St Patrick's
Mental Health Services

Outcomes Report 2016

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

SECTION 1

Introduction

1. Introduction

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

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

The 2016 Report is divided into 6 Sections. Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPMHS services are structured and how community, day-patient and inpatient services were accessed in 2016. SPMHS provides community and outpatient care through its Dean Clinic Community Mental Health Clinics and day-patient services through its Wellness & Recovery Centre. It provides inpatient care through its three approved centres, St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

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

outcomes for a range of clinical programmes and services. This information provides practice-based evidence of the efficacy of interventions and programmes delivered to service users during 2016, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

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

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

SECTION 2

Accessibility

2. St Patrick's Mental Health Services

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our services are accessed in a number of ways. These include our community care accessed through our Dean Clinic network of community mental health clinics, our day-patient care accessed through our Wellness and Recovery Centre and our in-patient care accessed through our three approved centres. This Section provides information about how our services were accessed through these services in 2016.

2.1. Community Based Services (Dean Clinics)

The SPMHS strategy, Mental Health Matters: Empowering Recovery (2013-2018), reinforces the organisation's commitment to the development of community mental health clinics. Since 2009 a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the organisation. SPMHS operates a total of seven Adult Dean Clinics and two Adolescent Clinics. Free of charge multi-disciplinary mental health assessments continue to be offered through the Dean Clinic network to improve access for service users.

Adult Dean Clinic Services

2.1.1. Dean Clinic Referrals Volume

Seven Adult Dean Clinics have been established to date and provide multi-disciplinary mental health assessment and treatment for those who can best be supported and helped within a community setting and provision of continued care for those leaving the hospital's in-patient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community Mental Health Services, Day Services and Inpatient Care. The clinics encourage and facilitate early intervention which improves outcomes. In 2016, there was a total of 2,068 Adult Dean Clinic referrals received from General Practitioners. This compares with a total of 1886 in 2015, representing an increase of 9.7%.

2.1.2. Dean Clinic Referral Source by Province

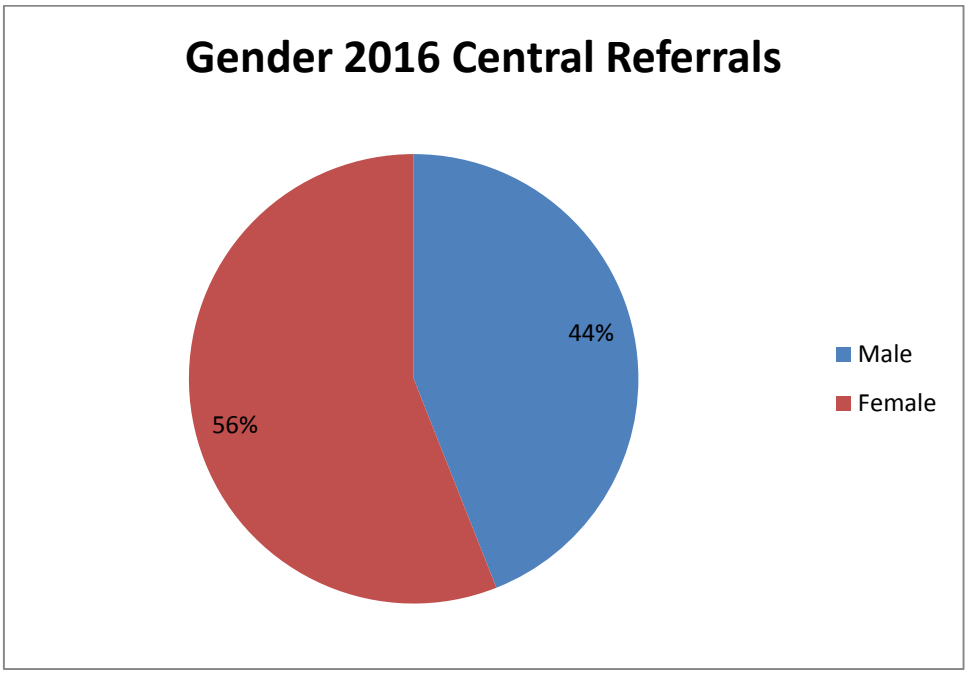
The following table illustrates the geographical spread of Dean Clinic Referrals by Province from 2011 to 2016. The highest referral volumes continued to be from Leinster in 2016 with 1320 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2011	1053	224	68	11	20
2012	1337	281	107	34	0
2013	1336	317	195	41	0
2014	1503	287	214	43	0
2015	1494	427	257	58	0
2016*	1320	444	243	45	16

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

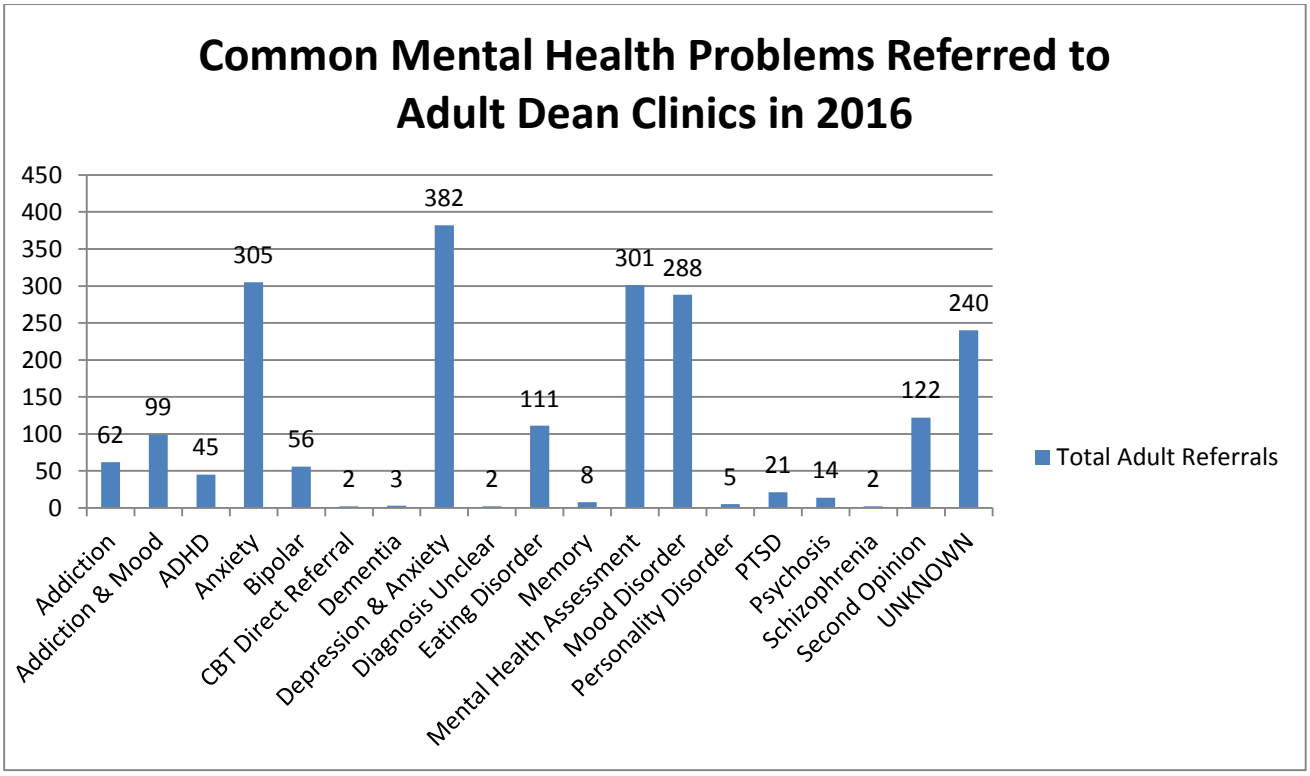
2.1.3. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic Adult referrals for 2016 was 56% female to 44% male.



2.1.4. Dean Clinic Referrals by Reason for Referral

The chart below documents the Common Mental Health Problems referred to the Dean Clinics throughout 2016 and shows Depression & Anxiety as the primary reason for referral.



2.1.5. Dean Clinic Activities (2010-2016)

2016 was a busy year clinically across all Dean Clinics. The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2010. Not all referrals result in an assessment, there are a number of reasons for this. In some cases a decision is made not to progress with an assessment as the service user is already under the care of another service. Others do not attend their appointments and other service users have a more immediate need and are assessed for possible urgent admission to inpatient care.

Year	No. of Referrals	No. of Assessments
2010	**692**	**573**
2011	**1376**	**924**
2012	**1759**	**1,398**
2013	**1889**	**1,422***
2014	**2047**	**1,287***
2015	**2236**	**1,461***
2016	**2068****	**1,204****
Totals	**12,067**	**8,269**

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

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

The following table summarises the total number of outpatient appointments or visits provided across Dean Clinics nationwide from 2010 to 2016.
Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager II Reviews, Clinical Nurse Specialist reviews, Nurse Reviews, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology, Psychotherapy.

Year	Total No of Dean Clinic Appointments
2010	5,220
2011	7,952
2012	12,177
2013	12,826*
2014	13,541*
2015	16,142*
2016	15,017**
Total	82,875

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

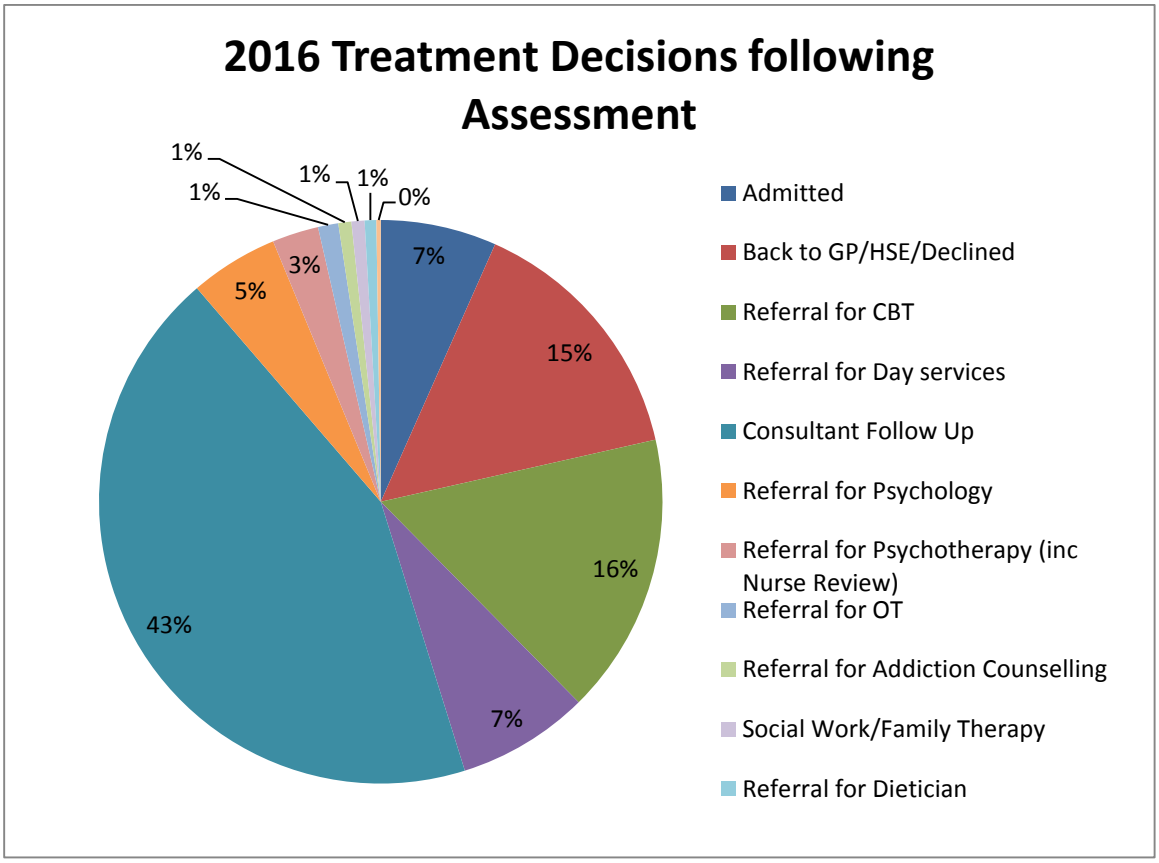
The table below summarises the number of first time inpatient admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2016.

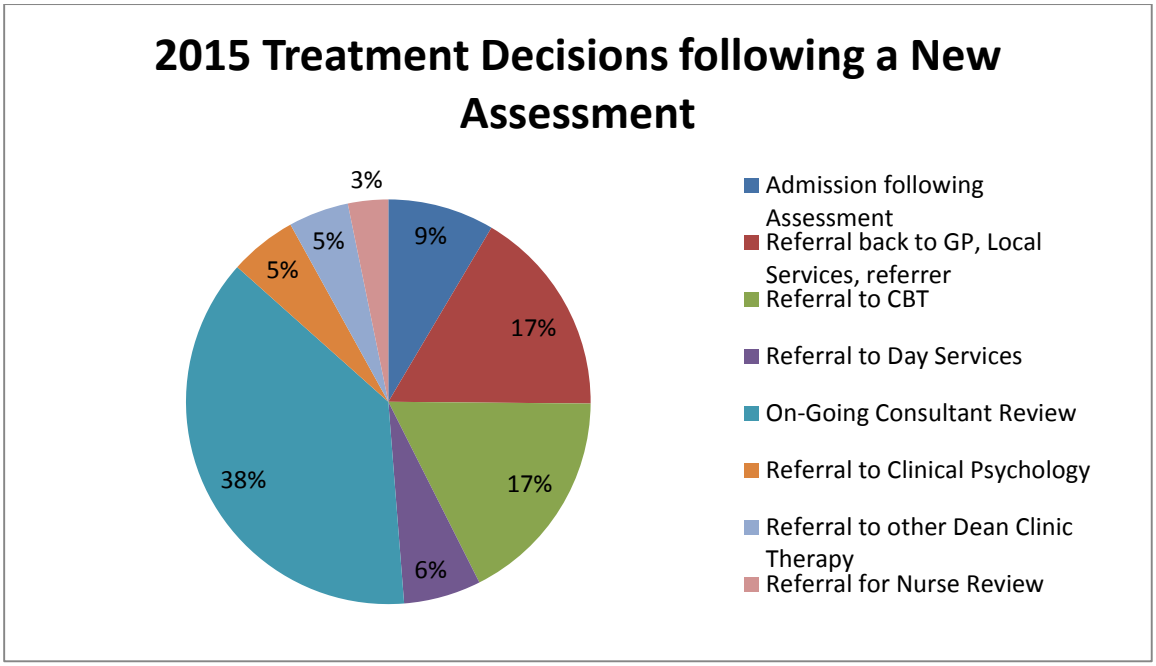
Year	First Admission
2011	150
2012	180
2013	225
2014	202
2015	235
2016	132*

*Excludes Adolescent Admissions from 2016;

2.1.6 Dean Clinic: Outcome of Assessments

The two charts below summarise and compare the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics for 2016 and 2015.





Adolescent Dean Clinic Services

2.1.7 Dean Clinics Referral Volume

In 2016, there were a total of 593 referrals received for the Adolescent Service. The adolescent Dean Clinics are based in Dublin and Cork.

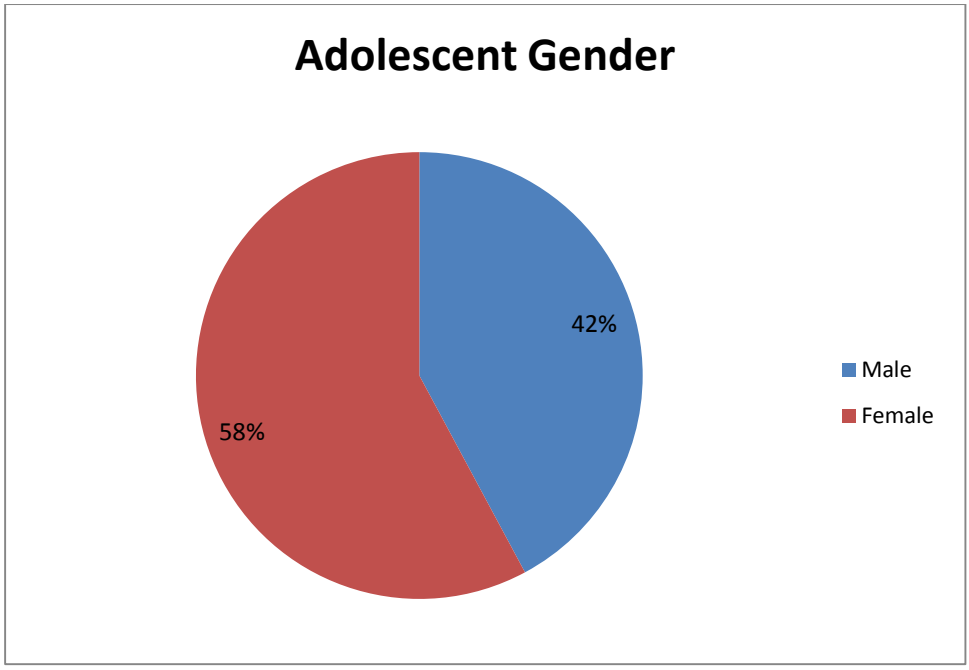
2.1.8 Dean Clinics Referral Source by Province

The following table illustrates the geographical spread of Adolescent Dean Clinic Referrals by Province for 2016. The highest referral volume is from Leinster at 311 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2016	311	231	39	8	4

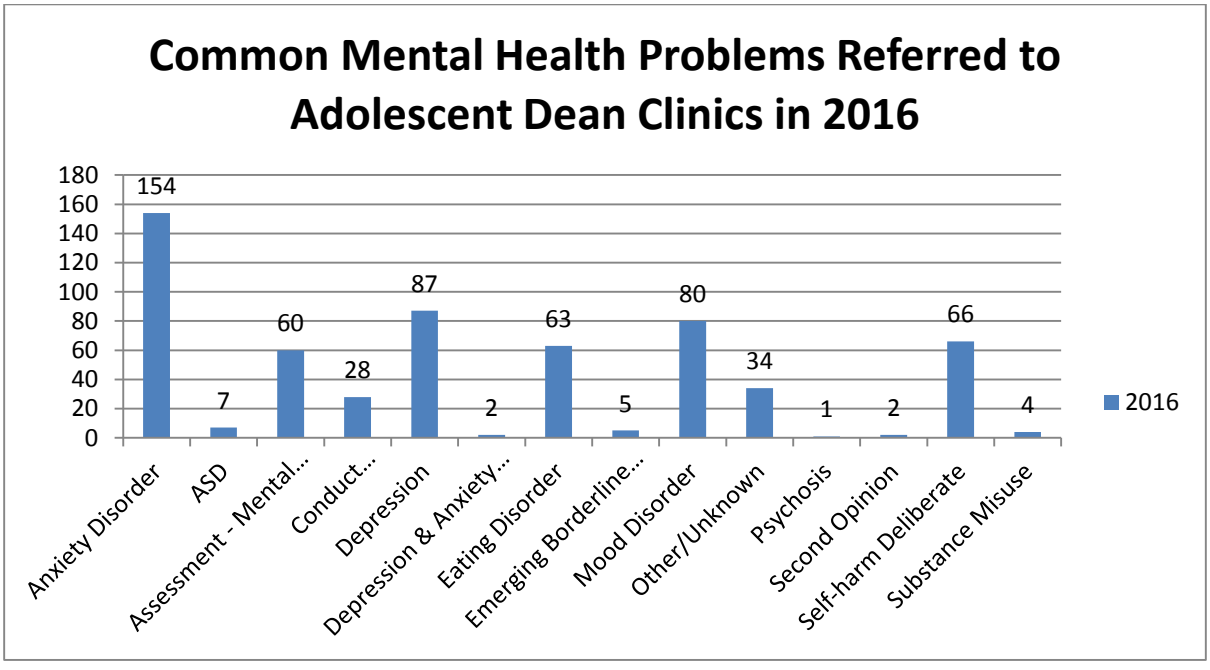
2.1.9 Dean Clinic Referrals by Gender

The Gender ratio of Dean Clinic Adolescent referrals for 2016 was 58% female to 42% male.



2.1.10 Common Mental Health Problems referred to Adolescent Dean Clinics

The chart below documents the Common Mental Health Problems referred to the Adolescent Dean Clinics throughout 2016 and shows Anxiety as the primary reason for referral.



2.1.11 Dean Clinic Activities

The table below summarises the number of Adolescent referrals and mental health assessments provided across the adolescent Dean Clinics in 2016. Not all referrals result in an assessment, there are a number of reasons for this. In some cases a decision is made not to progress with an assessment as the service user is already under the care of another service. Service users may not attend assessment appointments; decline the assessment offered and / or have a more immediate need and are referred for an admission assessment. In some cases patients may have been referred to a number of services and opt to take a local service. Parental consent is required prior to adolescent assessments taking place.

Year	No. Of Referrals	No. Of Assessments
2016	593	201

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

The following table summarises the total number of outpatient appointments or visits provided across Adolescent Dean Clinics nationwide in 2016.
Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager Reviews, Clinical Nurse Specialist Reviews, Nurse Reviews, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology, Psychotherapy, Dietician service.

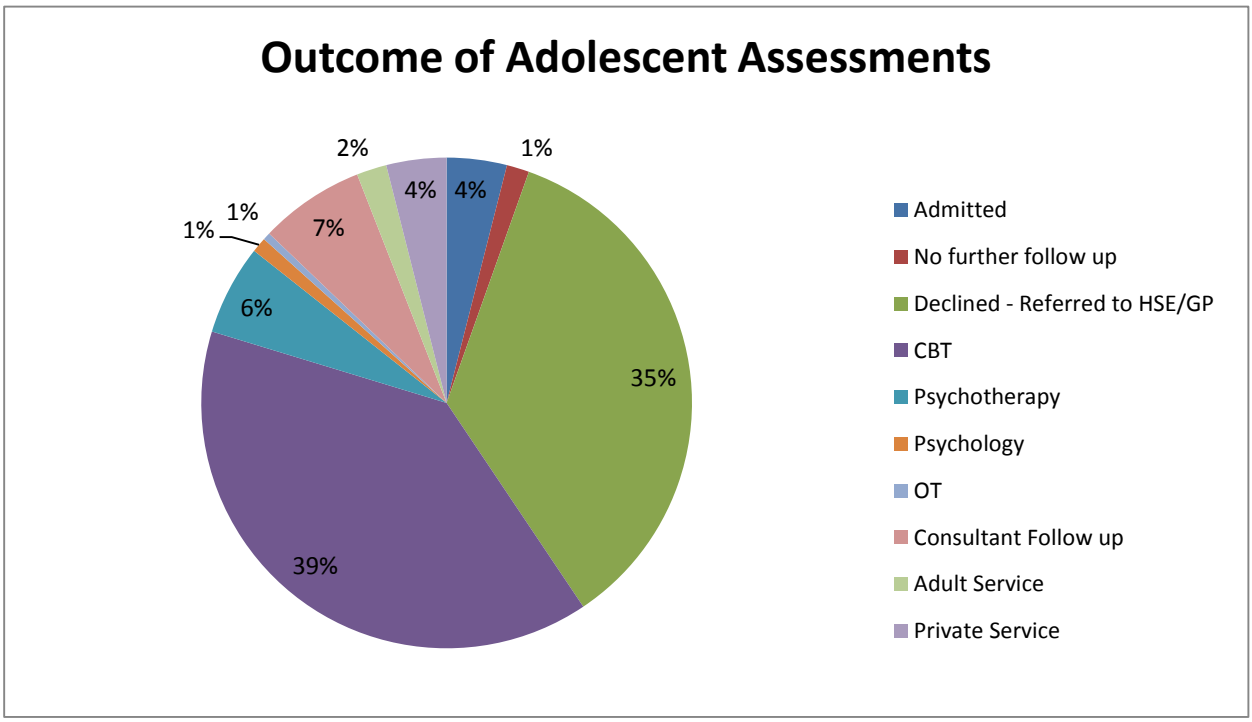
Year	Total No. Of Dean Clinic Adolescent Appointments
2016	1,944

The total number of admissions to Willow Grove Adolescent Unit in 2016 was 74. The table below summarises the number of first time inpatient admissions to Willow Grove following an Adolescent Dean Clinic assessment in 2016.

Year	First Admission
2016	68

2.1.12 Dean Clinic: Outcome of Assessments

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



2.2. SPMHS's Inpatient Care

SPMHS comprises three separate approved centres including St Patrick's University Hospital (SPUH) with 241 inpatients beds, St Edmundsbury Hospital (SEH) with 52 inpatient beds[1] and Willow Grove Adolescent Unit (WGAU) with 14 inpatient beds. In 2016, there were a total of 3,028 inpatient admissions across the organisation's three approved centres compared to 3,000 for 2015 and 3,015 for 2014.

2.2.1. SPMHS Inpatient Admission Rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the hospital's three approved centres; SPUH, SEH and WGAU for 2016.

The table below shows inpatient admission numbers and the percentage rates for Male and Female admissions. In 2016, 62.4% of admissions across all three Approved Centres were female, compared to 60.4% in 2015 and 62.3% in 2014.

No. of Admissions (% of Admissions) 2016				
	SEH	**SPUH**	**WGAU**	**Total**
Female	364 (71.5%)	1,463 (60.0%)	63 (78.8%)	1,890 (62.4%)
Male	145 (28.5%)	976 (40.0%)	17 (21.2%)	1,138 (37.6%)
Total	**509 (100%)**	**2,439 (100%)**	**80 (100%)**	**3,028 (100%)**

The table below shows the average age of service users admitted across the 3 Approved centres was 50.45 years in 2016. This compares to 48.58 years in 2015. The average age of adolescents admitted to WGAU was 15.92 years as compared with 15.44 years in 2015. The average age of adults admitted to SEH was 54.87 years in 2016 & 54.69 years in 2015. Finally, the average age of adults admitted to SPUH was 50.66 years in 2016 compared with 48.57 years in 2015.

[1] Up until 1 April 2016, St Edmundsbury Hospital functioned with 50 inpatient beds at which stage 2 additional beds were added to increase bed capacity at SEH from 50 to 52

Average Age at Admission 2016					
	SEH	SPUH	Total Adult	WGAU	Total
Female	55.42	51.8	52.52	15.89	51.3
Male	53.5	48.95	49.53	16.03	49.03
Total	54.87	50.66	51.38	15.92	50.45

2.2.2. SPMHS Inpatient Length of Stay 2016

The following Tables present the 2016 average length of stay (ALOS) for adult inpatients (over 18 years of age) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis and presentation of inpatient length of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2016 Adults	Number of Discharges	Percentage
Under 1 week	524	18%
1 -<2 weeks	267	9%
2-<4 weeks	556	19%
4-<5 weeks	376	13%
5-<6 weeks	321	11%
6-<7 weeks	250	8%
7-<8 weeks	181	6%
8-<9 weeks	142	5%
9-<10 weeks	91	3%
10-<11 weeks	74	2%
11 weeks -< 3 months	86	3%
3-<6 months	105	4%
6-12 months	6	0.2%
Total Number of Adult Discharges 2016	**2979**	**100%**

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

2016 WG	Number of Discharges	Percentage
Under 1 week	6	7%
1 -<2 weeks	1	1%
2-<4 weeks	5	6%
4-<5 weeks	6	7%
5-<6 weeks	8	10%
6-<7 weeks	4	5%
7-<8 weeks	6	7%
8-<9 weeks	8	10%
9-<10 weeks	5	6%
10-<11 weeks	6	7%
11 weeks -< 3 months	14	17%
3-<6 months	12	15%
Total Number of Adolescent Discharges 2016	**81**	**100%**

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpatients discharged in 2016)

The table below outlines the prevalence of diagnoses across SPMHS three Approved Centres during 2016 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded on admission and at the point of discharge are presented for all three of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Edmundsbury Hospital combined. The data presented is based on all inpatients discharged from SPMHS in 2016.

SPMHS Analysis of Inpatient Primary ICD Diagnoses

(For all inpatients discharged in 2016)

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

ICD Codes: Admission & Discharge **For All Service Users Discharged in 2016**	SPUH Admission ICD		SPUH Discharge ICD		SEH Admission ICD		SEH Discharge ICD		Total Adult Admission ICD		Total Adults Discharge ICD		WGAU Admission ICD		WGAU Discharge ICD	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	39	1.6	40	1.6	8	1.6	0	0.0	47	1.6	40	1.3	1	1.2	0	0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	409	16.5	415	16.8	25	4.9	37	7.3	434	14.6	452	15.2	0	0	0	0
F20-F29 Schizophrenia, schizotypal and delusional disorders	228	9.2	244	9.9	23	4.5	24	4.7	251	8.4	268	9.0	5	6.2	4	4.9
F30-F39 Mood [affective] disorders	1340	54.2	1257	50.8	377	74.5	360	71.1	1717	57.6	1617	54.3	32	39.5	30	37.0
F40-F48 Neurotic, stress-related and somatoform disorders	288	11.6	272	11.0	59	11.7	63	12.5	347	11.6	335	11.2	19	23.5	19	23.5
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	66	2.7	66	2.7	1	0.2	0	0	67	2.2	66	2.2	21	25.9	22	27.2
F60-F69 Disorders of adult personality and behaviour	94	3.8	153	6.2	12	2.4	21	4.2	106	3.6	174	5.8	1	1.2	0	0
F70-F79 Mental retardation	1	0	1	0.0	0	0	0	0	1	0	1	0.0	0	0	0	0
F80-F89 Disorders of psychological development	4	0.2	3	0.1	1	0.2	1	0.2	5	0.2	4	0.1	0	0	2	2.5
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	2	0.1	1	0.0		0		0	2	0.1	1	0.0	2	2.5	3	3.7
F99-F99 Unspecified mental disorder	2	0.1	21	0.8		0.0		0.0	2	0.1	21	0.7		0	1	1.2
Totals	2473	100	2473	100	506	100	506	100	2979	100	2979	100	81	100	81	100

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

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

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

The data below provides information on the types of services accessed by service users. In 2016, the WRC received a total of 1,943 day programme referrals compared to a total of 2,465 for 2015 a year on year reduction of 21%. 510 of the day programme referrals for 2016 came from Dean Clinics. This compares to a total of 816 day programme referrals from Dean Clinics in 2015.

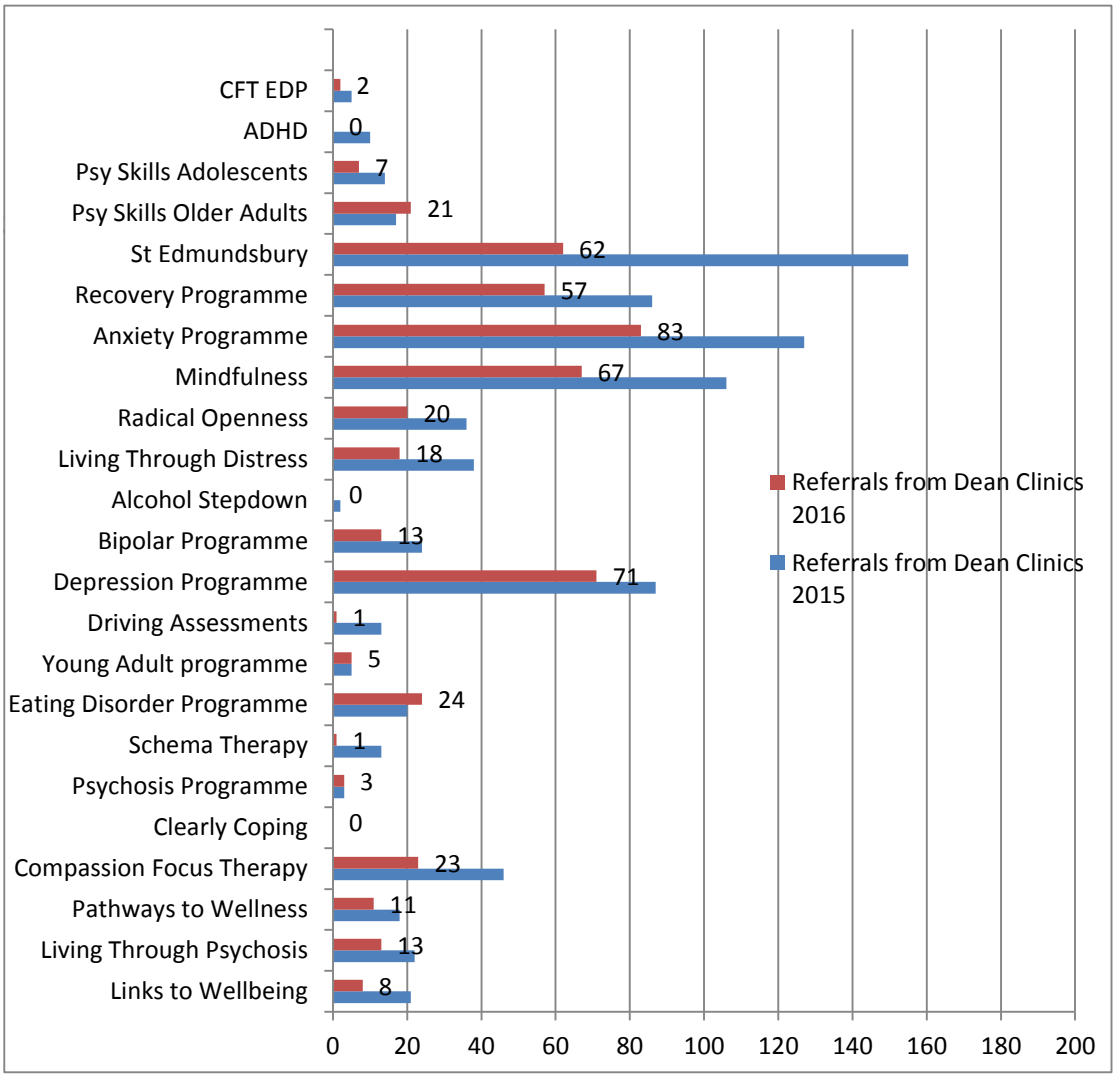
2.3.1. Day-Patient Referrals by Clinical Programme

The table below compares the total number of day programme referrals to each clinical programme for 2015 and 2016. In addition, day programme referrals received from the Dean Clinics are presented.

SPMHS Day Programmes	Total Day Patient Referrals 2015	Total Day Patient Referrals 2016	Total Day Patient Referrals from Dean Clinics 2015	Total Day Patient Referrals from Dean Clinics 2016
Links to Wellbeing	59	35	21	8
Living Through Psychosis	127	76	22	13
Pathways to Wellness	50	37	18	11
Compassion Focused Therapy	193	103	46	23
Clearly Coping	0	0	0	0
Psychosis Programme	16	9	3	3
Schema Therapy	27	28	13	1
Eating Disorder Programme	50	41	20	24
Young Adult programme	5	9	5	5
Driving Assessments	18	9	13	1
Depression Programme	271	324	87	71
Bipolar Programme	74	68	24	13
Alcohol Stepdown	129	112	2	0
Living Through Distress	155	107	38	18
Radical Openness	144	111	36	20
Mindfulness	183	115	106	67
Anxiety Programme	236	198	127	83
Recovery Programme	261	228	86	57
St Edmundsbury Services	384	247	155	62
Psychology Skills for Older Adults	25	60	17	21
Psychology Skills for Adolescents	21	9	14	7
Living with ADHD	10	0	10	0
Compassion Focused Therapy for Eating Disorders	27	17	5	2
Total	**2465**	**1943**	**868**	**510**

2.3.2. Day-patient Referrals by Gender

Of all referrals to day services in 2016 1188 (61%) were female and 757 (39%) were male. This compares to 67.7% female and 32.3% male in 2015.



3.3. Day-patient Referrals from Dean Clinics

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

In 2015, a total of 868 day patient referrals were made from Dean Clinics, representing 35.6% of the total referrals to Day Programmes, 11.36% less than 2015.

2.3.4. Day-patient Attendances for Clinical Programmes 2016-2015

In 2015, 1,397 day patients commenced day programmes. 1,213 commenced in 2016. These registrations represented a total of 13,343 and 13,085 half day attendances respectively. Therefore in 2015 each registered day service user attended on average 10.24 half days while in 2016 each registered day service user attended on average 10.78 half days.

Day Patient Attendances at Clinical Programmes

SPMHS Day Programmes	Total Day Patient registrations 2015	Total Day Patient registrations 2016	Total Day Patient Attendances 2015	Total Day Patient Attendances 2016
Links to Wellbeing	19	18	334	123
Living Through Psychosis	62	51	342	339
Pathways to Wellness	23	25	358	388
Compassion Focus Therapy	68	63	736	666
CFT Eating Disorders	15	10	152	245
Psychosis Programme	9	5	43	16
Schema Therapy	13	20	190	215
Eating Disorder	36	30	1523	871
Young Adult programme	2	7	19	96
Driving Assessments	13	10	13	10
Depression Programme	112	110	1148	1412
Bipolar Programme	46	38	428	206
Alcohol Stepdown	116	123	1009	860
Living Through Distress	74	70	593	717
Radical Openness	75	45	1000	1000
Mindfulness	126	84	710	438
Anxiety Programme	101	86	1048	1027
Recovery Programme	153	151	2526	2375
Living with ADHD	5	0	31	0
Psychology Skills Adolescents	11	13	124	207
Psychology Skills Older Adults	16	37	134	267
Day Services Based at St Edmundsbury				
Acceptance Commitment Therapy	87	86	600	617
Compassion Focused therapy	26	14	225	204
Healthy Self Esteem	38	22	398	216
Mindfulness	53	35	315	198

Mood Management	10	17	38	78
Radical Openness	10	12	191	193
Roles in Transition	26	31	86	101
Other Programmes*	0		0	
	1397	1213	14317	13085

*Until March 2014 all St Edmundsbury day programmes were captured under the heading of 'St Edmundsbury day programmes'. Since this date they are captured per individual programme.

2.3.5. Section Summary

In 2016, service users received a range of clinical programmes and services accessed through structured and defined inpatient, day-patient and outpatients care based on need, urgency and service user preference. Demand is a parameter of health service quality to provide information about how the organisation structures and resources its services, and thus the quality of these services. Information regarding service demand allows for the timely and appropriate resourcing of all day services. In 2016 day programmes continued to be improved and enhanced to allow for greater choice of services for service users and referrers. While the number of referrals to SPMHS day services decreased, attendance remained relatively strong, indicating a greater understanding of the services available and therefore more appropriate referral pathways. In 2015 56.6% of all those referred commenced a day programme. In 2016 that figure increased to 62.42%.

The reduced number of referrals and subsequent attendances at Day Services in 2016 following an upward trajectory in previous years is similar to a trend seen in 2010/2011, and can be attributed to a number of factors e.g. inpatient occupancy, geographic spread and economic conditions. As with 2010/2011, this change in referral and attendance patterns is an opportunity to reassess the timing and delivery methods of our programmes into 2017.

SECTION 3

Clinical Governance

3. Clinical Governance & Quality Management

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

3.1 Clinical Governance Measures Summary

Governance Measure	2012	2013	2014	2015	2016
Clinical Audits	25	19	10	16	26
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	608	635	627	666	860
Number of Incidents An event or ciscumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	1,707	2,098	2,227	2,423	2,605
Root Cause Analyses & Focused Reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	5	6	11	9	3
Number of Section 23's – Involuntary detention of a voluntary service user A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the Approved Centre (SPUH) - where the person indicates an intention to discharge from the Approved Centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	94	107	107	92	84
% Section 23's which progress to Involuntary admission (Section 24 - Form 13 Admissions) Following Section 23 an examination by the Responsible Consultant Psychiatrist and a second Consultant Psychiatrist the person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	46% (43)	37 % (40)	43% (46)	44% (41)	48% (41)
Number of Section 14's – Involuntary Admissions An involuntary admission that occurs as a result of an application from a spouse or relative, a member of An Garda Síochána, an Authorised Officer or a member of the public and a recommendation from a GP (the person is admitted as involuntary). A person subject to such an admission may decide to remain voluntarily.	35	46	52	39	60
% of Section 14's which progress to Involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	86% (30)	76% (35)	80% (42)	87% (34)	88% (53)
Number of Section 20/21 - Transfers Where an involuntary patient is transferred to an approved centre under *Section 20 or 21* of the Mental Health Act 2001, the clinical director of the centre from which he or she has been transferred shall, as soon as possible, give notice in writing of the transfer to the MHC on Statutory Form 10.	8	21	13	19	18
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	22	33	37	18	15
Number of Section 60 – Medication Reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of 3 months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	5	15	11	10	4
Number of Section 19 – Appeal to Circuit Court A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness.	5	6	2	2	0
Number of Tribunals held	72	96	91	63	72
Mental Health Commission Reporting – Number of ECT Programme's (Signed off) in 2016	119	129	143	103	142
Mental Health Commission Reporting – Number of Physical Restraint Episodes (SPUH + WGAU)	157	219	129	178	174

3.2. Clinical Audits

This section summarises briefly the clinical audit activity for St. Patrick's Mental Health Services in 2016. Clinical audit is an integral part of clinical governance. Its main purpose is to improve the quality of care provided to service users and the resulting outcomes. The clinical audit process is a cycle which involves measurement of the quality of care and services against agreed and proven standards for high quality and taking action to bring practice in line with these standards. A complete clinical audit cycle involves re-measurement of previously audited practice to confirm improvements and make further improvements if needed.

3.2.1. Overview of Clinical Audit Activity

The table below demonstrates the breakdown of projects by type undertaken in 2016 including those facilitated by clinical staff at local level and those carried out throughout the organization led by various committees.

No.	Audit Title	Audit Lead	Status at year end
1.	**Appropriate use of benzodiazepines and hypnotic drugs** The aim of this audit is to determine if the use of benzodiazepines and night sedation (z drugs) in St. Patrick's Hospital, St. Edmundsbury Hospital and Willow Grove Unit is appropriate, provide feedback to the multidisciplinary teams and change practice if needed.	Clinical Governance Committee	Re-audit completed in 2016.
2.	**The Clinical Global Impression (CGI) and Children's Global assessment Scale (CGAS) level of change of change pre and post inpatient treatment** To measure the CGI /CGAS outcomes for service users pre and post admission	Clinical Governance Committee	Yearly audit completed
3.	**Individual Care Plan Key Worker System** Ensure compliance with the Mental Health Commission standards and local policies at St. Patrick's University Hospital, St. Edmundsbury Hospital and Willow Grove Adolescent Unit.	Clinical Governance Committee	Three re-audit completed in 2016. Consecutive re-audit is scheduled for March 2017.
4.	**Audits of compliance with the Regulations for approved centres** To ensure compliance with the Mental Health Commission guidelines and rules of practice	Departmental Audits	Baseline audits and re-audits completed in 2016.
5.	**Use of sodium valproate** To ensure service users are prescribed valproate for an appropriate indication and safety of a potential unborn baby if a woman of a child bearing potential is prescribed valproate	Clinical Governance Committee	Baseline audit completed.
6.	**Prescribing and Monitoring of High Dose Antipsychotic Therapy (HDAT)** To determine whether appropriate monitoring is carried out for service users who are prescribed High Dose Antipsychotic Therapy HDAT.	Clinical Governance Committee	Re-audit completed in 2016.

No.	Audit Title	Audit Lead	Status at year end
7.	**Transfer of Residents** To ensure that full and complete written information regarding a service user provided to a receiving facility on a service user transfer to an approved centre or other health care facility.	Clinical Governance Committee	Baseline audit completed.
8.	**Admissions** To assess the quality of the psychiatric admission assessment record and to ensure that the documentation meets the MHC requirements of the Code of Practice on Admissions, Transfers and Discharges to and from an Approved Centre, section 15.3.	Clinical Governance Committee	Baseline audit completed.
9.	**Multidisciplinary Teams' weekly review of incidents** To ensure that the system for clinical incidents being reviewed by the MDTs at their weekly meetings and maintaining records of same has been implemented.	Clinical Governance Committee	Baseline audit completed.
10.	**Prescribing for substance misuse: alcohol detoxification (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE clinical guidelines on alcohol-use disorders (NICE CG100, 2010 and CG115, 2011).	Clinical Governance Committee	Baseline audit completed.
11.	**Prescribing antipsychotic medication for people with dementia (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE-SCIE Guideline on supporting people with dementia and their careers in health and social care – CG042 (2006).	Clinical Governance Committee	Baseline audit completed.

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

No.	Audit Title	Audit Lead	Status at year end
12.	**Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE Guideline on Violence and aggression: short-term management in mental health, health and community settings - NICE NG10 (2015).	Clinical Governance Committee	Baseline audit completed.
13.	**Adherence to the organisations protocol on falls risk prevention interventions** Ensure that service users identified as medium or high risk of fall or with fall episode are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Re-audit completed.
14.	**ECT Booklet** To assess consistency and appropriateness of the ECT documentation in accordance with the MHC guidelines.	Clinical Governance Committee	Re-audit completed.
15.	**Nursing Metrics** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit.
16.	**Infection Control Audits** Theses audits measure the implementation of policies and procedures relating to infection control	Infection Control Committee	These are yearly routine audits. Audits scheduled for 2016 were completed.

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

No.	Audit Title	Audit Lead	Status at year end
17.	**Audit on Audio/Visual Recording** To ensure current SPMHS practice on audio/visual recording is in compliance with the local policy and Data Protections Acts	Departmental Audit	Baseline audit completed.
18.	**Follow up of abnormal laboratory test results** To ensure that abnormal laboratory test results are correctly communicated, documented and reviewed.	Departmental Audit	Baseline audit completed.
19.	**Screening rates for osteoporosis in EDP inpatients with Anorexia Nervosa and EDNOS : Completed Audit Cycle** To determine whether all inpatients with a diagnosis of Anorexia Nervosa had an up to date DEXA scan according to the recommendations	Multidisciplinary Team	Completed.
20.	**An audit of the transition of care of 18 year old patients from Adolescent mental health services** To establish if transfer of care between Willow Grove Adolescent Unit/Dean Clinic Lucan Adolescent Outpatient Service and the Young Adult Service is occurring in line with best practice guidelines, with a view to improving the transfer of care process.	Multidisciplinary Team	Baseline audit completed.
21.	**The monitoring of vital signs in a psychiatric hospital in relation to the recognition of sepsis** To assess the recognition of sepsis in St. Patrick's Hospital	Multidisciplinary Team	Baseline audit completed.
22.	**Review compliance with documentation of last menstrual period for patients of child bearing potential on admission to SPUH** To review documentation on admission of LMP in clinical examination section and, if necessary, put in place measures to improve adherence to LMP documentation.	Multidisciplinary Team	Baseline audit completed.

No.	Audit Title	Audit Lead	Status at year end
23.	**Correct adherence to benzodiazepine and hypnotic withdrawal schedule** Measure adherence to the standard benzodiazepine and hypnotic detoxification schedules and the safety recommendations as stated in the SPMHS hospital guidelines and to implement changes to improve adherence to the guidelines.	Multidisciplinary Team	Baseline audit completed.
24.	**Pre-lithium commencement therapy treatments checks** To ensure that Lithium Therapy is efficacious and monitored effectively	Multidisciplinary Team	Baseline audit completed.
25.	**Audit to Assess the Practice of Prescribing Medication on medication record in Child and Adolescent Inpatient Unit (Willow Grove) of SPMHS** To assess prescribing practices on the medication record in Willow Grove Adolescent Unit and to ensure compliance with the local protocol.	Multidisciplinary Team	Completed.
26.	**Medical assessment and monitoring of adolescents with anorexia nervosa (AN)** Ensure compliance with gold standard medical monitoring protocol	Multidisciplinary Team	Completed.

3.2.2. Key Audit Outcomes for 2016

- A re-audit on the use of benzodiazepines and night sedation in St. Patrick's Mental Health Services showed a reduction in usage of this group of medications and a significant improvement in adherence to the guidelines and local protocols.
- A Clinical Audit Programme for the audits of compliance with the Regulations for approved centres has been developed and all Departments are actively involved.
- The findings from the audit on prescribing for alcohol detoxification support the fact that current alcohol detoxification screening, prescribing, and monitoring provided by the specialist teams in St. Patrick's Mental Health Services compare favourably to the levels established by other Mental Health Service Providers who participated in the POMH-UK audit.
- The audits on prescribing of Sodium Valproate, on prescribing and monitoring of High Dose Antipsychotic Therapy and on the Lithium therapy initiation led the Organization to work on improving practices regarding prescribing to women of child bearing potential.
- The clinical audit confirmed that abnormal laboratory test results are brought to the attention of the clinicians and acted upon by them in a timely manner.
- Greater junior doctors' involvement in clinical audit was achieved by putting in place enhanced support structures.

SECTION 4

Clinical Outcomes

4. Clinical Outcomes

Clinical outcome measurement has been in place in St Patrick's Mental Health Services since 2011 and is a priority for the service, embedded within clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2016 outcome measurement expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing shift towards an organisational culture that recognises the value of integrated outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important Considerations for Interpretation of Outcomes.

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

- The data reported in this chapter represent pre and post programme measurements.
- Pre and post measurement is carried out at the start and finish of programmes but other elements of care, simultaneous interventions, time, medications etc. may also play a part (any effects cannot be solely attributable to clinical programme intervention).
- Where appropriate to the analysis of outcomes, paired sample t-tests are used to determine if, across the sample, post-scores are statistically significantly different from pre-scores. Where a t-test is not appropriate the non-parametric alternative, a Wilcoxin Signed Rank test is used. **Statistical significance** indicates the extent to which the difference from pre to post is due to chance or not. Typically the level of significance is set at $p > 0.05$ which means that there is only a 5% probability that the difference is due to chance and therefore it is likely that there is a difference. Statistical significance provides no information about the magnitude, clinical or practical importance of the difference. It is possible that a very small or unimportant effect can turn out to be

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

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

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

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

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

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for Inpatient Care 2016

4.2.1. Objective

An evaluation of severity of illness measures completed at the point of inpatient admission, measures gradual inpatient outcomes for service users' and carried out when inpatient treatment is concluded. These scales are completed by clinicians using the Clinical Global Impressions (CGI) in case of adults and the Clinical Global Assessment Scale in the case of adolescents.

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

4.2.1.1. Background

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

The CGIS asks a clinician the question: "Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?" which is rated on the following seven-point scale: 1=normal, not

at all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.

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

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

4.2.1.2. Data Collection Strategy

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

A random sample was chosen from admissions to SPUH and SEH. The sample size was calculated for both approved centres together with 95% confidence level and 5% level of accuracy. Then the cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases for each ward within the services.

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

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

- Service user age and gender,
- Admission ICD code (primary and additional),
- Date of admission,
- Admission ward,
- Re-admission rate,
- Date of discharge,
- Baseline assessment scale score (CGIS or CGAS respectively)– recorded on the Individual Care Plan on or before the first MDT meeting,
- Date recorded against the baseline score,
- Final assessment scale score (CGIC or CGAS respectively)– recorded on the MDT meeting care plan review document,
- Date recorded against the final score.

4.2.2. Sample Description

		TOTAL ADULT SERVICE	WILLOW GROVE
Sample size		324	76
Admissions	1st admission	37%	91%
	Re-admission	63%	9%
Average age ± standard deviation		50±18	15 ± 1
Gender breakdown	Female	59%	75%
	Male	41%	25%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

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

		TOTAL ADULT SERVICE			WILLOW GROVE		
ICD-10 Admission Diagnosis Category		**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
F30-F39	Mood disorders	58%	58%	53%	54%	51%	39%
F40-F48	Neurotic, stress-related and somatoform disorders	15%	14%	15%	12%	13%	24%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	12%	17%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	4%	7%	7%	1.5%	1%	5%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	3%	3%	2%	23.5%	30%	26%
F00-F09	Organic, including symptomatic, mental disorders	0.5%	1%	0%	0%	0%	1%
F60-F69	Disorders of adult personality and behaviour	3.5%	6%	4%	9%	4%	1%
F80-F89	Disorders of psychological development	0%	0%	0%	0%	0%	0%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0.2%	0.3%	0%	1.5%	0%	3%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *Total adult service*

CGIS -Baseline measure of severity of illness		2014	2015	2016
		TOTAL	TOTAL	TOTAL
1	Normal, not at all ill	0.2%	0%	0%
2	Borderline mentally ill	2%	0%	0%
3	Mildly ill	9%	9%	10%
4	Moderately ill	32%	30%	30%
5	Markedly ill	33%	30%	30%
6	Severely ill	16%	18%	15%
7	Extremely ill	2%	0%	2%
	Not scored	6%	12%	13%

Table: *Total adult service*

CGIC – Final Global improvement or change score		2014	2015	2016
		Total	Total	Total
1	Very Much improved	15%	13%	13%
2	Much Improved	43%	49%	37%
3	Minimally Improved	13%	16%	15%
4	No Change	4%	6%	5%
5	Minimally Worse	1%	0%	0%
6	Much Worse	0%	0%	0%
7	Very Much Worse	0%	0%	0%
	Not scored	24%	16%	31%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		**2014**		**2015**		**2016**	
		Baseline	**Final**	**Baseline**	**Final**	**Baseline**	**Final**
100-91	Superior functioning	0%	0%	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	0%	0%	0%
80-71	No more than a slight impairment in functioning	0%	1.5%	0%	0%	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	24%	0%	12%	0%	45%
60-51	Variable functioning with sporadic difficulties	33%	65%	33%	68%	24%	38%
50-41	Moderate degree of interference in functioning	58%	4%	55%	10%	61%	8%
40-31	Major impairment to functioning in several areas	5%	1.5%	6%	0%	12%	4%
30-21	Unable to function in almost all areas	0%	0%	0%	0%	4%	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	5%	3%	6%	10%	0%	5%
Mean ±SD		50±5	57±16	49±5	57±4	45±7	59±7
Median		50	58	50	57	45	59
Wilcoxon Signed Ranks Test:		Z=-5.7017,p<.05		Z=-5.983, p<.001		Z=-5.485, p<.001	

4.2.4. Audit on Completion Rates of Baseline and Final CGI Scores

4.2.4.1. Clinical Audit Standards

Standard 1: Baseline score is taken within at least 7 days following admission;
Exception: Short admission;
Target level of performance: 100%.

Standard 2: Final score is taken within at least 7 days prior to discharge;
Exception: Short admission, unplanned discharge;
Target level of performance: 100%

4.2.4.2. Results

	TOTAL ADULT SERVICE			WILLOW GROVE		
	2014	2015	2016	2014	2015	2016
Baseline Assessment Scale Score						
% of clinical records with recorded baseline scores	94%	88%	87%	100%	94%	100%
% compliance with clinical audit standard no.1	90%	67%	84%	85%	72%	99%
Final Assessment Scale Score						
% of clinical records with recorded final scores	77%	84%	69%	99%	90%	95%
% compliance with clinical audit standard no. 2	70%	81%	83%	61%	80%	95%

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Mental Health Services inpatient discharges for 2016.

2. A female to male ratio was for adult service user's 1.4:1 for adults and WGAU 3:1 for adolescents.

3. Among the adults, there was a 7% increase in the number of service users who were admitted for the first time, in comparison to 2015. In the 2016 sample, 1st admissions accounted for 37% of adult service users.

4. 91% of WGAU admissions in 2016 were first admissions to a mental health service. There was a 4% increase in the number of first admissions in comparison to the 2015 data.

5. 2016 analysis of the primary ICD-10 codes showed that for the adult population the most frequent reasons for admission were mood disorders followed by behavioral disorders due to psychoactive substance use and neurotic, stress related, somatoform disorders.

6. In 2016 the breakdown of baseline clinical global improvement scores on admission shows that 30% of SPUH and SEH service users were markedly ill. Another 30% were moderately ill. 15% were severely ill. 2% of service users were extremely ill on admission.

7. Based on a sample of 224 (total cases with discharge CGI score documented) 93% of the sample were rated with an overall improvement (1 - very much improved (18%), 2 - much improved (54%) and 3 - minimally improved (21%)). The percentage of sample rated with an overall improvement is exactly same as it was observed in 2014 and 2015.

8. The majority (61%) of WG service users were scored as having a moderate degree of interference in functioning on admission. The ratings revealed an overall higher impairment of functioning in young people on admission in comparison to 2015 data.

9. The overall improvement rate for Willow Grove Adolescent Unit was 87% which gives a 12% increase in comparison to 2015 data. Of the sample 1% were found to have no change and this referred to a case with short 6 day admission. Another 5% were found to have dis-improved following in-patient treatment.

10. The audit shows that 31% final CGI scores were not recorded on discharge.

11. The audit shows that in 5% of cases the final CGAS score was not recorded on discharge. All these cases referred to short (below 7 days) admissions.

4.3. Acceptance & Commitment Therapy Programme

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

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

4.3.1. Descriptors

In 2016, data were available for a total of 72 participants. Both pre and post measures were available for 67 of those completing the programme, representing 93.1% of the sample.

4.3.2. ACT Outcome Measures

The following programme measures were used:

- **Acceptance & Action Questionaire II**

The Acceptance and Action Questionnaire (AAQ II: Bond et al., 2011) is a 10 item measure of experiential avoidance or the tendency to avoid unwanted internal experiences – the opposite of which is psychological flexibility. Service users are asked to rate statements on a seven point likert scale from 1 "Never True" to 7 "Always true". Scores range from 1 to 70 with higher scores indicating greater psychological flexibility/less experiential avoidance. The AAQ II has good validity, reliability (Cronbach's alpha is .84 (.78 - .88)), and 3- and 12-month test-retest reliability (.81 and .79, respectively) (Bond et al., 2011).

- **Behavioural Activation for Depression Scale**

The Behavioural Activation for Depression Scale (BADS: Kanter, Mulick, Busch, Berlin & Martell, 2007) measures behaviours hypothesized to underlie depression and examines changes in: activation, avoidance/rumination, work/school impairment, and social impairment. The BADS consists of 25 questions; each rated on a seven point scale from 0 "not at all" to 6 "completely". Scores range from 0 to 150 with higher scores representing increased behavioural activation. Mean scores for a non-clinical sample of undergraduate students were 110.51 (*SD* = 21.04) (Kanter et al., 2007) and for a community sample with elevated depressive symptoms the mean was 69.83 (SD =20.15) (Kanter, Rusch, Busch & Sedivy, 2009). The measure has good internal consistency (Cronbach's α ranging from .76 - .87), adequate test-retest reliability (Cronbach's α ranging from .60 - .76), and good construct and predictive validity (Kanter et al., 2007).

- **Five Facet Mindfulness Questionnaire**

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity- to inner experience, and non-judging of inner

experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 "never or very rarely true" to 5 "very often or always true". Scores range from 39 to 195 with higher scores suggesting higher levels of mindfulness. In a study of non-clinical samples participants who regularly practice mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practice mindfulness had a mean of 138.9 (*SD* = 19.2) (Lykins & Baer, 2009). The measure evidences good reliability (alpha co-efficient ranging from .72 to .92 for each facet) (Baer et al., 2006). Evidence for construct validity comes from analysis of data from samples with mindfulness meditation and no mindfulness meditation experience (Baer et al., 2006).

- **Work and Social Adjustment Scale**

The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a 9-point Likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in functioning. In a study including participants with Obsessive Compulsive Disorder or Depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Marks, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

- **The Self-Compassion Scale**

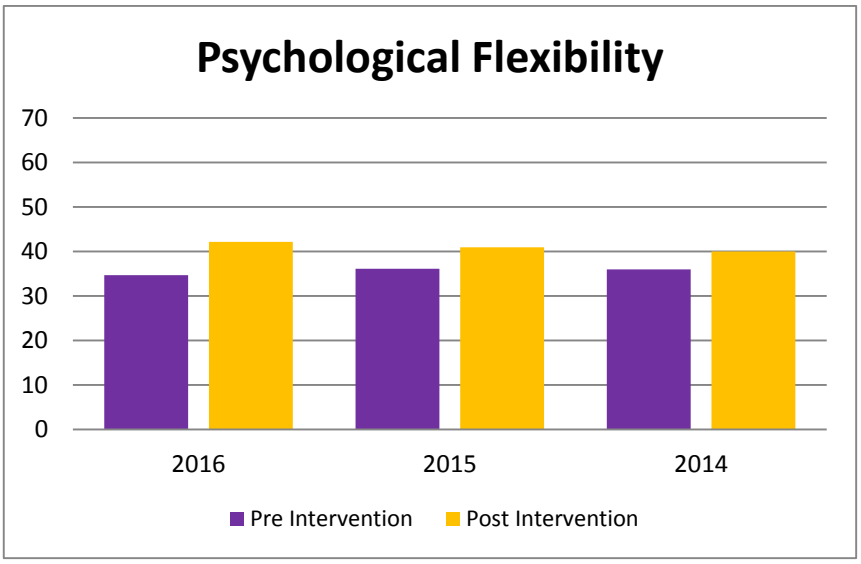
The Self-Compassion Scale (SCS) is a twenty-six item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; Self-Kindness, Self-

Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts. Each item is rated on a 5 point Likert scale, from 1 Almost Never to 5 Almost Always.

4.3.3. Results

Acceptance & Action Questionnaire-II

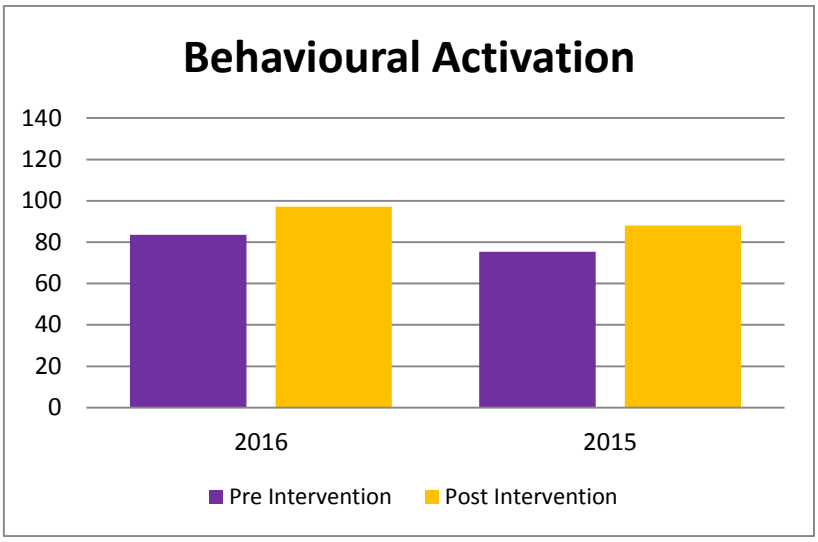
Graph: Psychological Flexibility as measured by the AAQ-II



Total scores on the AAQ-II showed a statistically significant increase, t (50) = 5.51, p < .05, which indicates greater psychological flexibility post programme. An effect size (*d)* of .77, indicates a medium effect size. Pre and Post mean scores on the AAQ-II were similar to those reported in previous years.

Behavioural Activation for Depression Scale (BADS)

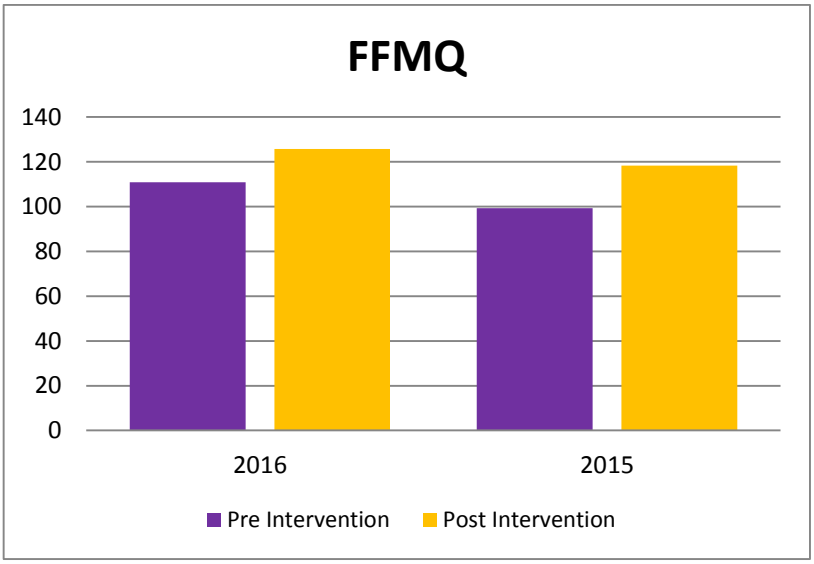
Graph: Behavioural Activation as measured by the BADS



Mean BADS scores increased significantly from (M = 83.57, SD =23.28) to (M = 97.18, SD = 22.75) indicating greater behavioural activation, t (50) = 3.80, $p < .05$, representing a medium effect size (d = .59). The percentage of those completing the programme with scores below 70 (the mean reported by Kanter et al. (2009) for a sample with elevated depressive symptoms) reduced from 37.7% to 11.8% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

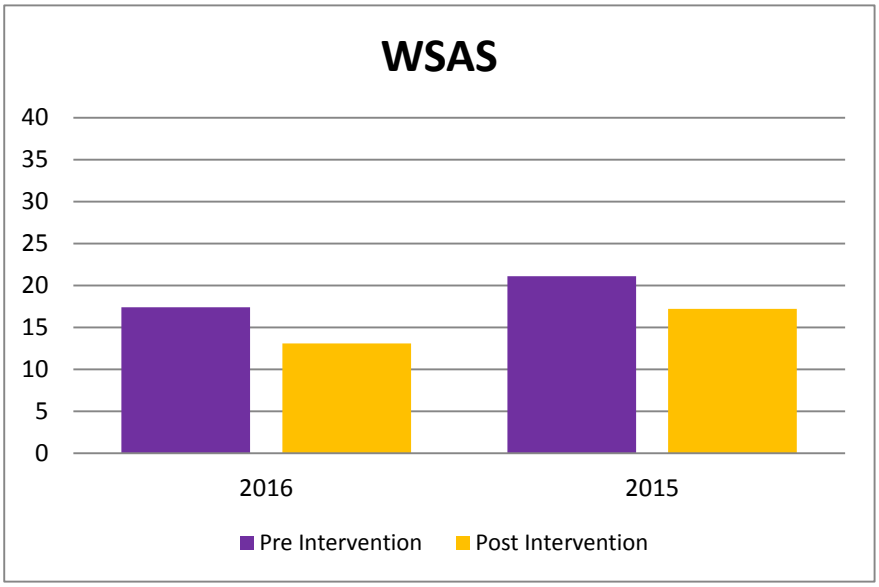
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (46) = 6.20, $p < .05$, from pre (M = 110.89, SD = 20.20) to post (M =125.77, SD = 20.33) indicating greater levels of overall mindfulness, with a medium effect size observed (Cohen's d =.73). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

Work and Social Adjustment Scale (WSAS)

Graph: Total Work and Social Adjustment Scale Scores



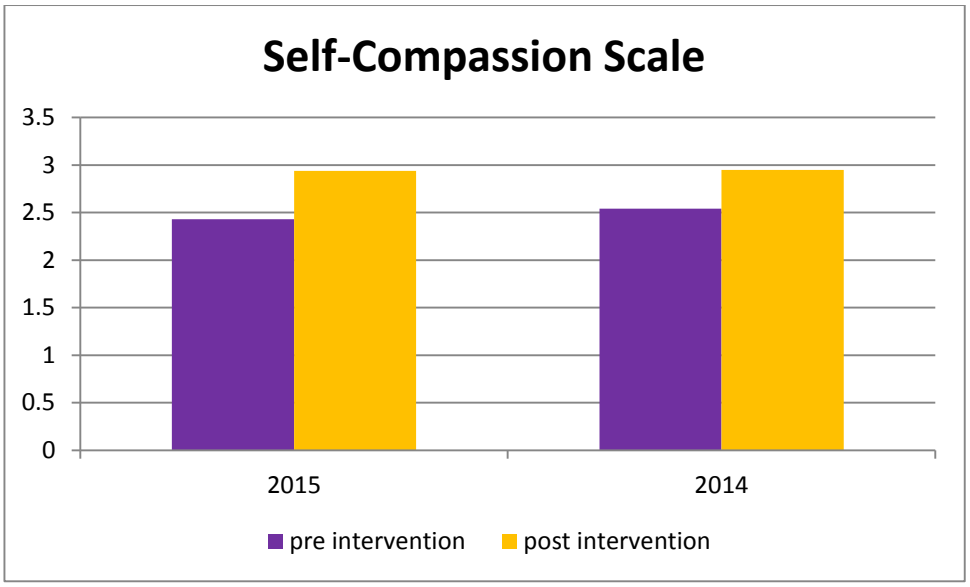
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (50) = 3.74, p <.05, from 17.39 (SD = 8.64) to 13.11 (SD =7.08), indicating less functional impairment. The effect size of Cohen's d =.54 indicates a small effect.

The scores on both pre and post means are within the range which indicates significant functional impairment but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 20% of those who completed the programme had scores below 10 when they started the programme, while 35.3% had scores below 10 on completion of the programme.

These findings are in line with the 2015 and 2014 outcomes reports that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

Self-Compassion Scale

Graph: Total scores on Self-Compassion Scale



Total SCS scores increased significantly, t (47) = 3.09, $p < .05$, from pre (M = 2.47, SD = .61) to post (M = 2.73, SD = .67) indicating higher overall levels of self-compassion post intervention. A small effect size was observed (Cohen's d = .40). Self-compassion is measured in six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts.

4.3.4. Summary

People who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. Comparisons show consistent results across 2016, 2015 and 2014. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of

mindfulness. This also allows for the potential comparison with published research. Programme facilitators added a measure of self-compassion in 2014 (Neff, 2003) and analysis of this measure suggests that promising change has continued between pre and post intervention scores, in its third year of use.

4.4.1. Alcohol and Chemical Dependency Programme Outcome Measures

- **Leeds Dependency Questionnaire (LDQ)**

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

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

Items are scored on a 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid,

psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

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

4.4.2. Descriptors

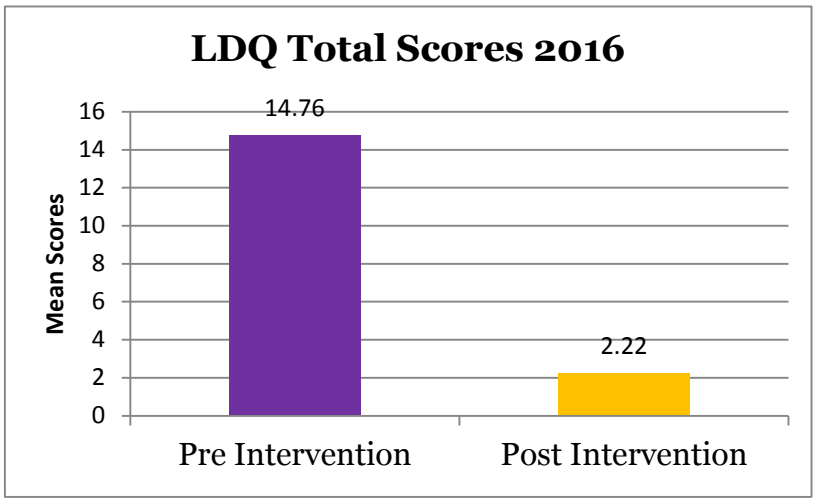
A total of 159 participants attended the full or modified programme in 2016, of whom, 102 participants completed the full programme. Pre and post data were available for 58 service users, which represents a 56.9% response rate. Of those that completed the programme, 58.6% of participants were male and 41.4% were female.

4.4.3 Results

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post programme participation. Following completion of the programme, a Wilcoxon Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, $z=5.73$, $p<.001$, with a large effect size ($r=.58$). The mean score on the total LDQ scores decreased from pre-programme to post-programme, as depicted in the graph below.

Leeds Dependency Questionnaire (LDQ)

Graph: Total scores on Leeds Dependency Questionnaire



4.4.4 Summary

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

These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and will continue to be used as the primary outcome measure in 2017. The low response rate means that the findings presented may not be representative of all participants who completed the programme and need to be interpreted in light of this. Response rates are expected to improve in 2017 as a result of post measures measures being administered as part of the exit interview.

4.5. Anxiety Disorders Programme

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

The programme is structured into two levels. Level 1 is a 5-week programme and includes group-based psycho-education and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based therapy, through behaviour workshops, which aid experiential goal work, fine tune therapeutic goals and identify possible obstacles, in order to address an individual's specific anxiety difficulties (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 provides a structured 8-week programme which is also based on a CBT approach focusing on shifting core beliefs, emotional processing and regulation, and increased exposure work. Service users typically attend Level 2 following discharge from hospital as an inpatient.

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

4.5.1. Anxiety Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2016. All service users attending the Anxiety Programme complete (or are rated on) the following measures, before starting the programme, after completing level

one of the programme and again after completing level two (if they have attended this level).

- **Beck Anxiety Inventory**

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

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a 21-item questionnaire developed to measure the intensity, severity, and depth of depression symptoms in patients with psychiatric diagnoses. Individual questions on the BDI assess mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores range from 0 – 63, where higher scores indicate, increased depressive symptoms. Scores can be interpreted in four qualitative categories: minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

- **Fear Questionnaire**

The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items which measure the extent to which potentially anxiety provoking situations are avoided using a 9-point Likert scale ranging from 0 "Would not avoid" to 8 "Always avoid". Four scores can be obtained from the Fear Questionnaire: Main Phobia Level of Avoidance, Total Phobia Score, Global Phobia Rating

and Associated Anxiety and Depression. For the purposes of this analysis the Total Phobia Score, was used. This measure has been found to be psychometrically sound with good discriminant validity and internal consistencies from .71 to .83 (Oei, Moylan, & Evans, 1991).

- **Yale Brown Obsessive Compulsive Scale**

Yale Brown Obsessive Compulsive Scale (Y-BOCS: Goodman et al., 1989) is widely considered the best available measure for assessing the severity of OCD and to measure the response to treatment. It was designed specifically to measure the severity of OCD regardless of the type of obsessions and compulsions. The Y-BOCS enables the clinician to rate the severity of the obsessions and compulsions separately e.g. (five items assess obsessions and five items assess compulsions) which enables the clinician to discern between the severity of obsessions and compulsions as well as have a global score of severity and response by adding the two separate scores.

Obsessions and compulsions are each assessed on a 5-point scale ranging from 0 "no symptoms" to 4 "severe symptoms" measuring the following: time spent engaging with obsessions and / or compulsions, the level of distress, the ability to resist and level of control over obsessions and compulsions. Scores are rated across five levels: Sub-clinical: 0 – 7; Mild: 8 – 14; Moderate: 16 – 23; Severe: 24 – 31; Extreme: 32 – 40. Taylor (1995, p. 289) states that: "When breadth of measurement, reliability, validity, and sensitivity to treatment effects are considered together, the YBOCS appears to be the best available measure for treatment outcome research".

- **Penn State Worry Questionnaire**

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

The PSWQ is a 16-item self-report measure. Participants are asked to rate worries on a 5-point scale ranging from 'Not at all typical of me' to 'Very typical of me', capturing the generality, excessiveness, and uncontrollability

of pathological worry. Total scores range from 16 to 80, with higher scores indicating greater worry. The reliability and validity of the PSWQ has been widely researched, positively correlating with other self-report measures of worry and aggregate peer ratings showing it to be of sound psychometric properties.

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

The Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009), aims to measure service users' feelings of safety, warmth, acceptance, and belonging within their social world. The measure is a brief 11-item, 5-point Likert scale, with responses ranging from 0 'Almost never' to 4 'Almost all the time'. Previous research has suggested that this scale's psychometric reliability is good (alpha=.92; Gilbert et al., 2009). This instrument was administered at time points, pre and post level 2.

- **Social Phobia Inventory (SPIN)**

The Social Phobia Inventory (SPIN; Connors et al., 2000) is a 17-item questionnaire developed by the Psychiatry and Behavioural Sciences Department at Duke University**.** The Social Phobia Inventory (SPIN) provides a patient-rated assessment of the three clinically important symptom domains of social phobia (Fear, Avoidance and Physiological Symptoms), with the practical advantages of brevity, simplicity and ease of scoring. The SPIN demonstrates solid psychometric properties, can be used as a valid measure of severity of social phobia symptoms, and is sensitive to the reduction in symptoms over time.

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

The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a 9-point Likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in functioning.

In a study including participants with Obsessive Compulsive Disorder or Depression, the scale developers report that "A WSAS score above 20 appears to suggest moderately severe psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Mark, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

4.5.2. Descriptors

Data were available for 72 people who completed the programme in 2016, of which 33 (45.8%) were female and 39 male (54.2%). Programme attendees ranged in age from 18 to 71 with an average age of 41.61 years (*SD* = 15.27). 54.2% or participants were in employment, 15.3% were unemployed, 11.1% were students, and 8.3% were retired, with the remaining percentage selecting "other". 55.6% of programme attendees were single, 31.9% were married, and 4.2% were separated. 41.7% of participants had achieved a 3rd level degree, 12.5% had a non-degree 3rd level education, and 43.1% had completed their Leaving Certificate. Post data were collected after Level 1 and Level 2 of the anxiety programme.

There were seven primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (40.3%), followed by Social Phobia/Anxiety (22.2%), Generalised Anxiety Disorder (18.1%), Agoraphobia (with/without panic) and Panic Disorder (12.5%), Specific Phobia and Health Anxiety (7%). The table below shows the percentage of people with each diagnosis over the past 4 years.

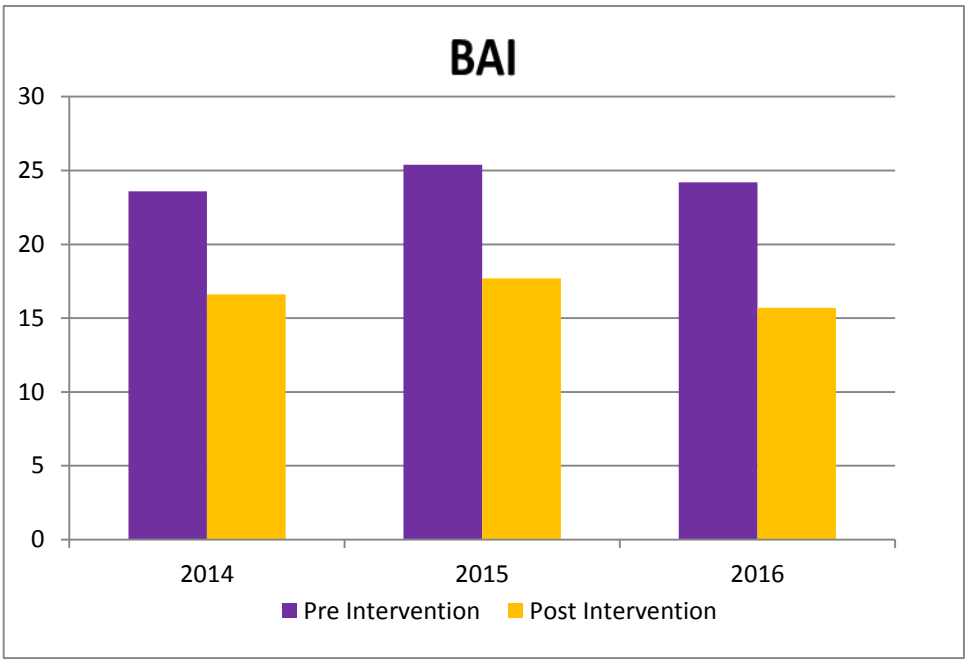
The majority of individuals with a diagnosis of OCD (n = 29) attended the OCD specific strand of the anxiety programme Level 1.

	2013		2014		2015		2016	
	N	%	N	%	N	%	N	%
Obsessive	50	42.0	40	44.9	35	35.7	29	40.3
Generalised	21	17.6	15	16.9	13	13.3	13	18.1
Social	20	16.8	18	20.2	21	21.4	16	22.2
Panic Disorder	9	7.6	9	10.1	11	11.2	7	9.7
Agorophobia	9	7.6	5	5.6	11	11.2	2	2.8
Health Anxiety	7	5.9	1	1.1	2	2	3	4.2
Specific Phobia	2	1.7	-	-	2	2	2	2.8

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved from the higher end of the moderate (*M* = 24.22, *SD* = 10.98) to the lower end of the moderate (*M* = 15.75, *SD* = 10.67) range on the measure. Changes were statistically significant, z = 5.98, p < .001, and reflect a large effect size (r = 0.49). At the pre measurement time point, 73.6% had anxiety scores in the

severe and moderate ranges, this dropped to 37.5% by the end of Level 1. See the table below for how these scores redistributed into the other categories.

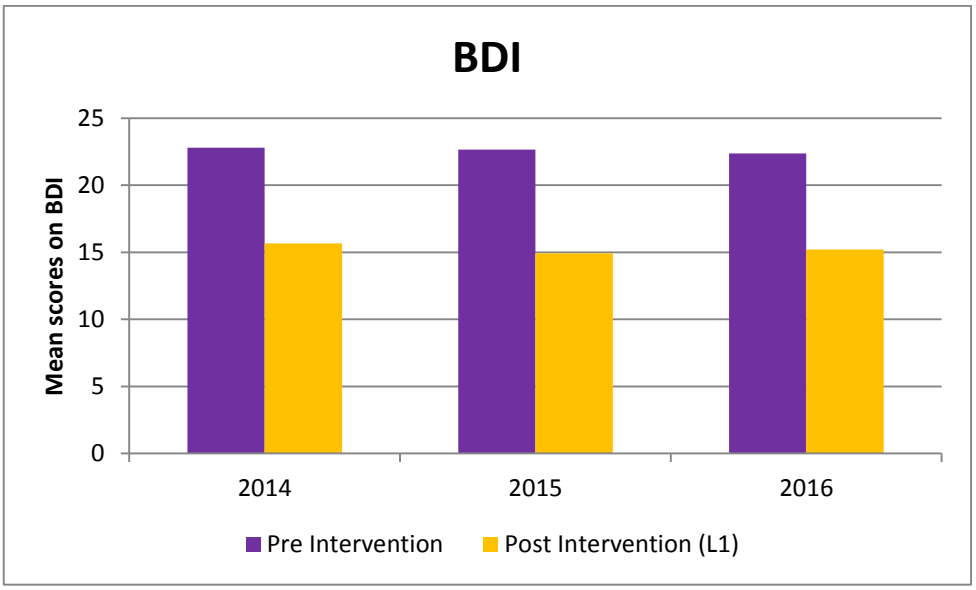
% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	8.3	30.6	12.5	52.1
Mild	18.1	31.9	25	22.5
Moderate	44.4	25	37.5	15.5
Severe	29.2	12.5	25	9.9
Totals	**100**	**100**	**100**	**100**

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

BAI	n	Pre Mean	Post Mean	T value	df	Sig.
Agoraphobic	2	46.00	28.5	7.00	1	.090
Social Phobia	16	22.75	16.75	3.24	15	.005
Panic Disorder	7	33.42	18.42	5.89	6	.001
GAD	13	23.31	13.07	5.09	12	.000
OCD	29	22.86	15.89	3.51	28	.002

Beck Depression Inventory (BDI)

Graph: Beck Depression Inventory Scores



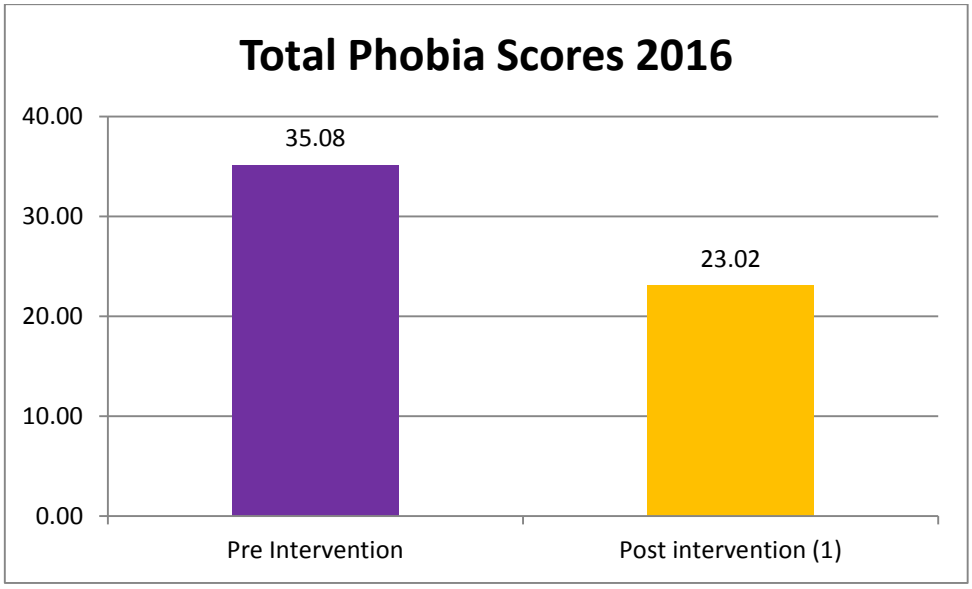
Mean scores on the Beck Depression Inventory were in the moderate range pre-intervention (M = 22.38, SD = 8.76) and showed a statistically significant drop to within the mild range post-intervention, (M = 15.22, SD =11.1), z = 5.12, p < .001, which represented a large effect size (r =.43). While 62.5% were classified has having moderate and severe depression before the programme, 25.4% were classified as such by the end (See the table above).

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

BDI	N	Pre Mean	Post Mean	T value	df	Sig.
Social Phobia	16	19.87	14.43	2.31	15	.036
Panic Disorder	7	22.86	14.28	2.98	6	.024
GAD	13	22.07	14.15	2.86	12	.014
OCD	28	23.25	16.85	3.04	27	.005
Agoraphobic	2	21.00	17.00	.571	1	.671

The Fear Questionnaire

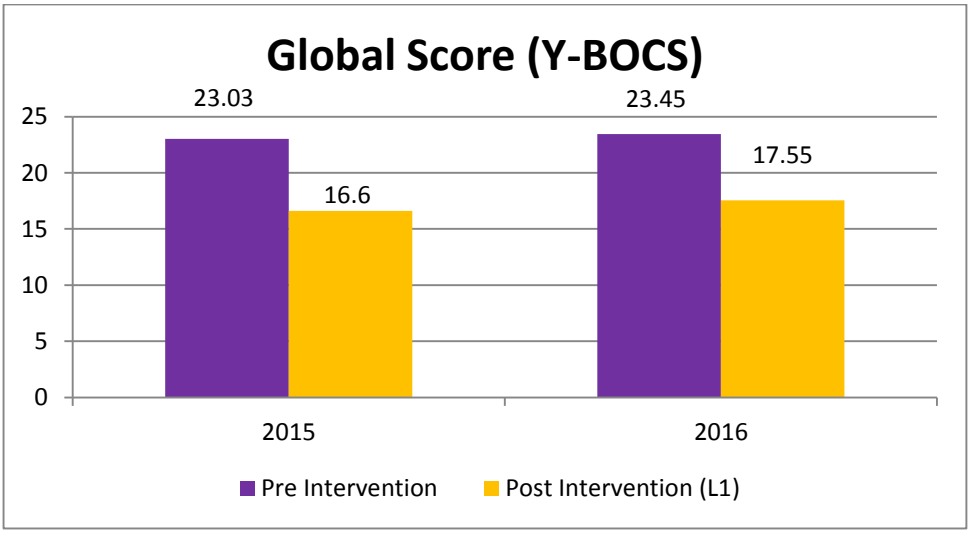
Graph: Fear Questionnaire Total Phobia Scores



A Wilcoxon Signed Rank test revealed a statistically significant difference between pre and post level 1 Total Phobia scores, $z = 5.85$, $p < .001$. The mean phobia score decreased from 35.08 (SD= 21.22) to 23.02 (SD=19.68), and represented a large effect size (r = .49).

The Yale Brown Obsessive Compulsive Scale

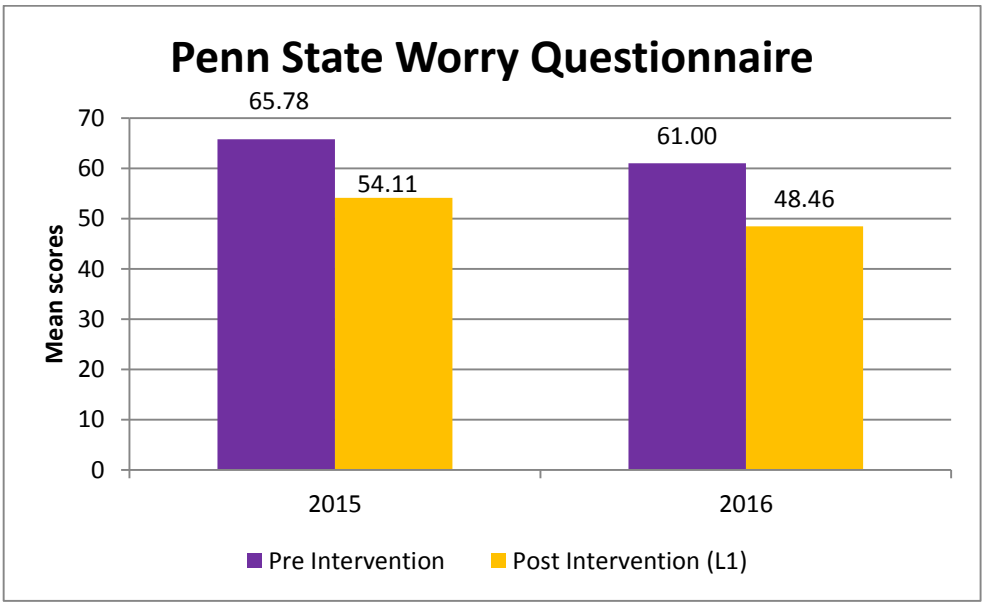
Graph: Yale Brown Obsessive Compulsive Scale



For those with OCD (n = 29), global (Y-BOCS) scores dropped significantly from 23.45 (*SD* = 5.84) to 17.55 (*SD* = 7.75), *t* (28) = 6.30, *p* <.001, (Cohen's *d* = 1.17), indicating an overall reduction in the severity of OCD symptoms with a large effect size.

Penn State Worry Questionnaire (PSWQ)

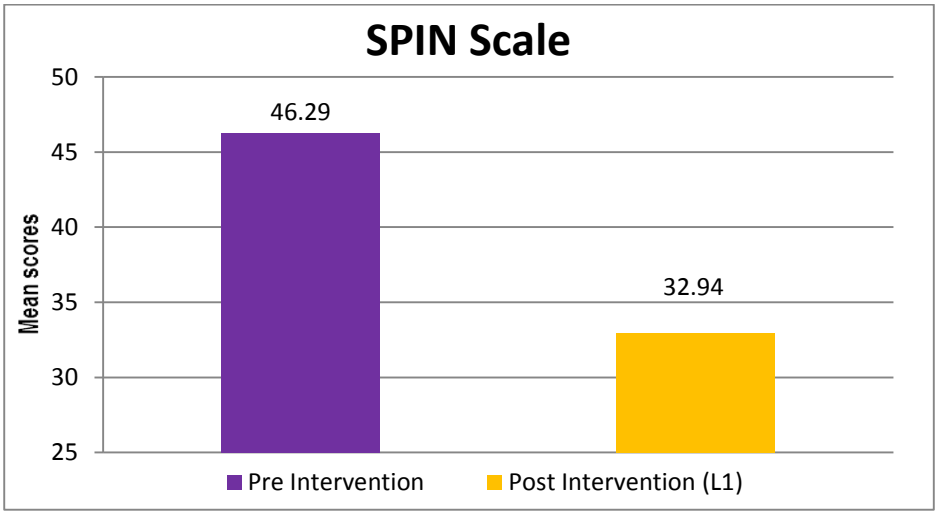
Graph: Penn State Worry Questionnaire



Participants' scores on the Penn State Worry Questionnaire dropped from 61.00 (SD = 9.23) to 48.46 (SD = 10.37), t (12) = 5.13, p < .000, which reflects a large effect size (Cohen's *d*= 1.42).

Social Phobia Inventory (SPIN)

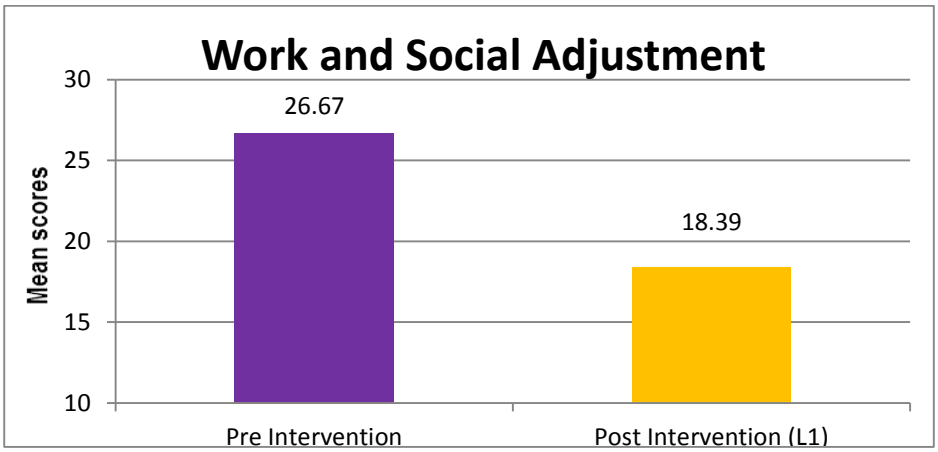
Graph: SPIN Scale



A statistically significant reduction in SPIN scores were observed, t (16) = 5.84, p<.001, from pre intervention (M = 46.29, SD = 9.14) to post level 1 intervention (M = 32.94, SD = 12.77), reflecting a large effect size (Cohen's *d* = 1.41).

The Work and Social Adjustment Scale

Graph: The Work and Social Adjustment Scale

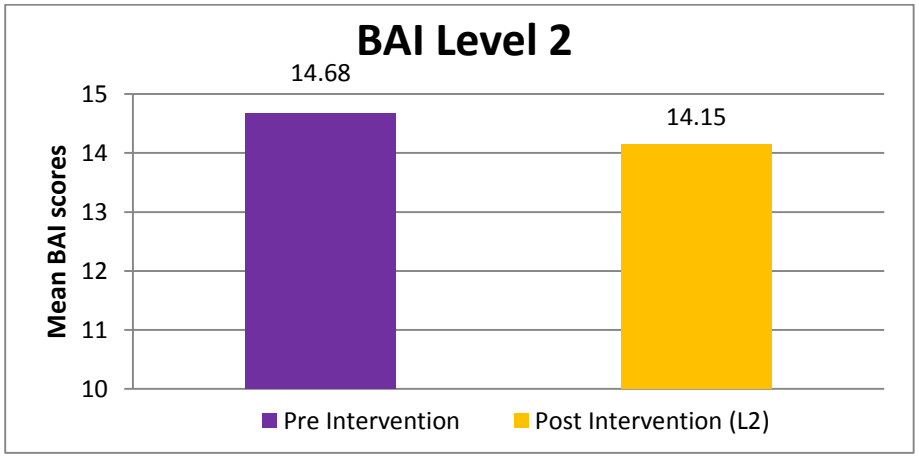


A statistically significant reduction in mean scores on the Work and Social Adjustment Scale was observed, t (70) = 7.44, p < .001, from pre intervention (M = 26.67, SD = 98.76) to post level 1 intervention (M = 18.39, SD = 9.90), reflecting a large effect size (Cohen's *d* = .88).

4.5.4. Level 2 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



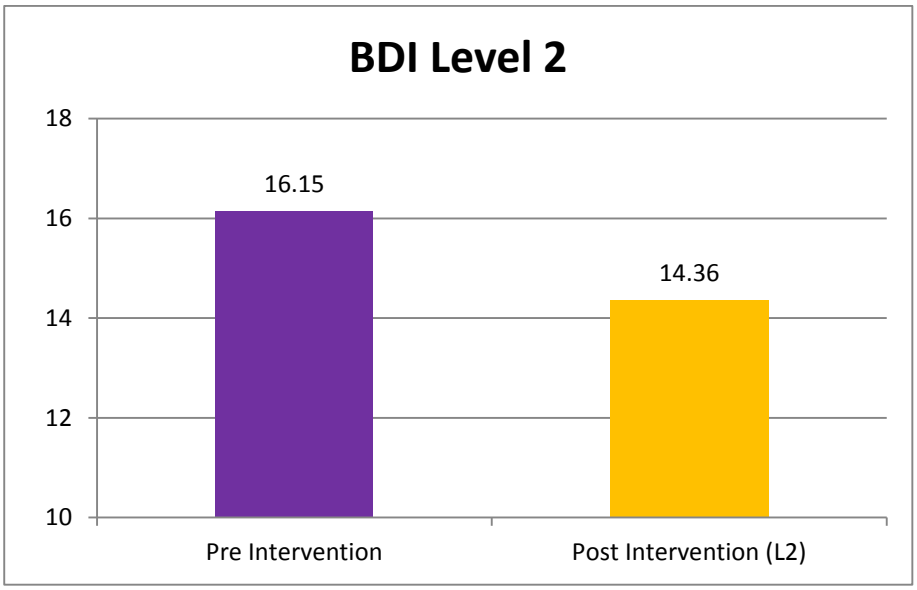
Pre and post level 2 scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programmes mean score decreased from M= 14.68 (SD=9.22) pre intervention to M=14.15 (SD=9.07) post intervention. However, this reduction was not statistically significant, t (18) = .45, p = .66. This small reduction may be explained by the mean pre level 2 intervention already falling within the lower end of the mildanxiety range.

At pre Level 2, 36.8% had anxiety scores in the moderate and severe range. This dropped to 31.6% by the end of Level 2 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	36.8%	36.8%	47.4%	47.4%
Mild	26.3%	31.6%	10.5%	31.6%
Moderate	26.3%	26.3%	26.3%	10.5%
Severe	10.5%	5.3%	15.8%	10.5%
Totals	100	100	100	100

Beck Depression Inventory (BDI)

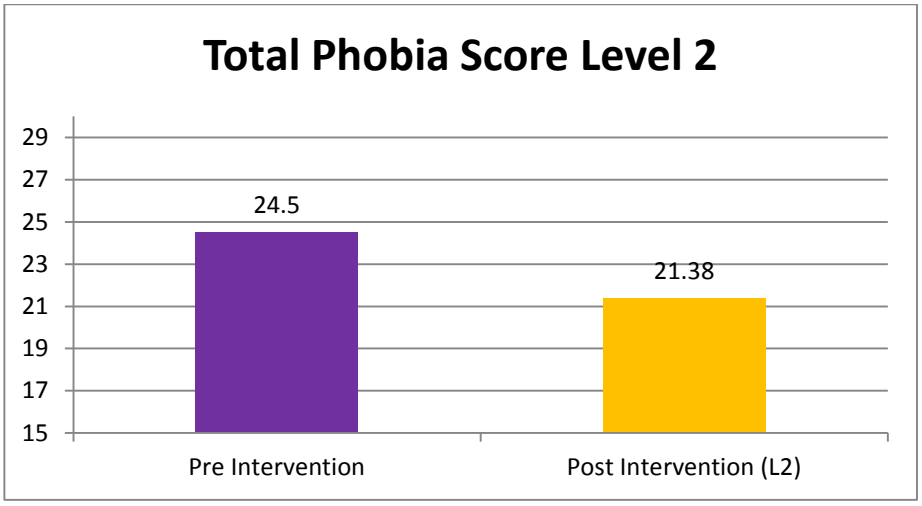
Graph: Beck Depression Inventory Total Scores



Average depression scores for those who completed the programme (indicated on the graph above) were in the mild range pre-intervention (*M* = 16.15, *SD* = 10.46) and remained within the mild range (*M* =14.36 , *SD* =9.25) post intervention level 2. This reduction in mean scores was not statistically significant however, t (18) = 1.49, p = .15.

The Fear Questionnaire

Graph: The Fear Questionnaire

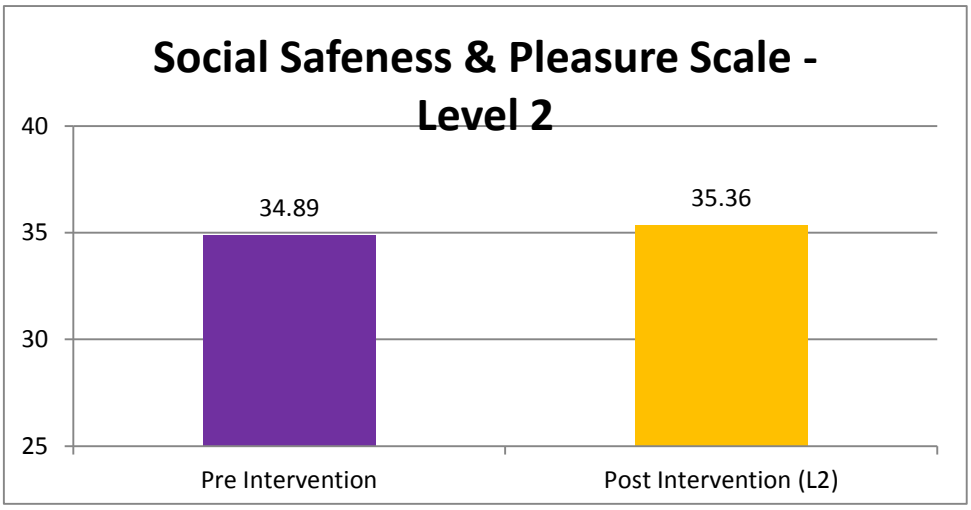


Total Phobia Scores dropped from a mean of 24.5 (*SD* = 17.21) to 21.38 (*SD* =17.35) post level 2. However, this reduction was not statistically significant, t (17) = .84, p = .41.

The Social Safeness and Pleasure Scale

Participant's scores on the Social Safeness and Pleasure Scale changed from a mean of 34.89 (SD= 8.35) pre level 2 intervention to 35.36 (SD=8.01) post intervention. However this increase was not statistically significant t (18) = .29, p=.77, but was a change in the intended direction.

Graph: The Social Safeness and Pleasure Scale



Work and Social Adjustment Scale

There was no difference observed between pre (M = 17.00, SD = 10.39) and post (M = 16.31, SD = 16.31) level 2 scores on the Social Work and Leisure Scale, t (18) = .45, p = .66.

4.5.5. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2016 suggested significant reductions in anxiety and depression symptoms, OCD symptoms, and reductions in pathological worrying and social anxiety. The majority of effect sizes observed were within the large range as shown on the table below.

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

Instrument	Effect Size
BAI	.49 (r)
BDI	.43 (r)
Fear Questionnaire	.49 (r)
Y-BOCS (Global Score)	1.17 (Cohen's *d*)
Penn State Worry Questionnaire	1.42 (Cohen's *d*)
Social Phobia Inventory	1.41 (Cohen's *d*)
Work and Social Adjustment Scale	.88 (Cohen's *d*)

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

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the anxiety programme in 2016 suggested further decreases in anxiety and depression symptoms. However these reductions were not statistically significant. This could be explained by BDI and BAI scores already falling within the mild ranges of these scales.There was no significant difference identified in phobia ratings post Level 2, however, this was expected given that the majority of phobia work was covered in Level 1.

There were no statistically significant changes observed on the Social Safeness and Pleasure Scale, or Work and Social Adjustment Scale. This non-significance could be attributed to the lower sample size in the Level 2 part of the programme.

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

4.6. Compassion Focused Therapy

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

Research has demonstrated the importance of self-compassion for psychological functioning (Neff & McGehee, 2010). Jazaeir et al. (2012) identified compassion as a predictor of psychological health and wellbeing and found that it was associated with fewer negative feelings and stress as

well as more positive feelings and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for clients experiencing high shame and criticism. Research has found that CFT is associated with reductions in depression, anxiety, shame, and self-criticism and increased ability to self soothe in response to emotional distress (Lucre & Corten, 2012). Research conducted on the CFT group in St. Patrick's demonstrated that group CFT was effective in reducing symptoms of mental ill health for service users who attended the group. These improvements were associated with improvements in self-criticism and fears of self-compassion (Cuppage, Baird, Gibson, Booth and Hevey, under review).

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

4.6.1. Compassion Focused Therapy Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the Compassion Focused Therapy Programme in 2016. All service users attending the CFT Programme are invited to complete the following measures, before starting the programme and again after completion. These measures have been selected because studies have shown them to be reliable and valid (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004: Gilbert et al., 2011), in other words, they provide a good measure of the intended outcome of the CFT programme.

- **Brief Symptom Inventory**

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

- **Fears of Self-Compassion**

The Fears of Self-Compassion Scale (FSCS; Gilbert, McEwan, Matos & Rivis, 2011) is a 15 item subscale of a longer measure designed to explore the fears of compassion for self (e.g. "I fear that if I am too compassionate towards myself, bad things will happen"). Higher scores are indicative of greater fears of self-compassion.

- **Social Safeness and Pleasure Scale**

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

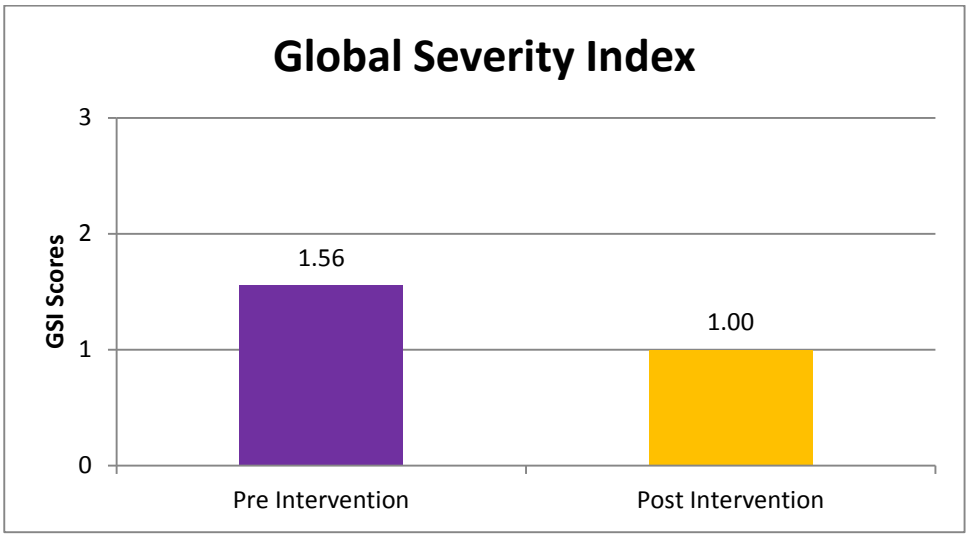
4.6.2. Descriptors

There were pre and post data available for 31 participants who completed the programme either at St Patrick's University Hospital or at St Edmundsbury Hospital in 2016. This represents approximately 78% of those who completed the programme in either location in 2016. Of these 31 service users, 21 (67.7%) were female and 10 (32.3%) were male. Programme attendees ranged in age from 21 to 72 years with an average age of 43.83 years. Three additional cycles of the CFT Programme began in 2016 but will not be completed until 2017. Data for those who started a cycle in 2016 but finished in 2017 will be included in next year's report

4.6.3. Results

Brief Symptom Inventory

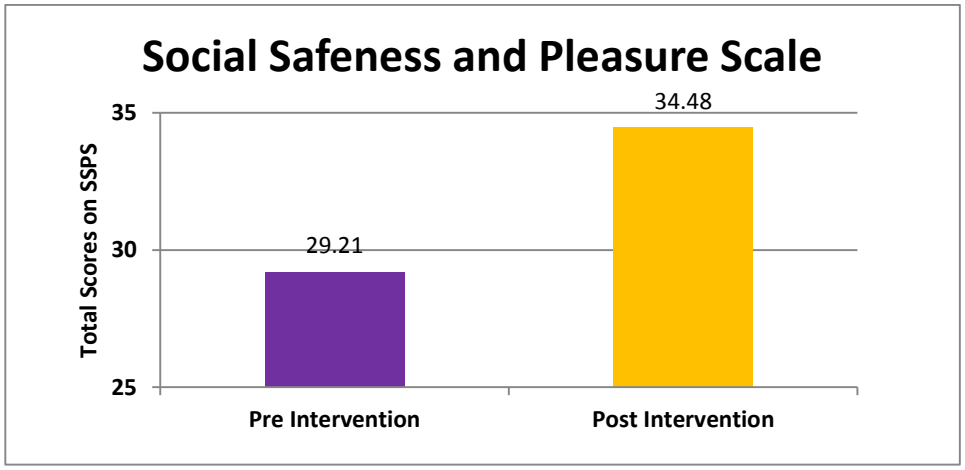
Graph: Brief Symptom Inventory GSI Scores



A significant decrease in psychological distress as measured by the Brief Symptom Inventory was observed in service users who completed the Compassion Focused Therapy programme in 2016, where t (30) = 4.79, p<.01. A large effect size was observed (*d* = .86).

Social Safeness and Pleasure Scale (SSPS)

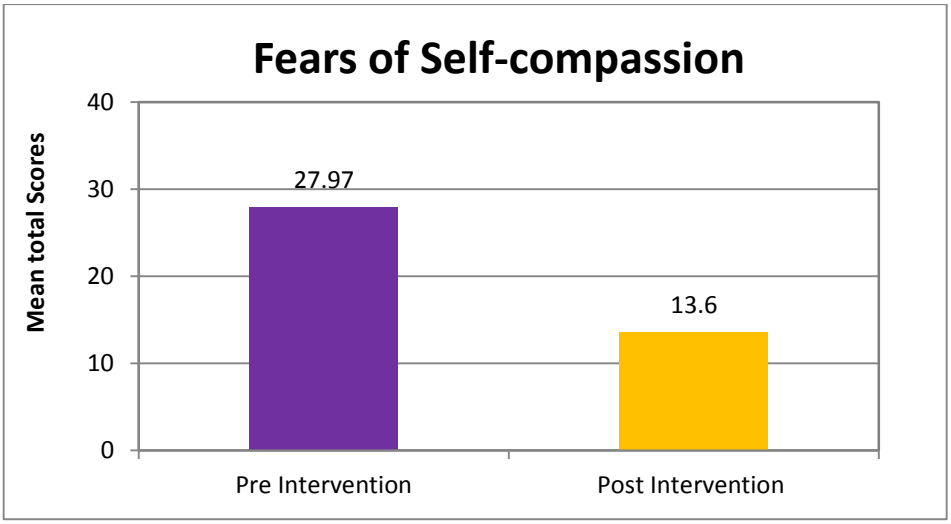
Graph: Social Safeness and Pleasure Scale (SSPS) Scores



Significant increases were observed from pre to post intervention on the Social Safeness and Pleasure Scale, whereby t (28) = 3.29, p<.01, with a medium effect size (r=.61). These findings suggest that following completion of the programme, service user's perception of how comfortable they were in interpersonal relationships and of how pleasurable they found interactions with others had improved.

4.6.3.2 The Fears of Self-Compassion Scale

Graph: The Fears of Self-Compassion Scale



A significant decrease in fears of self-compassion was observed in service users after they completed the CFT programme. A Wilcoxon Signed Rank Test revealed a statistically significant reduction in total Fears of Self-compassion, $z=3.87$, $p<.01$, with a large effect size ($r=.50$). These findings suggest that fears of developing and having self-compassion decreased from pre to post programme participation.

4.6.4. Summary

The Compassion Focused Therapy programme started in SPMHS in 2014. Since it began thirteen cycles of the group have been facilitated. The programme has received considerable interest within the hospital. Research by a Clinical Psychologist in Training was undertaken in 2014-5, titled "An Evaluation of a Compassion Focused Therapy Group Programme Designed for Individuals with High Self-Criticism and Shame". An article based on this study has been submitted for publication in a peer-reviewed journal.

Anecdotal feedback from clients who attended these groups has been largely positive, with clients reporting noticeable improvements in their lives. This feedback has been supported statistically by the findings of this report;

specifically by the reduction of symptoms of psychological distress as measured by the BSI following completion of the group.

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

The CFT group delivery format is currently under review in an effort to ensure a high quality service that meets service user's needs. Additional research on the CFT Programme is currently being undertaken by a Clinical Psychologist in Training. This research is titled "Investigating changes that occur as a result of engaging in a Compassion Focused Therapy group intervention".

4.7. Depression Recovery Programme

The Depression Recovery Service offers a group-based stepped level treatment programme in line with international best practice guidelines. The programme used to have three levels: A, B and C but the format of the programme changed in 2016 and Levels B and C were combined to create Level B.

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

Level B (Building Recovery - CBT and Compassion Focused Therapy Workshops) is a twelve week programme. For the first four weeks the programme aims to introduce the concepts of CBT (Cognitive Behavioural Therapy) and Compassion Focused Therapy. Workshops have been designed as a means of exploring the thought mood connection, the development of the vicious cycle and how to unravel them. The following eight weeks are

based on a closed Psychotherapy Programme that runs one day a week. This area of the programme utilises Cognitive Behavioural Therapy, Compassion Focused Therapy and Mindfulness.

4.7.1. Depression Recovery Programme Outcome Measures

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses. Its long form is composed of 21 questions, each designed to assess a specific symptom common among people with depression such as pessimism, sense of failure, mood, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores can range from 0 – 63, with higher scores indicating more severe depressive symptoms. Scores can be described as minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

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

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

4.7.2. Descriptors

Data were available for 262 participants who started the programme in 2016, 128 males and 134 females.

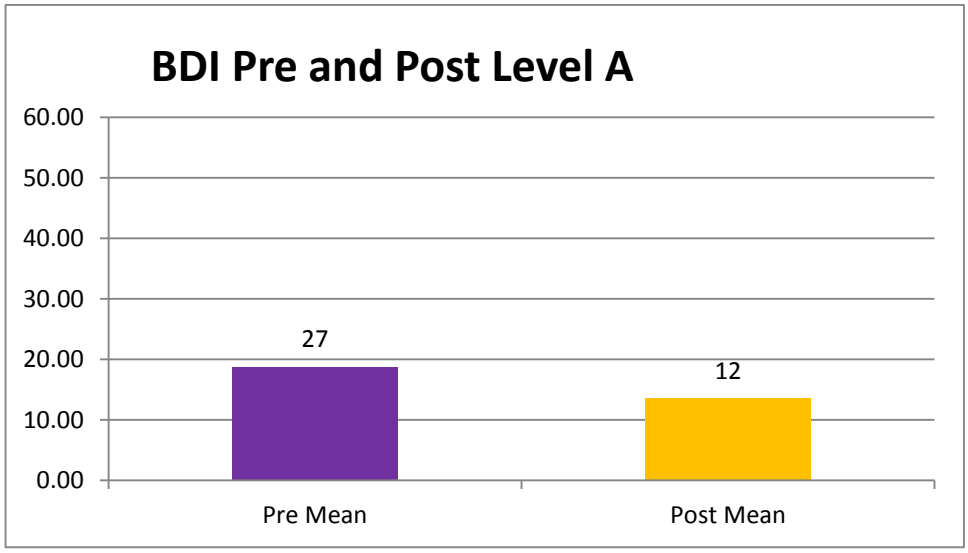
4.7.3. Results

Pre Level A and Post Level A

Beck Depression Inventory (BDI)

The average score for people moved from the moderate range (*Md* = 27) to the mild-moderate range (*Md* = 12) on the measure (see graph below). A Wilcoxin Signed Rank test revealed that the reduction was statistically significant, z= -10.77, p = .000, with a medium effect size (Cohen's *r* = 0.49).

Graph: Beck Depression Inventory Total Scores

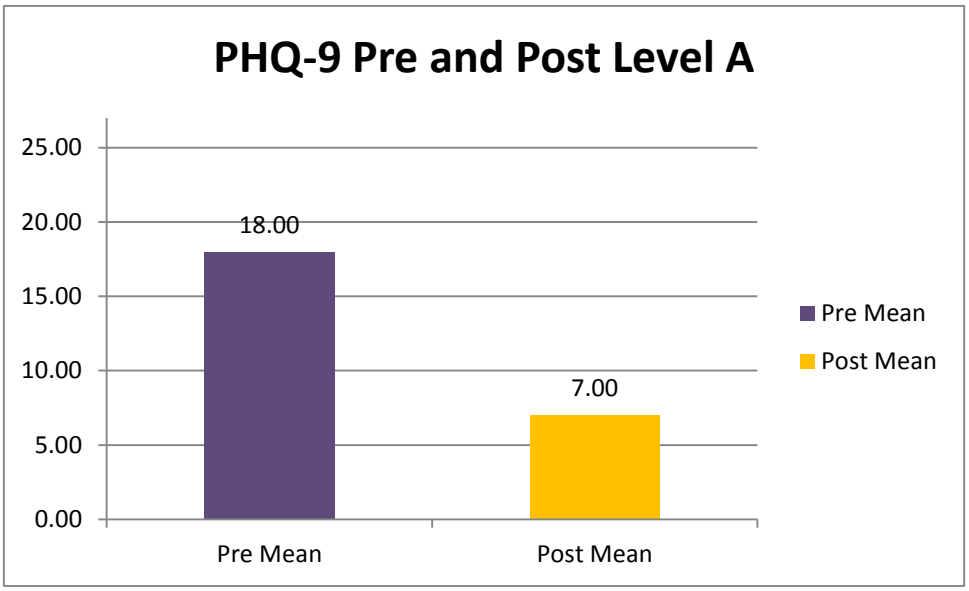


Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, pre and post Level A indicated that, on average, those who completed rated themselves in the moderately severe range (*Md* = 18) prior to the intervention and in mild to moderate range (*Md* = 7) following intervention. This reduction in mean scores is

statistically significant, A Wilcoxin Signed Rank test revealed z= - 10.90, p = .000, with a large effect size (Cohen's *r* = 0.50).

Graph: Patient Health Questionnaire-9 Scores



Pre Level B and Post Level B

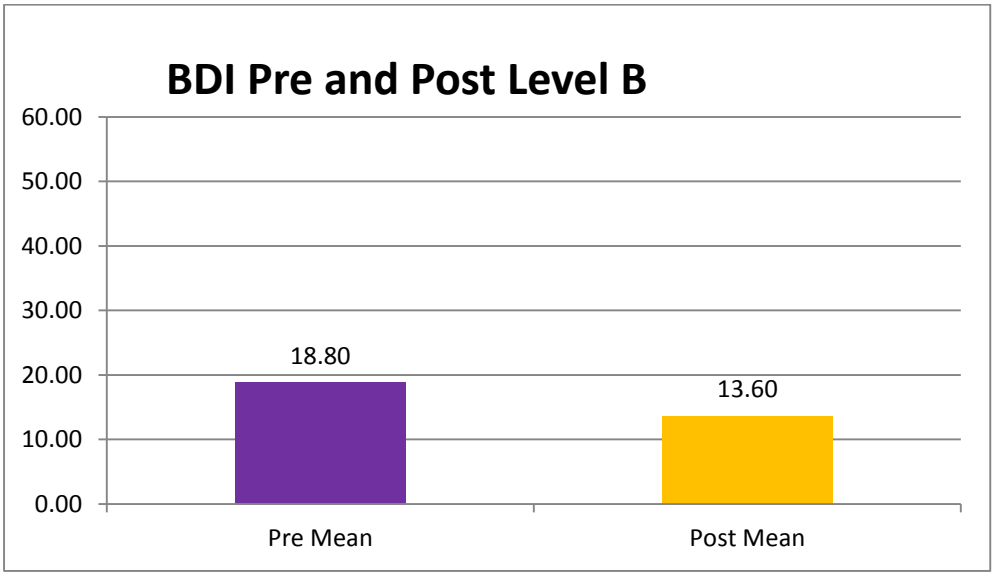
Prior to 2016, data was analysed from pre Level A to post Level B. However feedback from the clinical team in 2016 highlighted that the time between completing level A to commencing level B can vary significantly. There can be lengthy gaps in commencing level B due to the service user's choice and personnel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

Beck Depression Inventory (BDI)

Pre and post scores on the Beck Depression Inventory (see graph below) demonstrate that the average score for people who completed Level B of the Depression Programme moved from the upper end of the mild range range pre Level A (*M* = 18.8, *SD* = 11.71) to the lower end of the mild range (*M* =

13.6, *SD* = 11.3). This reduction in the mean score is statistically significant, t(15) = 5.45, p < .05, with a small effect size (Cohen's *d* = 0.45).

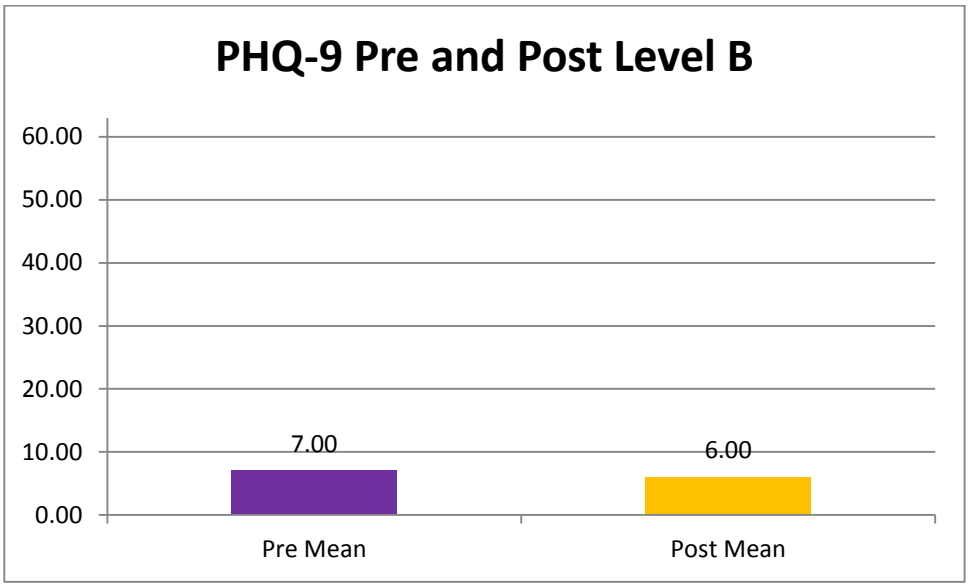
Graph: Beck Depression Inventory Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, indicated that, on average, those who completed Level B rated themselves in the mild range (*Md* =7) prior to Level B and remained in the mild range (*Md* = 6) following Level B. A Wilcoxin Signed Rank Test showed this reduction in mean scores is statistically significant, z = - 2.34, p <.05), with a medium effect size (Cohen's *r* = 0.33).

Graph: Patient Health Questionnaire-9 Scores



4.7.4. Summary

This is the third year the depression programme has been included in the SPMHS outcomes report. Two well established outcome measures were used to investigate the programme's effectiveness at reducing symptoms of depression. Both measures showed significant reductions in service users' mean scores following completion of the programme , particularly pre and post Level A. It is understandable that there would be less change pre and post Level B, as this follows Level A, so most symptomatic change would have already occurred with the initial intervention.

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

4.8. Dual Diagnosis Programme

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

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

It aims to assist the client in the recovery process by providing a bio-psychosocial support structure and the therapeutic environment necessary to foster their recovery. This includes a combination of group and 1:1 support to help in the transition from complex mental health and addiction issues to a more sustainable and healthy life in sobriety.

The Dual Diagnosis is a staged recovery programme, delivered by Psychiatrists, Addiction Counsellors, Ward based nursing staff, with input from other disciplines including Psychology, Social Work and Occupational Therapy and includes:

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

The programme includes the following elements:

- **Individual multi-disciplinary assessment:** This facilitates the development of an individual treatment care plan for each client.
- ***Psycho-education lectures:*** A number of lectures are delivered weekly with a focus on providing education on substance misuse and recovery, as well as approaches for managing mental health issues e.g. CBT, and Mindfulness. There is also a weekly family and patient lecture,

facilitated by Addiction Counsellors, providing information on substance misuse and recovery to clients and their families.

- ***Goal setting and change plan*:** This group is facilitated by therapists and encourages participants to put plans and structure in place for time spent outside of the hospital.
- ***Mental health groups:*** This is a psycho-educational group focussing on Mental Health related topics such as Depression, Anxiety and Recovery.
- ***Role play groups:*** This group aims to allow clients to actively practice drink/drug refusal skills, to learn how to communicate about mental health, and to manage relapse in mood and substance misuse. The group creates opportunities to role play real life scenarios that may have been relevant to the client or may be relavant in the future.
- ***Recovery plan:*** This group facilitates and supports clients in developing and presenting an individual recovery plan. It covers topics such as Professional Monitoring, Community Support groups, Daily inventories, Triggers, Physical care, problem solving, Relaxation, spiritual care, Balance Living, family/friends, work balance etc.
- ***Reflection group:*** This group provides a safe place to support clients through the process of change; an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- ***Relapse prevention and management groups:*** This group focuses on developing successful relapse prevention and management strategies.

4.8.1. Dual Diagnosis Outcome Measures

Leeds Dependency Questionnaire (LDQ)

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

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

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

4.8.2. Descriptors

214 participants attended the full or modified programme in 2016, of whom 145 completed the full programme. Pre and post data were available for 124 participants, with an even number of males and females. This data represents approximately 85.5% of those participants who completed the programme in 2016. This means that findings presented may not be representative of all participants who completed the programme and these findings need to be interpreted in light of this.

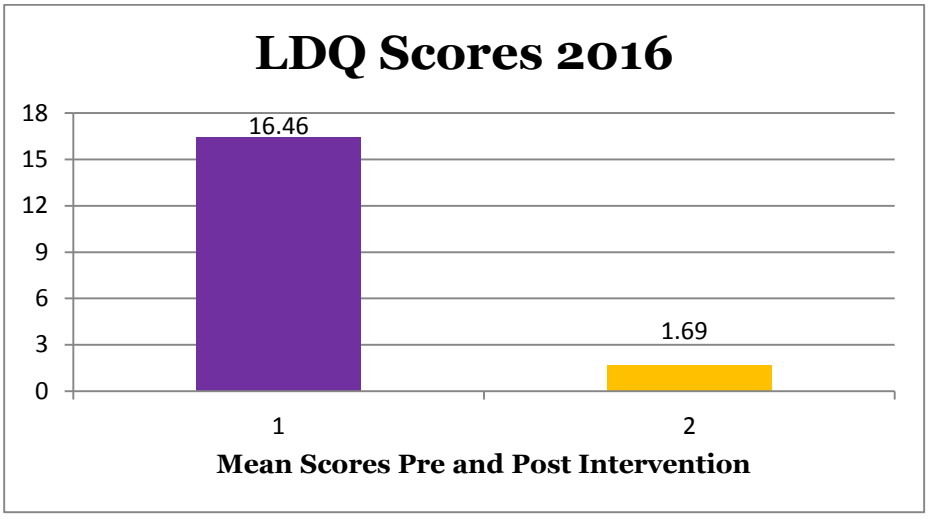
4.8.3. Results

Leeds Dependency Questionnaire

A Wilcoxin Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, $z=8.93$, $p<.001$, with a large effect size ($r=.59$).

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

Graph: Leeds Dependency Questionnaire Scores



4.8.4. Summary

Following completion of the Dual Diagnosis programme, significant and large reductions in psychological markers of alcohol/substance dependency were observed. These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and its use will continue in 2017.

These findings support previous studies and literature which regard the LDQ as a suitable tool for the evaluation of interventions for adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000) and psychiatric difficulties (Ford, 2003).

It is recognised that it can be challenging to collect psychometric data from individuals with substance use difficulties. According to Tober et al. (2000), service users with substance difficulties can find it difficult to commit to completing follow-up measures for many reasons including motivation, difficulties with attendance and convenience of appointment times given.

In 2014, despite efforts from clinical staff, collecting post data proved challenging and resulted in the data capture of only 26% of those who completed the programme in 2014.

To overcome this difficulty, it was decided that completion of post measures would happen in session with therapists during the exit interview and would become part of each client's discharge plan. This would be monitored using the referral spread sheet for service users and reviewed monthly by the Dual Diagnosis Service coordinator.

The pre and post data available for participants increased from 60.4% in 2015 to 85.5% in 2016. This represents a promising trend in improvements in data collection.

4.9. Living Through Distress Programme

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

Linehan's bio-social theory posits that difficulties with emotional under-control are disorders of self-regulation arising from a skills deficit. Emotional regulation difficulties result from biological irregularities combined with

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

Skills which aid patients to regulate their emotions are at the core of LTD. LTD focuses on both change and acceptance skills. The content is informed by Linehan's skills-based group intervention and has been modified to meet the needs of the organisation, based on clinical research on the efficacy of the group. Further skills such as interpersonal effectiveness skills are introduced in a once monthly Aftercare programme.

The format of the Living Through Distress skills group has changed since September, 2016. Level 1 of the programme provides 18 skill-group sessions, three times a week for 6 weeks. These sessions aim to focus on teaching mindfulness, distress tolerance and emotion regulation skills. Following these 18 sessions, the programme has introduced a 16-week Level 2 intervention for those who complete Level 1. Level 2 is now exclusively a day patient programme and is focused on building a life worth living and facilitating patients in generalising their use of skills beyond the hospital setting. These 16 sessions aim to address emotion regulation and interpersonal effectiveness in more depth.

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

4.9.1. Living Through Distress Programme Outcome Measures

- **Difficulties in Emotion Regulation Scale**

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

- **Distress Tolerance Scale**

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

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

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

4.9.2. Descriptors

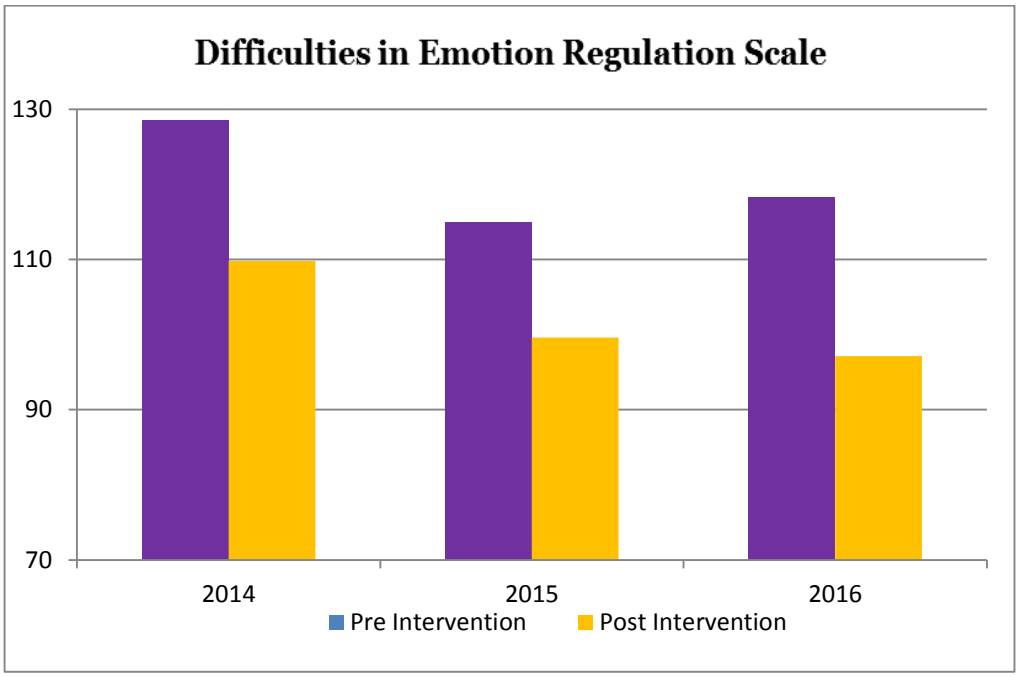
Pre and post data were available for 40 participants who completed the programme in 2016. Of those who had pre and post data, 87.5% were female and 12.5% were male. LTD attendees ranged in age from 18 to 64 years, with an average age of 32.45 (*SD* = 14.1). Their highest level of educational attainment ranged from Junior Certificate (11.1%), to Leaving Certificate (30.6%), to non-degree 3rd level qualification (25%), to 3rd level degree (19.4%) to postgraduate qualification (8.5%). Those who attended the group's current employment status was also recorded. 8.3% worked in the home, 5.6% were in part-time employment, 22.2% were in full-time employment, 19.4% were unemployed, 5.6% were retired, 27.8% were students and 11.1% chose other.

4.9.3. Results

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 118.3 (*SD* = 18.87) on the DERS pre to 97.17 (*SD* = 24.0) post completion of the programme, t (22) = 5.07, $p < .001$. This change represented a large effect size (Cohen's d = 1.05). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

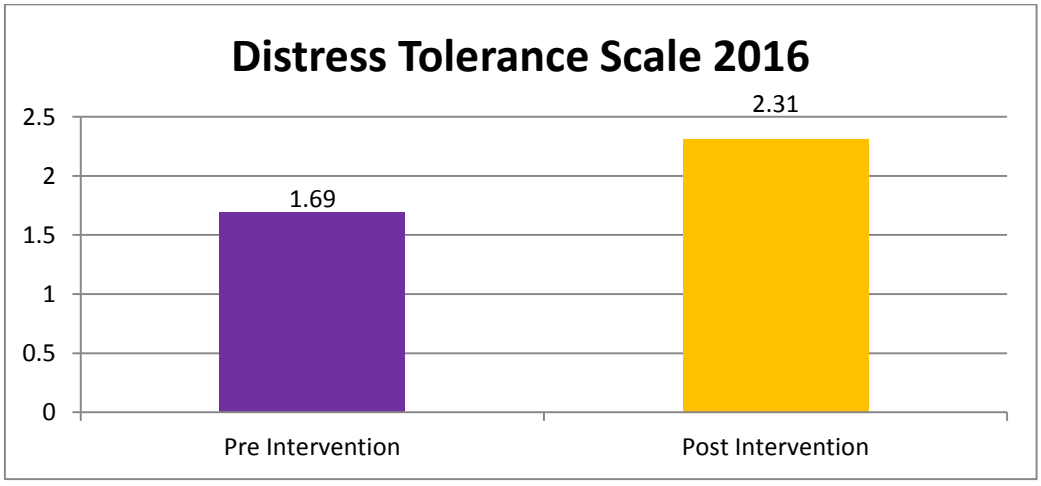


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 1.69 (*SD* = .71) before the programme on the DTS to 2.31 (*SD* = .87) after completing the programme, $z = 3.153$, $p < .01$, representing a medium effect size (r = .44).

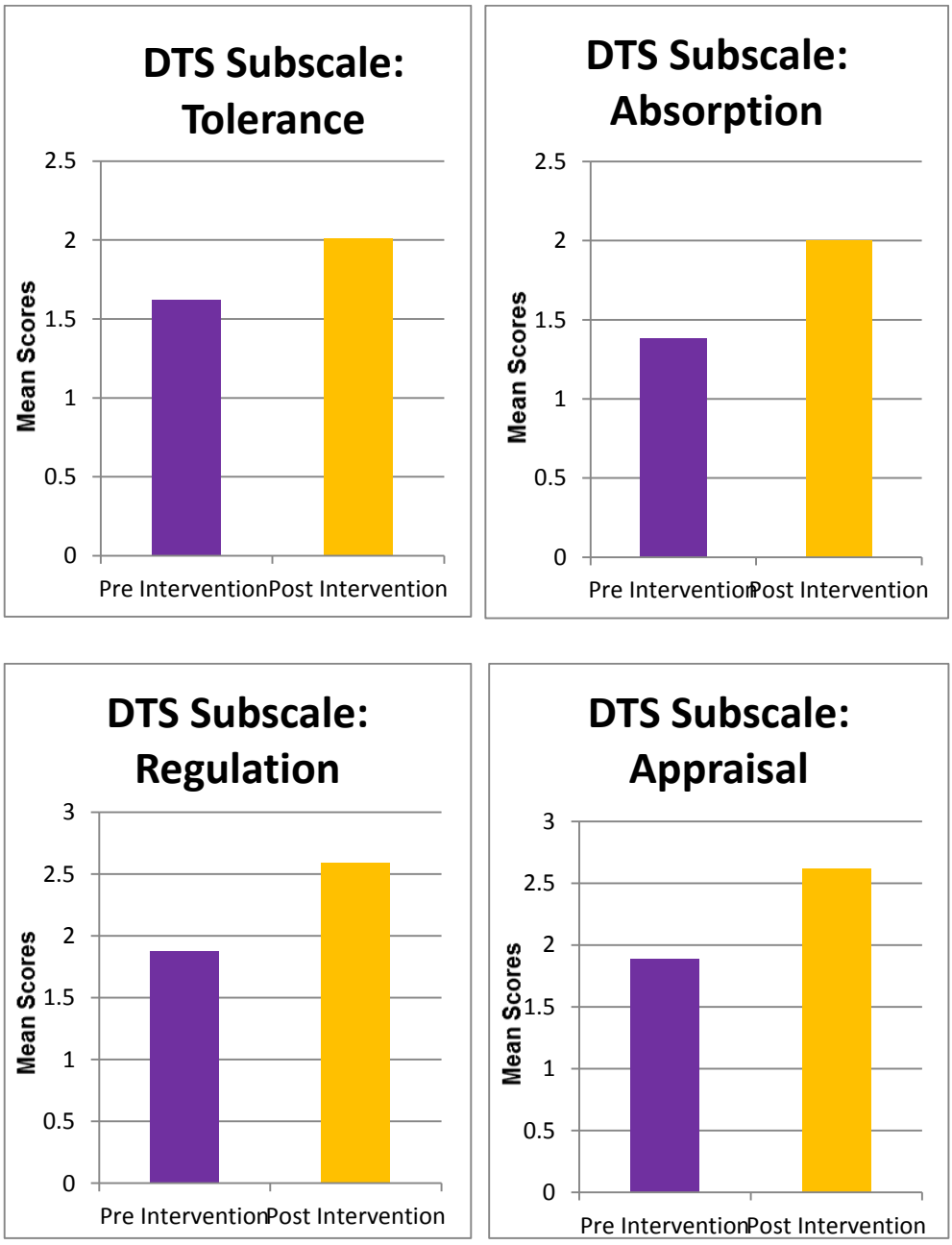
Graph: Distress Tolerance Scale Total Scores



Note: Higher scores indicate increased ability to tolerate distress

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

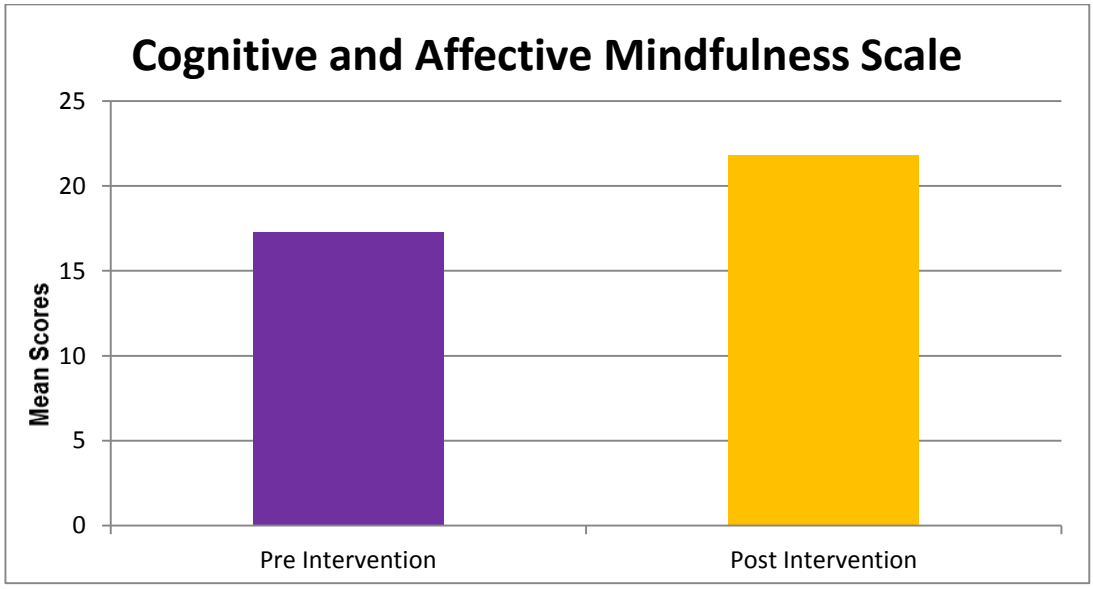
Graph: Distress Tolerance Scale Sub-scales



Cognitive and Affective Mindfulness Scale

Participants also had greater mindful qualities post intervention moving from a mean score of 17.3 (*SD* = 3.86) before the programme on the CAMS-R to 21.8 (*SD* = 4.08) after completing the programme, $z = 4.27$, $p < .001$, representing a large effect size (r= .55).

Graph: Cognitive and Affective Mindfulness Scale Total Scores



4.10.4. Summary

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

Outcome measures for the programme are expected to remain the same for the coming year. There is research ongoing on this programme which is looking at understanding problems of emotional over and under- control and response to the DBT informed interventions (i.e. LTD and RO). All the data for this project has been collected and it is currently being written up.

The programme was shortlisted for three awards at the Irish Health Care Centre Awards 2015.

4.10. Living through Psychosis Programme

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

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

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

4.10.1 Living Through Psychosis Programme Outcome Measures

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

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dys-regulation, comprising six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on

a 5-point scale from 1 “almost never” to 5 “almost always”. Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability (α = .93), construct and predictive validity, and test-retest reliability in the development study.

• **Fear of Recurrence Scale (FORSE)** (Gumley & Schwannauer, 1999)

The Fear of Recurrence Scale (FORSE) is a 23-item self-report inventory, which measures to what extent individuals with psychosis appraise their thinking and intrusions as threatening and indicative of relapse (Gumley & Schwannauer, 2006a). Higher total scores on FORSE are associated with greater positive symptoms, general psychopathology, and more negative illness beliefs (White & Gumley, 2009).

• **Recovery Assessment Scale** (RAS 21: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995).

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. The RAS-21 is a 21-item survey rated on a 5-point scale from 1 “Strongly Disagree” to 5 “Strongly Agree”. The RAS was found to have good test-retest reliability (r = 0.88) along with good internal consistency (Cronbach’s alpha = 0.93; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

4.10.2. Descriptors

Data were available for 29 people who completed the programme in 2016, of whom 13 (44.8%) were female and 16 were male (55.2%). Programme attendees ranged in age from 20 to 72 years with a mean age of 36.1 (SD=13.44). The mean age of onset was 29.71 years, with a range from 18-66 years. Of note 9 (31%) were first episode psychosis patients. Of those who attended 37.9% were employed, 41.4% were unemployed and 17.2% were

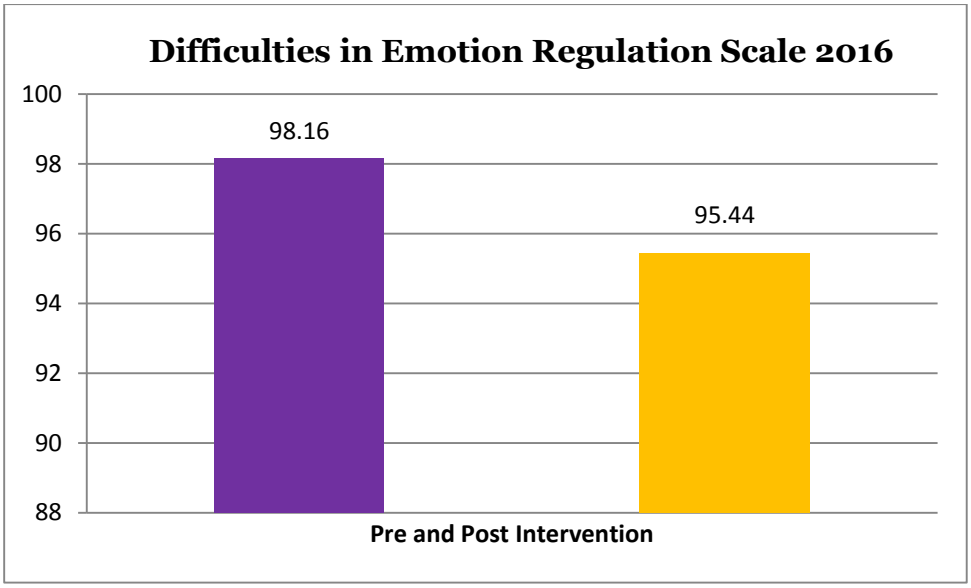
currently in education courses. Their levels of education ranged from Junior Certificate (10.3%), Leaving Certificate (20.7%), Apprenticeship (10.3%), Undergraduate (41.4%) to Postgraduate (17.2%).

4.10.3. Results

Difficulties in Emotion Regulation Scale

Participants experienced a decrease in difficulties regulating emotions moving from an average score of 98.16 (*SD* = 21.14) on the DERS to 95.44 (*SD* = 19.36) post completion of the programme, however, this change was not statistically significant, *t* (24) =1.14, p= .27. See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores



Note: Higher scores indicate greater difficulties with emotion regulation

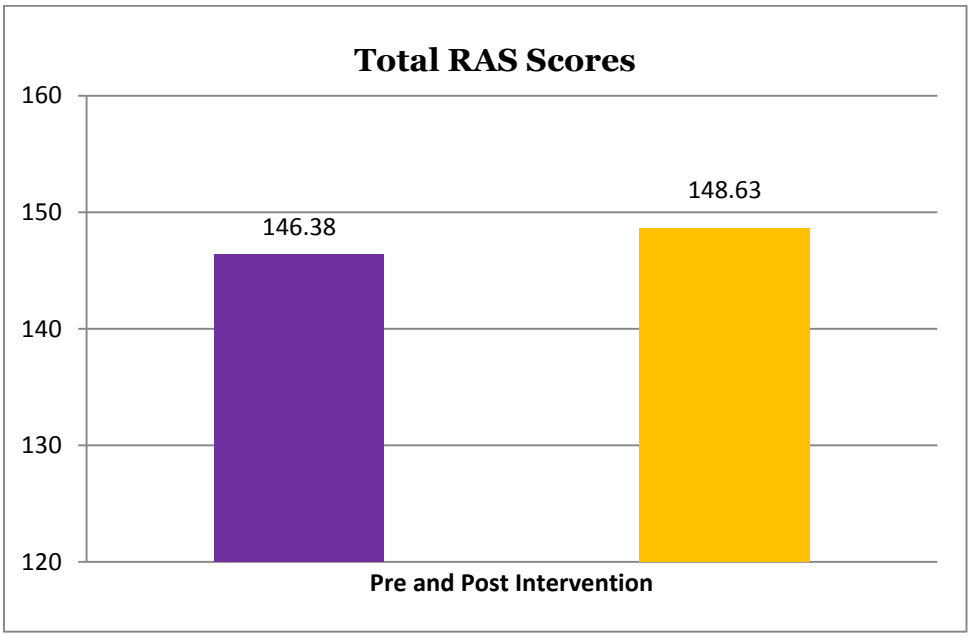
The Fear of Recurrence Scale (FORSE)

In terms of patients fear of recurrence measured by the Fear of Recurrence Scale (FORSE), there was no statistically significant change identified between pre and post measures , t(25) = .63, p=.54.

Recovery Assessment Scale

Total RAS scores increased from pre measurement (M=146.38, SD =.20.2) to post measurement (M=148.63, SD=17.67) on the Recovery Assessment Scale indicating greater overall recovery. However, this increase was not statistically significant, t (23) = .68, p = .50.

Graph: Recovery Assessment Scale Total Scores



Additional Research

A Doctoral Thesis research project due for publication in 2017, found clinically significant improvements from pre to post intervention on the measures outlined above (N=55 participants who attended Living Through Psychosis in 2015 and 2016).

Furthermore as part of the doctoral thesis qualitative interviews were carried out and analysed using Thematic Analysis. Five main themes were identified by group members who completed programme. Some of their quotes can be seen below:

Theme 1: Connecting

"I met people who have it as well and you know they're kind of not this scary image that's depicted in the media… they're just normal people going about their life day to day lives, who are just struggling with something, like a lot of people do and that's helped me"

Theme 2: Building Hope

"You get the tools to deal with the situations and… so as a result you are able to kind of calm yourself down or deal a little better or you know not be so scared or so sad"

Theme 3: Learning and Implementing

"Because I have a better idea of what can cause psychosis I've a better way of dealing with it"

Theme 4: Re–evaluating

'Hearing voices and um a bit of a break from reality that is kinda what I recognised psychosis to be. It's just a combination of symptoms and it's like… I think it really is like…I think it's like really acute anxiety and fear'.

Theme 5: Concluding and Recommending

'It was overall really positive experience, and I've made some good friends as well out of it. For me obviously with the stigma… I keep going back to it, but it really helped me in that regard and being able to relate to other people about it and stuff like that. I feel I have more skills to deal with the difficulties related to the illness and um… I don't feel so overwhelmed at the prospect of the future'.

4.10.4. Summary

The Living Through Psychosis programme continues to promote a service that engages the patient actively in their recovery. The programme draws on current research findings to determine key areas to target in psychological recovery. The findings presented above demonstrate that skills such as emotion regulation can be learnt during recovery from psychosis and that it can lead to improvements in many factors related to positive recovery. The programme has revised some of its outcome measures and continues to use the PSYRATS measure as a screening tool but no longer as an outcome measure. The programme continues to aim towards being a central part of care planning for each person in this vulnerable patient group.

New developments this year are the completion of one Doctoral research project and the commencement of a second research project. This year all

graduates of the programme are given the option of attending a level 2 programme which extends over 16 sessions. This is a pilot project and will be evaluated and reviewed in 2017.

4.11. Mindfulness Programme

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

4.11.1. Mindfulness Programme Outcome Measures

- **Five Facet Mindfulness Questionnaire**

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five specific facets of mindfulness: observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 “never or very rarely true” to 5 “very often or always true”. Scores range from 39 to 195 with higher scores indicative of greater mindfulness. The measure has shown good reliability in previous research (alpha = .72 to .92 for each facet; Baer et al., 2006).

4.11.2. Descriptors

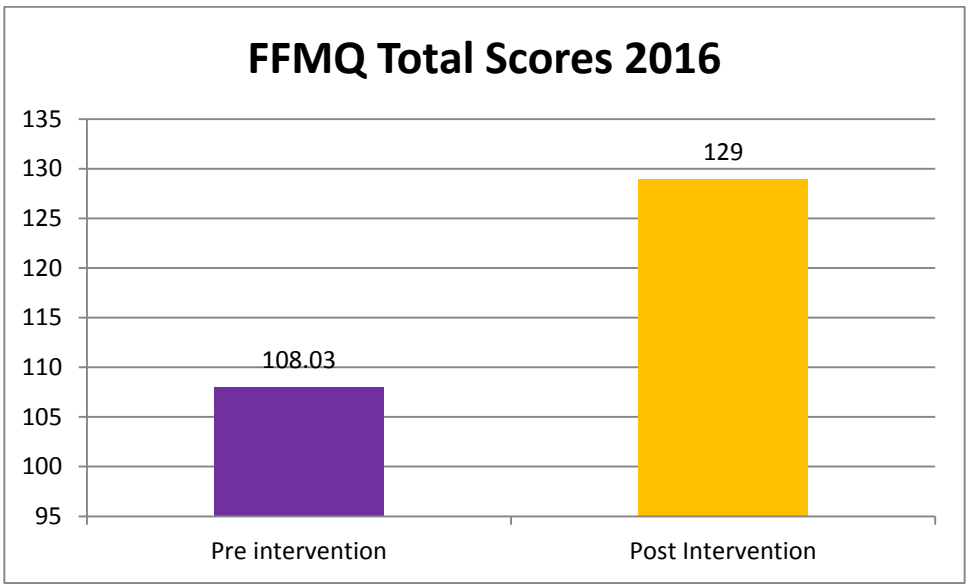
The Mindfulness Programme was delivered in St Patrick's University Hospital and St Edmundsbury Hospital. For the purpose of this report the data has been collated, analysed and reported on together.

Data was collected on 84 participants, 33 males (39.3%) and 51 females (60.7%). Pre and post data were available for 77 services users who completed the mindfulness programme across both sites. Participants age ranged from 20 to 71 years old (mean = 48 years).

4.11.3. Results

Five Fact Mindfulness Scale (FFMQ)

Graph: Five Facet Mindfulness Scale Total Scores



An examination of the combined data from across both sites revealed a significant increase in total scores on the FFMQ from pre intervention (M=108.03; SD=21.11) to post intervention (M=129; SD=18.07). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (57) = 7.61, p<.005, with a large effect size (Cohen's *d* = 1.06). These results suggest that, on average, service users who completed the outcome measure showed an increase in their tendency to be mindful in daily life.

Statistically significant increases were reported on all subscales, with large effect sizes for the "observing" (Cohen's *d* =0.86) and "non-reactivity to inner experience" domains (Cohen's *d* = 0.95). Medium effect sizes were reported on "acting with awareness" (Cohen's *d* =0.65), and "non-judgement of inner experience" (Cohen's *d* = 0.57). A low effect size was reported for the "describing" domain (Cohen's *d* = 0.41).

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

FFMQ	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*P value*	*Cohen's d*
Observe	23.69 (6.42)	28.51 (4.53)	6.31	66	.001	0.86
Describe	25.35 (6.57)	27.86 (5.33)	3.66	64	.001	0.41
Awareness	20.18 (5.89)	23.76 (5.11)	5.65	67	.001	0.65
Non-Judgement	21.15 (7.05)	25.97 (5.41)	5.80	65	.001	0.57
Non-Reactivity	17.83 (4.27)	21.73 (3.94)	6.99	62	.001	0.95

4.11.4. Summary

In line with the 2015 report, results for 2016 suggest that the programme continues to be successful in helping service users develop their capacity for mindfulness in daily life. The analysis revealed significant change a large effect size apparent for changes on the measure overall. Medium effect sizes were reported for most of the subscales, with of the "observing" and "non-reactivity to inner experience" domains, reporting large effect sizes.

4.12. Radical Openness Programme

The Radical Openness (RO) Programme is a therapeutic group delivered by the Psychology Department. The programme is based on an adaptation of DBT for "emotional over-control", developed by Tom Lynch (Lynch, Morse, Mendelson, and Robins, 2003; Lynch et al., 2007; Lynch and Cheavens, 2008). The programme is for those who have developed an emotionally over-controlled style of coping.

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

4.12.1. Radical Openness Programme Outcome Measures

- **Brief symptom Inventory**

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

- **The Social Connectedness Scale-Revised**

The SCS-R (Lee & Robins, 1995) is a fifteen-item self-report scale, which was designed to assess an individual's subjective sense of social connectedness to their social world. Increased scores reflect higher social connectedness. Each

item is rated on a 6 point Likert scale, from 1 Strongly Disagree to 6 Strongly Agree.

4.12.2. Descriptors

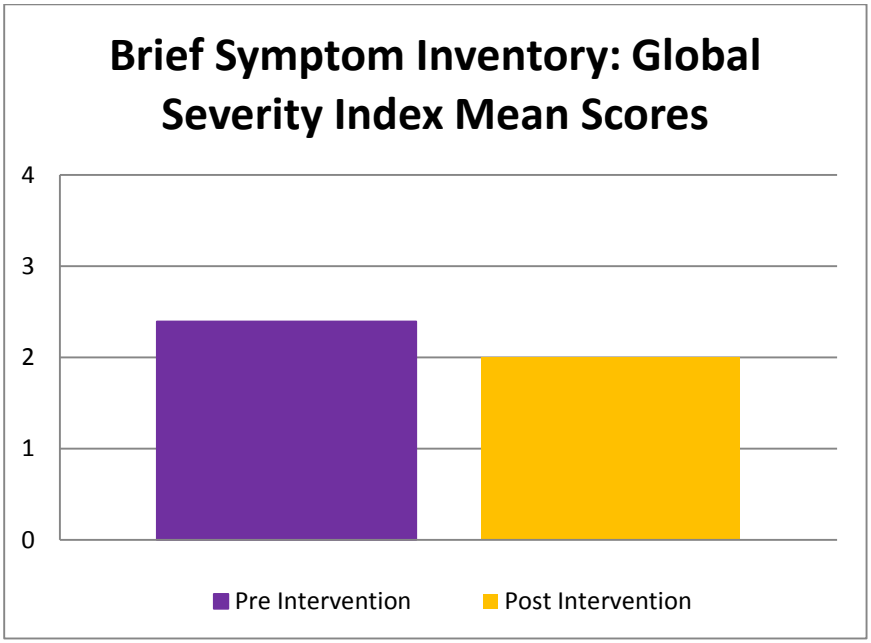
Pre and post data were available for 50 people who completed the programme in 2016. Where gender data was available, 35.8% were female and 43.4% were male and they ranged in age from 18 to 60 years (M=37.09; SD=13.31).

4.12.3. Results

Brief Symptom Inventory

A significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale on the Brief Symptom Inventory (BSI), whereby t(20)= 3.50, p<.05, reflecting a medium effect size (*d*= .57).

Graph: Brief Symptom Inventory Global Severity Index



Social Connectedness Scale: Revised

A significant change was also observed on the SCS-R, whereby t (30) = 4.32, p< .05, reflecting a medium effect size (Cohen's *d*=.79), suggesting that after the programme participants felt more connected to their social world.

Graph: Social Connectedness Scale: Revised

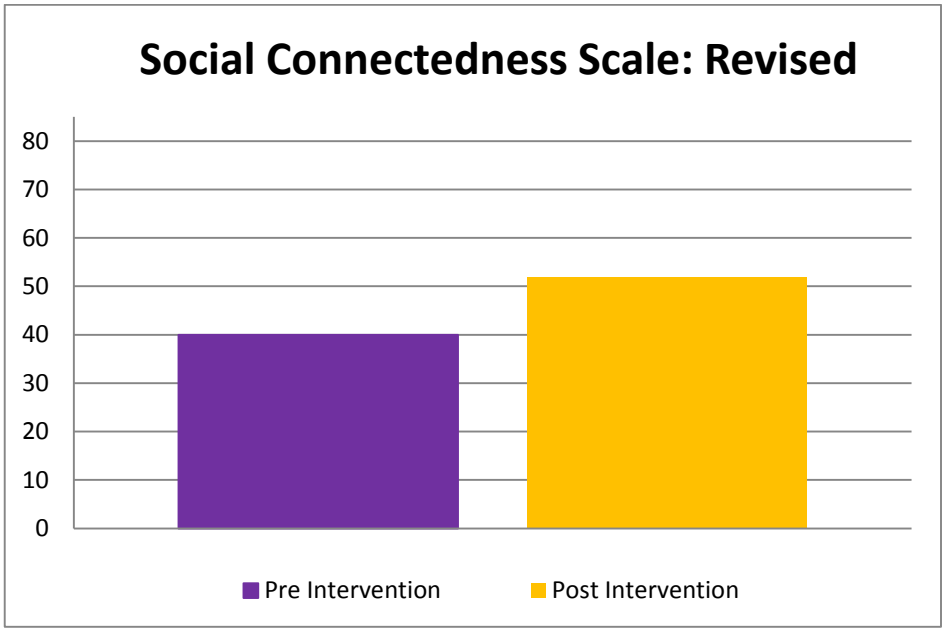


Table 1: *Results from paired samples t-tests for measures pre and post Radical Openness intervention.*

Scale	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
BSI	2.39 (.67)	2.00 (.61)	3.50	20	.002	.57
SCS-R	40.00 (15.57)	51.93 (14.59)	4.32	30	.005	.79

BSI=Brief Symptom Inventory, SCS-R=Social Connectedness Scale-Revised.

4.12.4. Summary

The Radical Openness programme teaches skills that provide new ways of coping for individuals who find it difficult to lessen their emotional control. This is a targeted approach for service users who are often underserved in

mental health care. In 2016 service users who completed Radical Openness showed reductions in psychological distress as measured by mental ill health symptoms as well as emotional avoidance (i.e. avoiding the internal experience of emotion) and increases in social connectedness. These findings were consistent with previous years.

There is ongoing research on this programme being undertaken by a doctoral student in Clinical Psychology, which is looking at understanding problems of emotional over- and under- control and response to the DBT informed interventions (i.e. LTD and RO) offered at St Patricks Mental Health Services.

4.13. Psychosis Recovery Programme

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

4.13.1. Psychosis Programme Outcome Measures

- **Recovery Assessment Scale**

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

quality of life. The RAS is a 41-item survey rated on a 5-point scale from 1 “Strongly Disagree” to 5 “Strongly Agree”. Twenty four of these items make up five sub-scales: ‘Personal confidence and hope’, ‘Willingness to ask for help’, ‘Ability to rely on others’, ‘Not dominated by symptoms’ and ‘Goal and success orientation’. The RAS was found to have good test-retest reliability (*r* = 0.88) along with good internal consistency (Cronbach’s alpha = 0.93; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

- **Drug Attitude Inventory**

The Drug Attitude Inventory (DAI: Hogan, Awad & Eastwood, 1983) is commonly used to measure service users’ attitudes towards psychotropic treatment. A valid and reliable 10 item brief version of the DAI has been developed (see Nielsen, Lindstrom, Nielsen and Levander, 2012) and was used in data collection for the psychosis programme from January 2015. The DAI-10 scoring ranges from -10 to 10. Whereby a total score of >0, indicates a positive attitude toward psychiatric medications. DAI-30 and DAI-10 were homogenous (r=0.82 and 0.72, respectively) with good test–retest reliability (0.79). The correlation between the DAI versions was high (0.94).

This shorter measure was introduced to reduce client and clinician burden in completion of measures for this programme, which had previously resulted in low response rates.

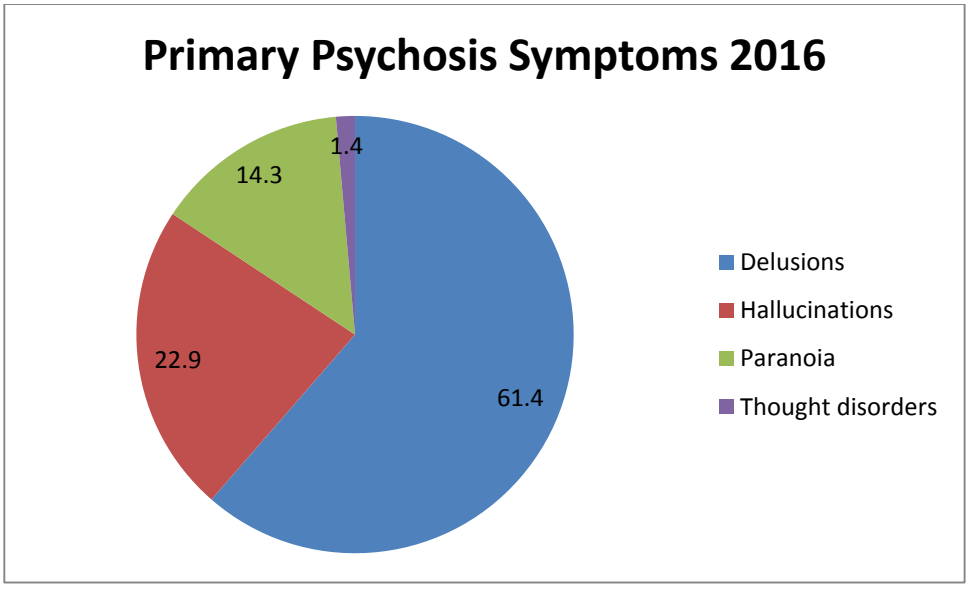
4.13.2. Descriptors

In 2016 pre and post RAS scores were available for 21 participants, and pre and post DAI scores were available for 20 participants. The average age of psychosis programme participants was 39.51 years (ranging from 18 to 79 years) with an even number of males (n=36) and females (n=36). 77.8% were single, 18.1% married, and 2.8% were separated or divorced. 31.9% were in employment, 22.2% were receiving disability allowance, and 12.5% were

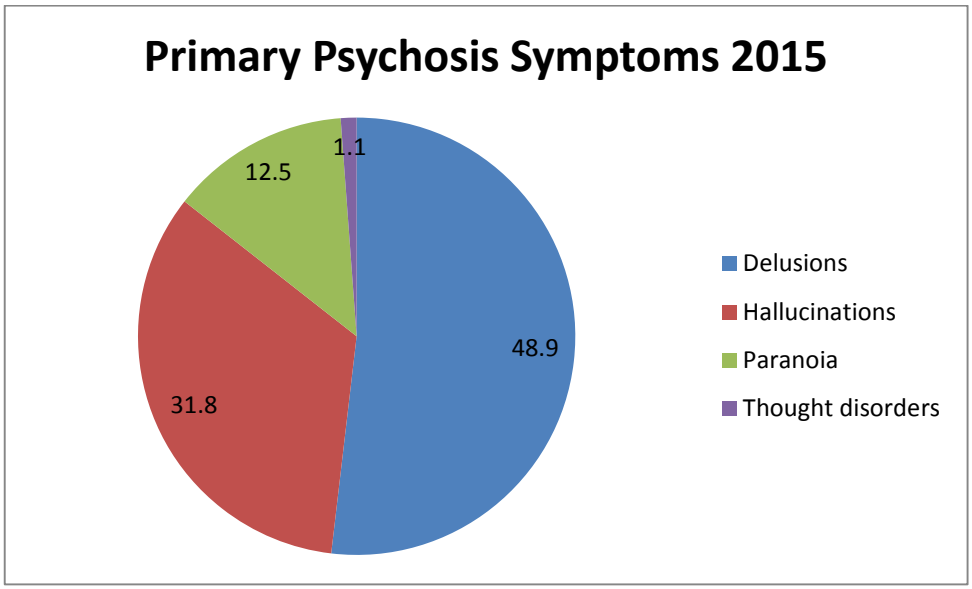
students. Over one quarter had attained a third level degree. 26.8% had completed the leaving certificate, with another 26.8% having a non-degree third level qualification. The remaining 22.6% had left school before the leaving certificate. The majority lived with family (69.9%) followed by living alone (24.7%). 5.5% were living with friends, or cohabiting. The majority of service users reported their ethnicity as white Irish (97.3%). Comparing 2015 to 2016, services users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

There were similar trends identified in the primary psychosis experience reported for service users in 2015 and 2016. In 2015 the primary reported symptoms were delusions, followed by hallucinations, and paranoia. In 2016 the primary reported symptoms occurred in the same order, delusions (61.4%), followed by hallucinations (22.9%), and paranoia (14.3%). See the figures below for reported primary psychosis symptoms in 2015 and 2016. The average attendance per client in 2016 was 9.4 sessions. Participants are permitted to attend multiple cycles of the programme.

Graph: Primary Psychosis Symptoms 2016



Graph: Primary Psychosis Symptoms 2015



4.13.3. Results

Recovery Assessment Scale

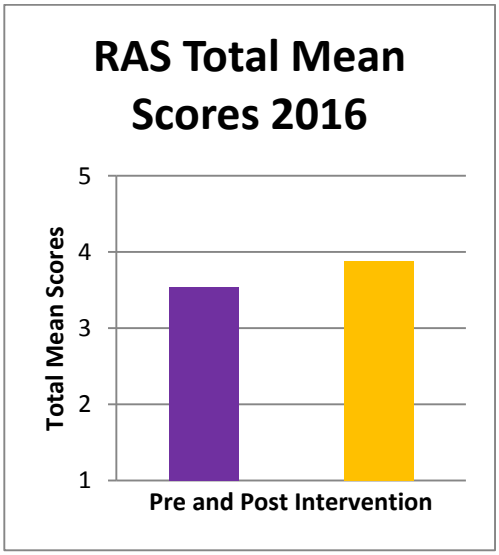
A Wilcoxon Signed Rank test identified a significant increase in mean total scores for the RAS at the post intervention time point z= 2.02, p <.05, reflecting a moderate effect size (Cohen's *r*: 29). Looking at the RAS sub-scale scores, significantly higher scores were identified post intervention for users on the 'Ability to rely on others' subscale only, z=2.31, p<.05, with a large effect size Cohen's *r*: .46). The difference between pre and post intervention means on the 'Confidence and Hope', 'Willingness to ask for help', 'Goal and Success Orientation', and 'No domination by symptoms' subscales were not statistically significant. See the table below for test statistics and figures for differences in pre and post intervention means and graphs on the following page for visual representations.

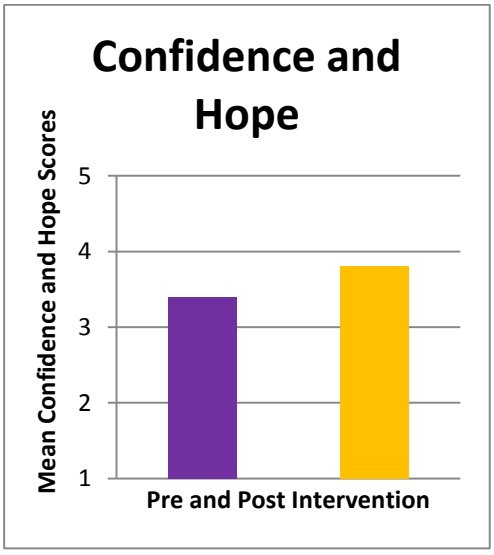
Table: *Results from Wilcoxon Signed Rank tests and Paired Sample T Tests for the RAS pre and post scores*

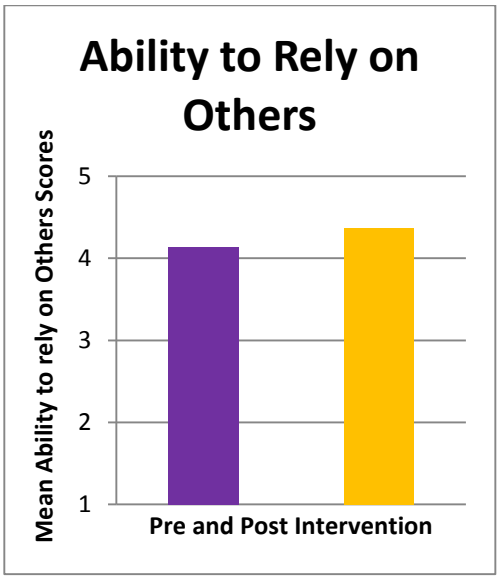
RAS	Pre Mean	Post Mean	*z*	*p*	Cohen's *r*
Mean Total	3.76 (.60)	3.87 (.75)	2.02	.043	.29
Confidence and Hope	3.58 (.76)	3.71 (.82)	1.88	.060	.27
Willingness to ask for Help	4.02 (.58)	3.88 (.81)	.409	.683	.08
Goal/ Success Orientation	3.81 (.62)	4.00 (.83)	1.91	.056	.38
Ability to Rely on Others	4.14 (.46)	4.35 (.82)	2.31	.021	.46
RAS	**Pre Mean**	**Post Mean**	***t***	***p***	**Cohen's *d***
No Domination by Symptoms	3.14 (.95)	3.36 (.77)	.93 (t)	.357	.19

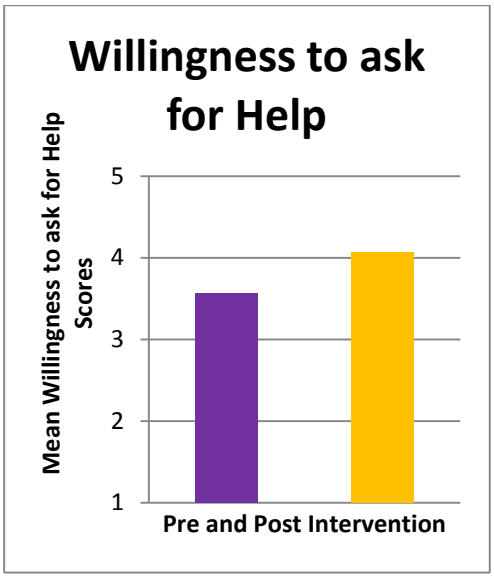
RAS = Recovery Assessment Scale.

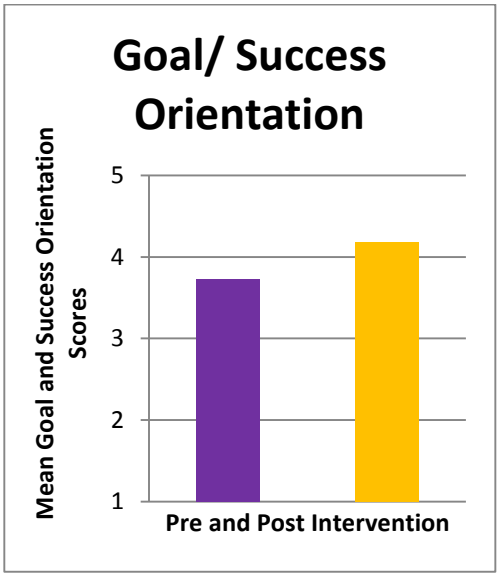
Graphs: Recovery Assessment Scale sub-scales

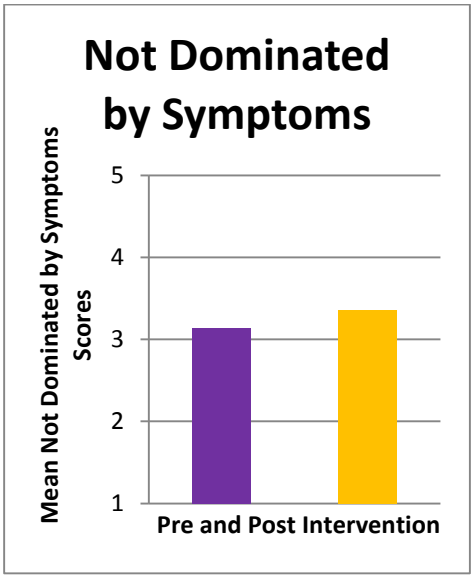






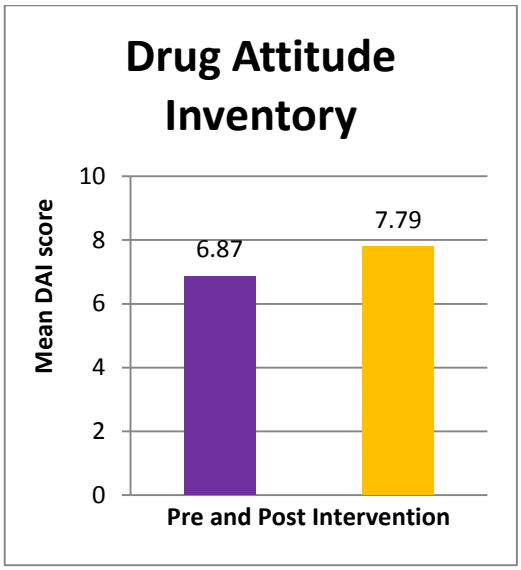






Drug Attitude Inventory

A Wilcoxin Signed Rank test identified a statistically significant increase in mean scores on the DAI-10 from pre intervention (M=6.87 SD=2.72) to post intervention (M=7.79; SD=2.43) z=2.4, p<.05, with a large effect size (Cohen's *r*: .35). This indicates that service users who completed the measures reported more positive views towards medication after completing the programme.



4.13.4. Summary

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

Programme staff explained that their client's inability to complete the measures accurately at the pre time point due to the acute nature of their illness has resulted in significant amount of lost data. Programme staff will be proactive in encouraging completion of measures accurately in order to increase response rates in 2017.

4.14. Recovery Programme

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

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

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

The programme is group based and focuses on accessing good health care, managing medications, self-monitoring their mental health using their WRAP; using wellness tools and lifestyle; keeping a strong support system; participating in peer support; managing stigma and building self-esteem. The option of attending fortnightly meetings at the recovery-focused 'Connections Cafe' is available to all participants. 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.

4.14.1. Recovery Programme Outcome Measures

• Recovery Assessment Scale

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

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

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

4.14.2. Descriptors

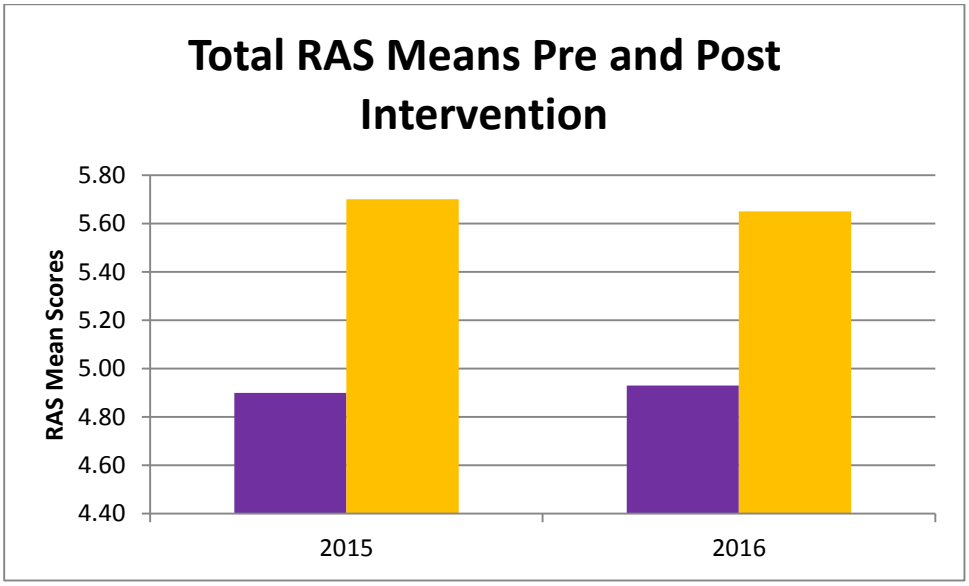
92 service users took part in the Recovery Programme in 2016. Pre and post data were available for 88 participants which represents 95.7% of those who attended in 2016. The average age of participants was 51 years and 58.7% were female.

4.14.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre measurement (*Md* = 4.93) to post measurement (*Md* = 5.65) indicating greater overall recovery. A Wilcoxin Signed Rank Test revealed this increase was statistically significant, z = -.6.37, p < .005, and represented a large effect (d = 0.50).

Graph: Recovery Assessment Scale: Mean Scores



The figures below show pre and post scores on the total and each of the five subscales: 'Personal Confidence and Hope', 'Willingness to ask for Help', 'Ability to rely on others', 'Not dominated by Symptoms' and 'Goal and Success Orientation'. A series of t-tests and Wilcoxin Signed rank tests were run in order to compare pre and post scores, mean and median scores,

standard deviations, z values, *p* values and effect sizes for each of the subscales. All subscales had large effect sizes, as shown in the tables below.

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

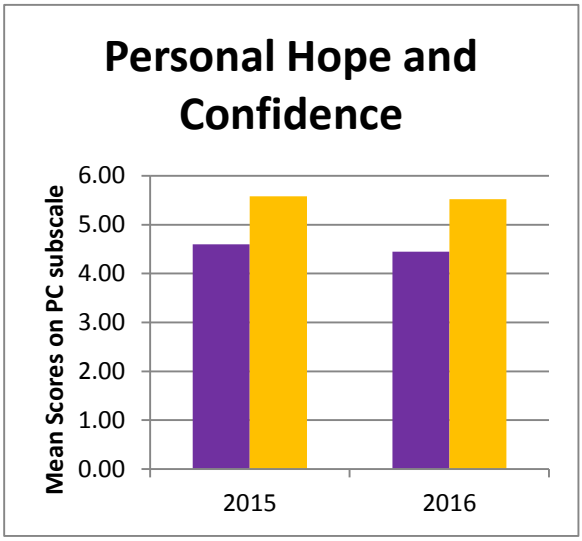
RAS	Pre *Mean (SD)*	Post *Mean (SD)*	*T value*	*P*	*Cohen's d*
Personal confidence	4.45 (1.04)	5.52 (.87)	9.40	.000	1.1
Willingness To Ask For Help	4.38 (1.31)	5.38 (1.00)	7.76	.000	.85

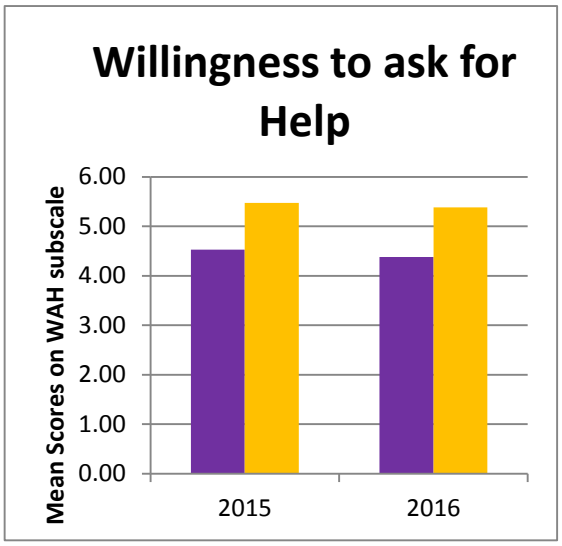
Table 2: Median scores on RAS (Wilcoxin Signed rank tests)

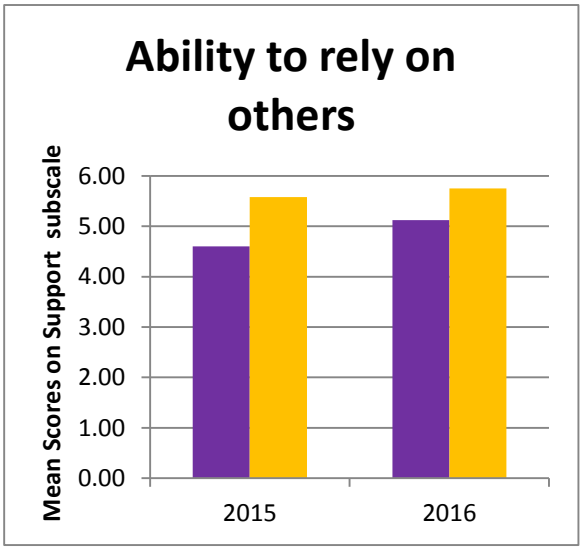
RAS	Pre *Median*	Post *Median*	*Z value*	*P*	*Cohen's r*
Ability To Rely On Others	5.12	5.75	6.05	.000	.64
Not Dominated By Symptoms	4.67	5.33	5.97	.000	.63
Goal and Success Orientation	5.40	6.00	6.67	.000	.70

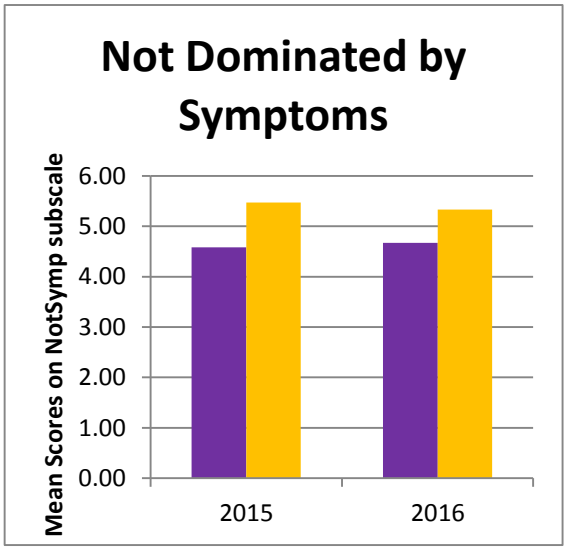
Scores on each of the 5 subscales improved significantly from pre to post measurement (see the graphs below).

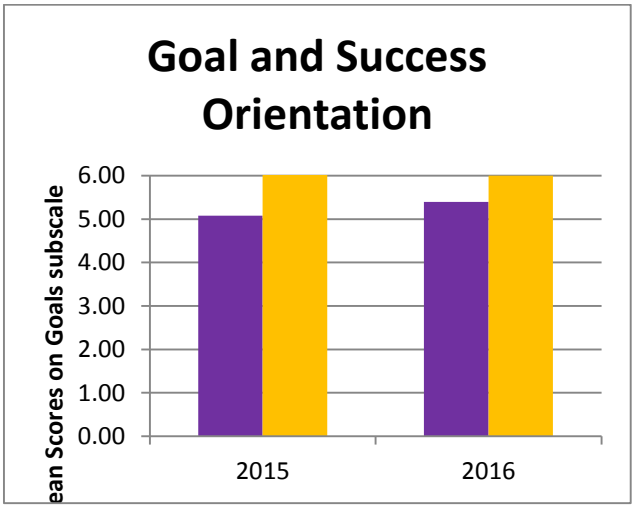
Graphs: Recovery Assessment Scale sub-scale









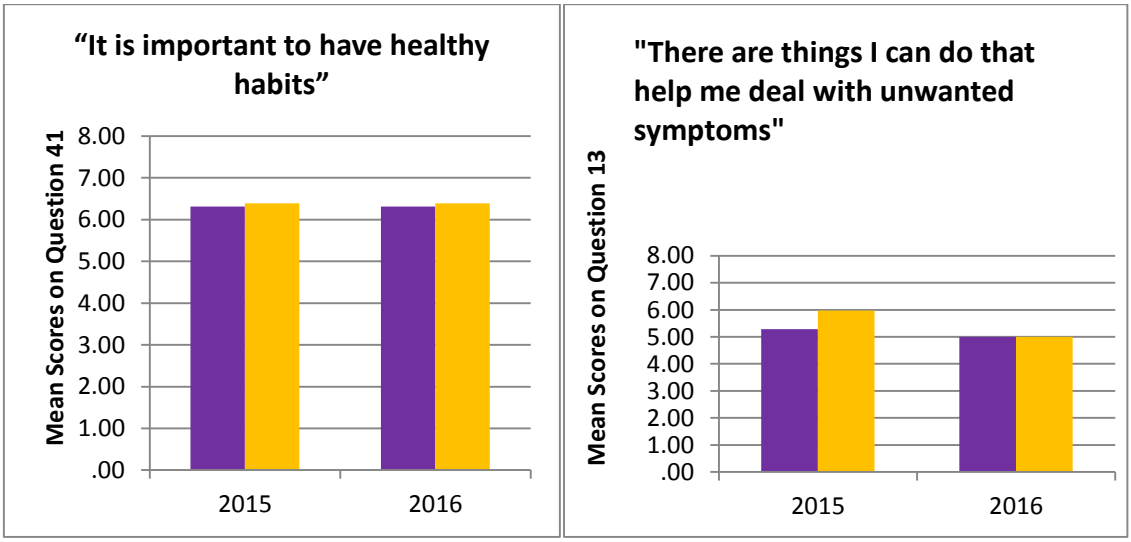


From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 "I can identify what triggers the symptoms of my mental illness", item 13 "There are things I can

do that help me deal with unwanted symptoms" and item 41 "It is important to have healthy habits".

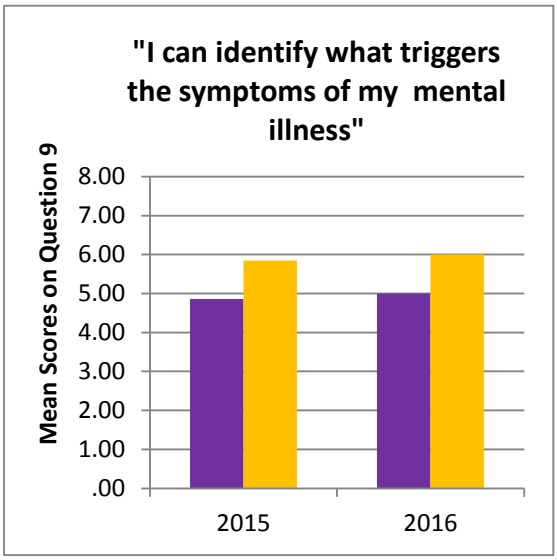
A series of Wilcoxin Signed Rank tests were run and scores improved significantly, $p<0.05$, from pre to post measurement (see the following graphs). Items 13 and 41 evidenced a medium effect sizes, r = .46 and .31 respectively.

Graph: Recovery Assessment Scale sub-scale



There was a large effect for item 9, "I can identify what triggers the symptoms of my mental illness", pre to post measurement, r = 0.60.

Graph: Recovery Assessment Scale sub-scales



4.14.4. Summary

Completion rates for 2016 were good with 95.7% completing measures pre and post intervention. The findings presented provide a meaningful insight into the effectiveness of the programme. Careful consideration has been given to the retention of the RAS as the primary outcome measure for the Recovery Programme. While there is no "gold standard" measure of recovery, the RAS has strong support for its psychometric properties. The RAS was found to meet a number of criteria set out by Burgess, Pirkis, Coombs and Rosen (2010), in their assessment of existing recovery measures including; measuring domains related to personal recovery, is brief, takes a service user perspective, is suitable for routine use, has been scientifically scrutinised, and demonstrates sound psychometric properties.

In summary, those who completed the programme showed significant improvements on the total RAS scale and on each of the 5 subscales. These improvements all demonstrated large effect sizes. This is an improvement on the last two years where medium to large effect sizes were observed.

In addition, all three of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements at post intervention, with medium to large effect sizes.

4.15. Willow Grove Outcome Measures

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

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

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

- Mood Disorders
- Anxiety Disorders
- Psychosis
- Eating Disorders

Our Treatment Approach

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

4.15.2 Willow Grove Outcome Measures

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

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was developed as an outcome measure for children and adolescents (3-18 years) engaging with mental health services (Gowers, Levine, Bailey-rogers, Shore & Burhouse, 2002). This measure provides a global assessment of the behaviour, impairments, symptoms and social functioning of children and adolescents with mental health problems. Studies such as Garralda et al. (2000) have found the validity and inter-rater

reliability of the HoNOSCA to be satisfactory. Lesinskiene, Senina & Ranceva (2007) investigated the use of the HoNOSCA in an inpatient child psychiatric unit and found satisfactory inter-rater reliability amongst multi-disciplinary team members. The measure has been regarded as suitable for use as a routine measure in mental health services and is used internationally.

The HoNOSCA is used to assess the most pertinent problems presenting during the previous two weeks. The measure is comprised of 15 items in total, with the first 13 items used to compute a total score (Bilenberg, 2003). These include: disruptive/aggressive behaviours, over-reactivity/concentration problems, self-injury, substance misuse, scholastic skills, physical illness, hallucinations/delusions, nonorganic somatic symptoms, emotional symptoms, peer relationships, self-care, family relationships and school attendance. All scales are scored on a 0-4 point rating from "no problems" to "severe problems". Higher scores are indicative of greater severity.

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

4.15.3. Descriptors

There were data available for 51 patients who were admitted in 2016. Of those, 13 (25.5%) were male and 38 (74.5%) were female. The age ranged from 13- 18 years, with a mean of 16.26 (SD=1.3).

4.15.4 Results

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

Table 1: Paired Samples T Test

	Pre	Post	*t*	*df*	p	*d*
Client Rated	22.62 (8.78)	16.83 (10.52)	3.67	42	.001	.56
Father Rated	20.91 (9.64)	11.16 (7.13)	4.65	23	.000	.94

Table 2: Wilcoxon Signed Rank Test

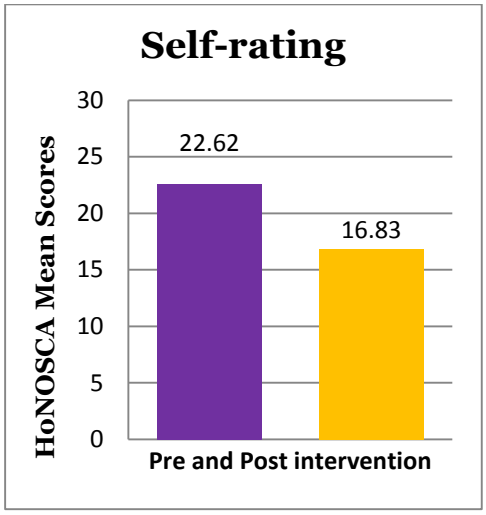
	Pre	Post	*z*	p	*r*
Clinician Rated	14.04 (6.13)	8.02 (4.12)	5.171	.000	.55
Mother Rated	22.44 (8.95)	12.97 (8.58)	4.61	.000	.53

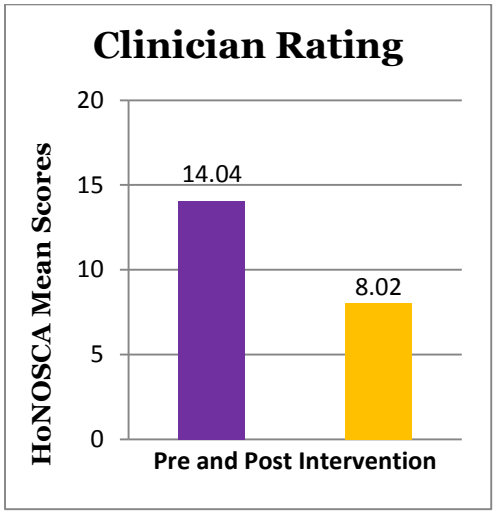
In order for the analysis to be run, each participant had to have a pre and a post score on the measure. Hence, the completion rates reported are not representative of all the data in the sample, but rather relate solely to the complete data, which can be analysed in this way.

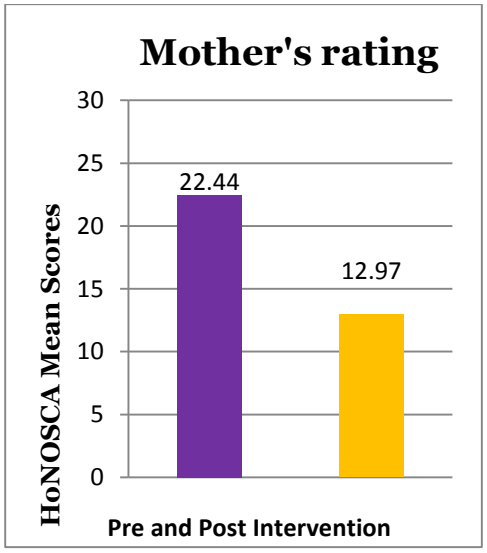
A significant decrease between total scores for the self-rated HoNOSCA was apparent at the post intervention time point (t (42) = 3.67 p = <.01), reflecting a medium effect size (Cohen's d: .56). A Wilcoxon Signed Rank test also revealed a statistically significant decrease in Clinician's rated HoNOSCA scores at the post intervention time point (z= 5.17, p <.01), with a large effect size (r=.55)

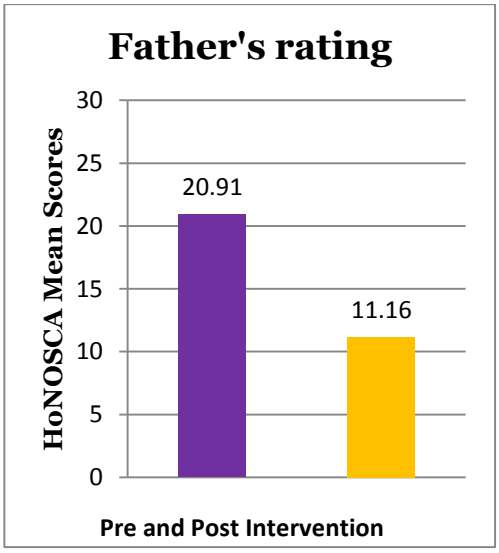
A significant decrease in total scores was also identified post intervention on mother's rated HoNOSCA (z=4.61, p <.01), which had a large effect size(r=.53); and on father's rated HoNOSCA (t (23) = 4.65; p=<.01), which had a large effect size (Cohen's d: .94).

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









4.15.5. Summary

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

It is of note that the response rates on the HoNOSCA in 2016 were lower than the previous year, and as such these results should be interpreted with caution.

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

The MDT is actively considering ways that data collection at discharge could be improved. Hence, it is anticipated that response rates will improve in 2017 and that it will be possible to conduct further analysis on the data to identify the breakdown of the pertinent presenting problems.

The measure has been commended in the literature for its ease of access for adolescents (Levine, Bailey-Rogers, Shore & Burhouse, 2002) and clinicians (Jaffa, 2000). It is expected to continue to serve as the primary outcome measure for 2017.

4.16.1. Sage Older Adults Psychology Skills Group

SAGE is a psychological therapy group for older adults who are experiencing difficulties with anxiety and /or depression and are interested in applying a psychological approach to their difficulties. The group is adapted from psychological theories about emotional regulation and emotional over-control (Linehan, 1993; Lynch et al, 2016), and how these can underpin certain recurrent mental health problems. The format is skills based, with eight skills taught twice over 16 sessions, which address problems of emotional regulation, interpersonal aloofness, emotional loneliness, and cognitive and behavioural rigidity.

This is the first year that outcomes for the SAGE programme have been reported. The group started in 2015, and was in its 5th cycle at the end of 2016. The programme is staffed by two psychologists and an assistant psychologist.

Sage Outcome Measures

Difficulties in Emotion Regulation Scale

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

Depression, Anxiety and Stress Scale

The 21-item Depression, Anxiety and Stress Scale (DASS) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. Each item comprises a statement and four short response options to reflect severity and scored from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*). In order to yield equivalent scores to the full DASS 42, the total score of each scale is multiplied by two (Lovibond & Lovibond, 1995) and ranges from 0 to 42. 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. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications

for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Descriptors

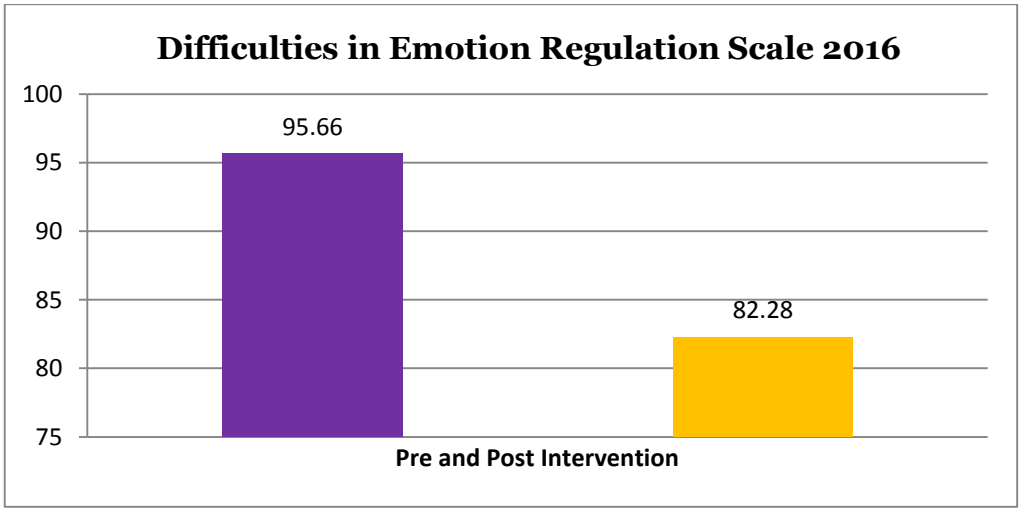
Data were available for 21 people who completed the programme in 2016, of whom 16 (76.2%) were female and 5 (23.8%) were male. Programme attendees ranged in age from 60 to 82 with a mean age of 69.38 (SD = 5.72). People attended an average of 12.86 sessions.

Results

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. A statistically significant decrease in difficulties regulating emotions was observed, moving from a mean score of 95.66 (SD = 23.7) to 82.28 (SD = 15.19) post completion of the programme, t (20) = 2.31, p < .05. This change reflected a medium effect size (Cohen's d = .5). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

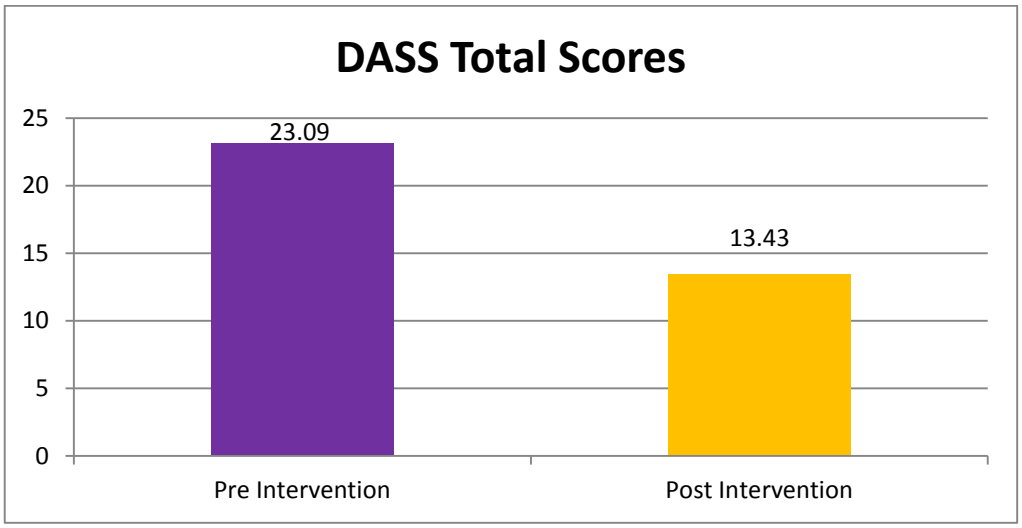


Note: Higher scores indicate greater difficulties with emotion regulation

Depression, Anxiety and Stress Scale (DASS)

Statistically significant improvements were observed on the DASS with mean pre scores of 23.09 (SD = 11.67) decreasing to 13.43 (SD = 8.7) post completion of the programme, t (20) = 3.76, p < .01. A large effect size was observed (Cohen's d = .82).

Graph: Depression, Anxiety and Stress Scale (Total)

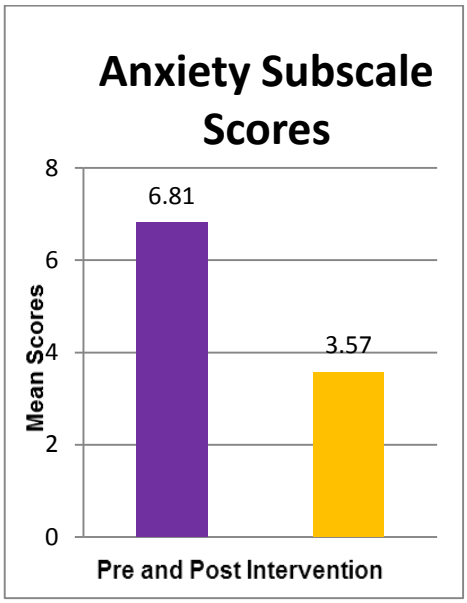


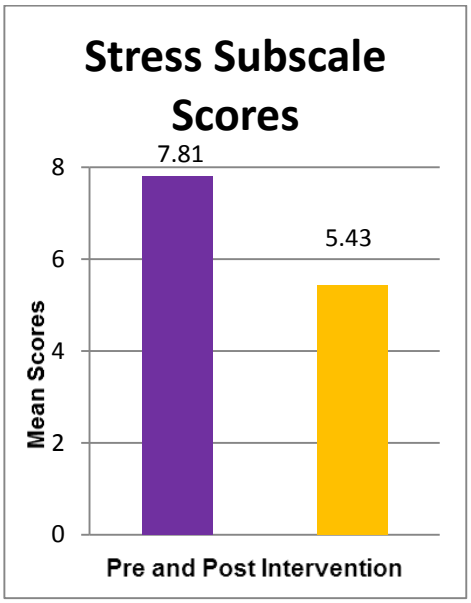
There are three subscales within the DASS and the figures below show pre and post scores on each of these subscales including: "Depression", "Anxiety", and "Stress". Following a series of Paired Sample T Tests, mean scores, t values, *p* values and effect sizes (*d*) for the subscales are shown in the following table.

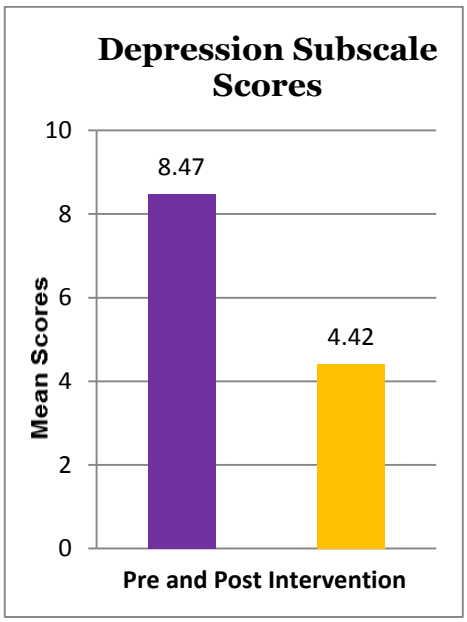
Table: DASS Subscale Scores

DASS	Pre *Mean*	Post *Mean*	t	*p*	*d*
Depression	8.47	4.42	3.49	.002	.76
Anxiety	6.81	3.57	3.29	.004	.72
Stress	7.81	5.43	2.51	.021	.55

Graphs: DASS Subscales







Scores on all three of the Depression, Anxiety and Stress subscales improved significantly from pre to post measurement, with all three reflecting medium effect sizes.

Summary

Improvements were observed in group member's ability to regulate their emotions as indicated by their pre and post DERS scores. Reductions were also noted in patient's depression, anxiety and stress levels as indicated by their scores on the DAS.

Anecdotally, group members have found the group to be “an invaluable tool to wellness” and “coping with everyday problems”. One group member said “I have come out of the group more confident and with the ability to cope better with my emotions”. Another service user said “it has made a more complete person of me”.

In 2016 a poster showcasing the group was awarded Best Poster Prize at the British Psychological Society, Faculty of Psychologists Working with Older People Annual Conference

It is expected that the DAS and DERS measures will continue to be used for routine data collection in 2017.

SECTION 5

Measures of Service User Satisfaction

5.1 Service User Satisfaction Questionnaires

5.1.1 Introduction

St Patrick's Mental Health Service is committed to listening to and acting upon the views of those who use and engage with its service. In order to enhance communication between service users and providers, a Service User Satisfaction Survey was developed and is distributed to service users who attend the Dean Clinics, Inpatient, and Day Programme services. This report outlines the views of a portion of Dean Clinic, Inpatient, and Day Programme service users from January to December 2016. The results of the service user satisfaction survey are collated for the first six months of each year and for each full year, to provide management and the board of governors' valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

5.1.2 Survey design

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

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

5.1.3 Data collection

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

Dean Clinics

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

Inpatient Adult Services

All service users discharged between January and December 2016 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online.

Day Programme Services

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

5.1.4. Findings

5.1.4.1. Dean Clinic (Community Services)

***Percentage of surveys received from Dean Clinics*:**

Dean Clinic	n	%
St Patrick's	15	18.3
Sandyford	4	4.9
Capel Street	17	20.7
Donaghmede	3	3.7
Galway	19	23.2
Lucan Adolescent	5	6.1
Cork	7	8.5
Lucan Adult	6	7.3
No Answer	6	7.3
Total	82	100

Service User Responses

How long did you wait for a first appointment?

Percentage of respondents who endorsed each first appointment waiting time frame

1st Appt. Waiting Time	n	%
<1 week	7	8.5
<2 weeks	13	15.9
<1 month	21	25.6
<2 months	17	20.7
>2 months	6	7.3
>4 months	11	13.4
No Answer	7	8.5
Total	82	100

Were you seen at your appointment time?

32.9% of respondents reported being seen on time, 22% of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic and 24.4% of respondents reported a half hour wait for their appointment on arrival to the clinic. Cumulatively 81.3% of respondents were seen within half an hour of their appointment time.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	27	32.9
Seen within 15 minutes	18	22.0
Seen within a half hour	20	24.4
Seen within hour	6	7.3
Seen within over 2 hours	9	11.0
No Answer	2	2.4
Total	82	100

Tell us about your experience of assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

Experience of assessment/therapy/review?	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did a member of the clinic staff greet you?	67	81.7	12	14.6	3	3.7	0	0
Did a member of the clinic staff explain clearly what would be happening?	61	74.4	14	17.1	2	2.4	5	6.1
Were you told about the services available to you to assist you in looking after your mental health?	49	59.8	21	25.6	7	8.5	5	6.1

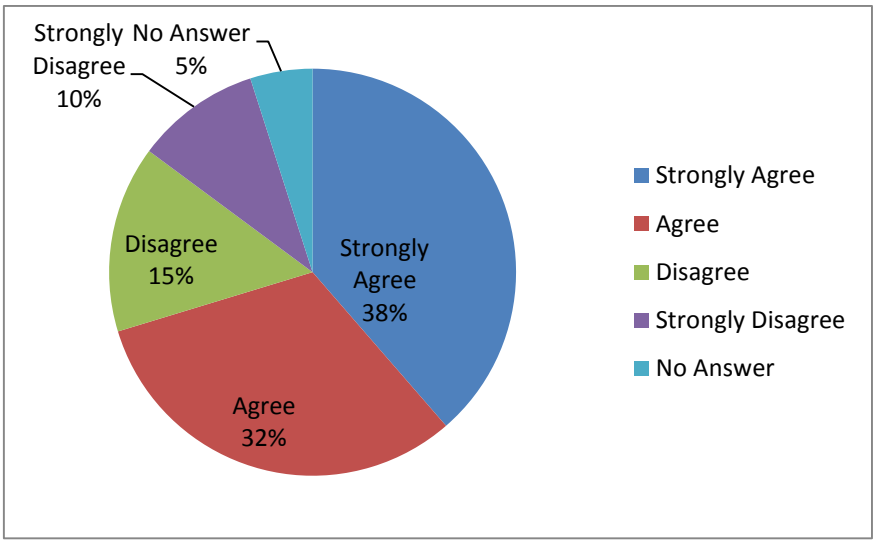
Tell us about your experience of care and treatment at the clinic following assessment

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

Respondents experience of care and treatment at the Clinic following assessment

Experience of Care & Treatment following your assessment?	Agree		Neither Agree or Disagree		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Treated as an individual	70	85.4	5	6.1	6	7.3	0	0	1	1.2
Treated with dignity & respect	68	82.9	3	3.7	8	9.8	0	0	3	3.7
Confidentiality was protected	71	86.6	2	2.4	8	9.8	0	0	1	1.2
Privacy was respected	70	85.4	1	1.2	10	12.2	0	0	1	1.2
Staff were courteous	68	82.9	7	8.5	6	7.3	0	0	1	1.2
Felt included in decisions about my treatment	66	80.5	2	2.4	13	15.9	0	0	1	1.2
Trusted my doctor/therapist/nurse	69	84.1	2	2.4	10	12.2	0	0	1	1.2
Appointments were flexible	61	74.4	8	9.8	10	12.2	0	0	3	3.7

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



How would you rate the Dean Clinic facilities?

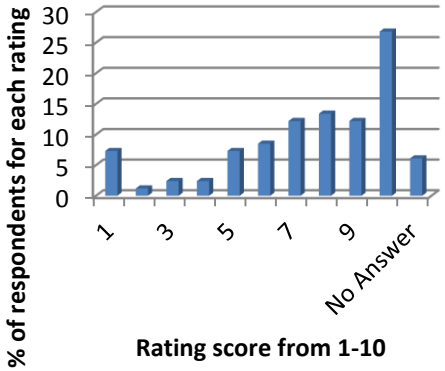
Respondents were asked to rate Dean Clinic facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Dean Clinic facilities, with all means

above 7. Furthermore the standard deviation was below 3 across all four areas showing small variation between responses, i.e. the majority of respondents responded favourably and similarly (see Table below).

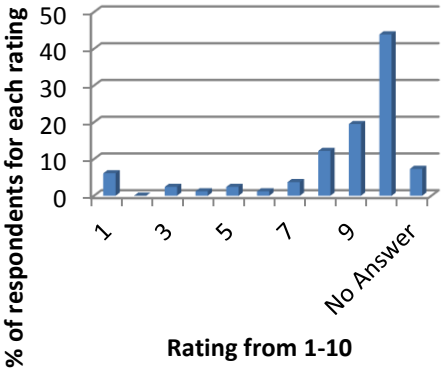
Respondents' scores of Dean Clinic facilities

Rate the following in relation to the Clinic…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	77	7.30	2.72
Cleanliness of Clinic	76	8.37	2.54
Calmness of environment	76	8.09	2.76
Welcome environment	75	7.88	2.85

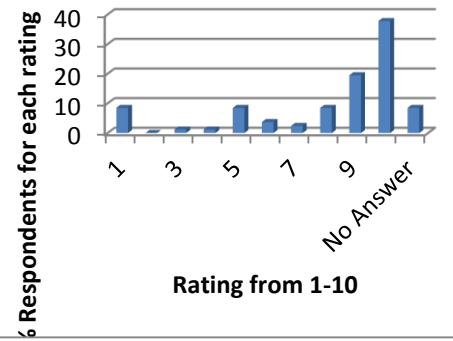
Clinic's decor/furniture



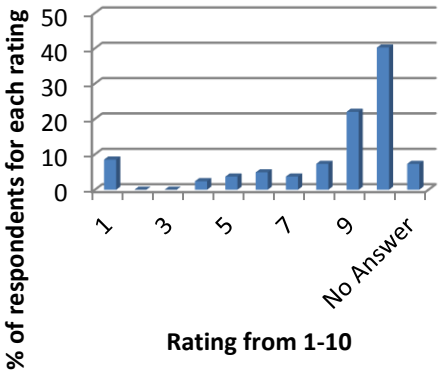
Cleanliness of the clinic



How welcoming was the clinic environment



How calm was the clinic environment



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

Service users who completed and returned the Service User Satisfaction Survey between January and December demonstrated a high level of satisfaction with the care they received. Service users rated their care and treatment at the Dean Clinic on a scale of 1 to 10; showing a mean score of 8.2 (N=77; SD=2.7). Respondents also indicated a high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.0 (N=77; SD=2.7).

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

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	%	n	%
1	7	8.5	7	8.5
2	0	0	0	0
3	0	0	0	0
4	1	1.2	1	1.2
5	3	3.7	5	6.1
6	2	2.4	4	4.9
7	5	6.1	2	2.4
8	12	14.6	11	13.4
9	10	12.2	14	17.1
10	37	45.1	33	40.2
No Answer	5	6.1	5	6.1
1-5	11	13.4	13	15.8
6-10	66	80.4	64	78.0
Total	77	100	77	100

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

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	77	8.2	2.7
Overall, the Dean Clinic	77	8.0	2.7

Further Service User Views

Dean clinic respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed

statements, and to give further voice to the users' experiences. Not all respondents answer these questions. Please find below a sample of answers

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

Positive Comments include:

- "I have been attending the clinic for 22 years and am very satisfied."
- "I have attended the old outpatient clinic before the Dean Clinic opened. Because the clinic is consultant lead I have been able to have continuous excellent care from my consultant and my drugs might be adjusted. I have been able to have a family, hold down a permanent job and enjoy my life."
- "Very helpful in my recovery, essential."
- "Visits are straight forward-never any problem."

Comments to learn from include:

- "It is extremely difficult to contact the clinic by phone which adds to anxiety."
- "The water machine is cold-can you fix the machine?"
- "The decor in the room that the therapy sessions happen needs to be added to. A bare white ofice with office chairs isn't exactly the most welcoming and relaxing environment."
- "Long waiting time to see consultant."

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

- "The amount of time for the consultation reflects what you need for your problems that day. All your struggles are teased out at your appointment."
- "Everyone I dealt with were very friendly and welcoming."
- "After the initial assessment I felt like I was getting the help I needed and wanted and this came as a huge relief."
- "Flexible visits- I had to change some appointments."

- “I liked the decor outside of the therapy room. It’s bright, clean and welcoming. I liked that I didn't have to wait too long in the waiting room and there was rarely other people in there.”
- “You feel they care about you. You're not another number.”
- “1st Class service.”
- “Felt at ease very quickly on visit.”
- “Friendly and efficient secretary. Very good consultation with consultant, easy to talk to and understanding.”

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

- “Directions to the Dean Clinic would be helpful e.g. small map.”
- “If there was a dean clinic in Limerick it would be great, but unfortunately there is not so otherwise I think it is great facilities for those suffering from mental health issues. It’s a far better hospital clinic than those hospitals of years ago where people were not treated with dignity or respect.”
- “It would be helpful to have a booklet/ web information on all possible treatments, group support etc.”
- “Tea, coffee and biscuits in waiting room- nice if you are waiting and if you have come on a long train journey.”
- “Reduce the cost of CBT appointments.”
- “Waiting room while waiting to be seen is very small and may feel claustrophobic for some visitors.”
- “Open windows in offices as I find myself falling asleep it's so stuffy.”

5.1.4.2 Adult Inpatient Services

Demographics

Service users discharged between January and December 2016 from adult inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online. 2986 discharges were processed in 2016, with a total of 410 (13.7%) surveys being returned to St Patrick's Adult Inpatient services. The response rate relates to the number of discharges, rather than the number of people discharged. When the number of individual people discharged (1909) is considered then the response rate increases to 21.5%. SPMHS is actively working on methods to improve response rates for 2017.

Table: *Number of adult inpatient surveys returned and discharges in 2016*

Month	Surveys Returned	Discharges
January	35	248
February	1	218
March	44	253
April	52	245
May	43	265
June	33	239
July	33	280
August	52	258
September	30	279
October	38	238
November	32	249
December	17	214
Total	410	2986

Service User Responses

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

The most common waiting time frames reported by respondents were between '4-7 days' (24.1%), and between '1-3 days' (23.9%), (see table below). 21.7% waited <1 day.

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

Waiting Time	n	%
<1 day	89	21.7
1-3 days	98	23.9
4-7 days	99	24.1
1-2 weeks	57	13.9
3-4 weeks	37	9.0
Don't know	20	5.0
No answer	10	2.4
Total	410	100.0

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

The most common waiting time frame reported by respondents was less than 1 hour, with 63.9% of respondents reporting this time period (see table below).

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

Waiting Time	n	%
<1 hr	262	63.9
1-2 hrs	82	20.0
2-3 hrs	23	5.6
3-4 hrs	8	2.0
>4 hrs	14	3.4
Don't know	9	2.2
No answer	12	2.9
Total	410	100.0

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

The most common waiting time frames reported by respondents were '1-2 hrs' (31.7%) and ''2-3 hrs' (23.7%) (see table below).

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

Waiting Time	n	%
<1 hr	80	19.5
1-2 hrs	130	31.7
2-3 hrs	97	23.7
3-4 hrs	50	12.2
>4 hrs	33	8.0
Don't know	13	3.2
No answer	7	1.7
Total	410	100.0

"Tell us about your experience of admission."

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

Tell us about your experience of admission.	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
When you came to the Hospital did a member of the assessment unit greet you?	308	75.1	54	13.2	36	8.8	12	2.9
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	287	70.0	61	14.9	40	9.8	22	5.3
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	308	75.1	64	15.6	26	6.3	12	2.9
Were you given written information about the Hospital and the services provided?	286	69.8	90	22.0	20	4.9	14	3.3

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

In relation to your care plan…	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
I understand what a care plan is	329	80.2	31	7.6	14	3.4	12	2.9	24	5.9
I was involved in the development of my care plan	237	57.8	60	14.6	64	15.6	20	4.9	29	7.1
I was offered a copy of my care plan	177	43.2	28	6.8	136	33.2	26	6.3	43	10.5
I was involved in the review of my care plan	208	50.7	59	14.4	82	20.0	20	4.9	41	10.0
There was a focus on recovery in the care and treatment offered	315	76.8	37	9.0	22	5.4	6	1.5	30	7.3
My care plan is key to my recovery	256	62.4	72	17.6	40	9.8	8	2.0	34	8.3

Service users' perceptions regarding their understanding, involvement and engagement in their care plan has been a significant focus for the organisation over recent years. The concept of a care plan isn't familiar for many service users, particularly those being admitted for the first time. There has been on-going work at multidisciplinary team level to inform service users and facilitate their involvement and engagement in their care planning process. Education and information regarding care planning, key working, recovery focus and multidisciplinary teams has also been on-going on an organisational level through a regular morning lecture and information booklets provided to all service users' on inpatient admission. This on-going focus has produced positive results, for example, as can be seen above 80.2% reported that they understood what a care plan is and 57.8% reported that they were involved in the development of their care plan.

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

	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Consultant Psychiatrist	301	73.4	26	6.3	50	12.2	2	0.5	31	7.6
Registrar	254	62.0	49	12.0	50	12.2	9	2.2	48	11.7
Key Worker	205	50.0	46	11.2	90	22.0	16	3.9	53	12.9
Nursing Staff	330	80.5	16	3.9	26	6.3	2	0.5	36	8.8
Psychologist	137	33.4	34	8.3	92	22.4	29	7.1	118	28.7
Occupational Therapist	157	38.3	47	11.5	78	19.0	29	7.1	99	24.1
Social Worker	136	33.2	57	13.9	59	14.4	39	9.5	119	29.0
Pharmacist	139	33.9	53	12.9	59	14.4	38	9.3	121	29.5
Other	108	26.3	31	7.6	39	9.5	36	8.8	196	47.7

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

Waiting Time	n	%
<1 week	68	16.6
1-2 weeks	52	12.7
2-3 weeks	28	6.8
>3 weeks	70	17.1
Not on programme	68	16.6
No Answer	124	30.2
Total	410	100.0

Just under a third of people (29.3%) waited up to two weeks to attend a programme.

Tell us about your care…

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

Experience of the team that worked with you	Strongly Agree		Agree		Disagree		Strongly Disagree		No answer	
	n	%	n	%	n	%	n	%	n	%
Trusted the team members	252	61.5	90	22.0	21	5.1	4	1.0	43	10.5
Treated with dignity and respect	261	63.7	86	21.0	20	4.9	6	1.5	37	9.0
Protected my confidentiality	267	65.1	81	19.8	14	3.4	4	1.0	44	10.7
Respected my privacy	264	64.4	80	19.5	18	4.4	7	1.7	41	10.0
Were courteous	270	65.9	81	19.8	10	2.4	5	1.2	44	10.7
Felt included when my team discussed medical issues at my beside / in my room	241	58.8	87	21.2	19	4.6	9	2.2	54	13.2
Respected me as an individual	261	63.7	86	21.0	15	3.7	7	1.7	41	10.0

Tell us about your experience of discharge…

Table: *Respondents' perceived involvement in discharge*

Experience of Discharge from Hospital	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you discuss and agree your discharge with your treating team?	333	81.2	28	6.8	8	2.0	41	9.9
Do you think you were given enough notice of your discharge from hospital?	338	82.4	31	7.6	6	1.5	35	8.5
Do you have a discharge plan?	282	68.8	69	16.8	15	3.7	44	10.7
Do you know what to do in the event of a further mental health crisis?	297	72.4	53	12.9	15	3.7	45	11

Tell us about your experience of hospital activities…

Tell us about your experience of hospital activities	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you attend any of the activities during the day?	348	84.9	47	11.5	1	0.2	14	3.4
Did you attend any of the activities in the evenings and at weekends?	268	65.4	119	29.0	3	0.7	20	4.9
Was there a range of activities that you could get involved in?	344	83.9	45	11	6	1.5	15	3.7
At the weekend were there enough activities available for you?	159	38.8	181	44.1	30	7.3	40	9.6

The majority of respondents felt that there was a range of activities they could get involved in (83.9%). However, 44.1% indicated that there were not enough activities available in the hospital at weekends.

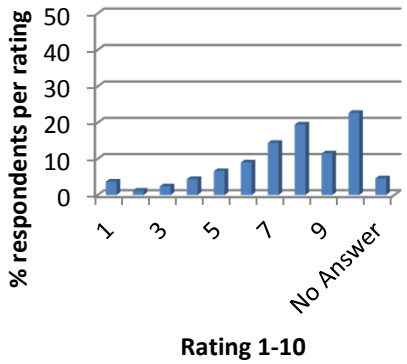
Tell us about your experience of hospital facilities…

A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with all means above 7. In particular, the cleanliness of the ward (8.9) and Communal areas (8.8) received high scores as well. The standard deviation across most areas was close to 2 indicating that there was significant variation in responses.

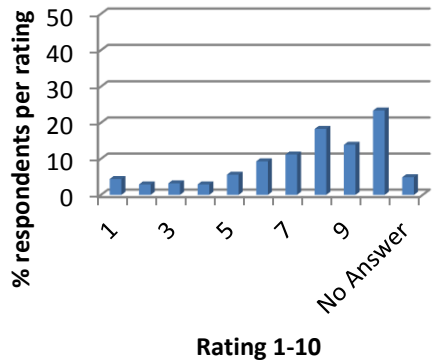
Table: *Respondents' scores of Hospital facilities*

Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	391	7.3	2.4
Food on Ward	390	7.4	2.5
Service in ward dining areas	393	8.6	1.9
Cleanliness of ward areas	394	8.9	1.7
Cleanliness of Communal areas	383	8.8	1.7
Hospital Facilities	377	7.9	2.2
Garden Spaces	379	8.5	2.0

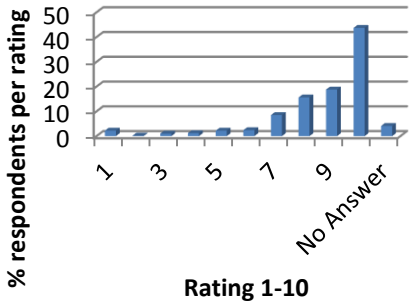
Décor/ Furniture



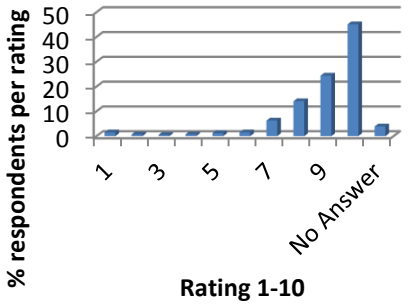
Food on Ward



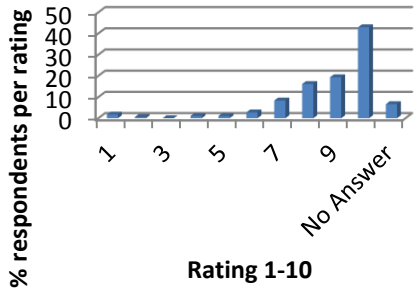
Service in dining areas



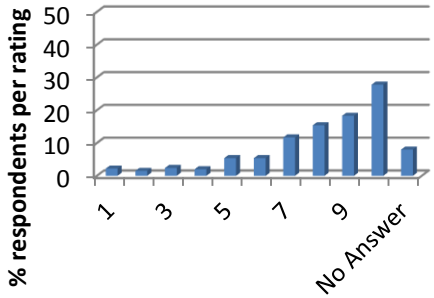
Cleanliness of ward area



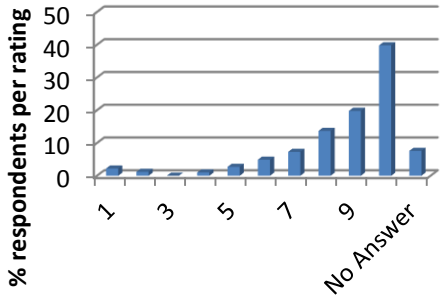
Cleanliness of communal areas



Hospital Facilities



Garden Spaces



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

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would disclose to others that they received support from St Patrick's. The majority of respondents felt they had more positive views towards mental health difficulties in general (80%) and towards their own mental health difficulties (78.5%) and felt that they would share with others that they received support from St Patrick's (67.6%).

Table: *Experiences of stigma*

Tell us about your views and perceptions regarding mental illness following your stay…	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Are your views regarding mental illness in general more positive than they were?	328	80.0	38	9.3	18	4.4	26	6.3
Are your views regarding your own mental illness more positive than they were?	322	78.5	47	11.5	16	3.9	25	6.1
Will you tell people that you have stayed in St Patrick's?	277	67.6	59	14.4	43	10.5	31	7.5

Overall views of St Patrick's Mental Health Services

Service users who completed and returned the Service User Satisfaction Survey demonstrated a high level of satisfaction with the care they received, rating their care and treatment in Hospital on a scale of 1 to 10, with a mean of 8.5 (N=391; SD=2.0). Respondents also demonstrated a high level of satisfaction with the Hospital overall, rating the Hospital on a scale of 1 to 10, with a mean of 8.7 (N=392; SD=1.7).

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

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	%	n	%
1	8	2.0	6	1.5
2	2	0.5	1	0.2
3	4	1	1	0.2
4	7	1.7	3	0.7
5	9	2.2	10	2.4
6	18	4.4	12	2.9
7	29	7.1	31	7.6
8	68	16.6	75	18.3
9	79	19.3	90	22.0
10	167	40.7	163	39.8
No Answer	19	4.5	18	4.4
1-5	30	7.4	21	5
6-10	361	88.1	371	90.6
Total	399	100.0	399	100.0

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

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	391	8.5	2.0
The Hospital	392	8.7	1.7

Further Service User Views

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

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

Positive Comments include:

- " All staff very aproachable and understanding. I love the idea of a key worker and openness of service users being involved in care plan."
- "Meeting with my psychologist X really helped me progress in my recovery. She helped me get through many difficult times. Dean Swift ward was the best in hospital. I felt very secure there."
- "Staff are super, nursing staff couldn't be more helpful or better, they are professionalism personified. I won't name names but there are a couple or so that stand out, even amongst general excellence, the only criticism that I would have is that weekends can be very long for people who can't go out or have nowhere to go."
- "Activities and food have improved a lot since I was in 2003."
- "Staff were professional, caring and always helpful. Regarding food, I liked the variety on offer, particularly the fruit."
- "I am so grateful- you saved my life."
- "I felt comfortable because the nursing staff made me feel I would get better and I felt safe."

Comments to learn from include:

- "I think an ATM would be beneficial. Tea/coffee machines also."
- "More weekend activities would really help. Extended hours of art, pottery & craft would alleviate boredom & help recovery."
- "Renovation done on the ward were necessary but quite disturbing. Would be better to move patients for a few days. Very hard to rest during the day with drilling, banging etc."
- "The two toilets to serve the bay area were filthy at times (showers outdated)."
- "The yoga and pilates programme did not take any account of the patients. It was just a series of exercises, going through the motions, no music, no interest, no way tailoring the sessions to cater for its participants."

Q: Was there anything particularly good about your care?

- “Can't say enough about how good and caring the staff here are. That includes the cleaning staff and the catering staff.”
- “Respect, efficiency, understanding, non-judgemental, encouraging.”
- “My care was excellent at all times. I recovered slowly and was given all the time I needed to get well. The kitchen staff were excellent, attentive, kind.”
- “Having a private room essential for my recovery. Some of the nurses on the ward were very helpful as well. To have a medical team including psychiatrist, psychologist, social worker as well as occupational therapist allowed me to cover all the issues that needed to be addressed.”
- “Plenty to do during the day. Daily activities and twilight was very beneficial
- “Knowing there was a team of experts at your dispense. The morning lectures and information centre are excellent.”
- “I felt included in my care and I felt comfortable discussing any issues that came up, particularly those affecting me personally.”
- “The professionalism and compassion of the staff.”
- “I felt minded, taken care of because I really needed minding. I felt safe. I was treated with great respect.”
- “The comfortable accommodation and the positive attitude of my doctor. Meals very good and breaks for snacks between meals.”
- “I felt that all involved in my care plan: nurses, doctors, counsellors catered for my specific needs and were very attentive and put a lot of work and thought into my post discharge care.”
- “I found the surroundings in the hospital warm, friendly and relaxing. This helped my body and mind to relax which contributed significantly to my recovery as did the food I received.”
- “I learned what my early warning signs are and how to keep myself well. I am still attending courses even though I am no longer and inpatient which is great as you feel it makes it easier adjusting back to your 'normal' life.”
- “I loved sitting out in the garden.”

Q: What could we improve?

- “The cleaning trollies on the ward should not be left in the centre of the corridor but pushed to the side it is like an obstacle course trying to walk.”
- “Proper orientation on admission. Hospital, ward, condition, each ward to have leaflets and map of hospital. Fixed bloods/ MDT/Care plan form/ consultant clinics to be displayed. Give patients max information: some will use, some won't.”
- “There should be a service for the family members of the patient.”
- “The prices of shop should be at same level as a supermarket, too expensive. Bulletin boards are too hit and miss, timetables too individual.”
- “More activities at the weekend, the food could be better, very little variety.”
- “ It would be great if the art rooms were open at the weekend (also the library).”
- “Food. Should be able to meet psychiatrist team more than once a week.”
- “Even though everything was excellent from staff on all levels, I feel there could be some other therapeutic classes like massage, facials, relaxation therapies that would be of benefit.”
- “P.R. to the outside world, the hospital is like a school or university, hugely enlightened & at the cutting trust of mental wellness in the spirit of its founder Swift.”
- “More activities for men, very craft focused.”
- “Better communication overall. Address delays in moves to other wards. Key workers need to be aware of their role and act on it. Address failures in care plans. Feedback from complaints/ comment cards needed and expected.”
- “More activities at the weekend, an organised queuing system for meds is a must. Currently it causes some folks stress, including me.”
- “Just one thing, temple as a building, medical facility. Also: prices charged for toiletries in shop are just morally wrong.”
- “Have an area to play games maybe. The gym is great but is focused on individuals not teams.”

5.1.4.3 Day Services

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

Day Services Service User Satisfaction Survey Response Rate

Month	Surveys Distributed	Surveys Returned
January	158	26
February	120	12
March	126	12
April	129	52
May	117	15
June	140	22
July	105	16
August	91	10
September	52	26
October	79	0
November	41	11
December	64	21
Total	1222	223

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Recovery	79	35.4
Mindfulness	57	25.6
Other	30	13.5
Depression	15	6.7
St Edmundsbury	16	7.2
Bipolar	5	2.2
Eating Disorder	5	2.2
No answer	5	2.2
Anxiety	4	1.8
Radical Openness	3	1.3
Living Through Distress	2	.9
Alcohol Step Down	2	.9
Young adult	0	0
Pathways to Wellness	0	0

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

86.1% of respondents reported living in Leinster.

Province	n	%
Leinster	192	86.1
Connaught	14	6.3
Munster	7	3.1
Ulster	3	1.4
Don't want to say	0	0
Missing	7	3.1
Total	223	100

The majority of respondents had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. 39.4% had experienced an in-patient stay and 41.4% had attended as an outpatient at the Dean Clinic.

Service	n	%
Dean Clinic	96	43
In-patient stay	71	31.8
In-patient day programme	10	4.5
Other day programme	14	6.3
Not applicable	22	9.9
Associate Dean consultation	4	1.8
No answer	6	2.7

Service User Responses

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

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

Wait time	n	%
Less than 1 day	14	6.3
1-3 days	49	22
4-7 days	57	25.6
1-2 weeks	44	19.7
2-4 weeks	31	13.9
More than 4 weeks	16	7.2
No answer provided	12	5.4

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

Tell us about your experience of starting a programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
When you came to the hospital did a member of Day Services greet you?	174	77	20	9	22	9.9	7	3.1
When you came to hospital did a member of Day Services explain clearly what would be happening?	186	83.4	19	8.5	12	5.4	6	2.7
When you commenced the programme did a member of staff explain the timetable?	207	92.8	4	1.8	6	2.7	6	2.7
Were you given a written copy of the timetable and other relevant information?	193	86.5	15	6.7	7	3.1	8	3.6

Respondents also generally reported an informed ending to the programme, with 98.6% of valid responses agreeing that they knew when the programme was to end. Over 80% of respondents felt that the programme met their expectations and felt that they know what to do in the event of a further mental health crisis. The majority of respondents reported that they had received information regarding the organisation's support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Did you know in advance when the programme was due to end?	217	97.3	1	.4	2	.9	3	1.3
Did the programme meet all your expectations?	197	88.3	13	5.8	8	3.6	5	2.2
Have you been given details of the hospital's support and information service?	184	82.5	25	11.2	4	1.8	10	4.5
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	195	87.4	11	4.9	9	4	8	3.6

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

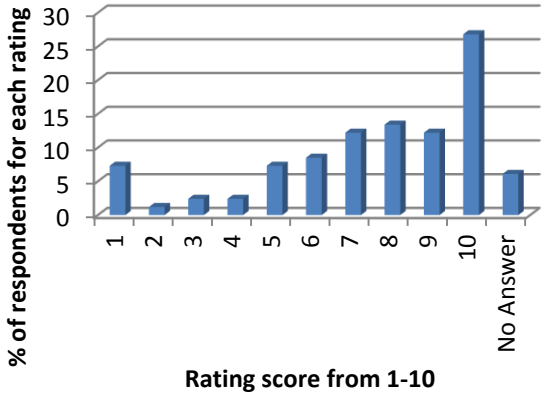
Tell us about your experience of stigma following your attendance at St Patrick's.

As you are prepared to leave the programme...	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Do you feel that your views regarding mental ill-health in general are more positive than they were?	198	88.8	8	3.6	13	5.8	4	1.8
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	193	86.5	6	2.7	20	9	4	1.8
Will you tell people that you have attended St Patrick's	130	58.3	37	16.6	49	22	7	3.1

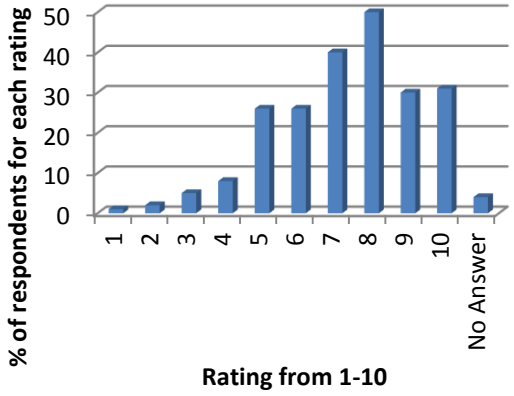
How would you rate the Day Services Facilities?

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

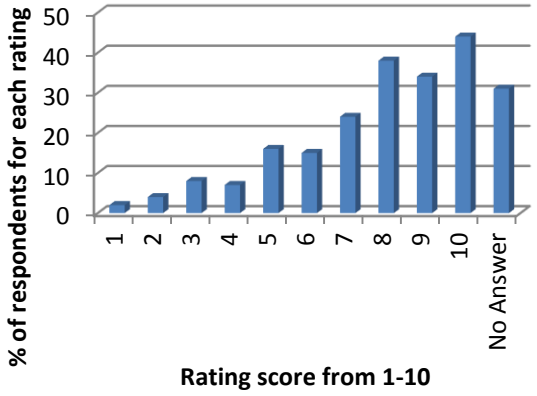
Food/Restautant



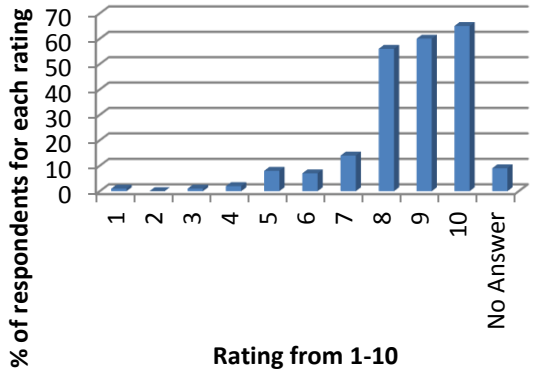
Decor/Furniture



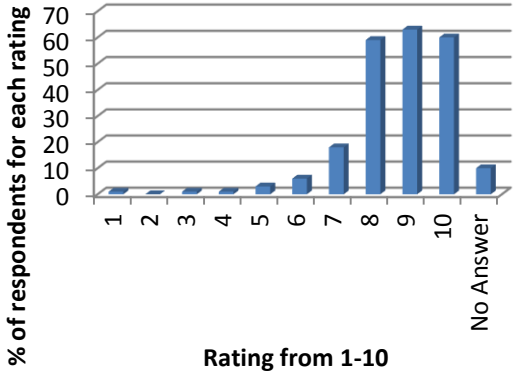
Parking



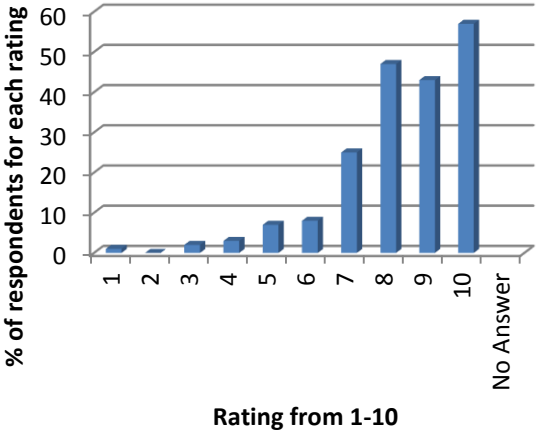
Cleanliness: Day service areas



Cleanliness: Communal areas



Garden Spaces



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

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

Score	n	%
1	1	.4
2	0	0
3	1	.4
4	0	0
5	2	.9
6	6	2.7
7	19	8.5
8	49	22
9	63	28.3
10	78	35
No answer	4	1.8
1-5	4	1.8
6-10	215	96.4

96.4% rated their care and treatment between 6 and 10.

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

Score	n	%
1	0	0
2	0	0
3	1	.4
4	0	0
5	5	2.2
6	2	.9
7	16	7.2
8	52	23.3
9	57	25.6
10	88	39.5
No answer	2	.9
1-5	6	2.7
6-10	215	96.4

96.4% rated the St Patrick's Mental Health Day Services overall, between 6 and 10.

Further Service User Views

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

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

Positive comments include:

- " Excellent team with good communication, encouraged the group to work together"
- "I had a great enjoyable stay, I have never been given an opportunity like this and found it extremely helpful"
- "Excellent information passed on brilliantly by fantastic facilitators"
- "Calm, courteous, patient-centred"
- "Staff are so caring and polite"
- "Excellent facilitators- warm, friendly, respectful and supportive"
- "Life changing, both the CFT and Mindfulness programme have been essential in helping me cope with my mental issues"
- "Excellent staff and members of the group. Felt very supported"
- "Found the links to wellbeing programme very good. Learnt a lot about dieting, mindfulness and communication skills"
- "It was good. I have improved and I will have a better understanding of my mental health."
- "Extremely Supportive, professional, collaborative and helpful, beneficial from consultant to admin and group facilitators"
- "I found the group aspect was helpful. We bonded as a group and shared our experiences and helped each other"
- "I really like the people who run the course. I felt like they were there for you"
- "It was a great, positive, encouraging experience, very educational and empowering"

- "Enjoyed the whole experience of meeting others in the group with similar problems and daily struggles"
- "My stay in St Pats was the best psychiatric facility I have attended thus far. The staff are pleasant and friendly, nurses are courteous and friendly"
- "Excellent care from medical team and all other teams esp in Occupatioanl Therapy and WRAP"
- "Organised well. Good to have lunch voucher and parking pass"

Comments to learn from include:

- "The food in the cafe could be improved"
- "I think that a course should not be run if numbers are low. I have attended other courses with higher numbers and found it more beneficial. I found in smaller sessions I was waiting for it to finish and there was a lot of silences as if to pass the time"
- "I felt there was no checking in with me as a participant after the course ended, as to whether I found it helpful or not"
- "More focus on aftercare"
- "It would be nice to be at the lunch by breaking at 12.45 and 13.45"
- "I feel that just as there is an interview before the course, there should definitely be one after it finishes"

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

- " Very nice friendly supportive staff. Very knowledgeable too"
- "You are catered for in every way"
- "The coordination of groups and the facilitators"
- "The tutors and the CD provided which will help me practise mindfulness in the future"
- "The organisation of the programme. The team involved in the programme, the support and advice given"
- "Delivery of ACT programme was superb"
- "Explanation supported by practical application"
- "Mindful walking outside"

- “Meeting other people with mental health illness and other problems”
- “The presentations by the facilitators were just excellent”
- “I was able to discuss my experiences knowing that what is said in the group is confidential”
- “Connecting with other people with mental health difficulties”
- “Everyone very helpful and reassuring even when I began course feeling very depressed, I was encouraged to keep going”
- “Being part of a group”
- “Was treated very well on my day service. I like that the class size was small. I learned a lot from it”
- “Meeting other service users that were the same as me, hearing their story and path to recovery or what happened if they slipped back”
- “Warm, efficient, courteous, professional, sensitive, welcoming, positive across all staff levels and functions”
- “Illness was not discussed. Everybody in the group was non-judgemental”
- “Voucher was nice to get for food. Free parking for my car appreciated”
- “Empathy patience and listening, thank you”

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

- “Would be good to have a monthly follow- up for the mindfulness programme. Or reminder texts”
- “I would like to have the course extended as I feel the content needs more time to be absorbed and practised - there was a lot to take in. Bit more role play”
- “A review day, or gradual release from programme. Phasing out from weekly to fortnightly or monthly”
- “Less forms to fill in”
- “More details of what is available and how to access”
- “Lighting in the room”
- “More chair work please”
- “Getting access to the lift was sometimes a problem.”
- “Comfier chairs. Better ventilation.”

- “Do more music therapy. I found this particularly good for facilitating discussion”
- “2nd toilet available. Kettles boiled”
- “As a day patient in St. Pats I liked the buzz of the coffee shop where patients and public could meet. I believe St. Eds could benefit from such a place”
- “USB stick or weblink to download Meditation practices on smartphone”
- “Include a complimentary tea or coffee for break”
- “Would like number on course to be average of 10. When small group found under spot light bit”
- “Some sessions could be reduced and put into a half day”
- “Better soundproofing of therapy rooms. The noise could sometimes be intrusive.”
- “More emphasis on aftercare and to cope independently”
- “Maybe shorter lunch break and finish earlier”
- “Little bit more of an understanding of what are the goals/aims at the start”

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2016

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

The multi-disciplinary team are committed to on-going quality improvement. This report presents the responses from the survey which was distributed to young people and parents/carers following an inpatient stay in the Willow Grove Adolescent Unit in 2016.

5.2.1. Methodology

Willow Grove is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (Q.N.I.C.), a group of similar units which conduct yearly peer review cycles. The Network is co-ordinated by the Royal College of Psychiatrists in the United Kingdom and every two years their standards are reviewed and updated in line with best practice. The satisfaction survey used is an adapted version of a standard Child and Adolescent Mental Health Service (CAMHS) inpatient satisfaction questionnaire, taken from the COSI-CAPs study, recommended by Q.N.I.C.

5.2.1.1. Respondents

Parents and young people were asked to complete this measure on the day of discharge. 55 young people and 83 parents/carers completed the questionnaire. Response rates for service users were 75.3%. As surveys were anonymous and some service users may have only one parent/carer, this response rate could not be calculated. The number of surveys returned by young people and parents/carers were up 25% and 33.8% respectively in 2016 compared with the previous year.

In 2015, a shortened questionnaire was introduced for the first time, which was given to young people and their parents on the day of discharge. This was in an attempt to increase the response rate to this survey, which may account for the increase in available data compared to 2014. There was a 25% and 33.8% increase in surveys returned by young people and parents/carers respectively in 2016 compared with the previous year.

5.2.1.2. Survey Design

The questionnaire asked young people a set of questions which gather information on their experiences of access to services, the environment and facilities, the therapeutic services offered, the ability of the service to help young people and parents manage mental health difficulties, discharge preparation, professionalism of staff and confidentiality and rights.

The questionnaires asked parents and young people to rate a number of statements preceded by the statement, 'What is your overall feeling about…', answers ranged from 1 'Very unhappy' to 5 'Very happy'. The young person's questionnaire also included a 5 point Likert scale ranging from 1 'Very poor' to 5 'Very good', printed with corresponding smiley faces to help young people to understand the response options.

5.2.2. Results

Quantitative Responses

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

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

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

Please tell us how satisfied you were with aspects of our service	Median rating	
	Young person	Parent/ Carer
Experience of accessing the service	4	5
Information received prior to admission	3	5
Information provided by St Patricks website	3	4
The process of assessment and admission	4	5
The information given on admission	4	5
The environment and facilities	4	5
The overall atmosphere (or feel) of the unit	4	5
The cleanliness/ appearance of the unit	4	5
The meals provided	3	4
Visiting arrangements	4	4
Safety arrangements on the unit	5	5
Experience of care and treatment	4	5
Access to group therapy	4	5
Access to individual therapy	4	5
Access to leisure activities and outings	4	4
Access to a range of professionals	4	5
Access to key workers/allocated nurse	4	5
Access to educational support	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)/ collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4	4
How you felt you were listened to/ respected	4	5
Confidentiality of service	5	5
Opportunity to attend discharge planning meeting	4	5
Your preparation for discharge	4	N/A
Weekend/midweek therapeutic leave arrangements	4	5
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	4	5
Provision of family support	4	5
Opportunity to attend parents support group	N/A	4
Opportunity to attend Positive Parenting Course	N/A	4.5
Was your child's stay helpful in addressing mental health difficulty?	N/A	5
Providing you with Skills to manage your mental health	4	N/A

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

Further Service User Views

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

Q: What did you like best about the unit?

Young people:

- "Friendly environment and decoration/ the other young people"
- "Being able to be around others like myself who understand what I'm going through"
- "The nursing staff were really helpful and friendly"
- "Welcoming and normal environment"
- "Atmosphere. Friendly staff. Very clean"
- "The sense of community among the young people"
- "The young people, the bedrooms, support for school"
- "The range of activities and groups available. Constant supportive community"
- " Nurses and young people, really nice environment"
- " Key working"

Parents/ caregivers:

- "Excellent guidance and very professional staff"
- "Friendly and caring atmosphere. All staff happy to provide info/updates, willing to acknowledge mistake/issue when it arose. Very good engagement with school also"
- "It was a safe and secure place. The staff were devoted and caring"

- “The staff were professional and courteous at all times. They were vigilant concerning their changes and always met you at the door with a welcoming smile”
- “Great atmosphere, positive, not like hospital, camaraderie, wonderful staff, very good facilities, excellent rooms, caring nurturing environment.
- “Supportive atmosphere and conducive of building relationships with staff and other young people”
- “Each bedroom unit was well equipped and clean, found it very secure, staff were fabulous”
- “I found the communication between myself and staff excellent. Great care and help and advice”

Q: What did you dislike about the unit?

Young people

- “Felt like not enough exercise/activities done in the week. Some meals weren't appealing in look or taste”
- “The lack of confidentiality with parents and not saying beforehand it would be told to your parents”
- “Not getting outside enough”
- “We need to get outside more for fresh air. We should have somewhere we can express our anger”
- “Boring groups i.e. always having a lot of art. It’s nice but not too much”
- “Not being allowed in our rooms throughout the day but I understand why”
- “Having nothing to do when unable to attend groups”
- “Bed time”
- “Some of the groups were a bit patronizing”

Parents/ caregivers

- “There was nothing I disliked about the unit”
- “At times it was difficult to attend all meetings. A lot of time commitment”
- “More facilities needed for exercise e.g. access to gym etc.”
- “Very small reception area”

- “Would have liked a little more communication regarding how her treatment was going.”
- “Would like better feedback from staff regarding weight, mood etc.”
- “The reception area is a but small and I found sometimes this led to a lack of privacy for people waiting in it”
- “The sometimes lack of communication between staff”
- “Expensive car parking”
- “My child had some complaints about the food”
- “Last minute changes in plans- very hard to put arrangements in place (leave/family meals etc.)”

Is there anything you would change about the unit?

Young people

- “ More time outside”
- “Visiting times”
- “Better organization for activity groups”
- “Access to gym during visiting hours for those who don't have visitors”
- “More freedom”
- “Different groups. Less WRAP”
- “More educational services throughout the year”
- “Add a swing set”
- “I’d change the amount of activity groups to more beneficial psychology or therapy groups”
- “For the young people to be more open about feelings and emotions”

Parent/ caregiver

- “No. Overall very happy”
- “Waiting area is quite cramped. Free parking for parents”
- “Maybe more physical exercise-access to a gym perhaps”
- “More space to accommodate family visits, activities”
- “A little more info from the care team on treatment plan. Not a major issue however. Look at food quality”

- “Meal quality and choice could be looked at”
- “Would have liked a more regular update on overall improvements and progress. Would suggest one to one psychotherapy. Feel it worked better as opposed to group therapy”
- “More access to exercise area”
- “Follow up therapy to be properly set up so that plan is in place prior to discharge”
- “Mid-week leave for patients. Logistically it was difficult for us.”
- “I would like to see the young people doing more physical activity. I think if the young people could get out in the fresh air more it would be good”
- “More contact with key worker and team”
- “More communication with parents but other than that it was great and I would like to thank everyone.

SECTION 6

Conclusions

6.1. Conclusions

1. The SPMHS outcomes report is now in the 5th year and the 2016 report builds on the previous reports from 2012 onwards. Service evaluation, outcome measurement, clinical audit and service user experience surveys continue to be used routinely in the context of improving the quality of service delivery.

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

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

4. Clinical outcomes data was added for the SAGE Programme (Older Adults Psychology Skills Group) in 2016. 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. Work was also commenced in 2016, to establish further additional outcome measures to determine the efficacy of more services in 2017.

5. The scope of audit across the organisation was further strengthened in 2016, consistent with the requirements of the Mental Health Commission's 2016 revisions to the Judgement Support Framework.

6. Strengths: Few, if any, other services in Ireland has provided the same level of insight into service accessibility, efficacy of clinical programmes/services and service user satisfaction. The report also demonstrates the organisation's willingness and ability to reflect on results and use results to identify ways to improve practice. For example, this year's report demonstrates continued improvements from 2015's results for inpatient service users' perceptions regarding their involvement in the care planning process support the team based. This supports the on-going organisational wide efforts to increase service user involvement and engagement with their care planning process. The broad range of measures regarding clinical outcomes, service accessibility and service user satisfaction provide valuable information for the organisation regarding the commissioning and improvement of services.

7. Challenges: Not all services within the organisation are reporting clinical outcomes in this report yet, however SPMHS have continued the expansion of those services reporting again in 2016. It is difficult to benchmark the results of this report as no other organisation similar to SPMHS produces a comparable report. In order to best capture the efficacy of clinical programmes and services, there have been changes in the outcome measures used, which can create difficulties when comparing results to previous reports. The report's clinical outcome results cannot be solely attributed to the service or intervention being measured and are not developed to the standard of randomised control trials.

SECTION 7

References

7.1. References

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