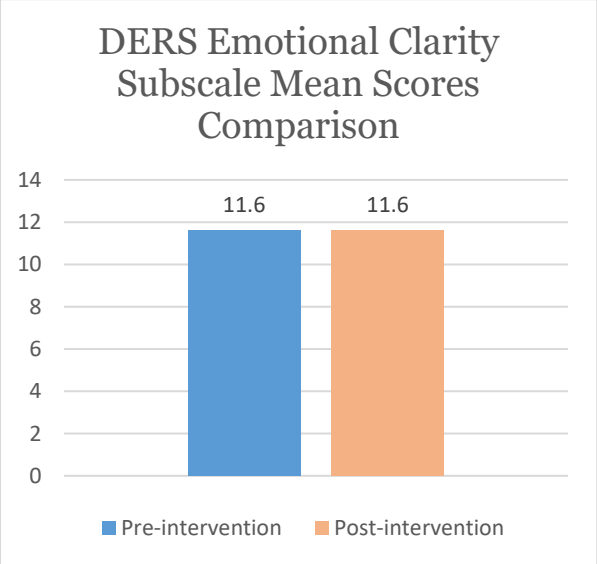


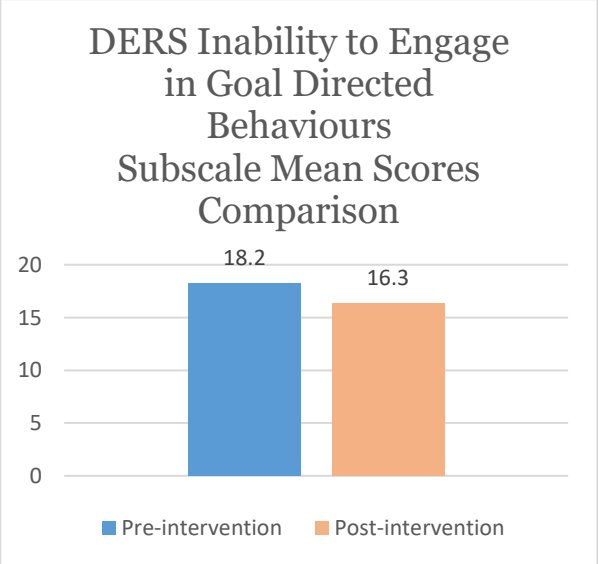

DERS Non-Acceptance of Emotions Subscale Mean Scores Comparison
25
20
15
10
5
0
22
13.8
Pre-intervention
Post-intervention


DERS Impulse Control Subscale Mean Scores Comparison
20
15
10
5
0
18.3
12.5
Pre-intervention
Post-intervention


DERS Emotional Awareness Subscale Mean Scores Comparison
20
15
10
5
0
18.7
14
Pre-intervention
Post-intervention

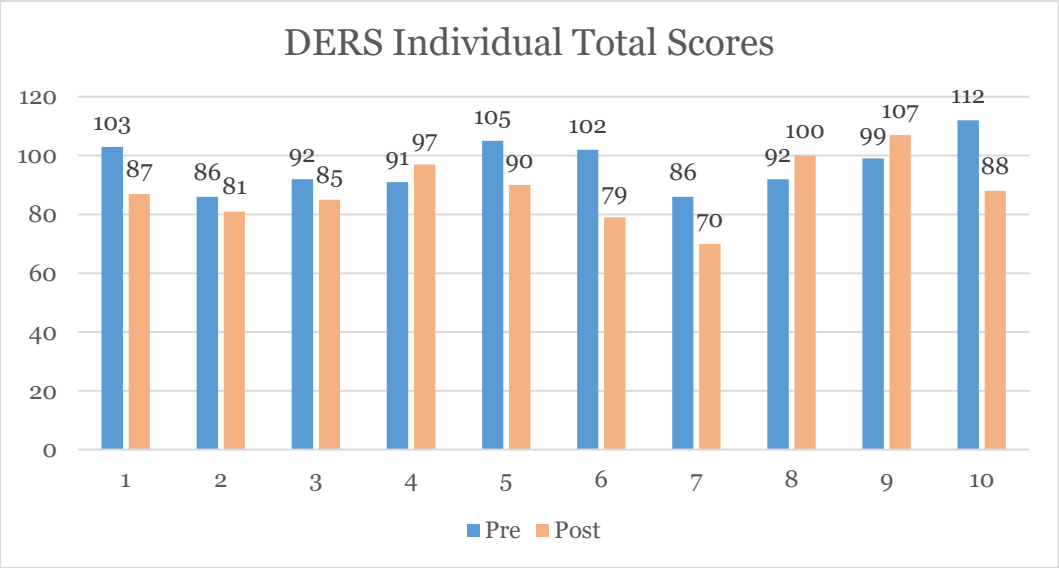

DERS Emotional Regulation Strategies Subscale Mean Scores Comparison
40
30
20
10
0
30
20.2
Pre-intervention
Post-intervention


DERS Emotional Clarity Subscale Mean Scores Comparison
14
12
10
8
6
4
2
0
11.6
11.6
Pre-intervention
Post-intervention


DERS Inability to Engage in Goal Directed Behaviours Subscale Mean Scores Comparison
20
15
10
5
0
18.2
16.3
Pre-intervention
Post-intervention

Further examination of the individual scores indicates that seven out of ten (70%) participants showed a reduction in DERS total scores from pre-intervention to post-intervention (see Figure 4.79).

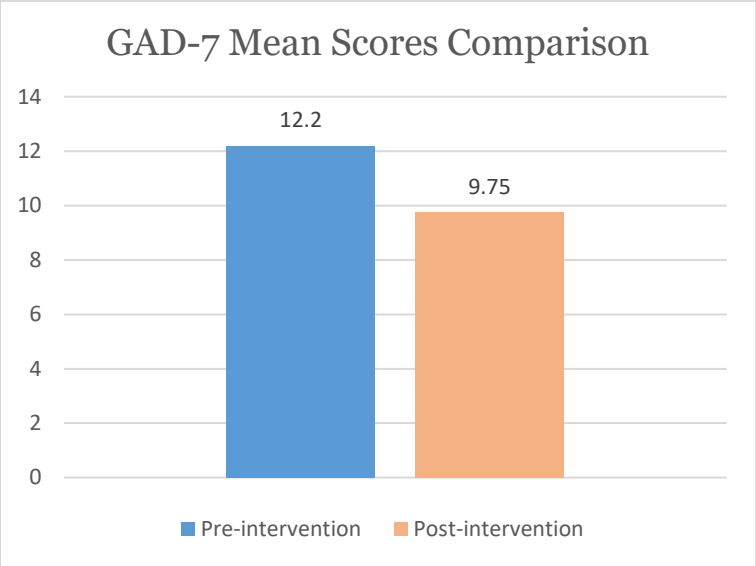
Figure 4.79. *Pre and post individual scores of the Difficulties in Emotion Regulation Scale (DERS) total scores.*




### The Generalised Anxiety Disorder-7 (GAD-7)

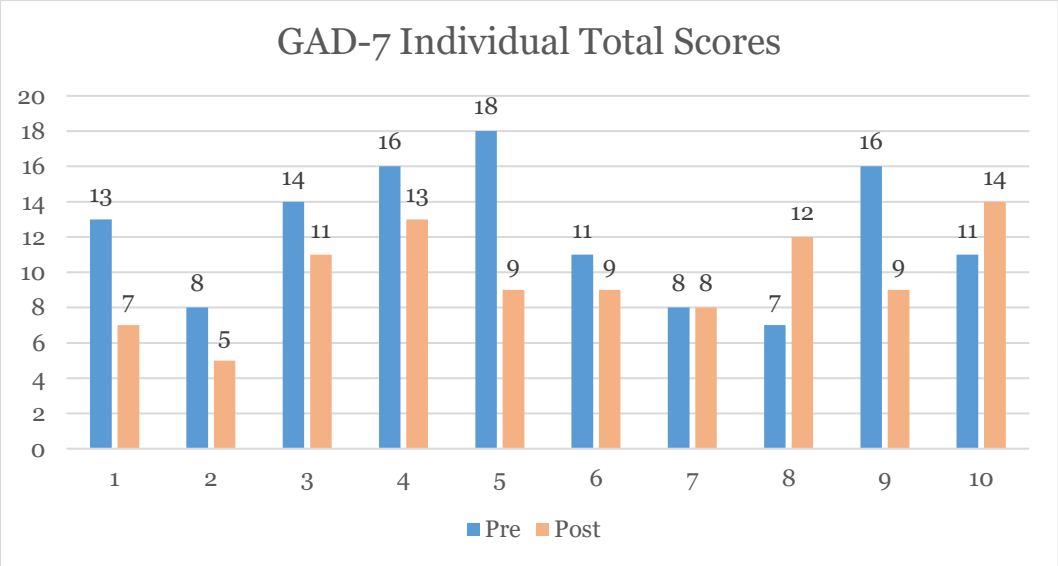
Comparison of service user mean scores on the GAD-7 indicated a decrease in scores from pre-intervention ($M$ = 12.20 $SD$ = 3.82) to post-intervention ($M$ = 9.75 $SD$ = 2.78). The finding indicates that those who completed the programme did reduce their anxiety symptoms (see Figure 4.80).

Figure 4.80. *Pre and post-group mean scores for the Generalised Anxiety Disorders-7 (GAD-7).*




Further examination of the individual scores indicates that seven out of ten (70%) participants showed a reduction in GAD-7 total scores from pre-intervention to post-intervention (see Figure 4.81).

Figure 4.81. *Pre and post-group individual scores for the Generalised Anxiety Disorders-7 (GAD-7).*

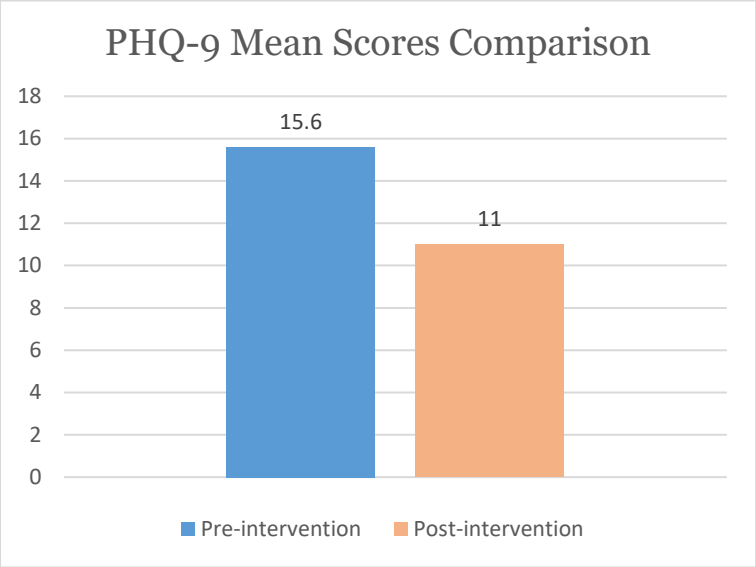



### The Patient Health Questionnaire-9 (PHQ-9)

Comparison of service user mean scores on the PHQ-9 indicated a decrease in scores from pre-intervention ($M$ = 12.20 $SD$ = 3.82) to post-intervention ($M$ = 9.75 $SD$ = 2.78).

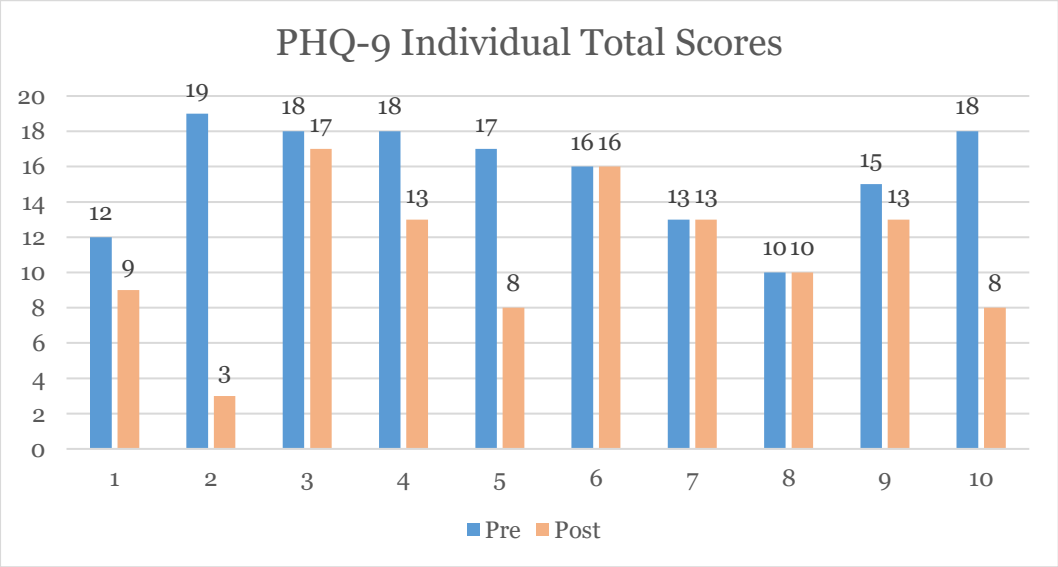
The finding indicates that those who completed the programme did reduce their symptoms related to depression.

Figure 4.82 *Pre and post-group mean scores for the Patient Health Questionnaire-9 (PHQ-9).*




As can be seen from the below graph, further examination of the individual scores indicates that seven out of ten (70%) participants showed a reduction in PHQ-9 total scores from pre-intervention to post-intervention. Three out of ten (30%) participants showed no change in scores from pre-intervention to post-intervention.

Figure 4.83 *Pre and post-group individual scores for the Patient Health Questionnaire-9 (PHQ-9).*

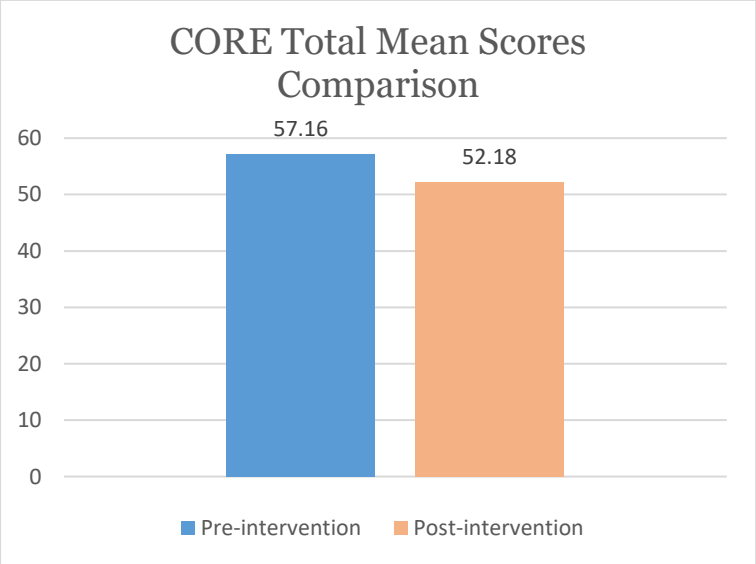


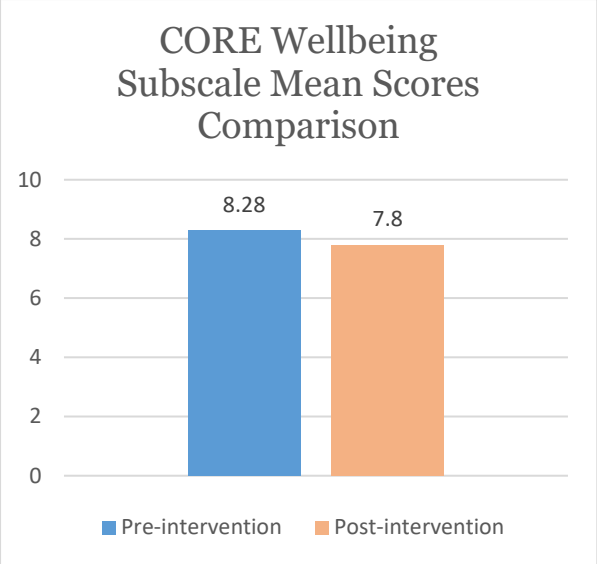
### The Clinical Outcomes in Routine Evaluation (CORE)

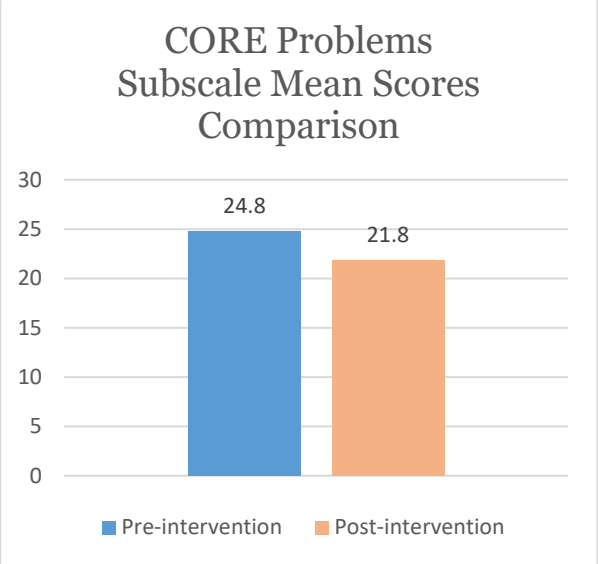
There was a reduction in the CORE total scores from pre-intervention (*M* = 57.16; *SD* = 7.67) to post-intervention (*M* = 52.18; *SD*= 10.73). There was further a reduction of scores on: the CORE subscale wellbeing from pre-intervention (*M* = 8.28 *SD* = 2.39) to post-intervention (*M* = 7.8 *SD* = 1.93); the CORE subscale of problems from pre-intervention (*M* = 24.8 *SD* = 6.2) to post-intervention (*M* = 21.8 *SD* = 7.08); the CORE subscale life functioning from pre-intervention (*M* = 22.48 *SD* = 3.73) to post-intervention (*M* = 21.17 *SD* = 3.71); the CORE subscale of risk from pre-intervention (*M* = 1.6 *SD* = 1.43) to post-intervention (*M* = 1.4 *SD* = 1.71).

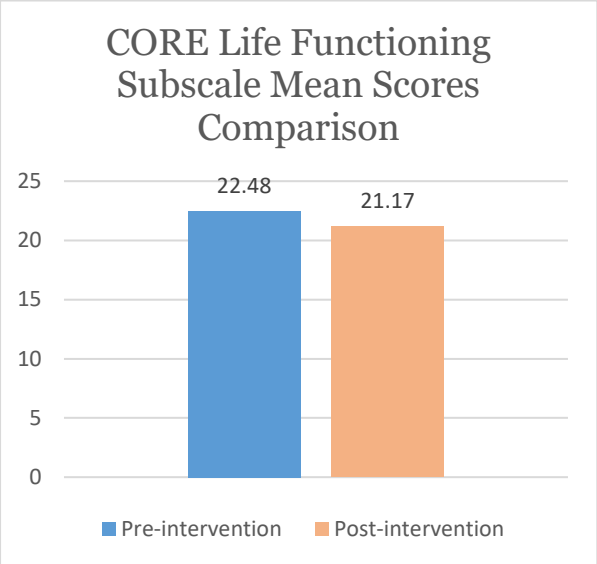
This measure assesses the overall functioning in the context of psychological distress of someone seeking intervention. The above findings indicate that those who completed the programme yielded a reduction in their total score or across the subscales that identify wellbeing, life functioning or risk/harm (see Figure 4.94).

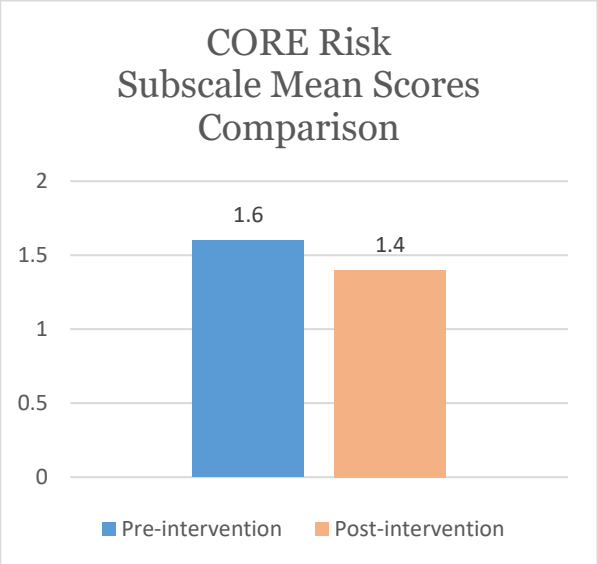
Figure 4.84. *Pre and post-group mean scores for the Clinical Outcomes in Routine Evaluation (CORE) total and subscale scores.*





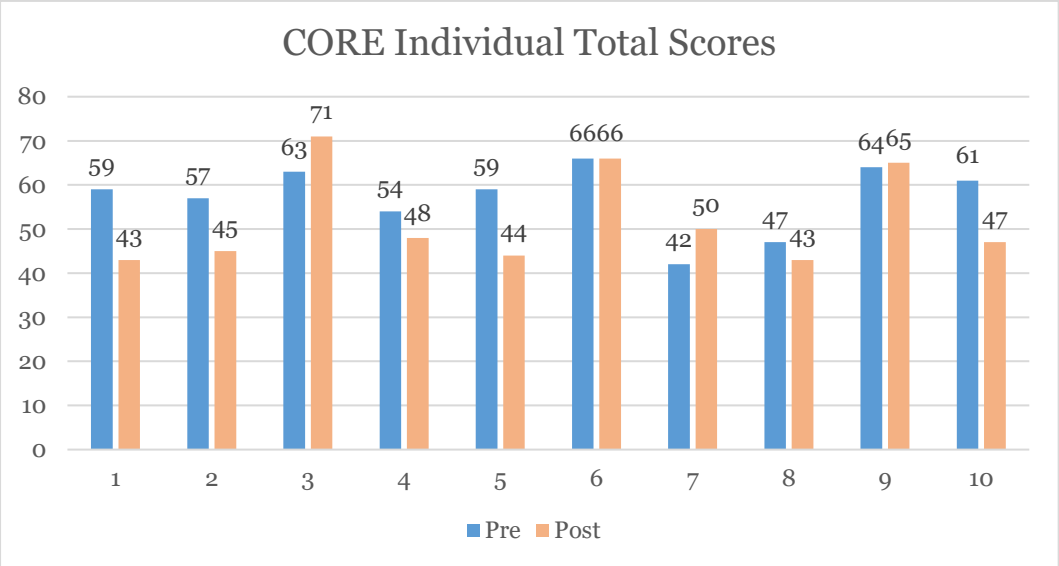




Further examination of the individual scores indicates that six out of ten (60%) participants showed a reduction in CORE total scores from pre-intervention to post-intervention (see Figure 4.85).

Figure 4.85 *Pre and post-group individual scores for the Clinical Outcomes in Routine Evaluation (CORE).*




### 4.13.4. Summary

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

In 2024, the young adults who completed the novel programme showed increases in their capacity for emotional regulation strategies, as well as having reported improvements in non-acceptance of emotions, impulse control and emotional awareness. Results also showed reductions in PHQ-9, GAD-7 and CORE scores.

## 4.14. Dialectical Behavioural Therapy (DBT) Programme

Dialectical Behaviour Therapy (DBT) was originally developed as treatment for borderline personality disorder (BPD), which is characterised by patterns of emotional and behavioural dysregulation, that often lead to self-harming and suicidal behaviours (Flynn et al, 2019). DBT is an integration of behaviour therapy, Zen Buddhism, and an overarching dialectical philosophy (Robins, 2002).

DBT directly targets 1) life threatening behaviour, 2) behaviours by therapist and client that interfere with delivery of the therapy, and 3) other dangerous, severe or destabilising behaviours (Linehan et al., 2006).

To address these targets DBT seeks to address five functions 1) increasing behavioural capabilities, 2) improving motivation for skilful behaviour, 3) assuring generalisation of gains to the environment, 4) structuring the treatment environment to reinforce adaptive or functional behaviours, and 5) enhancing therapist capabilities and motivation to treat clients effectively (Linehan et al., 2006).

These functions are spread across four modes of therapy 1) weekly individual psychotherapy sessions, 2) weekly group skills training, 3) phone coaching as needed (within the therapist's limits), and 4) weekly therapist consultation team meetings (Linehan, 1993). Standard DBT is delivered over the course of a year, with the entire skills repertoire being repeated twice in the skills training group.

## Efficacy/ Effectiveness of DBT

### Standard DBT

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

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

### Brief DBT

A promising research focus investigates the effectiveness of DBT delivered in briefer timeframes. There is no evidence base for what constitutes an optimal psychotherapy length for BPD (McMain et al., 2018). The first randomised control trial of DBT (Linehan et al., 1991) showed that significant improvements appeared as early as four months into the 12-month intervention, suggesting that shortened DBT interventions may be effective (Seow et al., 2022). However, currently the optimal length of intervention is unknown (McMain et al, 2018). Delivering DBT in a briefer timeframe has a number of advantages for service users. Firstly, risk of self-harm is reduced more rapidly, potentially increasing safety more quickly and reducing the need for inpatient admission. Secondly, a briefer treatment means that more people can be treated by a specific service provider, thus reducing cost. Finally, a briefer treatment period may reduce the amount of dropout, which remains high in comprehensive and skills only DBT (Seow et al., 2022).

While research in this area is scant, there are existing studies that have focussed on briefer models of DBT. One RCT has been conducted comparing six months of standard DBT to treatment as usual, for female veterans with a diagnosis of BPD. Although the sample was small (n=10 in each group), six months of DBT resulted in greater improvement in the areas of suicidal ideation, hopelessness, depression and anger expression (Koons et al., 2001). An Australian non-randomised study with a larger sample (n = 45) showed significant improvement compared to treatment as usual, in suicidal ideation/ non-suicidal self-injury, emergency department visits, hospital admissions and bed days. Participant self-report showed a significant improvement in depression, anxiety, and general symptom severity (Pasieczny & Connor, 2011). McMain et al. (2022), in a randomised control non-inferiority trial discovered that six months of DBT is non-inferior to 12 months of DBT in terms of clinical effectiveness.

### Skills Only DBT

In recent years, research has reflected attempts to adapt DBT to address resource requirements. One direction was to offer only the skills group modality. Lyng et al (2020)

compared six months of standalone DBT skills training group for adults with BPD to six months of standard DBT. The standalone skills took a stepped care approach, excluding individuals who had engaged in self-harming or suicidal behaviour in the past six months. They found no difference between outcomes between the two treatment conditions. Skills only research has generally led to recommendations that skills only DBT be utilised as an adjunctive or stepped down approach (eg. Lyng et al., 2020; Neacsiu et al., 2010, working with individuals who are not currently engaging in self-harmful or suicidal behaviour.

The DBT programme in St Patrick's University Hospital is a Stage 1 DBT programme "focusing on moving from out-of-control behaviour to behaviour control, even (or especially) in the presence of high-intensity emotions" (Rizvi & Sayrs, 2020). DBT in St Patrick's Mental Health Services is offered transdiagnostically. Rather than in response to one specific diagnoses, intervention is offered to individuals who exhibit a pervasive history of difficulties understanding and managing their emotions and impulsive attempts to regulate emotion with actions or behaviours that are maladaptive. DBT in St Patrick's Mental Health Services is delivered in a more intensive fashion, with group skills teaching occurring twice weekly over a three-month period.

In 2024, nine DBT groups took place in St Patrick's Mental Health Services. Three were brief intensive comprehensive streams, three were DBT informed skills groups delivered in person, and three were DBT informed skills groups delivered online to those unable to travel to St Patrick's University Hospital. All groups were closed, meaning no new members join once the group has commenced. See table 4.15 below for details of all interventions.

Table 4.15. Types of DBT interventions

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

Data from nine cycles of the programme are described below, all of which finished in 2024. Data analysis of the Comprehensive DBT and DBT skills group are reported separately.

### 4.14.1. DBT Outcome Measures

- **Difficulties in Emotion Regulation Scale (DERS):** see page 150

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

The Dialectical Behaviour Therapy Ways of Coping Checklist (DBT-WCCL; Neacsiu et al, 2010) is a 59-item self-report inventory measuring DBT skills use. It contains two main subscales the DBT skills subscale (DSS) and the Dysfunctional Coping Subscale (DCS). The measure consists of 59 items scored on a four-point Likert scale (0 = never used; 3 = regularly used). Higher mean scores on the DSS indicate greater use of DBT skills while higher mean scores on the DCS indicate greater use of unhelpful coping behaviours. Test-retest reliability and content validity analyses showed the scale to have good to excellent properties (Neacsiu et al., 2010). The test has been validated for use as a measure of DBT skills use in a psychiatric population beyond the original borderline personality disorder sample the originators studied (Stein et al, 2016).

- **Five Facet Mindfulness Questionnaire – Short Form (FFMQ-SF)**

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

### 4.14.2. Descriptors for DBT Comprehensive Programme

Pre and post-programme data were available for 17 participants who completed the DBT Comprehensive programme in 2024. Of the 17 participants, 76.5% were female and 23.5% were male. DBT attendees ranged in age from 19 to 51 years, with a mean age of 28.06 years (SD = 8.75). Of the thirteen participants who responded regarding education, their highest level of educational attainment included Junior Certificate (7.69%), Leaving Certificate (23.08%), third level non-degree qualification (23.08%), third level degree (30.77%) and postgraduate qualification (15.38%). Attendees' current employment status was also recorded, of the twelve participants who responded, 33.33% were in full-time employment, 33.33% were unemployed, 16.67% were students, and 16.67% listed other.

### 4.14.3. Results: DBT Comprehensive Programme

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. . Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 17 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

#### Difficulties in Emotion Regulation Scale (DERS)

Due to the small sample size, changes in the DERS scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in DERS scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991). In accordance with this method, statistically reliable change was reflected by RCI values equal to or larger than 1.96. The cut-off score indicating clinically meaningful improvement on the DERS was 95. Participants were classified as "clinically meaningful improvement" (passed RCI criterion and DERS score decreased to below

cut-off score), “reliable improvement” (passed RCI criterion but the score did not decrease below DERS cut-off score), “no reliable change” (did not pass RCI criterion) or “reliable deterioration” (passed RCI criterion but symptom score increased). As outlined in the table 4.16, five participants (29.41%) reported clinically significant improvement, seven participants (41.18%) reported reliable improvement, four participants reported uncertain change (23.53%), and one participant (5.88%) reported reliable deterioration (see table 4.16).

Table 4.16. *Results from Reliable Change Index (RCI) for the DERS pre and post scores for each group member*

| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 141 | 98 | -6.15 | Reliable improvement |
| 2 | 107 | 149 | 6.01 | Reliable deterioration |
| 3 | 163 | 66 | -13.88 | Clinically meaningful improvement |
| 4 | 137 | 101 | -5.15 | Reliable improvement |
| 5 | 150 | 130 | -2.86 | Reliable improvement |
| 6 | 169 | 116 | -7.58 | Reliable improvement |
| 7 | 139 | 140 | 0.14 | No reliable change |
| 8 | 123 | 67 | -8.01 | Clinically meaningful improvement |
| 9 | 151 | 115 | -5.15 | Reliable improvement |
| 10 | 153 | 123 | -4.29 | Reliable improvement |
| 11 | 161 | 160 | -0.14 | No reliable change |
| 12 | 141 | 84 | -8.16 | Clinically meaningful improvement |
| 13 | 155 | 149 | -0.86 | No reliable change |
| 14 | 146 | 66 | -11.45 | Clinically meaningful improvement |
| 15 | 153 | 86 | -9.59 | Clinically meaningful improvement |

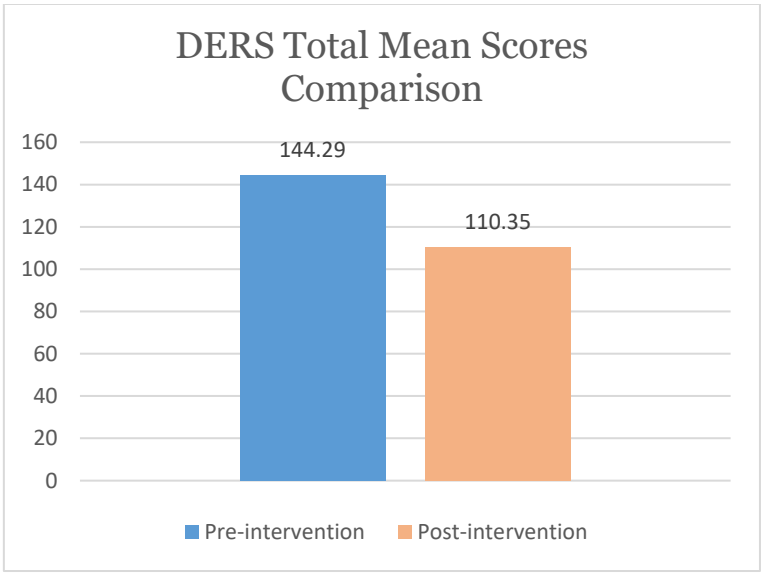
| | | | | |
|---|---|---|---|---|
| 16 | 138 | 127 | -1.57 | No reliable change |
| 17 | 126 | 99 | -3.86 | Reliable improvement |

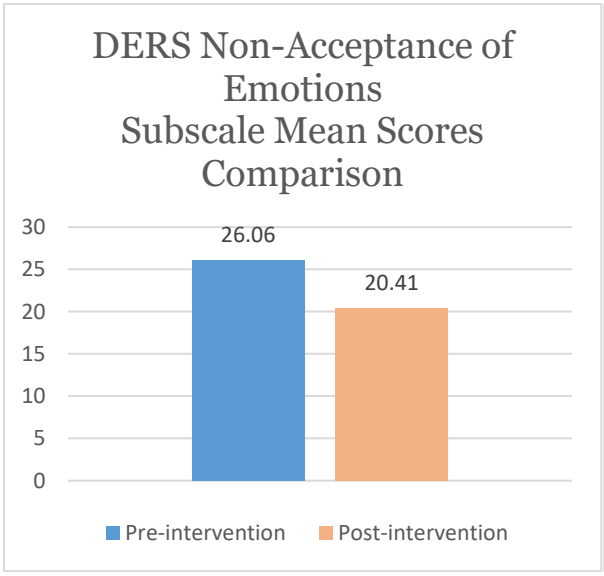
Comparison of service user mean scores on the DERS indicated a decrease in scores from pre-intervention (*M* = 144.29; *SD* = 15.63) to post-intervention (*M* = 110.35; *SD* = 20.29).

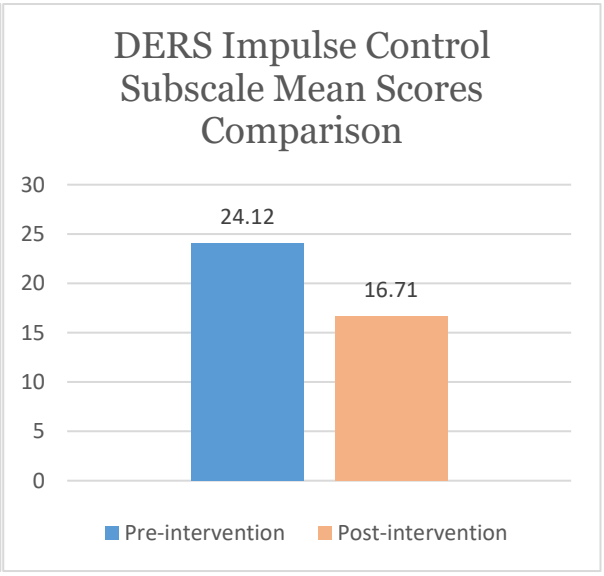
There were reductions in mean scores for all six of the DERS sub-scales. There was a reduction in the DERS sub-scale Non-Acceptance of Emotions scores from pre-intervention (*M* = 26.06; *SD* = 3.73) to post-intervention (*M* = 20.41; *SD* = 7.3). There was a reduction in the DERS sub-scale Impulse Control from pre-intervention (*M* = 24.12; *SD* = 3.59) to post-intervention (*M* = 16.71; *SD* = 5.86). There was a reduction in the DERS sub-scale Emotional Awareness from pre-intervention (*M* = 20.65; *SD* = 4.9) to post-intervention (*M* = 16.94; *SD* = 4.94). There was a reduction in the DERS sub-scale Emotional Regulation Strategies from pre-intervention (*M* = 33,71; *SD* = 3.57) to post-intervention (*M* = 24.47; *SD* = 8.33). There was a reduction in the DERS sub-scale Inability to Engage in Goal-Directed Behaviours when Distressed from pre-intervention (*M* = 21.41; *SD* = 3.73) to post-intervention (*M* = 17.12; *SD* = 4.26). There was a reduction in the DERS sub-scale Emotional Clarity from pre-intervention (*M* = 18.35; *SD* = 4.06) to post-intervention (*M* = 14.71; *SD* = 4.62).

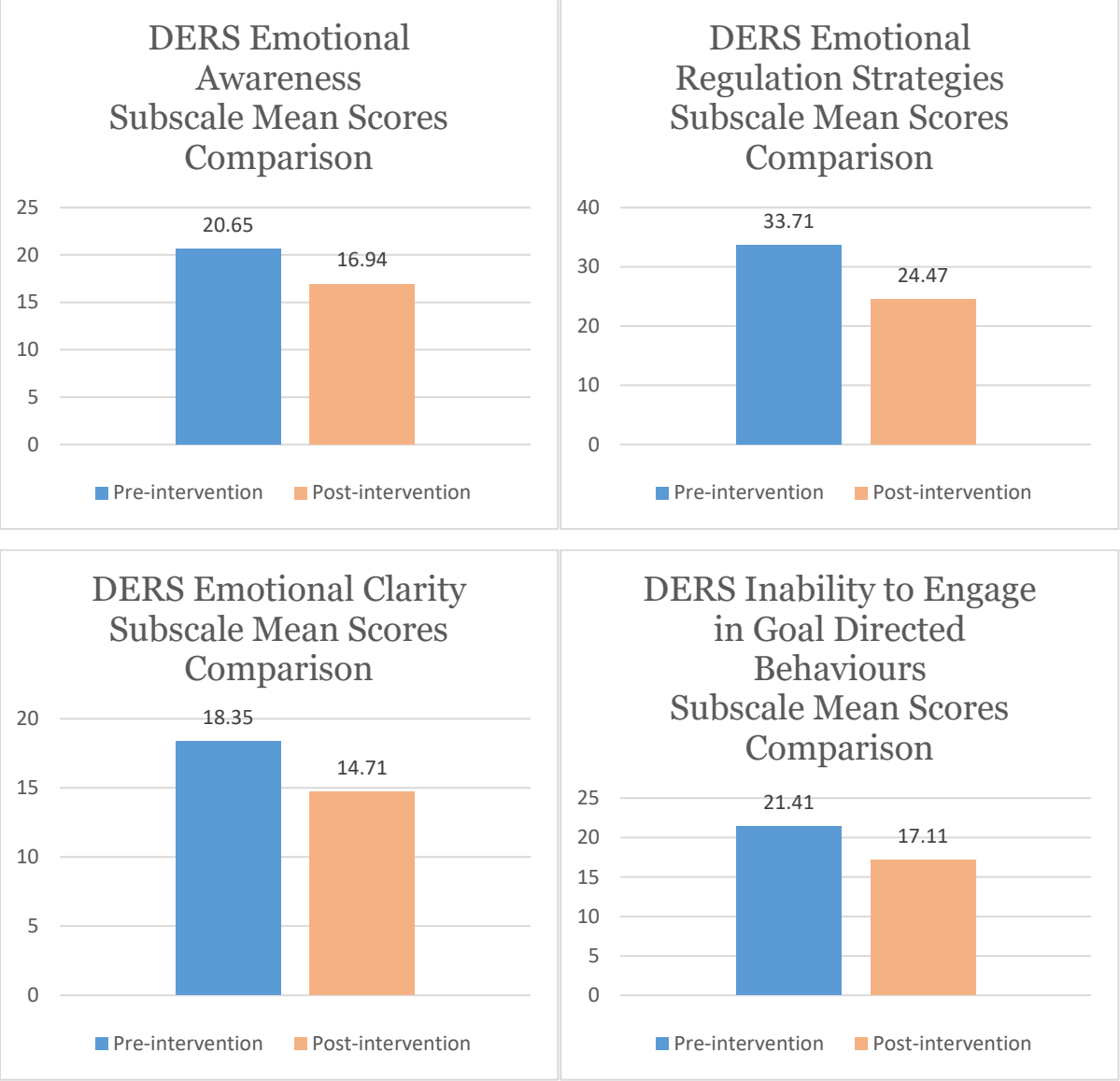
These findings indicate that those who completed the DBT Comprehensive programme in 2024 increased their capacity for emotional regulation as well as yielded improvements in impulse control and emotional awareness (see Figure 4.86 below).

Figure 4.86. *Pre and post-group mean scores for the Difficulties in Emotion Regulation Scale (DERS) total and subscale scores.*



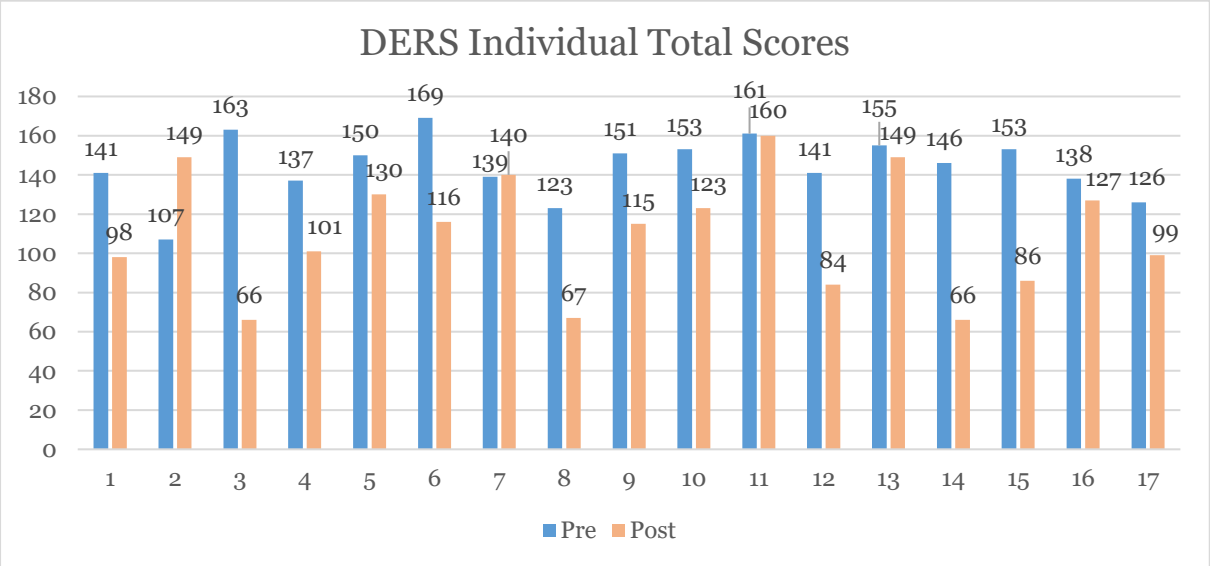






As can be seen from Figure 4.87, further examination of the individual scores indicates that 15 out of 17 (88.24%) participants showed a reduction in DERS total scores from pre-intervention to post-intervention (see Figure 4.87).

Figure 4.87. *Pre and post individual scores of the Difficulties in Emotion Regulation Scale (DERS) total scores.*

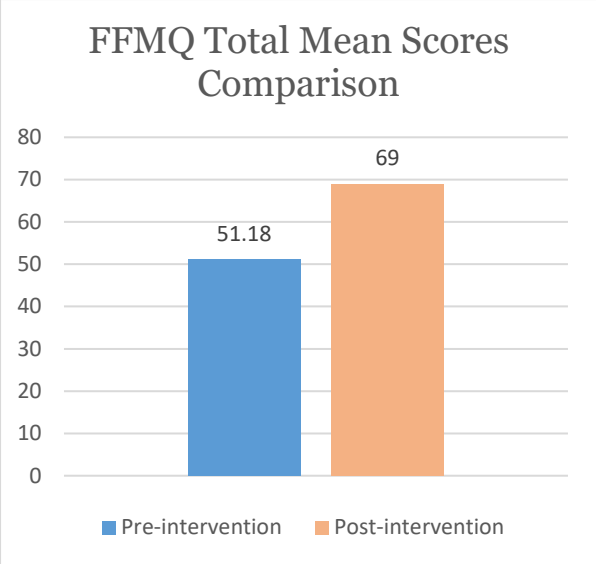


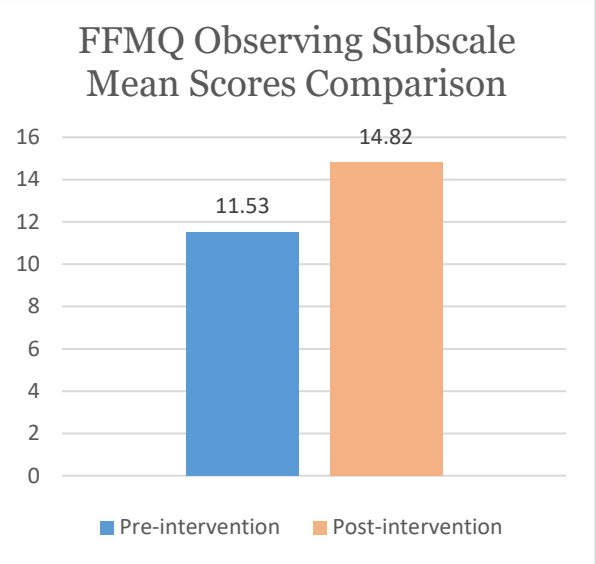

**Five Facet Mindfulness Questionnaire – Short Form (FFMQ-SF)**

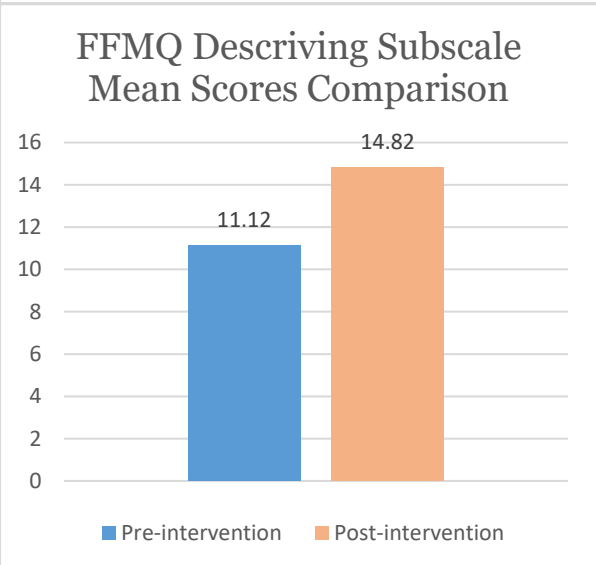
Comparison of service user mean scores on the FFMQ-SF indicated an increase in scores from pre-intervention (*M* = 51.18; *SD* = 10.19) to post-intervention (*M* = 69; *SD* = 17.12), suggesting that participants had greater mindful qualities upon completion of the programme.

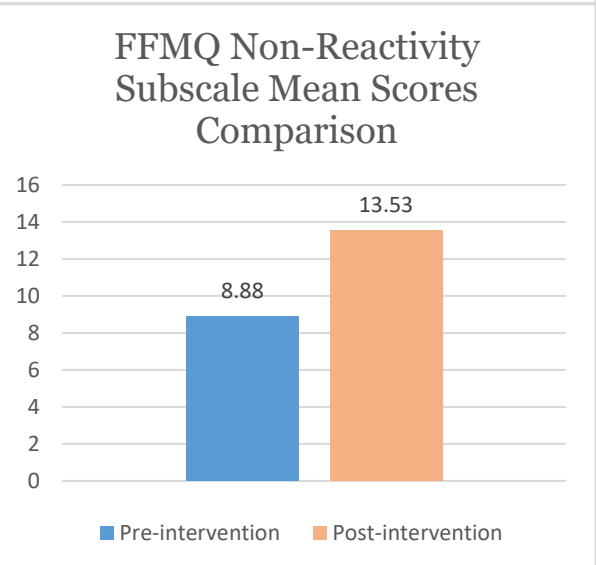
Mean scores increased for all five of the FFMQ-SF sub-scales. Mean scores on the Observing subscale increased from 11.53 (*SD* = 3.48) at pre-intervention to 14.82 (*SD* = 3.66) at post intervention. Mean scores on the Describing subscale increased from 11.12 (*SD* = 3.62) at pre-intervention to 14.82 (*SD* = 3.21) at post intervention. Mean scores on the Non-Reactivity subscale increased from 8.88 (*SD* = 2.32) at pre-intervention to 13.53 (*SD* = 4.21) at post intervention. Mean scores on the Acting with Awareness subscale increased from 11.29 (*SD* = 4) at pre-intervention to 13.00 (*SD* = 4.94) at post intervention. Mean scores on the Non-Judging subscale increased from 8.35 (*SD* = 3.12) at pre-intervention to 12.82 (*SD* = 5.21) at post intervention (see Figure 4.88 below).

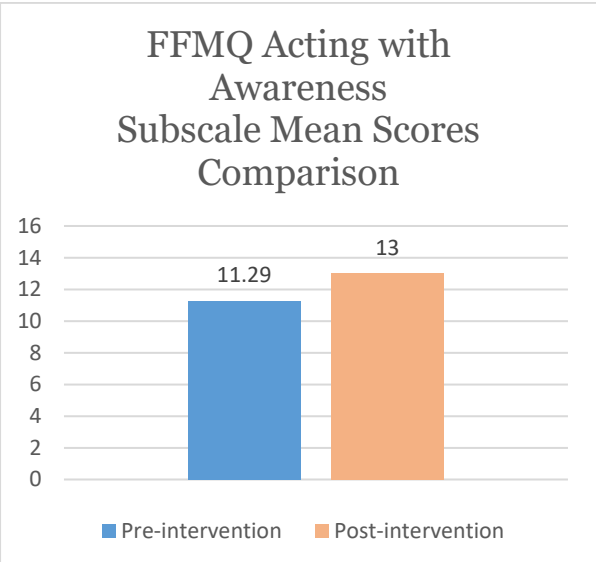
Figure 4.88. *Pre and post-group mean scores for the FFMQ-SF total and subscale scores.*

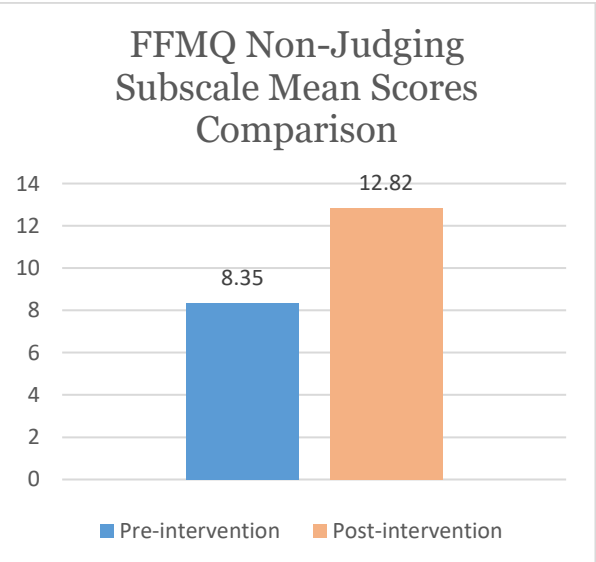

FFMQ Total Mean Scores Comparison
80
70
60
50
40
30
20
10
0
51.18
69
Pre-intervention
Post-intervention


FFMQ Observing Subscale Mean Scores Comparison
16
14
12
10
8
6
4
2
0
11.53
14.82
Pre-intervention
Post-intervention


FFMQ Descriving Subscale Mean Scores Comparison
16
14
12
10
8
6
4
2
0
11.12
14.82
Pre-intervention
Post-intervention

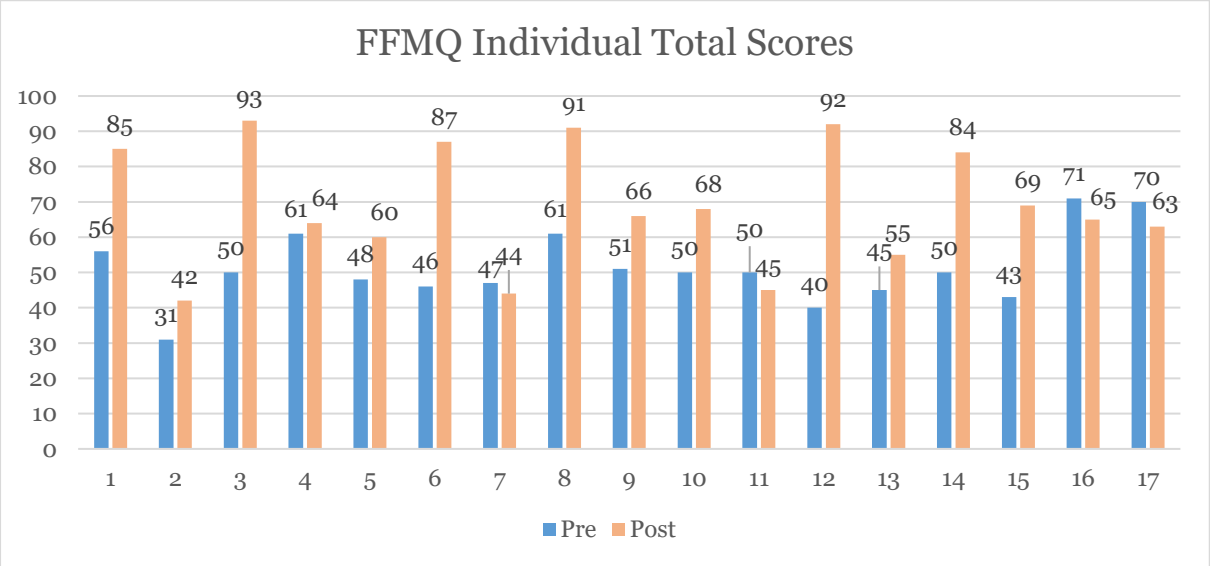

FFMQ Non-Reactivity Subscale Mean Scores Comparison
16
14
12
10
8
6
4
2
0
8.88
13.53
Pre-intervention
Post-intervention


FFMQ Acting with Awareness Subscale Mean Scores Comparison
16
14
12
10
8
6
4
2
0
11.29
13
Pre-intervention
Post-intervention


FFMQ Non-Judging Subscale Mean Scores Comparison
14
12
10
8
6
4
2
0
8.35
12.82
Pre-intervention
Post-intervention

As can be seen from Figure 4.95, further examination of the individual scores indicates that 13 out of 17 (76.47%) participants showed a reduction in FFMQ-SF total scores from pre-intervention to post-intervention (see Figure 4.89).

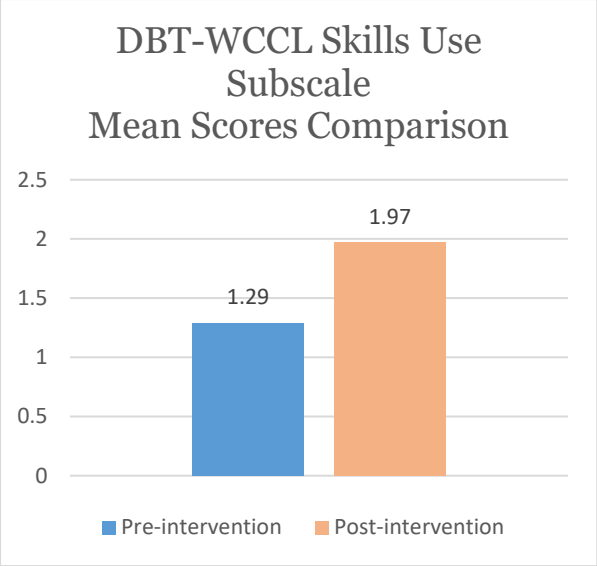
Figure 4.89. *Pre and post individual scores of the FFMQ-SF total scores.*

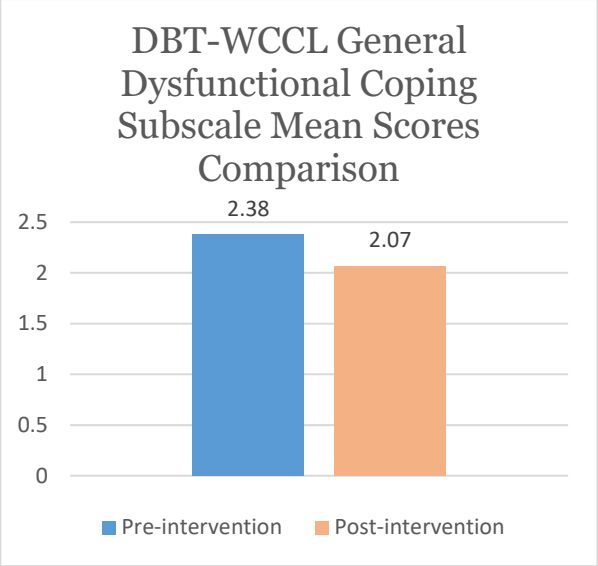


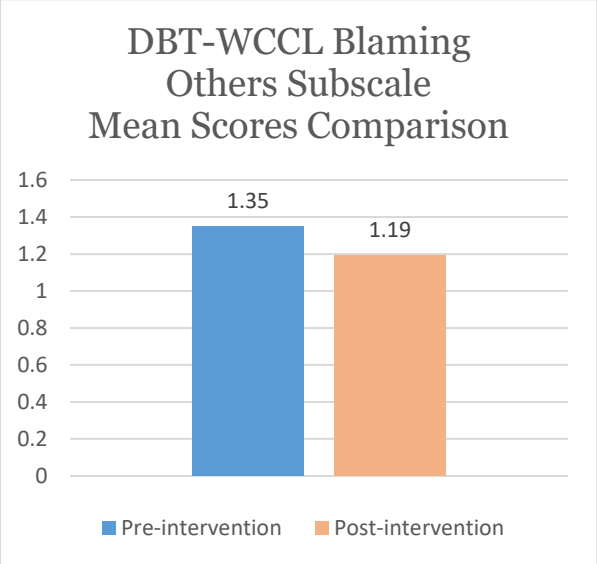

### DBT Ways of Coping Checklist (WCCL)

Results for the DBT WCCL sub-scales indicated that participants reported a increase in the use of their DBT Skills. Mean scores on the Skills Use Subscale increased from 1.29 (*SD* = 0.46) at pre-intervention to 1.97 (*SD* = 0.42) at post-intervention. Mean scores on the General Dysfunctional Coping Subscale decreased from 2.38 (*SD* = 0.42) at pre-intervention to 2.07 (*SD* = 0.57) at post-intervention. This indicates that participants' abilities to cope improved upon completing the intervention. Participants mean scores on the Blaming Others Subscale also showed a reduction from 1.35 (*SD* = 0.76) to 1.19 (*SD*= 0.63) post-intervention (see Figure 4.90)

Figure 4.90. *Pre and post-group mean scores for the DBT-WCCL subscale scores.*

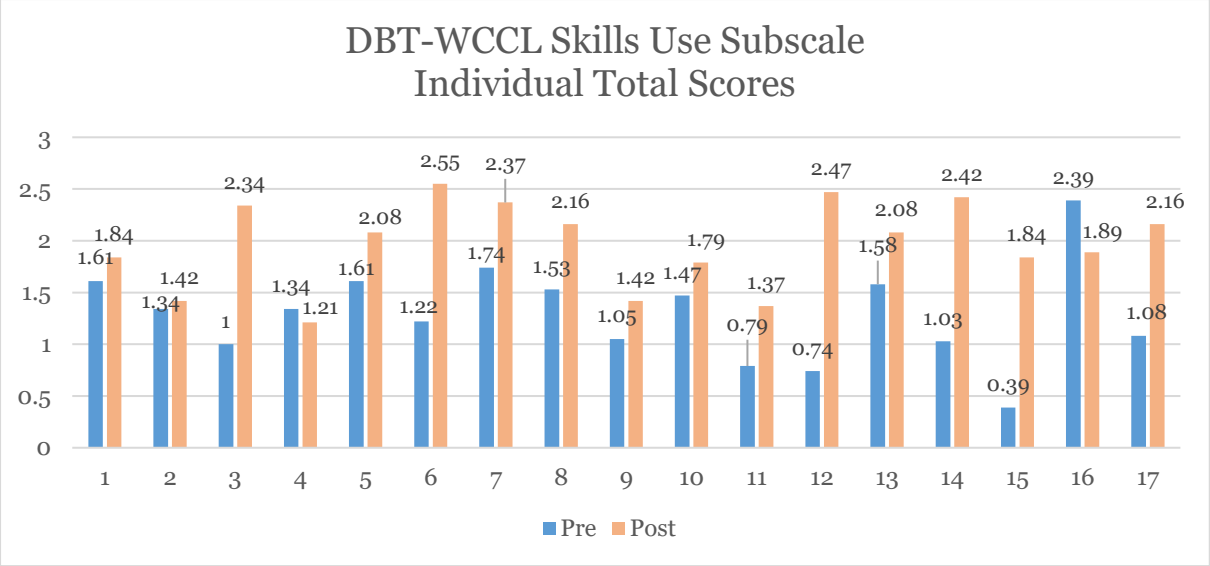


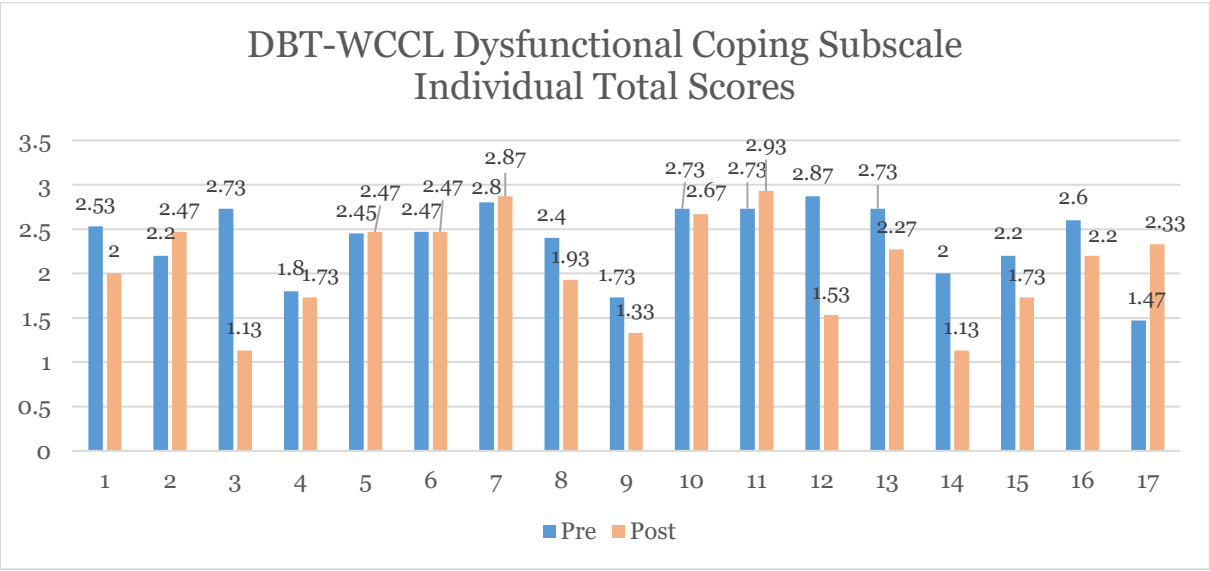



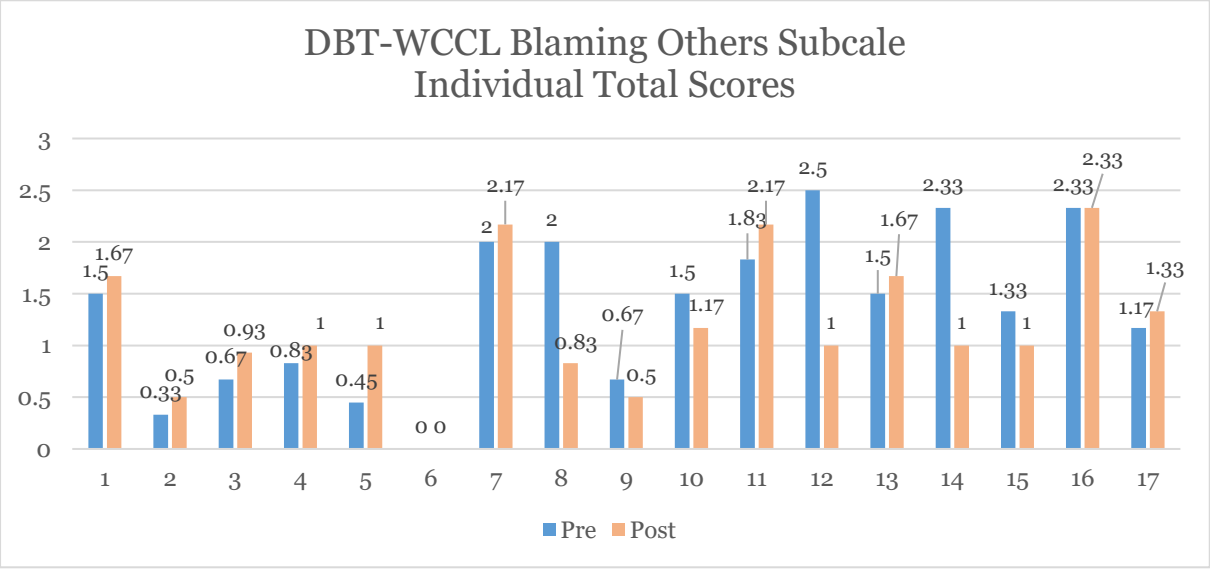




As can be seen from Figure 4.91, further examination of the individual scores indicates that 15 out of 17 (88.24%) participants showed an increase in the DBT-WCCL Skills Use Subscale from pre-intervention to post-intervention, 11 out of 17 (64.71%) participants showed a reduction in the DBT-WCCL Dysfunctional Coping Subscale scores from pre-intervention to post-intervention, and 6 out of 17 (35.29%) participants showed a reduction in the DBT-WCCL Blaming Others Subscale scores from pre-intervention to post-intervention (see Figure 4.91).

Figure 4.91. *Pre and post individual scores of the DBT-WCCL individual total scores.*


DBT-WCCL Skills Use Subscale
Individual Total Scores
3
2.5
2
1.5
1
0.5
0
1.61 1.84
1.34 1.42
1 2.34
1.34 1.21
1.61 2.08
1.22 2.55
1.74 2.37
1.53 2.16
1.05 1.42
1.47 1.79
0.79 1.37
0.74 2.47
1.58 2.08
1.03 2.42
0.39 1.84
2.39 1.89
1.08 2.16
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
Pre Post


DBT-WCCL Dysfunctional Coping Subscale
Individual Total Scores
3.5
3
2.5
2
1.5
1
0.5
0
2.53 2
2.2 2.47
2.73 1.13
1.8 1.73
2.45 2.47
2.47 2.47
2.8 2.87
2.4 1.93
1.73 1.33
2.73 2.67
2.73 2.93
2.87 1.53
2.73 2.27
2 1.13
2.2 1.73
2.6 2.2
1.47 2.33
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
Pre Post


DBT-WCCL Blaming Others Subcale
Individual Total Scores
3
2.5
2
1.5
1
0.5
0
1.5 1.67
0.33 0.5
0.67 0.93
0.83 1
0.45 1
0 0
2 2.17
2 0.83
0.67 0.5
1.5 1.17
1.83 2.17
2.5 1
1.5 1.67
2.33 1
1.33 1
2.33 2.33
1.17 1.33
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
Pre Post

### 4.14.4. Descriptors for DBT Skills Only Group

Complete pre and post data was available for 46 participants who completed the DBT Skills Only group in 2024. Of these 46, 32 (69.6%) were female and 14 (30.4%) were male. The mean age of participants was 41.48 (SD = 13.30), ranging from 20 to 67 years.

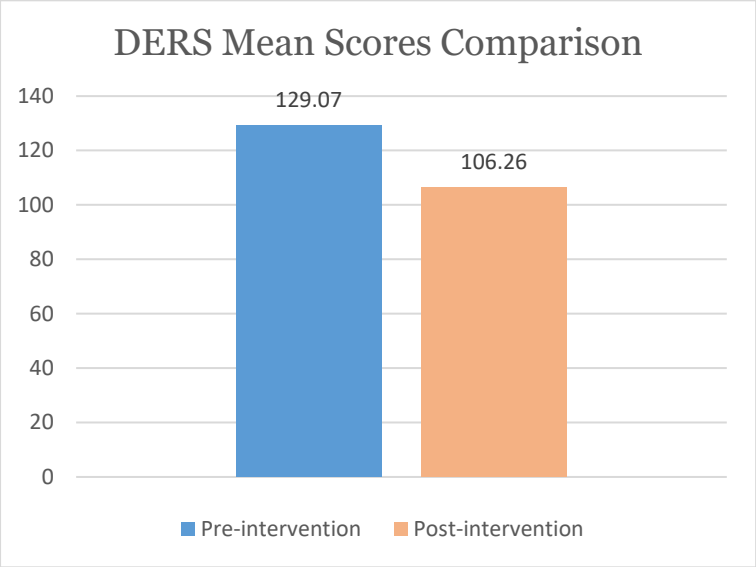
Their highest level of educational attainment included Junior Certificate (2.78%), Leaving Certificate (8.33%), third level non-degree qualification (11.11%), third level degree (41.67%) and postgraduate qualification (30.56%). 5.55% chose 'other' as their highest level of educational attainment. Attendees' current employment status was also recorded. 37.14% were in full-time employment, 22.86% were unemployed, 11.43% were in part-time employment, and 28.57% chose other.

### 4.14.5. Results for DBT Skills Only Group

#### Difficulties in Emotion Regulation Scale (DERS)

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post-intervention. Participants experienced a decrease in difficulties regulating emotions moving from a mean score of 129.07 (*SD* = 20.83) on the DERS at pre-intervention to 106.26 (*SD* = 24.49) post-completion of the programme; $t$ (45) = 6.90, $p$ < .001. This change represented a large effect size (Cohen's $d$ = 1.02). See Figure 4.92 below for visual representation.

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




*Note: Higher scores indicate greater difficulties with emotional regulation*

### Five Facet Mindfulness Questionnaire – Short Form (FFMQ-SF)

Pre and post data was available for 46 participants who completed this measure during 2024. Total mean scores of 62.42 (*SD* = 10.61) at pre-intervention increased to 70.27 (*SD* = 13.95) at post-intervention, suggesting that participants had greater mindful qualities upon completion of the programme. A paired samples t-test indicated that this increase was statistically significant, *t*(45) = -4.80, *p* = <.001 with medium to large effect size (*d* = .71).

Significant increases were observed across four of the five subscales in the FMMQ (see Figure 4.99 for visual representation). There was a non-significant increase on total scores on the observing subscale from 12.88 (*SD* = 3.34) at pre-intervention to 13.59 (*SD* = 3.47) at post-intervention.

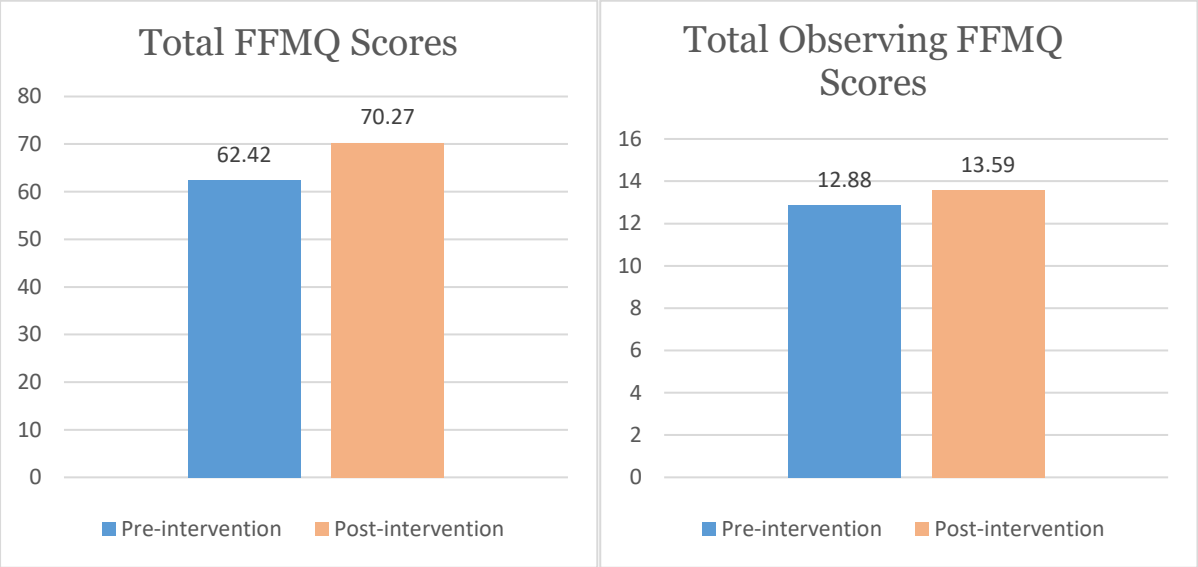
Total scores on the describing subscale increased from 14.46 (*SD* = 4.31) at pre-intervention to 15.78 (*SD* = 4.30) at post-intervention, *t* (45) = -3.10, *p* = .003. A small to medium effect size was observed (*d* = .46).

Total scores on the Nonreactivity subscale increased from 11.30 (*SD* = 3.55) at pre-intervention to 12.96 (*SD* = 3.87) at post-intervention, *t* (45) = -2.91, *p* = .006. A small to medium effect size was observed (*d* = .43).

Total scores on the Acting with Awareness subscale increased from 11.89 (*SD* = 3.54) at pre-intervention to 14.09 (*SD* = 3.81) at post-intervention, *t*(45) = -4.41, *p* < .001. A medium effect size was observed (*d* = .65)

Total scores on the nonjudging subscale increased from 11.88 (*SD* = 3.29) at pre-intervention to 13.86 (*SD* = 4.11) at post-intervention, *t* (45) = -3.23, *p* = .002. A small to medium effect size was observed (*d* = .48).

Figure 4.93. *Pre and post-group mean scores of Total FFMQ-SF And Total Subscale Scores.*



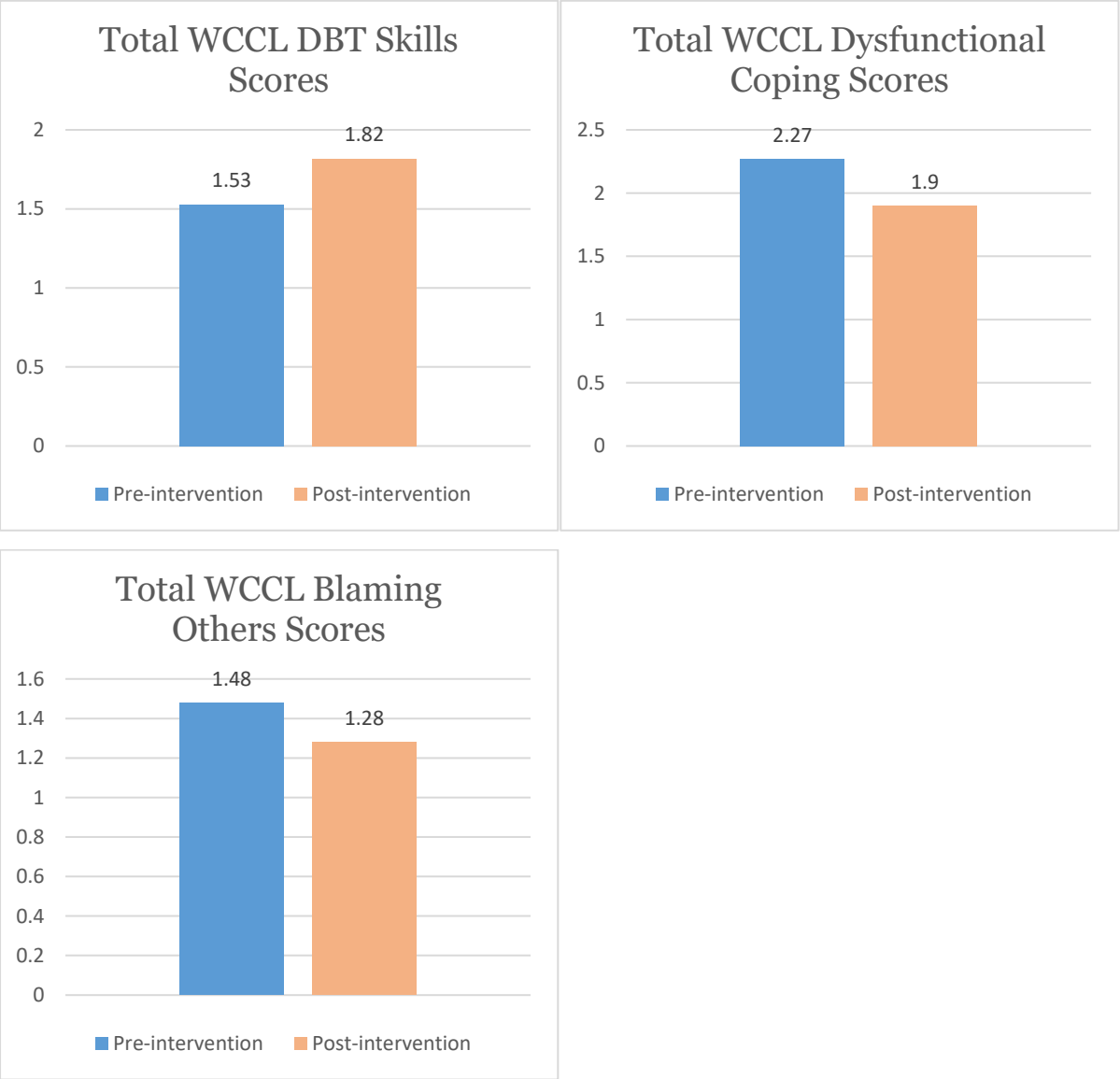

### Ways of Coping Checklist (WCCL)

Results for the WCCL sub-scales indicated that participants reported a significant increase in the use of their DBT Skills. Mean scores on the Skills Use Subscale increased from 1.53 (*SD* = 0.44) at pre-intervention to 1.82 (*SD* = 0.47) at post-intervention, $t$ (45) = -4.09, $p < .001$, with a medium effect size ($d$ = .60).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased significantly from 2.23 (*SD* = 0.38) at pre-intervention to 1.90 (*SD* = 0.50) at post-intervention, $t$ (45) = 4.63, $p < .001$, with a medium effect size ($d$ = .68). This indicates that participants' abilities to cope improved upon completing the intervention.

Participants mean scores on the Blaming Others Subscale also showed a significant reduction from 1.48 (*SD* = 0.63) to 1.28 (*SD*= 0.61) post-intervention, *t* (45) = 2.23, *p* = .031, with a small effect size (*d* = .33) (see Figure 4.94).

Figure 4.94. *Pre and post-group mean scores of Ways of Coping checklist subscales.*




### 4.14.6. Summary

For participants with pre and post-data, significant improvements were observed in the acquisition of DBT coping skills, and the reduction of maladaptive coping strategies. Our service users reported improvement elements of mindfulness and a reduction in difficulty regulating emotion in both the comprehensive and skills only groups with

variations across both streams of the programme. Effect size calculations demonstrated small to large effect sizes for significant results. As the DBT programme is a DBT informed stage 1 intervention focussing on initial stabilisation of maladaptive attempts to cope with dysregulated emotion, these outcomes are reflective of the programme meeting its clinical goals.

## 4.15. Compassion-Focused Therapy for Psychosis Programme

Compassion Focused Therapy for Psychosis (CFT-P) is a group-based psychology programme for adults who have experienced or live with psychosis. It aims to help individuals to learn how to cope with emotional and psychological difficulties associated with living with psychosis. The programme was formerly known as Living Through Psychosis (LTP). It was decided to change the name of the programme in keeping with the content of the sessions which are compassion therapy focused.
In 2024, the programme continued to offer a group informed predominantly by Compassion Focused Therapy (CFT; Gilbert, 2014), which includes eleven weekly group sessions as well as a screening pre-group, a mid-way individual review session and an end of therapy session. Areas of focus in the group include: i) developing a psychological understanding of psychosis; ii) having a safe space to connect with others about challenges associated with having experienced psychosis; iii) exploring what it means to be self-compassionate and working on ways to develop more self-compassion, iv) learning new skills to cope with difficult emotions and to feel more calm/soothed and v) a new addition to the group – to formulate their experiences of psychosis in the context of their lives. It is hoped that through addressing these areas, service users will experience a reduction in self-judgment, shame and distress relating to their experiences.

### 4.15.1. Descriptors

16 individuals completed the CFT-P programme in 2024, across three cycles. Pre and post self-report data was available for 14 out of those 16 (87.51% rate of return). Programme attendees ranged in age from 27 to 62 years, with a mean age of 42.5 (SD =

10.73). Of the fourteen participants that completed the pre and post measures, eight participants were male, and six participants were female.

Missing Value Analysis (MVA) was carried out to account for any missing data. As the data was determined as Missing Completely at Random by Little's Test (Cheng & Evanston, 2013) the Expectation Maximisation method was applied to the dataset before any total scores were computed or statistical analyses carried out. Due to the small sample size, statistical significance could not be determined for changes in scores pre-to-post intervention. Instead, participants individual pre and post measure scores are reported below. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

### 4.15.2. Compassion Focused Therapy for Psychosis Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the CFT-P programme in 2024. All service users attending the CFT-P programme are invited to complete the measures listed below at assessment for the programme and again upon completion.

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

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

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

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

- **The Southampton Mindfulness Questionnaire (SMQ)**

The Southampton Mindfulness Questionnaire (SMQ; (Chadwick, Hember, Mead, Lilley, & Dagnan, 2007) assesses awareness of distressing thoughts and images defined as a concept consisting of four related constructs: awareness of cognitions as mental events in wider context; allowing attention to remain with difficult conditions; accepting such difficult thoughts and oneself without judging; and letting difficult cognitions pass without reactions such as rumination. The measure consists of 16 items and is measured on a seven-point Likert scale, from zero – 'strongly disagree', to six – 'strongly agree'. Total scale scores range from zero to 96.

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

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

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

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

The PBEQ is a 13-item self-report measure of appraisals of psychotic-like experiences, in the domains of negative appraisal of experience, external shame, and internal

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

### 4.15.3. Results

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

Mean scores on the CMAS Self Compassion Scale increased from 88.57 (*SD* = 17.26) pre intervention to 101.79 (*SD* = 12.15) following engagement in the programme. As seen in the graphs below, twelve of fourteen participants (85.71%) reported an increase in overall self compassion from pre to post intervention.

Due to the small sample size, changes in total CMAS self compassion scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in CMAS scores were not attributable to chance or measurement error, an RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than or equal to 1.96. The calculated cut-off score indicating clinically meaningful improvement on the CMAS self compassion scale was 85. Participants were classified as “clinically meaningful improvement” (passed RCI criterion and CMAS score increased to above cut-off score), “reliable improvement” (passed RCI criterion but the score did not increase above CMAS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score decreased). As outlined in table 4.17, five participants (35.71%) reported clinically significant improvement, while two participants (14.29%) reported reliable improvement, and seven participants reported uncertain change (50%).

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

CMAS = Compassionate Motivation and Action Scales

| Participant | Pre-Score | Post Score | RCI Value | Category |
|---|---|---|---|---|
| 1 | 107.00 | 112.00 | 0.68 | Uncertain change |
| 2 | 101.00 | 96.00 | -0.68 | Uncertain change |
| 3 | 86.00 | 91.00 | 0.68 | Uncertain change |
| 4 | 78.00 | 99.00 | 2.84 | Clinically Significant Improvement |
| 5 | 94.00 | 123.00 | 3.92 | Reliable Improvement |
| 6 | 111.00 | 114.00 | 0.41 | Uncertain change |
| 7 | 95.00 | 105.00 | 1.35 | Uncertain change |
| 8 | 116.00 | 122.00 | 0.81 | Uncertain change |
| 9 | 59.00 | 90.00 | 4.19 | Clinically Significant Improvement |
| 10 | 82.00 | 103.00 | 2.84 | Clinically Significant Improvement |
| 11 | 71.00 | 91.00 | 2.70 | Clinically Significant Improvement |
| 12 | 62.00 | 103.00 | 4.32 | Clinically Significant Improvement |
| 13 | 89.00 | 87.00 | -0.27 | Uncertain change |
| 14 | 89.00 | 89.00 | 0.00 | Uncertain change |

The three subscales within the Self Compassion Scale were also analysed. The compassionate intention subscale mean score remained relatively unchanged increasing slightly from 30.93 (*SD* = 4.78) to 31.71 (*SD* = 2.70) from pre to post-intervention. Analysis of individual scores showed that this increased for five out of fourteen participants (35.71%), while remaining unchanged for six of fourteen participants (42.86%). The distress tolerance subscale mean score increased from 28.86 (*SD* = 8.36) to 35.14 (*SD* = 6.14), with individual scores increasing on this subscale for nine of fourteen participants (64.29%). Similarly, the compassionate

action subscale mean score increased from 28.79 (*SD* = 8.34) to 34.93 (*SD* = 6.11), with eleven of fourteen participants (78.57%) reporting increased scores on this subscale post-intervention.

Figure 4.95. *Pre and Post Group Mean Scores of Compassionate Motivation and Action Scales (CMAS) total and subscales scores*

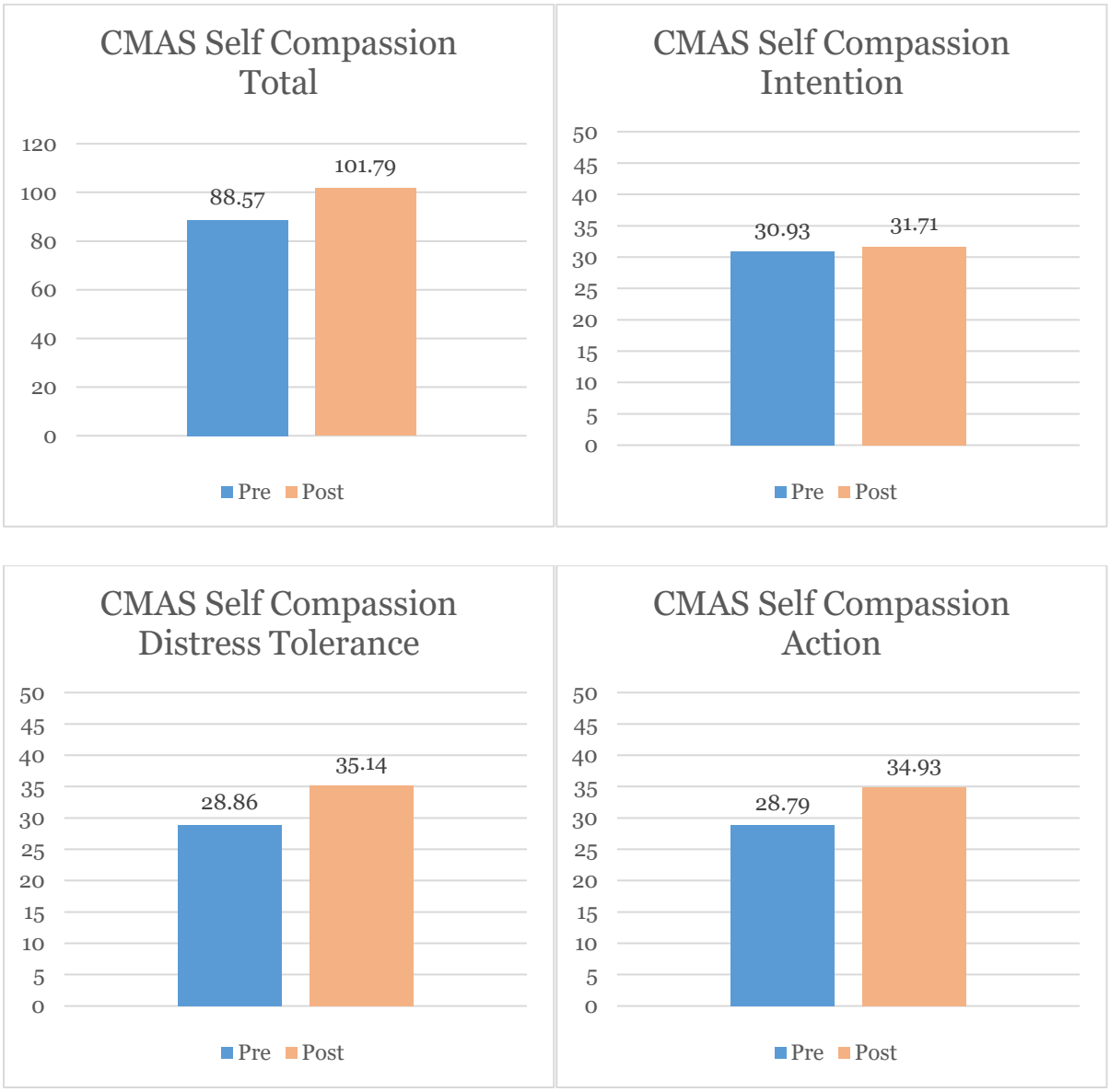
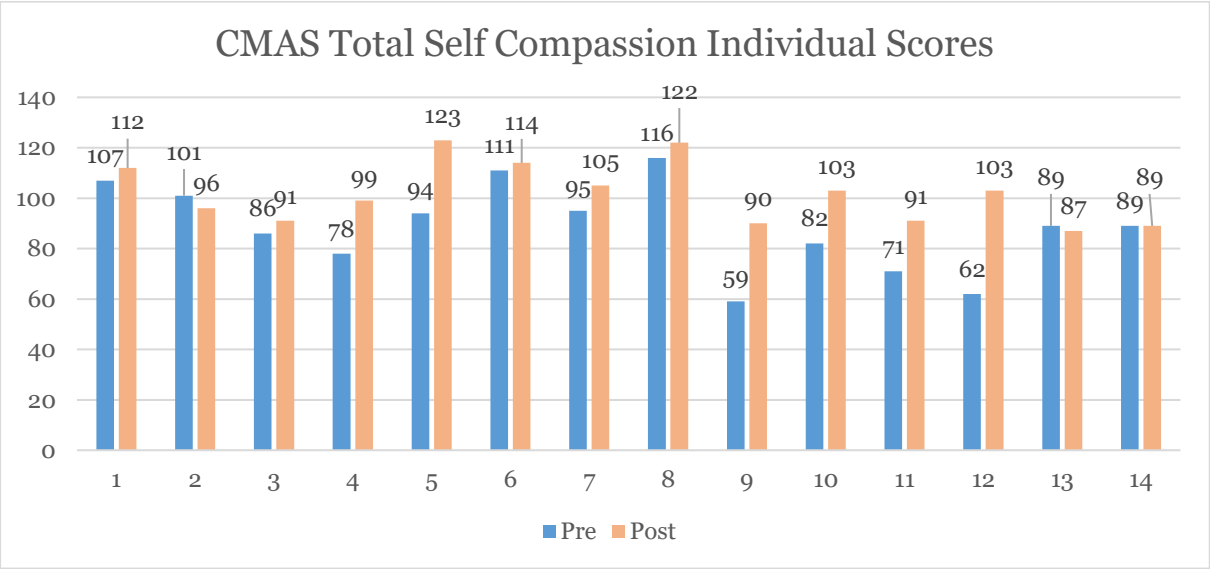
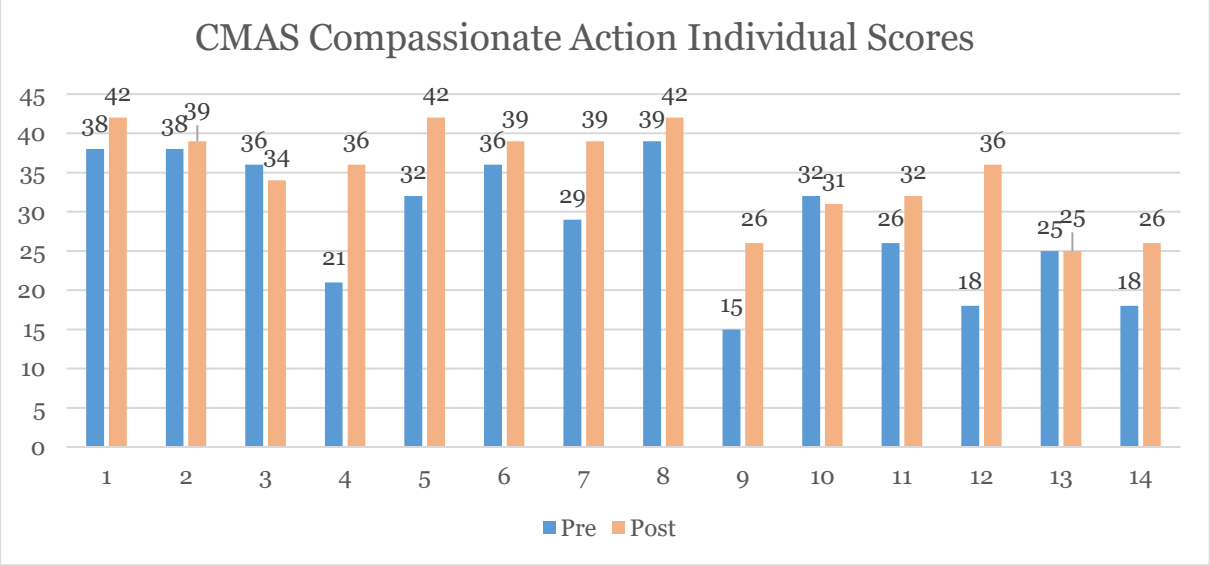
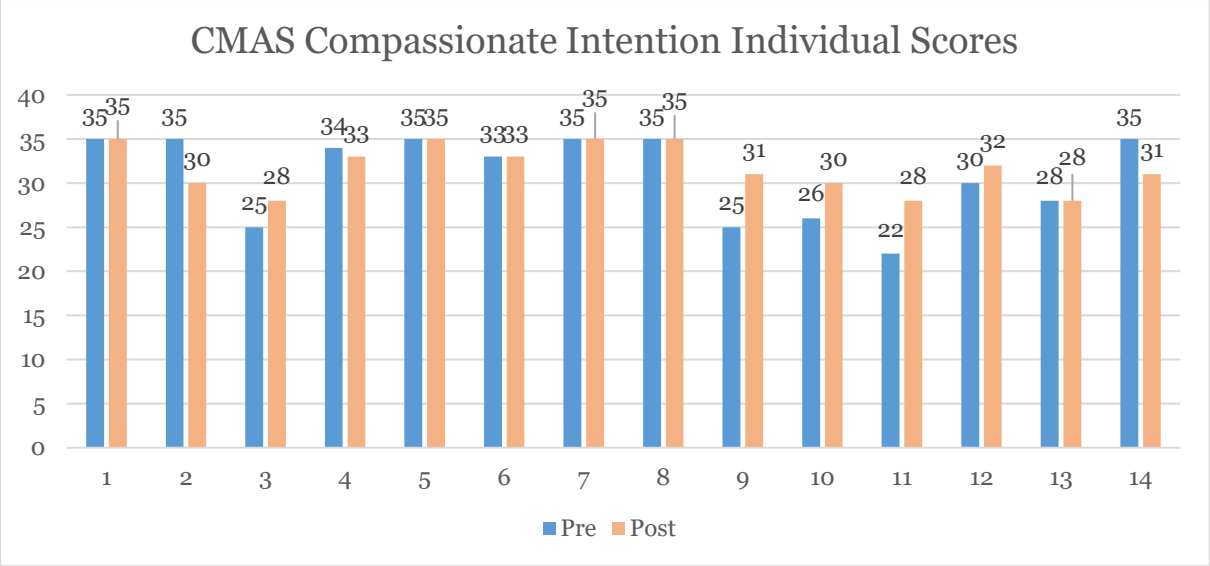
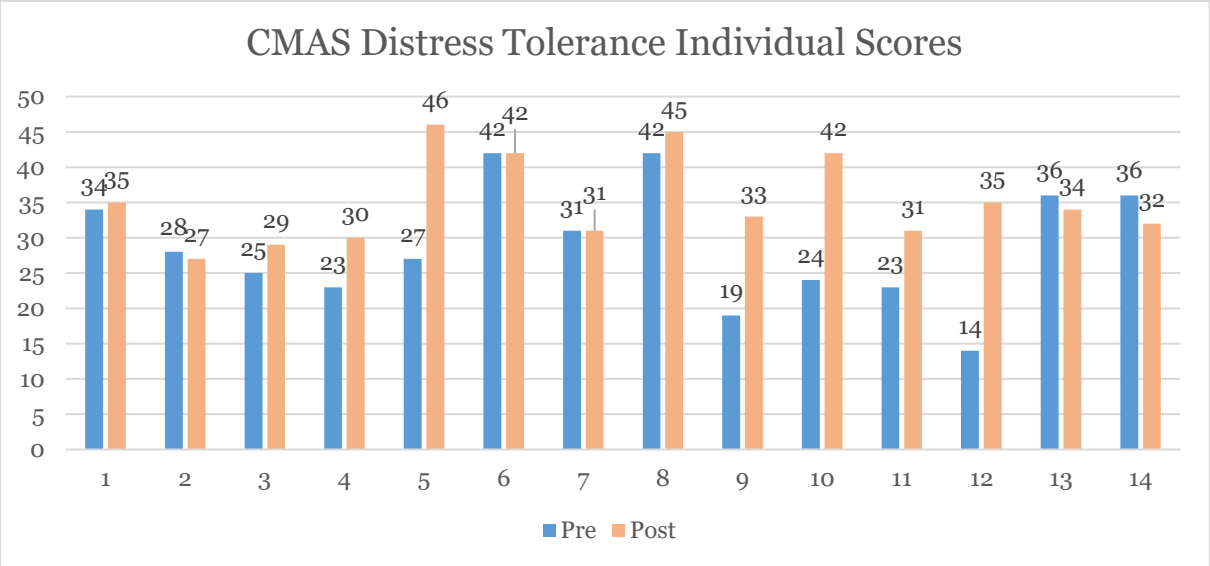


Figure 4.96. *Pre and Post Group Individual Scores of Compassionate Motivation and Action Scales (CMAS) total and subscales scores*



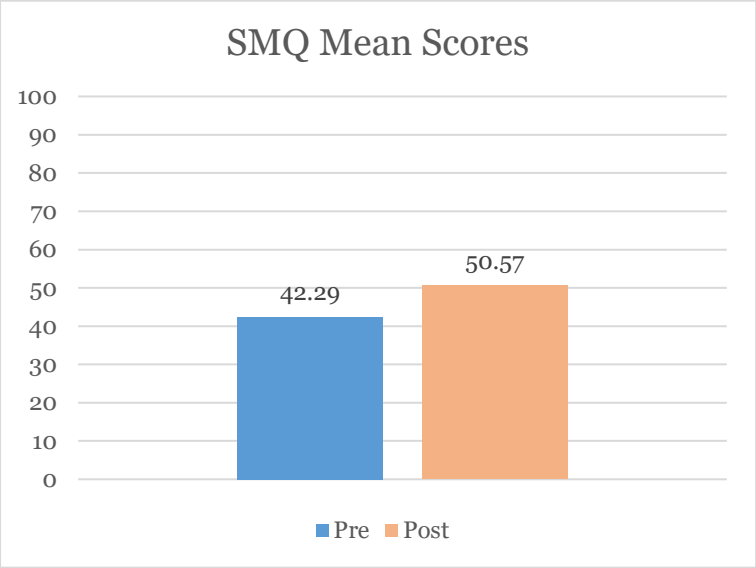


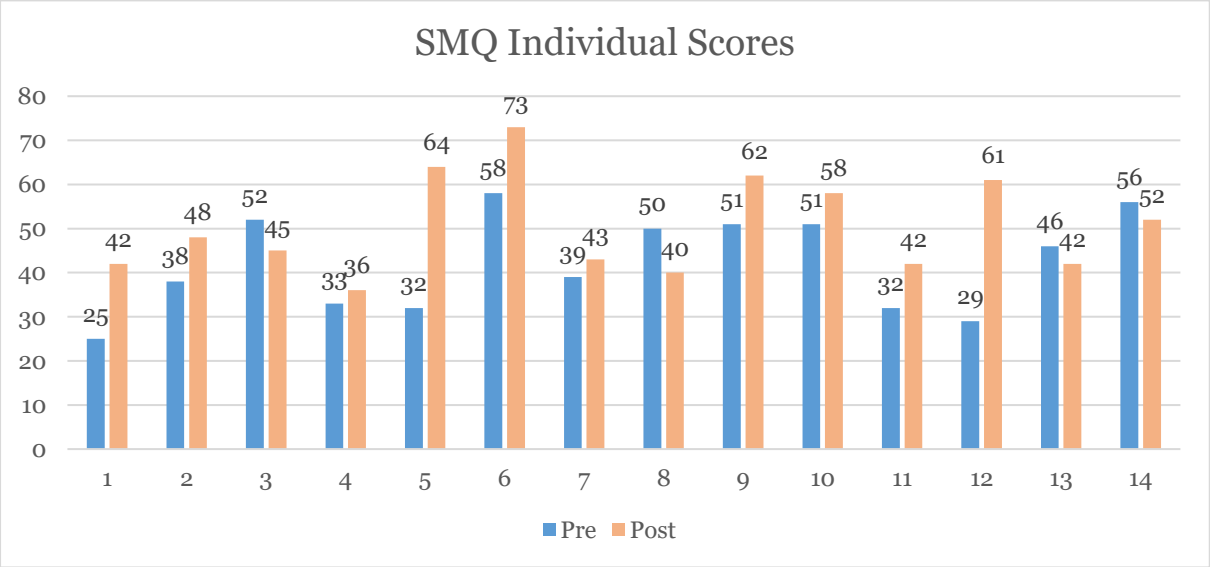




### Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ mean scores suggests that individuals' tendency to mindfully respond to distressing thoughts and images increased. Higher scores on this measure indicate greater mindful awareness. Service users demonstrated a mean score of 42.29 (*SD* = 10.94) at pre-intervention and a mean score of 50.57 (*SD* = 11.16) following the intervention. As shown in Figure 4.97, mindfulness scores increased for ten out of fourteen participants (71.43%) post-intervention.

Figure 4.97. *Pre and Post Group total and individual mean scores of Southampton Mindfulness Questionnaire (SMQ)*

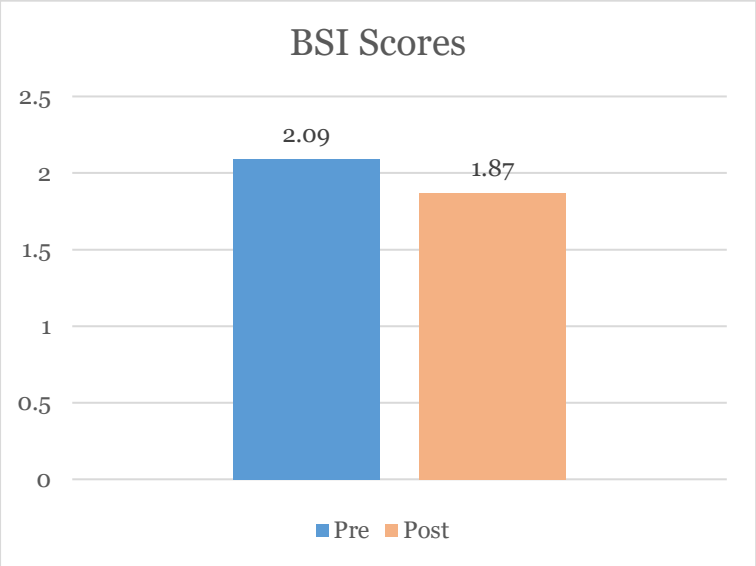


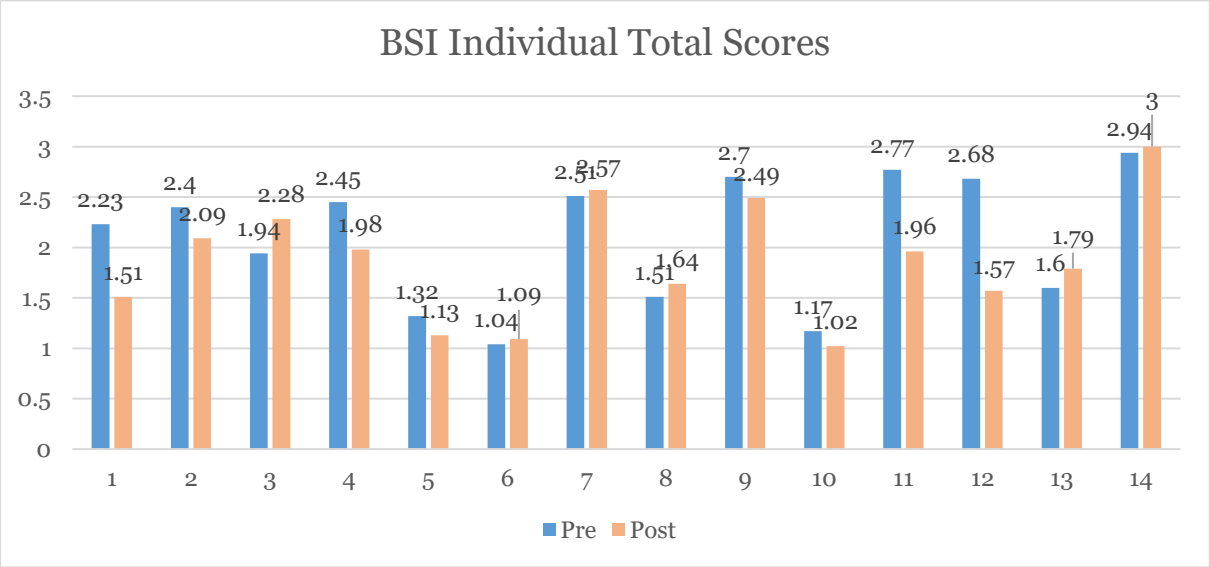




### The Brief Symptom Inventory (BSI)

Global distress levels as measured by the BSI Global Index score demonstrated a very small increase following the intervention. The mean score of 2.09 (*SD* = 0.65) pre-intervention decreased to 1.87 (*SD* = 0.59) post-intervention. Scores on this measure increased for eight out of fourteen participants (57.14%) post-intervention.

Figure 4.98. *Pre and Post Group total and individual mean scores of Brief Symptom Inventory (BSI)*

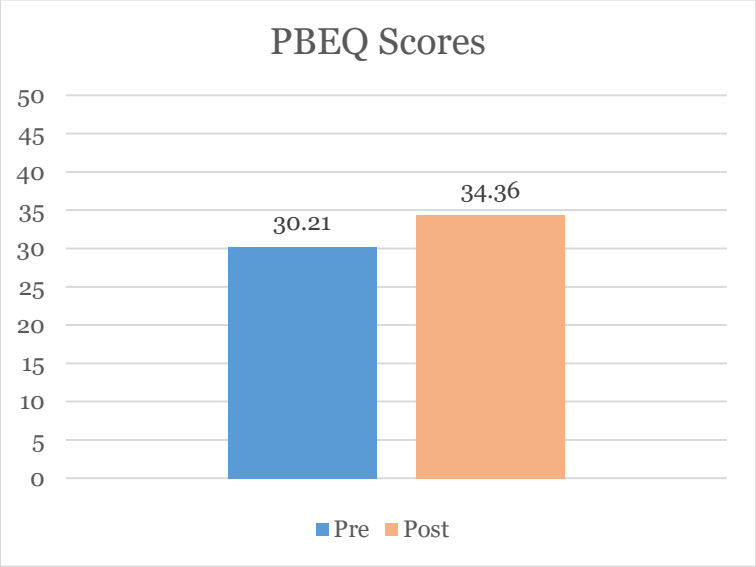


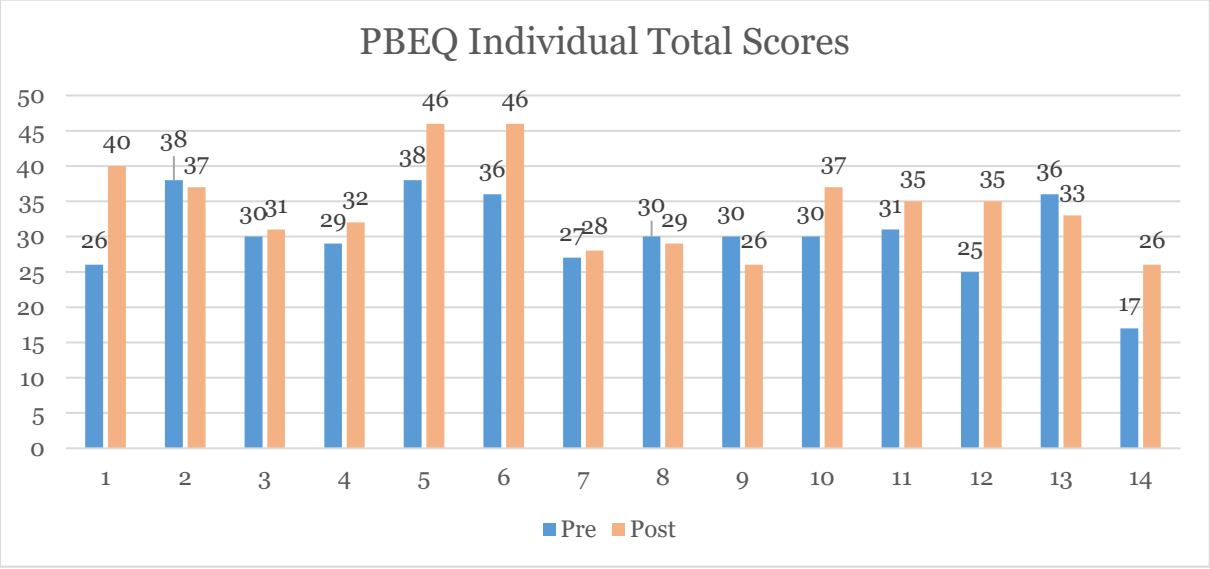




### The Personal Beliefs about Experiences Questionnaire (PBEQ)

Mean scores on the PBEQ increased slightly following engagement with the programme. The mean score beforehand was 30.21 (*SD* = 5.69), this increased to 34.36 (*SD* = 6.48) at post-intervention. Scores on this measure increased for ten of fourteen participants (71.43%) post-intervention.

Figure 4.99. *Pre and Post Group total and individual mean scores of Personal Beliefs about Experiences Questionnaire (PBEQ)*




### 4.15.3. Summary

The CFT-P Programme continues to offer an opportunity for service users to develop skills to cope with emotional and psychological challenges relating to recovering from and living with psychosis. The results of this analysis indicate that group members

appear to be developing their capacity for compassion for the self and others in terms of both motivation and action. It is important to consider the impact of the small sample size when measuring significant change. The CFT-P team will continue to develop the programme offering during 2025 to address the psychological needs of service users with psychosis.

## 4.16 Focused Acceptance and Commitment Therapy Programme

Following consultation and feedback from service users, the 8-week Mindfulness day programme was replaced with an 8-week Focused Acceptance and Commitment Therapy (FACT) day programme in April 2024. The reasons cited by service users included that a half day of mindfulness was too long and that several other day programmes include elements of mindfulness practice. Following a 6-week FACT pilot in early 2024, feedback indicated that FACT offered an ideal balance between mindfulness and acceptance, which was appropriate for most diagnoses.

FACT is an 8-week online group therapy which uses acceptance and mindfulness strategies to help service users transform their relationship with unwanted experiences, such as unwanted thoughts, emotions, memories, or bodily sensations. While FACT does not aim to change these unwanted experiences, it helps individuals to accept these experiences and focus on actions that are guided by chosen values. FACT balances acceptance and mindfulness-based skills with commitment strategies aimed at helping individuals move towards what matters most, while practicing acceptance of what is outside of their control.

Due to the change in programme structure and length, coupled with a transition from Mindfulness to the FACT programme, only the last 2024 cycle of FACT will be reported. Due to this, it is expected for participant rates to be higher in the 2025 report.

### 4.16.1 Descriptors

Pre and post data were collected for ten participants who completed the FACT programme in 2024. Six of the participants were female and four were male. Participant's ages ranged from 32 years to 61 years (M = 48.5, SD = 11.07).

### 4.16.2. FACT Programme outcome measures

- **Acceptance and Action Questionaire II:** see page 54
- **Depression Anxiety and Stress Scale (DASS-42**) see page 229

The 42-item Depression, Anxiety and Stress Scale (DASS-42) is a set of three self-report scales designed to measure depression, anxiety, and stress (Lovibond & Lovibond, 1995). Higher scores are indicative of higher levels of depression, anxiety, and/or experienced stress. The DASS-42 has been shown to have good validity and reliability (Cronbach's alpha = .84 - .91).

- **Five Facet Mindfulness Questionnaire (FFMQ):** see page 55

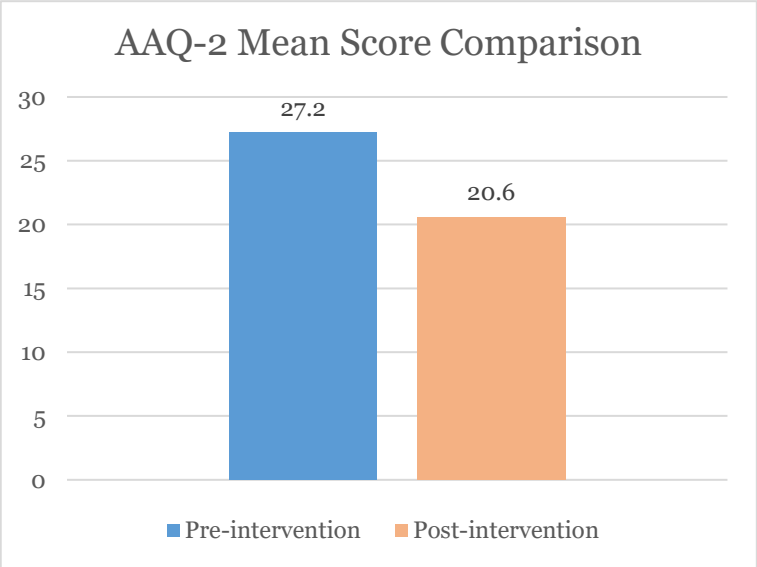
### 4.16.3 Results

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the 10 participants who returned both pre and post measures are given to reflect the outcome of the intervention.

#### Acceptance and Action Questionaire II (AAQ-II)

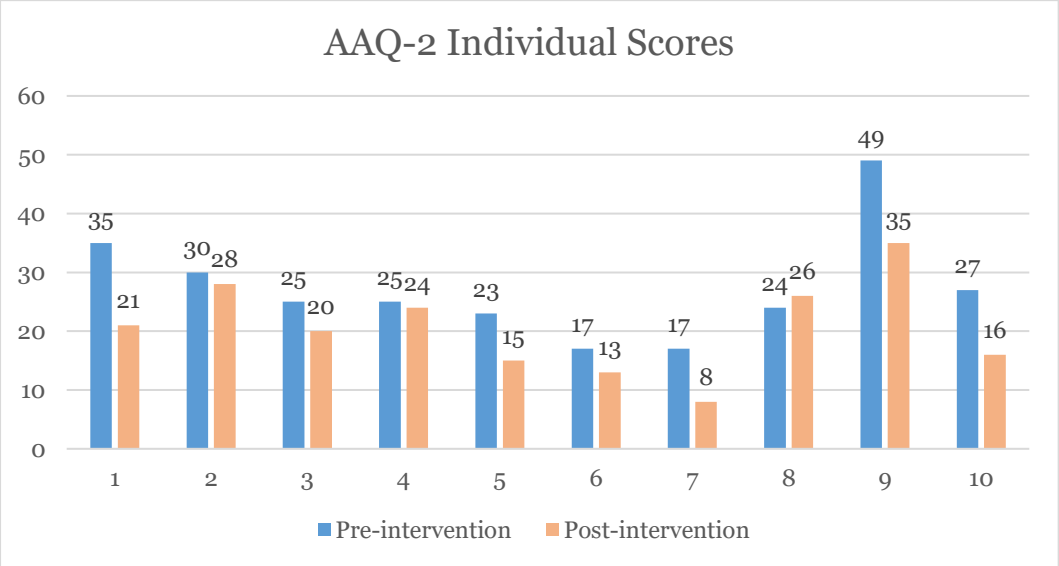
There was a decrease in total scores from pre-intervention (*M* = 27.20, *SD* = 9.37) to post-intervention (*M* = 20.60, *SD*= 7.98). This finding indicates that those who completed the FACT programme in 2024 had more psychological flexibility post-intervention (see Figure 4.100).

Figure 4.100. *Pre and post mean scores of the Acceptance and Action Questionnaire - II (AAQ-II).*




Further examination of the individual scores indicates that seven out of ten participants (70%) demonstrated a reduction in AAQ-2 scores from pre-intervention to post-intervention (see Figure 4.101).

Figure 4.101. *Pre and post individual scores of the Acceptance and Action Questionnaire – II (AAQ-II).*




### Depression Anxiety and Stress Scale (DASS-42)

Analysis of the three subscales (Depression, Anxiety and Stress) within the DASS-42 revealed a decrease in psychological difficulties from a pre-intervention to post

intervention. There was a decrease in total scores on the depression subscale from pre-intervention (*M* = 12, *SD* = 12.74) to post-intervention (*M* = 5.1, *SD*= 4.8) (see Figure 4.102). There was a decrease in total scores on the anxiety subscale from pre-intervention (*M* = 6.4, *SD* = 4.95) to post-intervention (*M* = 2.2, *SD*= 2.44) (see Figure 4.103). There was a decrease in total scores on the stress subscale from pre-intervention (*M* = 13.8, *SD* = 8.7) to post-intervention (*M* = 8.9, *SD*= 3.9) (see Figure 4.104).

Figure 4. 102. *Pre and post mean* scores of Depression Anxiety and Stress Scale (DASS-42) depression subscale.

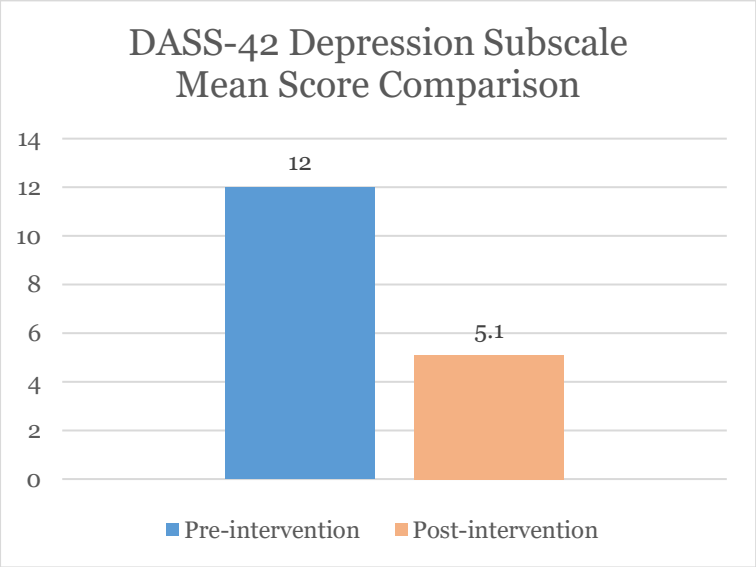



Figure 4. 103. *Pre and post mean* scores of Depression Anxiety and Stress Scale (DASS-42) anxiety subscale.

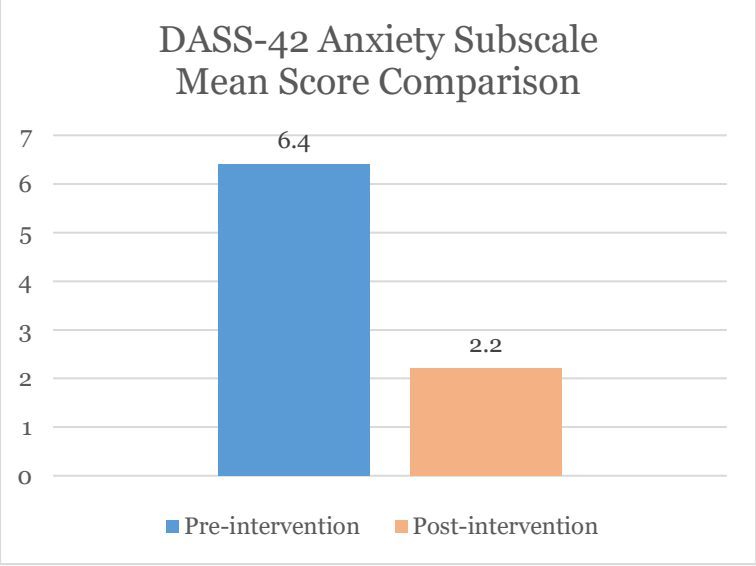
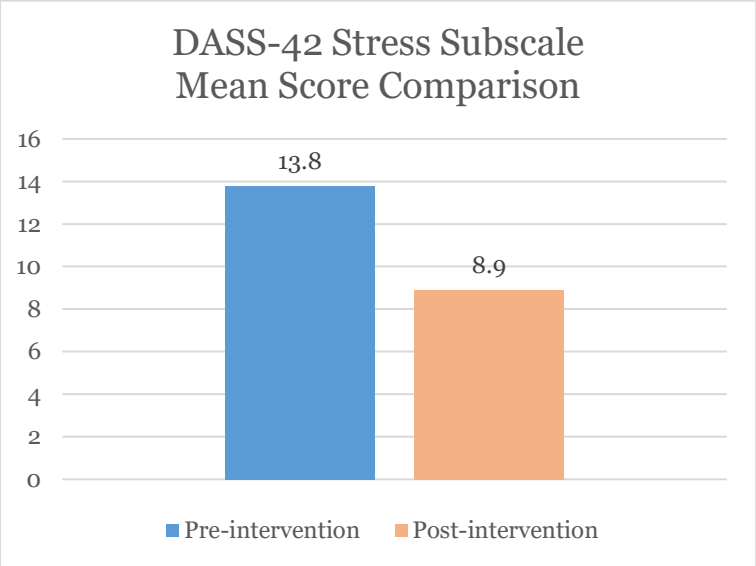


Figure 4. 104. *Pre and post mean* scores of Depression Anxiety and Stress Scale (DASS-42) stress subscale.




Further examination of individual Scores on the DASS-42 are as follows:

Eight out of ten participants (80%) reported reduced depression scores at the end of the intervention. Seven out of ten participants (70%) reported reduced anxiety scores post-intervention. Seven out of ten participants (70%) reported reduced stress scores post-intervention.

See Figures 4.105 to 4.107 below for visual representation of changes in individual scores from pre to post intervention.

Figure 4.105. *Pre and post individual* scores of Depression Anxiety and Stress Scale (DASS-42) – depression subscale.

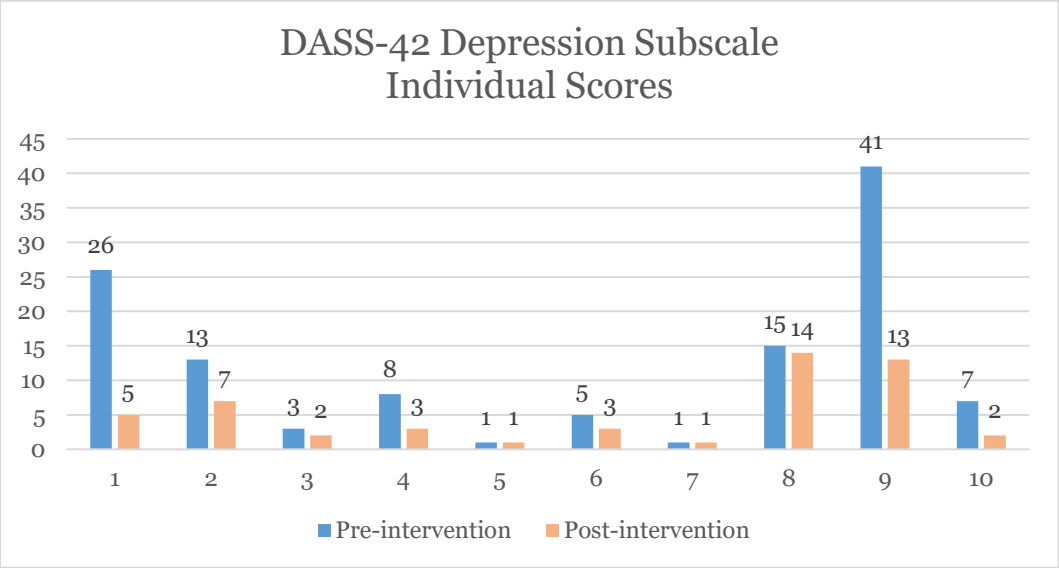



Figure 4.106. *Pre and post individual* scores of Depression Anxiety and Stress Scale (DASS-42) – anxiety subscale.

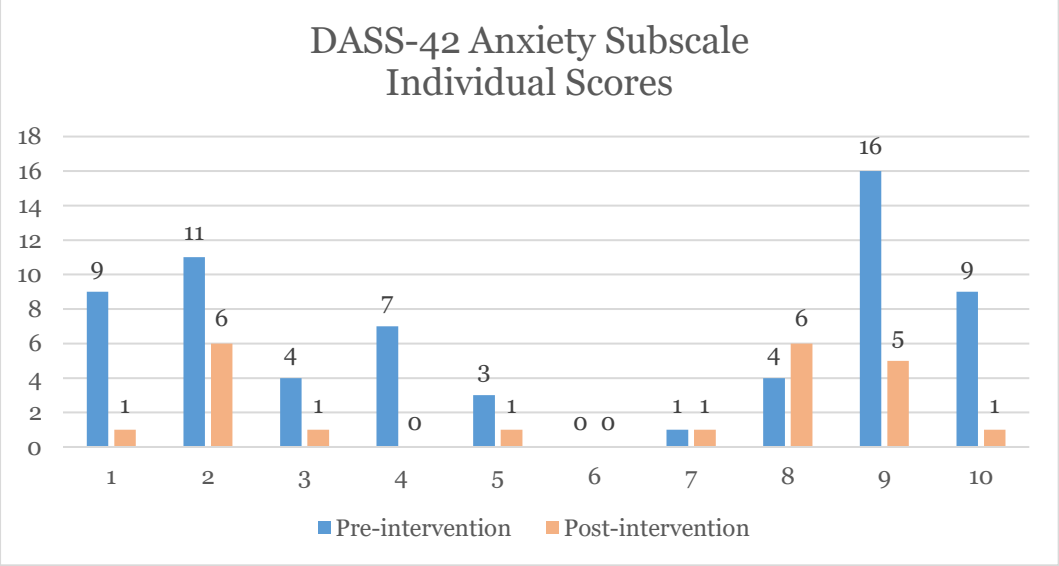
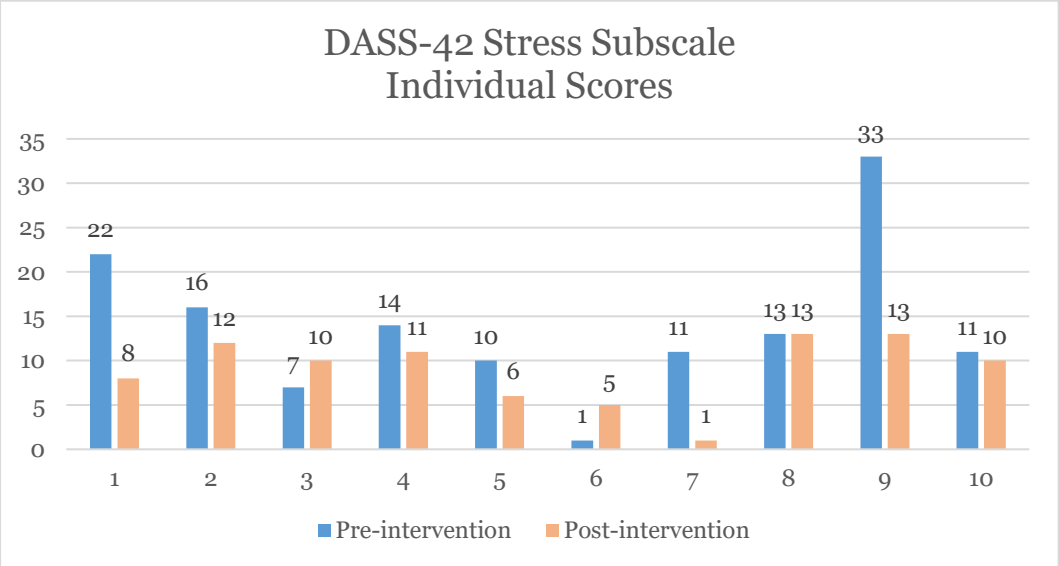


Figure 4.107. *Pre and post individual* scores of Depression Anxiety and Stress Scale (DASS-42) – stress subscale.

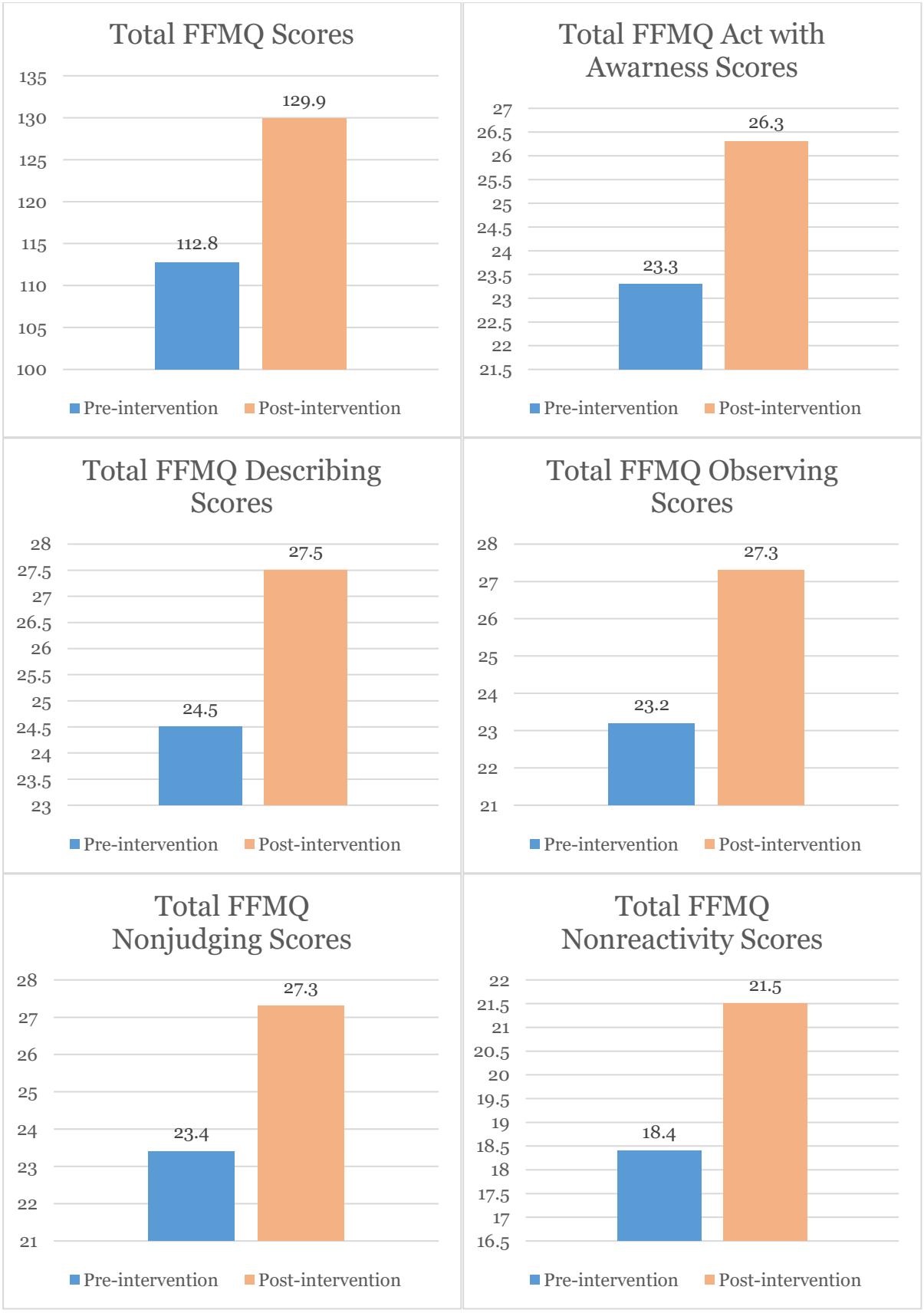



### Five Facet Mindfulness Questionnaire (FFMQ)

Total mean scores of 112.80 (*SD* = 21.43) at pre-intervention increased to 129.90 (*SD* = 18.62) at post-intervention, suggesting that participants had greater mindful qualities upon completion of the programme. Mindfulness is defined in this context as observing, describing, acting with awareness, non-reactivity to inner experience and non-judging of inner experience.

Total scores on the act with awareness subscale increased from 23.3 (*SD* = 5.44) at pre-intervention to 26.3 (*SD* = 4.5) at post-intervention. Total scores on the describing subscale increased from 24.5 (*SD* = 6.77) at pre-intervention to 27.5 (*SD* = 3.54) at post-intervention. Total scores on the observing subscale increased from 23.2 (*SD* = 6.34) at pre-intervention to 27.3 (*SD* = 5.19) at post-intervention. Total scores on the nonjudging subscale increased from 23.4 (*SD* = 6.98) at pre-intervention to 27.3 (*SD* = 6.93) at post-intervention. Total scores on the nonreactivity subscale increased from 18.4 (*SD* = 4.38) at pre-intervention to 21.5 (*SD* = 3.34) at post-intervention (see Figure 4.108).

Figure 4. 108. *Pre and post-group mean scores for FFMQ total and subscale scores*



Further examination of individual Scores on the FFMQ are as follows. Eight out of ten (80%) participants showed an overall increase in total FFMQ scores. Eight out of ten (80%) participants showed an increase in total Acting with Awareness scores. Seven out of ten (70%) participants showed an increase in Describing scores. Nine out of ten (90%) participants showed an increase in Observing scores. Nine out of ten (90%) participants showed an increase in Nonjudging scores. Eight out of ten (80%) showed an increase in Nonreactivity scores.

See Figures 4.109 to 4.114 for visual representation of changes in individual scores from pre to post intervention.

Figure 4.109. *Pre and post individual* scores of Five Facet Mindfulness Questionnaire (FFMQ)

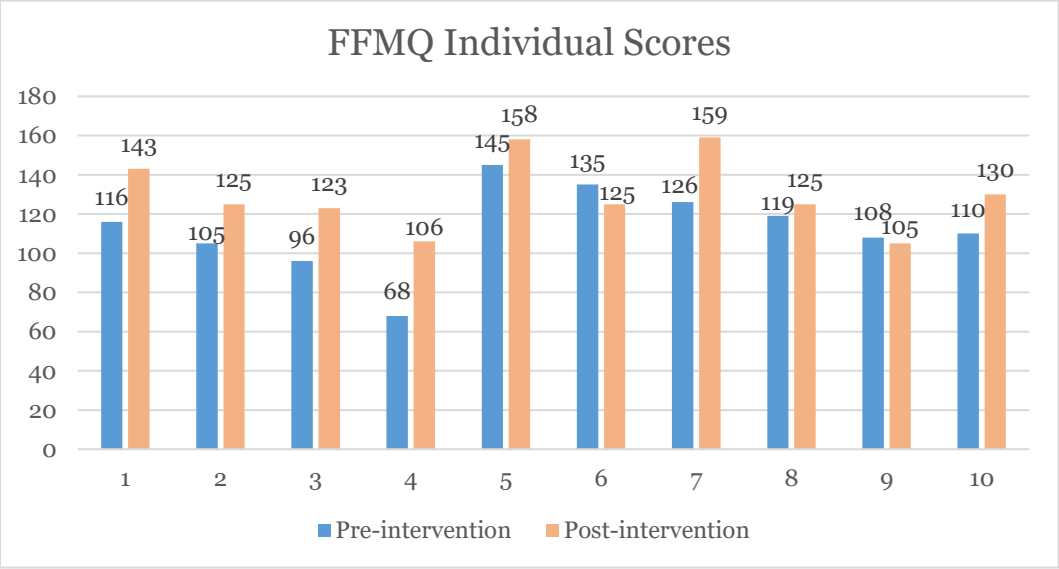


Figure 4.110. *Pre and post individual* scores of Five Facet Mindfulness Questionnaire (FFMQ) – Act with Awareness Subscale

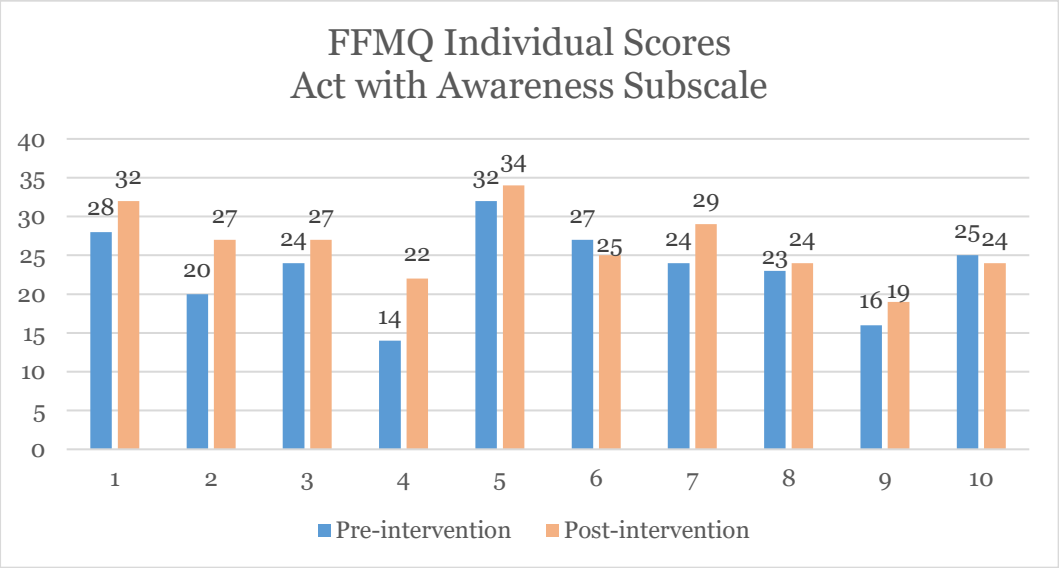



Figure 4.111. *Pre and post individual* scores of the FFMQ – Describing Subscale

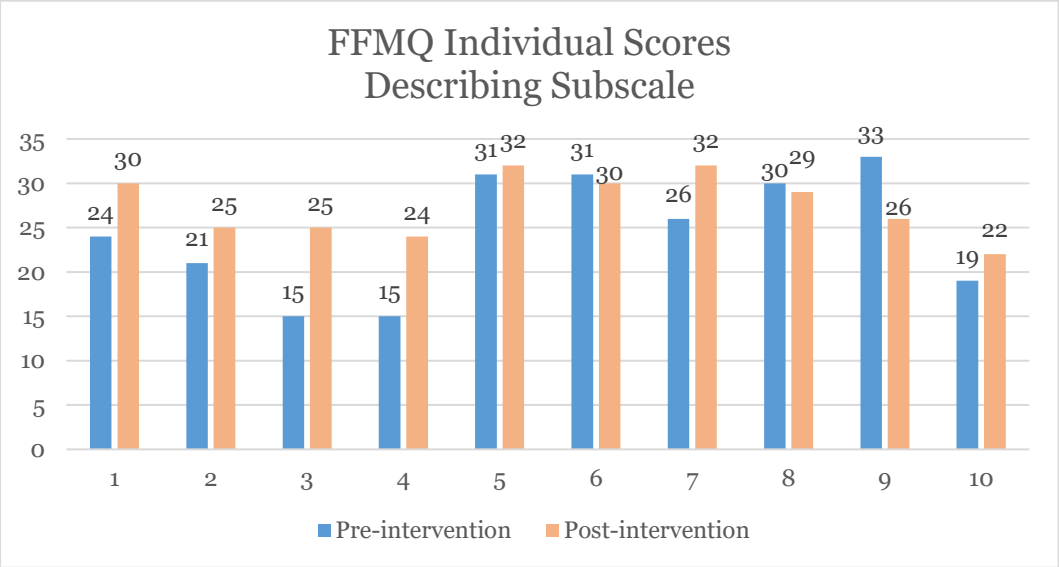


Figure 4.112. *Pre and post individual* scores of the FFMQ – Observing Subscale

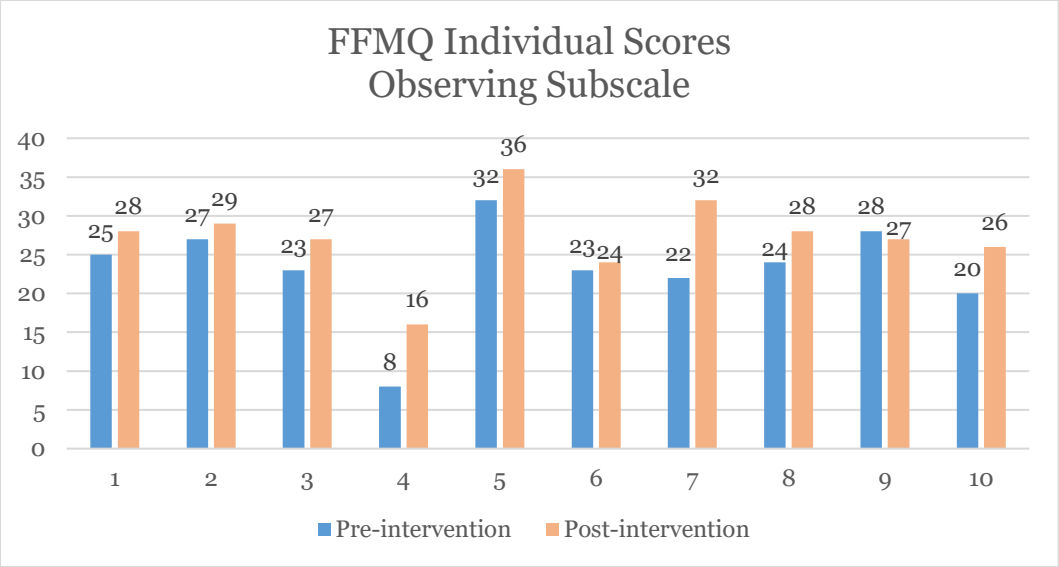



Figure 4.113. *Pre and post individual* scores of the FFMQ – Nonjudging Subscale

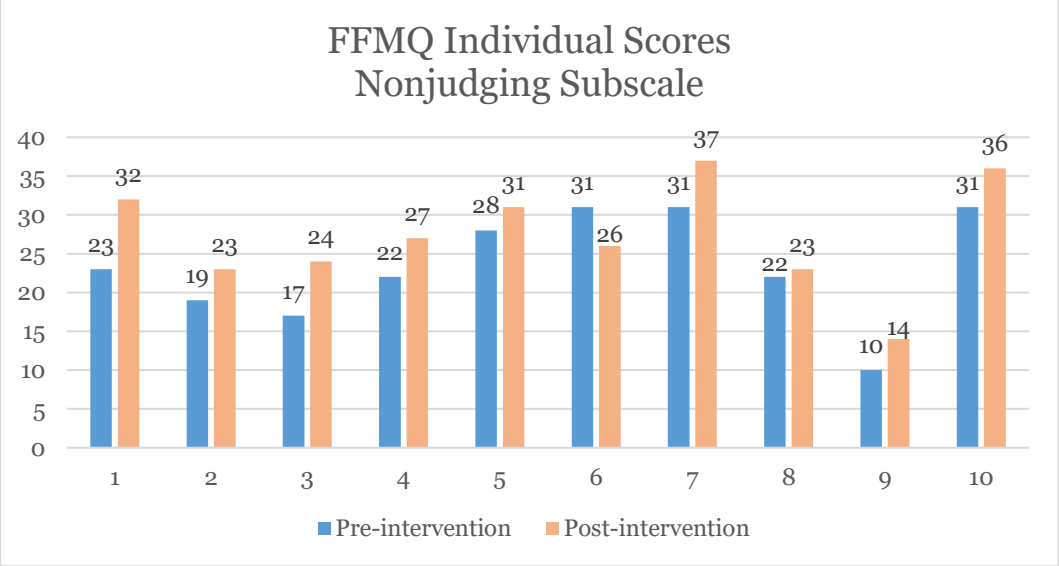
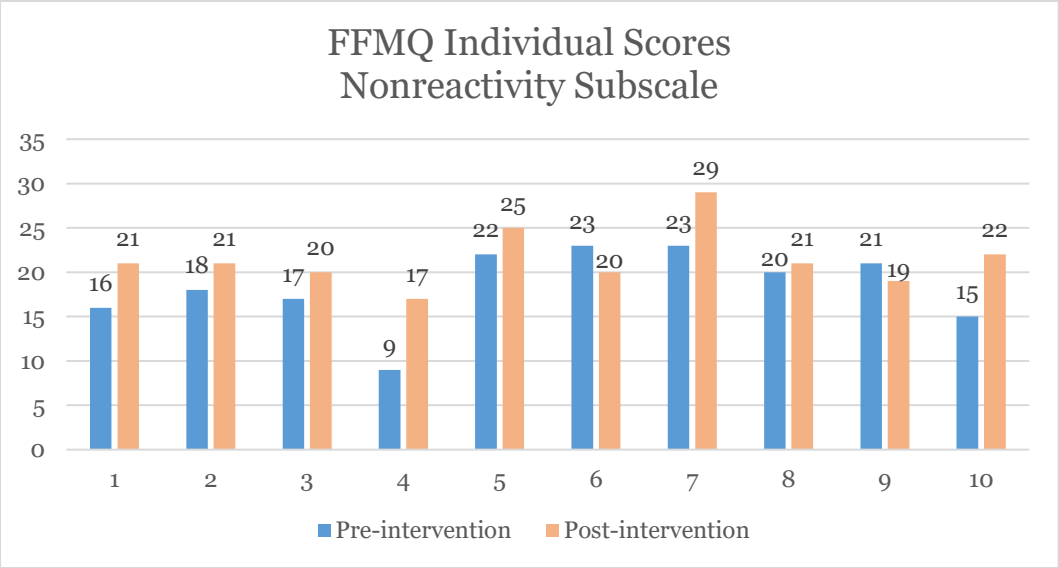


Figure 4.114. *Pre and post individual* scores of the FFMQ – Nonreactivity Subscale




### 4.16.4. Summary

In 2024, service users who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, and reduction in symptoms of depression, anxiety, and stress, as measured by the available psychometrics. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of mindfulness.

## 4.17. Psychology Skills Group for Adolescents

The Psychology Skills Group for Adolescents is an online psychological group therapy that aims to support young people (and their parents) to understand themselves and their difficulties and learn new ways to manage them. The group teaches a range of skills from Dialectical Behaviour Therapy for Adolescents (DBT-A), Radically Open Dialectical Behaviour Therapy (RO-DBT), and Group Radical Openness (GRO) in a multi-family context. The group invites parents or caregivers to attend and participate alongside their young person to help support them in learning and practicing new

coping skills. The group runs on a rolling basis for one afternoon per week for 22 weeks. The group is comprised of four modules: Orientation/Mindfulness, Managing Emotions, Distress Tolerance, Relationships (Interpersonal Effectiveness), and Walk the Middle Path. Modules vary in length between two and five sessions.

### 4.17.1. Descriptors

In 2024, nine families participated in PSG-A. Of these nine, two families withdrew from the programme and their data have been excluded due to the absence of two measures. Their demographic data will be included here for descriptive analyses. The mean age of young people attending was approximately 16 years old (M=16.56, SD =1.01). 6 of the 9 young people were female, with 3 male participants. 1 of the parents were male and 8 of the parents were female. Pre and post data were available for 6 young people, and 7 parents, as one young person did not return measures.

### 4.17.2. Psychology Skills Group for Adolescents Outcome Measures

The following section presents a summary of clinical outcome measures used by the PSGA programme in 2024. All service users and their parents attending the PSGA programme are invited to complete the measures listed below at assessment for the programme and again upon completion. In March 2024, some changes were made to the PSG-A outcome measures. These included removing the Brief Reasons for Living Inventory – Adolescents (BRFLA) and Revised Children's Anxiety and Depression Scale (RCADS), as well as adding the Beck Youth Inventory – Depression Scale (BYI-D). The parent version of the RCADS was also removed from the parent outcome measures. Measures were changed in order to reduce the burden on service users while also aiming to more accurately capture the goals of the programme.
Due to the small sample size statistical significance could not be determined for changes in scores on a number of measures below. For these measures, participants' individual pre and post measure scores are reported instead. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs.

- **Difficulties in Emotion Regulation Scale (DERS):** see page 153

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) was completed by young people before and after taking part in group, while parents completed the Difficulties in Emotion Regulation Scale – Parents (DERS-P).

- **DBT Ways of Coping Checklist (DBT-WCCL):** see page 165

The DBT Ways of Coping Checklist (DBT-WCCL; Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010) was completed by young people and parents at pre- and post-intervention.

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

The Brief Reasons for Living Inventory – Adolescents (BRFL-A; Osman et al., 1996) was completed by young people at pre and post intervention. The BRFL-A assesses factors protecting against suicidal behaviour in adolescents and is comprised of five subscales: Family Alliance (FA), Suicide-Related Concerns (SRC), Self-Acceptance (SA), Peer-Acceptances and Support (PAS), and Future Optimism (FO). In the BRFL-A, specific reasons that people might have for not ending their life are presented and participants are asked to rate how important each reason is to them for staying alive. The measure consists of 32 items scored on a six-point Likert scale (1 = not at all important; 6 = extremely important). Higher mean scores on subscales indicate greater perceived importance of factors protecting against suicide. The BRFL-A demonstrates good internal consistency and good construct, convergent, predictive, and discriminant validity (Osman et al., 1996). As previously stated, this measure was used until March 2024 and was therefore not completed by all service users.

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

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

indicative of higher levels over and under controlled traits, respectively. The OUT-Ma is currently undergoing validation in the adolescent community population.

- **Strengths and Difficulties Questionnaire (SDQ) and Strengths and Difficulties Questionnaire – Parents (SDQ-P).**

The Strengths and Difficulties Questionnaire (SDQ) was completed by the young people, while parents completed the Strengths and Difficulties Questionnaire – Parents (SDQ-P). This questionnaire is used to assess children's mental health and can be completed by children and young people themselves, by their parents or by their teachers. It can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening. It measures 5 dimensions: emotional problems, conduct problems, hyperactivity/inattention problems, peer problems, and prosocial behaviour. Items are measured on a 3-point Likert scale (0 = Not True; 1 = Somewhat True; 2 = Certainly True). This widely used measure has demonstrated good reliability and validity (Giannakopoulos et al., 2013; Mieloo et al., 2012).

- **Revised Children's Anxiety and Depression Scale (RCADS)**

The Revised Children's Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire with subscales including: separation anxiety disorder, social phobia, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood (major depressive disorder). It also yields a Total Anxiety Scale (sum of the 5 anxiety subscales) and a Total Internalizing Scale (sum of all 6 subscales). Additionally, The Revised Children's Anxiety and Depression Scale – Parent Version (RCADS-P) similarly assesses parent report of youth's symptoms of anxiety and depression across the same six subscales. The RCADS can be used for tracking symptoms as well as providing additional information for assessment. This measure has shown good reliability on subscales and total scale (Chorpita, Moffitt, & Gray, 2005) as well as high validity (Esbjørn et al., 2012; Donnelly, Fitzgerald, Shevlin, & Dooley, 2019). This measure was also used until March 2024 and was therefore not completed by all service users.

- **Beck Youth Inventory – Depression Scale (BYI-D)**

The BYI-D (Beck et al., 2001) scale was completed by young people before and after taking part in group. The BYI-D assesses depressive symptoms, and measures sadness, negative thoughts about oneself and future, and associated bodily symptoms. The measure consists of 20 items scored on a four-point Likert scale (0= never; 3 = always) and includes items from five domains: negative views of the self, negative views of the world in general, hopelessness (referred to as "motivational"), and physiological and emotional symptoms of depression. One summated score is obtained from the items on the scale. Total scale scores range from 0 to 60 with higher total scores indicating greater depressive symptoms. This measure has shown good internal consistency and test-retest reliability (Beck et al., 2001) as well as high validity (Steer et al., 2001).

- **SCORE-15**

The SCORE-15 is a self-report measure of family functioning and provides rich information about group member's experiences and perspectives on their familial relationships. It consists of 19 items, which are scored on a 5-point Likert scale (1 = Describes us: Very well; 5 = Describes us: Not at all). The SCORE-15 has been shown to have strong consistency and reliability and can be used to monitor proven indicators of progress in group therapy (Stratton et al., 2014).

- **Goal Based Outcomes (GBO)**

The GBO tool is a way of evaluating progress towards goals in clinical work with children, young people, and their families and carers. The GBO compares how far a child or young person feels they have moved towards reaching a goal that they have set for themselves at the beginning of an intervention, on a 10-point Likert scale (1 = Goal not at all met; 10 = Goal reached). Research on the reliability and validity of this measure is ongoing but some studies have demonstrated good internal consistency (Edbrooke-Childs et al., 2015).

### 4.17.3. Results

As mentioned above, participants' individual pre and post measure scores are reported as statistical significance could not be determined for changes in scores due to the small sample size.

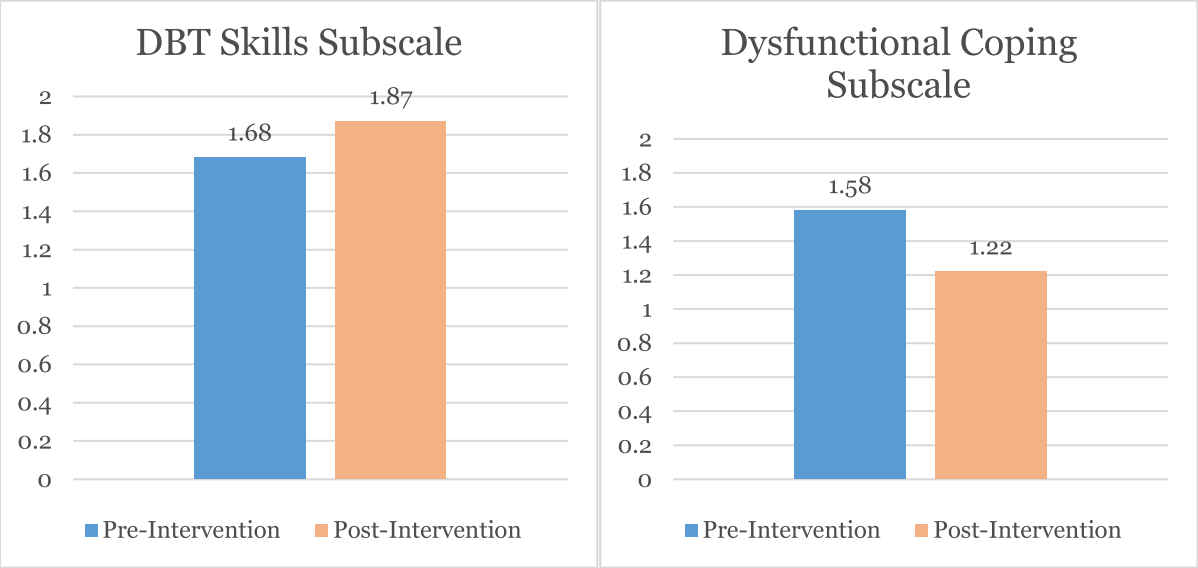
As some changes were made to outcome measures as reported above from March 2024 onwards, the Brief Reasons for Living Inventory – Adolescents (BRFLA) and Revised Children's Anxiety and Depression Scale (RCADS) have not been reported for those who began the intervention prior to March 2024, and the Beck Youth Inventory – Depression Scale (BYI-D) has not been reported for those who began the intervention after March 2024. These measures have not been reported to protect the confidentiality of participants, as participant numbers for each of these measures were less than five individuals.

### DBT Ways of Coping Checklist (DBTWCCL)

The DBTWCCL was completed by parents and young people. Mean scores indicated that DBT skill use (DSS) increased from pre-intervention to post intervention. At pre-intervention, parents and young people had a mean DSS score of 1.68 (*SD*=.57). Post-intervention, parents and young people achieved a mean DSS score of 1.87 (*SD*=.45). Both pre and post scores fell within the "Typical Clinical" range.

Mean scores on the Dysfunctional Coping Skills subscale (DCS) decreased from pre to post intervention. At pre-intervention, parents and young people had a mean score of 1.58 (*SD*=.42) on the DCS, pre-group scores fell within the "Typical Clinical" range, post-group scores fell within the "Low Clinical" range. At post-intervention, this was 1.22 (*SD*=.49). Due to the small sample size, the statistical significance of these changes could not be determined. Taken together, these results indicate that use of DBT skills increased, while use of unhelpful coping mechanisms decreased.

Figure 4.115. *Pre and Post Group mean score of DBT Ways of Coping Checklist (DBTWCCL) subscales.*




### Difficulties in Emotional Regulation (DERS)

The DERS and DERS-P were completed by young people and their parents. Pre and post intervention data were available for six of the young people. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=106.33, *SD* = 12.16) – High Average to post-intervention (M=90.33, *SD* = 25.02) - Average.

Due to the small sample size, changes in total DERS scores were analysed using the Reliable Change Index (RCI) for each participant. In order to ensure that changes in DERS scores were not attributable to chance or measurement error a RCI was calculated for each participant using the Jacobson-Truax (1991) method. In accordance with this method, statistically reliable change was reflected by RCI values larger than 1.96. The calculated cut-off score indicating clinically meaningful improvement on the DERS was 95. Participants were classified as “clinically meaningful improvement” (passed RCI criterion and DERS score decreased to below cut-off score), “reliable improvement” (passed RCI criterion but the score did not decrease below DERS cut-off score), uncertain change (did not pass RCI criterion) or deterioration (passed RCI criterion but symptom score increased). As outlined in table 4.18, two participants (33.33%) reported clinically significant improvement, while two participants (33.33%)

reported reliable improvement, one participant reported uncertain change (16.67%), and one participant (16.67%) reported reliable deterioration.

Table 4.18: *Results from Reliable Change Index (RCI) for the DERS pre and post scores for each group member*

DERS = Difficulties with Emotion Regulation Scale

| Participant | Pre-Score | Post Score | RCI Value | Category |
|---|---|---|---|---|
| 1 | 88 | 73 | -3.30 | Reliable improvement |
| 2 | 105 | 126 | 4.62 | Deterioration |
| 3 | 119 | 109 | -2.20 | Reliable improvement |
| 4 | 99 | 65 | -7.47 | Clinically Significant Improvement |
| 5 | 120 | 68 | -11.43 | Clinically Significant Improvement |
| 6 | 107 | 101 | -1.32 | Uncertain Change |

Pre and post DERS-P responses were available for seven of the parents. Analysis showed that parent's ratings of their child's difficulties with emotional regulation decreased from an average of 104.00 (*SD* = 19.64) to 94.57 (*SD*=18.84).

As shown in the figures 4.116 and 4.117 below, five of six young people (83.33%) reported a decrease in overall difficulties regulating emotions post-intervention. Similarly, all seven parents (100%) also reported a decrease in overall difficulties regulating emotions post-intervention.

Figure 4.116. *Pre and Post Group total mean score of Difficulties in Emotional Regulation (DERS) and Difficulties in Emotional Regulation- Parents (DERS-P).*

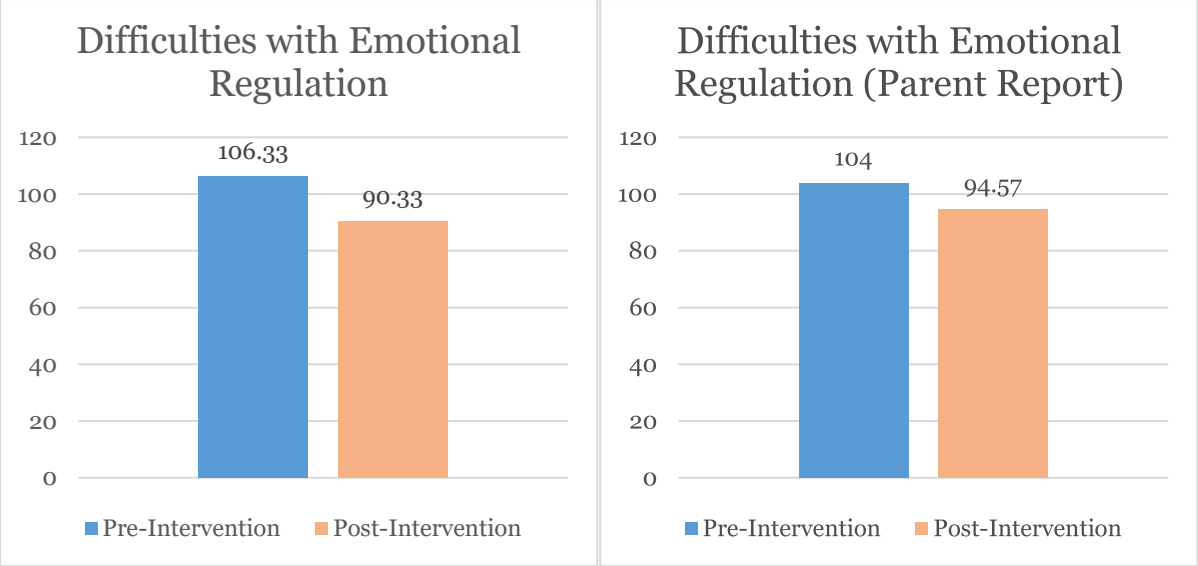
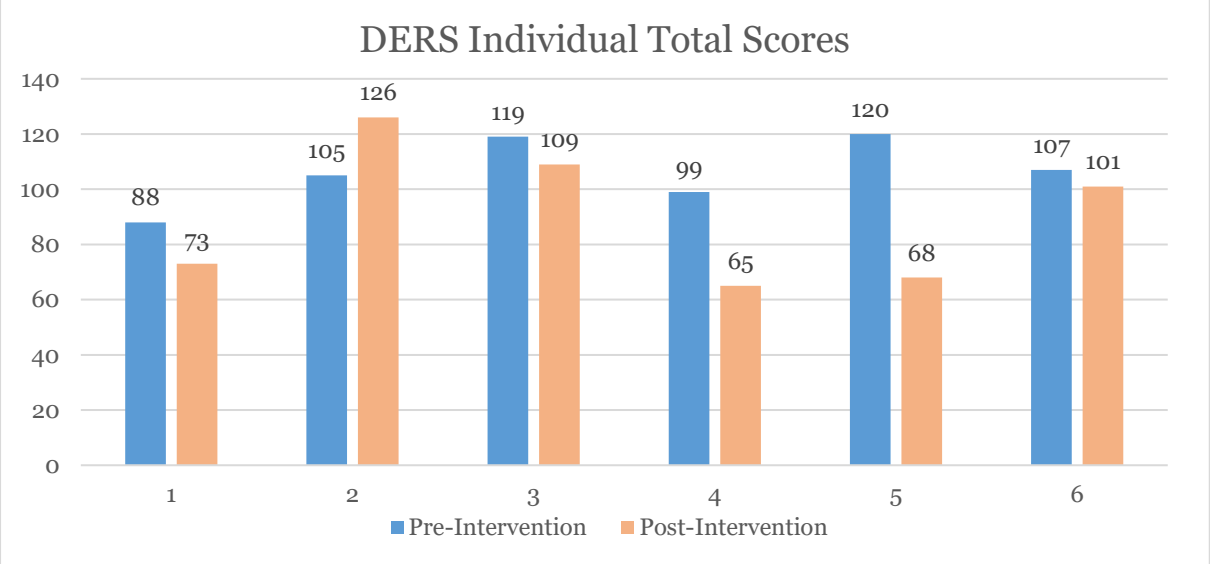
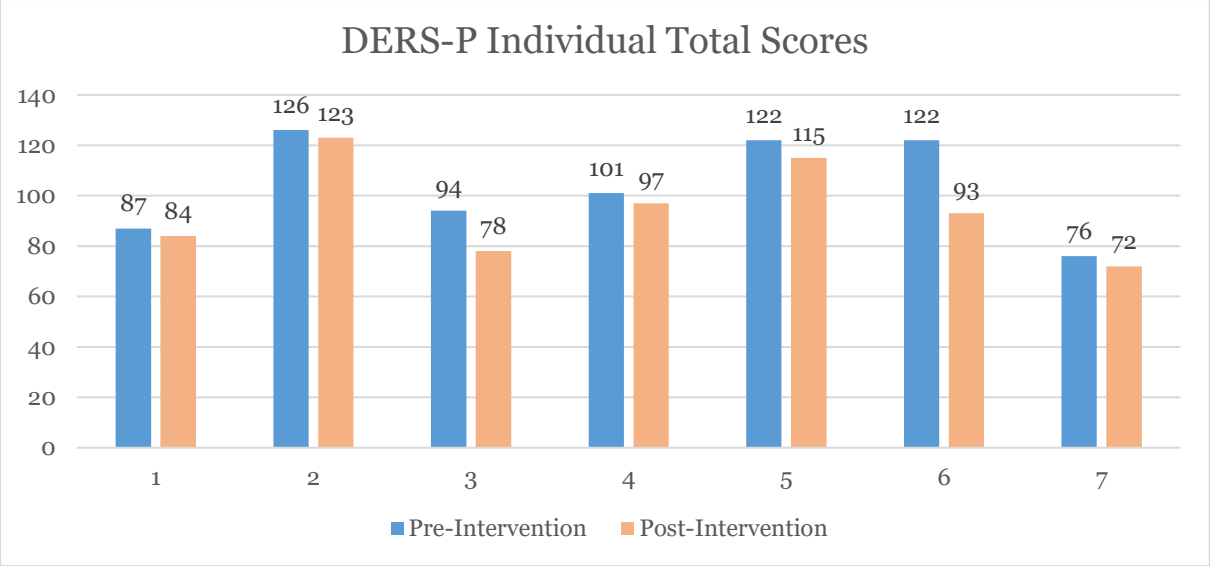



Figure. 4.117 *Pre and Post Individual total scores of Difficulties in Emotional Regulation (DERS) and Difficulties in Emotional Regulation- Parents (DERS-P).*






### Adolescent Over and Under Control Trait Measure (OUTM)

The Adolescent Over and Under Control Trait Measure (OUTM) is comprised of two subscales, one measuring under control traits and one measuring over control traits. Pre-intervention, the mean under control subscale score was 2.09 (*SD* = 0.96). Post intervention, this decreased slightly to a mean of 1.91 (*SD* = .69). Pre-intervention, the mean over control score was 3.25 (*SD* = .62). Post intervention, this increased slightly to a mean of 3.27 (*SD* = 1.14). Numerically, these findings suggest under control decreased following engagement in the intervention, while over control slightly increased.

As illustrated in figures 4.119 and 4.120, four out of six young people (66.67%) reported a decrease in under-control traits post-intervention, while three out of six (50%) young people reported an increase in over-control traits post-intervention.

Figure 4.118. *Pre and Post total mean scores of Adolescent Over and Under Control Trait Measure (OUTM).*

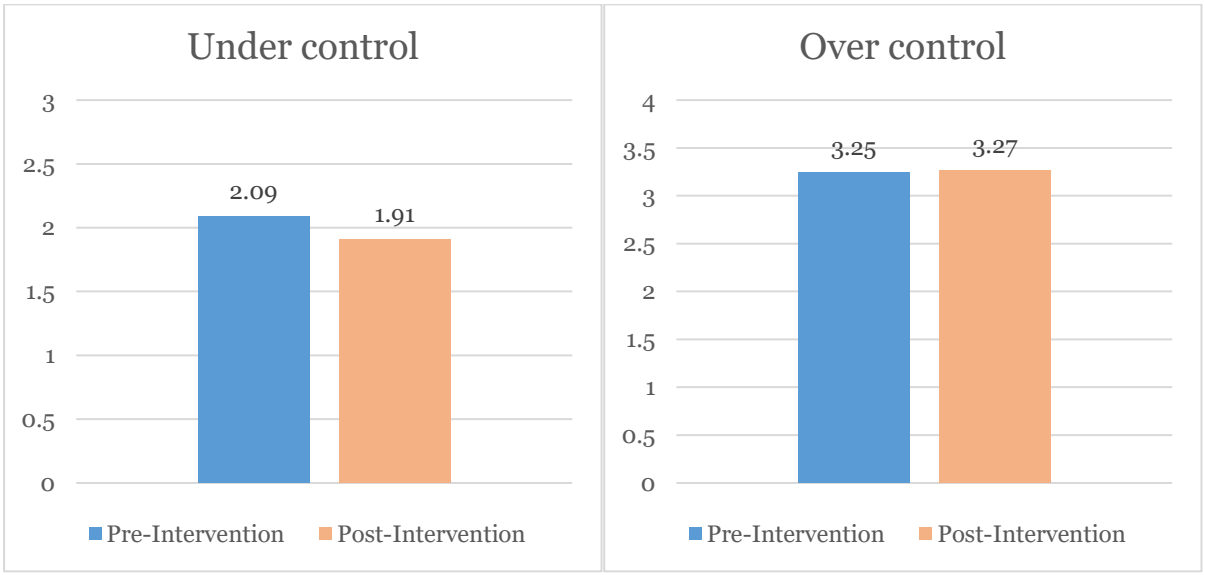



Figure 4.119. *Pre and Post Individual total scores of Adolescent Overcontrol (OUTM).*

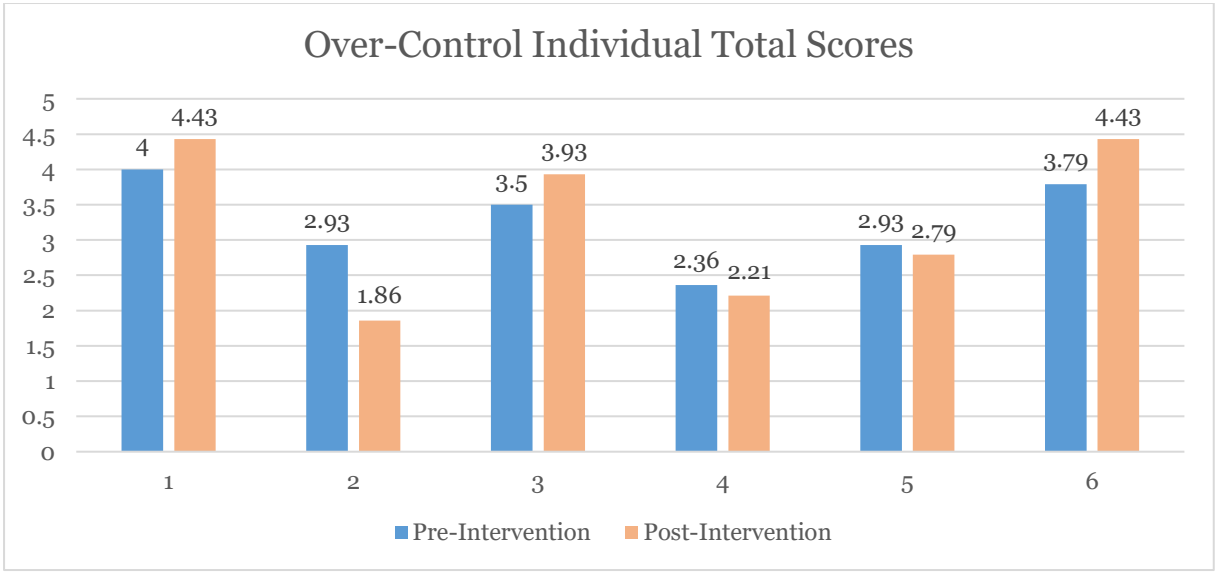
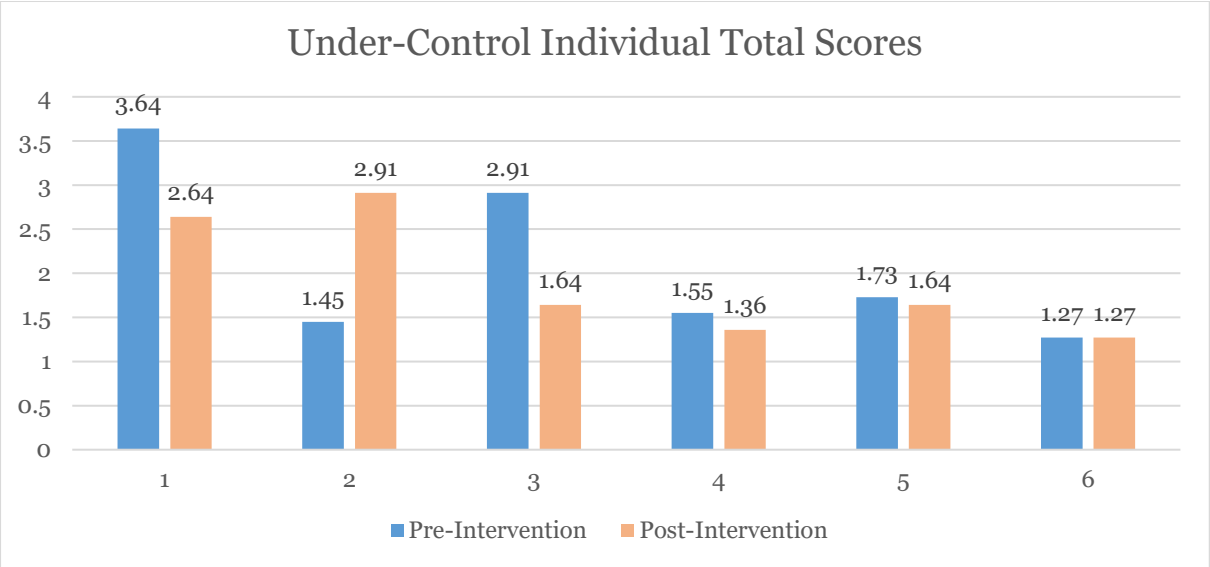


Figure 4.120. *Pre and Post Individual total scores of Adolescent Under-control (OUTM).*




**Strengths and Difficulties Questionnaire (SDQ) and Strengths and Difficulties Questionnaire – Parents (SDQ-P).**

Pre-intervention, the mean total difficulties score was 14.17 (*SD*= 4.96) – just above the "Slightly Raised" range. This fell to 14.0 (*SD* = 4.36) – "Close to Average" post intervention. Pro-social behaviour was found to increase slightly from a mean of 8.33 (*SD* = 1.37) to 8.5 (*SD* = 1.76). Both scores fell within the "Close to Average" range. As shown in Figure 4.121, two out of six young people (33.33%) reported a decrease in total difficulties post-intervention.

This improvement in total difficulties was also reflected in parental reports. Pre-intervention, parents reported a mean of 15.43 (*SD*= 5.80) – "Slightly Raised" range. This fell to 12.0 (*SD* = 3.83) – "Close to Average" range post intervention. Pro-social behaviour was found to increase slightly from a mean of 9.0 (*SD* = 1.0) to 9.14 (*SD* = 1.07). Both of these scores were in the "Close to Average" range. Six out of seven parents (85.71%) reported a decrease in total difficulties post-intervention.

Figure 4.121. *Pre and Post mean scores of Strengths and Difficulties Questionnaire (SDQ) total and subscales.*

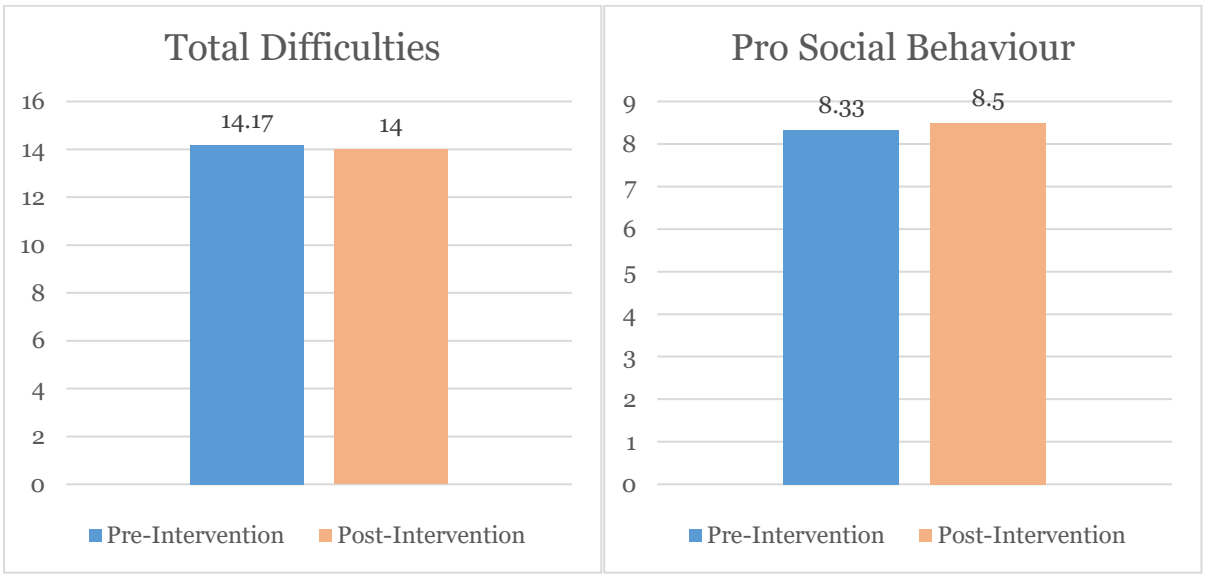



Figure 4.122. *Pre and Post individual scores of Strengths and Difficulties Questionnaire (SDQ).*

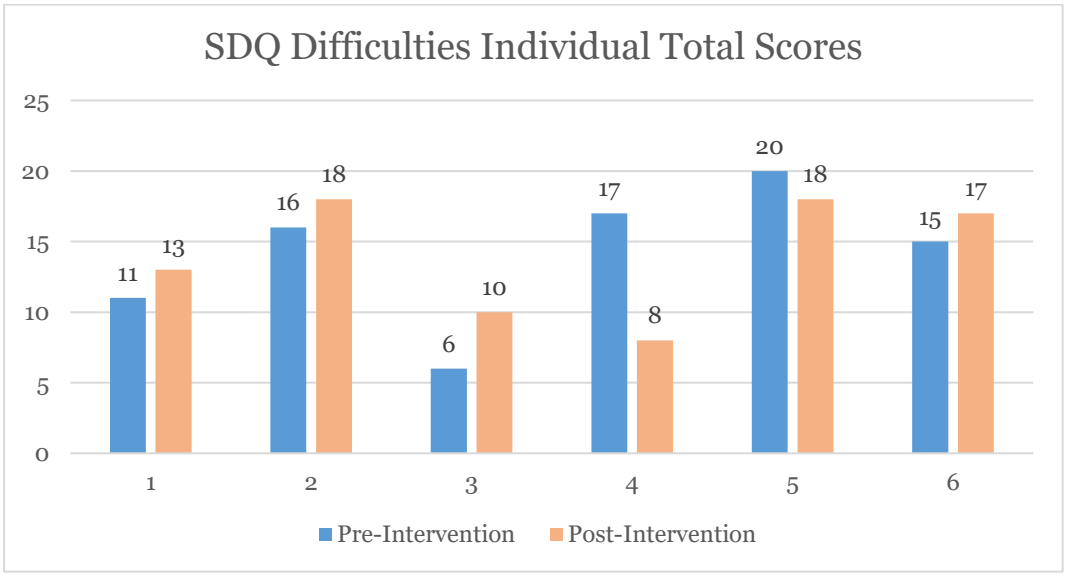


Figure 4.123. *Pre and post mean scores of Strengths and Difficulties Questionnaire - Parents (SDQ-P) total and subscales.*

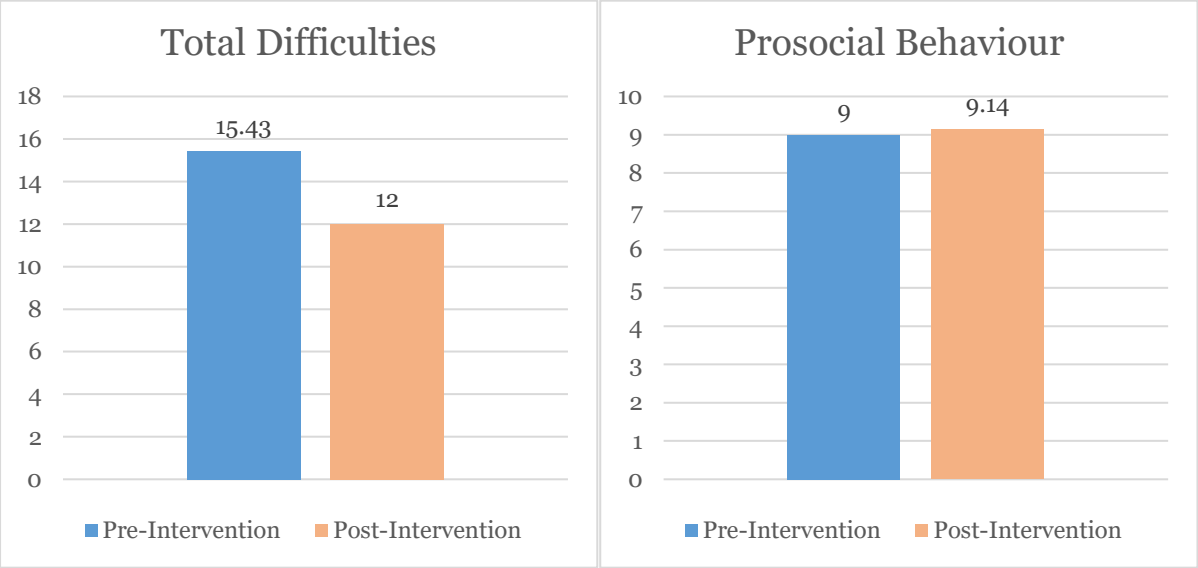
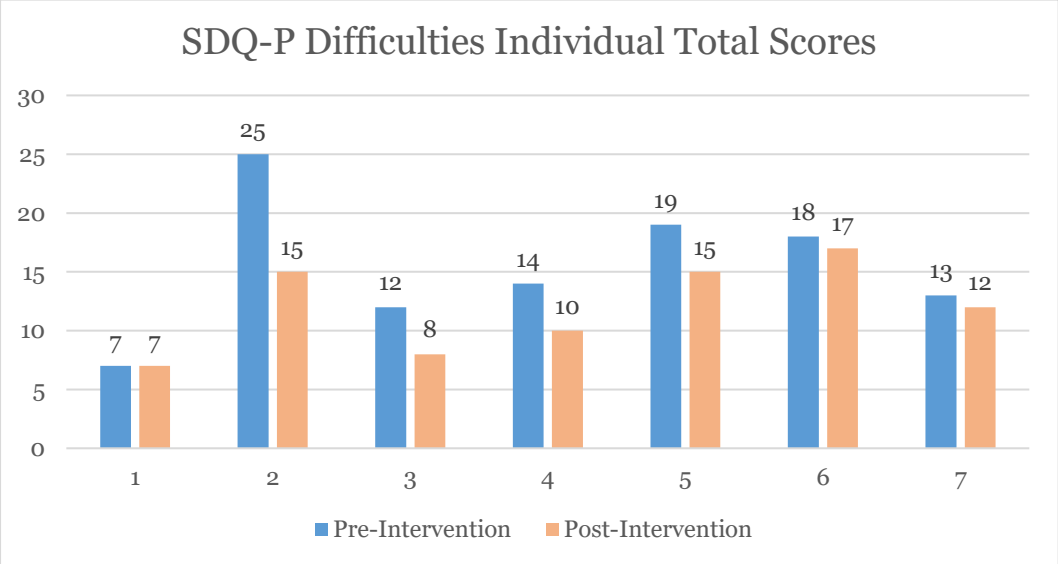



Figure 4.124. *Pre and post individual scores of Strengths and Difficulties Questionnaire-Parent (SDQ-P).*

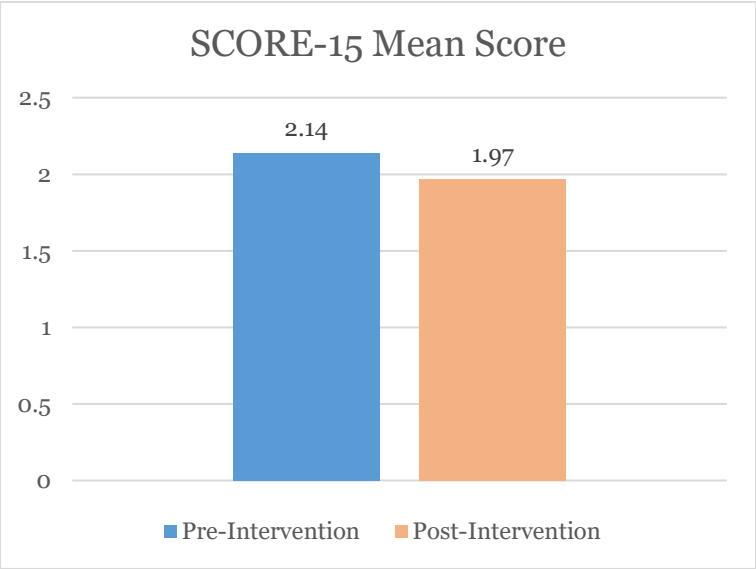



## SCORE-15

Both parents and young people were asked to complete the SCORE-15 before and after taking part in the group, as a measure of family functioning. Levels of family functioning reported by young people and parents remained relatively unchanged from before

group (M = 2.14, *SD* = .73) to after group (M = 1.97, *SD* = .83). Due to the small sample size statistical significance could not be determined for this change. However, scores remained within the "Below Clinical" range.

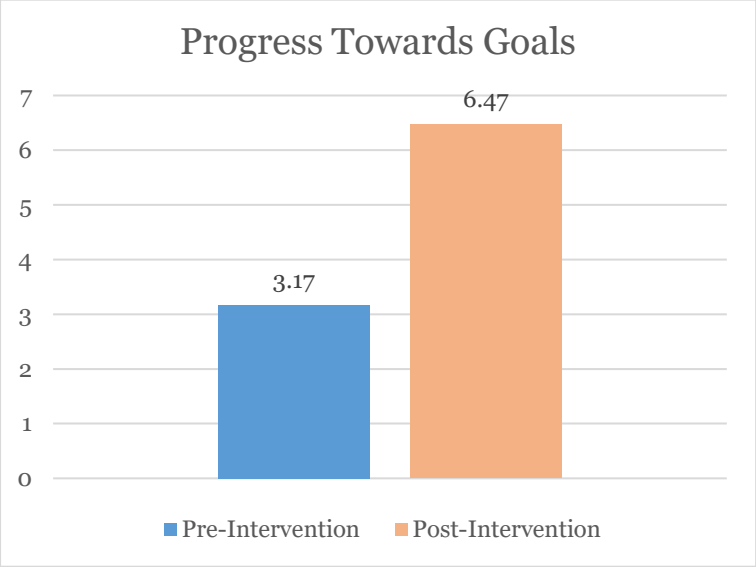
Figure 4.125. *Pre and Post total mean scores of Score 15.*




### Goal Based Outcomes

Both parents and young people were asked to complete their Goal Based Outcomes for goals set out at the beginning of groups. Scores on this outcome reflect how close the young person/parent felt to achieving their goal, with higher scores indicating being closer to achieving that goal. GBO scores increased from a mean of 3.17 out of a possible 10 (*SD* = 1) to 6.47 out of a possible 10 (*SD* = 2.68), with a score of 10 indicating that the goal had been achieved. This trend indicated parents and young people made progress in achieving their goals post intervention.

Figure 4.126. *Pre and Post total mean scores of Goal Based Outcomes.*




### 4.16.3. Summary

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

The findings presented provide a meaningful insight into the effectiveness of the programme. The results indicate that by attending the group, young people developed an increased capacity to regulate their emotions. Young people who completed the group also evidenced an increase in the use of DBT skills when coping with difficulty. Levels of under control traits decreased slightly following the programme. They also reported an increase in their prosocial behaviour and a decrease in their difficulties. Their endorsement in protective factors against harm to themselves also increased following attendance. Both parents and children who took part in the group reflected progress towards their goals, having completed the programme.

## 4.17. (Group) Radical Openness Programme

Group Radical Openness (GRO) is a transdiagnostic group therapy intervention for service users presenting with mental health difficulties associated with costly and

harmful overcontrol. GRO was developed in St Patrick's Mental Health Services. Overcontrol, sometimes referred to as too much self-control, underlies a range of mental health difficulties. These include certain Axis I mood and eating disorders and Axis II presentations, such as Obsessive-Compulsive Personality Disorder and Avoidant Personality Disorder.

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

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

### 4.17.2. Descriptors

A total of 54 people completed GRO in 2024. 52.8% of the participants were male, 47.2% were female. Participant's ages ranged from 22 years to 66 years (M=41.92, SD=13.06). Of the 54 people, 19 completed the programme online and 35 completed the group in-person. Pre and post-outcome data were available for 36 people, representing an 66.67% return rate.

Missing Value Analysis (MVA) was carried out to examine the type of missingness within the data. Where data was found to be Missing Completely at Random by Little's test (Cheng & Evanston, 2013), the Expectation Maximisation method was applied before any total scores were computed or analyses carried out.

### 4.17.1. Group Radical Openness Programme outcome measures

The GRO programme has five outcome measures that explore change in the key areas targeted by the programme. These are: the Five Factor Obsessive Compulsive Inventory (Short Form) (FFOCI-SF), the Brief Symptom Inventory (BSI), the Revised Adult

Attachment Scale – Close Relationships Version (RAAS), the Personal Need for Structure Scale (PNS), and the Emotion Regulation Questionnaire (ERQ).

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

The FFOCI-SF (Samuel et al., 2012) is a 48-item self-report questionnaire which explores traits of obsessive-compulsive personality disorder (OCDP) that are associated with overcontrol. The FFOCI-SF is based on the conceptual framework of the five-factor model of personality. The questionnaire is made up of 12 sub-scales: excessive worry, detached coldness, risk-aversion, constricted, inflexibility, dogmatism, perfectionism, fastidiousness, punctiliousness, workaholism, doggedness, and ruminative deliberation. Each item is rated on a five-point Likert scale from one (strongly disagree), to five (strongly agree). Higher scores indicate greater identification with OCPD traits.

Research has found that the FFOCI-SF has good psychometric properties with strong internal and external validity, and strong reliability with a Cronbach's alpha ranging from .77 to .87 (Samuel et al., 2012). Additionally, a strong similarity coefficient has been found between the long and short form of the measure. (Griffin, Suzuki, Lyman et al., 2018). This report focuses on total scores of the FFOCI-SF to determine overall levels of overcontrol.

- **Brief Symptom Inventory (BSI):** see page 183
- **Revised Adult Attachment Scale – Close Relationships Version (RAAS)**

The RAAS (Collins, 1996) is an 18-item measure of relationship attachment. It contains three sub-scales: Close, Depend, and Anxiety. Respondents are asked to rate each statement on a five-point scale from one (not characteristic of me at all), to five (very characteristic of me). Higher scores on the Close and Depend subscales indicate greater comfort with closeness and intimacy (depending on others) in everyday life. Lower scores on the Anxiety subscale indicate less fear of rejection. The RAAS is highly correlated with the long form Adult Attachment Scale (AAS) and has been found to have good internal and external validity (Graham & Unterschute, 2015).

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

The PNS (Neuberg & Newsom, 1993) is an 11-item self-report questionnaire consisting of two sub-scales: Desire for Structure and Response to Lack of Structure. Respondents are asked to rate each statement on a six-point scale from one (strongly disagree), to six (strongly agree). Higher scores indicate greater desire for structure and a dislike for unstructured and unpredictable situations (inflexibility). The measure has shown good reliability in previous research, with a Cronbach's alpha of 0.62 for Desire for Structure and 0.73 for Response to Lack of Structure (Hamtiaux & Houssemand, 2012).

- **Emotion Regulation Questionnaire (ERQ)**

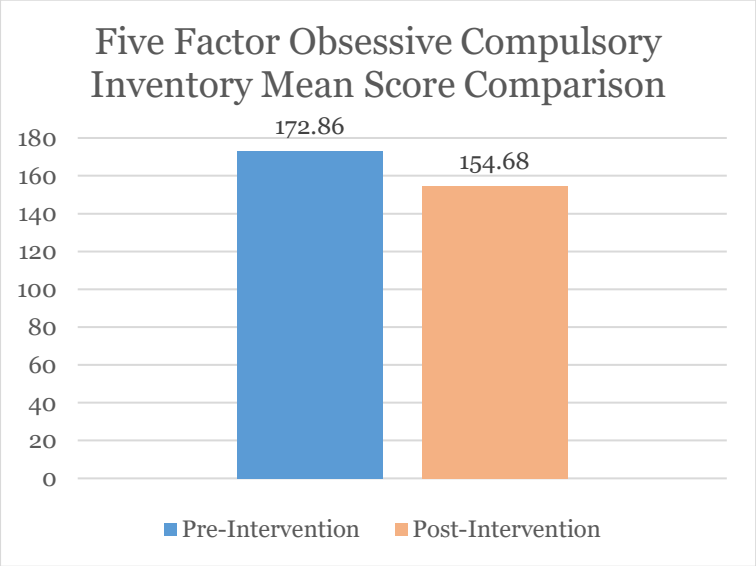
The ERQ (Gross & John, 2003) is a 10-item self-report measure consisting of two subscales: Cognitive Reappraisal and Expressive Suppression. Cognitive Reappraisal describes the process of confronting automatic thoughts and assumptions regarding emotions and reframing them in a more helpful way. Expressive Suppression describes the ability to control or suppress responding to emotional experiences. Participants are asked to rate each statement on a seven-point scale from one (strongly disagree), to seven (strongly agree). The ERQ has been found to have high internal validity, and good convergent and discriminant validity (Preece, Becerra, Robincon et al. 2019).

### 4.17.3. Results

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

A statistically significant change was observed on the FFOCI-SF, whereby $t$ (35) = 5.29, $p$=0.00, reflecting a large effect size (Cohen's $d$ = 0.88). This suggests that after completing the programme participants were experiencing a reduction in overcontrolled traits associated with OCPD.

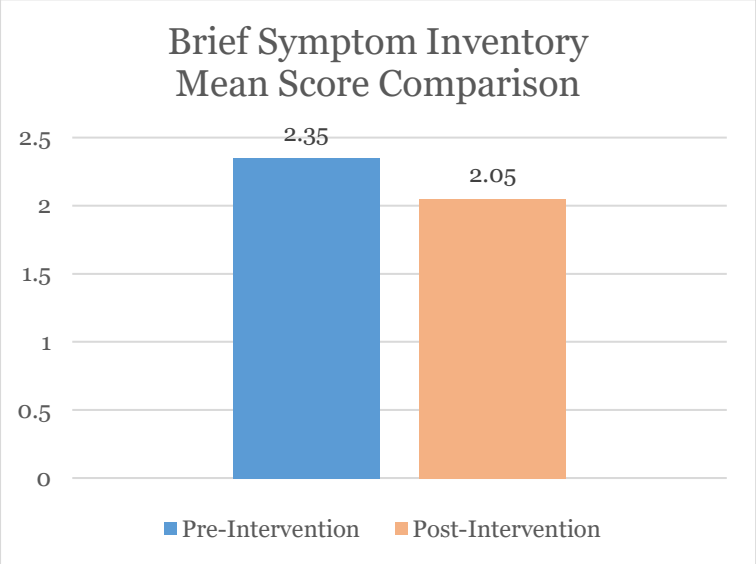
Figure 4. 127. *Pre and post total mean scores of Five Factor Obsessive Compulsive Inventory (Short Form) (FFOCI-SF)*




### Brief symptom Inventory (BSI)

A statistically significant reduction in service users' psychological distress was also observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale of the BSI, whereby $t$ (35) = 3.53, $p$=.000 reflecting a medium effect size (*Cohen's d*= 0.59).

Figure 4. 128. *Pre and post total mean scores of Brief symptom Inventory (BSI)*



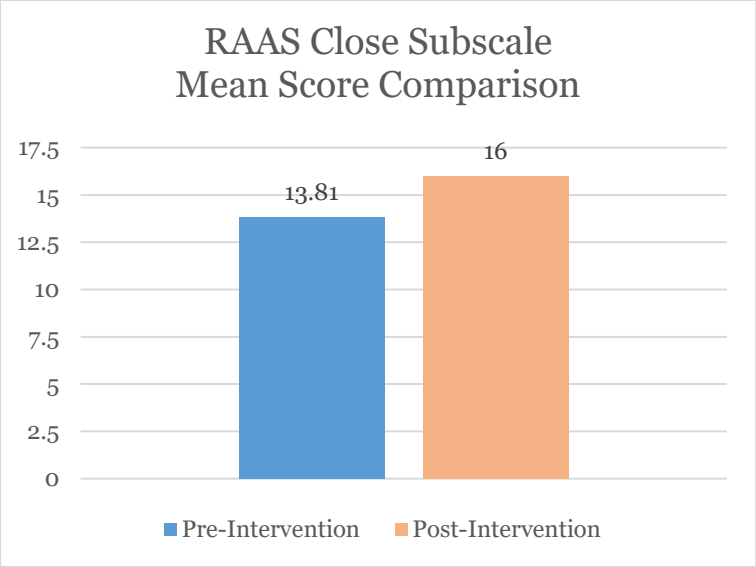

### Revised Adult Attachment Scale – Close Relationships Version (RAAS)

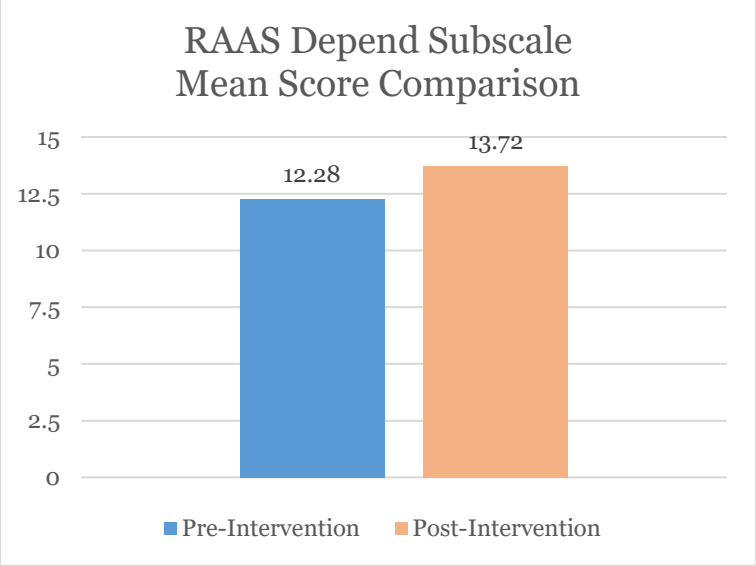
The Close subscale measures the extent to which a person is comfortable with closeness and intimacy. The Depend subscale measures the extent to which a person feels they can depend on others to be available when needed. The Anxiety subscale measures the extent to which a person is worried about being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

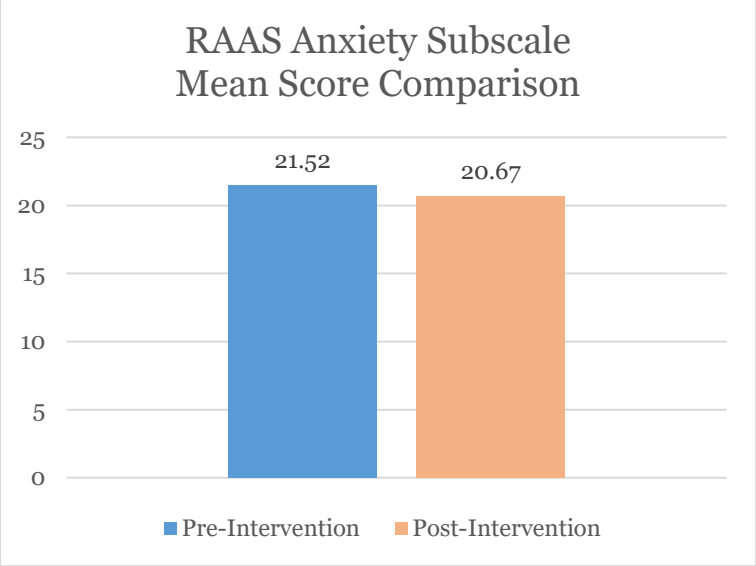
On the Close subscale, there was a statistically significant improvement pre to post-intervention ($t$ (35) = -3.08, $p$ = .004) reflecting a medium effect size (*Cohen's d*= -0.51). On the Depend subscale, a statistically significant improvement pre to post-intervention was observed, whereby ($t$ (35) =-2.46, $p$ = .02), reflecting a small effect size (*Cohen's d*= -0.41). On the Anxiety subscale, there were no statistically significant differences pre to post-intervention ($t$ (35) = 0.92, $p$ = .36).

These results show that participants felt more closeness in their relationships post intervention and they felt they could depend on others when needed. There were no significant results in the anxiety subscale suggesting that participants did not experience any change in fear of rejection post-intervention.

Figure 4. 129. *Pre and post mean scores of Revised Adult Attachment Scale – Close Relationships Version (RAAS) total and subscales*



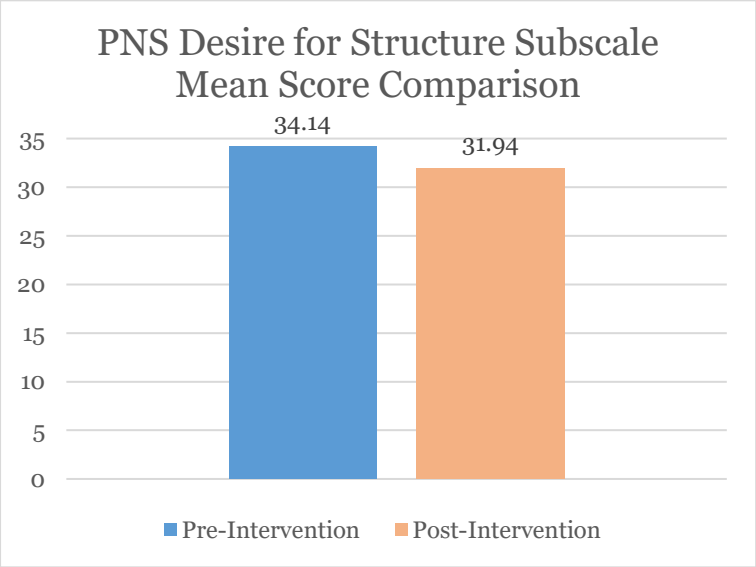






### Personal Need for Structure Scale (PNS)

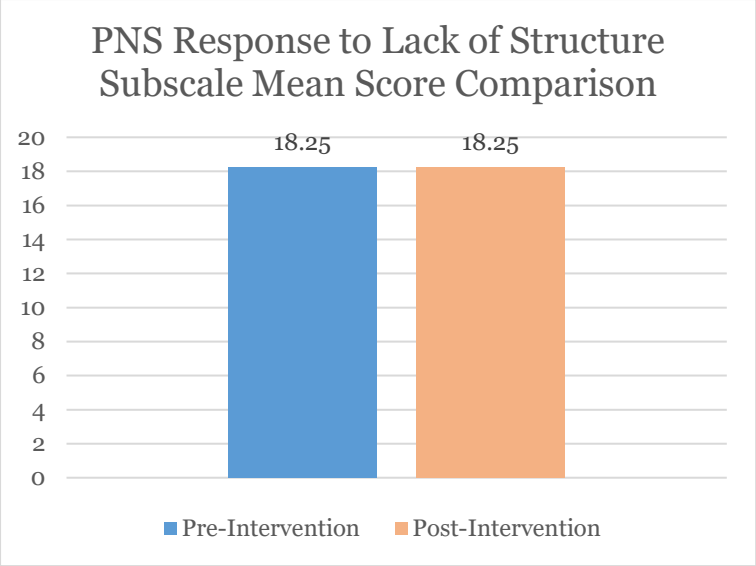
There was a statistically significant difference on the Desire for Structure subscale from pre to post-intervention $t$ (35) = 3.11, $p$ = .004, with a medium effect size (*Cohen's* $d$=0.52.) This indicates that participants' desire for structure in their daily lives reduced (indicating more flexibility) after completing the programme.

Figure 4.130. *Pre and post total mean scores of Personal Need for Structure Scale subscale (PNS)*




No statistically significant changes were found on the Response to Lack of Structure subscale from pre to post intervention, as no correlation or t-tests can be computed because the standard error difference between the pre and post-intervention was zero. These findings indicate that participants did not report a change in their response to a lack of structure between pre and post-intervention. However, past research on the GRO programme has shown that there were significant changes in participant's response to lack of structure six months post completion of GRO (Egan, Long, McElvaney, & Booth, 2022). This indicates that improvements in flexibility occurred in the months following the programme when service users had time to implement and embed their learning.

Figure 4. 131. *Pre and post mean scores of Personal Need for Structure Scale (PNS) subscale.*



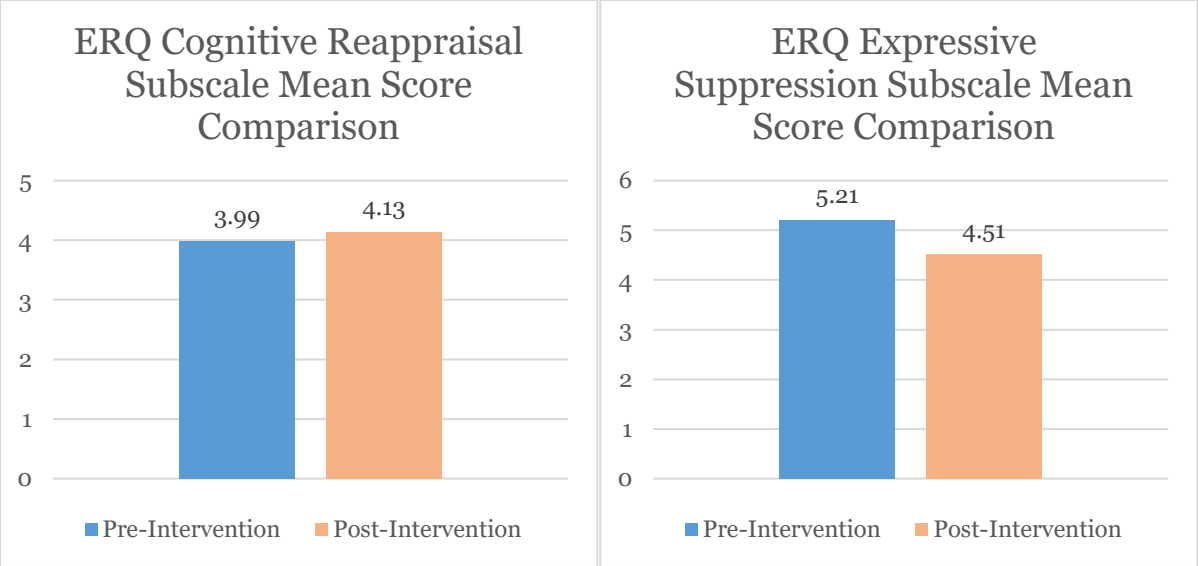

### Emotion Regulation Questionnaire (ERQ)

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

On the Cognitive Reappraisal subscale, there was no significant change pre to post-intervention whereby $t$ (35) = -0.64, $p$ = o.53. This suggests that participants did not experience an increase in ability to confront unhelpful cognitions regarding emotions.

On the Expressive Suppression subscale, significant change was observed pre to post intervention whereby, $t$ (35) = 3.75, $p$= .000, with a medium effect size (Cohen's $d$= 0.63). This suggests that participants reported less suppression of their emotions following completion of the programme.

Figure 4. 132. *Pre and post mean scores of Emotion Regulation Questionnaire (ERQ) subscales.*




### 4.17.4. Summary

The Group Radical Openness (GRO) programme supports individuals to develop understanding and awareness of their overcontrol. The programme targets and encourages new ways of coping that are less costly and less harmful. This is a vital programme for service users who are often underserved in mental healthcare.

In 2024, service users who completed the GRO programme showed significant reductions in overcontrolled traits and reductions in overall psychological distress. Results also found that service users reported feeling closer and more connected to people in their lives and they felt they could depend on others when needed after completing the programme. There were significant improvements in participant's desire for structure following completion of the programme indicating more flexibility in their lives. Service users also showed significant reductions in their suppression of emotions.

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

## 4.18 Recovery Programme

The Recovery Programme is a structured 10-day programme based on the Wellness and Recovery Action Plan (WRAP) approach designed by Mary Ellen Copeland of the Copeland Centre (1992). The WRAP approach focuses on assisting service users who have experienced mental health difficulties to regain hope, personal responsibility through education, self-advocacy, and support. The recovery model emphasises the centrality of the personal experience of the individual and the importance of mobilising the person's own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. The Recovery Programme at SPMHS is delivered through the Wellness and Recovery Centre for day service users.

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

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

### 4.18.1 Descriptors

Pre and post data were collected for 20 participants who completed the Recovery programme in 2024. Fifteen of the participants were female (75%) and five were male (25%). Participant's ages ranged from 38 years to 77 years ($M$ = 60.15 $SD$ = 9.29)

### 4.18.2 Recovery Programme Outcome Measures

- **Recovery Assessment Scale – Revised**

The Recovery Assessment Scale (RAS: Giffort et al., 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 et al., 1999). The Recover Assessment Scale – Revised (RAS-R; Corrigan et al., 2004) consists of 24 items on a five-point Likert scale (from Strongly Disagree to Strongly Agree). These 24 items represent five dimensions of personal recovery: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and not dominated by symptoms. The RAS-R has been shown to have good reliability (Cronbach's alpha = 0.90; Biringer & Tjoflåt, 2018).

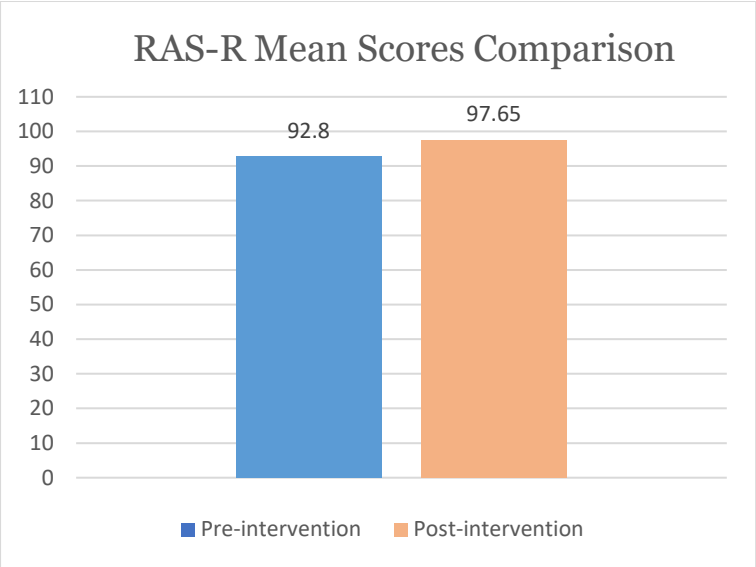
### 4.18.3 Results

Results were examined and compared in greater detail including overall mean, and individual scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's $d$ = 0.5). Therefore, for each measure individual results for the twenty participants who returned both pre and post measures are given to reflect the outcome of the intervention.

#### Recovery Assessment Scale - Revised

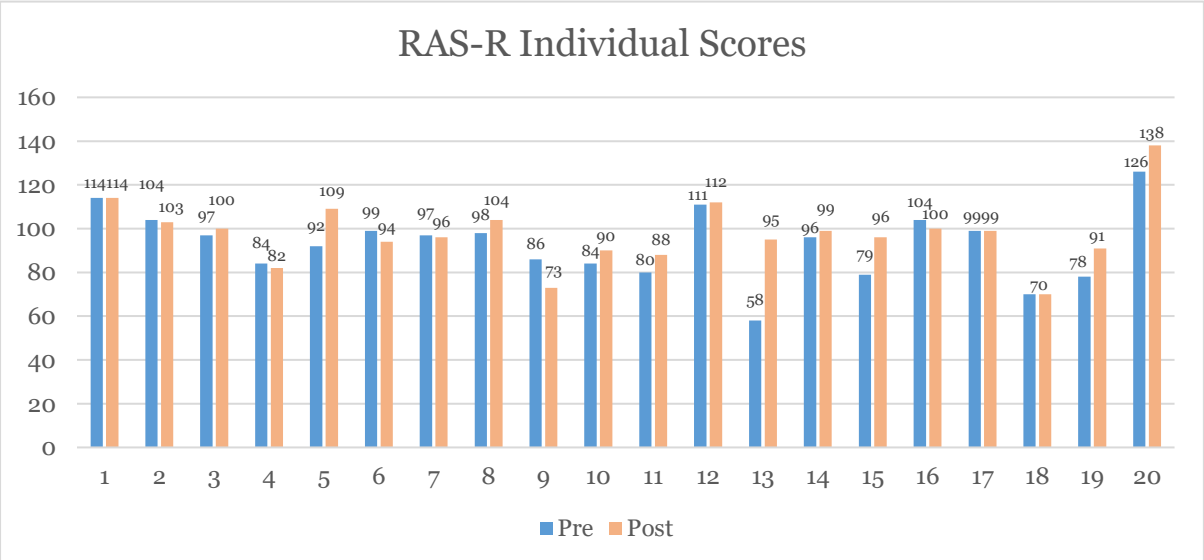
There was an increase in total scores from pre-intervention ($M$ = 92.80 $SD$ = 15.88) to post-intervention ($M$ = 97.65 $SD$ = 14.78). This finding indicates that those who completed the Recovery programme in 2024 showed enhanced levels of recovery (see figure 4.133).

Figure 4.133. *Total RAS-R mean scores pre and post-inervention*




As can be seen from figure 4.134, further examination of the individual scores indicates that 11 out of 20 participants (55%) demonstrated an increase in RAS-R scores from pre-intervention to post-intervention. Three out of 20 participants (15%) demonstrated no change in scores.

Figure 4.134. *Pre and post individual scores of the RAS-R.*



### 4.18.4 Summary

The findings presented provide insight into the effectiveness of the programme. Careful consideration has been given to the retention of the RAS-R as the primary outcome measure for the Recovery Programme. While there is no 'gold standard' measure of recovery, the RAS-R has strong support for its psychometric properties. In summary, those who completed the programme showed improvements on the total scale.

## 4.19. The SAGE Programme (Psychological Therapy Group for Older Adults)

SAGE is a psychological therapy group for older adults who are experiencing difficulties with anxiety and/or depression and are interested in applying a psychological approach to their difficulties. The group is adapted from psychological theories based on emotional regulation and emotional over-control (Lynch 2018; Booth & Egan, 2023), and how these can contribute to recurrent mental health difficulties. Themes addressed in the programme are difficulties with emotional inhibition, interpersonal aloofness, psychological rigidity and the role they play in maintaining mental health issues. Outcome measures used have been selected to reflect these three therapeutic themes, as well as an overall measure of mental health symptomatology.

### 4.19.1 Descriptor

11 older adult service users completed the programme in 2024, 7 of whom were female (63.6%), and 4 of whom were male (36.4%). Programme attendees ranged in age from 68 to 82 years old, with a mean of 75.18 (*SD* = 4.36). Pre and post data was available on the measures below for all 11 participants. There were no missing items in any of the measures completed in 2024, as a result of efforts made by the Sage team to ensure all measures are completed.

### 4.19.2. SAGE Outcome Measures

- **Depression Anxiety and Stress Scale (DASS-21**): see page 91
- **Personal Need for Structure Questionnaire (PNS):** see page 219

High scores on the PNS are indicative of higher levels of rigidity and need for structure. Lower scores indicate a greater ability to manage novel situations, which in this context is interpreted as evidence of greater flexibility, one of the goals of this intervention.

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

The ECQ-EI (Roger & Najarian, 1989) 14-item subscale aims to measure emotional inhibition. Lower scores are indicative of decreased emotional inhibition and suppression, a goal of the intervention.

- **Revised Adult Attachment Scale (RAAS):** see page 239
- **Emotional Regulation Questionnaire (ERQ):** see page 242

This was included as a general measure of the emotional regulation strategies of older adults.

### 4.19.3. Results

Due to the small sample size, statistical significance could not be determined for changes in scores pre-to-post intervention. Means and individual scores are displayed instead. The small sample size is partly due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs, but also may be related to the barriers which exist for older people in accessing psychological therapies (Wuthrich & Frie, 2015), Liu & Gellatly, 2020).

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

Analysis of the total of the three subscales (Depression, Anxiety and Stress) within the DASS-21 revealed an increase in psychological difficulties from a pre-intervention mean of 35.27 (*SD* = 12.11) to 37.09 (*SD* = 17.54) at post intervention. Scores on the Depression subscale showed a decrease from 12.36 (*SD* = 6.12) to 11.45 (*SD* = 8.63), and on the Stress subscale from 14.55 (*SD* = 5.30) to 14.18 (*SD* = 5.17). However, scores on the Anxiety subscale increased from 8.36 (*SD* = 5.20) to 11.45 (*SD* = 6.14), see Figure 4.135.

Figure 4.135. *Pre and Post mean* scores of Depression Anxiety and Stress Scale (DASS-21) total and subscales


Looking at individual scores for this small sample, total scores on the DASS-21 decreased for six out of eleven participants (54.55%) post-intervention. Seven out of eleven participants (63.64%) reported reduced depression scores at the end of the intervention, while five out of eleven participants reported reduced stress (45.45%) scores post-intervention. Only two out of eleven participants (18.18%) reported reduced anxiety scores post-intervention which demonstrates a trend of increasing anxiety. Clinical cut-off scores for the DASS-21 subscales range from 'normal' to 'extremely severe'.

Score ranges on the depression subscale are as follows: normal (0-9), mild (10-13), moderate (14-20), severe (21-27) and extremely severe (28+). Score ranges on the anxiety subscale are as follows: normal (0-7), mild (8-9), moderate (10-14), severe (15-19) and extremely severe (20+). Score ranges on the stress subscale are as follows: normal (0-14), mild (15-18), moderate (19-25), severe (26-33) and extremely severe (34+).

Please see Figure 4.136 to 4.137 below for visual representation of changes in individual scores from pre to post intervention.

Figure 4.136. *Pre and Post individual total mean* scores of Depression Anxiety and Stress Scale (DASS-21)

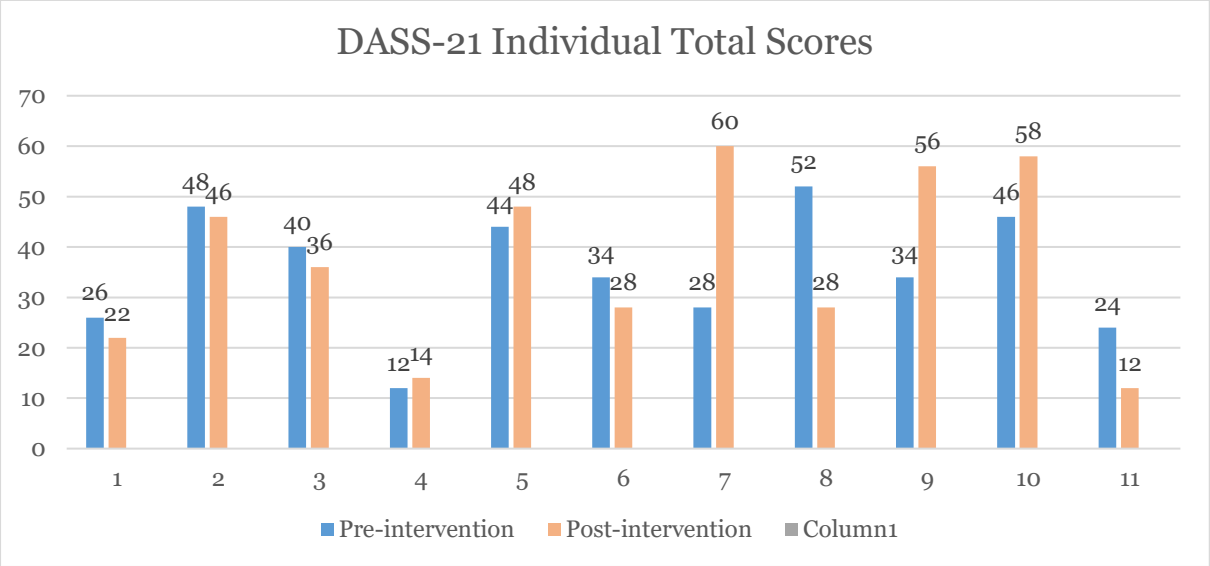
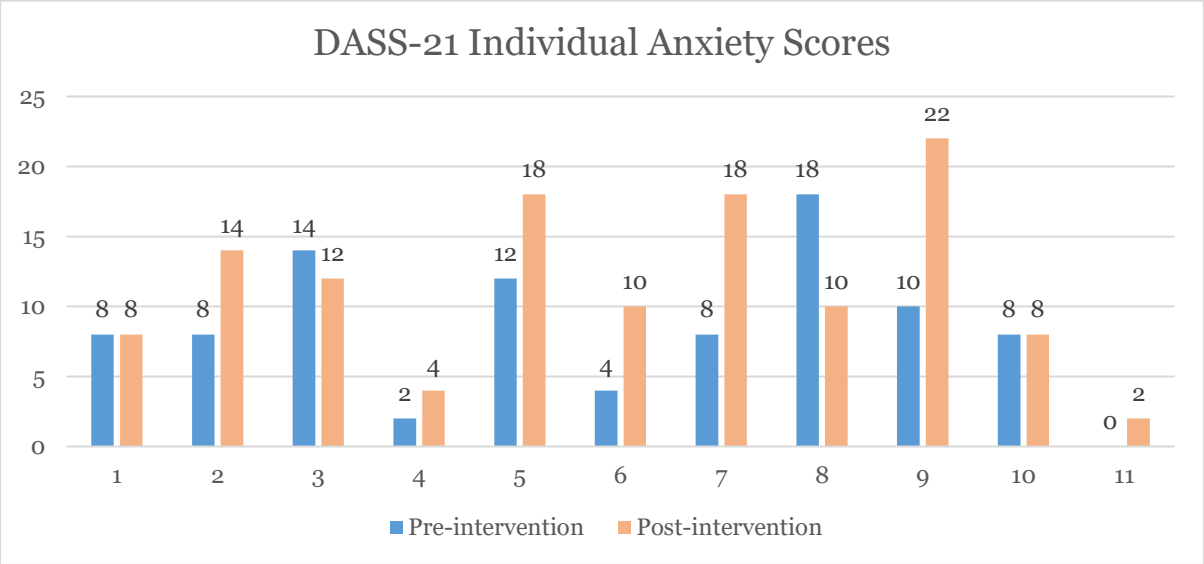
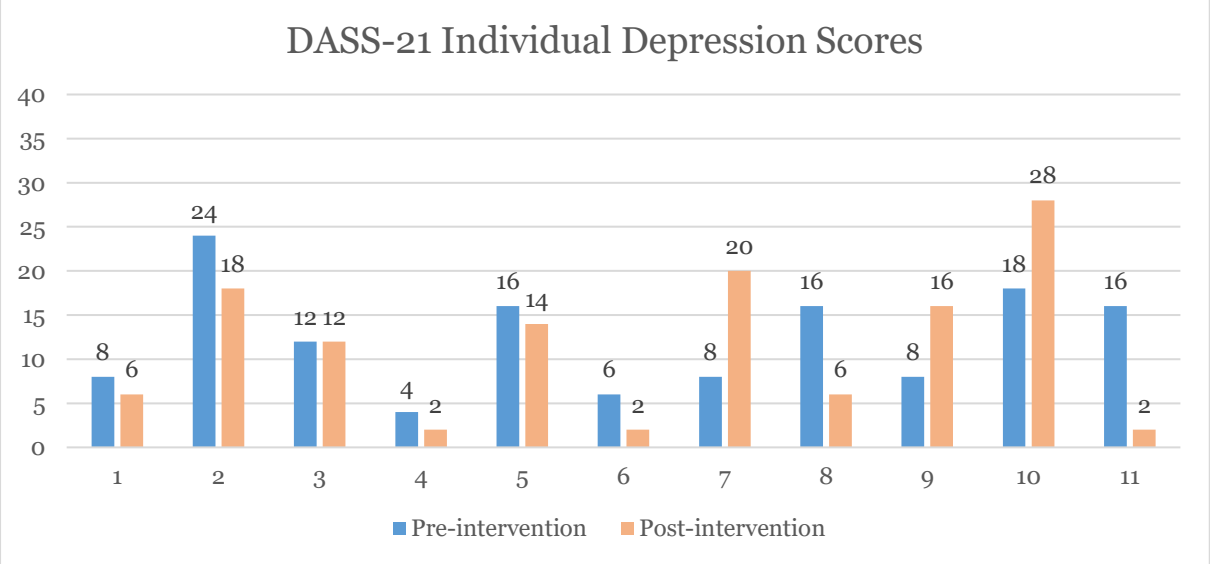
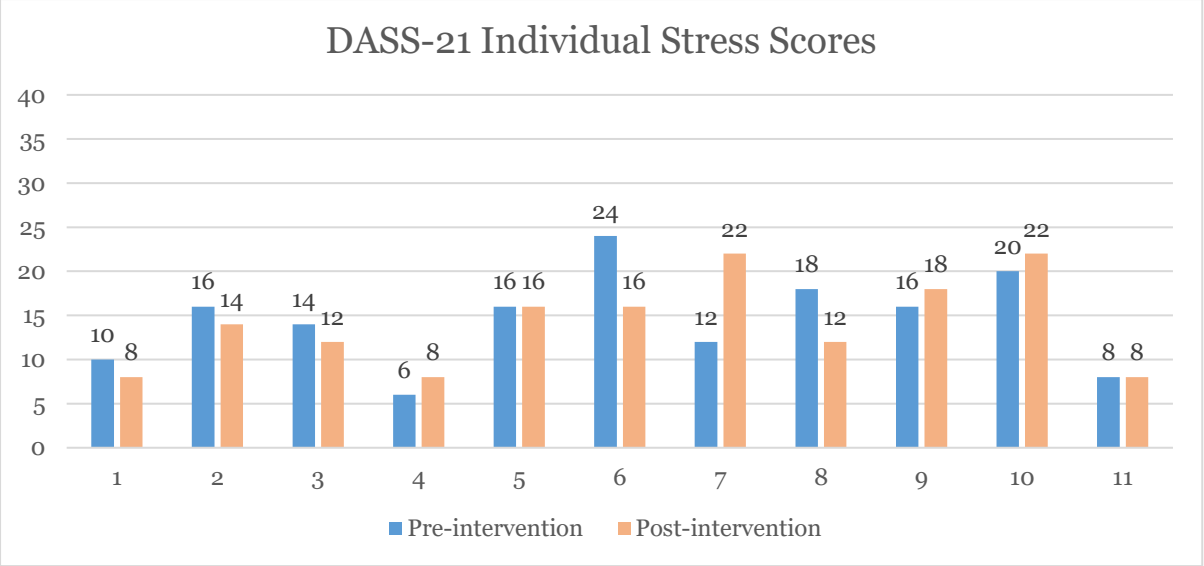


Figure 4.137. *Pre and Post individual mean* scores of Depression Anxiety and Stress Scale (DASS-21) subscales






### Personal Need for Structure (PNS)

The mean scores on the PNS decreased from 48.09 (*SD* = 5.28) at pre-intervention to 44.73 (*SD* = 6.23) at post-intervention, see Figure 4.138 below. Nine out of eleven participants (81.82%) reported a greater ability to manage novel situations, which in this context is interpreted as evidence of greater flexibility, having completed the intervention. Individual scores are displayed in Figure 4.139.

Figure 4.138. *Pre and Post mean* scores of *Personal Need for Structure (PNS)*

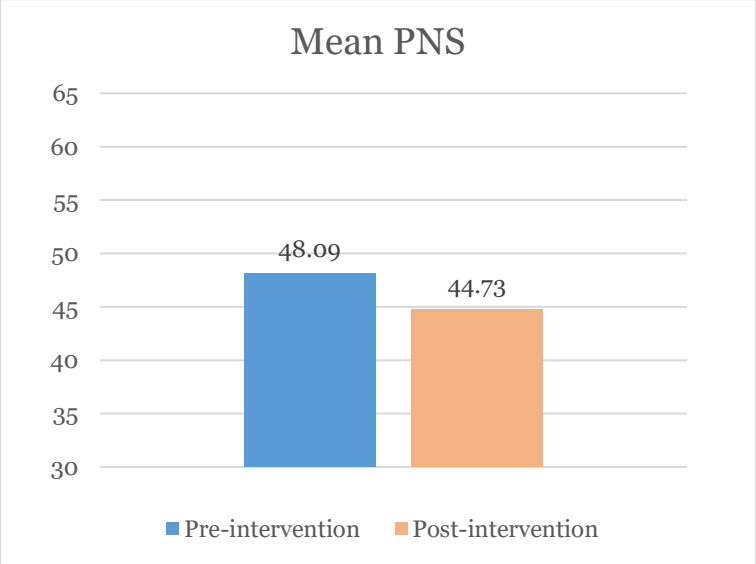
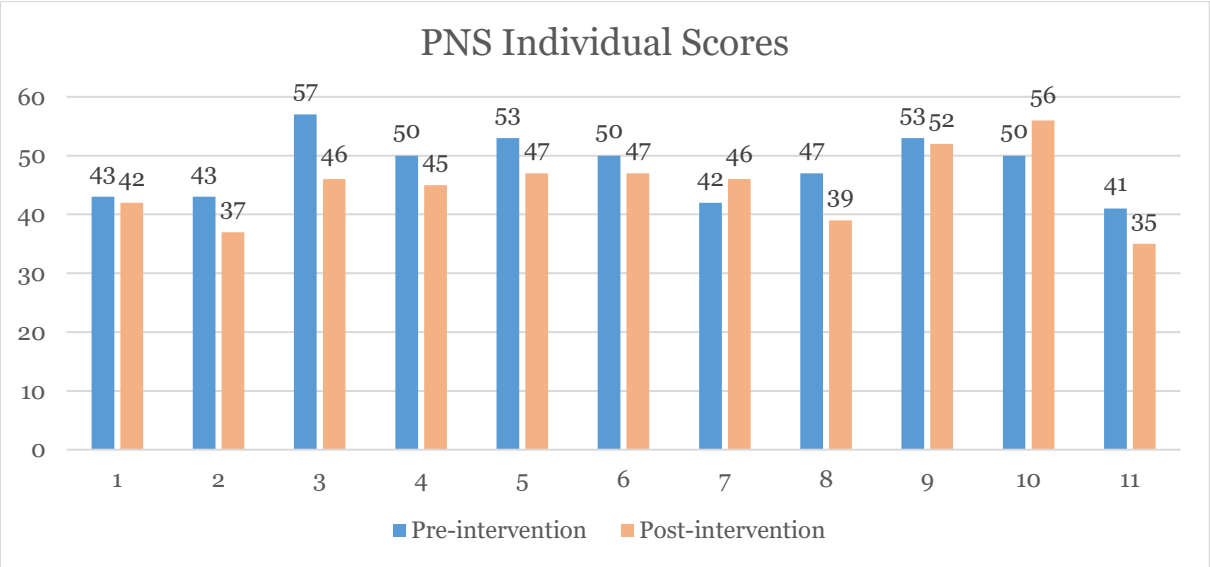


Figure 4.139. *Pre and Post individual mean* scores of *Personal Need for Structure (PNS)*




### Emotion control questionnaire – Emotional inhibition (ECQ-EI)

The total mean score on the ECQ-EI showed a decrease from 8.45 (*SD* = 2.50) at pre-intervention to 6.73 (*SD* = 2.65) at post intervention, Figure 4.140, indicating a decrease in the level of emotional inhibition post intervention. Individual scores are displayed in Figure 4.141, with seven out of eleven participants (63.64%) endorsing decreased levels of emotional inhibition and suppression.

Figure 4.140. *Pre and Post total mean* scores of *Emotional Inhibition subscale (ECQ-EI)*

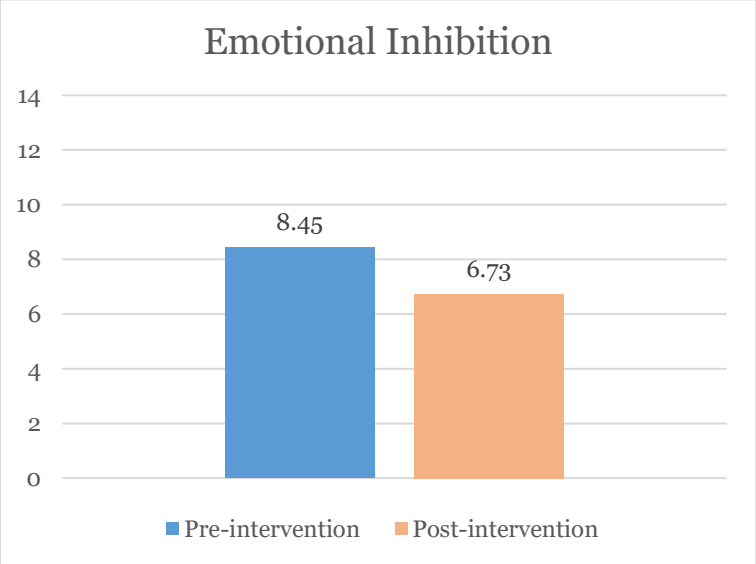
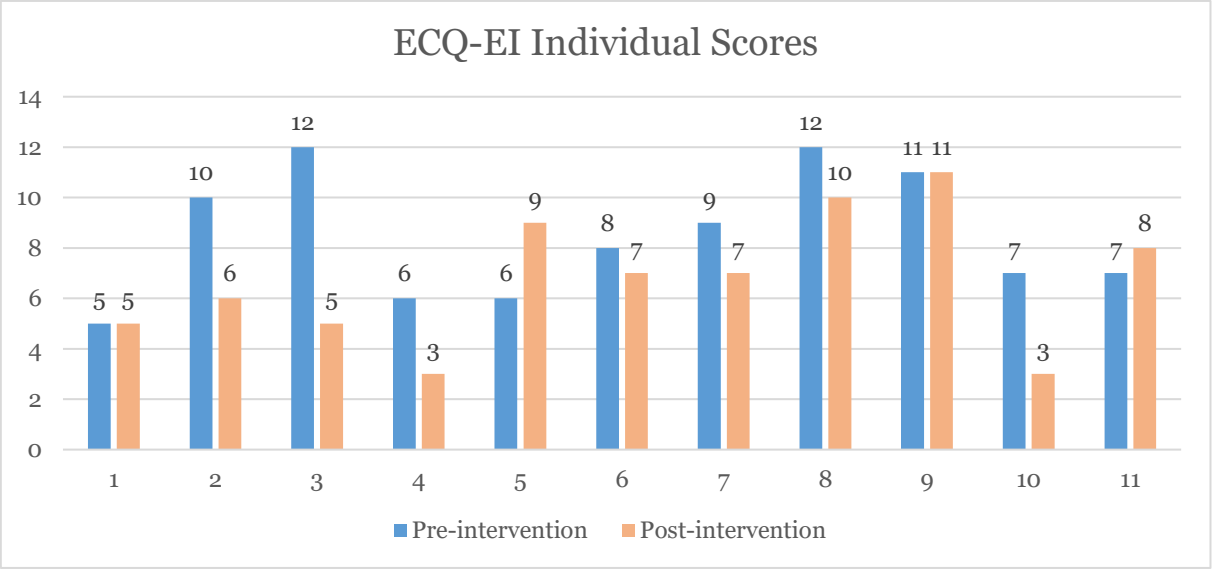


Figure 4.141. *Pre and Post individual mean* scores of *Emotional Inhibition subscale (ECQ-EI)*




### Revised Adult Attachment Scale (RAAS)

Mean scores on the Closeness subscale slightly increased from a mean of 17.36 (*SD* = 3.59) pre-intervention to 17.64 (*SD* = 3.29), post-intervention, Figure 4.142. Mean scores on the Dependency subscale increased from a mean of 18.64 (*SD* = 4.52) to 19.64 (*SD* = 3.17), see Figure 4.145 and 4.146 below for individual scores on these subscales. Both increases were taken to mean greater ability to tolerate closeness and intimacy post intervention. Mean scores on the Anxiety subscale levels were found to decrease from 17.82 (SD = 3.73) to 16.73 (SD = 5.88) at post-intervention, see Figure 4.143. This was taken as indicating less fear of rejection post intervention.

Figure 4.142. *Pre and Post mean* scores of *Revised Adult Attachment Scale (RAAS) Closeness and Dependency Subscales*

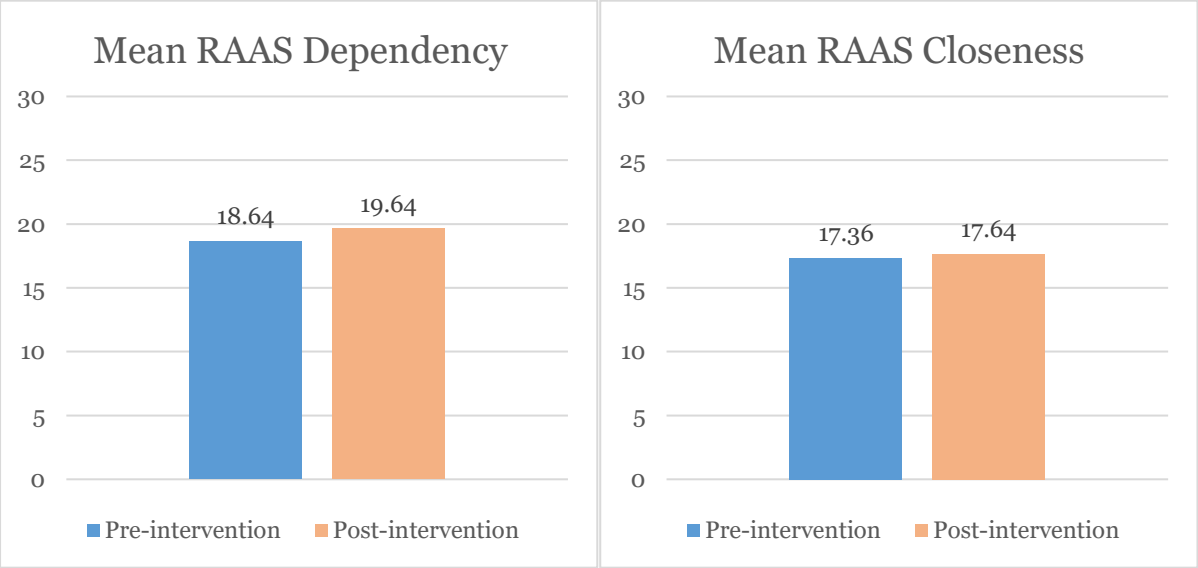



Figure 4.143. *Pre and Post mean* scores of *Revised Adult Attachment Scale (RAAS) Anxiety Subscale*

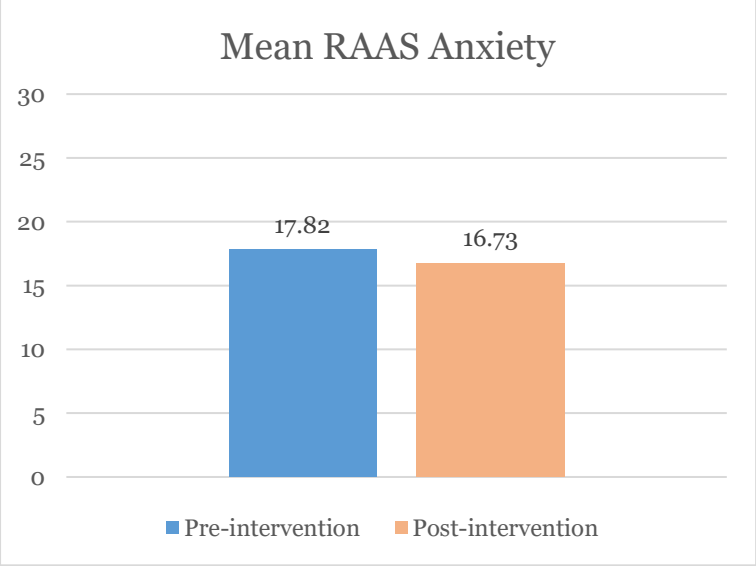
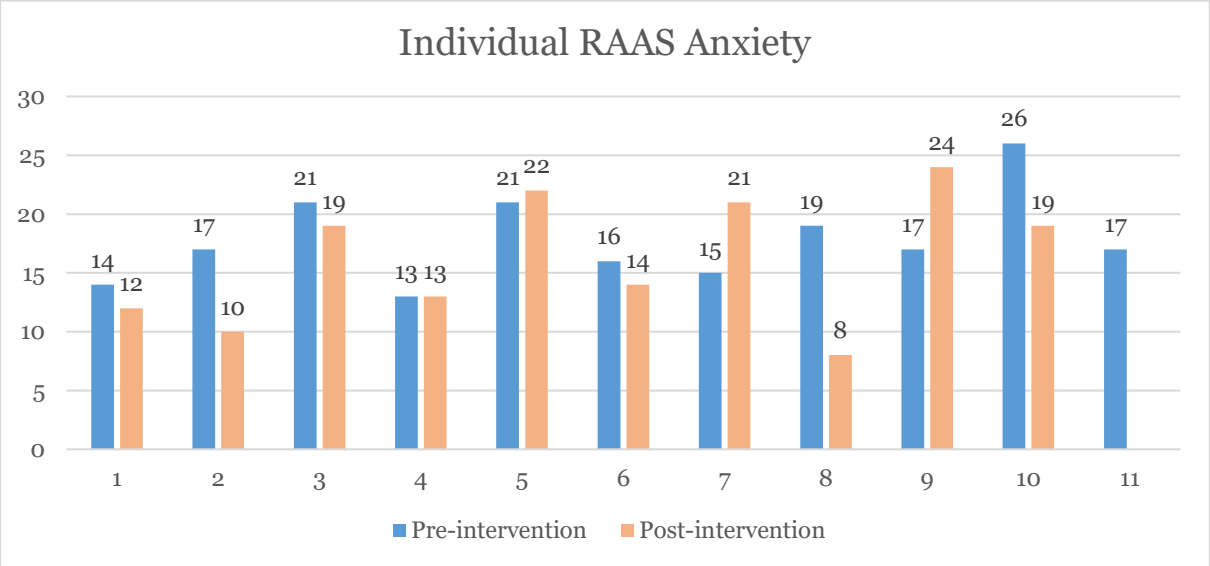
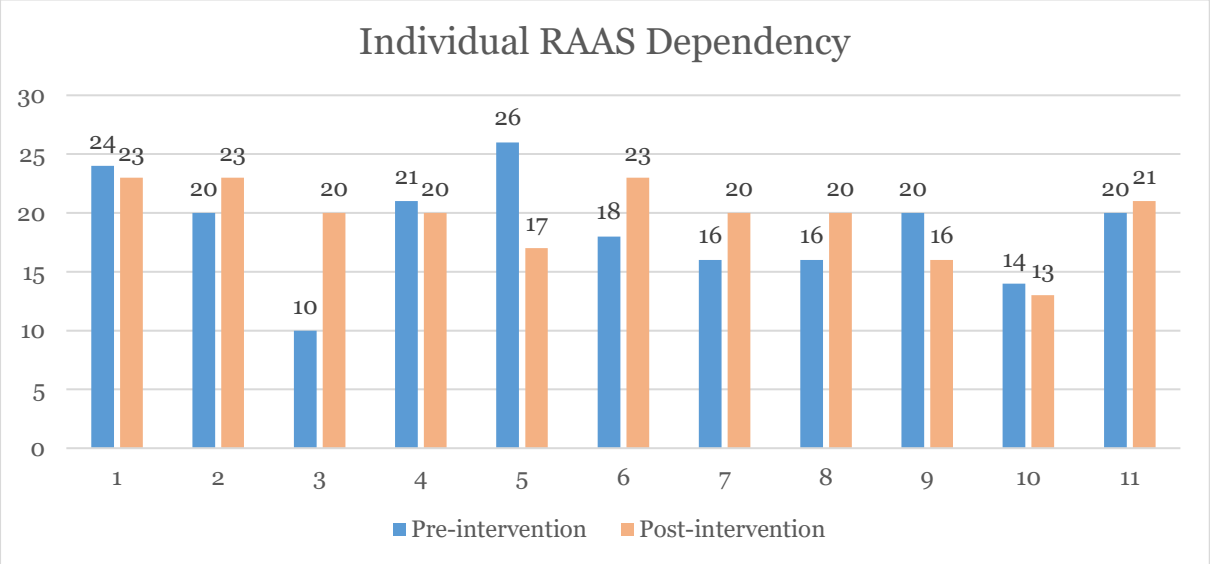


Figure 4.144. *Pre and Post individual* scores of *Revised Adult Attachment Scale (RAAS) Anxiety Subscale*



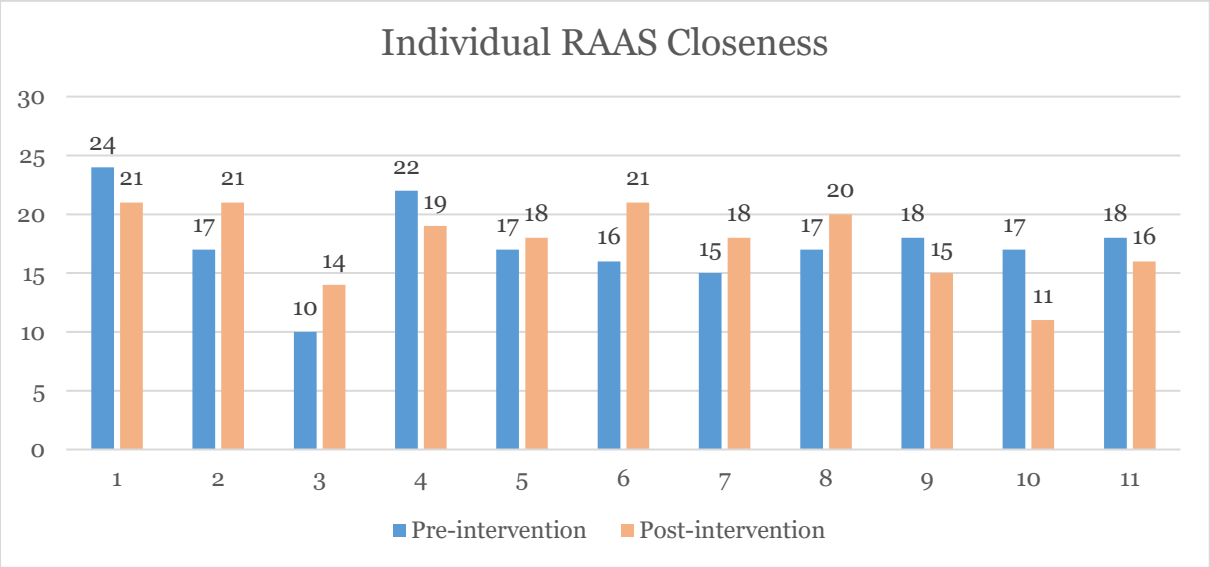

Six out of eleven participants (54.55%) reported less anxiety meaning less fear of rejection having completed the intervention. Please see Figure 4.145 above for visual representation.

Figure 4.145. *Pre and Post individual* scores of *Revised Adult Attachment Scale (RAAS) Dependency Subscale*



Six out of eleven participants (54.55%) endorsed greater comfort with closeness and intimacy in everyday life, having completed the intervention. Please see Figure 4.145 above for visual representation.

Figure 4.146. *Pre and Post individual* scores of *Revised Adult Attachment Scale (RAAS) Closeness Subscale*

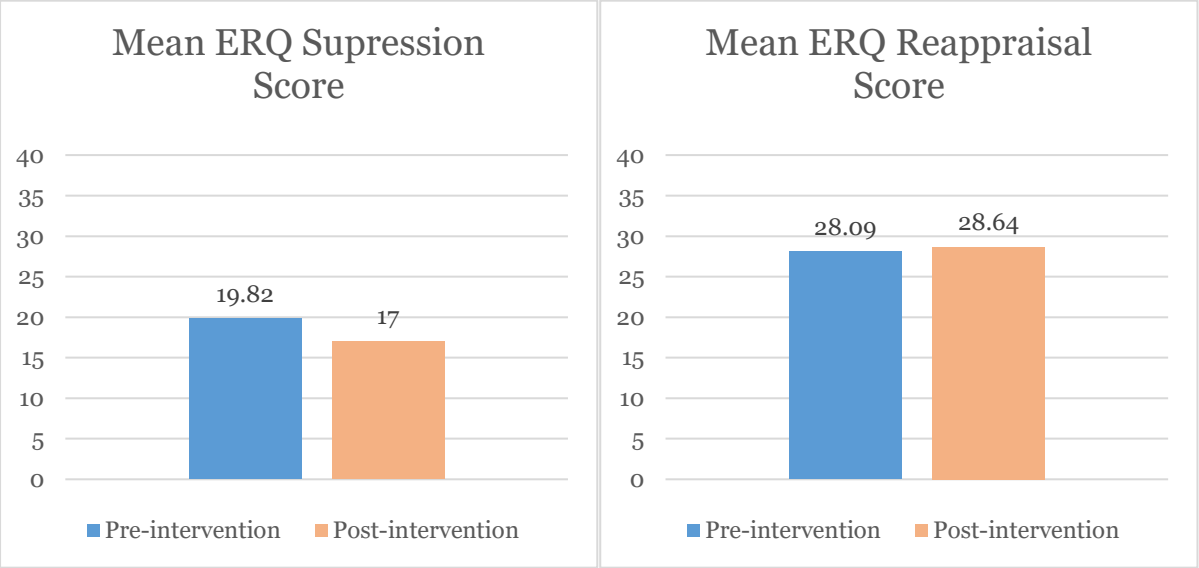



Six out of eleven participants (54.55%) reported greater comfort with closeness in everyday life after completing the intervention, as shown in Figure 4.146 above.

### Emotion Regulation Questionnaire (ERQ)

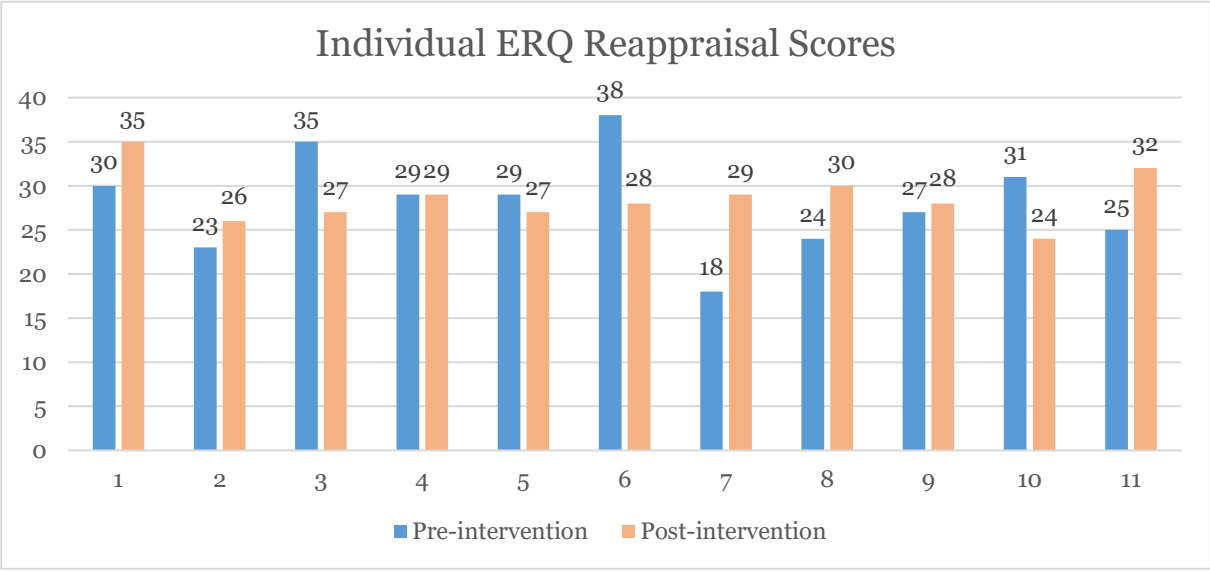
The mean score for reappraisal increased from 28.09 (SD= 5.61) at baseline to 28.64 (SD= 2.98) post-intervention. Expressive suppression, which describes the ability to control or suppress the urge to respond to emotional experiences, decreased from a mean of 19.82 (*SD*= 3.66) to 17.0 (*SD*= 4.27). Mean and individual scores for these subscales are displayed in Figure 4.147.

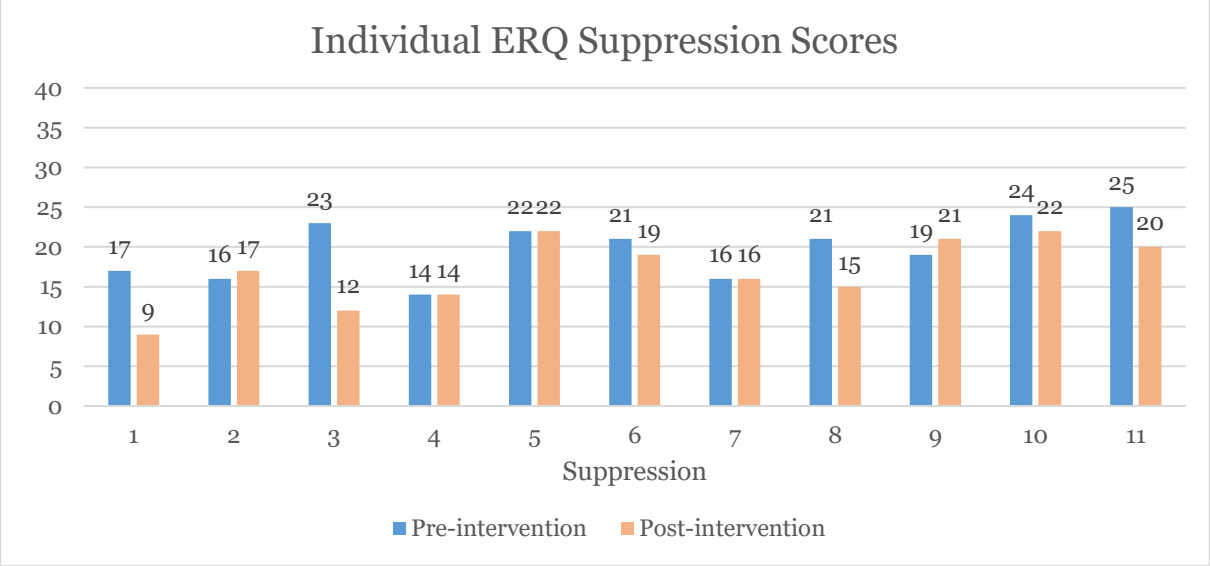
Figure 4.147. *Pre and Post mean scores of Emotion Regulation Questionnaire (ERQ) Reappraisal and Suppression subscales*




Six out of eleven participants (54.55%) reported increased use of reappraisal as a strategy for managing difficult emotional experiences having completed the intervention, as shown in Figure 4.148. Six out of eleven participants (54.55%) reported less use of suppression as a coping strategy for difficult emotional experiences having completed the intervention, also shown in Figure 4.148 below.

Figure 4.148. *Pre and Post individual scores of Emotion Regulation Questionnaire* (ERQ) *Reappraisal and Suppression subscales*






### 4.19.4. Summary

A full data set without missing values was collected from the small number of participants who completed the Sage programme in 2024. Most measures in the battery of outcome measures indicate positive changes endorsed by most service users in the areas targeted by the programme: increased emotional expression and decreased use of inhibition and suppression, increased psychological flexibility and greater closeness and intimacy in relationships. The increase in cognitive reappraisal on the ERQ was understood as a greater level of awareness of, and ability to think about emotional experiences in general, a useful first step towards responding to emotions in a more healthy and beneficial way.

However, there was an overall increase in mental health symptomatology as measured by the DASS-21, which was largely accounted for by the increase in items endorsed on the anxiety subscale. We noted that this was apparently at odds with the types of qualitative comments participants often made at the end of the programme in 2024, for example “I’m coping better with anxiety and (more able to) try new things”. It may be that an increase in anxiety type symptoms is experienced by participants as a by-product of their increase flexibility, emotional connection and intimacy. For example, increasing flexibility involves challenging behavioural avoidance, and embracing novelty and play; these are experiences which are difficult and uncomfortable for our participants to try out initially. Similarly, increasing intimacy and closeness is also

uncomfortable and difficult, though, just as with flexibility, ultimately leads to greater psychological health. This endorsing of anxiety symptoms in the context of increased overall psychological health also is compelling in light of the changes seen across all other outcomes measures in the direction predicted by the intervention as a whole. The outcomes measures used within the programme are kept under review.

21 cycles of Sage have been completed up to 2024. This is the second year of the hybrid screen technology, which allowed for a far better online experience for service users who occasionally needed to attend remotely, usually for physical health reasons. This is particularly relevant for our older adult cohort who often have a higher level of physical health issues and concerns around travel and safety at certain times of year in particular.

## 4.20. Trauma Group Programme

The Trauma Group Programme is a therapeutic group delivered by the Psychology Department. The programme is for individuals with a history of complex trauma. The group has three stages adapted from Judith Herman's Model of Trauma Recovery (Herman, 1992). It incorporates both group and individual work, memory reprocessing, compassion-focused therapy and attachment theory. Stage one includes safety, stabilisation and connection. Stage two aims to work on remembering and reprocessing memories. Individual work runs alongside the group in stage two. Stage three focuses on looking forward and reclaiming the participants' life from trauma. This format of three stages is considered as best practise (Willis, Dowling, O' Reilly, 2022). The group is offered over a seven-month period which includes twice a week for six weeks, then once a week for twelve weeks (during this time participants also engage in individual memory processing therapy work) and then twice a week for five weeks. The programme was delivered all in person in 2024.

### 4.20.1. Descriptors

A total of eight people who were referred completed cycle seven of the Trauma programme in 2024. Eight participants returned pre and post outcome measures. Five of the participants were female and three were male. Participant's ages ranged from 24 years to 64 years ($M$= 45.13, $SD$= 14.79). Pre-treatment completion of the Adverse

Childhood Experience (ACEs) indicated that 6 out of 8 returned ACEs measures scored four and above, with one participant scoring 4; two participants scoring 5; one participant scoring 6; one participant scoring 7 and one participant scoring 8. The higher the ACE score the more at risk the client is to chronic health problems, mental health difficulties, social difficulties, and substance misuse in adulthood.

### 4.20.2. Trauma Group Programme Outcome Measures

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

The PTSD Checklist is a 20-item self-report checklist of post-traumatic stress disorder (PTSD) symptoms based closely on the DSM-5 criteria (PCL-5; Lang & Stein, 2005). Service users rate each item from 0 – 'not at all', to four – 'extremely', to indicate the degree to which they have been impacted by that symptom over the past month. The PCL has demonstrated strong psychometric properties. Estimates of internal consistency (Cronbach's alpha) range between 0.94 (Blanchard et al, 1996) to 0.97 (Weathers et al. 1994). Test-retest reliability has been reported as .96 at two to three days and 0.88 at one week (Blanchard et al.,1996; Ruggiero et al.,2003). Higher scores indicate higher experiencing of PTSD symptoms. A cut-off raw score of 38 indicates a provisional diagnosis of PTSD. This cut-off has high sensitivity (.78) and specificity (.98) (Cohen et al., 2015). When used to track symptoms over time, a minimum 10-point change represents clinically significant change.

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

The Dissociative Experiences Scale- Taxon (DES- T) (Bernstein and Putnam, 1986) is an 8-item self-report sub scale of the DES which measures dissociation among clinical populations. Each item is rated from 0-100% which indicates what percentage of time the individual experiences dissociation. High numbers indicate higher levels of dissociation and the mean score is calculated by summing the eight items.

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

The PTCI (Foa, Ehlers, Clark, Tolin & Orsillo, 1999) is a 36-item self-report scale that was designed to measure trauma-related thoughts and beliefs. Each item is rated on a seven-point Likert scale from 1 – 'totally disagree', to 7 – 'totally agree'. The measure consists of three subscales measuring negative cognitions about self, negative

cognitions about the world and self-blame. Higher scores indicate higher post-traumatic cognitions. This scale has been normed using three categories of individuals; a non-traumatised population, a traumatised population without PTSD and a traumatised population with PTSD. The median score for the non-traumatised group was 45.5, for the traumatised group without PTSD was 49 and for the traumatised group with PTSD the median score was 133.

- **Compassionate Engagement and Action Scales (CEAS):** see page 92

### 4.20.3. Results

Results were examined and compared in greater detail including overall mean, individual and cycle scores. Due to the small sample size, statistical analysis of the outcome measures was not possible. The small sample size is due to the fact that this programme is a specialist intervention delivered to a small group of service users, to meet their specific therapeutic needs. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 27 participants would have been required to detect a medium effect size (Cohen's *d*=0.5). Therefore, for each measure individual results for the eight participants who returned both pre and post measures are given to reflect the outcome of the intervention.

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

There was a decrease in total PTSD scores for the PCL-5 checklist from pre-intervention (*M* = 52.38 *SD* = 10.27) to post-intervention (*M* = 35.88, *SD*= 21.11) This finding indicates that those who completed the trauma programme in 2024 had a reduction in PTSD symptoms post-intervention (see Figure 4.149).

Due to the small sample size, changes in the PCL scores were analysed using the Reliable Change Index (RCI) for each participant. To ensure that changes in PCL-5 scores were not attributable to chance or measurement error a reliable change index (RCI) was calculated for each participant using the Jacobson-Truax method (1991).

In accordance with this method, statistically reliable change was reflected by RCI values larger than or equal to 1.96. The cut-off score indicating clinically meaningful

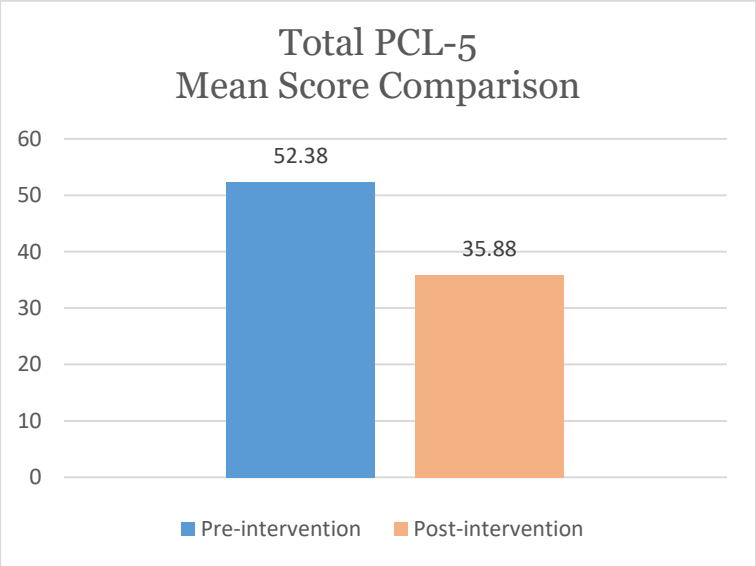
improvement on the PCL-5 was 33. Participants were classified as “clinically meaningful improvement” (passed RCI criterion and PCL-5 score decreased to below cut-off score), “reliable improvement” (passed RCI criterion but the score did not decrease below PCL-5 cut-off score), “uncertain change” (did not pass RCI criterion) or “reliable deterioration” (passed RCI criterion but symptom score increased).

Results from the RCI demonstrate that six out of 8 participants (75%) demonstrated clinically meaningful improvement, one participant (12.5%) demonstrated uncertain change and one participant (12.5%) demonstrated reliable deterioration (see table 4.19).

Table 4.19. *Results from Reliable Change Index (RCI) for the PCL-5 pre and post scores for each group member*

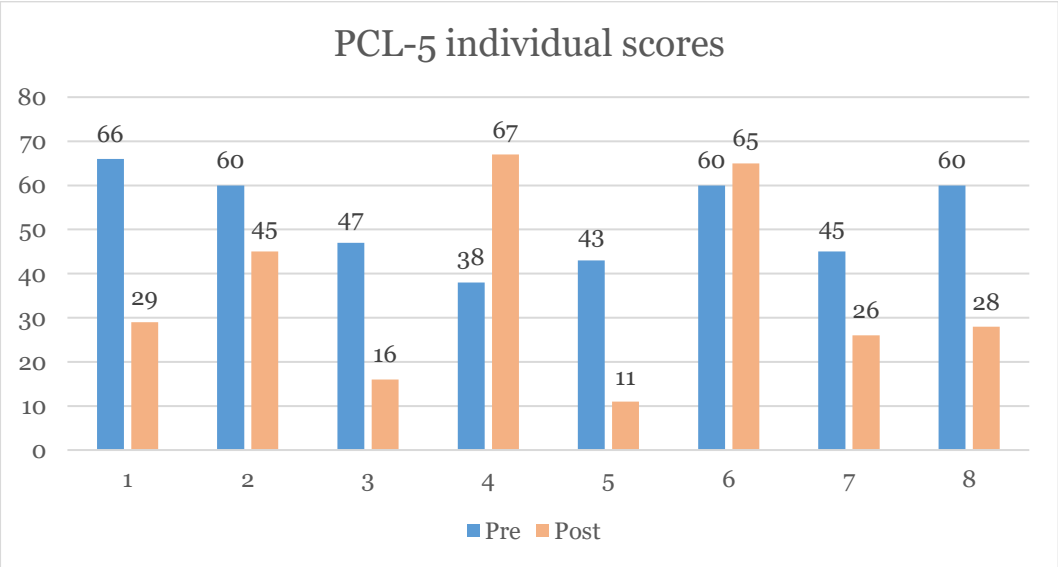
| Participant | Pre score | Post score | RCI value | Category |
|---|---|---|---|---|
| 1 | 66 | 29 | -4.82 | Clinically meaningful improvement |
| 2 | 60 | 45 | -1.96 | Clinically meaningful improvement |
| 3 | 47 | 16 | -4.04 | Clinically meaningful improvement |
| 4 | 38 | 67 | 3.78 | Reliable deterioration |
| 5 | 43 | 11 | -4.17 | Clinically meaningful improvement |
| 6 | 60 | 65 | 0.65 | Uncertain change |
| 7 | 45 | 26 | -2.48 | Clinically meaningful improvement |
| 8 | 60 | 28 | -4.17 | Clinically meaningful improvement |

Figure 4.149. *Pre and post mean scores of Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5).*




As can be seen from Figure 4.150, further examination of the individual scores indicates that six out of eight participants (75%) demonstrated a clinically significant reduction in PCL scores from pre-intervention to post-intervention (10 points or greater). In addition, five participants (62.5 %) have moved from meeting criteria for a provisional diagnosis of PTSD pre-intervention (cut off score 33 or higher) to no longer meeting criteria post intervention (see Figure 4.150).

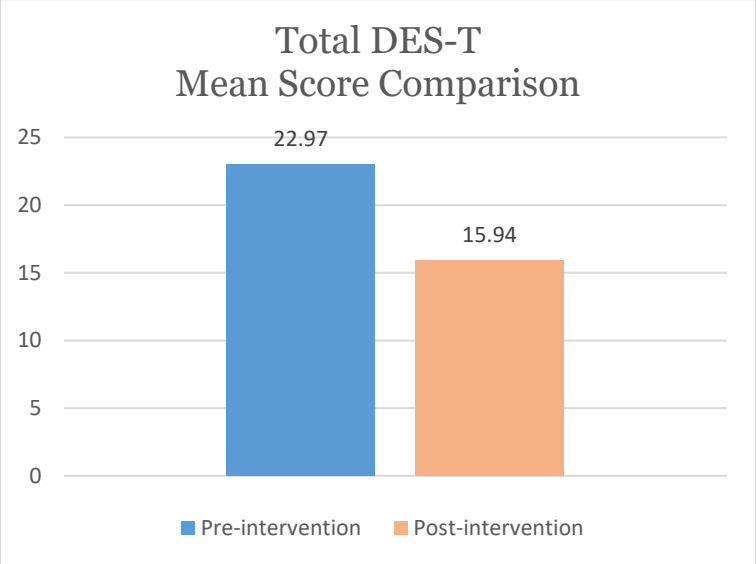
Figure 4.150. *Pre and post individual scores of Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 (PCL-5).*



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

The total dissociation mean scores for 2024 decreased from pre-intervention (*M* = 22.97; *SD* = 16.94) to post-intervention (*M* = 15.94; *SD* = 12.88) (see Figure 4.151).

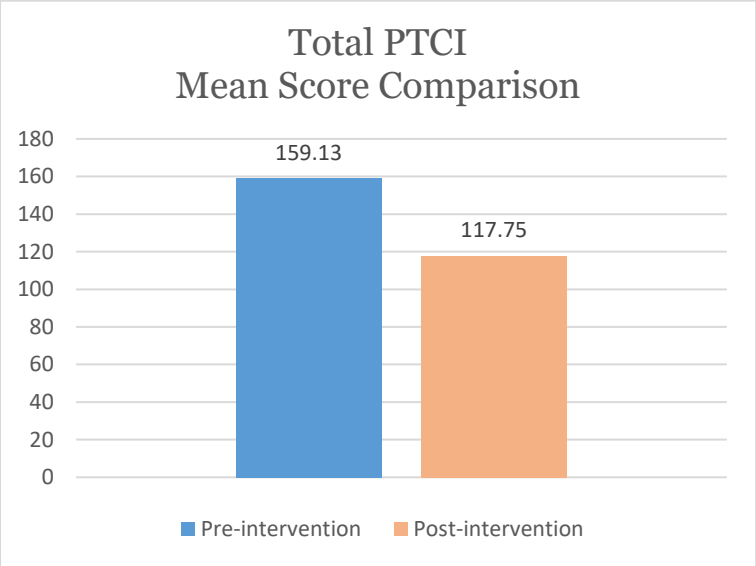
Figure 4.151. *Pre and post mean scores of the Dissociative Experiences Scale - Taxon (DES- T)*.




### The Post Traumatic Cognitions Inventory (PTCI)

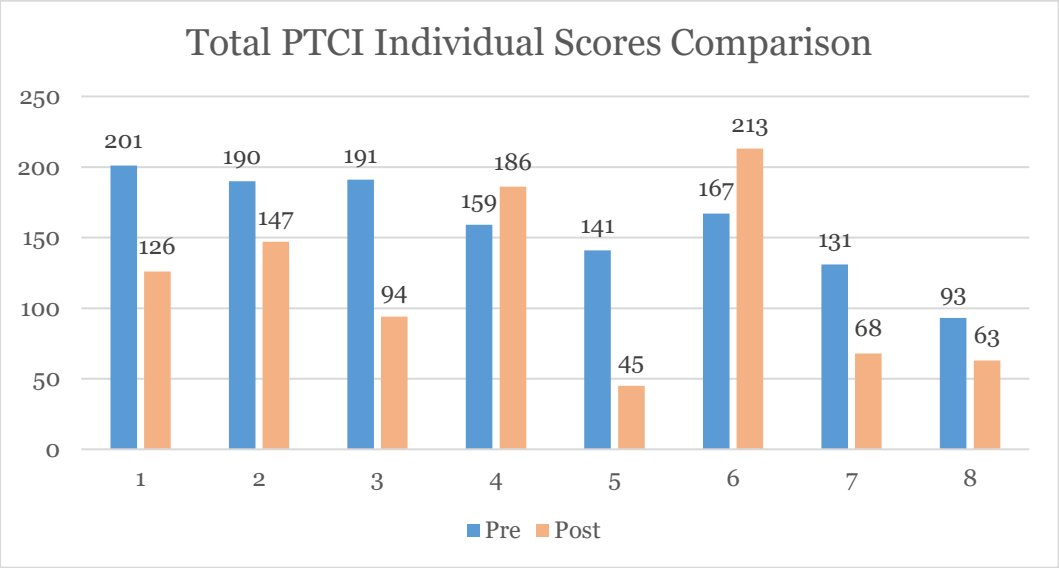
There was a decrease in total PTCI scores from pre-intervention (*M* = 159.13; *SD* = 36.40) to post-intervention (*M* = 117.75; *SD* = 60.93) (see Figure 4.152).

Figure 4.152. *Pre and post mean scores of the Post Traumatic Cognitions Inventory (PTCI).*




Further examination of individual total PTCI scores indicates that six of out eight (75%) participants who completed the programme in 2024 had a reduction in post-traumatic cognition symptoms post-intervention (see figure 4.153). Six out of eight (75 %) participants scored 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. Three out of eight (37.5 %) participants yielded reduction in post-traumatic cognition symptoms and demonstrated a significant reduction in scores, no longer meeting this criteria post-intervention following completion of the programme (see Figure 4.153).

Figure 4.153. *Pre and post individual scores of the Post Traumatic Cognitions Inventory (PTCI) total.*




In addition, five out of eight (62.5%) demonstrated reductions across the subscale 'self-blame', six out of eight (75 %) demonstrated reductions across the subscale 'negative cognitions about the self' and five out of eight (62.5 %) across the subscale 'negative cognitions about the world'. These findings indicate that participants who completed the trauma programme significantly reduced their PTSD symptoms associated with trauma related thoughts and beliefs (see Figure 4.154 to Figure 4.156).

Figure 4.154. *Pre and post individual scores of the Post Traumatic Cognitions Inventory (PTCI) - self blame subscale.*

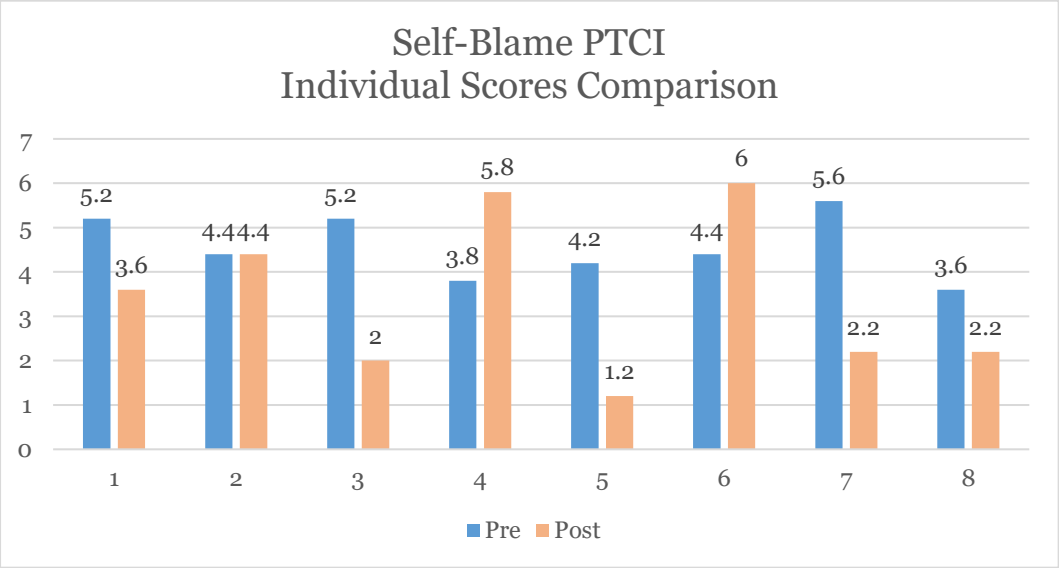



Figure 4.155. *Pre and post individual scores of the Post Traumatic Cognitions Inventory (PTCI) - negative cognitions to self subscale.*

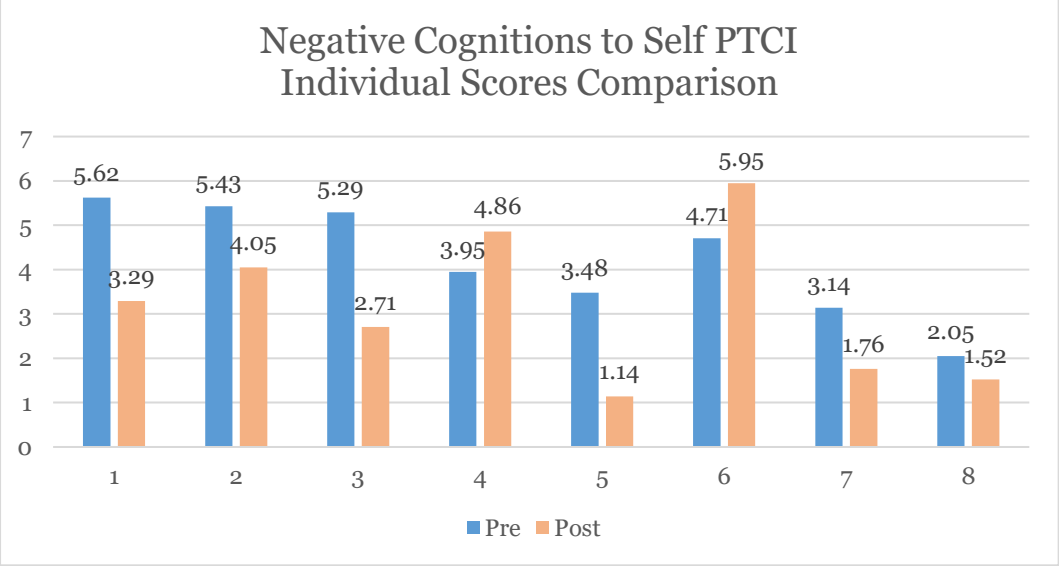
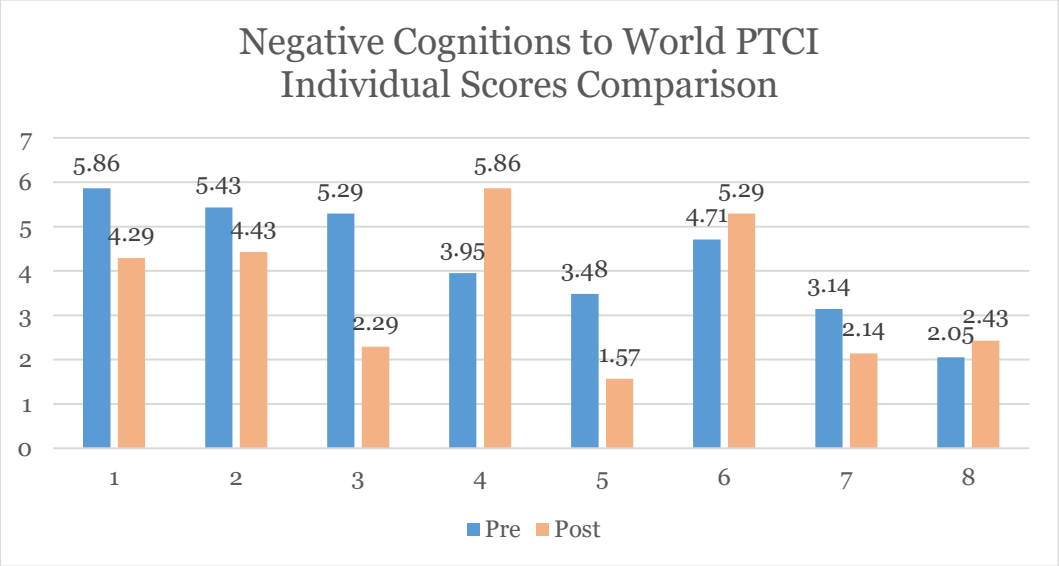


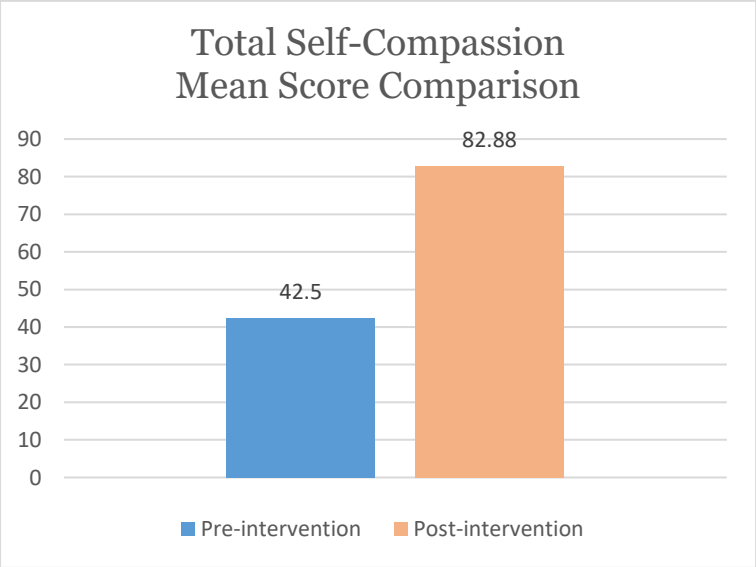
Figure 4.156. *Pre and post individual scores of the Post Traumatic Cognitions Inventory (PTCI) - negative cognitions to world subscale.*




### Compassionate Engagement and Action (CEA) Scales

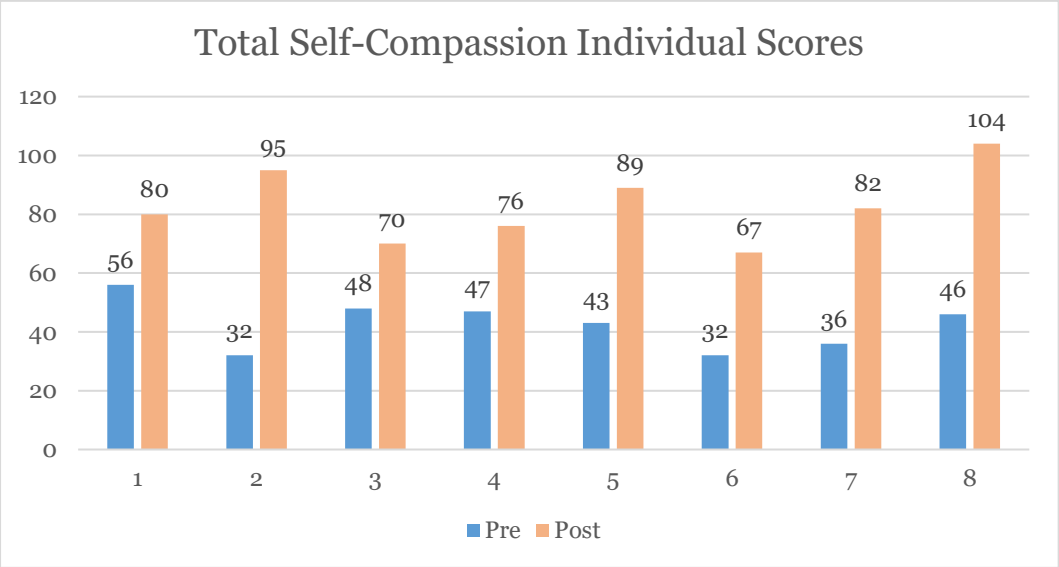
There was an increase in total self-compassion scores from pre-intervention (*M* = 42.5; *SD* = 8.52) to post-intervention (*M* = 82.88; *SD* = 12.56) (see Figure 4.157).

Figure 4.157. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) self-compassion subscale.*



Further examination of the individual scores indicated that six out of eight participants (83.5%) demonstrated an improvement on the self-compassion subscale (see Figure 4.158)

Figure 4.158. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) - self-compassion subscale.*




There was an increase in total compassion to others scores from pre-intervention (*M* = 57.25; *SD* = 8.55) to post-intervention (*M* = 97; *SD* = 6.52) (see graph below). Further examination of individual scores indicate that eight out of eight participants demonstrated an increase in compassion to others (see Figure 4.159 and Figure 4.160).

Figure 4.159. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) - compassion to others subscale.*

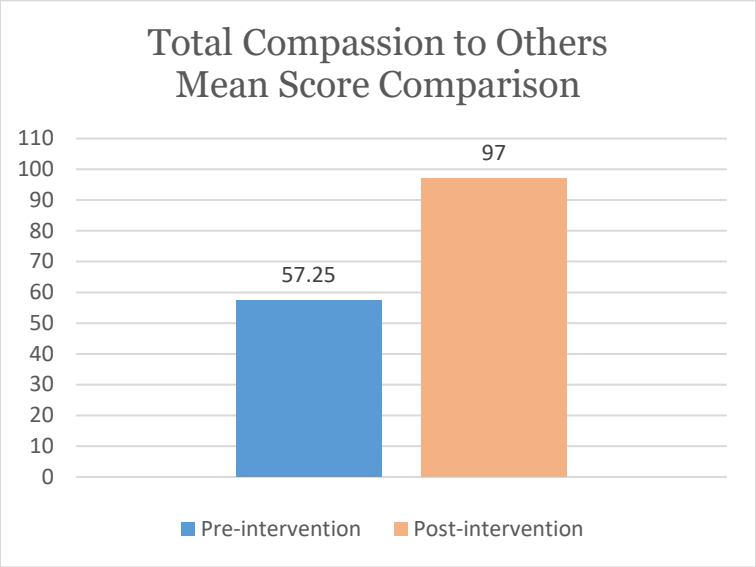
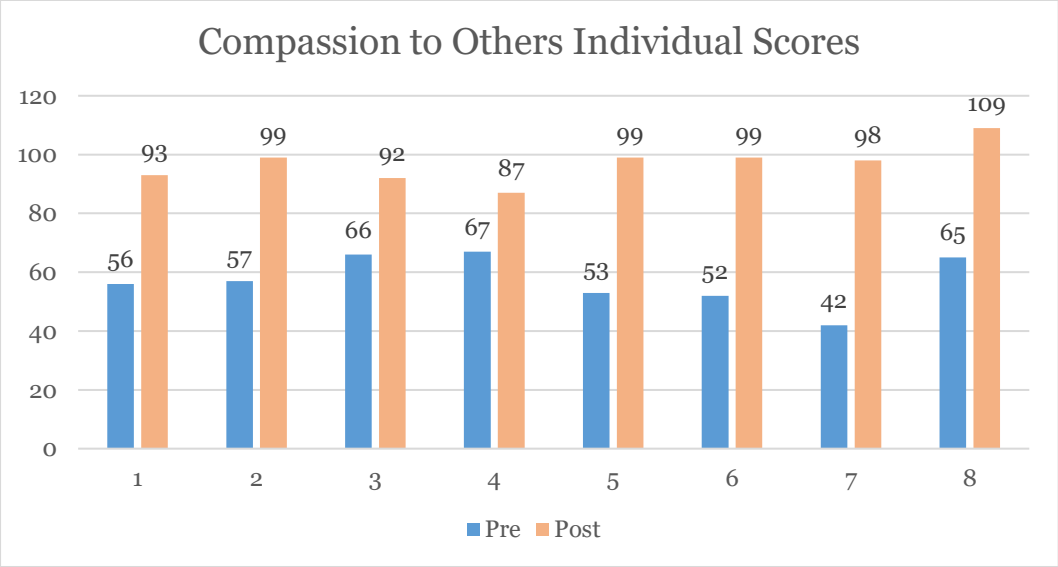
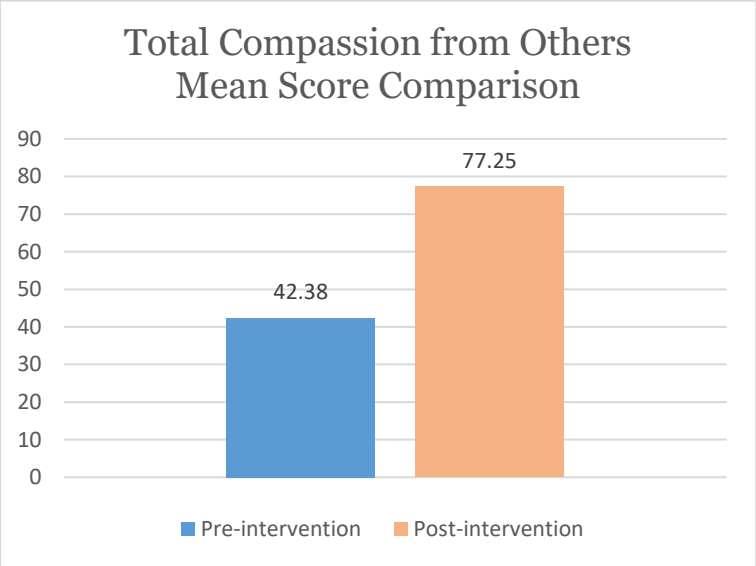



Figure 4.160. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) Compassion to others subscale*.



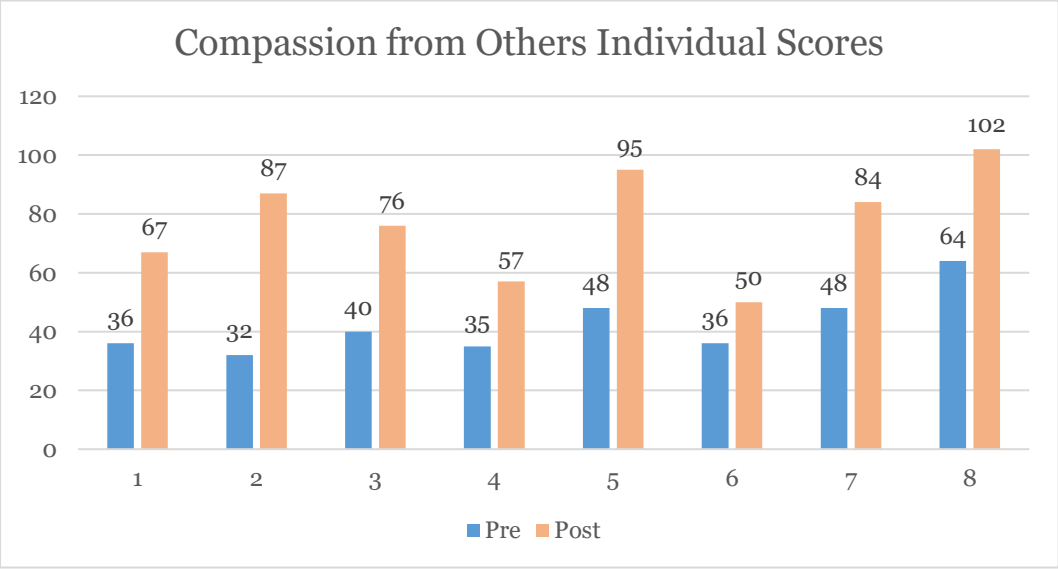

There was an increase in total compassion from others scores from pre-intervention (*M* = 42.38; *SD* = 10.56) to post-intervention (*M* = 77.25; *SD* = 18.23) (see Figure 4.161).

Figure 4.161. *Pre and post mean scores of the Compassionate Engagement and Action (CEA) - compassion from others subscale*.




Further exploration of individual scores indicates that eight of eight participants (100%) demonstrated an increase in perceived levels of compassion from others post-intervention (see Figure 4.162).

Figure 4.162. *Pre and post individual scores of the Compassionate Engagement and Action (CEA) - compassion from others subscale*.



### 4.20.4. Summary

The Trauma programme aspires to reduce participants' symptoms of PTSD and increase their capacity for compassion in their relationships with themselves and others. The analysis of group and individual scores overall demonstrated promising positive results. These results indicate that the Trauma Programme is effective in delivering its aims. There were improvements in reducing PTSD symptoms post-intervention as demonstrated through findings from the PCL and PTCI measures. Another aim of the programme was to increase participant's capacity for compassion, and the results indicate there were improvements in self-compassion, compassion for others and receiving compassion from others. In conclusion, the 2024 trauma programme demonstrated promising results in relation to reducing trauma symptoms and improving the capacity to cultivate compassion. These outcome reports are consistent with previous qualitative research exploring participants' experiences of attending the Trauma Programme (Willis, Dowling, Deehan, O' Reilly 2022).

## 4.21. Willow Grove Adolescent Unit

Willow Grove is the inpatient adolescent service of SPMHS. The 14-bed unit opened in April 2010 and aims to provide evidence-based treatment in a safe and comfortable environment to young people between the ages of 12 and 17 years who are experiencing mental health difficulties. The unit is an approved centre accepting voluntary and involuntary admissions. The team consists of medical and nursing personnel together with clinical psychologists, cognitive behavioural therapists, social worker/family therapists, occupational therapists, registered advanced nurse practitioners and teaching staff.

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

- Mood disorders
- Anxiety disorders
- Psychosis

- Eating disorders

### Treatment approach

Care is delivered from a multidisciplinary perspective. The unit provides a group programme in addition to individual therapy and treatment focuses on skills to assist and maintain recovery and promote personal development. Groups include psychotherapy, self-esteem, assertiveness, life skills, communication skills, WRAP group, advocacy, music, drama, gym, and activity/creative groups. Education is also a central component of the programme and tailored for individual needs.

### 4.21.1. Willow Grove outcome measures

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

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was developed as an outcome measure for children and adolescents (three to 18 years) engaging with mental health services (Gowers, Levine, Bailey-rogers, Shore & Burhouse, 2002). This measure provides a global assessment of the behaviour, impairments, symptoms and social functioning of children and adolescents with mental health problems. Studies such as Garralda et al. (2000) have found the validity and inter-rater reliability of the HoNOSCA to be satisfactory. Lesinskiene, Senina & Ranceva (2007) investigated the use of the HoNOSCA in an inpatient child psychiatric unit and found satisfactory inter-rater reliability amongst MDT members. The measure has been regarded as suitable for use as a routine measure in mental health services and is used internationally.

The HoNOSCA is used to assess the most pertinent problems presenting during the previous two weeks. The measure is comprised of 15 items in total, with the first 13 items used to compute a total score (Bilenberg, 2003). These include disruptive/aggressive behaviours, over-reactivity/concentration problems, self-injury, substance misuse, scholastic skills, physical illness, hallucinations/delusions, non-organic somatic symptoms, emotional symptoms, peer relationships, self-care, family relationships and school attendance. All scales are scored on a zero to four-point Likert

scale from ‘no problems’, to ‘severe problems’. Higher scores are indicative of greater severity of difficulty.

In line with the collaborative ethos of the unit, the HoNOSCA’s were completed at admission and discharge by the young person (self-rated), parent and clinician.

### 4.21.2. Results

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

Pre and post scores on measures were available for 84 out of 90 service users (93.33%) who were admitted to and discharged from Willow Grove inpatient care in 2024. Analysis was run on pre and post data received up until January 15th 2025.

As illustrated in table 4.20 below, a significant decrease in total scores for the client rated HoNOSCA was apparent from pre-intervention ($M$ = 18.70 $SD$ = 8.06) to post-intervention ($M$ = 13.06 $SD$ = 7.1), $t(83) = 6.77$, $p < .001$. A medium to large effect size was observed (Cohen’s $d$ = .74) (see Figure 4.160).

A significant decrease in total scores for the parent rated HoNOSCA was apparent from pre-intervention ($M$ = 17.34 $SD$ = 8.23) to post-intervention ($M$ = 12.2 $SD$ = 6.33), $t(82) = 5.91$, $p < .001$. A medium effect size was observed (Cohen’s $d$ = .65) (see Figure 4.161).

A significant decrease in total scores for the clinician rated HoNOSCA was observed from pre-intervention ($M$ = 5.06 $SD$ = 3.50) to post-intervention ($M$ = 4.15 $SD$ = 2.82), $t(61) = 5.92$, $p = .033$. A small effect size was observed (Cohen’s $d$ = .28) (see Figure 4.162).

Table 4.20: *HONSOCA Client and Parent rated paired samples t-tests results*

| | Pre | Post | *n* | *t* | *df* | *p* | *d* |
|---|---|---|---|---|---|---|---|
| Client rated | M = 18.70<br>SD = 8.06 | M = 13.06<br>SD = 7.1 | 84 | 6.77 | 83 | <.001 | .74 |
| Parent rated | M = 17.33<br>SD = 8.23 | M = 12.2<br>SD = 6.33 | 83 | 5.92 | 82 | < .001 | .65 |
| Clinician rated | M = 5.06<br>SD = 3.50 | M = 4.15<br>SD = 2.82 | 62 | 2.18 | 61 | .033 | 61 |

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

Figure 4.163. *Pre and post mean scores of Health of the Nation Outcome Scales for Children and Adolescents* - Client Rated scale.

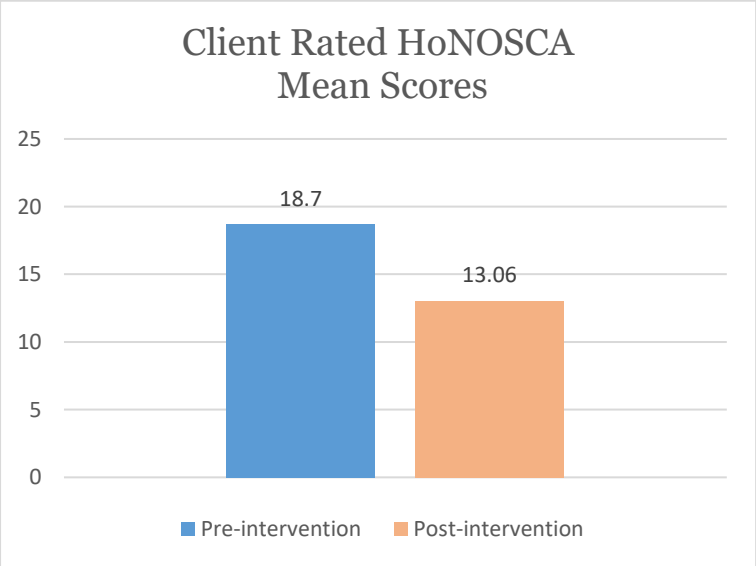


Figure 4.162. *Pre and post mean scores of Health of the Nation Outcome Scales for Children and Adolescents* - Parent Rated scale.

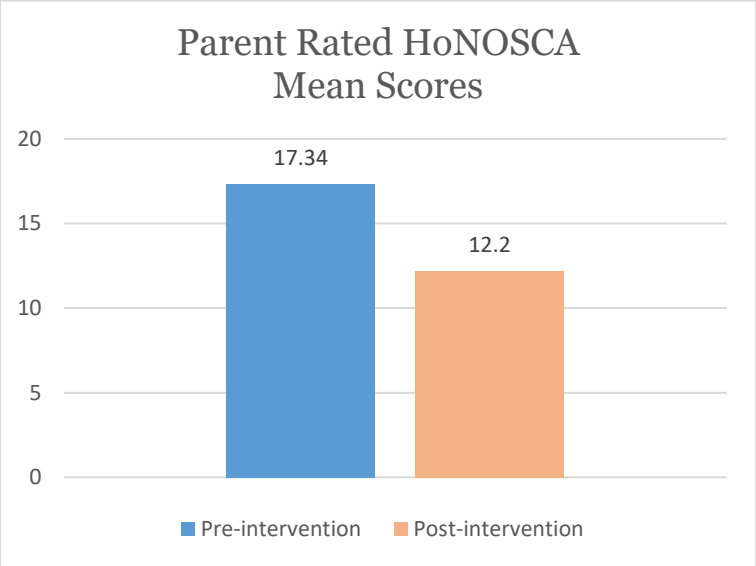
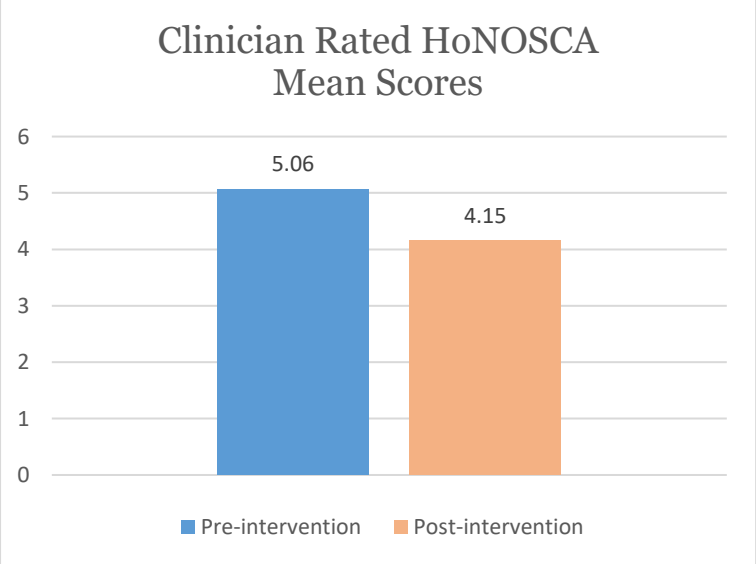



Figure 4.163. *Pre and post mean scores of Health of the Nation Outcome Scales for Children and Adolescents* - Clinician Rated scale.




### 4.21.3. Summary

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

The measure has been commended in the literature for its ease of access for adolescents (Levine, Bailey-Rogers, Shore & Burhouse, 2002) and clinicians (Jaffa, 2000). It is expected to continue to serve as the primary outcome measure for 2025.

# SECTION FIVE
# Measures of service user experience

## 5. Service User Experience Questionnaire

### 5.1. Introduction

SPMHS is committed to listening to, and acting upon, the views of those who use and engage with its service. To enhance communication between service users and providers, the Service User Experience Survey was developed and is distributed to service users who attend inpatient care, Dean Clinics and day programme services. This report outlines the views of a portion of inpatient, Dean Clinic and day programme service users from January to December 2024. The results of the Service User Experience Survey are collated every month to provide management and the Board of Governors with valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

#### 5.1.2. Survey Design

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

One of the priorities of this project was that all service users would be made aware that participation was voluntary and anonymous. The data was collected data using the online survey tool, Survey Monkey and descriptive graphs were created using Microsoft Excel.

### 5.1.3. Data Collection

In accordance with SPMHS' aim to go paperless where possible, and to make it easy for service users to provide feedback, the use of printed versions of the surveys was phased out in January 2022. This change means all service users with an email address on file receive an invitation to complete the survey online. Where service users have no email address on file, they receive a letter by post that indicates four options for how they can access the survey. This includes the option to receive a printed version of the survey by post if required.

## 5.2 Dean Clinics

In 2024, Dean Clinic appointments were delivered face-to-face and remotely by technology-enabled care. Service User Experience Surveys were sent by email to service users attending Dean Clinic appointments remotely, with letters sent to service users who did not have an email informing them of how they could access the survey. Service users also sent responses via a QR code which was attached to Dean Clinic letters. Service users who attended appointments in person were given the Service User Experience Survey to complete onsite or to return by post. The survey received 745 responses in 2024 and the mode of collection was 610 by email, 85 paper format, 33 by QR code and 17 via the SPMHS website.

This is a considerable increase from 348 responses received in 2023. The increase in this response rate was the result of a big drive by the Dean Clinic staff to increase the service user experience response rates.

### Dean Clinic Survey Respondent Demographics

The majority of Dean Clinic survey responses in 2024 were from females (63%, n=473), aged between 61 and 80 years of age (40%, n=300) and who live in Leinster (67%, n=496). 49% (n=332) of respondents said they heard about the Dean Clinic while they were an inpatient.

Figure 5.1. *Gender profile of Dean Clinic survey respondents*

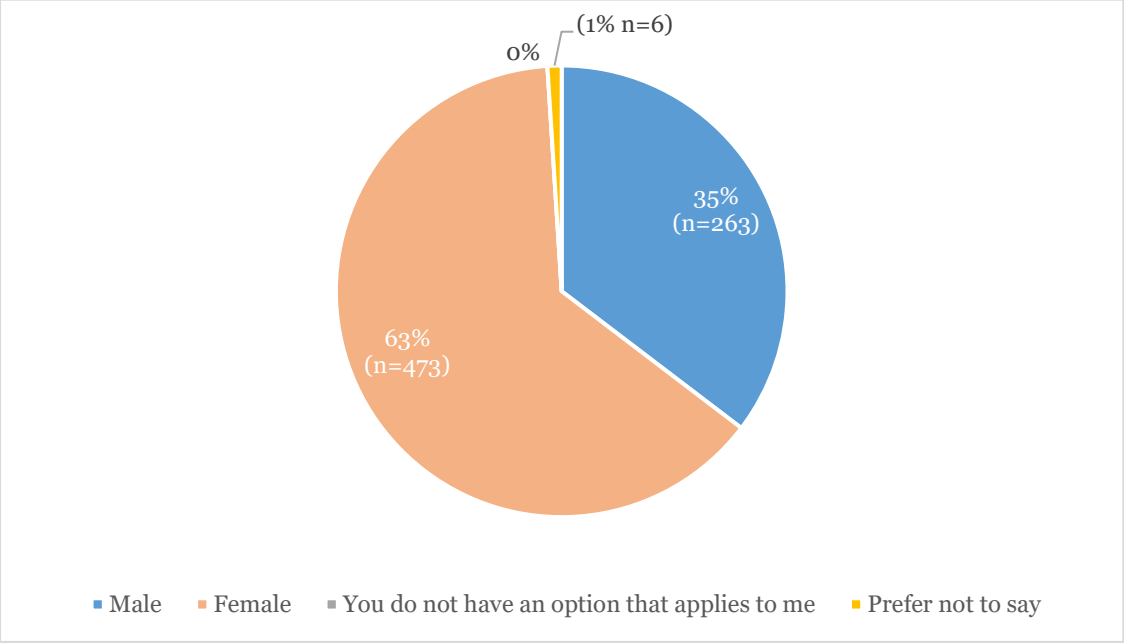



Figure 5.2. *Age profile of Dean Clinic survey respondents*

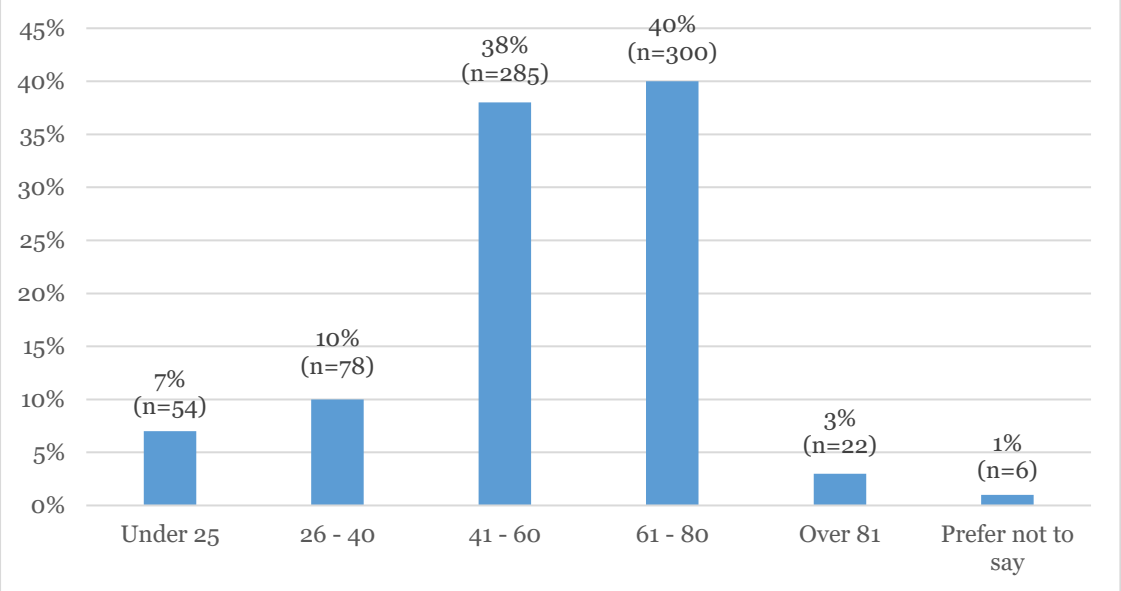


Figure 5.3. *Location of Dean Clinic survey respondents*

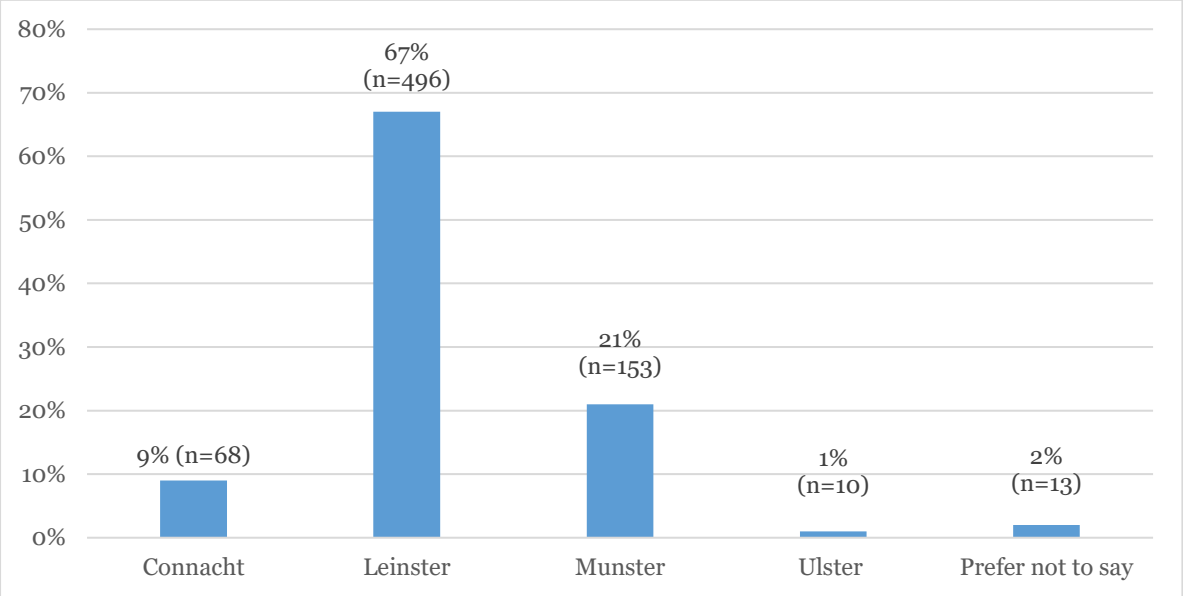



Figure 5.4. *How respondents heard about Dean Clinic*

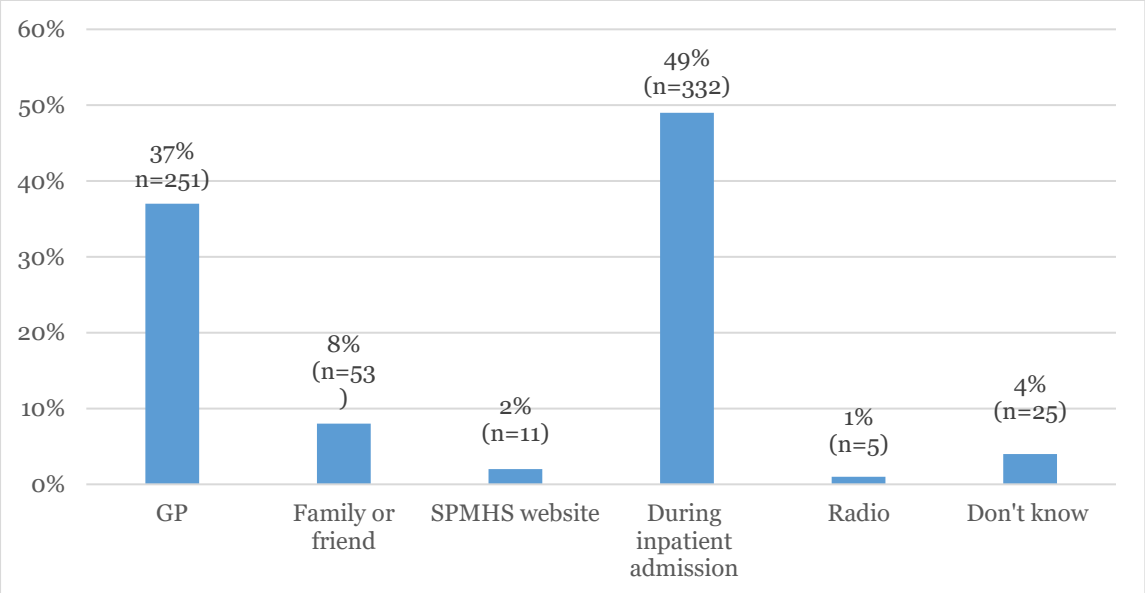
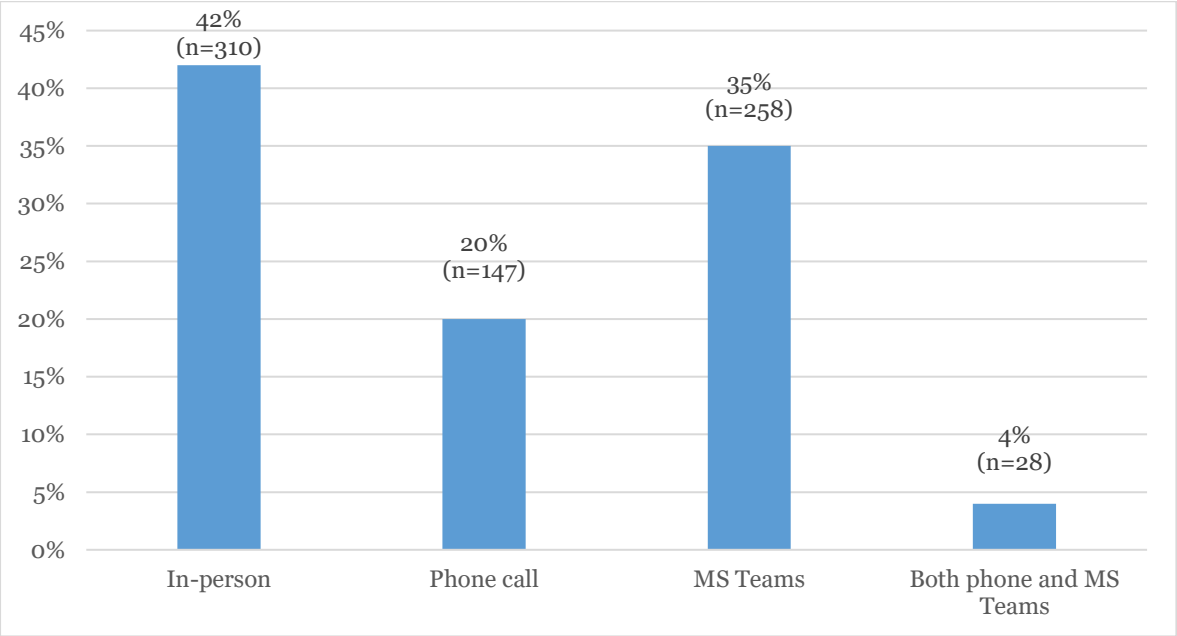


Figure 5.5. *How respondents attended their most recent Dean Clinic appointment*




## Dean Clinic in person appointment feedback

The following section of this report details the feedback provided by 38% (n=286) of Dean Clinic survey respondents who attended their appointments in person between January and December 2024.

## Experience of attending Dean Clinic appointment in person

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

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

| Please tell us about your experience of attending the Dean Clinic | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| It was convenient for me to access the Dean Clinic | 137 | 48 | 107 | 38 | 21 | 7 | 15 | 5 | 5 | 2 | **285** |
| I was welcomed in a friendly and professional manner by the Dean Clinic staff | 192 | 67 | 82 | 29 | 8 | 3 | 2 | 1 | 2 | 1 | **286** |
| I was shown where the facilities were in the Dean Clinic, such as the bathroom and waiting room | 157 | 55 | 82 | 29 | 25 | 9 | 16 | 9 | 4 | 1 | **284** |

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

| Tell us about your experience of your Dean Clinic appointment | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| I was treated with dignity and respect | 209 | 73 | 56 | 20 | 9 | 3 | 6 | 2 | 5 | 2 | **285** |
| My confidentiality was protected | 201 | 72 | 57 | 21 | 17 | 6 | 2 | 1 | 1 | 0 | **278** |
| My privacy was respected | 197 | 72 | 64 | 23 | 7 | 3 | 4 | 1 | 1 | 0 | **273** |
| I felt included in decisions about my treatment | 189 | 67 | 62 | 22 | 15 | 5 | 8 | 3 | 7 | 2 | **281** |
| I trusted my doctor or therapist or nurse | 200 | 71 | 51 | 18 | 16 | 6 | 6 | 2 | 9 | 3 | **282** |
| My appointment was value for money | 116 | 41 | 76 | 27 | 48 | 17 | 19 | 7 | 23 | 8 | **282** |
| I would recommend the Dean Clinic to family and friends | 156 | 55 | 78 | 28 | 27 | 10 | 6 | 2 | 16 | 6 | **283** |

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

| **How would you rate...?** | **...your care and treatment** | | **...experience of SPMHS overall** | |
|---|---|---|---|---|
| | n | **% Of those who responded** | n | **% Of those who responded** |
| 1 | 9 | 3 | 11 | 4 |
| 2 | 4 | 2 | 2 | 1 |
| 3 | 6 | 2 | 8 | 3 |
| 4 | 5 | 2 | 5 | 2 |
| 5 | 10 | 4 | 9 | 3 |
| 6 | 8 | 3 | 9 | 3 |
| 7 | 18 | 6 | 15 | 3 |
| 8 | 37 | 13 | 36 | 13 |
| 9 | 59 | 21 | 62 | 22 |
| 10 | 122 | 44 | 119 | 43 |
| No answer | 8 | - | 10 | - |
| 1-4 | 24 | 9 | 26 | 10 |
| 5+ | 254 | **91** | 250 | **90** |
| **Total** | 286 | 100 | 286 | 100 |

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

| **How would you rate...?** | **N** | **Mean (μ)** |
|---|---|---|
| Your care and treatment | 278 | 8.3 |
| Overall experience of SPMHS | 276 | 8.3 |

The average rating between one and 10 of care and treatment from 278 respondents who attended appointments in person was 8.3 out of 10. The average rating between one and 10 of overall experience of SPMHS from 276 respondents who attended appointments in person was 8.3 out of 10.

### Dean Clinic remote appointment feedback

The following section of this report details the feedback provided by 57% (n=422) Dean Clinic survey respondents who attended their appointments remotely between January and December 2024.

### Experience of attending Dean Clinic appointments remotely

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

### Devices used to attend Dean Clinic appointments remotely

The majority of Dean Clinic survey respondents used smartphones (38%, n=162), followed by laptops (33%, n=139). 10% (n=44) of respondents used a mobile phone without internet to attend their appointment remotely. 12% (n=52) used tablets and 6% (n=25) used personal computer (PC) to access their appointment remotely in 2024.

Figure 5.6. *Devices used by respondents to attend their most recent Dean Clinic appointment*

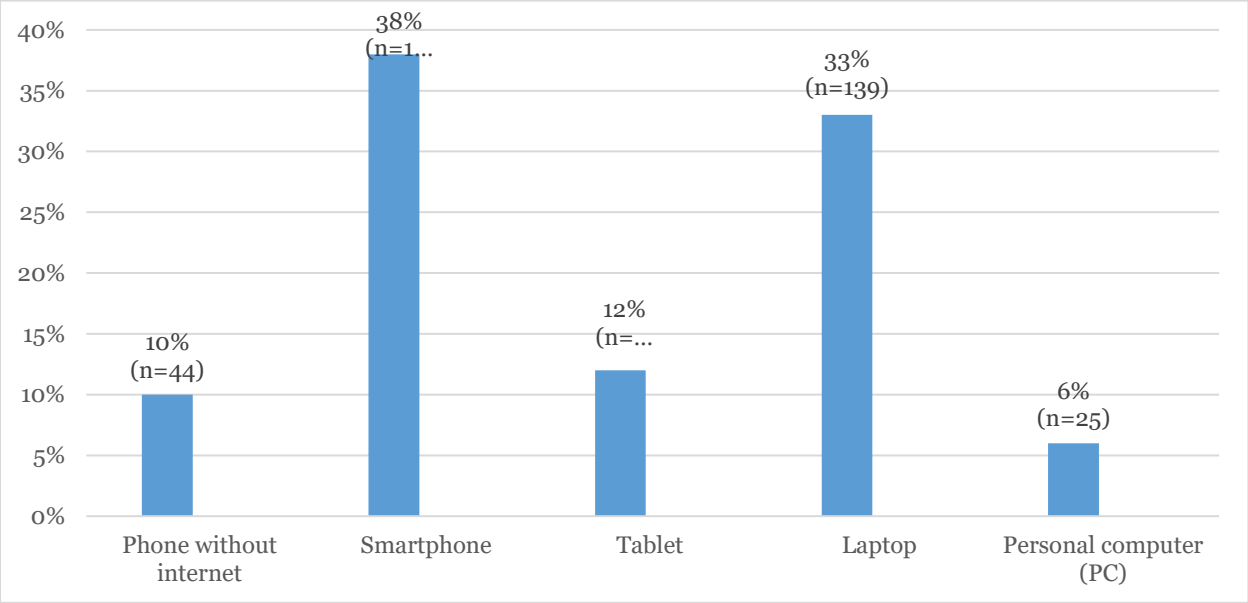


Figure 5.7. *Dean Clinic respondents who contacted the SUITS service for IT support to access their remote appointment*

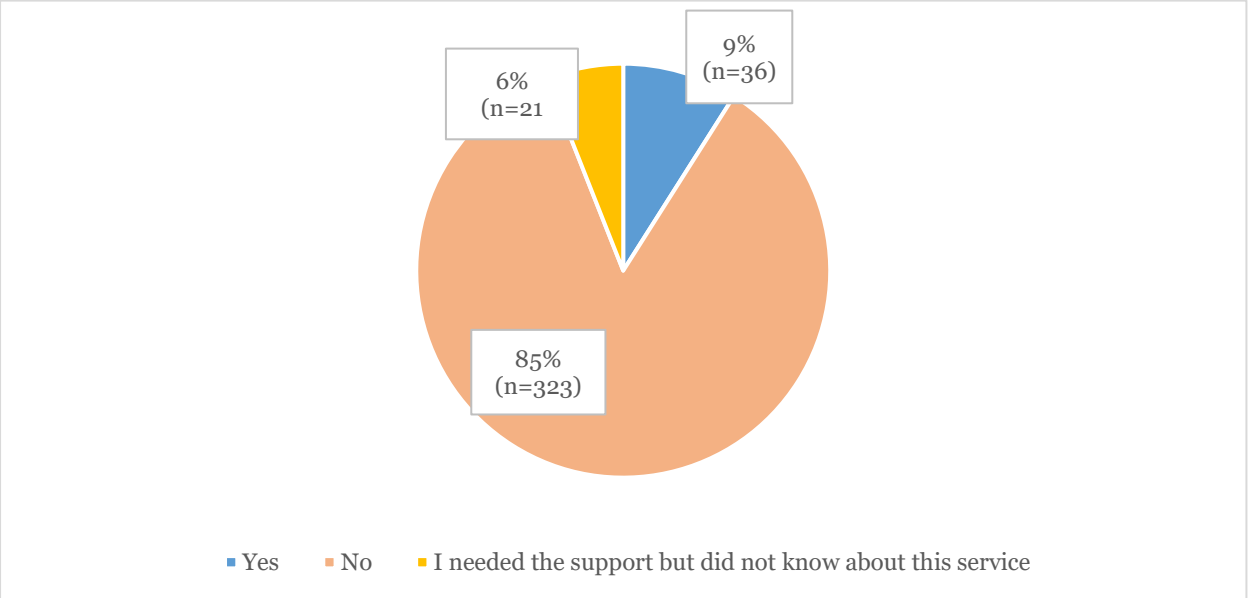



Table. 5.5. *Dean Clinic survey respondents' rating of experience of contacting the SUITS service*

| If you did contact the SUITS service | how would you rate the support they provided, | % Of those who responded |
|---|---|---|
| 1 | 2 | 5 |
| 2 | 0 | 0 |
| 3 | 1 | 2 |
| 4 | 0 | 0 |
| 5 | 1 | 2 |
| 6 | 3 | 7 |
| 7 | 3 | 7 |
| 8 | 5 | 11 |
| 9 | 5 | 11 |
| 10 | 24 | 55 |
| Number who answered | 44 | - |
| 1-4 | 3 | 7 |
| 5+ | 41 | **93** |

9% (n=44) of Dean Clinic survey respondents who attended appointments remotely answered this question based on their experience of the SUITS service in 2024. This saw

93% (n=41) of respondents provide a rating of five out of 10 stars or higher, down slightly from 95% in 2023. The average rating was 8.5 out of 10.

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

| **Please tell us about your experience of remotely accessing our services:** | **Strongly agree** | | **Agree** | | **Neither agree or disagree** | | **Disagree** | | **Strongly disagree** | | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **N** |
| It was convenient for me to access my appointment remotely | 236 | 62 | 110 | 29 | 19 | 5 | 11 | 3 | 6 | 2 | **382** |
| It was clearly explained to me how to access my appointment using either phone or video | 198 | 52 | 129 | 34 | 25 | 7 | 21 | 6 | 5 | 1 | **378** |
| Attending my appointment remotely was a positive experience | 191 | 50 | 125 | 33 | 30 | 8 | 27 | 7 | 11 | 3 | **384** |
| I would consider the option of attending Dean Clinic appointments by phone or video in the future | 188 | 49 | 117 | 30 | 44 | 11 | 27 | 7 | 8 | 2 | **384** |

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

| **Please tell us about your experience of remotely accessing our services:** | **Strongly agree** | | **Agree** | | **Neither agree or disagree** | | **Disagree** | | **Strongly disagree** | | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I was treated with dignity and respect | 295 | 76 | 66 | 17 | 11 | 3 | 7 | 2 | 7 | 2 | **386** |
| My confidentiality was protected | 280 | 74 | 75 | 20 | 17 | 4 | 2 | 1 | 5 | 1 | **379** |
| My privacy was respected | 274 | 72 | 83 | 22 | 16 | 4 | 2 | 1 | 5 | 1 | **380** |
| I felt included in decisions about my treatment | 256 | 66 | 77 | 20 | 25 | 6 | 16 | 4 | 11 | 3 | **385** |
| I trusted my doctor or therapist or nurse | 277 | 72 | 62 | 16 | 19 | 5 | 18 | 5 | 10 | 3 | **386** |
| My appointment was value for money | 166 | 43 | 91 | 23 | 68 | 17 | 32 | 8 | 32 | 8 | **389** |
| I would recommend the Dean Clinic to family and friends | 223 | 58 | 90 | 24 | 40 | 10 | 13 | 3 | 16 | 4 | **382** |

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

| **How would you rate…?** | **…your care and treatment** | | **…experience of SPMHS overall** | |
|---|---|---|---|---|
| | n | **% Of those who responded** | n | **% Of those who responded** |
| 1 | 13 | 4 | 13 | 4 |
| 2 | 7 | 2 | 9 | 2 |
| 3 | 9 | 2 | 11 | 3 |
| 4 | 9 | 2 | 11 | 3 |
| 5 | 18 | 5 | 19 | 5 |
| 6 | 10 | 3 | 11 | 3 |
| 7 | 27 | 7 | 26 | 7 |
| 8 | 39 | 10 | 40 | 11 |
| 9 | 63 | 16 | 60 | 15 |
| 10 | 187 | 49 | 177 | 47 |
| No answer | 40 | - | 45 | - |
| 1-4 | 38 | 10 | 44 | 12 |
| 5+ | 344 | **90** | 333 | **88** |
| Total | 422 | 100 | 422 | 100 |

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

| How would you rate...? | N | Mean (μ) |
|---|---|---|
| Your care and treatment | **382** | **8.3** |
| Overall experience of SPMHS | **378** | **8.1** |

The average rating between one and 10 of care and treatment from 382 respondents who attend appointments remotely was 8.3 out of 10. The average rating between one and 10 of overall experience of SPMHS from 378 respondents who attended appointments remotely was 8.1 out of 10.

## 5.3. Adult inpatient services

Service users discharged from inpatient and Homecare treatment between January and December 2024 were invited to complete either the inpatient Service User Experience Survey or the Homecare Service User Experience Survey.

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

253 responses were received to the inpatient Service User Experience Survey and 41 to the Homecare Service User Experience Survey. This is a total of 294 responses for this 12-month period.

### 5.3.1. Demographics

The majority of respondents to the inpatient survey in 2024 were female (57%, n=144), aged between 41 and 60 years of age (41%, n=103), and living in Leinster (65%, n=166).

Figure 5.8. *Gender profile of inpatient survey respondents in 2024*

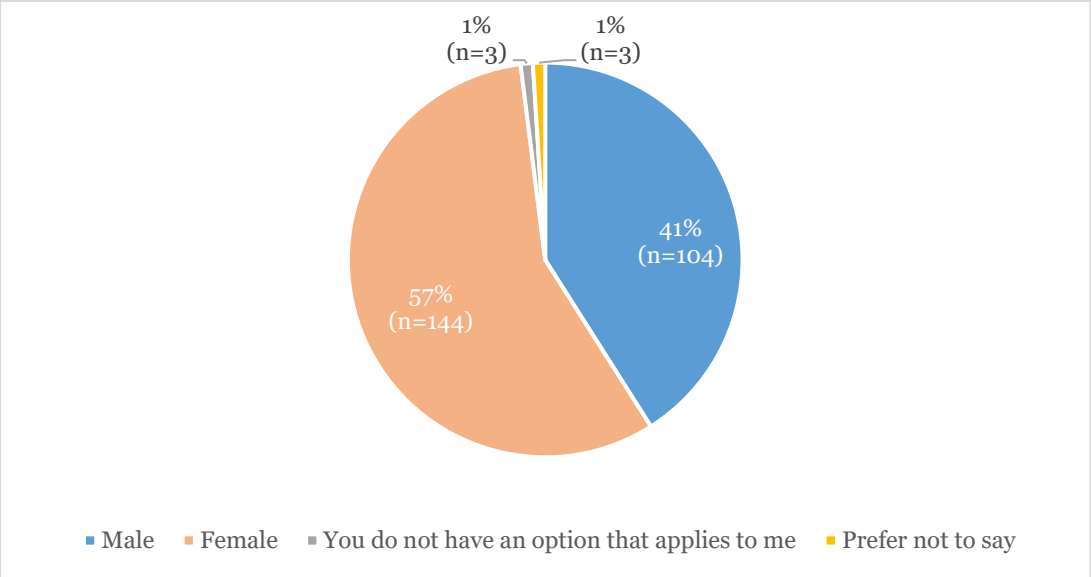



*Figure 5.9. Age profile of inpatient survey respondents in 2024*

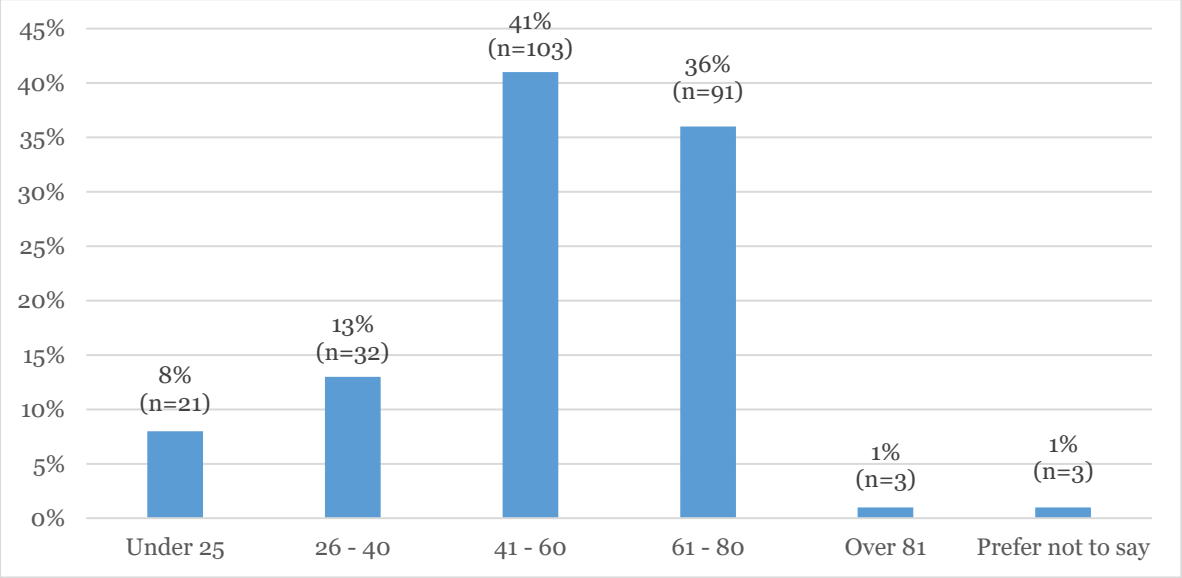


Figure 5.10. *Location of inpatient survey respondents in 2024*

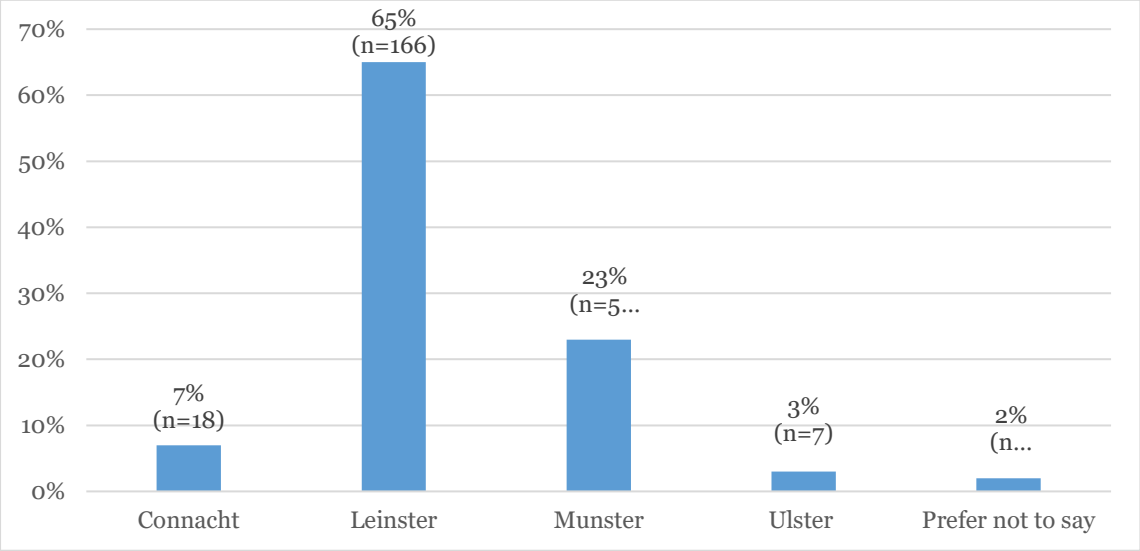


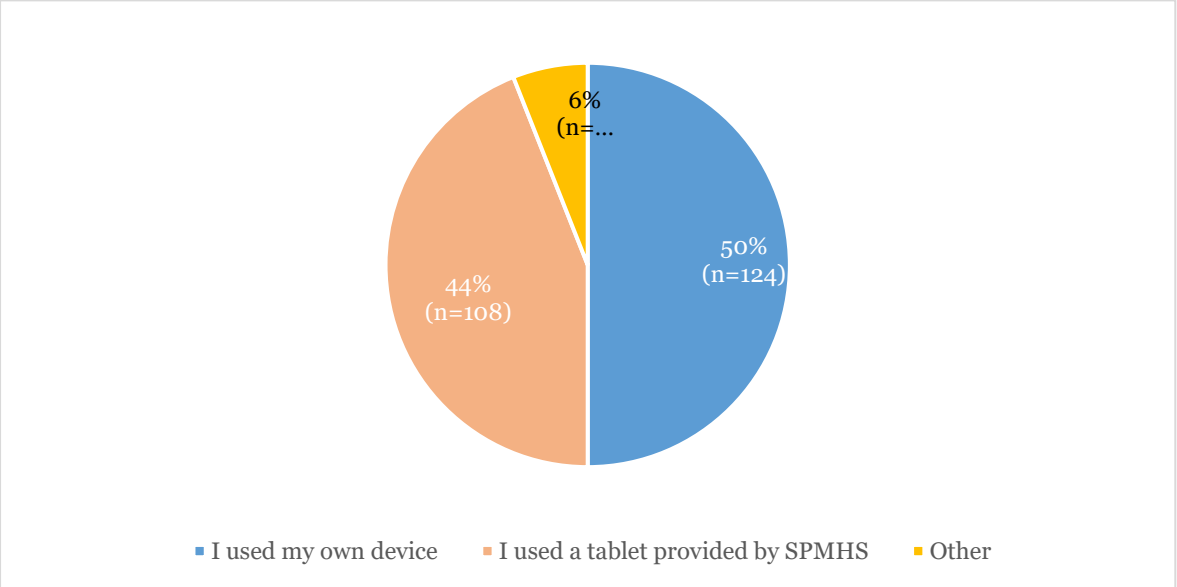

Table 5.10. *Respondents' opinions regarding their experience of admission to hospital in 2024*

| Tell us about your experience of admission | Strongly agree | | Agree | | Disagree | | Neither agree or disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| The admission process was explained to me by a member of staff | 132 | 52 | 99 | 39 | 9 | 4 | 10 | 4 | 4 | 2 | **254** |
| The ward routine, such as mealtimes and visiting arrangements, was explained to me by a member of staff | 120 | 48 | 90 | 36 | 16 | 6 | 20 | 8 | 6 | 2 | **252** |
| The activities available to me, and how to access them, was explained to me by a member of staff | 96 | 38 | 92 | 36 | 24 | 9 | 35 | 14 | 6 | 2 | **253** |
| Shortly after I was admitted, a member of staff explained how I would access appointments and activities remotely | 83 | 33 | 95 | 38 | 35 | 14 | 24 | 10 | 6 | 14 | **251** |
| I found inpatient activities easy to access | 103 | 41 | 113 | 45 | 19 | 8 | 14 | 6 | 3 | 1 | **252** |

### Accessing remote inpatient appointments and activities

44% (n=108) respondents said they used a tablet provided by SPMHS to access remote appointments and activities while they were an inpatient in 2024.

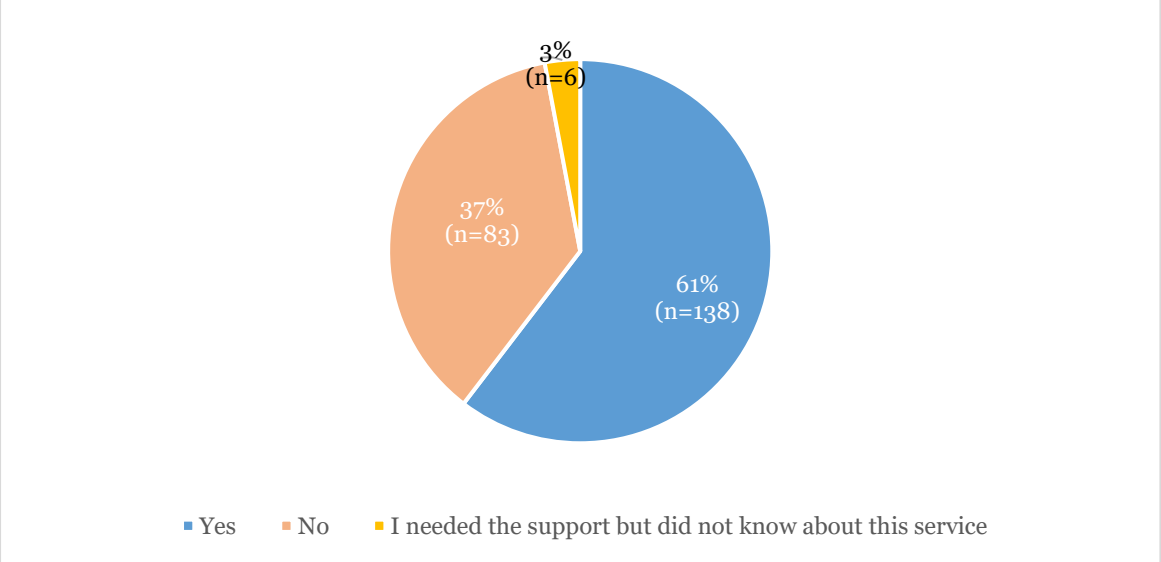
Figure 5.11. *Devices used by respondents to access remote appointments and activities during their inpatient admission.*




### IT Support

Survey respondents were asked if they needed technical support, and if they did, if they then contacted the Service User IT Support (SUITS) service.

Figure 5.12. *Respondents who contacted the Service User IT Support (SUITS) service*



### Experience of SUITS service for inpatient respondents

Inpatient survey respondents who contacted the SUITS service during their inpatient treatment were asked to rate their experience on a scale of 1 to 10, where 1 star is poor, and 10 stars is excellent.

95% (n=145) of respondents provided a rating of 5 stars or higher out of 10 for their experience of the SUITS service between January and December 2025. The average rating was 8.5 out of 10.

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

| **If you did contact the SUITS service** | **how would you rate the support they provided** | **% Of those who responded** |
|---|---|---|
| **Rating** | **n** | **%** |
| 1 | 2 | 1 |
| 2 | 1 | 1 |
| 3 | 2 | 1 |
| 4 | 3 | 2 |
| 5 | 13 | 9 |
| 6 | 2 | 1 |
| 7 | 11 | 7 |
| 8 | 23 | 15 |
| 9 | 14 | 9 |
| 10 | 82 | 54 |
| Number who answered | 153 | - |
| 1-4 | 8 | 5 |
| 5+ | 145 | **95** |

### Hospital staff

Respondents to the inpatient survey were asked to rate their experience of the staff who cared for them using the options of poor, good, excellent, or 'not applicable'.

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

| | Poor | | Good | | Excellent | | Not applicable | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n |
| Nursing staff | 13 | 5 | 46 | 18 | 195 | 77 | 0 | 0 | **254** |
| Consultant psychiatrist | 18 | 7 | 40 | 16 | 190 | 75 | 6 | 2 | **254** |
| Registrar | 14 | 6 | 79 | 31 | 148 | 59 | 12 | 5 | **253** |
| Key Worker | 27 | 11 | 76 | 30 | 113 | 45 | 34 | 14 | **250** |
| Psychologist | 9 | 4 | 33 | 13 | 115 | 47 | 90 | 36 | **247** |
| Occupational Therapist | 6 | 2 | 44 | 18 | 96 | 39 | 101 | 41 | **247** |
| Social Worker | 8 | 3 | 35 | 14 | 64 | 26 | 138 | 56 | **245** |
| Pharmacist | 7 | 3 | 54 | 22 | 112 | 45 | 77 | 31 | **250** |
| Healthcare Assistant | 10 | 4 | 40 | 16 | 47 | 117 | 81 | 33 | **248** |
| Household staff | 8 | 3 | 42 | 17 | 182 | 72 | 21 | 8 | **253** |
| Catering staff | 9 | 4 | 52 | 20 | 188 | 74 | 5 | 2 | **254** |
| Other (e.g. Counsellor, therapist etc) | 6 | 3 | 42 | 18 | 98 | 42 | 88 | 38 | **234** |

Table 5.13. *Respondents' overall experience while an inpatient in St Patrick's Hospital in 2024*

| | Strongly agree | | Agree | | Neither agree nor disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| The quality of food available was of a high standard | 66 | 26 | 88 | 35 | 49 | 19 | 31 | 12 | 18 | 7 | **252** |
| There was a good selection of food available | 64 | 25 | 97 | 38 | 34 | 13 | 39 | 15 | 18 | 7 | **252** |
| The daily activities provided were interesting and helpful | 93 | 37 | 102 | 40 | 37 | 15 | 15 | 6 | 6 | 2 | **253** |
| The weekend activities were interesting and helpful | 35 | 14 | 87 | 35 | 66 | 26 | 36 | 14 | 26 | 10 | **250** |
| The cleanliness in the hospital was of a high standard | 152 | 60 | 74 | 29 | 12 | 5 | 7 | 3 | 8 | 3 | **253** |
| My accommodation was of a high standard | 103 | 41 | 80 | 32 | 39 | 16 | 23 | 9 | 6 | 2 | **251** |

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

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I was given notice of my discharge | 133 | 53 | 91 | 36 | 10 | 4 | 9 | 4 | 10 | 4 | **253** |
| I felt ready to be discharged | 125 | 49 | 85 | 33 | 23 | 9 | 9 | 4 | 12 | 5 | **253** |
| I was provided with details about the day programmes available at SPMHS | 77 | 31 | 84 | 33 | 34 | 14 | 33 | 13 | 23 | 9 | **251** |
| I was provided with details of my follow up appointments | 96 | 38 | 98 | 39 | 17 | 7 | 18 | 7 | 23 | 9 | **252** |
| Following my admission, I am confident that I would know what to do in the event of a possible future mental health crisis | 122 | 48 | 85 | 34 | 21 | 8 | 10 | 4 | 15 | 6 | **253** |

### Attitudes towards mental health

To better understand respondents' attitude towards mental health, respondents were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, strongly disagreed with or disagreed with statements about their own perceptions when leaving hospital.

Table 5.15. *Respondents' attitudes towards mental health*

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I felt comfortable talking about my mental health prior to my inpatient admission | 66 | 26 | 77 | 31 | 30 | 12 | 61 | 24 | 17 | 7 | **251** |
| I would feel comfortable talking to family about my mental health following my inpatient admission | 94 | 37 | 95 | 38 | 29 | 12 | 20 | 8 | 13 | 5 | **251** |
| I would feel comfortable talking to friends about my mental health following my inpatient admission | 78 | 31 | 103 | 41 | 37 | 15 | 20 | 8 | 13 | 5 | **251** |
| I would feel comfortable talking to colleagues about my mental health following my inpatient admission | 41 | 16 | 50 | 20 | 80 | 32 | 45 | 18 | 34 | 14 | **250** |

Table 5.16. *Recommending SPMHS to others*

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I would recommend St Patrick's Mental Health Services to others | 160 | 63 | 52 | 21 | 20 | 8 | 9 | 4 | 12 | 5 | **253** |

### Overall experience of inpatient care and treatment

Respondents to the inpatient survey are asked to rate on a scale of 1 to 10 their overall experience of the inpatient care and treatment they received while attending St Patrick's Hospital, where 1 star is poor, and 10 stars is excellent.

The average rating between one and 10 of care and treatment from 250 inpatient survey respondents was 7.9 out of 10. The average rating between one and 10 of the overall experience of SPMHS from 247 inpatient survey respondents was 7.8 out of 10.

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

| How would you rate...? | ...your care and treatment | | ... overall experience of SPMHS | |
|---|---|---|---|---|
| | n | % Of those who responded | n | % Of those who responded |
| 1 | 7 | 3 | 10 | 4 |
| 2 | 3 | 1 | 4 | 2 |
| 3 | 10 | 4 | 5 | 2 |
| 4 | 6 | 2 | 12 | 5 |
| 5 | 18 | 7 | 16 | 6 |
| 6 | 8 | 3 | 8 | 3 |
| 7 | 24 | 10 | 23 | 9 |
| 8 | 44 | 18 | 40 | 16 |
| 9 | 38 | 15 | 44 | 18 |
| 10 | 92 | 37 | 85 | 34 |
| No answer | | | | |
| 1-4 | 26 | 10 | 31 | 13 |
| 5+ | 224 | **90** | 216 | **87** |
| Total | 250 | 100 | 247 | 100 |

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

| How would you rate...? | N | Mean (μ) |
|---|---|---|
| Your overall care and treatment | 250 | 7.9 |
| Overall experience of SPMHS | 247 | 7.8 |

## 5.4. Homecare Service User Experience Survey

This section provides an overview of the feedback received from 41 respondents to the Homecare survey between January and December 2024.

### Homecare survey respondent demographics

The majority of Homecare survey respondents in 2024 were female (61%, n=25), aged between 41 and 60 years (41%, n=17), and who live in Leinster (60%, n=24).

Figure 5.13. *Gender profile of Homecare survey respondents in 2024*

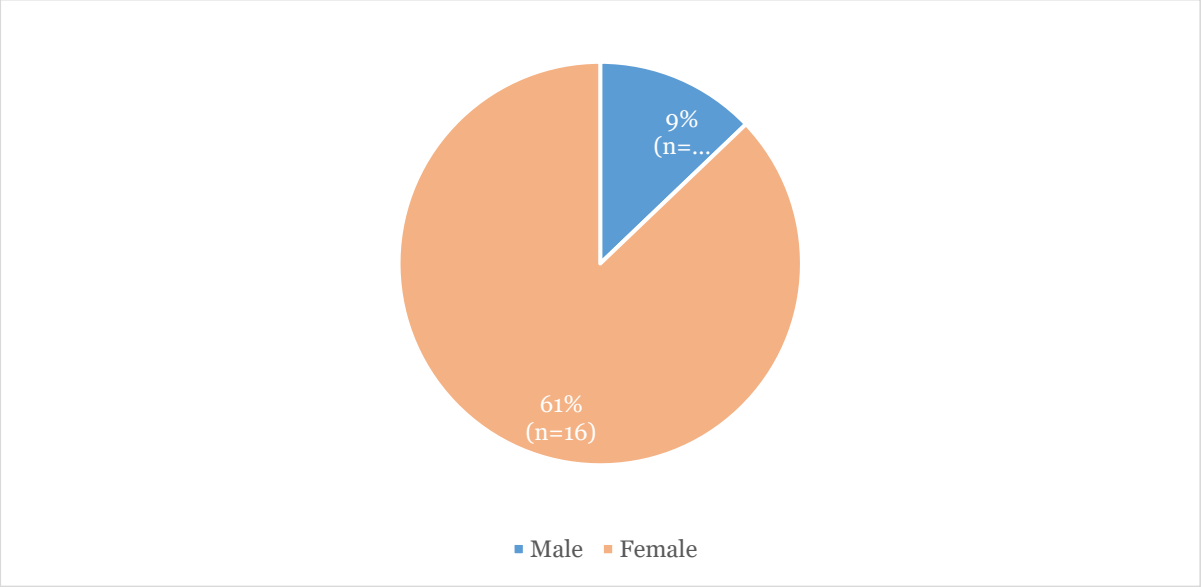



Figure 5.14. *Age profile of Homecare survey respondents in 2024*

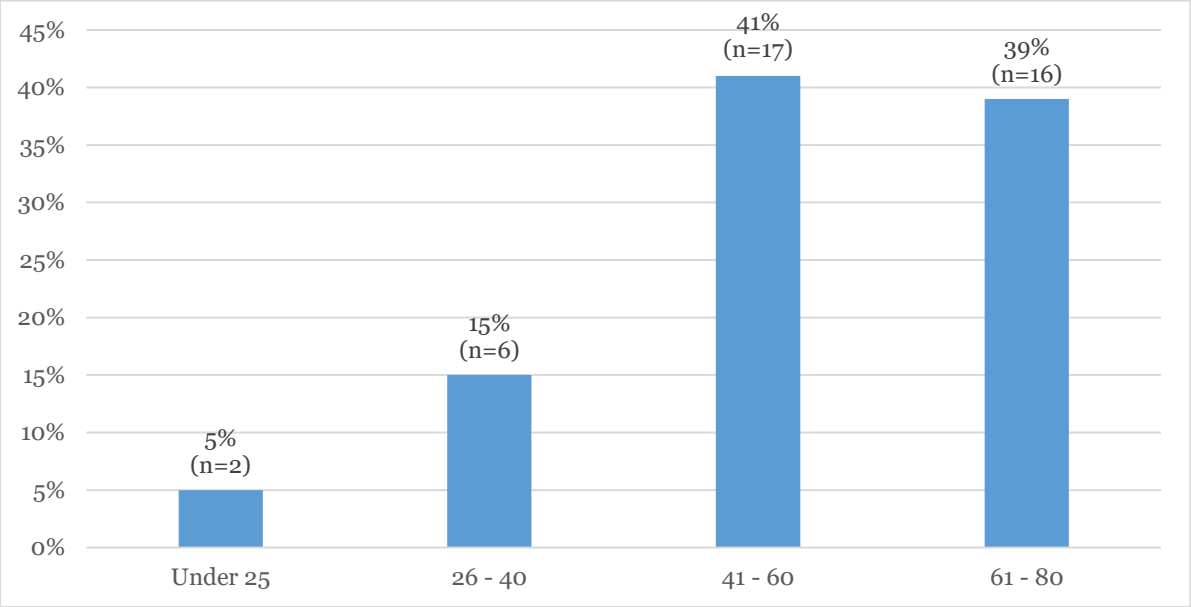
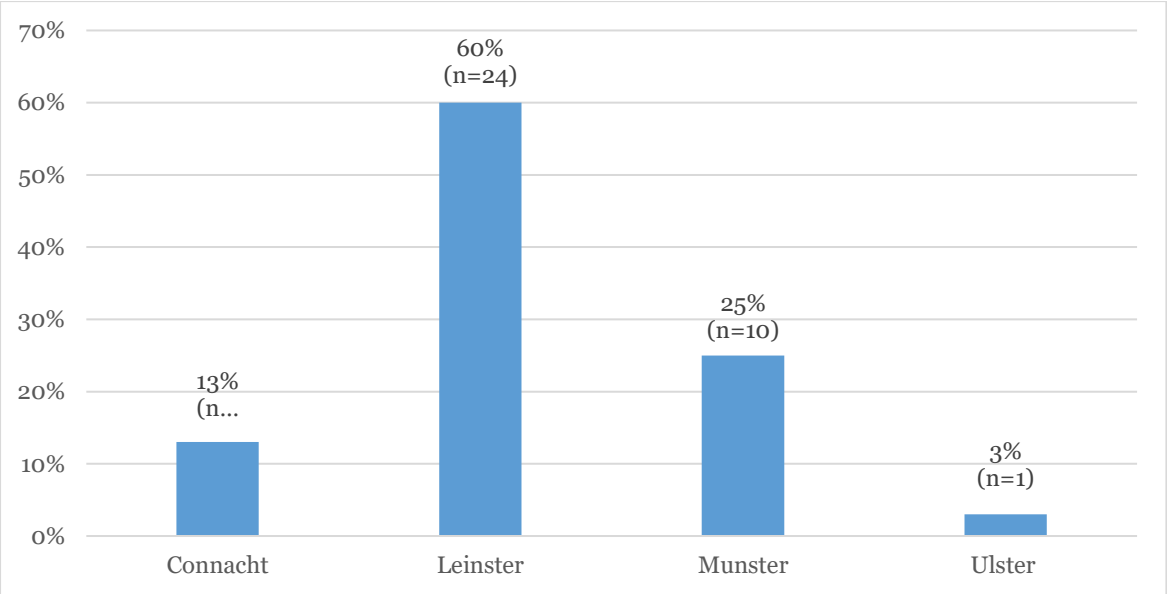


Figure 5. 15. *Location of Homecare survey respondents in 2024*




### Type of admission

Respondents are asked to indicate if their admission was Homecare only or if they had also been admitted as an inpatient.

Figure 5. 16. *Type of admission*

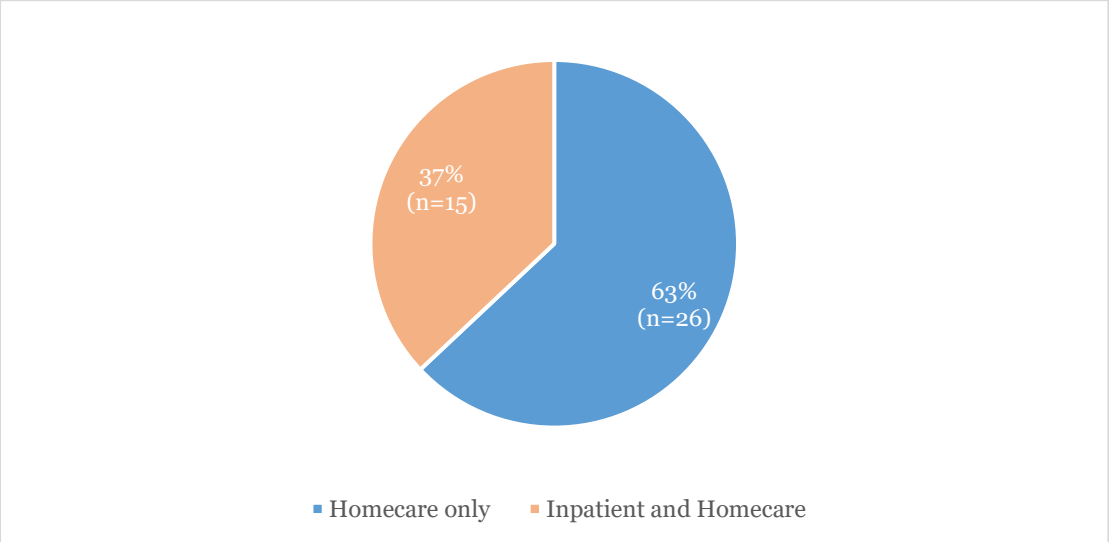


Figure 5.17. *How respondents accessed Homecare services*

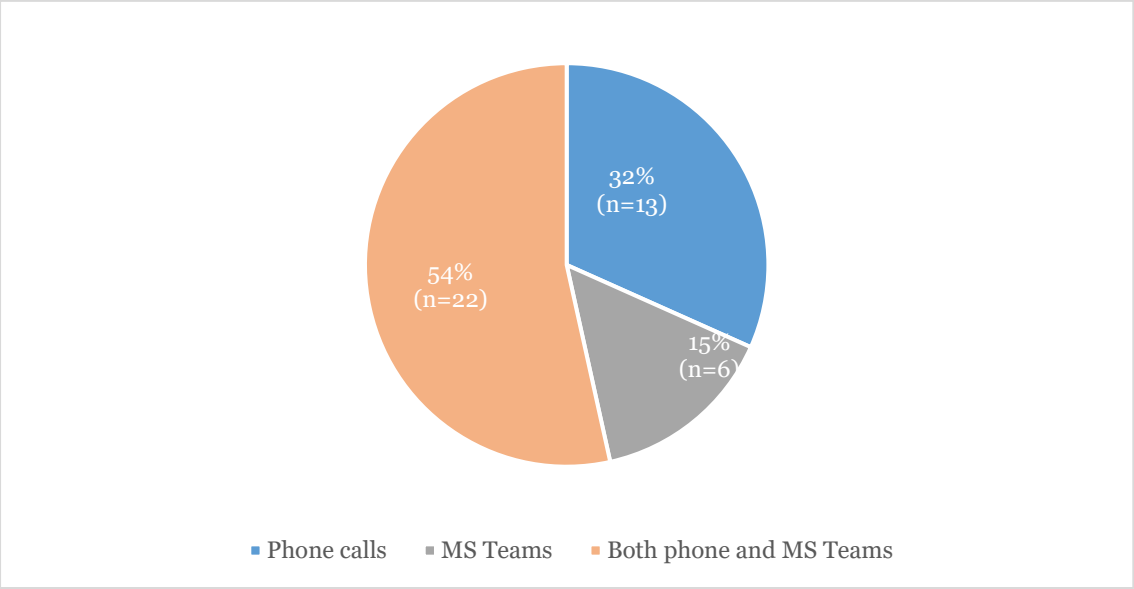
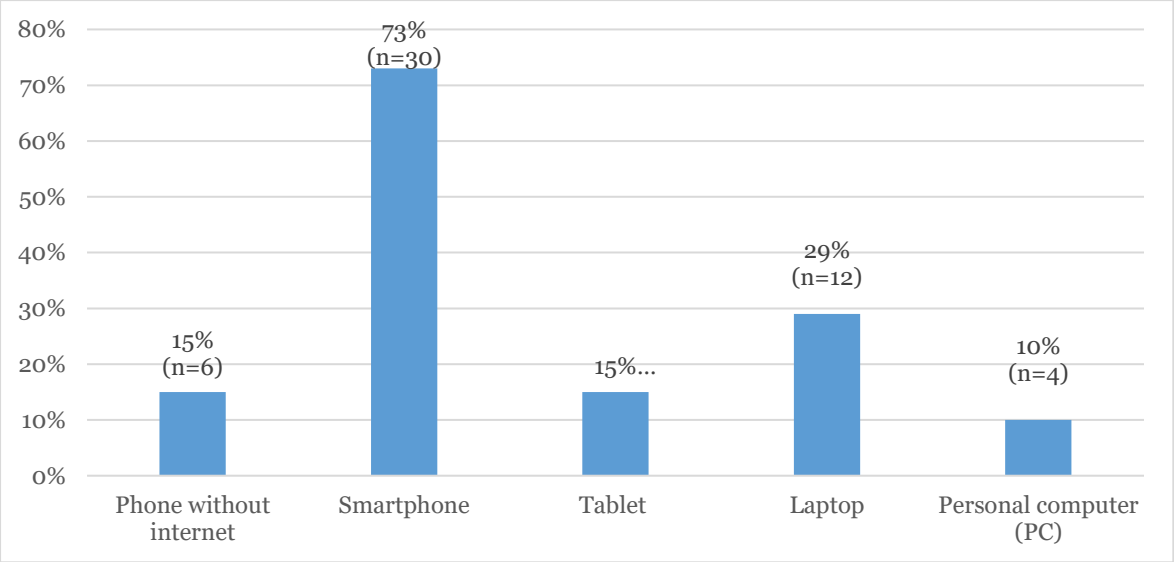
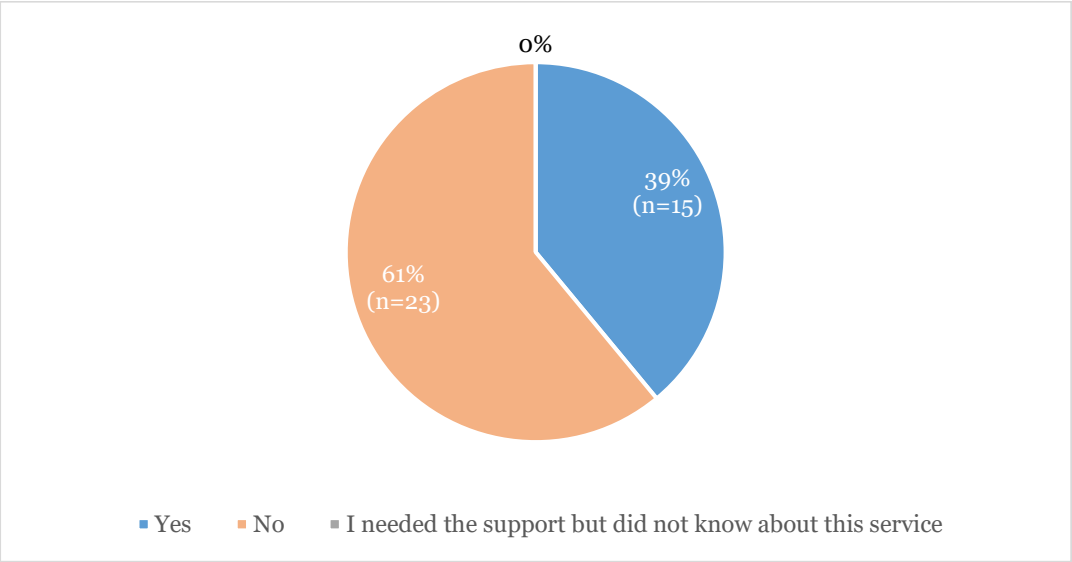



Figure 5.18. *Type of devices used by respondents to access Homecare appointment and activities*



### IT Support

Figure 5. 19. *Respondents who accessed the SUITS service to access Homecare appointments and activities*




39% (n=15) of respondents said they did contact SUITS, a decrease from 35% in 2023. 61% (n=23) of Homecare survey respondents said they did not contact the SUITS service for IT support to access services in 2024, down from 61% in 2023. No respondents said they needed support but were unaware of this service.

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

| **If you did contact the SUITS service** | **how would you rate the support they provided,** | **% Of those who responded** |
|---|---|---|
| **Rating** | **n** | **%** |
| 1 | 0 | 0 |
| 2 | 0 | 0 |
| 3 | 0 | 0 |
| 4 | 0 | 0 |
| 5 | 2 | 10 |
| 6 | 0 | 0 |
| 7 | 4 | 20 |
| 8 | 2 | 10 |
| 9 | 4 | 20 |
| 10 | 8 | 40 |
| Number who answered | 20 | 100 |
| 1-4 | 0 | 0 |
| 5+ | 20 | **100** |

Table 5.20. *Homecare survey respondents' experience of beginning Homecare in 2024*

| Tell us about your experience of beginning Homecare | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | n | % | n | % | n | % | n | % | n |
| How to access care and treatment while on Homecare was clearly explained to me | 20 | 49 | 18 | 44 | 1 | 2 | 2 | 5 | 0 | 0 | **41** |
| The activities available to me, and how to access them, were explained to me by a member of staff | 20 | 49 | 17 | 41 | 2 | 5 | 2 | 5 | 0 | 0 | **41** |
| I found Homecare services easy to access | 21 | 53 | 15 | 38 | 1 | 3 | 3 | 8 | 0 | 0 | **40** |

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

| | Poor | | Good | | Excellent | | Not Applicable | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n |
| Nursing staff | 1 | 2 | 11 | 27 | 29 | 71 | 0 | 0 | **41** |
| Consultant psychiatrist | 2 | 5 | 5 | 13 | 33 | 83 | 0 | 0 | **40** |
| Registrar | 3 | 8 | 6 | 15 | 25 | 64 | 5 | 16 | **39** |
| Key worker | 2 | 5 | 9 | 23 | 23 | 57 | 6 | 15 | **40** |
| Psychologist | 3 | 7 | 2 | 5 | 21 | 51 | 15 | 37 | **41** |
| Occupational Therapist | 0 | 0 | 2 | 5 | 20 | 40 | 19 | 46 | **41** |
| Social worker | 2 | 5 | 1 | 3 | 13 | 35 | 21 | 57 | **37** |
| Pharmacist | 5 | 13 | 8 | 21 | 12 | 32 | 13 | 34 | **38** |
| Healthcare Assistant | 0 | 0 | 6 | 15 | 14 | 36 | 19 | 49 | **39** |
| Other | 0 | 0 | 7 | 17 | 12 | 29 | 22 | 54 | **41** |

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

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I felt using MS Teams and/or telephone calls did not prevent me from being able to express myself when talking to my team | 25 | 61 | 7 | 17 | 4 | 10 | 4 | 10 | 1 | 2 | **41** |
| I felt using MS Teams and/or telephone calls did not stop me from feeling understood by my team | 25 | 61 | 7 | 17 | 5 | 12 | 3 | 7 | 1 | 2 | **41** |
| I had access to my prescription and medication | 24 | 60 | 15 | 38 | 0 | 0 | 1 | 3 | 0 | 0 | **40** |
| I received regular calls from my consultant | 21 | 51 | 13 | 32 | 2 | 5 | 4 | 10 | 1 | 2 | **41** |
| I received regular calls from nursing staff | 33 | 80 | 7 | 17 | 1 | 2 | 0 | 0 | 0 | 0 | **41** |
| I received regular calls from my key worker | 11 | 28 | 13 | 33 | 8 | 21 | 1 | 3 | 6 | 15 | **39** |
| I felt any issues I had were understood by my team | 24 | 59 | 9 | 22 | 4 | 10 | 3 | 7 | 1 | 2 | **41** |
| I felt any issues I had were addressed by my team | 22 | 54 | 14 | 34 | 2 | 5 | 2 | 5 | 1 | 2 | **41** |

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

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I was given notice of my discharge | 17 | 44 | 18 | 46 | 3 | 8 | 1 | 3 | 0 | 0 | **39** |
| I felt ready to leave Homecare | 17 | 43 | 16 | 40 | 7 | 18 | 0 | 0 | 0 | 0 | **40** |
| I was provided with details about St Patricks' day services | 13 | 32 | 17 | 41 | 5 | 12 | 4 | 10 | 2 | 5 | **41** |
| I was provided with details of my follow-up appointments | 22 | 54 | 16 | 39 | 0 | 0 | 1 | 2 | 2 | 5 | **41** |
| I know what to do in the event of a further mental health crisis | 22 | 54 | 14 | 34 | 4 | 10 | 0 | 0 | 1 | 2 | **41** |
| I would consider the option of attending appointments with my SPMHS team by MS Teams or phone in the future | 24 | 59 | 9 | 22 | 0 | 0 | 6 | 15 | 2 | 5 | **41** |

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

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I felt comfortable talking about my mental health to friends and family prior to my Homecare admission | 12 | 29 | 5 | 12 | 3 | 7 | 21 | 51 | 0 | 0 | **41** |
| I would feel comfortable talking to family about my mental health following my Homecare admission | 20 | 49 | 8 | 20 | 9 | 22 | 3 | 7 | 1 | 2 | **41** |
| I would feel comfortable talking to friends about my mental health following my Homecare admission | 14 | 34 | 6 | 15 | 10 | 24 | 9 | 22 | 2 | 5 | **41** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| I would feel comfortable talking to colleagues about my mental health following my Homecare admission | 8 | 20 | 3 | 7 | 12 | 29 | 13 | 32 | 5 | 12 | **41** |

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

| | **Strongly agree** | | **Agree** | | **Neither agree or disagree** | | **Disagree** | | **Strongly disagree** | | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I would recommend St Patrick's Mental Health Services to others | 33 | 80 | 4 | 10 | 3 | 7 | 0 | 0 | 2 | 1 | **41** |

### Overall experience of Homecare care and treatment

Respondents to the Homecare survey are asked to rate on a scale of 1 to 10 their overall experience of the care and treatment they received while on Homecare, where 1 star is poor, and 10 stars is excellent.

Table 5.26. *Homecare respondents' ratings of care and treatment and overall experience of SPMHS*

| **How would you rate...?** | **...your care and treatment** | | **... overall experience of SPMHS** | |
|---|---|---|---|---|
| | N | **% Of those who responded** | n | **% Of those who responded** |
| 1 | 1 | 2 | 1 | 2 |
| 2 | 0 | 0 | 0 | 0 |
| 3 | 1 | 2 | 1 | 2 |
| 4 | 0 | 0 | 0 | 0 |
| 5 | 2 | 5 | 1 | 2 |
| 6 | 1 | 2 | 2 | 5 |
| 7 | 1 | 2 | 2 | 5 |
| 8 | 8 | 20 | 7 | 17 |
| 9 | 7 | 17 | 7 | 17 |
| 10 | 20 | 40 | 20 | 40 |
| No answer | 0 | - | 0 | - |
| 1-4 | 2 | 4 | 2 | 4 |
| 5+ | 39 | **96** | 40 | **96** |
| Total | 41 | 100 | 42 | 100 |

#Table 5.27. *Homecare respondents' ratings of care and treatment and overall experience of SPMHS*

| How would you rate...? | N | Mean (μ) |
|---|---|---|
| Your care and treatment | 41 | 8.6 |
| Overall experience of SPMHS | 42 | 8.6 |

The average rating between one and 10 of care and treatment from 41 Homecare survey respondents was 8.6 out of 10. The average rating between one and 10 of the overall experience of SPMHS from 42 Homecare survey respondents was 8.8 out of 10.

## 5.5. Day programme services

SPMHS offers mental health programmes through the day service's Wellness and Recovery Centre. A range of programmes are offered either in person at St Patricks University Hospital or remotely via MS Teams. The programmes aim to support people experiencing recovery from mental ill-health and promote positive mental health.

### 5.5.1. Survey response rate

In 2024, 773 Day Programme service users were invited by email to complete the Day Programme Service User Experience Survey. A further 41 service users were invited by letter to complete this survey.

The Day Programme Service User Experience Survey received 96 responses in 2024. This is a decrease from the 145 responses received in 2023. Several day programmes invite participants to provide feedback by completing surveys that are programme specific and this may account for the low number of responses received to the Day Programmes Service User Experience Survey.

Table 5. 28. *Day service programmes attended by survey respondents*

| Name of programme | n | % |
|---|---|---|
| Acceptance & Commitment Therapy (ACT) | 17 | 19 |
| Access to Recovery Programme | 27 | 30 |
| Aftercare | 9 | 10 |
| Anxiety Disorders Programme | 6 | 7 |
| *Bipolar Recovery Programme | 1 | 1 |
| *Compassion Focused Therapy | 5 | 5 |
| *Depression Recovery Programme | 3 | 3 |
| Formulation | 1 | 1 |
| *Group Radical Openness (GRO) | 2 | 2 |
| *Healthy Self-Esteem Programme | 1 | 1 |
| Pathways to Wellness Programme | 7 | 8 |
| Recovery (WRAP®) Programme | 12 | 13 |
| Total | 91 | 100 |

### Day programmes survey respondent demographics

The majority of day programme survey respondents in 2024 were female (63%, n=60), aged between 41 and 60 (48%, n=46) years of age and who live in the Leinster region (73%, n=70). The majority of feedback (30%, n=27) was provided by respondents who attended the *Access to Recovery* programme.

Figure 5.20. *Gender profile of day programme survey respondents in 2024*

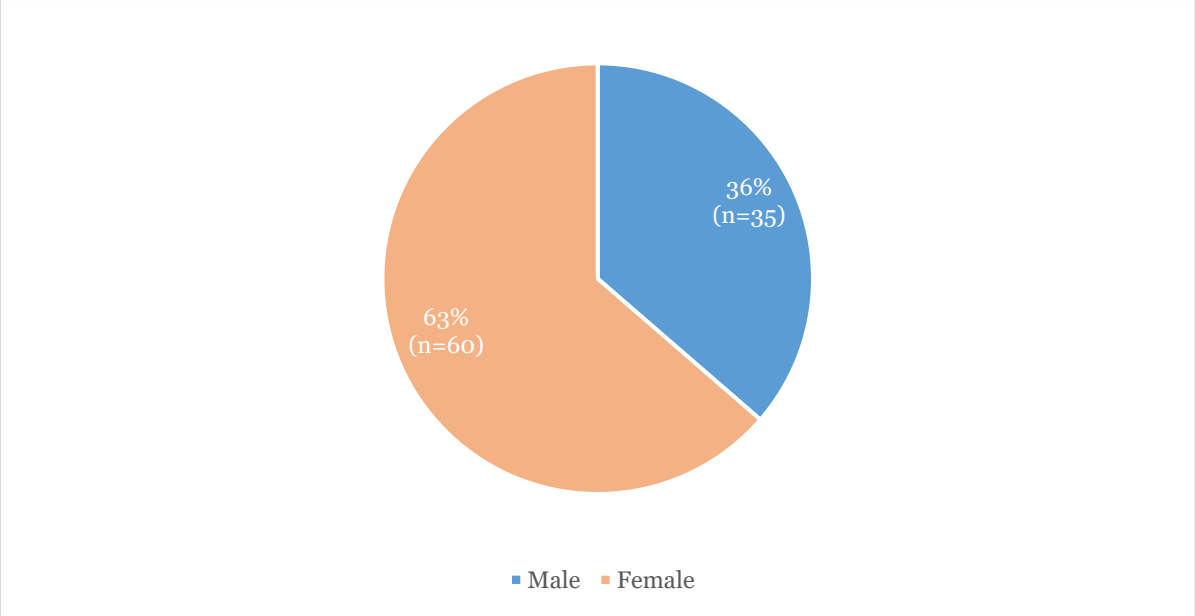



Figure 5.21. *Age profile of day programme survey respondents in 2024*

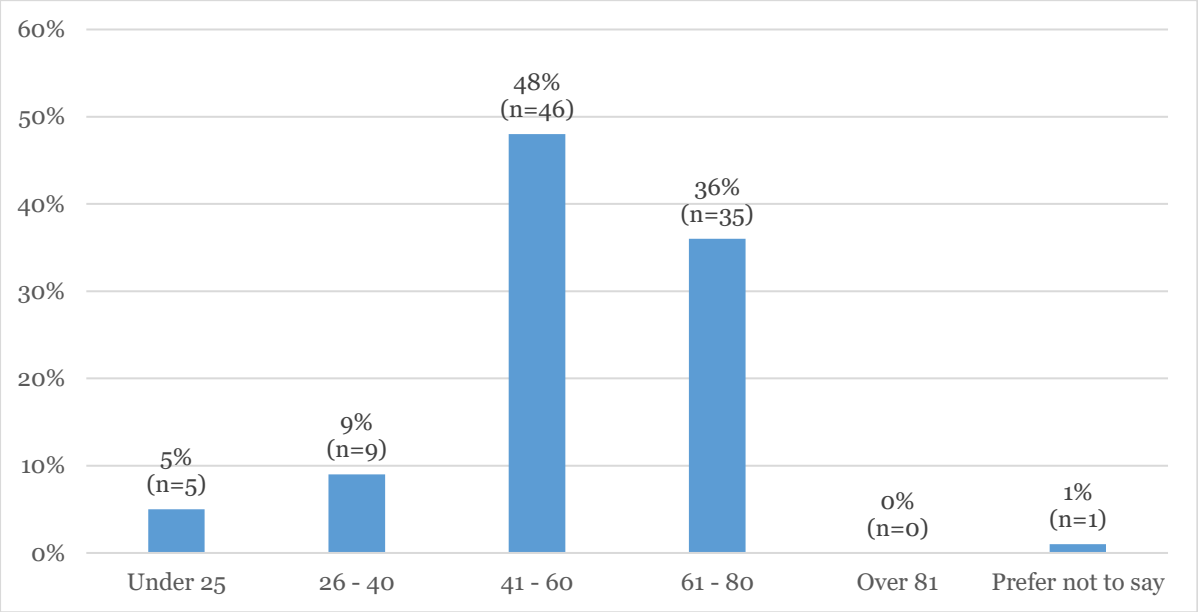


Table 5.22. *Location of day programme survey respondents in 2024*

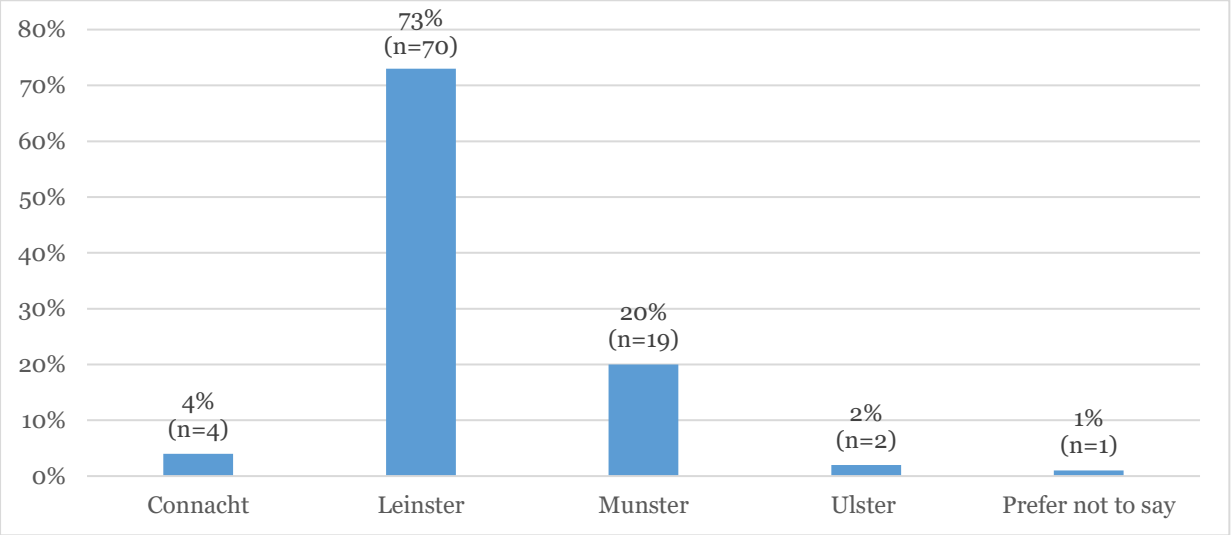


Figure 5.23. *How day programme survey respondents attending programmes in 2024*

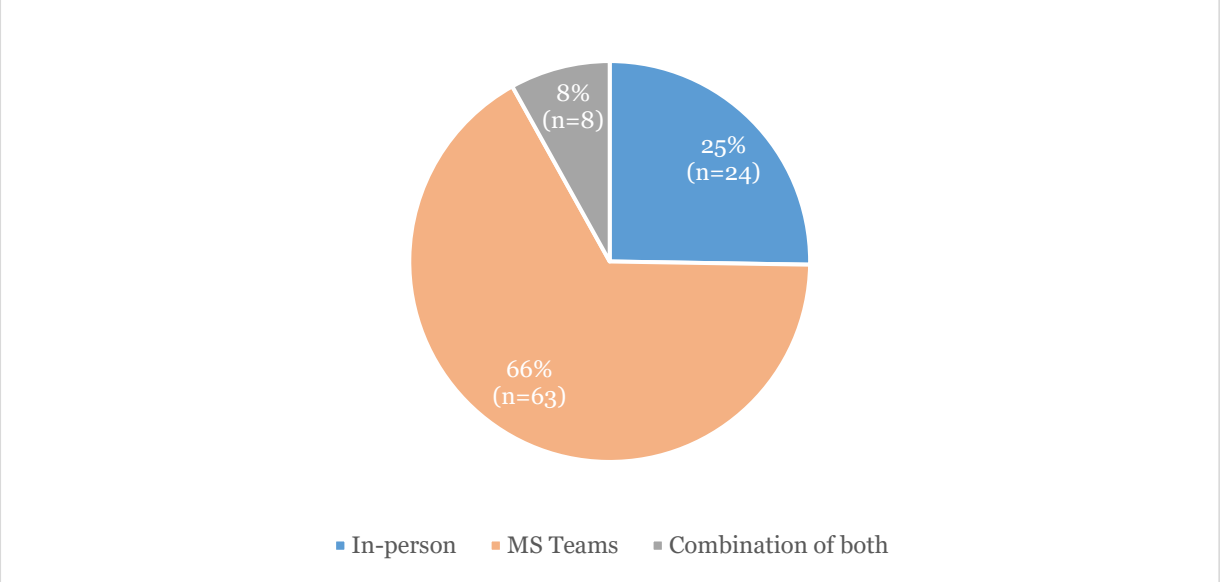



Figure 5.24. *Devices used by day programme survey respondents to attend programmes remotely in 2024*

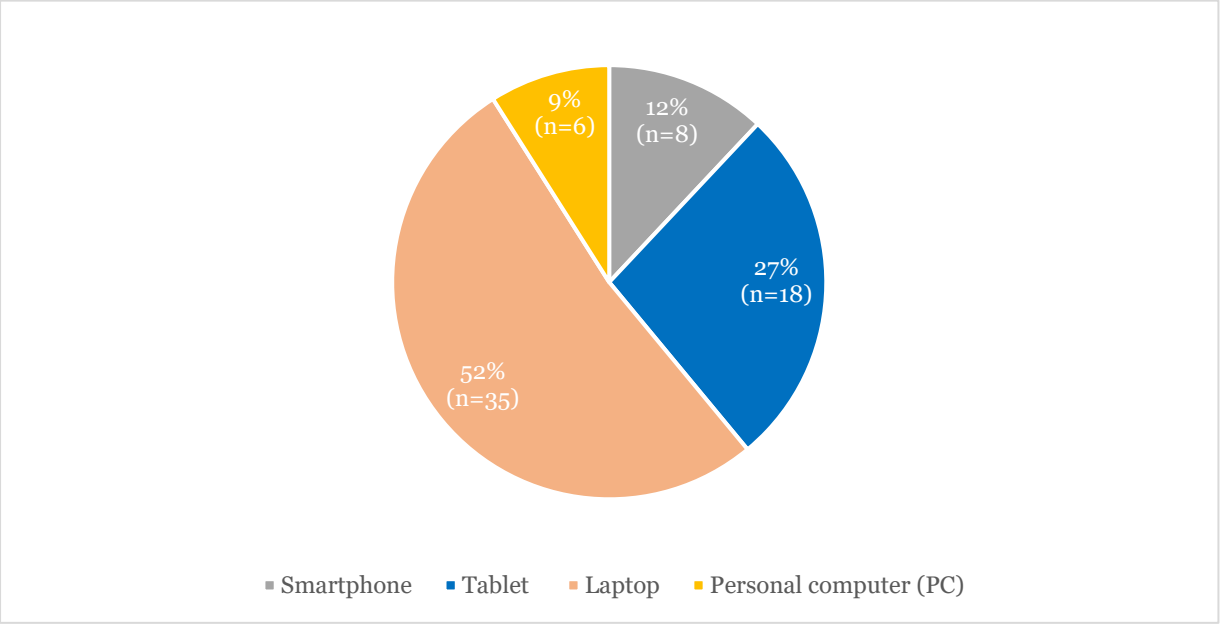


Figure 5.25. *Day programme survey respondents who contacted SUITS for support to attend programmes remotely in 2024*

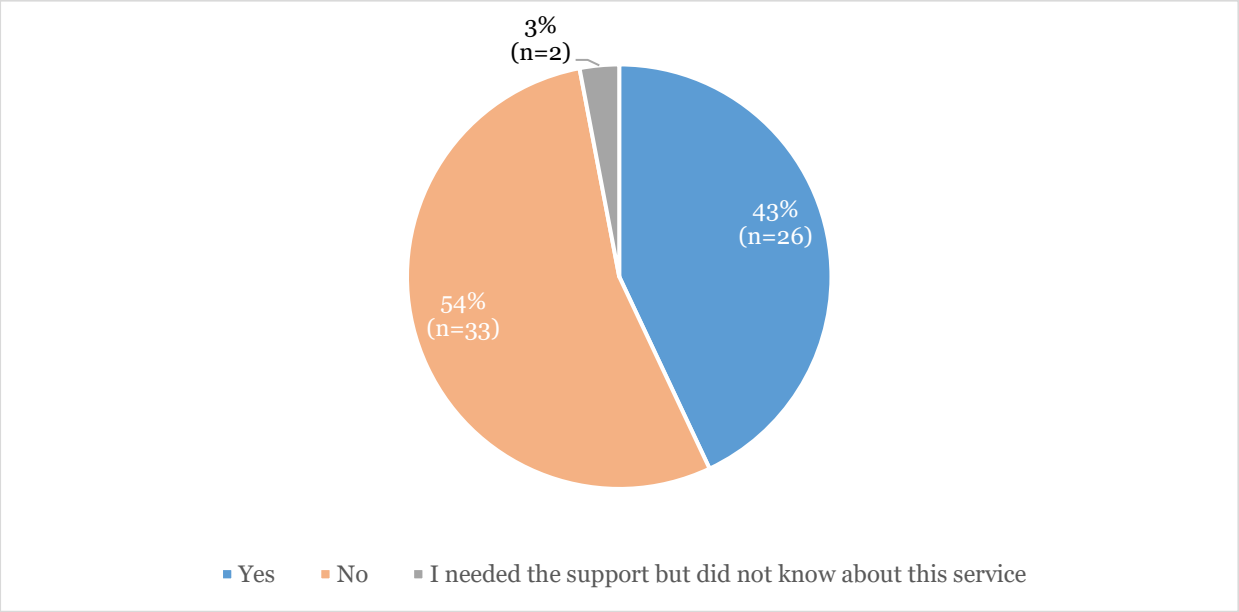



Table 5.29. *Day programme survey respondents' rating of experience of contacting the SUITS service*

| If you did contact the SUITS service, | how would you rate the support they provided, | % Of those who responded |
|---|---|---|
| **Rating** | **n** | **%** |
| 1 | 0 | 0 |
| 2 | 0 | 0 |
| 3 | 0 | 0 |
| 4 | 0 | 0 |
| 5 | 2 | 8 |
| 6 | 2 | 8 |
| 7 | 2 | 8 |
| 8 | 2 | 8 |
| 9 | 5 | 21 |
| 10 | 11 | 46 |
| Number who answered | 24 | - |
| 1-4 | 0 | 0 |
| 5+ | 24 | **100** |

### Experience of attending day programmes

Day programme survey respondents who completed all or some of their programmes remotely were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their experience of beginning their day programme remotely.

Table 5.30. *Day programme survey respondents' experience of beginning day programmes remotely in 2024*

| Please tell us about your experience of remotely accessing our services: | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| How to access my programme using MS Teams was clearly explained to me | 37 | 56 | 18 | 27 | 8 | 2 | 3 | 5 | 0 | 0 | **66** |
| Using MS Teams to access my programme was convenient | 36 | 55 | 24 | 36 | 3 | 5 | 1 | 2 | 2 | 3 | **66** |
| Using MS Teams to attend my programme was a positive experience | 35 | 53 | 21 | 32 | 7 | 11 | 1 | 2 | 2 | 3 | **66** |
| I would consider the option of attending programmes by MS Teams in the future | 38 | 58 | 18 | 27 | 7 | 11 | 3 | 5 | 0 | 0 | **66** |

Table 5.31. *All day programme survey respondents' experience of their day programme in 2024*

| Please tell us about your experience of remotely accessing our services: | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| A member of staff explained clearly what would be happening in the programme | 59 | 69 | 26 | 30 | 1 | 1 | 0 | 0 | 0 | 0 | **86** |
| A member of staff explained the timetable to | 59 | 69 | 26 | 30 | 10 | 10 | 0 | 0 | 0 | 0 | **86** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| me when I started the programme | | | | | | | | | | | |
| I trusted the members of my programme team | 65 | 78 | 15 | 18 | 2 | 2 | 1 | 1 | 0 | 0 | **83** |
| I was always treated with dignity and respect | 68 | 79 | 13 | 15 | 3 | 3 | 2 | 2 | 0 | 0 | **86** |
| Members of my programme team were courteous and respected me as an individual | 71 | 83 | 12 | 14 | 3 | 3 | 0 | 0 | 0 | 0 | **86** |
| Members of my programme team were knowledgeable and easy to understand | 71 | 83 | 13 | 15 | 2 | 2 | 0 | 0 | 0 | 0 | **86** |

Table 5.32. *All day programme survey respondents' experience of finishing day programmes in 2024*

| **Please tell us about your experience of remotely accessing our services:** | **Strongly agree** | | **Agree** | | **Neither agree or disagree** | | **Disagree** | | **Strongly disagree** | | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| I knew in advance when the programme was due to finish | 49 | 58 | 22 | 26 | 9 | 11 | 3 | 4 | 1 | 1 | **84** |
| The programme met all of my expectations | 41 | 48 | 26 | 31 | 11 | 13 | 7 | 8 | 0 | 0 | **85** |
| Having completed my programme, I am confident that I would know what to do in the event of a possible future mental health crisis | 45 | 53 | 29 | 34 | 8 | 9 | 3 | 4 | 0 | 0 | **85** |

### Attitudes towards mental health having completed day programmes

Respondents to the day programme survey were asked if they strongly agreed with, agreed with, neither agreed or disagreed with, or strongly disagreed with statements about their attitudes towards mental health after completing their programme.

Table 5.33. *Day programme survey respondents' attitudes towards mental health having completed day programmes in 2024.*

| Please tell us about your experience of remotely accessing our services: | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| I felt comfortable talking about my mental health to friends and family prior to completing this day programme | 15 | 17 | 27 | 31 | 20 | 23 | 19 | 22 | 5 | 6 | **86** |
| I would feel comfortable talking to family about my mental health having completed this day programme | 26 | 31 | 34 | 40 | 13 | 15 | 11 | 13 | 1 | 1 | **85** |
| I would feel comfortable talking to friends about my mental health having completed this day programme | 22 | 26 | 31 | 36 | 17 | 20 | 13 | 15 | 2 | 2 | **85** |
| I would feel comfortable talking to colleagues about my mental health having completed this day programme | 11 | 13 | 6 | 19 | 25 | 30 | 22 | 26 | 10 | 12 | **84** |

Table 5.34. *Recommending SPMHS to others*

| | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| I would recommend St Patrick's Mental Health Services to others | 66 | 77 | 12 | 14 | 7 | 8 | 1 | 1 | 0 | 0 | 86 |

Table 5.35. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending day programmes in 2024*

| **How would you rate...?** | **...your care and treatment** | | **...experience of SPMHS overall** | |
|---|---|---|---|---|
| | n | **% Of those who responded** | n | **% Of those who responded** |
| 1 | 0 | 0 | 0 | 0 |
| 2 | 0 | 0 | 0 | 0 |
| 3 | 0 | 0 | 1 | 1 |
| 4 | 1 | 1 | 2 | 2 |
| 5 | 5 | 6 | 7 | 8 |
| 6 | 4 | 5 | 0 | 0 |
| 7 | 6 | 7 | 7 | 8 |
| 8 | 11 | 13 | 9 | 11 |
| 9 | 14 | 16 | 14 | 17 |
| 10 | 45 | 52 | 44 | 52 |
| No answer | 10 | - | 12 | - |
| 1-4 | 1 | 1 | 3 | 3 |
| 5+ | 85 | **99** | 81 | **97** |
| **Total** | 86 | **100** | 84 | **100** |

Table 5.36. *Respondents' ratings of care and treatment and overall experience of SPMHS while attending day programmes in 2024*

| **How would you rate...?** | **N** | **Mean (μ)** |
|---|---|---|
| Your care and treatment | 86 | 8.8 |
| Overall experience of SPMHS | 84 | 8.7 |

The average rating between one and 10 of care and treatment from 86 respondents who completed day programmes was 8.8 out of 10. The average rating between one and 10 of overall experience of SPMHS from 84 respondents who completed day programmes was 8.7 out of 10.

## 5.6. Willow Grove Adolescent Unit Service User Experience 5.6.1. Survey 2024

Willow Grove Adolescent Unit (WGAU) of SPMHS (previously described in this document). The unit provides inpatient and Homecare treatment for young people between the ages of 12 and 17 years who are experiencing mental health difficulties. It also has an associated outpatient Dean Clinic located in St Patricks University Hospital, Dublin, which offers assessment and treatment services for adolescents. The MDT are committed to ongoing quality improvement. This report presents the responses from the WGAU Service User Satisfaction Surveys received between January and December 2024.

### 5.6.2. Methodology

WGAU is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (QNIC), a group of similar units which conduct yearly peer review cycles. The Network is co-ordinated by the Royal College of Psychiatrists in the United Kingdom and every two years their standards are reviewed and updated in line with best practice. The satisfaction survey used is an adapted version of a standard Child and Adolescent Mental Health Service (CAMHS) inpatient satisfaction questionnaire, taken from the COSI-CAPs study, recommended by QNIC.

### 5.6.3. Respondents

Young people and their parents are invited to complete paper versions of the WGAU inpatient Service User Satisfaction Survey at the point of discharge. Young people and their parents/carers who were discharged from a Homecare are invited to complete the survey by email.

In 2024, 23 young people and 57 parents/carers completed the inpatient survey. The number of inpatient surveys returned by young people in 2024 increased by 53% and the number of surveys completed by parents/carers increased by 36% when compared with 2023, where responses were provided from 15 young people and 42 parents/carers.

The WGAU Homecare survey was completed by seven young people and 20 parents/carers in 2024. The number of Homecare surveys returned by young people in 2024 decreased by 22% and the number of surveys completed by parents/carers increased by 300% when compared with 2023, where responses were provided from nine young people and five parents/carers.

### 5.6.4. Survey design

The WGAU survey asked young people a set of questions which gather information on their experiences of access to services, the environment and facilities of the unit, the therapeutic services offered, the ability of the service to support young people and parents to manage mental health difficulties, discharge preparation, professionalism of staff and confidentiality and rights.

The questionnaires asked parents and young people to rate a number of statements preceded by the statement - 'what is your overall feeling about…'. Answers ranged from one = very unhappy, to five = very happy. The young person's questionnaire also included this five-point Likert scale ranging from one = very poor, to five = very good, printed with corresponding smiley faces to help young people to understand the response options.

### 5.6.5. WGAU inpatient survey results

#### Quantitative responses

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

### Access

The statement in the access section of the survey that was rated 5 – 'very happy' by the majority of young people (48%, n=10) was with the information provided by the St Patrick's website. This statement received the least number of 'very happy' responses (53%, n=29) from parents' in their version of the survey.

### Environment

The statement in the environment section of the survey that was rated 5 – 'very happy' by the least number of young people (9%, n=12) was with the meals provided. This statement received the least number of 'very happy' responses 42% (n=23) of parents.

Several comments from young people referred to the noise and lack of privacy in the unit. Several comments from parents refer to the lack of outdoor space, limited opportunities to exercise in the unit and the high cost of parking.

### Care and Treatment

69% (n=38) of parents said they were 'very happy' with the care and treatment their child received. 58% (n=30) rated 5 – 'very happy' that their child's stay was useful in addressing their mental health difficulty.

35% (n=8) of young people said they were 'very happy' with the care and treatment they received. 41% (n=9) rated 5 – 'very happy' that they were provided with the skills to manage their mental health.

The confidentiality of the service (86%, n=18) and access to leisure activities (65%, n=15) both ranked 5 – 'very happy' by the majority of young people. The confidentiality of the service (81%, n=44) and their child's access to key workers/allocated nurse both ranked 5 – 'very happy' by the majority of parents (78%, n=43).

*Table 5.37. Median responses to WGAU inpatient Service User Satisfaction Survey*

| Please tell us how satisfied you were with the following aspects of the service: | Parents | Young people |
|---|---|---|
| Experience of accessing the service | 5 | 4 |
| Information received prior to admission | 5 | 4 |
| Information provided by St Patrick's website | 4 | 4 |
| The process of assessment and admission | 5 | 4 |
| The information given on admission | 5 | 4 |
| The environment and facilities | 5 | 4 |
| The overall atmosphere or feel of the unit | 5 | 4 |
| The cleanliness of the unit | 5 | 4 |
| The meals provided | 4 | 3 |
| Visiting arrangements | 5 | 4 |
| Safety arrangements on the unit | 5 | 4 |
| Experience of care and treatment | 5 | 4 |
| Access to group therapy | 5 | 5 |
| Access to individual therapy | 4 | 4 |
| Access to leisure activities and outings | 4 | 5 |
| Access to a range of professionals | 4 | 5 |
| Access to key workers/allocated nurses | 5 | 5 |
| Access to educational supports | 4 | 5 |
| Access to an independent advocacy group | 4 | 4 |
| Your level of contact with the treatment team | 4 | 4 |
| Information received on treatment plan | 4 | 4 |
| Your involvement (young person)/your collaboration (parent) in treatment plan | 4 | 4 |
| Your opportunity to give feedback to the treatment team | 4 | 4 |
| How you felt you were listened to/respected | 4 | 4 |
| Confidentiality of the service | 5 | 5 |
| Opportunity to attend discharge planning meeting | 5 | 5 |
| Weekend/mid-week therapeutic leave agreements | 5 | 4 |
| Information given to you to prepare for discharge | 4 | 4 |

| | | |
|---|---|---|
| **Having a service identified for follow up care** | 4 | 4 |
| **Provision of family support** | 4 | 4 |
| **Opportunity to attend parents support group** | 4 | n/a |
| **Opportunity to attend positive parenting course** | 4 | n/a |
| **Was your child's stay helpful in addressing their mental health difficulty?** | 4 | n/a |
| **Providing you with skills to manage mental health** | n/a | 4 |

### 5.7. WGAU Homecare survey results

#### Quantitative responses

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

#### Access

The statement in the access section of the Homecare survey that was rated 5 – 'very happy' by the majority of young people (65%, n=13) was with the information received prior to Homecare admission. This statement received the least number of 'very happy' responses (43%, n=3) in parents' version of the survey.

#### Care and Treatment

Access to individual therapy (43%, n=3) ranked 5 – 'very happy' by the majority of young people. The confidentiality of the service (68%, n=13) was ranked 5 – 'very happy' by the majority of parents.

30% (n=6) of parents said they were very happy with the care and treatment their child received. 25% (n=5) rated 5 – 'very happy' that their child's Homecare admission was useful in addressing their mental health difficulty.

29% (n=2) of young people said they were 'very happy' with the care and treatment they received while on Homecare. 43% (n=3) rated 5 – 'very happy' that they were provided with the skills to manage their mental health.

*Table 5.38. Median responses to WGAU Homecare Service user Experience Survey*

| Please tell us how satisfied you were with aspects of the service | Parents | Young people |
|---|---|---|
| Waiting time for admission to Homecare | 4 | 5 |
| The information you received prior to Homecare admission | 4 | 4 |
| The information provided by St Patrick's website | 4 | 4 |
| The process of assessment and admission | 4 | 4 |
| The information given on admission | 4 | 5 |
| Experience of care and treatment | 4 | 4 |
| Experience of daily contact calls | 4 | 4 |
| Access to group therapy | 1 | 1 |
| Access to individual therapy | 4 | 4 |
| Access to a range of professionals | 3 | 4 |
| Access to key workers/allocated nurses | 4 | 4 |
| Access to educational supports | 2 | 1 |
| Information received on treatment plan | 4 | 4 |
| Your level of contact with the treatment team | 4 | 4 |
| Your involvement (young person)/your collaboration (parent) in treatment plan | 4 | 4 |
| How you felt you were listened to/respected | 4 | 4 |
| Confidentiality of the service | 5 | 4 |
| Opportunity to attend discharge planning meeting | 4 | 4 |
| Information given to you to prepare for discharge | 4 | 4 |
| Having a service identified for follow up care | 4 | 4 |

| | | |
|---|---|---|
| **Access to family support** | 3 | 4 |
| **Was your child's Homecare admission useful in addressing their mental health difficulty?** | 3 | n/a |
| **Providing you with skills to manage mental health** | n/a | 4 |

## 5.8. Adolescent Dean Clinic

### 5.8.1 Surveys 2024

In 2024, Adolescent Dean Clinic appointments were delivered face-to-face and remotely by technology-enabled care. The Adolescent Dean Clinic gathers feedback from young people attending the service through the use of a Service User Experience survey. The format of this survey is the same as the version used by adult service users.

The survey was sent by email to the parents/carers of young people who had attended Adolescent Dean Clinic appointments inviting them to ask the young people to complete the survey. Access to the survey was also displayed in the Adolescent Dean Clinic where young people attending appointments could access the survey using a QR code. In 2024, this survey was completed by 76 young people. This is an increase of 80% from 42 survey responses received in 2023.

#### Adolescent Dean Clinic survey respondent demographics

The majority of the adolescent Dean Clinic survey responses in 2024 were from females (64%, n=49), aged between 15 and 17 years of age (59%, n=44) and who live in Munster (57%, n=42). 48% (n=32) of respondents said they heard about the Dean Clinic adolescent service from their General Practitioner (GP).

*Figure 5.24. How respondents heard about Adolescent Dean Clinics*

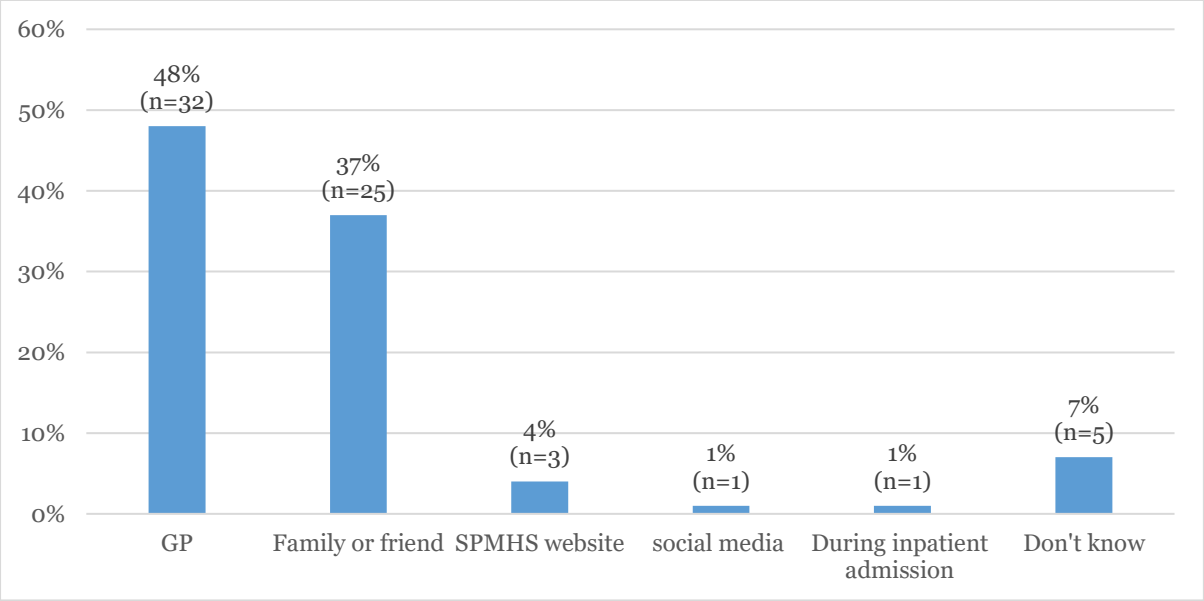
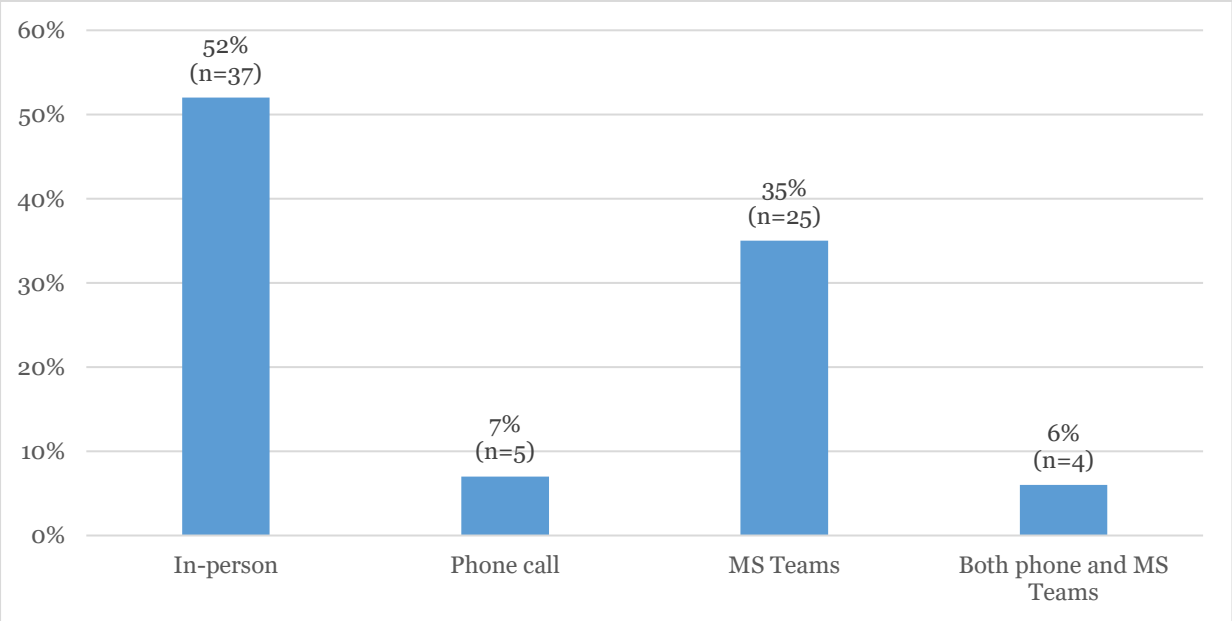



*Figure 5.25. How respondents attended their most recent Adolescent Dean Clinic appointment*




The majority of respondents (52%, n=37 attended their Adolescent Dean Clinic appointment in-person in 2024. 35% (n=25) said they attended their Adolescent Dean Clinic appointments by MS Teams. 7% (n=5) of respondents said they accessed their

appointment by phone calls, and 5% (n=4) said they used both phone calls and MS Teams to attend their appointment.

### Adolescent Dean Clinic in person appointment feedback

The following section of this report details the feedback provided by 28.3% (n=13) of Adolescent Dean Clinic survey respondents who attended their appointments in person between January and December 2024.

*Table 5.39. Dean Clinic adolescent survey respondents experience of attending adolescent Dean Clinics in person*

| Please tell us about your experience of attending the Adolescent Dean Clinic | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| The Adolescent Dean Clinic location was convenient for me to access the Dean Clinic | 9 | 27 | 16 | 48 | 5 | 15 | 3 | 9 | 0 | 0 | **33** |
| I was welcomed in a friendly and professional manner by the Adolescent Dean Clinic staff | 27 | 82 | 4 | 12 | 1 | 3 | 0 | 0 | 1 | 3 | **33** |
| I was shown where the facilities were in the Adolescent Dean Clinic, such as the bathroom and waiting room | 19 | 58 | 10 | 30 | 3 | 9 | 0 | 0 | 1 | 3 | **33** |

### Experience of staff during in person Adolescent Dean Clinic appointment

*Table 5.40. Adolescent Dean Clinic survey respondents experience of staff during their Dean Clinic in person appointment*

| Tell us about your experience of your Adolescent Dean Clinic appointment | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| I was treated with dignity and respect | 25 | 76 | 5 | 15 | 1 | 3 | 0 | 0 | 2 | 6 | **33** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **My confidentiality was protected** | 23 | 72 | 8 | 25 | 0 | 0 | 0 | 0 | 1 | 3 | **32** |
| **My privacy was respected** | 22 | 69 | 9 | 28 | 0 | 0 | 0 | 0 | 1 | 3 | **32** |
| **I felt included in decisions about my treatment** | 21 | 64 | 5 | 15 | 4 | 12 | 2 | 6 | 1 | 3 | **33** |
| **I trusted my doctor or therapist or nurse** | 24 | 73 | 3 | 9 | 1 | 3 | 4 | 12 | 1 | 3 | **33** |
| **My appointment was value for money** | 8 | 24 | 8 | 24 | 8 | 27 | 0 | 0 | 1 | 3 | **33** |
| **I would recommend the Dean Clinic to family and friends** | 18 | 55 | 8 | 24 | 4 | 12 | 2 | 6 | 1 | 3 | **33** |

*Table 5.41. Respondents' ratings of care and treatment and overall experience of SPMHS while attending Adolescent Dean Clinics in person*

| **How would you rate...?** | **...your care and treatment** | | **...experience of SPMHS overall** | |
|---|---|---|---|---|
| | n | **% Of those who responded** | n | **% Of those who responded** |
| **1** | 0 | 0 | 0 | 0 |
| **2** | 1 | 3 | 1 | 3 |
| **3** | 0 | 0 | 0 | 0 |
| **4** | 2 | 6 | 1 | 3 |
| **5** | 2 | 6 | 2 | 6 |
| **6** | 1 | 3 | 1 | 3 |
| **7** | 0 | 0 | 1 | 3 |
| **8** | 3 | 9 | 5 | 16 |
| **9** | 10 | 31 | 8 | 25 |
| **10** | 13 | 41 | 13 | 41 |
| **No answer** | 1 | - | 1 | - |
| **1-4** | 3 | 9 | 2 | 6 |
| **5+** | 29 | 91 | 30 | 94 |
| **Total** | 33 | 100 | 33 | 100 |

*Table 5.42. Respondents' ratings of care and treatment and overall experience of SPMHS while attending Adolescent Dean Clinics in person*

| How would you rate...? | N | Mean (μ) |
|---|---|---|
| **Your care and treatment** | 32 | 8.4 |
| **Overall experience of SPMHS** | 32 | 8.5 |

The average rating between one and 10 of care and treatment from 32 respondents who attended their appointments in person was 8.4 out of 10. The average rating between one and 10 of overall experience of SPMHS from 32 respondents who attended appointments in person was 8.5 out of 10.

### Adolescent Dean Clinic remote appointment feedback

The following section of this report details the feedback provided by 36% (n=27) Adolescent Dean Clinic survey respondents who attended their appointments remotely in 2024.

### Devices

The majority of Adolescent Dean Clinic survey respondents used smartphones (42%, n=14) followed by laptops (39%, n=13, tablets (12%, n=4), and 6% (n=2) used personal computer (PC) to access their appointment remotely in 2024.

3% (n=1) of respondents said they contacted the Service User IT (SUITS) service for technical support in 2024 but did not complete the question that asked them to provide a rating from one to ten about their experience.

*Table 5.43. Adolescent Dean Clinic survey respondents' experience of attending their appointment remotely*

| Please tell us about your experience of remotely accessing our services: | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n |
| It was convenient for me to access my appointment remotely | 15 | 56 | 10 | 37 | 2 | 7 | 0 | 0 | 0 | 0 | **27** |
| It was clearly explained to me how to access my appointment using either phone or video | 15 | 56 | 11 | 41 | 1 | 8 | 0 | 0 | 0 | 0 | **27** |
| I felt using technology to attend my appointment was a positive experience | 10 | 37 | 12 | 44 | 4 | 15 | 1 | 4 | 0 | 0 | **27** |
| I would consider the option of attending Dean Clinic appointments by phone or video in the future | 7 | 26 | 13 | 48 | 4 | 15 | 3 | 11 | 0 | 0 | **27** |

*Table 5.44. Adolescent Dean Clinic survey respondents' experience of staff while attending their appointment remotely*

| Please tell us about your experience of remotely accessing our services: | Strongly agree | | Agree | | Neither agree or disagree | | Disagree | | Strongly disagree | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | N | % | n |
| I was treated with dignity and respect | 21 | 78 | 5 | 19 | 0 | 0 | 1 | 4 | 0 | 0 | **27** |
| My confidentiality was protected | 20 | 74 | 6 | 22 | 1 | 4 | 0 | 0 | 0 | 0 | **27** |
| My privacy was respected | 19 | 70 | 6 | 22 | 2 | 7 | 0 | 0 | 0 | 0 | **27** |
| I felt included in decisions about my treatment | 19 | 70 | 5 | 19 | 1 | 4 | 0 | 0 | 2 | 7 | **27** |
| I trusted my doctor or therapist or nurse | 19 | 70 | 6 | 22 | 1 | 4 | 1 | 4 | 0 | 0 | **27** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **My appointment was value for money** | 12 | 44 | 12 | 44 | 1 | 4 | 1 | 4 | 1 | 4 | **27** |
| **I would recommend the Dean Clinic to family and friends** | 15 | 56 | 10 | 37 | 0 | 0 | 1 | 4 | 1 | 4 | **27** |

*Table 5.45. Adolescent Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

| **How would you rate...?** | **...your care and treatment** | | **...experience of SPMHS overall** | |
|---|---|---|---|---|
| | n | **% Of those who responded** | n | **% Of those who responded** |
| 1 | 1 | 4 | 1 | 4 |
| 2 | 0 | 0 | 0 | 0 |
| 3 | 1 | 4 | 1 | 4 |
| 4 | 0 | 0 | 0 | 0 |
| 5 | 0 | 0 | 0 | 0 |
| 6 | 0 | 0 | 0 | 0 |
| 7 | 0 | 0 | 2 | 7 |
| 8 | 4 | 15 | 2 | 7 |
| 9 | 8 | 31 | 8 | 30 |
| 10 | 12 | 46 | 13 | 48 |
| No answer | 1 | - | 0 | - |
| 1-4 | 2 | 8 | 2 | 8 |
| 5+ | 24 | **92** | 25 | **92** |
| Total | 27 | 100 | 27 | 100 |

*Table 5.46. Adolescent Dean Clinic respondents' ratings of care and treatment and overall experience of SPMHS while attending appointments remotely*

| **How would you rate...?** | **N** | **Mean (μ)** |
|---|---|---|
| **Your care and treatment** | 28 | 8.8 |
| **Overall experience of SPMHS** | 28 | 8.7 |

The average rating between one and 10 of care and treatment from 26 respondents who attend Adolescent Dean Clinic appointments remotely was 8.8 out of 10. The average

rating between one and 10 of overall experience of SPMHS from 27 respondents who attended their appointment remotely was 8.7 out of 10.

# SECTION SIX
# Conclusions

## 6.1. Conclusions

1. The SPMHS fourtenth *Outcomes Report* builds on the previous reports. Service evaluation, outcome measurement, clinical audit and service user experience surveys are now being used routinely in the context of improving the quality-of-service delivery. The annual *Outcomes Report* has also provided positive feedback to the staff who deliver the outcomes driven services within SPMHS. Recruitment and ongoing education/training is underpinned by a service user-centred philosophy and the attainment of positive outcomes. The skills, talents and commitment of staff are reflected in the positive outcomes within this report.

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

3. The clinical staff delivering the programmes and services continue to identify the appropriate validated clinical outcome measures and utilise them as a routine part of clinical service delivery. Clinical outcome measurement is now an established practice within SPMHS. Clinical staff continue to drive ways to expand or improve how outcomes are measured and utilised to maintain and improve services. In 2024, there was an increase in the number of the clinical programmes utilising a secure service user electronic portal (Your Portal), to send clinical outcome measures for completion by consenting service users attending their clinical programme. The service users were then able to complete the outcome measures via the secure portal, which were instantly accessible for review by the clinical staff delivering the programme of care.

4. The scope of audit across the organisation was further strengthened in 2024, consistent with the requirements of the Mental Health Commission's Judgement

Support Framework (2025). Clinical audit is utilised within SPMHS as part of robust clinical governance processes in order to deliver continuously improving services.

5. Strengths: SPMHS continues to provide a detailed insight into service accessibility, efficacy of clinical programmes and service user experience. Reporting this breadth of routinely collected clinical outcomes demonstrates a willingness to constantly re-evaluate the efficacy of clinical programmes and services in an open and transparent way. A detailed service user experience survey encompassing all service delivery within SPMHS is now well established, reinforcing the organisation's commitment for service user-centred care and treatment. In 2024, overall Service User Experience Survey response rates remained strong, with an increase in responses to the Dean Clinic, in-person inpatient and Homecare service surveys. The results presented in this annual outcomes report are reflective of the continued achievement of excellent levels of compliance on annual mental health commission inspection in 2024. The organisation delivered a full and comprehensive outcomes report in 2024, demonstrating the commitment of all SPMHS staff to continuously measure and improve our services. In keeping with efforts to expand the number of services incorporated in this report, an additional programme was added to the *Outcomes Report* this year: The Focused Acceptance and Commitment Therapy Programme. Technology-enabled care continues as an effective option for clinical service delivery and providing access and convenience to service users.

6. Challenges: We continue in our efforts to expand the number of services included within the SPMHS Outcomes Report, but as yet we do not have all areas of service delivery included. Efforts to benchmark the results of this report remain very difficult. Work is onging to assess the percentage of referrals accepted for treatment by SPMHS, with the goal to continuously improve accessibility to all of our services. In order to best capture the efficacy of clinical programmes and services, there have been changes in the outcome measures used, which can create difficulties when comparing results to previous reports. The report's clinical outcome results cannot

be solely attributed to the service or intervention being measured and are not developed to the standard of randomised control trials.

# SECTION SEVEN
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