

Cambridgeshire and Peterborough



NHS Foundation Trust

Understanding children, young people and families

Darwin Centre for Young People

Annual Report

April 2014 – March 2015



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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 14 inpatient beds, plus provision for 2 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, outreach workers, dietician and teachers. Therapeutic groups include those themed around mentalization (please see the AMBIT Approach below), keeping safe, health and promoting social and communication skills such as in the art therapy 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 two to three 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 September 2011, the Pupil Referral Unit to which the Darwin Learning Centre belongs to was rated "Outstanding" 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. 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.

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 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 2014 to 31st March 2015. 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:

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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.

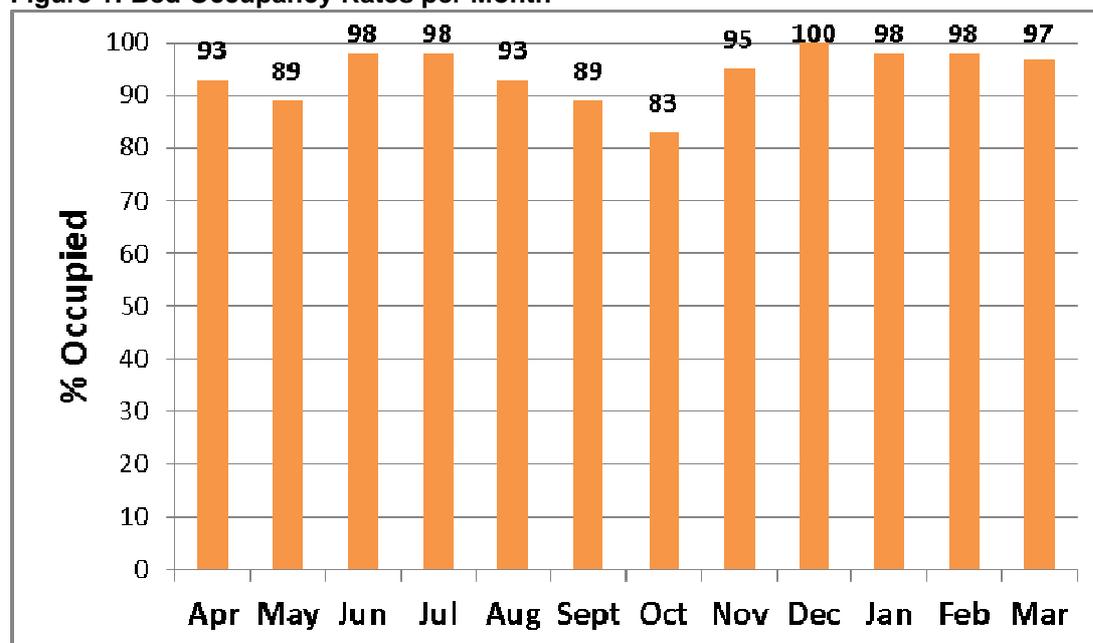
If you would like more information on the AMBIT approach and how it applies to the Darwin Centre, please visit <http://ambit-darwin.tiddlyspace.com/>

Clinical Activity

Bed Occupancy

Figure 1 shows the proportion of occupied beds per month during the financial year 2014-2015, based on 14 beds.

Figure 1: Bed Occupancy Rates per Month



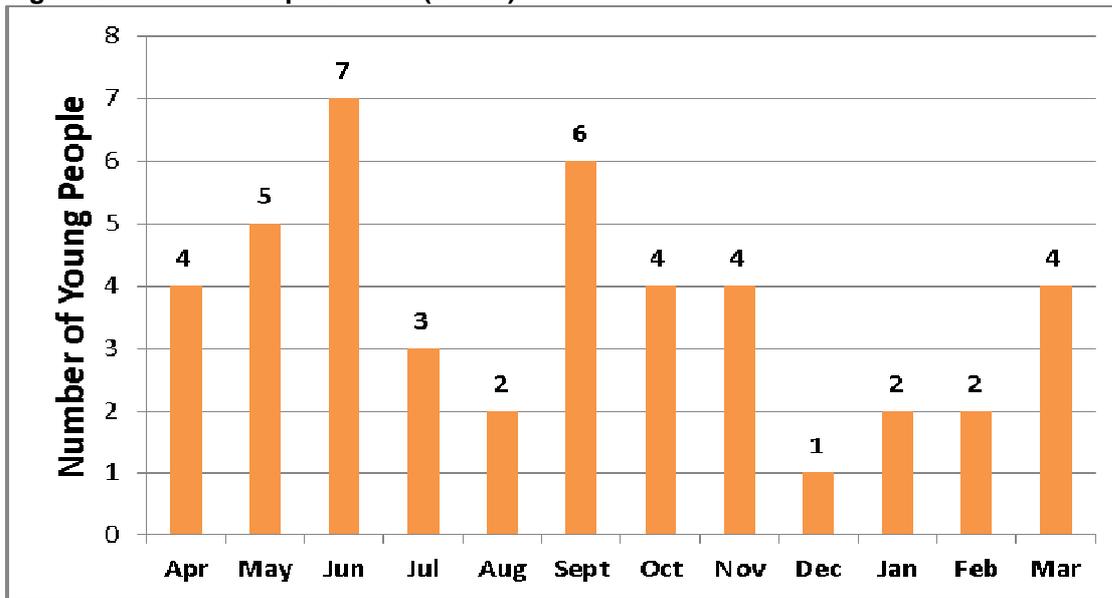
Referrals

During 2014/2015, the Darwin Centre received 155 referrals, of which 150 were urgent referrals and 5 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 referrers timescale.

Admissions

We admitted 44 young people during the financial year (one was admitted as a day patient and two received both inpatient and day patient treatment). Seven young people had been admitted to our service in previous years and one young person had been admitted twice in the same financial year. Figure 2 shows the number of young people admitted to the Centre each month.

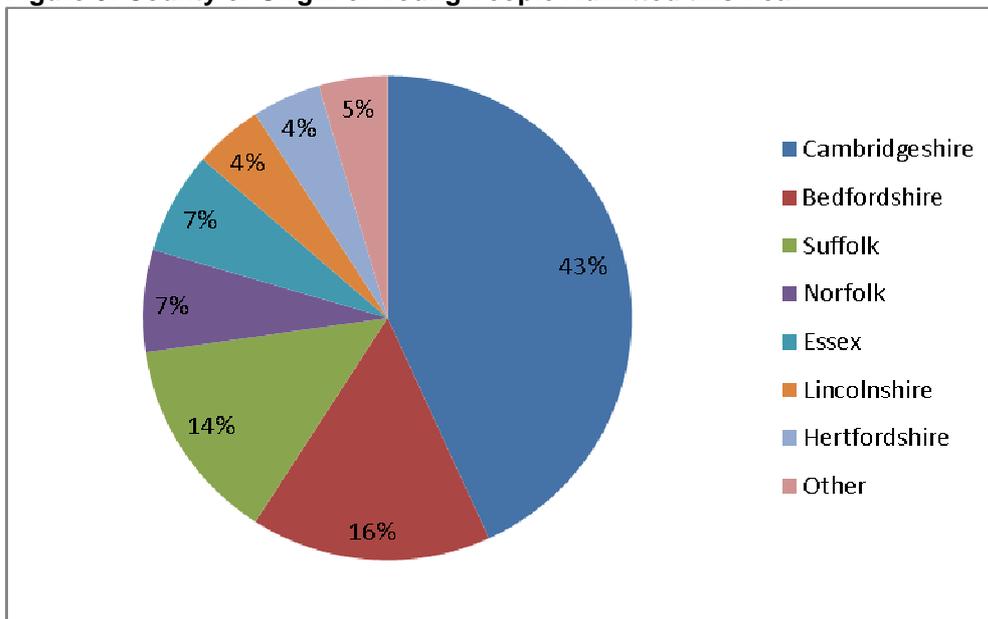
Figure 2: Admissions per Month (n = 44)



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 (43%), followed by Bedfordshire (16%) and Suffolk (14%).

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



Waiting Times

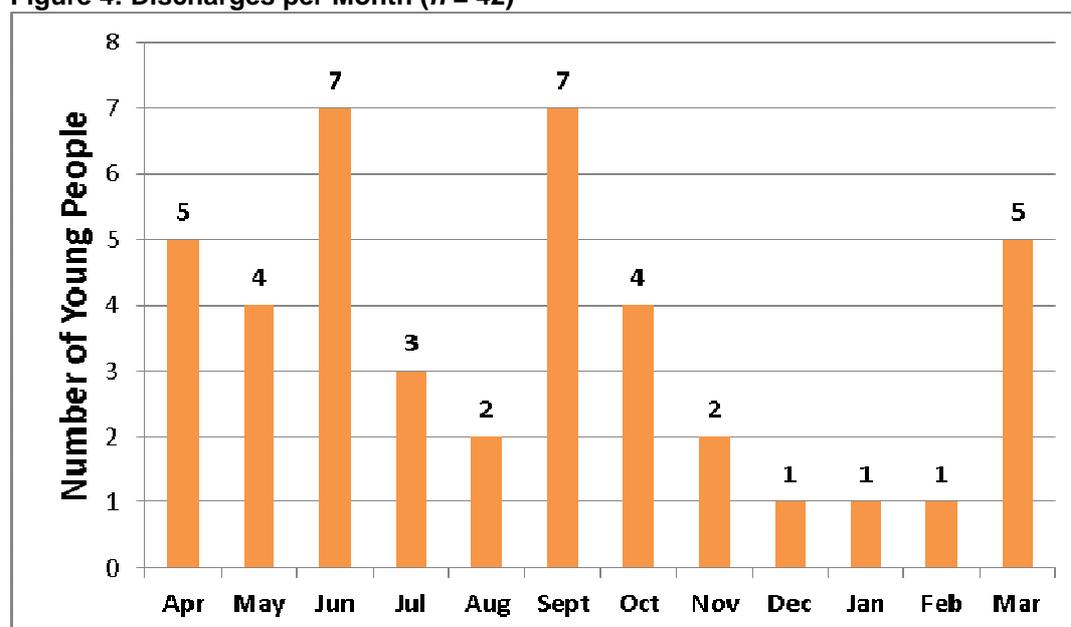
Of the admissions that took place this year, 20 were through emergency referrals (within 24 hours), 13 through urgent referrals, and 11 through planned referrals. The average waiting time between referral and admission was 6.84 days ($SD= 14.53$). As can be seen in Table 1, waiting times vary considerably 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 %	92 %	45 %
Less than a month	0 %	8 %	36 %
More than a month	0 %	0 %	18 %

Discharges

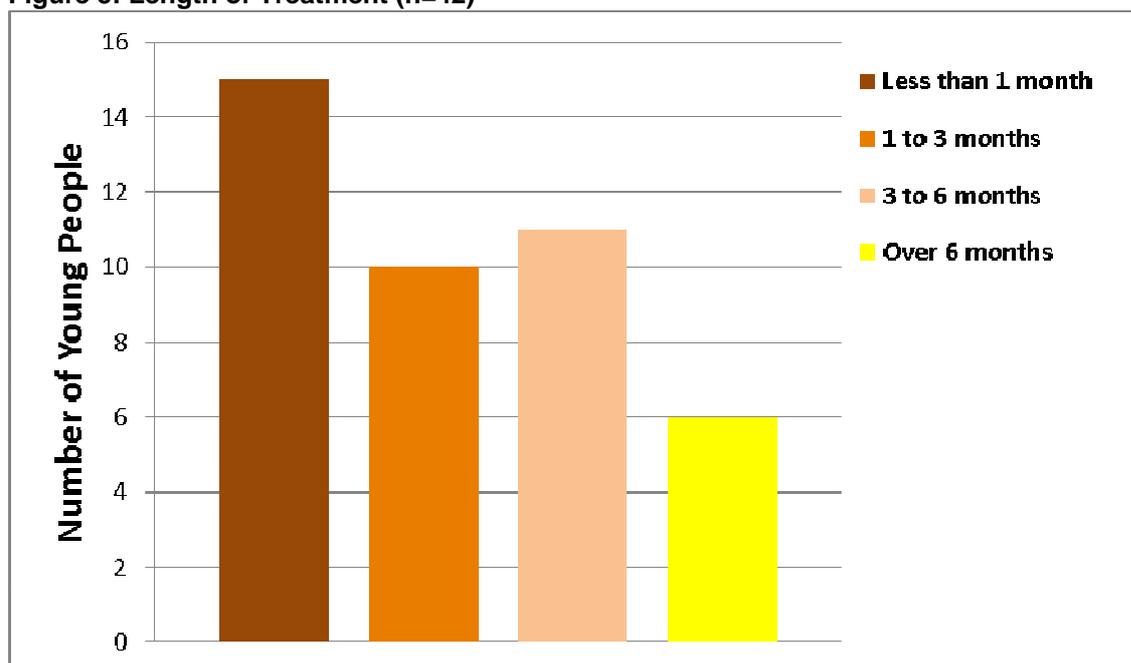
We had 42 discharges this year (39 inpatients, 3 receiving both inpatient and day patient treatment); Four young people had been re-admitted more than once during the financial year, and five had been treated by our service in previous years. The number of discharges per month is displayed in Figure 4.

Figure 4: Discharges per Month (n = 42)

Length of Treatment

The average length of treatment was 100.26 days (14 weeks; just under 3 and a half months). Figure 5 shows the variation that can occur within this, with patients staying from less than one week to over a year ($SD = 142.3$). Two young people were 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=42)



Discharge Type

The majority of discharges were planned (81%) with 12% being self-discharges (discharge against medical advice) and 7% unplanned discharges (staff-initiated due to sudden circumstances)

Treatments Post-Discharge.

The majority of young people were referred back to the referrer (83%) although on occasion, young people are referred to another agency (10%) or a follow up is provided by the unit in an outpatient context (e.g. school provision or continued individual/family therapy sessions; 7%)

Types of treatment post-discharge include outpatient community CAMHS (74%), adolescent outreach teams provided by the unit (7%) or transfer to another inpatient unit (7%).

Formal Complaints

We received two formal complaints during this period. One has been investigated and results have been fed back to the carers and young people involved about the changes made in accordance. The second complaint is currently still undergoing investigation.

Serious Incidents

There was one serious incident this financial year. As a result, we have developed good guidance questions to aid mental state and risk assessments prior to young people going on unescorted leave which are documented on the patient's online records. This is then audited monthly.

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. Since the results of these newly added variables/measures were not reported in the previous annual report (due to an insufficient amount of data), the current annual report will include those discharged since June 2013 when reporting on newly collected demographic variables.

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.

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 42 young people *discharged* between 1st April 2014 and 31st March 2015. 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: 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	40	95	40	95	40	95
HoNOSCA						
- Young Person	29	69	21	50	18	43
- Parent	19	45	17	40	11	26
- Clinician	33	79	32	77	27	64
SDQ						
- Young Person	30	71	21	50	20	48
- Parent	19	45	17	40	11	26
ARI						
- Young Person	23	55	17	40	15	36
- Parent	18	43	14	33	10	24

* based on 42 young people discharged this year.

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 not unique to our service; A recent audit of three CAMHS services found that only 16% of cases had complete data [8].

Description of Patient Group

Gender

There were 27 (64%) females and 15 (36%) males in this year's cohort.

Age

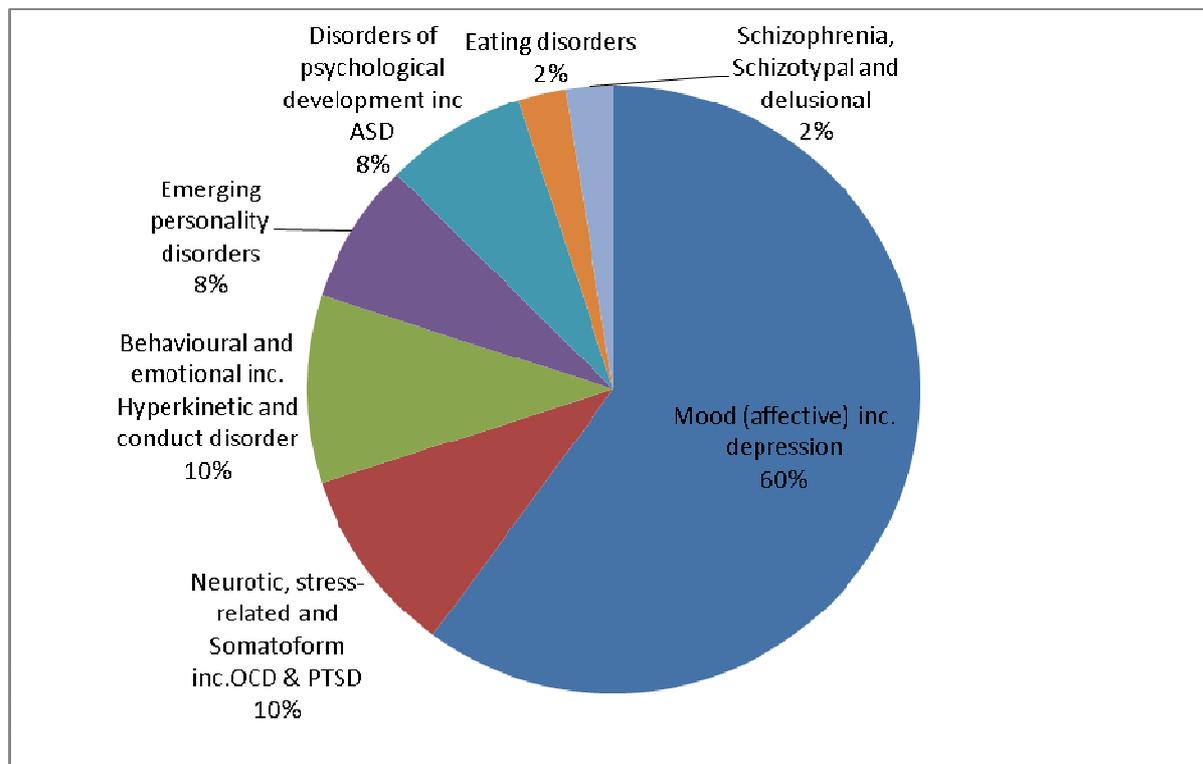
The average age at admission was 15.81 ($SD = 1.19$), with a range of 13 to 17 years.

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 emerging disorder of adult personality and behaviour such as borderline personality disorder.

Eighteen 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 (20%), 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 (21%) were assessed or treated under the Mental Health Act during their stay (seven under Section 2 – admission for assessment, one under Section 3 – admission for treatment, and one under Section 5.2).

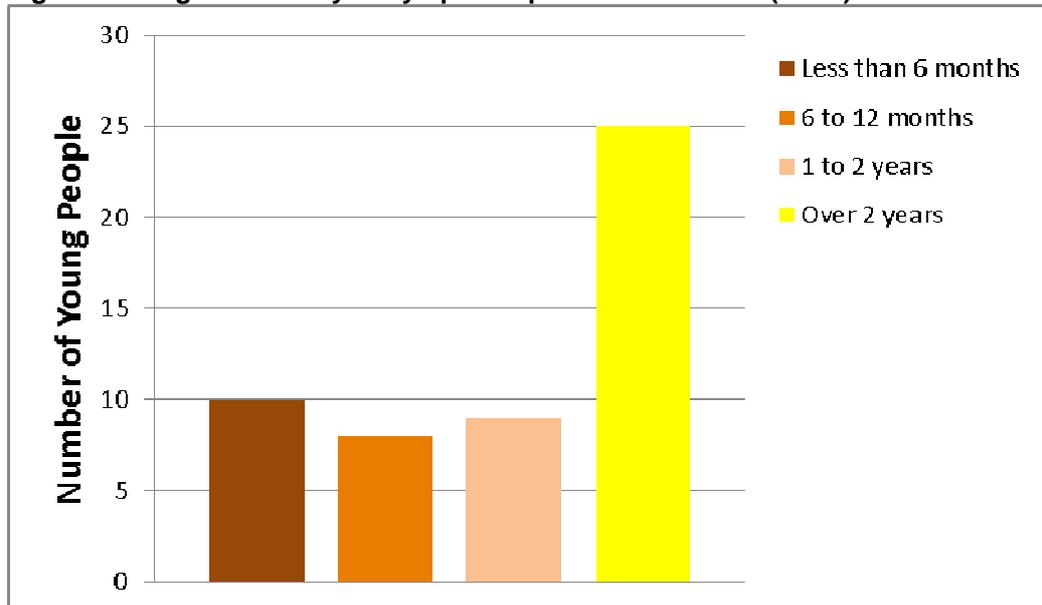
Other Demographic Variables

The following sections include the data available for 12 young people discharged since June 2013 as these results were not captured in the previous report. Details are provided in the appendix with respect to each financial year (i.e. June 2013 to 31st March 2014 and 1st April 2014 to 31st March 2015).

Length of History

Figure 7 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 7: Length of history of symptoms prior to admission (N=52)



Past Treatment

Forty-eight (92%) young people had received treatment prior to admission. The majority were being treated by outpatient community CAMHS (64%) followed by another Inpatient CAMHS unit (19%) and a paediatric ward (11%). Other prior treatment included intervention from specialist teams such as eating disorders and psychosis.

Prior Social Circumstances

The majority of young people lived with both biological parents (31%) followed by one biological parent and their partner (23%) and a single parent (25%). Other carers included formal foster parents, adoptive parents and the local authority (children's home).

The majority of young people attended mainstream secondary school or were in further/higher education prior to admission (65%). Other young people were not in school due to exclusion (14%) or had left school after the age of 16 (11%) or were provided with alternative forms of education such as home schooling.

Twenty (38%) young people had a carer with a psychiatric diagnosis.

Twenty-one (39%) young people have reported a history of physical, sexual or emotional abuse.

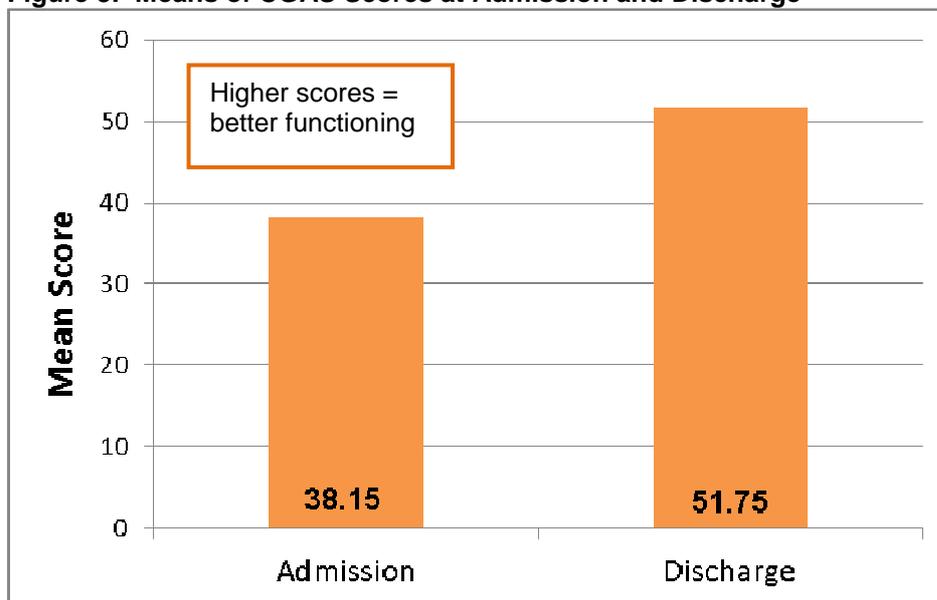
Results

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. CGAS scores were available for 39 patients discharged this year (Two young people did not received CGAS ratings as they were admitted for less than one week). As can be seen from Figure 8, 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 paired t-test indicated that this increase was significantly different ($t_{(37)}=8.07, p<.001$).

Figure 8: Means of CGAS Scores at Admission and Discharge



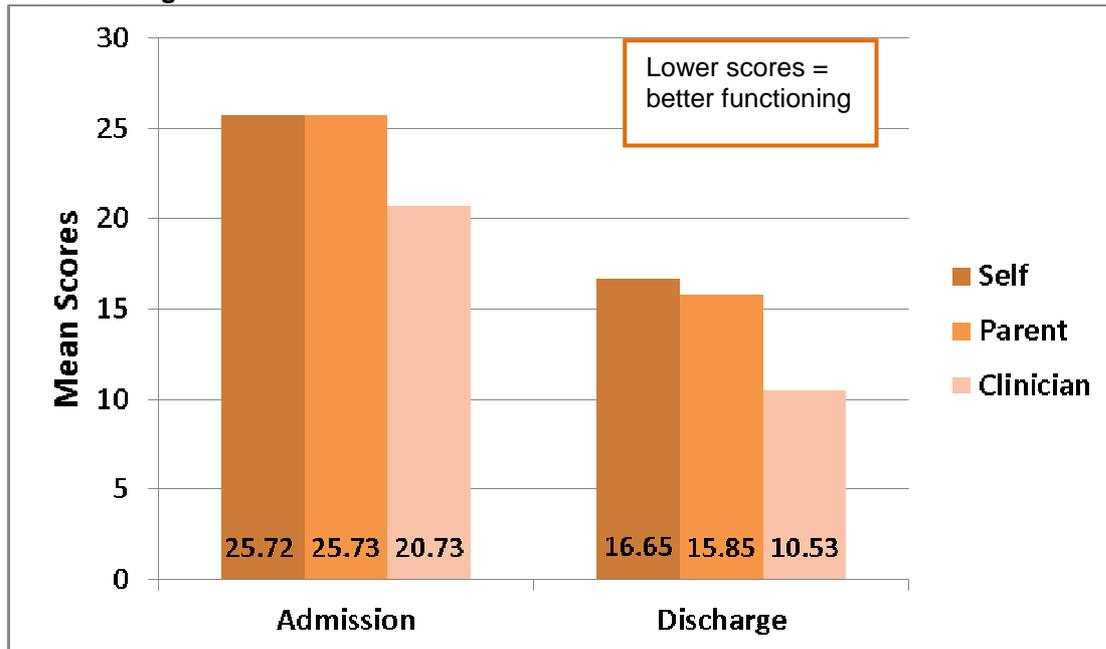
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

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 9, young people, parents/carers and clinicians reported a reduction in HoNOSCA total scores at discharge. These reductions were significantly different for all three informants (clinician: $W=322.5$, $p<.001$; self: $W=147$, $p=.002$; parent: $t_{(10)}=4.11$, $p=.002$).

Figure 9: 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 10 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. Self-reported scores were significantly lower at discharge ($t_{(19)}=4.17$, $p<.001$, however parent scores were not significantly different ($t_{(10)}=1.30$, $p>.05$).

Figure 10: Means of Self- and Parent-Reported SDQ Total Scores at Admission and Discharge

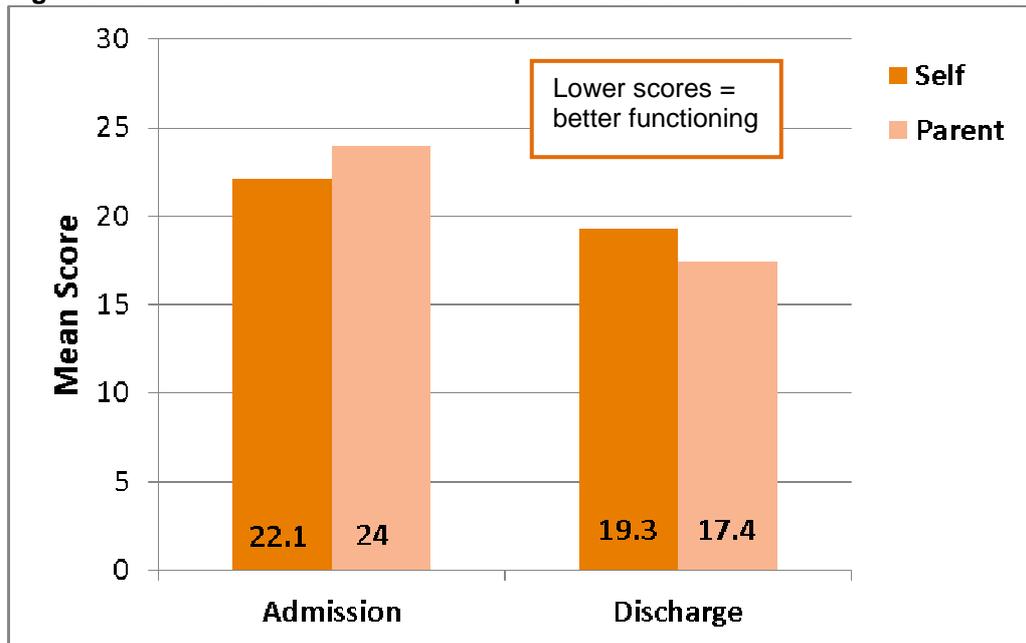
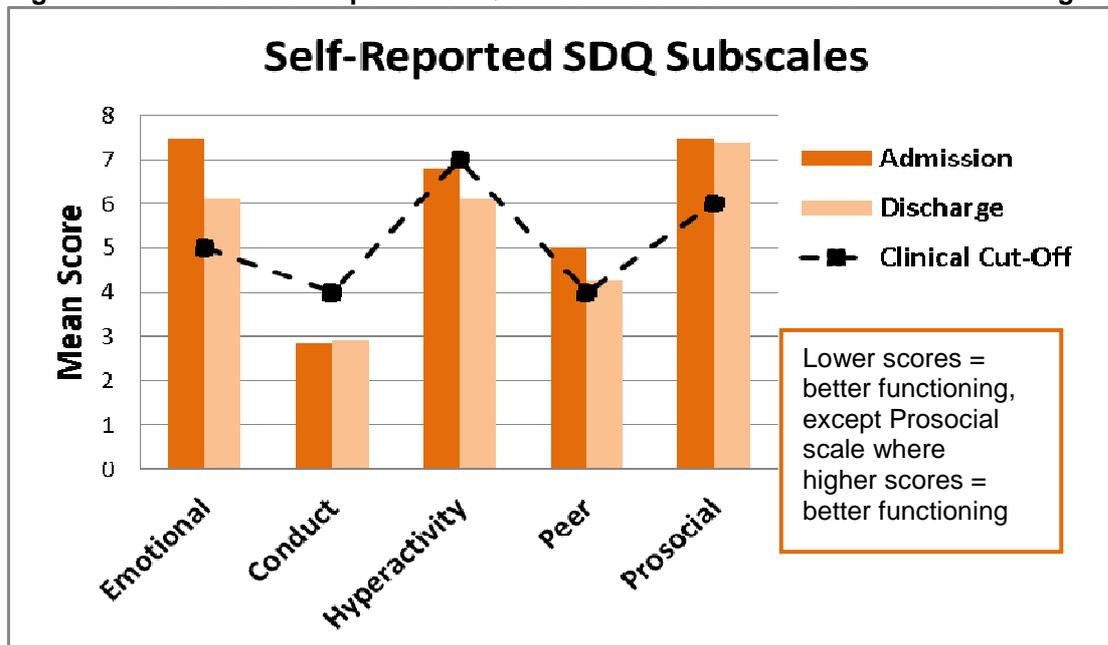


Figure 11 and Figure 12 provide the breakdown of self- and parent-reported mean scores for each of the five subscales.

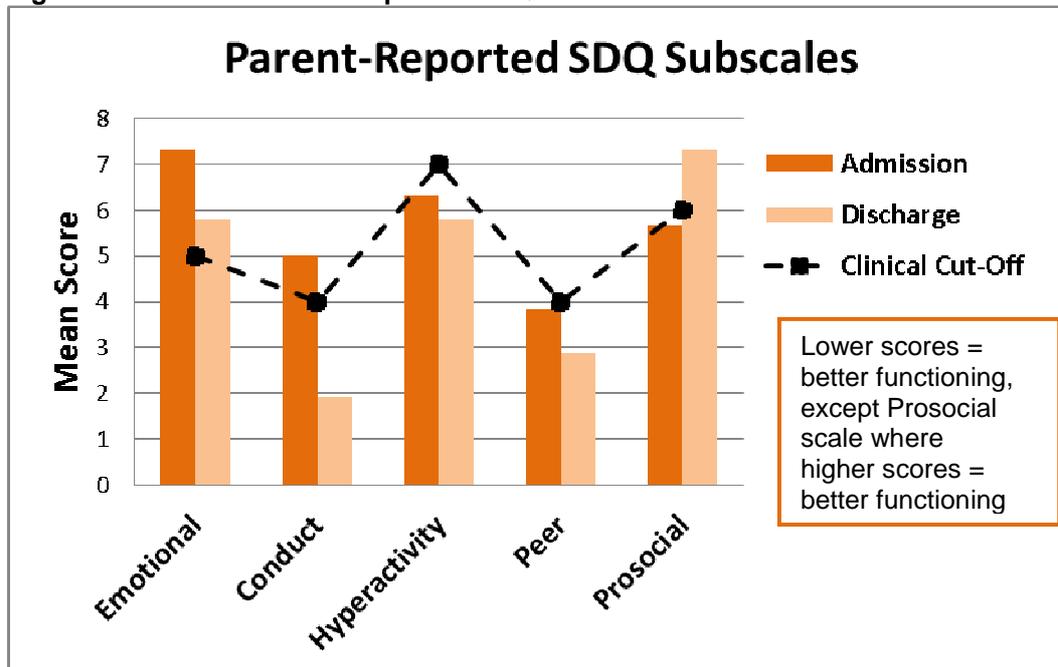
Figure 11: Means of Self-reported SDQ Subscale Scores at Admission and Discharge



The self-report shows how Emotional Symptoms significantly decreased at discharge ($W=116.5, p=.001$) but was still within the clinical range. Conduct problems remained below the clinical range at admission and discharge and were not significantly different ($t_{(19)}=.69, p>.05$). Hyperactivity and concentration problems were at borderline severity at admission and significantly decreased further at discharge ($t_{(19)}= 3.48, p=.003$). Peer problems were in the clinical range at admission and significantly decreased towards the clinical cut-off at discharge ($t_{(19)}= 2.56, p=.02$).

Pro-social behaviour remained in the non-clinical range at admission and discharge and did not differ significantly ($t_{(10)} = 1.0, p > .05$).

Figure 12: 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 ($W=36.5, p > .05$). Conduct problems significantly decreased from the clinical to the non-clinical range at discharge ($t_{(10)} = 2.80, p = .02$). Hyperactivity and concentration problems decreased from borderline severity (6) to the non-clinical range although this decrease was not significant ($W=37, p > .05$). Peer problems were in the borderline range at admission (3) and decreased to the non-clinical range although this was not a significantly different reduction ($t_{(10)} = .60, p > .05$). Pro-social behaviour was in the borderline severity range (5) at admission and improved to non-clinical severity at discharge, although again this was not significant ($t_{(10)} = 1.0, p > .05$).

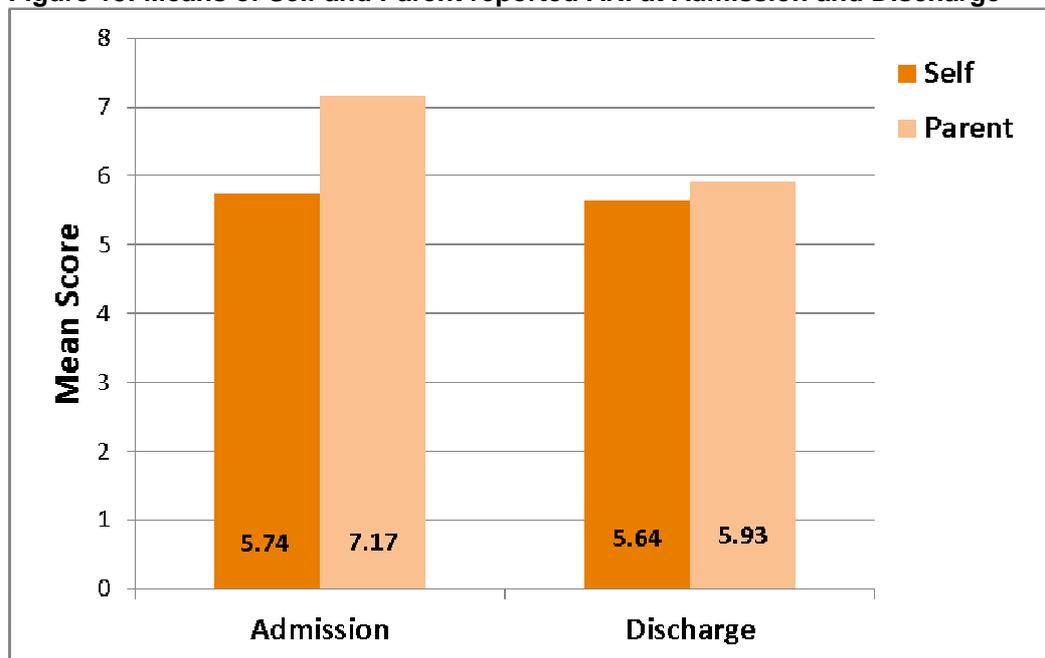
It should be noted that the insignificant results are more likely to be due to the low number of parent responses. In order to detect a large effect size, at least 15 matched cases are needed to have sufficient power when running paired sample t-tests. However, in this case there were only 11 matched 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 13 shows the means of ARI scores at admission and discharge reported by young people and their parents/carers.

Figure 13: Means of Self and Parent reported ARI at Admission and Discharge



As shown in Figure 13, self-reported ARI scores were similar at admission and discharge and were not significantly different ($t_{(14)}=.57, p>.05$). Parent-reported scores decreased at discharge indicating a decrease in the perceived level in the young person's irritability and anger. However, this difference was not significant ($W=38, p>.05$).

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 2014 to 31st March 2015, 26 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 combined with the results from this financial year.

Table 3 presents the results from the 110 surveys that young people completed from 1st February 2014 up until 31st March 2015.

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

Survey Questions	<i>% of Times Young People responded YES</i>
Are there activities, groups or things to do during the weekday?	100%
Do you know what your medication and, or treatment, prescribed by this ward is for?	100%
When you arrived on the ward, did staff make you feel welcome?	100%
Do you feel you are treated with respect and dignity by our staff?	99%
Are Staff polite and friendly?	99%
Do you know who your care-co-ordinator, named nurse or key worker is?	98%
Are you helped to make choices about your care and treatment?	96%
Do you have a care plan?	98%
Do you understand what is in your care plan?	96%
Were your views taken into account when medication was prescribed by this ward?	90%
Have you had a weekly meeting with a nurse or doctor?	94%

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 e.g. redecoration of the dining room
- Several young people being trained on recruitment and selection so that they are eligible to sit on service user interview panels
- Several young have sitting on service user interview panels
- 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 young person writing and designing a leaflet/publication for the unit
- Young people helping create the holiday programs by deciding on activities they would like to do
- Young people volunteering to participate in the QNIC self review young person interview
- Young people volunteering to lead QNIC team on tour of unit
- Parents/carers volunteering to participate in QNIC self review parent/carer interviews

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.

Due to poor response rates for the previous financial year, we are capturing results together with results from the period 1st April 2014 to 31st March 2015.

Young People

Out of the 9 completed patient exit satisfaction questionnaires that we received back:

- 8 young people said they were either *Very Happy* or *Happy* with the personal manner of staff
- 8 young people said they were either *Very Happy* or *Happy* with the overall service they received
- 7 young people were either *Very Happy* or *Happy* with the length of time before their first appointment/assessment was arranged
- 7 young people were either *Very Happy* or *Happy* with the length of time between discharge and first follow up appointment
- 6 young people were either *Very Happy* or *Happy* with how effective they found the service in helping the relationship between them and their family

- 6 young people were either *Very Happy* or *Happy* with the ability of professionals to listen to and understand the worries their families had about them

Out of the 7 completed questionnaires where young people answered questions 21a-m (2 young people chose not to answer questions 21a-m):

- 6 young people were either *Very Happy* or *Happy* with their experience of Education
- 7 young people were either *Very Happy* or *Happy* with their experience of the Nursing team
- 6 young people were either *Very Happy* or *Happy* with their experience with their Primary nurse
- 5 young people were either *Very Happy* or *Happy* with their experience of Mentalization Group

Parents/Carers

Of the 7 completed parent/carer exit satisfaction questionnaires that we received back:

- 7 parents/carers were either *Very Happy* or *Happy* with the personal manner of staff
- 7 parents/carers were either *Very Happy* or *Happy* with how professionals kept time of appointments
- 7 parents/carers were either *Very Happy* or *Happy* about the length of time between discharge and the first follow up appointment
- 6 parents/carers were either *Very Happy* or *Happy* with how we handled confidentiality and respect for their child's rights
- 6 parents/carers were either *Very Happy* or *Happy* with how information was given to their child about the nature of their problems and what to expect
- 5 parents/carers were either *Very Happy* or *Happy* about the advice given to their child about what to do while on leave

We introduced several new questions on the questionnaire this financial year. Of the 5 completed questionnaires we received back from 1st April 2014 to 31st March 2015:

- 5 parents/carers were either *Very Happy* or *Happy* with the Education provided by the service
- 5 parents/carers were either *Very Happy* or *Happy* with their experience of the Nursing team
- 5 parents/carers were either *Very Happy* or *Happy* with their experience with their child's primary nurse
- 4 parents/carers were either *Very Happy* or *Happy* with their experience of the ward doctors
- 5 parents/carers were either *Very Happy* or *Happy* with their experience of Reception staff
- 4 parents/carers were either *Very Happy* or *Happy* with their experience of the Consultant

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

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.

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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

	Admission				Discharge			
	All Available		Complete		All Available		Complete	
Measure:	Mean	SD	Mean	SD	Mean	SD	Mean	SD
CGAS	38.15	7.66	38.08	7.75	51.75	7.79	51.54	7.78
HoNOSCA								
- Young Person	25.72	7.87	27.78	7.21	16.65	8.26	16.69	8.04
- Parent	25.73	9.26	27.18	6.66	15.85	8.76	16.23	8.16
- Clinician	20.73	7.29	20.07	7.5	10.53	4.56	10.22	4.6
SDQ								
- Young Person	22.13	5.15	23.15	4.7	19.33	5.19	19.15	5.25
- Parent	19.53	7.19	19.46	5.4	17.45	4.96	17.27	5.41
ARI								
- Young Person	5.74	3.72	6.4	3.46	5.64	4.48	6.12	4.55
- Parent	7.17	3.47	7.78	3.38	5.93	2.76	5.56	3.28

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.**

Table 5: Demographic variables with respect to financial year

Variable:	2013		2014	
	N	%	N	%
Length of History				
- Less than 6 months	2	17	8	20
- 6 to 12 months	1	8	7	18
- 1 to 2 years	0	0	9	22
- More than 2 years	9	75	16	40
Prior Treatment				
- Adult Psychiatric Ward	0	0	1	3
- Early Intervention Psychosis Team	1	10	0	0
- Inpatient CAMHS	3	30	6	16
- Out-patient Community CAMHS	4	40	26	70
- Paediatric ward	1	10	4	11
- Specialist Eating Disorder inpatient unit	1	10	0	0
Carer Type				
- Both biological parents	5	42	11	28
- Single parent	3	25	10	25
- Biological parent and partner	2	17	10	25
- Formal foster parents	0	0	3	7
- Adoptive parents	1	8	2	5

- Other (e.g. Local authority)	1	8	4	10
Education Type				
- Mainstream secondary school	1	25	19	47
- Further/higher education	1	25	8	20
- No school (exclusion/no other provision)	1	25	5	13
- N/A (left school – post 16)	0	0	5	13
- Other	1	25	3	7
Carer with Psychiatric diagnosis	3	25	17	43
Abuse Type				
- None Reported	10	71	21	51
- Physical	0	0	3	7
- Sexual	4	29	3	7
- Emotional	0	0	3	7
- Multiple/Other	0	0	9	21
- Not Known	0	0	3	7

Note: 2013 represents data available for those discharged between 1st June 2013 to 31st March 2014

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.