

Darwin Centre for Young People

Annual Report

April 2016 – March 2017



Table of Contents

About Us	3
Introduction	3
Our Aims and Goals.....	3
Treatment and Programmes	3
AMBIT Approach	4
The Darwin Learning Centre School.....	4
Patient and Parent Involvement.....	4
Outreach	5
Our Performance	5
Activity period in this report.....	5
Clinical Activity	7
Bed Occupancy.....	7
Referrals	7
Admissions.....	7
County of Origin.....	8
Waiting Times	8
Discharges	9
Length of Treatment	9
Formal Complaints.....	10
Serious Incidents	10
Clinical Effectiveness	11
Overview and Aims of Routine Outcome Measurement.....	11
Description of Patient Group.....	12
Gender.....	12
Age	12
Diagnosis	12
Mental Health Act Status	14
Other Demographic Variables.....	14
Length of History.....	14
Past Treatment	15
Prior Social Circumstances.....	15
Results.....	15
Children’s Global Assessment Scale (CGAS).....	16
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)	16
Strengths and Difficulties Questionnaire (SDQ).....	17
Affective Reactivity Index (ARI)	19
Service User and Parent/Carer Feedback and Experience.....	21
News and Updates	24
Teaching and Training	24
Research Database and QNIC ROM	24
References.....	25
Appendices	27
A Word of Caution on Routine Data and its Interpretation	28

About Us

Introduction

The Darwin Centre for Young People is an NHS Tier 4 adolescent inpatient acute ward based in Fulbourn, Cambridge. We offer assessment and treatment for young people aged 13-17 presenting with severe and acute mental health problems. Young people are referred by their local mental health services if they have been unable to make progress whilst remaining at home with the support of local outpatient treatment. The unit has provision for 14 patients, including up to two day patients.

We provide services to young people from Cambridgeshire, Peterborough, Norfolk, Suffolk and Bedfordshire although young people from all areas are eligible for referral/admission subject to funding agreements and capacity for the family to travel to the centre.

This report is aimed at all those with an interest in the Darwin centre, including patients, families, Commissioners, external agencies/clinicians and Darwin centre staff. It aims to openly report and feedback on work of the unit, outcomes and developments during the activity period.

Our Aims and Goals

We aim to provide a high quality, multi-disciplinary mental health service for young people experiencing severe emotional and/or mental health difficulties. We offer a systemic approach to the needs of the young people and their family, and we work in close partnership with patients, parents and/or carers. Our systemic approach means we aim to understand and work with the wider context and relationships in the lives of young people who come to the Darwin Centre

We pride ourselves on our ability to work closely and effectively with external children's agencies and education in order to ensure that the needs of the young person are met both whilst in our care and after discharge.

Treatment and Programmes

We aim to offer young people a variety of activities as part of a therapeutic programme, which we expect all young people to take part in. They are given opportunities to work both individually and as part of a group.

During a young person's stay, they will be offered a comprehensive range of assessment and treatments by our multi-disciplinary team composed of doctors, nursing staff, family therapist, clinical psychologists, occupational therapist, art therapist, music therapists, outreach workers, dietician and teachers. Therapeutic groups include those themed around mentalization, "Understanding Emotions Group" (please see the AMBIT Approach below), music therapy, keeping safe, health and promoting social and communication skills such as in the art therapy,

“Ask Anything Group”, “Recovery Group”, “Sensory Group” and “Out and About” group.

The length of stay and type of admission depends on the young person’s individual needs and circumstances; most young people stay for around four to five months, but we can offer longer treatment when appropriate. We aim to work in partnership with young people, their families/carers and local services to help them return home as soon as they are able to. We work towards supported home leave very quickly, often within the first two weeks of admission.

AMBIT Approach

In January 2013 we introduced an innovative team-based framework called AMBIT (Adolescent Mentalization-Based Integrative Therapy). At its core is mentalization, which is the capacity to make sense of one’s own and other people’s behaviour in terms of intentional mental states (for example feelings, beliefs, desires, reasons, needs¹). The ability to think about and make sense of one’s own thoughts and feelings is a critical part of managing one’s own feelings. In addition, thinking about other’s thoughts and feelings is central to improving interpersonal relationships.

AMBIT provides a framework for promoting a team-wide approach to our work with young people, families, wider support networks and across the staff team. Through AMBIT, we aim to stimulate and promote mentalization both in the young person and those who work with/care for the young person. We aim to foster a secure and trusting relationship between young people and members of the Darwin centre team as we recognize that therapeutic change for many young people occurs through relationships with others.

The Darwin Learning Centre School

Young people at the unit attend the Darwin Learning Centre School. At its last OFSTED inspection in November 2016, the Pilgrim Pupil Referral Unit to which the Darwin Learning Centre belongs to was rated “Outstanding” for the third time in succession. The school aims to enable students to continue their mainstream school work as much as possible, with staff liaising closely with students’ home schools. The school provides teaching in the core curriculum subjects, as well as a flexible learning environment where students are able to carry out their own individual study, including The Jamie Oliver BTEC award, Unit Award AQA Scheme and AQA PSE. As the Darwin Learning Centre School is a registered exam centre, it is possible for students to take their exams here and students are supported to pursue their future and further education options. Six students took their GCSE’s last summer with 97% achieving A*-C grades. Students are also involved in a range of extra-curricular activities, such as woodwork/DIY, music (piano and guitar) and PE. The unit has a gym which patients are allowed to use with a member of staff present. Staff members are trained to safely support the young people in the gym and are able to create personalised fitness programmes.

Patient and Parent Involvement

The Darwin Centre has a dedicated involvement post: the Head of Patient and Parent Involvement (HOPPI). The HOPPI’s main role is to ensure that young people and parents are given opportunities to be involved in their treatment and participate

in the development of the service more generally. They are also involved in co-ordinating ward activities outside of school and organising holiday programmes.

Outreach

The unit has an Outreach post whose role is to ensure that young people have as smooth a transition as possible between the Darwin Centre and the community. To achieve this, they assist young people in maintaining links with their local community whilst in hospital, mainly working within the home and educational environments. They are involved in the admission process, carrying out home assessments of the family's mental health needs. The Outreach workers also support the transition for up to six weeks post-discharge, co-ordinating and nurturing the supportive community links in order for discharge to be successful and the young person to remain out of hospital. This role is currently vacant and we are looking to recruit.

Our Performance

The performance of the service is judged based upon service users' experience, satisfaction and the use of validated clinical outcome measures which this report will present. We also work in line with QNIC (Quality Network for Inpatient CAMHS) and CPFT standards on key areas such as care planning and the ward environment. As a result of our performance against the QNIC standards in February 2017, the Darwin Centre has been awarded accreditation until 2020. Specific strengths highlighted during the accreditation review include the pleasant ward and school environments, including large outdoor spaces, accommodation for different spiritual and cultural needs, a broad skill mix within the team, and the supportive atmosphere reported by both staff and patients.

Areas of improvement, which we have acted upon, include evidencing of training across both permanent and bank/agency staff members, and demonstrating that information is communicated effectively to young people and their parents and carers.

Activity period in this report

This report describes activity during the financial year from 1st April 2016 to 31st March 2017. In addition, the results can be used to monitor the appropriateness of unplanned admissions, which is a current aim of the Darwin Centre.

The information presented in this report was collected from a variety of sources: a large amount of it is recorded on an electronic database maintained since 2012. Other sources include the Head of Patient and Parent Involvement's records; CPFT's business IT and Learning and Development departments; and Serco's Datix department.

Contact for Further Information

We welcome comments, feedback and questions about this report to:

Laura Hannah, Research Assistant, laura.hannah@cpft.nhs.uk

James Fairbairn, Clinical Psychologist: james.fairbairn@cpft.nhs.uk

Visit our website www.darwincentre.cpft.nhs.uk for an electronic version of this and previous reports, for the QNIC Accreditation Report 2017, and for more information about the Darwin Centre for Young People.

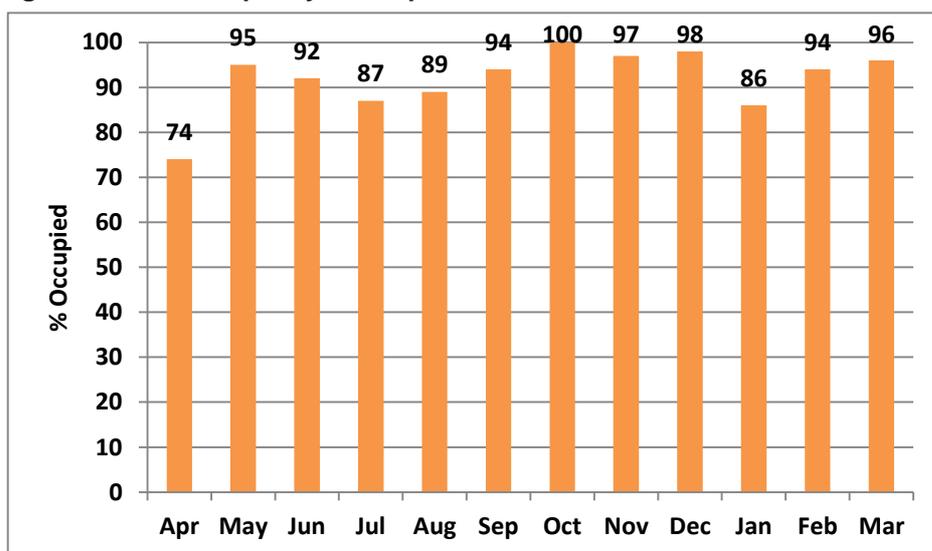
If you would like more information on the AMBIT approach and how it applies to the Darwin Centre, please visit <http://ambit-darwin.tiddlyspace.com/>

Clinical Activity

Bed Occupancy

Figure 1 shows the proportion of occupied beds per month during the financial year 2016-2017, based on 14 beds.

Figure 1: Bed Occupancy Rates per Month



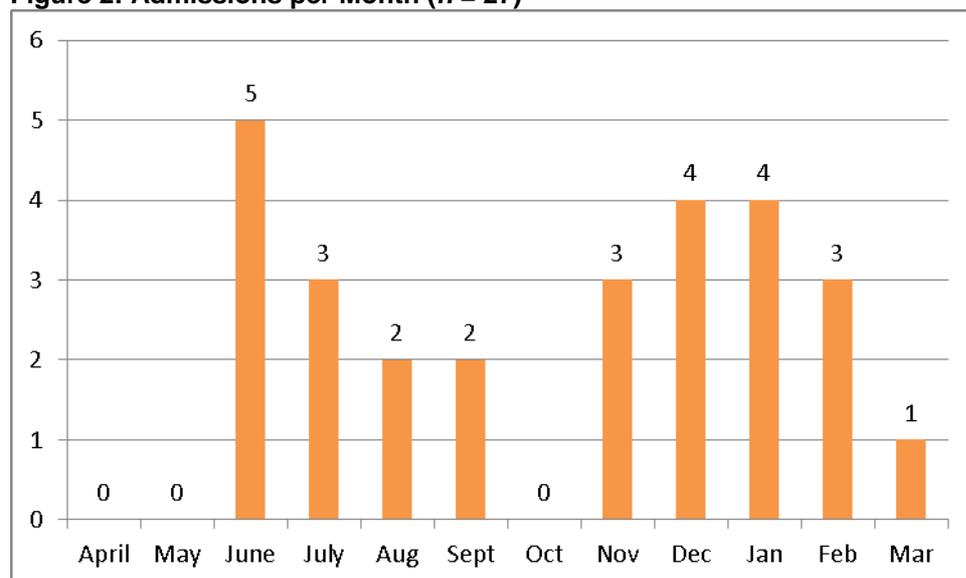
Referrals

During 2016/2017, the Darwin Centre received 72 referrals, of which 60 were urgent referrals and 12 were planned. Many referrals were for urgent or emergency beds that we were unable to accept as there was not a vacant bed within the referrer's timescale.

Admissions

We admitted 27 young people during the financial year (all patients were admitted with an inpatient status, however two received both inpatient and day patient treatment). Three young people had been admitted to our service in previous years and one young person was admitted twice in the same financial year. Figure 2 shows the number of young people admitted to the Centre each month.

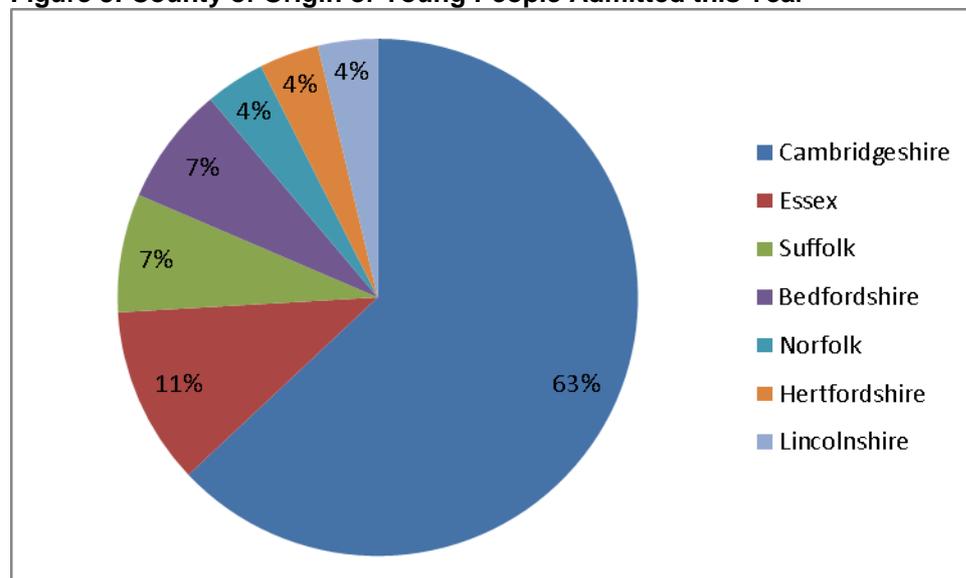
Figure 2: Admissions per Month (n = 27)



County of Origin

Figure 3 shows the county of origin of young people admitted during the financial year. The majority of young people were referred from professionals within Cambridgeshire (63%), followed by Essex (11%), Suffolk (7%), and Bedfordshire (7%).

Figure 3: County of Origin of Young People Admitted this Year



Waiting Times

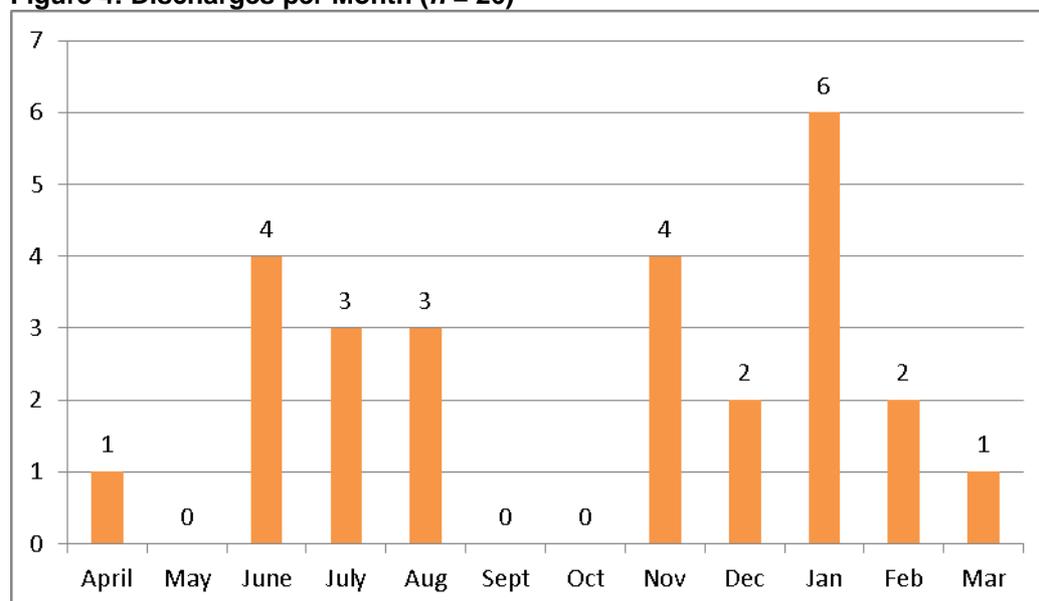
Of the admissions that took place this year, 4 were through emergency referrals (within 24 hours), 8 through urgent referrals, and 15 through planned referrals. The average waiting time between referral and admission was 9.33 days ($SD= 13.82$). As can be seen in Table 1, waiting times vary considerably depending on type of referral.

Table 1: Waiting Times from Referral to Admission by Referral Type

Waiting Times	Referral Type		
	Emergency (within 24 hours)	Urgent	Planned
Less than a week	100 %	88 %	53 %
Less than a month	0 %	0 %	20 %
More than a month	0 %	12 %	27 %

Discharges

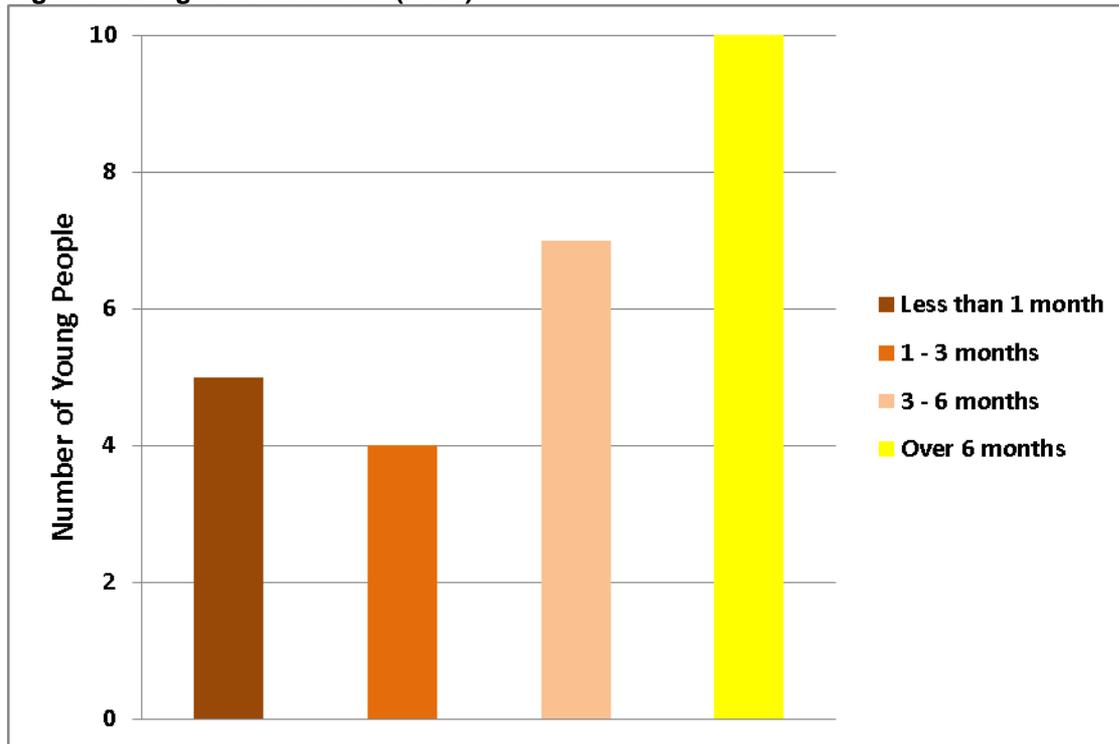
We had 26 discharges this year, all patients received inpatient treatment. Three young people were re-admitted more than once during the financial year. The number of discharges per month is displayed in Figure 4.

Figure 4: Discharges per Month (n = 26)

Length of Treatment

The average length of treatment was 181.19 days (26 weeks; 5.5 months). Figure 5 shows the variation that can occur within this, with patients staying from one week to over a year ($SD = 168.24$). One young person was discharged within one day of admission. Furthermore, it is worth noting that part of young people's treatment involves spending time on home leave and integrating back in the community, therefore there will be periods during the admission when young people will not be spending all of their time on the unit.

Figure 5: Length of Treatment (n=26)



Discharge Type

The majority of discharges were planned (96%) with one young person self-discharging (discharge against medical advice).

Treatments Post-Discharge.

The majority of young people were referred back to the referrer (85%) although on occasion, young people are referred to another agency (15%).

Types of treatment post-discharge include; outpatient community CAMHS (80%), transfer to another inpatient unit (8%), transfer to Specialist ED inpatient unit (4%), Early Intervention for Psychosis teams (4%) and Residential Social Care (4%).

Formal Complaints

We received one formal complaint during this period. The complaint is currently being investigated and the outcome plus the next steps will be fed back to family and staff involved.

Serious Incidents

No serious incidents have occurred during this year.

Clinical Effectiveness

Overview and Aims of Routine Outcome Measurement

The importance of routine outcome measurement in evaluating clinical effectiveness is highlighted in national policies such as the UK Government's NHS Outcomes Framework (Department of Health, 2010), and the National Service Framework (NSF) for Children and Young People, "Every Child Matters" (Department of Health, 2007).

At the Darwin Centre we routinely collect questionnaires at admission and discharge from young people, parents/carers, and clinicians. In this way, we ensure that a variety of viewpoints are taken into consideration. The measures that we use are those recommended by the QNIC Routine Outcome Measurement service (QNIC ROM). These include the Children's Global Assessment Scale (CGAS; [2]), the Health of the Nation Scale for Children and Adolescents (HoNOSCA; [3]), and the Strengths and Difficulties Questionnaire (SDQ; [4; 5]).

Since summer 2013, we started recording a range of demographic variables (e.g., previous treatment received, family composition, ethnicity, school attendance, etc...), which we share regularly (in anonymised format) with the QNIC ROM central team for aggregate analyses and comparisons with other inpatient services.

In April 2014, we added the Affective Reactivity Index (ARI; [6]) to our Routine Outcome Measures in order to assess changes in irritability and proneness to anger during their admission.

Additionally, in November 2016 we began to employ the SCORE-15 [15] with both the young people and their parent/carers and the RCADS [16] with the young people. The initial analysis suggests a difference between admission and discharge, specific statistics will be reported in next year's review.

Our long-term aim is to be able to capture and evaluate what leads to change and predicts positive outcomes for the young people that we treat here at the Darwin Centre.

The demographic and clinical outcomes data presented in this section are based on the 26 young people *discharged* between 1st April 2016 and 31st March 2017. It should be noted that young people in this cohort were not necessarily admitted during the same financial year. However, the presentation of data in this way allows admission and discharge data of the same individuals to be matched, which is how outcome measurement is defined [7].

Table 2 provides an overview of the number of measures we collected during the year. As can be seen, we do not have complete data available for all patients (i.e. not all young people, parents/carers and clinicians completed the measures at both admission and discharge). This is a challenge faced by all CAMHS services that we are collectively working to improving; A recent audit of three CAMHS services found that only 16% of cases had complete data [8].

Table 2: Numbers and Percentages of Measures Collected This Year *

Measure:	<i>Admission</i>		<i>Discharge</i>		<i>Complete (Both Time Points)</i>	
	N	%	N	%	N	%
CGAS	26	100	26	100	26	100
HoNOSCA						
- Young Person	13	50	15	58	10	38
- Parent	21	81	12	46	11	42
- Clinician	26	100	26	100	26	100
SDQ						
- Young Person	16	62	17	65	11	42
- Parent	19	73	13	50	8	31
ARI						
- Young Person	19	73	18	69	14	54
- Parent	22	85	13	50	12	46

* based on 26 young people discharged this year.

Description of Patient Group

Gender

There were 20 (77%) females, 5 (19%) males and 1 (4%) young person that identified as transgender in this year's cohort.

Age

The average age at admission was 15.8 ($SD = 1.55$), with a range of 12 to 17 years.

Diagnosis

The young people that are referred and admitted to the Darwin Centre usually have a complex psychiatric history. Figure 6 shows the different categories of psychiatric disorders (according to ICD-10 criteria) that the young people presented with at admission to the Darwin Centre. As can be seen, the majority of young people presented with neurotic, stress-related and somatoform disorders, such as post-traumatic stress disorder and generalized anxiety disorder. Other prevalent diagnoses were mood disorders for example; moderate depressive episode and severe depressive episode with psychotic symptoms.

Sixteen young people (62%) also met diagnostic criteria for a secondary (38%) or tertiary (23%), comorbid psychiatric disorder at the time of admission. These results in Figure 7 display the complexities that the young people present with at the Darwin Centre.

Figure 6: Primary Diagnoses per Broad ICD-10 Categories

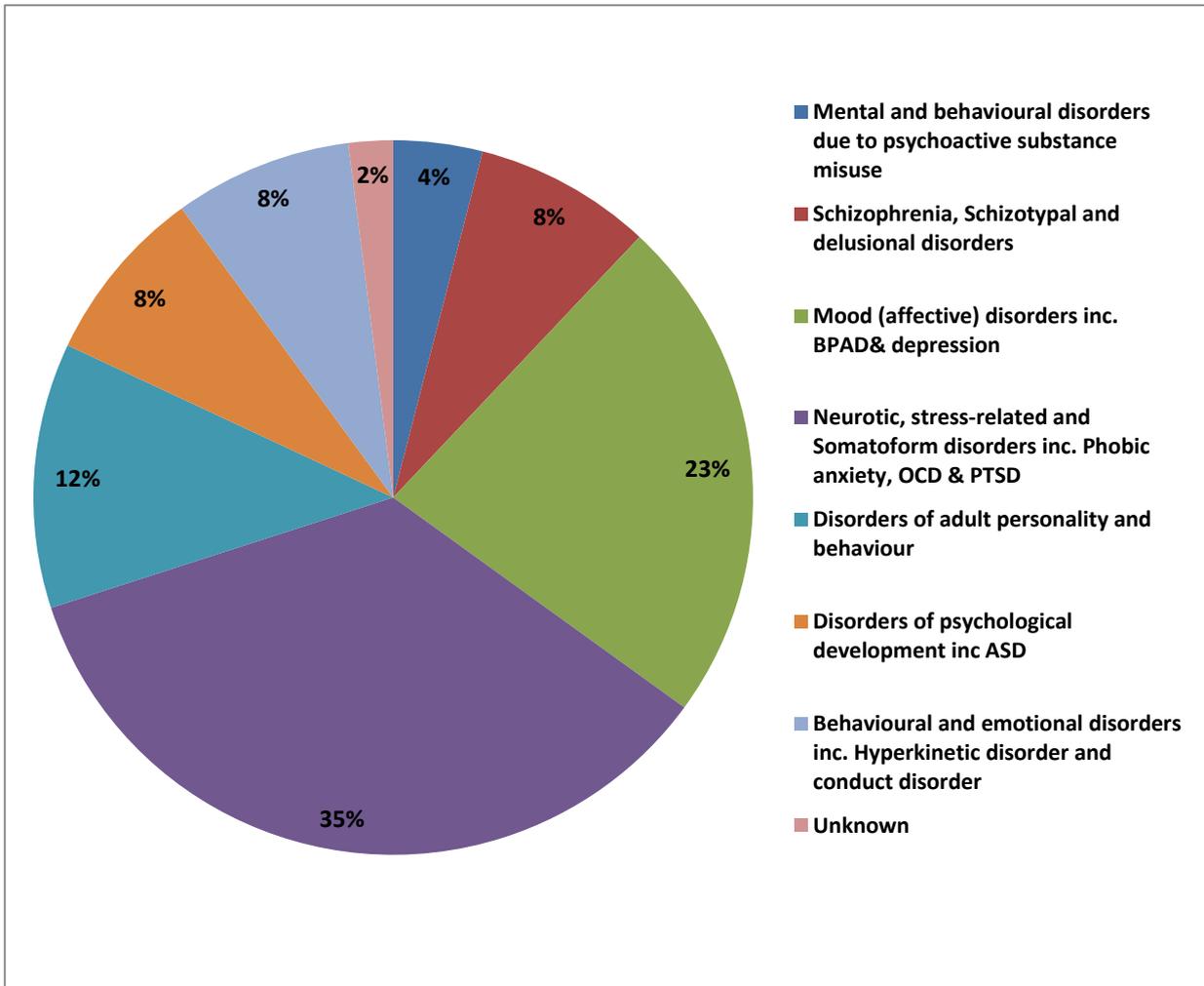
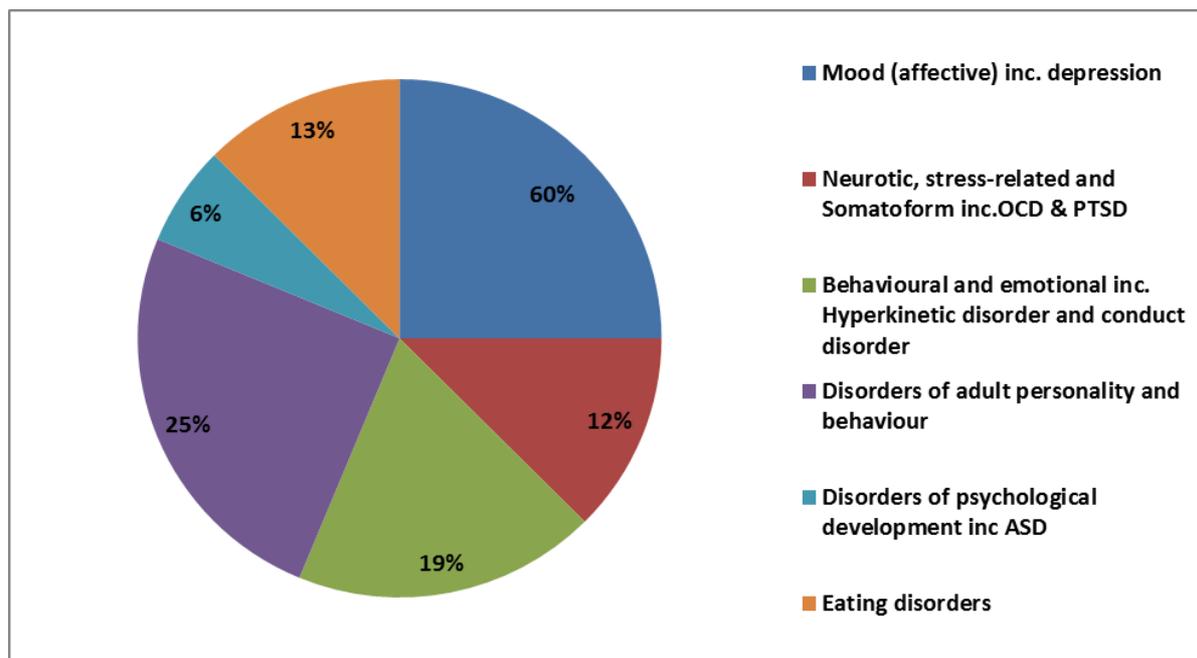


Figure 7: Co-morbid Diagnosis per Broad ICD-10 Categories



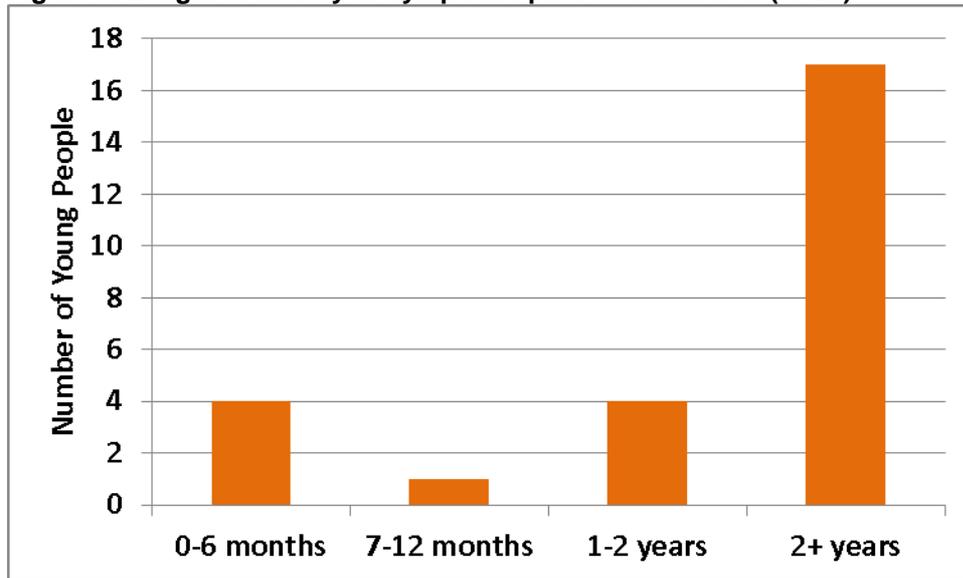
Mental Health Act Status

A total of 12 young people (52%) were placed under the Mental Health Act at either on or during admission (seven under Section 2 – admission for assessment, four under Section 3 – admission for treatment, one young person was detained on both a section 2 and 3 however at different times during their admission). It is important to remember that three young people were re-admitted more than once during the financial year, therefore the 50% has been calculated from a sample of 23.

Other Demographic Variables

Length of History

Figure 8 shows the length of history that young people have presented with current symptoms at similar severity before admission. Most young people have presented with symptoms for over two years.

Figure 8: Length of history of symptoms prior to admission (N=26)

Past Treatment

All of the young people had received treatment prior to admission. The majority were being treated by outpatient community CAMHS (54%) followed by a paediatric ward (23%), another Inpatient CAMHS unit (15%) and specialised eating disorder inpatient units (8%).

Prior Social Circumstances

The majority of young people lived with both biological parents (50%) followed by a single parent (23%), biological mother and their partner (19%) and adoptive parents (8%).

The majority of young people attended mainstream secondary school or were in further/higher education prior to admission (73%). Other young people attended a LEA special needs day school (12%), received Home tuition provided by the LEA (8%), or had left school after the age of 16 (8%).

Twelve (46%) young people had a carer with a psychiatric diagnosis.

Nine (35%) young people have reported a history of physical, sexual, emotional or multiple types of abuse.

Results

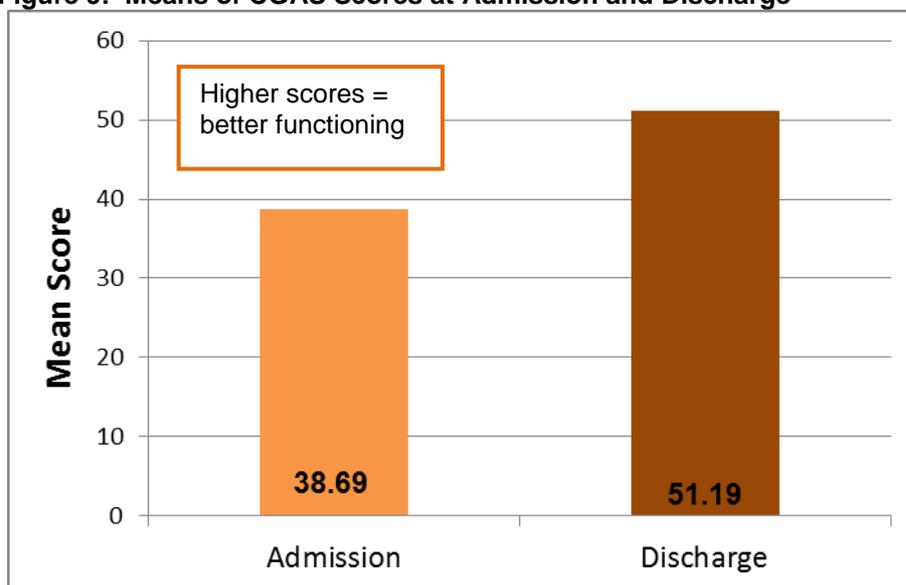
Statistical tests were used to confirm whether there were significant differences in CGAS, HoNOSCA, SDQ and ARI scores at admission and discharge. Where data were normally distributed and there were equal variances between samples, Paired t-tests were run to assess these differences. Where data were not normally distributed, the Wilcoxon signed-rank test was used.

Children's Global Assessment Scale (CGAS)

The CGAS is a clinician-rated measure of global functioning, including psychological, social and school functioning, on a continuum from 1 (“needs constant supervision”) to 100 (“superior functioning”). In addition to being completed at admission and discharge, CGAS ratings are also carried out on a weekly basis as part of ward round, and are discussed by the MDT together with the young person.

As can be seen from Figure 9, the mean CGAS scores at admission were in the **31 – 40** range, indicating a major impairment in functioning in several areas or an inability to function in one area. At discharge, mean scores improved to the **51 - 60** range, which indicates variable functioning with sporadic difficulties/symptoms in several areas where disturbances would be apparent in specific settings. A related-samples Wilcoxon signed rank test indicated that this difference was significantly different, ($z=-3.58$, $p=.001$).

Figure 9: Means of CGAS Scores at Admission and Discharge

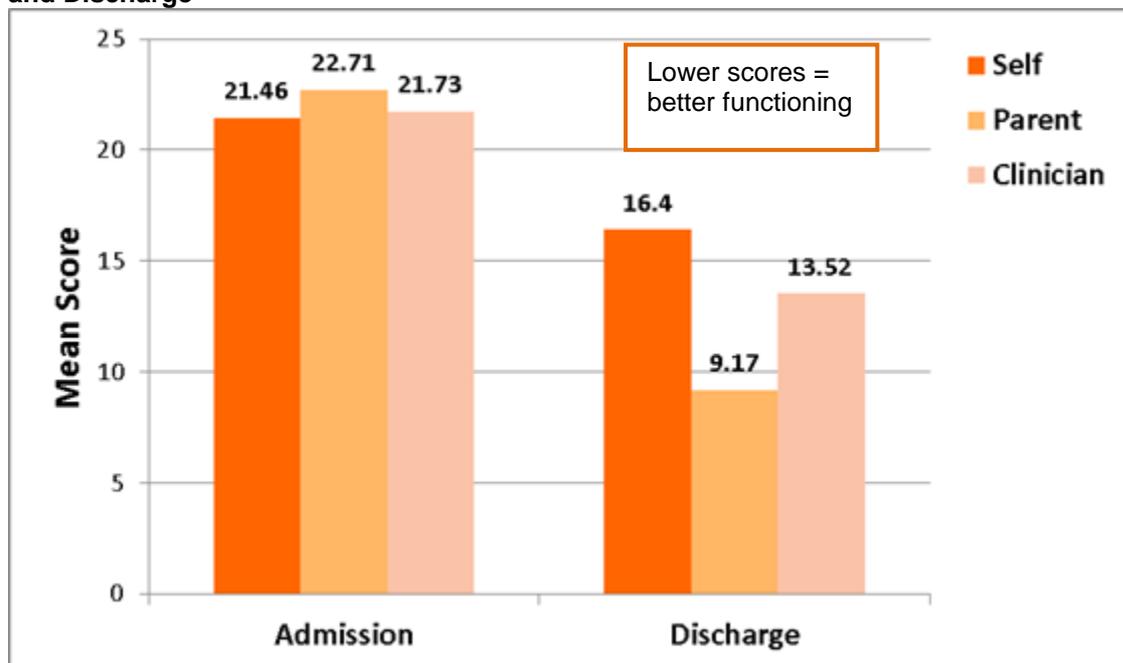


Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The HoNOSCA is a 13-item widely-used measurement tool that assesses young people's current mental health status, including behaviours, impairments, symptoms, and social functioning. There are three versions of the HoNOSCA: self-rated, parent-rated and clinician-rated. Each item is scored on a five-point scale from 0 (no problem) to 4 (severe problem). Therefore, a higher score indicates more impaired functioning. Total scores range from 0 to 52.

As can be seen from Figure 10, young people, parents/carers and clinicians reported a reduction in HoNOSCA total scores at discharge. These reductions were significantly different for the clinician scores ($t(25)=7.83$, $p<.001$) and parent/carer scores ($t(10)=3.5$, $p<.05$). The decrease in score was not significant for the young people informant ($z=-.102$, $p>.001$).

Figure 10: Means of Self-, Parent- and Clinician-Reported HoNOSCA total scores at Admission and Discharge

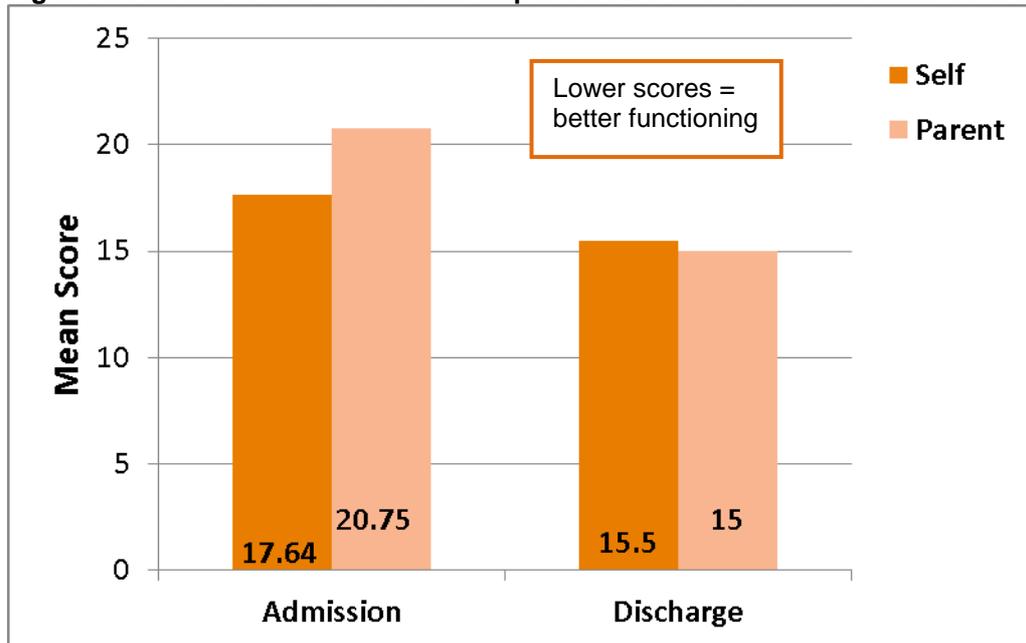


Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a measure of behaviour and symptom severity and their impact on functioning. Both a self-reported and a parent-reported version exist. It consists of 25 statements that relate to different aspects of functioning. These can be added up to obtain a total score, as well as five subscale scores: emotional symptoms, conduct problems, attention and concentration, peer problems and pro-social behaviour. Items are scored on a three-point scale from 0 (*Not true*) to 2 (*Certainly true*). A higher score indicates more severity, apart from the pro-social behaviour scale, in which a higher score indicates better functioning. Published thresholds for clinical and borderline ranges of symptom severity are provided for ease of interpretation [14].

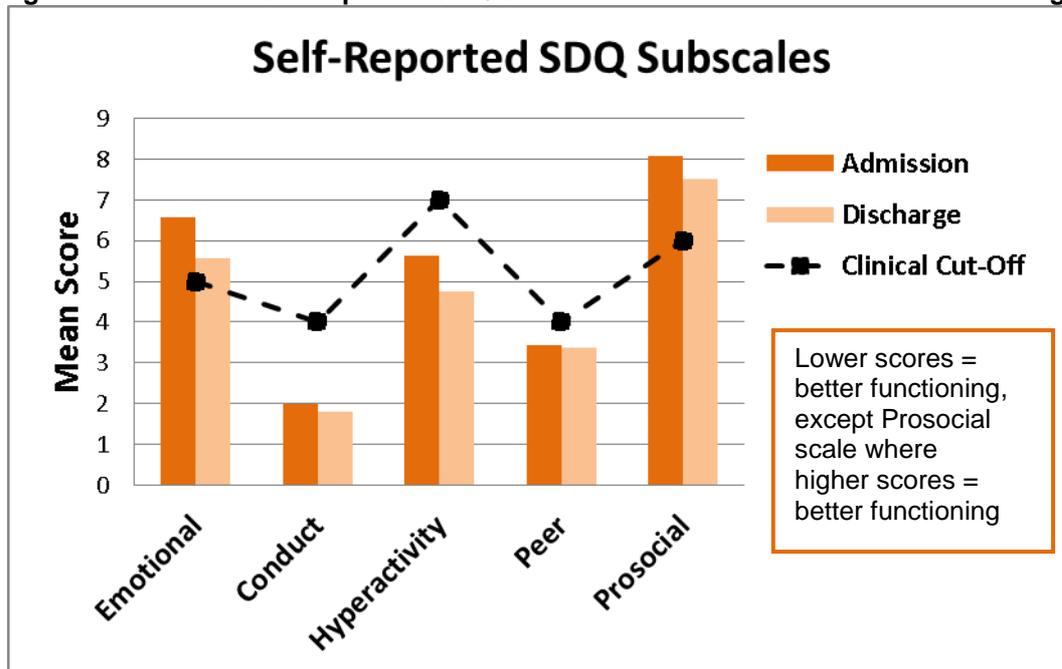
Figure 11 shows the means of SDQ total scores at admission and discharge, reported by young people and their parent/carer. At admission the self reported mean total fell into the borderline severity (16-19), whereas the parent/carers reported a mean total in the clinical range (17-40). At discharge, both informants reported a decrease to borderline severity. Parent/carer scores were significantly lower at discharge ($t(7)=3.09$, $p<.05$), however self reported scores were not significantly different ($z=-.141$, $p>.05$).

Figure 11: Means of Self- and Parent-Reported SDQ Total Scores at Admission and Discharge



Figures 12 and Figure 13 provide the breakdown of self- and parent-reported mean scores for each of the five subscales.

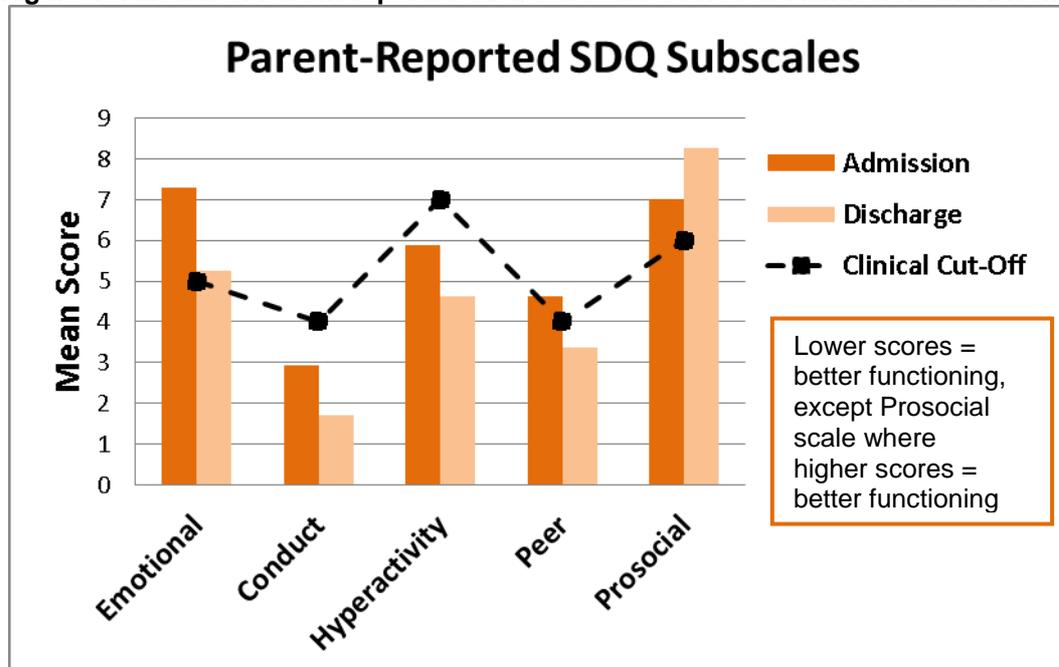
Figure 12: Means of Self-reported SDQ Subscale Scores at Admission and Discharge



The self-report shows how Emotional Symptoms decreased at discharge to within the non-clinical range, however this change was not significant ($t(10)=.21, p>.05$). Conduct problems remained below the clinical range at admission and discharge and were not significantly different ($t(10)=.58, p>.05$). Hyperactivity and concentration problems were at borderline severity at admission and decreased to below the clinical threshold at discharge, but this difference was not significant

($t(10)=.38, p>.05$). Peer problems decreased however remained on the non clinical/borderline threshold and the change was not significant ($t(10)=.69, p>.05$). Pro-social behaviour remained in the non-clinical range at admission and discharge and did not differ significantly ($z=-.35, p=>.05$).

Figure 13: Means of Parent-reported SDQ Subscale Scores at Admission and Discharge



The Parent-report shows how Emotional Symptoms were similar to the self-report in that scores reduced at discharge but were still within the clinical range and this decrease was not significant ($t(7)=1.99, p>.05$). Conduct problems decreased from the clinical threshold to the non-clinical range at discharge ($t(7)=2.12, p>.05$). Hyperactivity and concentration problems decreased from borderline severity (6) to the non-clinical range although this decrease was not significant ($t(7)=1.85, p>.05$). Peer problems were in the borderline range at admission (3) and decreased at discharge, although this was not a significantly different reduction ($z=-1.58, p>.05$). Pro-social behaviour increased however remained in the non-clinical range (5) at admission and discharge, and again this difference was not significant ($t(7)=-1.53, p>.05$).

It should be noted that the insignificant results are more likely to be due to the low number of responses. In order to detect a large effect size, at least 15 matched cases are needed to have sufficient power when running paired sample t-tests. However, in this case there were only 11 (self reported) and 8 (parent/carer) matched cases available thus giving insufficient power to detect significant results.

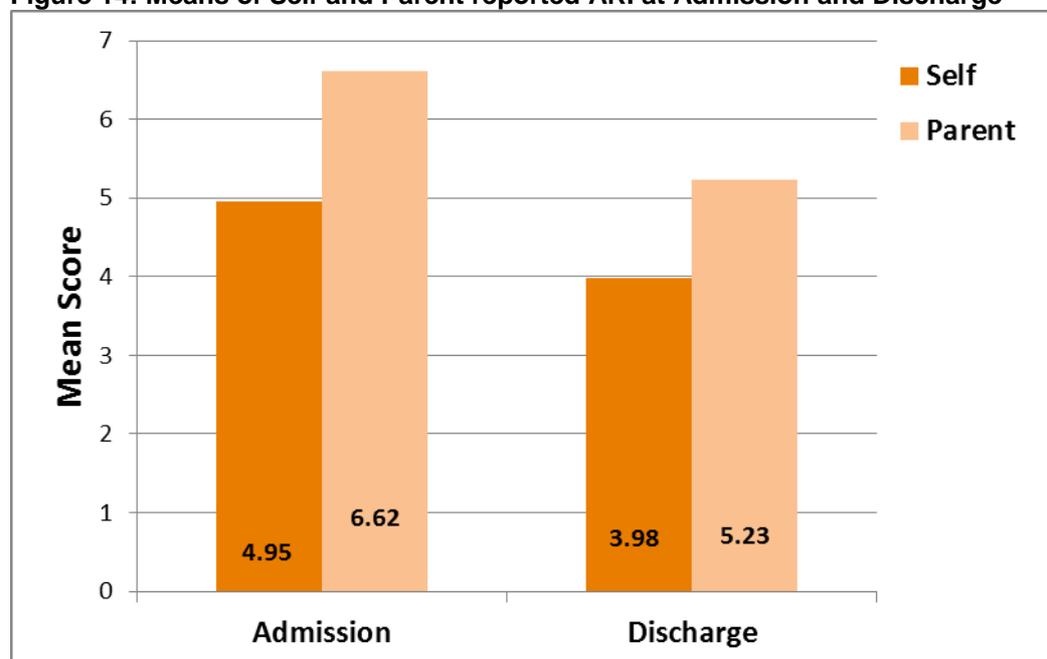
Affective Reactivity Index (ARI)

The ARI is a self and parent measure of irritability and proneness to anger. It consists of six questions assessing 1) the threshold for an angry reaction; 2) frequency of angry feelings and behaviours; 3) duration of such feelings/behaviours as well as a question about the extent to which irritability interferes with every day

life. Items are scored on a three-point scale from 0 (Not true) to 2 (Certainly true). Higher scores indicate higher irritability.

Figure 14 shows the means of ARI scores at admission and discharge reported by young people and their parents/carers.

Figure 14: Means of Self and Parent reported ARI at Admission and Discharge



As shown in Figure 13, self-reported ARI scores decreased at admission and discharge however were not significantly different ($z=-.78, p>.05$). Parent-reported scores decreased at discharge indicating a decrease in the perceived level in the young person's irritability and anger. However, again this difference was not significant ($t(11)=1.62, p>.05, r = 0.2$).

Service User and Parent/Carer Feedback and Experience

Inpatient iPad Survey

CPFT requires each inpatient unit to give every service user the opportunity to complete a monthly anonymous iPad survey, in which they are asked a series of questions about the service they are receiving. The questions cover the following areas: care and welfare, nutritional needs, respect and involvement and additional support. Service users are under no obligation to complete the survey and their care will not be affected in anyway should they choose not to complete the survey. Due to the Darwin Centre being moved from the Specialist Directorate into the Children, Young People and Families Directorate in Summer 2016, the data examined and reported on below is taken from the period: 01.08.16 – 31.03.17

The table below presents the results from the 52 surveys that young people completed between this period

Survey Questions	<i>% of Times Young People responded YES</i>
Are Staff polite and friendly?	100
Do you have a care plan?	100
Do you know who your care co-ordinator, named nurse or lead professional is?	97.14
Are there activities, groups or things to do during the weekday?	94.74
Do you know what your medication and, or treatment, prescribed by this ward is for?	93.55
When you arrived on the ward did staff make you feel welcome?	92.11
Do you understand what is in your care plan?	91.67

In addition, 92% of young people who completed surveys, rated their overall care as either Good or Okay (the response options being Good, Okay or Poor)

Our highlighted areas for improvement are:

- Quality of food
- How to better support young people to feel safe
- Weekend and evening activities and things to do

Exit Satisfaction Questionnaires

Once a young person is *discharged* from the service, both them and their parents/carers are sent an exit satisfaction questionnaire to complete. We ask questions as recommended by QNIC, in addition to some service specific questions relating to our individual environment and therapeutic program. The rating options are Very Unhappy, Unhappy, Mixed, Happy, Very Happy, Not Applicable.

Parents/Carers

Out of the 6 completed parent/carer exit satisfaction questionnaires that we received back:

- 5 parents/carers were Very Happy with their experience of our Reception team
- 4 parents/carers were Very Happy or Happy with the Darwin Learning Centre
- 4 parents/carers were Very Happy or Happy with their experience of the Nursing Team
- 4 parents/carers were Very Happy or Happy with their child's Primary Nurse
- 4 parents/carers were Very Happy or Happy with their experience of Family Therapy
- 4 parents/carers were Very Happy or Happy with the confidentiality and respect for their child's rights
- 4 parents/carers were Very Happy or Happy with professionals keeping time of appointments

Our highlighted areas for improvement are:

- Service parents/carers received in a general sense
- Advice given to parents/carers
- Explanations given to parents/carers about treatments given to their child

Carer Survey

The Carer Survey was launched in September 2015. We ask parents/carers of patients currently at the unit to complete the survey via the ipad or a paper version, the data from which the Head of Patient and Parent Involvement enters onto the meridian reporting system. We report on this data on a monthly basis, and use both the quantitative and qualitative data to improve practice.

Our target is to make sure we complete at least 2 surveys per month.

The table below presents the results from the 31 surveys parents/carers completed between the period 01.04.16 – 31.03.17

Survey Questions	<i>% of Times Parents/Carers responded YES or Good</i>
How would you rate the overall service received for the person you care for?	92.86
Have you felt able to raise concerns about the care received for the person you care for?	90.32
Have you felt valued and listened to about the support the person you care for has received?	77.42 (with a further 19.35% responding "Sometimes")
Have you felt included and involved in all stages of the journey for the person you care for?	70.97 (with a further 29.03% responding "Sometimes")

Our highlighted areas for improvement are:

- The support we give parents/carers

Patient and Parent/Carer Involvement

Activities to involve service users and their families continue to be prominent in the culture of the service. Involvement activities this year included:

- Young people continuing to be involved in making decisions about changes to the environment
- Several young people trained on recruitment and selection in order to be eligible for service user interview panels
- Several young people sitting on service user interview panels, including interviewing for the posts of Psychologist, Family Therapist, Band 6 Nurse, and Band 5 Nurse.
- Discharged young people and parents/carers providing us with Messages of Hope that we display both on our website and in our “Messages of Hope Book” on the ward
- A fortnightly “Have your say” meeting with all young people, where they are able to raise worries, concerns, ideas or suggestions about the way the service operates
- A monthly Parent/Carer Support Group led by our Social Worker Nicola Chrisp, whereby parents of current and past patients are able to attend to receive peer support from one another.
- A monthly Parent/Carer non clinical Newsletter, co written by patients and staff.
- Past patient returning to provide training for the team.

Compliments

Parents/Carers

“Both day-to-day contact with nurses and HCA staff and through family therapy was always supportive, realistic and non-judgmental. It has been invaluable in helping us re-think things.”

“I think the support my daughter received was excellent, from the doctors and nursing staff through to the staff at the unit's school. They could have offered even more support, but she wasn't always able to access it due to the severity of her anxiety.”

“I have felt the whole team are well informed and communicate well. The team have been very good at listening and proactively questioning for possible ways to help understand my daughter”

“This team has been outstanding throughout our involvement communication both within the team and with parents has been excellent”

“Staff are very caring, information and communication with the adolescent mindfully conducted and honest”

Patients

“The nurses are nice and the school is great.”

“The staff are very friendly and are always on hand to help you if you are struggling or in difficulty.”

“They (staff) are supportive and most of the time they listen to me and respect my decisions, if appropriate”

“The staff deal with incidents very professionally and make sure that they are considering patient dignity when having to be treated or calmed down”

“They (staff) are very caring and compassionate and are always there to help you and assist you in distress”

“There are many groups that go on across the ward”

“They really do let you have an input into the care plan”

News and Updates

Teaching and Training

The unit offers on-going placements for junior doctors, psychiatrists in higher training, student nurses and trainee clinical psychologists. We also sometimes have student social workers and trainee art therapists on placement.

The whole team receive AMBIT training, and new members of staff are regularly trained as part of the rolling induction programme.

Research Database and QNIC ROM

We share our data with QNIC Routine Outcome Measurement Service on a regular basis. This allows us to evaluate our service and compare our effectiveness to that of other inpatient services in the country.

In the future, we hope to be able to use the routine outcome data that we collect to understand what changes for young people during an admission to the Darwin Centre and what predicts positive outcomes.

References

- [1] Bevington, D., Fuggle, P., Fonagy, P., Target, M., & Asen, E. (2012). Innovations in practice: Adolescent Mentalization-Based Integrative Therapy (AMBIT) – A new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. *Child and Adolescent Mental Health, 18*(1), 46-51.
- [2] Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry, 40*(11), 1228-1231.
- [3] Gowers, S.G., Harrington, R.C., Whitton, A., Beevor, A., Lelliott, P., Jezzard, R., & Wing, J. (1999). Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Glossary for HoNOSCA score sheet. *British Journal of Psychiatry, 174*, 428-431.
- [4] Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry, 38*, 581-586.
- [5] Goodman, R., Meltzer, H., & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry, 7*, 125-130.
- [6] Stringaris, A., Goodman, R., Ferdinando, S., Razdan, V., Muhrer, E., Leibenluft, E., Brotman, M. (2012). The Affective Reactivity Index: a concise irritability scale for clinical and research settings. *Journal of Child Psychology and Psychiatry, 53*(11), 1109-1117.
- [7] Batty, M. J., Moldavsky, M., Foroushani, P. S., Pass, S., Marriott, M., Sayal, K., & Hollis, C. (2013). Implementing routine outcome measures in child and adolescent mental health services: from present to future practice. *Child and Adolescent Mental Health, 18*(2), 82–87.
- [8] Hall, C. L., Moldavsky, M., Taylor, J., Sayal, K., Marriott, M., Batty, M. J., ... Hollis, C. (2014). Implementation of routine outcome measurement in child and adolescent mental health services in the United Kingdom: a critical perspective. *European Child & Adolescent Psychiatry, 23*, 239–242.
- [9] Johnston, C., & Gowers, S. (2005). Routine outcome measurement: A survey of UK child and adolescent mental health services. *Child and Adolescent Mental Health, 10*(3), 133–139.
- [10] Law, D., & Wolpert, M. (Eds.). (2014). *Guide to using outcomes and feedback tools with children, young people and families*. London: CAMHS Press.
- [11] Dawson, J., Doll, H., Fitzpatrick, R., Jenkinson, C., & Carr, A. J. (2010). Routine use of patient reported outcome measures in healthcare settings. *BMJ, 340*, c186.
- [12] Wolpert, M. (2014). Uses and abuses of patient-reported outcome measures (PROMs): Potential iatrogenic impact of PROMs implementation and how it can be mitigated. *Administration and Policy in Mental Health, 41*, 141–145.
- [13] Wolpert, M., Deighton, J., De Francesco, D., Martin, P., Fonagy, P., & Ford, T. (2014). From 'reckless' to 'mindful' in the use of outcome data to inform service-level performance management: perspectives from child mental health. *BMJ Quality and Safety*, Published Online First: [23 January 2014].
- [14] <http://www.sdqinfo.org/py/sdqinfo/c0.py>.

- [15] Stratton, P, Bland, J., Janes, E & Lask, J. (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family Therapy*. 32, 232-258.
- [16] Chorpita, B. F., Yim, L. M., Moffitt, C. E., Umemoto L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A Revised Child Anxiety and Depression Scale. *Behaviour Research and Therapy*, 38, 835-855.

Appendices

Table 3: Means and Standard Deviations of All Measures at Admission and Discharge, for the "All Available" and "Complete" Samples

Measure:	<i>Admission</i>				<i>Discharge</i>			
	All Available		Complete		All Available		Complete	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
CGAS	38.69	7.98	38.69	7.98	51.19	11.07	51.19	11.07
HoNOSCA								
- Young Person	21.46	8.81	18.9	7.98	16.4	10.25	17.2	11.71
- Parent	22.71	7.02	21.36	7.35	9.17	9.03	9.64	9.32
- Clinician	21.73	4.62	21.73	4.62	13.65	4.05	13.65	4.05
SDQ								
- Young Person	17.64	5.87	16.45	5.85	15.5	6.15	14.82	5.44
- Parent	20.75	5.97	20.88	4.64	15	6.25	15.38	6.09
ARI								
- Young Person	4.49	3.87	4.86	4.42	4	3.98	3.93	3.77
- Parent	6.62	5.29	7.58	4.98	5.23	4.48	5.5	4.56

Note: The "All Available" sample includes young people for whom at least one measure was available. The "Complete" sample includes young people for whom matched admission and discharge measures were available. The graphs in the main sections of the report are based on the "All Available" sample. Statistical tests based on complete samples.

Table 5: Demographic variables

Variable:	N	%
Length of History		
- Less than 6 months	4	15
- 6 to 12 months	1	4
- 1 to 2 years	4	15
- More than 2 years	17	66
Prior Treatment		
- Adult Psychiatric Ward	0	0
- Early Intervention Psychosis Team	0	0
- Inpatient CAMHS	4	15
- Out-patient Community CAMHS	14	54
- Paediatric ward	6	23
- Specialist Eating Disorder inpatient unit	2	8
Carer Type		
- Both biological parents	13	50
- Single parent	6	23
- Biological parent and partner	5	19
- Formal foster parents	0	0
- Adoptive parents	2	8
- Other (e.g. Local authority)	0	0

Education Type		
- Mainstream secondary school	17	65
- Further/higher education	2	8
- Home tuition provided by the LEA	2	8
- N/A (left school – post 16)	2	8
- Other	3	11
Carer with Psychiatric diagnosis	12	46
Abuse Type		
- None Reported	17	65
- Physical	1	4
- Sexual	4	15
- Emotional	0	0
- Multiple/Other	4	15
- Not Known	0	0

A Word of Caution on Routine Data and its Interpretation

In this section, we would like to draw attention to some of the challenges involved in routine outcome measurement, and to the reasons why the reader is invited to interpret the data with caution. We would also like to explain the benefits that outcome measurement can offer for evaluating and improving the care we provide. Among the factors that have impacted our data collection are brief admissions, unplanned discharges, and low return rates of questionnaires. These are challenges faced by most, if not all, CAMHS services in the implementation of routine outcome measurement [8; 9; 10; 11]. As a result, the data we have presented and analysed may be under-representative of the young people who received treatment at the Darwin Centre during the year. In fact, those who completed the measures may present with different characteristics from those who did not complete the measures [13]. Interestingly, other services that are also implementing routine outcome monitoring (e.g., Children and Young People's IAPT) have decided to only report outcomes at service level if 90% of cases have complete data (i.e. pre- and post-treatment; [12]). Analysis of routine outcome measures is further confounded by other biases, such as differences in young people's characteristics at admission and lack of a comparison group. Being able to look at services' outcomes and interpret them in a way that can directly inform and improve clinical care is the ultimate goal of routine data collection, but the kind of careful analyses it requires is still under development [12; 13]. We would rather encourage readers to take a critical perspective that acknowledges the complexities and uncertainties of the data [13].

At present, we feel that the real benefit that outcome measurement can bring is in clinical practice, i.e. for guiding treatment, supporting the team to reflect on the care they provide, encouraging multiple perspectives and actively seeking young people's views on their difficulties and achievements. When used meaningfully in these ways, outcome measures can foster engagement and help provide a more person-centred approach to treatment [12; 11]. These are all goals that our service is aiming towards.