

Cambridgeshire and Peterborough



NHS Foundation Trust

Understanding children, young people and families

Darwin Centre for Young People

Annual Report

April 2013 – March 2014



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About Us

Introduction

The Darwin Centre for Young People is an NHS Tier 4 inpatient and day patient acute ward offering assessment and treatment to young people aged 12-17 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 16 young people: 14 inpatients and 2 day patients.

Based in Fulbourn, Cambridge, the Darwin Centre provides services to young people from Cambridgeshire, Peterborough, Norfolk, Suffolk and Bedfordshire. However, under the new National Commissioning arrangements, young people from all areas are eligible for referral/admission to the Darwin 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 work 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, outreach workers, dietician and teachers.

The length of stay and type of admission depends on the young person's individual needs and circumstances; Most young people stay for around two to three months, but we can offer longer treatment if needed. 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 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, which was awarded 'outstanding' by OFSTED in September 2011 for the second 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. 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. Students are also involved in a range of extra-curricular activities.

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.

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.

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) standards and CPFT standards on key areas such as care planning and the environment.

As a result of our performance against the QNIC standards in February 2013, the Darwin Centre has been accredited as 'excellent' until 24th April 2016. Specific strengths highlighted during the accreditation review include the pleasant ward and school environments, the comprehensiveness of the care plans, the variety of treatments provided, the quality of joint working on the unit, and the supportive atmosphere reported by both staff and patients.

Areas of improvement, which we have acted upon, include increased clinical psychology time, and developing ways to signpost parents/carers to important information.

Activity period in this report

This report describes activity during the financial year from 1st April 2013 to 31st March 2014.

The information presented in this report was collected from a variety of sources: a large amount of it is recorded on an electronic database we maintain 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:

Evelyn Tong, research assistant, evelyn.tong@cpft.nhs.uk (new in post October 2014)

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 2013, and for more information about the Darwin Centre for Young People.

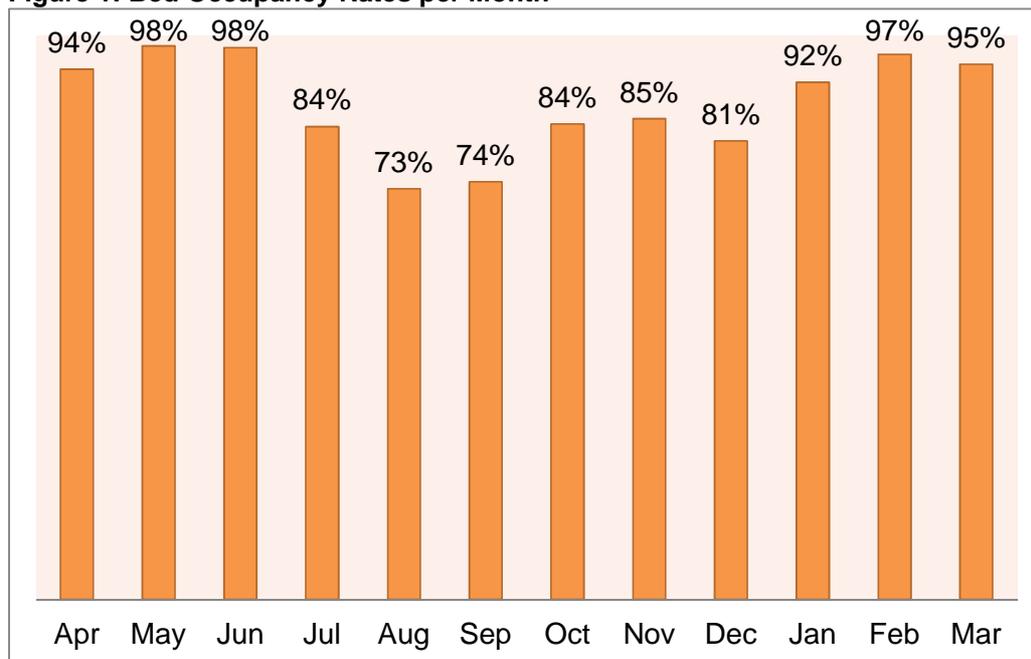
If you would like more information on the AMBIT approach and how it applies to the Darwin Centre, please visit <http://ambit-darwin.tiddlyspace.com/>

Clinical Activity

Bed Occupancy

Figure 1 shows the proportion of occupied beds per month during the financial year 2013-2014, based on 14 beds.

Figure 1: Bed Occupancy Rates per Month



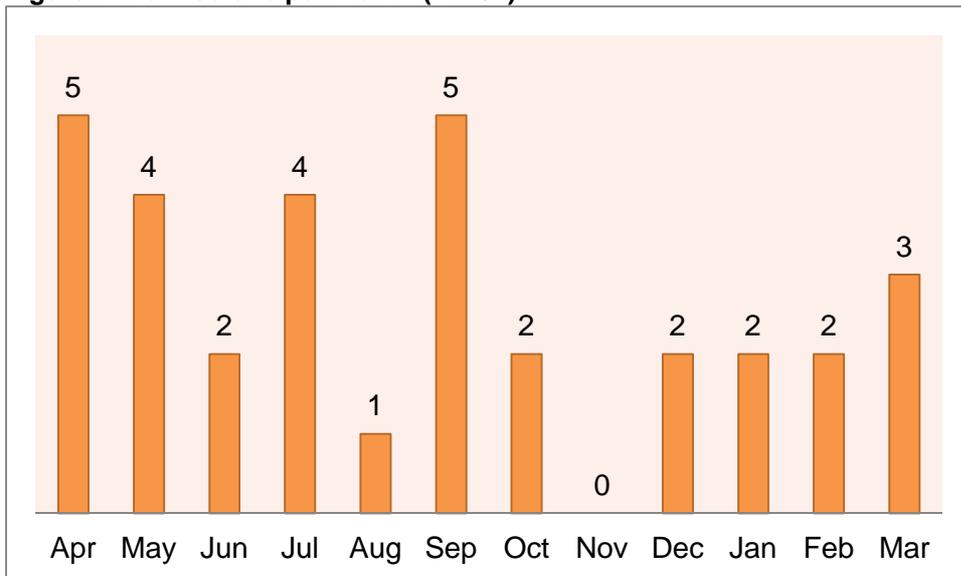
Referrals

During 2013/2014, the Darwin Centre received 216 referrals; Of these, 78% were urgent referrals, 21% were planned and 1% unknown.

Admissions

We admitted 32 young people during the financial year (one was admitted as day patient and two received both inpatient and day patient treatment). Six young people had been admitted to our service in previous years. Figure 2 shows the number of young people admitted to the Centre each month.

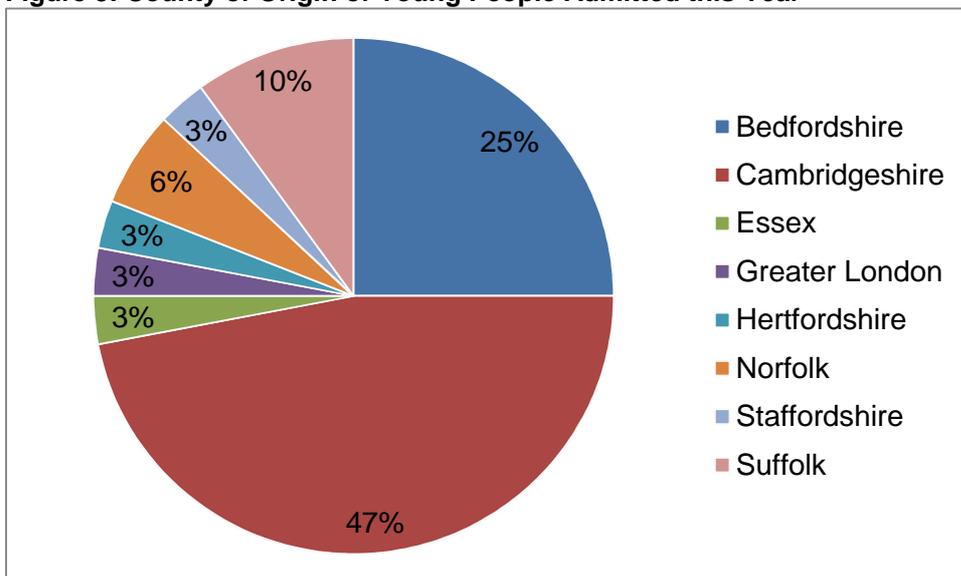
Figure 2: Admissions per Month (n = 32)



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 (47%), followed by Bedfordshire (25%) and Suffolk (10%).

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



Waiting Times

Of the admissions that took place this year, 12 were through urgent referrals, 13 through planned referrals, and 6 through emergency referrals (within 24 hours)¹. The

¹ This information was not available for one young person.

average waiting time between referral and admission was 10.62 days (Standard Deviation, $SD = 17.52$). As can be seen in Table 1, waiting times vary considerably depending on type of referral.

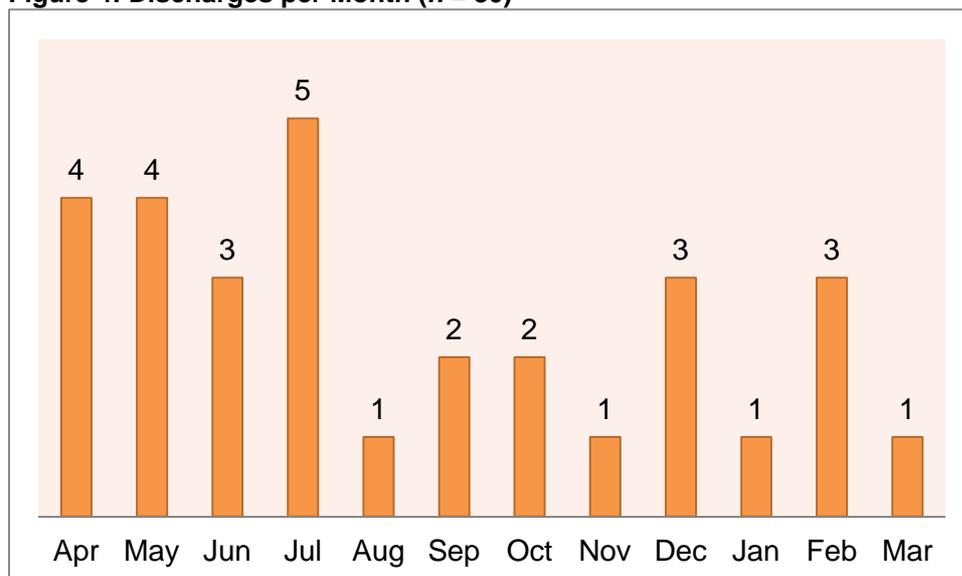
Table 1: Waiting Times from Referral to Admission by Referral Type

Waiting Times	Referral Type		
	Emergency (within 24 hours)	Urgent	Planned
Less than a week	100 %	83 %	50 %
Less than a month	0 %	17 %	33 %
More than a month	0 %	0 %	17 %

Discharges

We had 30 discharges this year (29 inpatient discharges and one day patient); Of these, two were of young people who received treatment twice during the financial year, and nine that had been treated by our service in previous years. The number of discharges per month is displayed in Figure 4.

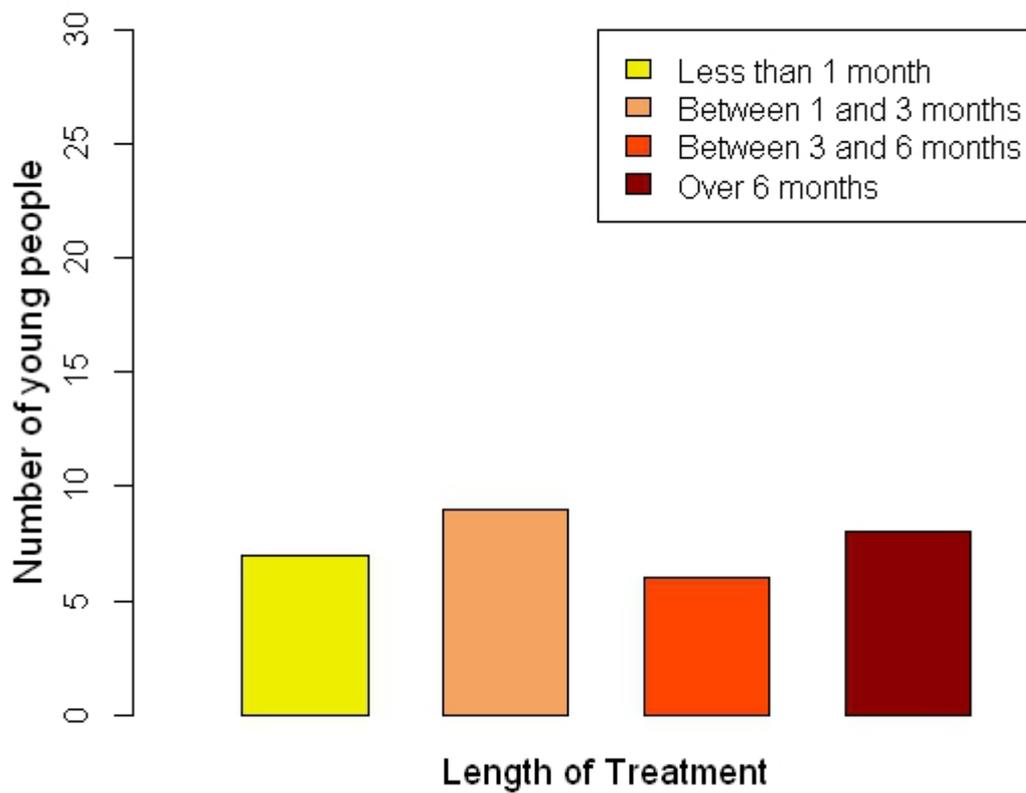
Figure 4: Discharges per Month ($n = 30$)



Length of Treatment

The average length of treatment was 115 days (16 weeks, just over three and a half months); However, as it is evident from Figure 5, there was much variation within this, with a range of stay from one day to over a year ($SD = 99.78$). 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



Formal Complaints

We received one formal complaint during this period. This led to us reviewing how we communicate with specific local services.

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 the summer of 2013, we have also 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.

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 30 young people *discharged* between 1st April 2013 and 31st March 2014. 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 [6].

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

Measure:	Admission		Discharge		Complete (Both Time Points)	
	N	%	N	%	N	%
CGAS	27	90%	27	90%	27	90%
HoNOSCA						
- Young Person	21	70%	15	50%	13	43%
- Parent	6	20%	9	30%	4	13%
- Clinician	27	90%	18	60%	18	60%
SDQ						
- Young Person	20	66%	15	50%	12	40%
- Parent	6	20%	9	30%	4	13%

* based on 30 young people discharged this year.

Error! Reference source not found. 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 not unique to our service; A recent audit of three CAMHS services found that only 16% of cases had complete data [7].

Description of Patient Group

Gender

Of the young people admitted, 24 (80%) were females and 6 (20%) males.

Age

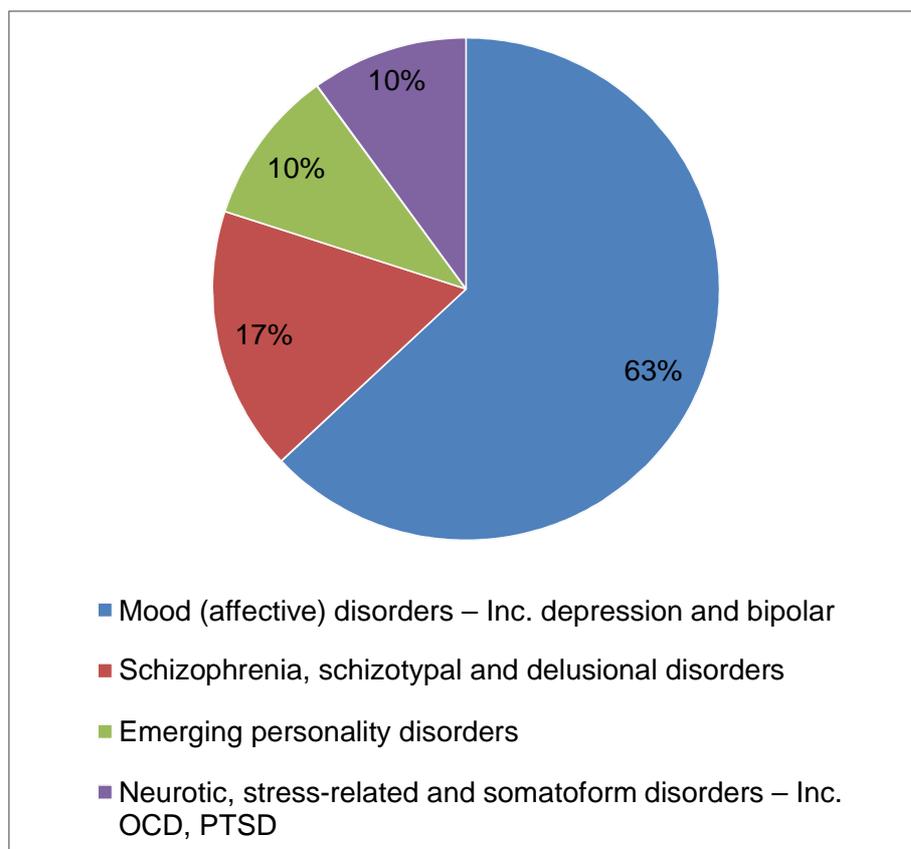
The average age at admission was 15.57 ($SD = 1.13$), with a range of 14 to 17 years.

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 a mood disorder. Other prevalent diagnoses were neurotic, stress-related and somatoform disorders such as obsessive-compulsive disorder, and delusional disorders such as schizophrenia.

Ten young people also met diagnostic criteria for a secondary, comorbid psychiatric disorder at the time of admission. Most frequently, this was for an eating disorder (60%), and an emerging disorder of adult personality and behaviour (20%).

Figure 6: Diagnoses per Broad ICD-10 Categories



Mental Health Act Status

A total of 9 young people (30%) were assessed or treated under the Mental Health Act during their stay (four under Section 2 – admission for assessment, four under Section 3 – admission for treatment, and one under Section 5.2).

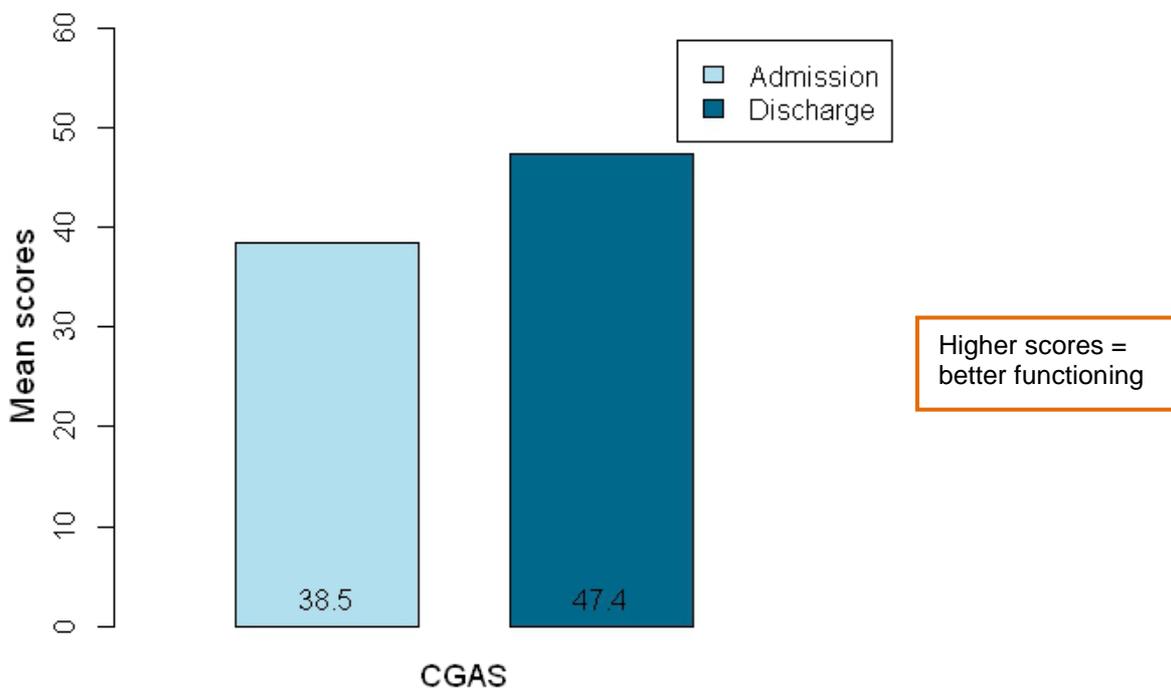
Results

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.

CGAS scores were available for 27 patients discharged this year (3 young people did not received CGAS ratings: two because they were admitted for less than a week and one because they received day patient treatment). As can be seen from Figure 7, 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 **41 – 50** range, which indicates a moderate degree of impairment in functioning in most social areas or severe impairment in one area.

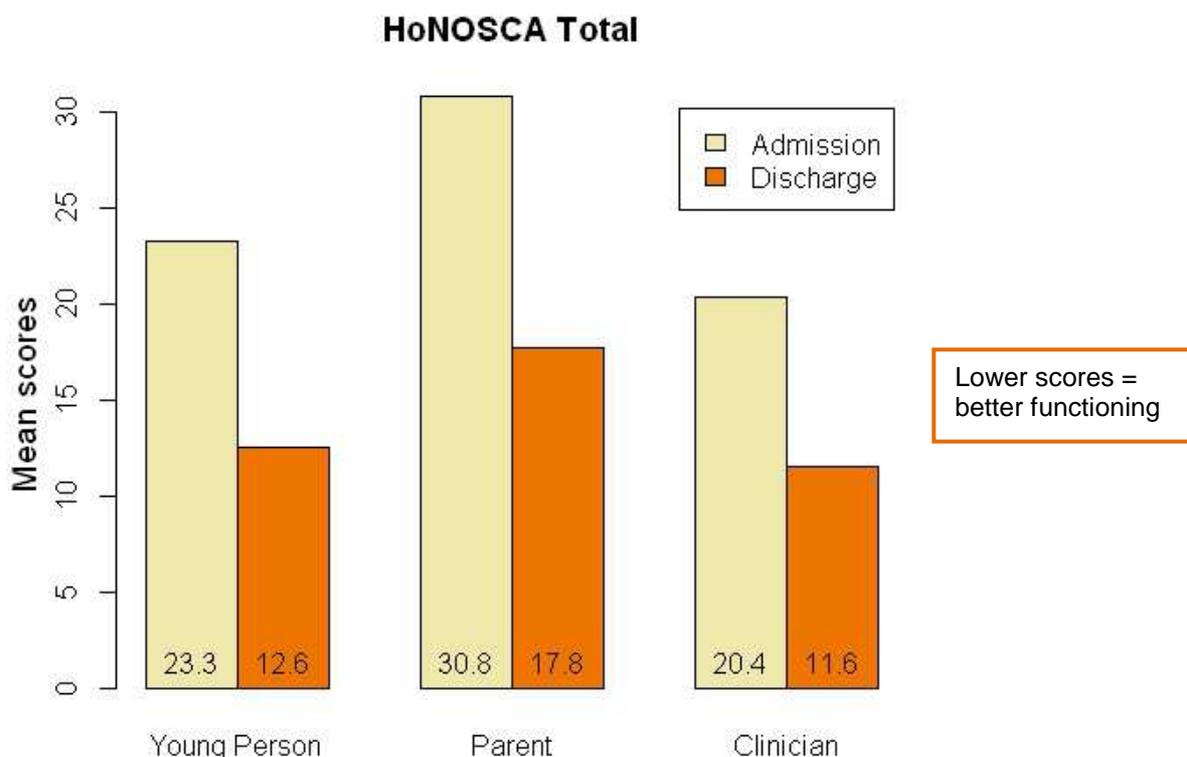
Figure 7: Means of CGAS Scores at Admission and Discharge



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 8, young people, parents/carers and clinicians reported a reduction in HoNOSCA total scores at discharge.

Figure 8: 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 [13].

Figure 9 shows the means of SDQ total scores at admission and discharge, reported by young people and their parent/carer. Both informants reported a mean total score in the clinical range (between 20 and 40) at admission. At discharge, this decreased to borderline severity (between 16 and 19) according to both self- and parent report.

Figure 9: Means of Self- and Parent-Reported SDQ Total Scores at Admission and Discharge (Lower scores = better functioning)

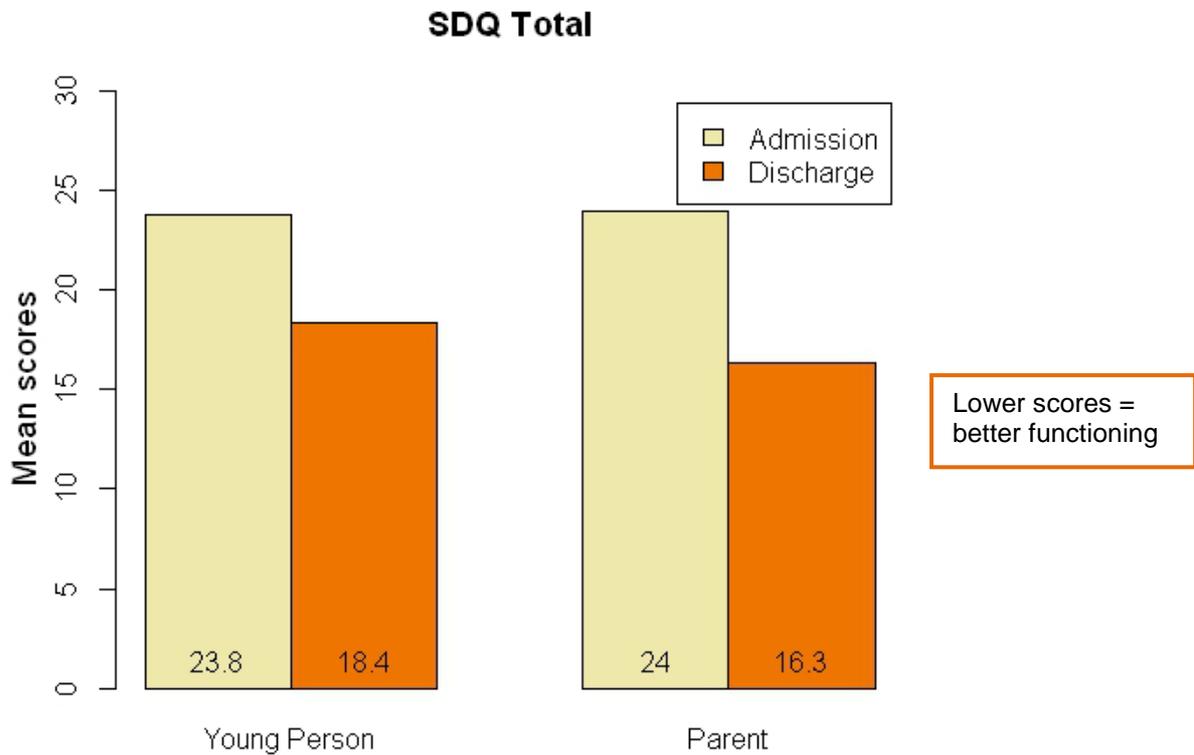


Figure 10 and

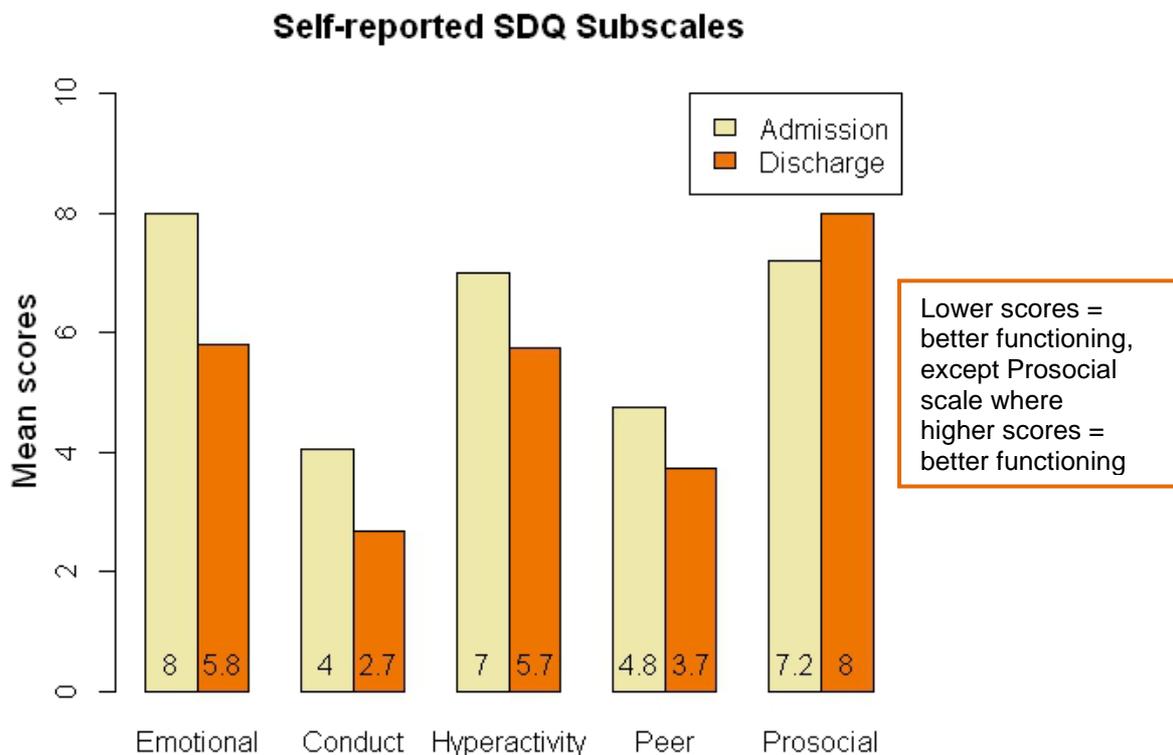
According to the parent/carer report, Emotional Symptoms decreased from the clinical (7 to 10) to the non-clinical range (below 6). Conduct problems decreased from the clinical (5 to 10) to the non-clinical range (below 3) at discharge. Hyperactivity and concentration problems decreased from the borderline (6) to the non-clinical range. Peer problems were not in the clinical range at admission, and

they further decreased at discharge. Pro-social behaviour was in the borderline severity range (5) at admission and improved to non-clinical severity (between 6 and 10) at discharge.

Figure 11 provide the breakdown of self- and parent-reported mean scores for each of the five subscales.

According to the self-report, in the Emotional Symptoms scale, the problems decreased from the clinical (between 7 and 10) to the non-clinical range (below 6). Conduct problems were of borderline severity at admission (4) and they decreased to the non-clinical range at discharge. Hyperactivity and concentration problems were in the clinical range (between 7 and 10) at admission and decreased to the non-clinical range at discharge (below 6). Peer problems were of borderline severity at admission (between 4 and 5) and they decreased to non-clinical severity at discharge. Pro-social behaviour was in the non-clinical range (between 6 and 10) at admission and further improved at discharge.

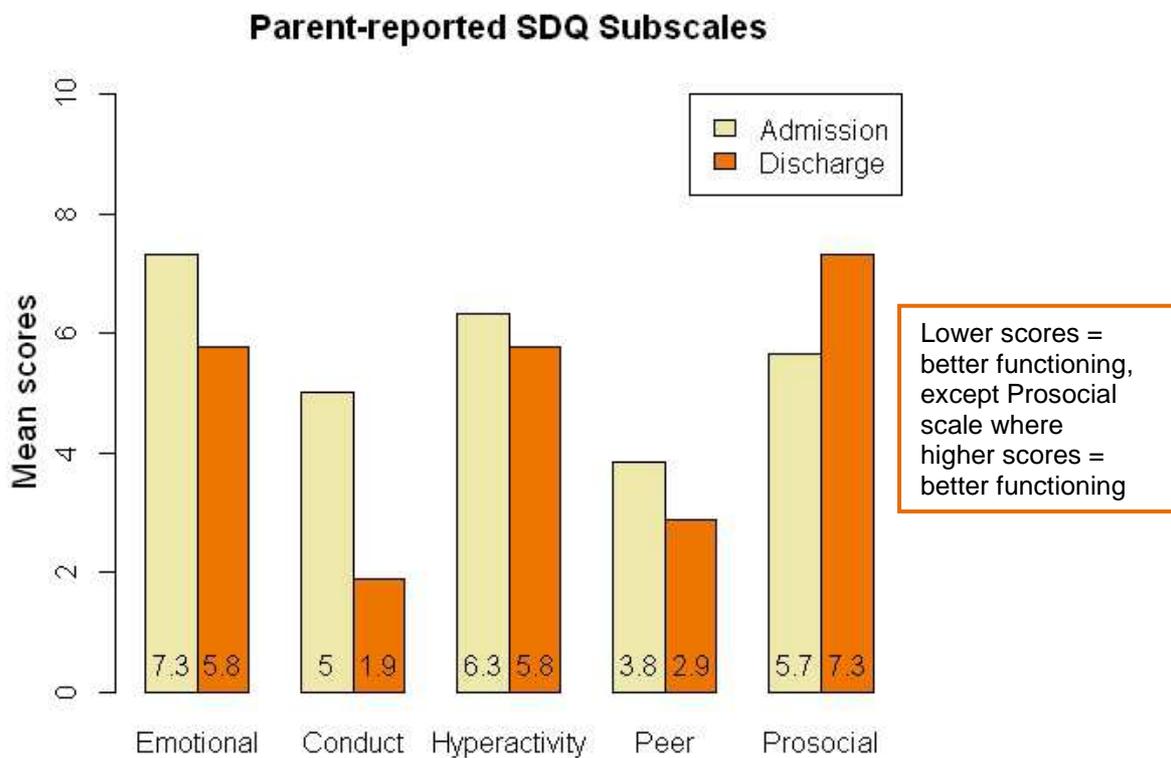
Figure 10: Means of Self-reported SDQ Subscale Scores at Admission and Discharge



According to the parent/carer report, Emotional Symptoms decreased from the clinical (7 to 10) to the non-clinical range (below 6). Conduct problems decreased from the clinical (5 to 10) to the non-clinical range (below 3) at discharge. Hyperactivity and concentration problems decreased from the borderline (6) to the non-clinical range. Peer problems were not in the clinical range at admission, and they further decreased at discharge. Pro-social behaviour was in the borderline

severity range (5) at admission and improved to non-clinical severity (between 6 and 10) at discharge.

Figure 11: Means of Parent-reported SDQ Subscale Scores at Admission and Discharge



Service User and Parent/Carer Feedback and Experience

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 any way should they choose not to complete the survey. During the period from 1st April 2013 to 31st March 2014, 11 young people chose not to participate in the survey.

From February 2014, the wording of many of the questions changed, as did the response options. There were also questions removed and new ones added. The results from 1st February 2014 up until 31st March 2014 will therefore be captured in next year's report.

Table 3 presents the results from the 81 surveys that young people completed from 1st April 2013 up until 31st January 2014.

Table 3: Young People's Responses to the Inpatient iPad Survey

Survey Questions	% of Times Young People responded YES
Do you understand what is in your care plan?	100%
Have you been offered support in finding or keeping work?	100%
Have you had a care review meeting to discuss your care?	100%
Do you have a care plan?	99%
When you arrived on the ward, did staff make you feel welcome?	98%
Are the purposes of medication and treatments explained in a way you can understand?	97%
Do staff listen carefully to you?	95%
Do you have trust and confidence in our staff?	95%

We also routinely send exit satisfaction questionnaires to both young people and their parents/carers following discharge. This year the return rate of questionnaires has been very low (only 3 received from young people and parents/carers during this time), therefore we will capture the results from these along with next year's results.

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 received AMBIT training in January 2013, and new members of staff are regularly trained as part of the rolling induction programme.

Research Database and QNIC ROM

Over the summer, alongside the outcome measures, we started to collect a wide range of demographic measures that provide us with a better understanding of our patient group. We hope to report on these in next year's annual report, when we will have more complete data.

We have also developed a research database that allows accurate and fairly quick data entry, thus making routine outcome measurement less time-consuming and more reliable. In addition, 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.

Patient and Parent Involvement Activities

Activities to involve service users and their families are 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 being trained on recruitment and selection so that they are eligible to sit on service user interview panels
- Young people sitting on service user interview panels
- Discharged young person fundraising for the unit and returning to sit on a service user interview panel
- 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" on 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 parent of a discharged young person sharing her experience via audio recording at the Trust Board Meeting

- Young people working together over a period of time to produce a mentalization mural for the entrance corridor

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Appendices

Table 4: Means and Standard Deviations of All Measures at Admission and Discharge, for the "All Available" and "Complete" Samples

<i>Measure:</i>	<i>Admission</i>				<i>Discharge</i>			
	All Available		Complete		All Available		Complete	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
CGAS	38.48	5.34	38.48	5.34	47.44	11.43	47.44	11.43
HoNOSCA								
- Young Person	23.33	8.86	24.62	10.08	12.6	7.42	10.54	4.88
- Parent	30.83	11.72	27.5	7.94	17.78	6.74	20.25	6.85
- Clinician	20.37	5.72	19.83	5.14	11.61	4.42	11.61	4.42
SDQ								
- Young Person	23.8	3.46	24.75	2.56	18.4	7.74	17.58	4.58
- Parent	24	7.72	24.75	7.72	16.33	7.18	19	8.21

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. For details of sample sizes, refer to **Error! Reference source not found.**

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 [7; 8; 9; 10]. A consequence of these challenges is that the data presented in the following sections may be under-representative of the young people that 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 [11]. 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; [10]). 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].

Given these important caveats, we refrained from analysing our data using statistical tests and instead opted for simpler descriptive summaries. These serve the purpose of giving the reader a general overview of our patient group and service outcomes

over the year, whilst also reminding us to avoid drawing any simplistic conclusions. What we would rather encourage is 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 in reflecting 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 [11; 10]. These are all goals that our service is aiming towards.

Therefore, in light of these important considerations, we would suggest interpreting the results presented with caution.