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# WELCOME

Welcome to the CAMHS Quality Networks' newsletter, summer edition. In this issue we will be giving a brief overview of the past several months of work within the Quality Network for Inpatient CAMHS (QNIC) and the Quality Network for Community CAMHS (QNCC), along with independent contributions from select network members.

QNIC has just finished its 15<sup>th</sup> Cycle with a total of 117 units participating in the process, both internationally and here in the UK. Nearly a third of our member units have been involved in the accreditation process, showing a clear commitment to quality improvement across the network.

As usual, our Annual Forum, this year in York, was well-attended. Over 150 service representatives appeared at the workshops, presentations, and the afternoon debate, using the opportunity to network with other services.

QNCC, now in the middle of its 11<sup>th</sup> Cycle, has also been developing throughout 2015. Membership numbers continue to increase and units continue to show impressive levels of engagement across the board.

We would like to thank all those who offered contributions to the newsletter this year. It was great to see the variety of innovative ways that professionals are working to improve the quality of CAMHS care for their units. We look forward to hearing from many more over the next cycle.

## Upcoming Dates for your Diary

### Participation Special Interest Day

Wednesday 13th July — Royal College of Psychiatrists — London

### Social Media Special Interest Day

Monday 19th September — Royal College of Psychiatrists — London

### Accreditation Training

Monday 5th September — Royal College of Psychiatrists — London

### Accreditation Training

Wednesday 12th October — Manchester Art Gallery — Manchester

### National CAMHS Conference — QNCC Annual Forum

Wednesday 23rd November — Royal College of Psychiatrists — London

### Teachers Special Interest Day

Monday 5th December — Royal College of Psychiatrists — London

*If you would like any more information about any of these events, or would like to book a place, please contact the CAMHS team on 0203 701 2663 or email [harriet.clarke@rcpsych.ac.uk](mailto:harriet.clarke@rcpsych.ac.uk)*

## Do you like Art?

The Young People's Centre is a multi-professional CAMHS community based service working with young people between the ages of 14 years and 18 years living within the Greater Belfast area. We serve a population in Belfast Trust area of 340, 000 (child & adult). The service operates, via appointment, generally from 9-5 Monday – Friday. Evening clinics are available also.



*Young People's Centre Belfast*

The Young People's Centre has the advantage of being housed within an old terraced red brick building, having plenty of character, but having become somewhat in need of refurbishment over time. Following a refurbishment of our building in 2013 it was looking fresh and new, but somewhat clinical. Inviting comments from our service users around what they thought of their new building, amongst many

positive comments, it was suggested that they felt the walls were too blank and clinical. In specific, the new waiting area had a large blank wall which was the perfect blank canvas for some art work. It was the constructive service user feedback that inspired us to think about how we could get our young people involved in deciding what to put on the walls, being their building as much as it was ours, and being unsure what our young people and families would see as aesthetically pleasing.

This was the beginning of a partnership with Artscare who have a number of artists working within the Belfast trust to create artwork alongside children, adults and staff throughout the various services and facilities. We made contact with Andrea Spence, artist in residence, and agreed that she would come and meet with some young people who may be interested in being a

part of creating an artwork for the waiting area. In terms of recruitment, posters were placed on the walls in the waiting room and clinical rooms inviting anyone interested in being involved to tell their therapist or leave their name at reception. Around 15 people initially expressed an interest and were invited to come and meet with two of the Young People's Centre staff and the artist. After meeting with the young people and sharing ideas about artwork, themes about



*YPC staff, Artscare and service users at the Artwork 'launch'*

journeys, seasons within life, psychological growth and change began to emerge when thinking about their time in the YPC. We decided that our final artwork would be a tree, to represent growth and capturing the idea of changing with the seasons. The artwork was completed over five sessions with an outline of a giant tree being collaged with different colours to represent the different seasons. We eventually mapped these onto 24 smaller canvases. Although there was value in the whole group working together on producing the tree, during the later sessions some of the young people expressed the desire to complete something unique to themselves on the artwork also. For this reason we created a variety of animals and wildlife, for example, owls for the branches and foxes for the undergrowth. These animals were largely hand drawn and had verses and text woven throughout them, in this way being personal to the young people and their own particular journey. The artwork was secured to the waiting room

wall and has remained a visual focal point and a topic of conversation ever since.

The feedback we have had on this project has been overwhelmingly positive. Alongside comments about the quality of the end product, there was a strong sense that the young people themselves enjoyed being part of a project that did not involve them talking about their mental health, but just involved them engaging in artwork and expressing themselves in a different way.

We formally launched the artwork with a coffee morning for service users and their families and invited also other services and our Children Services Manager to celebrate this partnership. Since this artwork was completed we have continued our partnership with Artscare and have completed a second project involving clay and mosaic pieces for our new art room. Our third project involves an artwork involving young people, parents and staff and this is something we are very excited about.



*Completed Artwork in the waiting room*

In times of increased waiting lists and demand upon clinical time it is refreshing to be reminded about the need to continue to support projects that impact positively on mental health and wellbeing asides from formal psychological therapies. It also continues to be important to hear the voice of our young people, to give them ownership

of their care and their building, and to never cease to find creative ways of engaging them.

**Dr Caroline Thompson**, *Clinical Psychologist, Young People's Centre, Belfast*



*Plaque*

## Meet The Team:

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Edited by Tom Johnstone

## **Re-feeding treatment and the impact on clinicians**

Department of Health officials have brought to our attention and asked us to share the findings of a paper which is being prepared for publication. The findings were presented at European Council on Eating Disorders (ECED) meeting in 2015. This is the abstract from that presentation:

### ***Against their will: The psychological impact on clinicians who force-feed patients***

**Richard Sly**, Lecturer in Mental Health, University of East Anglia  
**Lisa Cotter**, University of East Anglia  
**Catherine Houlihan**, University of East Anglia

*When anorexia threatens the life of a patient, it is sometimes necessary to use forced treatment. This often involves tube feeding the patient against their will, and there is evidence to suggest that this is happening with increased regularity in the UK. Up to now, there has been little attention paid to the impact that this treatment approach has on those clinicians who have to turn from carers into enforcers. These processes are of great importance to understand: clinicians who have to perform such duties require appropriate levels of training and supervision to enable them to cope with these experiences. This is particularly salient when considering the risks of burnout, sick leave, and compassion fatigue that may lead to poor standards of care if these needs are left unaddressed. This is the first study to address these issues. In depth interviews with 12 specialist eating disorders clinicians in the UK explored their experiences of delivering forced care for patients with anorexia. Interpretative phenomenological analysis was utilised to identify core themes of these clinicians experiences. These core themes include: (1) A difficulty in managing a dual role of carer/*

*enforcer; (2) issues of physical and psychological safety; (3) burnout both on the micro (short term, individual) and macro (long term, team) level; and (4) dehumanisation of the patient and disassociation from the act of force feeding. This study identifies key issues that clinicians experience when faced with working with patients who require coercive forms of treatment. It also discusses ways in which these clinicians and clinical teams can be supported based on these findings, and contains recommendations for updating guidelines and policies for this important area.*

This recent study has highlighted that the rates of providing involuntary treatment to treat anorexia nervosa via the enforcement of re-feeding has risen. This may well be a direct correlation with the rise in number of people who are severely ill with eating disorders being admitted to hospital. Incidentally, there has been a reduction in the past year, but this came after a period of a decade of increases in admissions. (HSCIC Monthly Hospital Episode Statistics, March 2016)

While the study itself will have limitations, we have been asked to draw everyone's attention to the Junior Marsipan (Managing Really Sick Patients with Anorexia Nervosa) guidance for children and young people (pages 42-47) (<http://www.rcpsych.ac.uk/files/pdfversion/CR168nov14.pdf>) and the overall guidance for all ages ([http://www.rcpsych.ac.uk/pdf/CR189\\_a.pdf](http://www.rcpsych.ac.uk/pdf/CR189_a.pdf)) which sets out how to manage re-feeding in detail.

We know that all staff need to balance the benefits against the risks of such treatment and that re-feeding involuntarily can be a necessity to save lives. Clinical supervision and support for staff is needed across multi-disciplinary teams to manage such difficult issues. We would be grateful if you could draw the relevant aspects of this guidance to the attention of your teams as a reminder.

## ***The importance of young people involvement in mental health services***

My first year as a young person's advisor has opened my eyes to both the wonderful things services are doing, and also to the issues within the mental health system. I have enjoyed every review I have been fortunate enough to participate in. Despite the nerves during the first few reviews, I always left feeling amazed at staff members' dedication and hard work in helping young people and their families. My experiences so far have enabled me to widen my knowledge about the mental health system and deepen my passion for helping others.

I feel privileged to be able to engage with young people and families during the reviews and for the opportunity to hear and express their views on the service. Perhaps it is because I am able to relate to their experiences that I am able to understand how frustrating and tiring restrictions and changes can be; however I feel determined to give service users a voice. I constantly find myself amazed at how incredibly strong and brave young people and their families are, and also how hard services are trying to meet the increasing needs of young people and their families.

What is most gratifying for me about the work of a young advisor is that we are able to help clinicians develop strategies that will benefit future service users, allowing their journey and experience with the CAMHS to be a positive one. One of my big aims as an advisor is to highlight the importance of the involvement of young people in shaping services. We are able to promote and encourage service user involvement so that community CAMHS and inpatient units are able to develop further and ultimately create more effective and beneficial strategies. Young advisors can encourage this by exploring new ways to involve young people and families with the teams to further

advance care and treatment, therefore giving us the opportunity to work with clinicians to reduce young people's anxieties and struggles by implementing changes. Ideas that have come up include young persons' interview panels or peer support, where recovered ex-service users come and talk about treatment with a new service user. It is through these kind of ideas that mental health services can explore and meet the needs of young people and provide effective and successful support and treatment.

It fills me with pride at how we as advisors are able to provide a voice for young people and their families thus shaping the service with service user's suggestions. Young people's involvement is vital as it means that future service users are more likely to have a positive experience with the service rather than a negative one. My experience working with the college so far has been invaluable. It has enabled me to reflect on both my positive and negative experiences and made me appreciate how incredible some staff members were during my treatment. I look forward to the many more reviews, training days and young advisor's days that are to come and I can only hope that my involvement is helping make a difference for current and future service users.

**Hayley May**, *Young Person Advisor*

### **Puzzle Corner**

Working in CAMHS involves understanding a lot of acronyms. Can you fill in the blanks and work out what these stand for?

**DBT:** D \_\_\_\_\_ B \_\_\_\_\_ Therapy

**CPA:** Care P \_\_\_\_\_ A \_\_\_\_\_

**MDT:** M \_\_\_\_\_ D \_\_\_\_\_ Team

**BMA:** B \_\_\_\_\_ Medical A \_\_\_\_\_

**PWP:** P \_\_\_\_\_ Wellbeing P \_\_\_\_\_

## ACCREDITED SERVICES

Accreditation is the means by which we measure excellence within inpatient CAMHS care, and we would like to congratulate the following services on currently achieving this status:

### QNIC

- The Evergreen Centre
- Galaxy House
- Junction 17
- The Iveagh Centre
- Riverside Unit
- Stephenson House
- Acorn Lodge
- Chalkhill Inpatient Unit
- The Darwin Centre
- Collingham Child and Family Unit
- Dewi Jones Unit
- Coborn Centre
- The Junction
- Horizon Unit
- Mildred Creak Unit
- Simmons House
- Maple Ward
- The Sett
- Snowfields Adolescent Unit
- Mulberry Unit
- Orchard Unit
- Hope Unit
- Beechcroft Ward 1
- Ash Villa

### QNCC

- CHATTS
- Portsmouth City CAMHS
- St Helens CAMHS
- Warrington & Halton
- Wigan CAMHS
- Portsmouth LD CAMHS

## Experiences of Recovery in Tier 4 CAMHS

'Recovery' has previously tended to mean a reduction in clinical symptoms, simple as that. However, with the advent of the Recovery movement and an increasing acknowledgement of the views of those who use services, its meaning has become much more diverse. The recovery movement stresses the importance of finding and maintaining hope: believing in oneself; having a sense of personal agency; remaining optimistic about the future (BPS, 2009). Rachael Perkins (2012) describes recovery as "... making sense of, and finding meaning in, what has happened; discovering your own resources, resourcefulness and possibilities; building a new sense of self, meaning and purpose in life; growing within and beyond what has happened to you; and pursuing your dreams and ambitions." The Recovery movement has been spear-headed by experts through experience, such as Liz Pitt and colleagues (Pitt et al, 2007) in the context of psychosis, who highlighted the importance of complex and idiosyncratic processes, which often involved rebuilding life, rebuilding self and hope for a better future. This seminal paper underlined the significance of subjective experience in a hitherto highly medicalised field.

Tier 4 or inpatient CAMHS services have traditionally demonstrated outcomes by clinician-rated measures of symptoms and functioning, general satisfaction questionnaires or condition-specific standardised outcomes. There are many subjective recovery measures in circulation more widely, but none as yet that capture the specific journey that a young person makes during their time on an inpatient ward. The purpose of an inpatient admission is often to facilitate engagement with stepped-down services, to empower young people with the tools and resilience to work with community CAMHS teams or placement providers, rather than to move below 'clinical cut-offs'. Despite this aim, we are lacking

in the facility to measure this outcome in a standardised way. What do young people notice on discharge.....A renewed sense of self? A better understanding? Slightly less hopelessness? Higher levels of perceived support? Normalisation and validation of difficulties? The research in this area is severely lacking and the ideas above emerge from my own clinical experiences, personal values and academic awareness, rather than any idiosyncratic, personal experience, which is much less than the young people we work with deserve.

The field as it stands paints a complex picture. Adolescents report feeling as though they are 'living in an alternative reality' while as an inpatient, and a sense of disconnection that might have far-reaching negative effects (Haynes, Eivors, and Crossley, 2011). In contrast, other groups have highlighted a strong sense of control and collaboration, and the importance of peer relationships in the inpatient journey (Offord, Turner and Cooper, 2006). In the adult literature, qualitative studies have identified that therapeutic relationships are a key part of users' experience of inpatient admission (Gilburt et al, 2008; Hughes et al, 2009); those deemed as positive characterised by effective communication, cultural sensitivity, and the absence of coercion (Gilburt et al, 2008). It is not clear whether similar themes apply for young people in tier 4 CAMHS services, and how the experience of inpatient care relates to idiosyncratic concepts of recovery.

In order to fulfil the need for a more subjective, user-defined concept and therefore measure of recovery, myself and a team from the University of Manchester are embarking on a 3-phase project to establish a new outcome measure for Tier 4 CAMHS. The process will involve the qualitative identification of themes, generation of items to form a measure and psychometric validation of the measure in terms of reliability and validity. Our aim is to involve young people who use our services from the

outset, initially conducting focus groups as part of our standard practice to gather their views on the current way we measure our effectiveness. We will begin with an exploration of what recovery means to those exiting our services, using qualitative interviews and analysis. The project is still in the planning stages and therefore we would welcome any pointers to relevant literature, hints or questions from interested clinicians and/or service user representatives.

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**Sandra Bucci**, *Senior Lecturer, University of Manchester*

**Tony Morrison**, *Professor of Clinical Psychology, University of Manchester*

## Welcome Meetings

As a family therapist working in the Wells Unit, a secure inpatient CAMHS service, I was pleased to see that this year's CQUIN targets for all secure and tier 4 CAMHS include the target of 'improving CAMHS care pathway journeys by enhancing the experience of family/carer'. And I was thrilled to see that one of the standards to be achieved for this target is 'Each provider must arrange a welcome meeting within one week of admission' (Standard 4). We developed the practice of Welcome Meetings (Bownas and Wilson, 2012) in the early days of the Wells Unit (Dimond and Chiweda, 2011). They were a response to our growing awareness that, for families, the admission to our unit of their young relatives provoked huge anxieties and was often experienced as critical or undermining of their role. We noticed that negative cycles could develop in which families became more challenging and, in response, professionals became more distancing. We wanted the young people admitted to the Wells Unit to be able to draw on the resources of *both*

family *and* professionals, so we were looking for ways of avoiding those negative cycles and, instead, forming collaborative partnerships with families and community professionals right from the beginning. Our early experiments with welcome meetings proved so successful that they soon became part of our core practice.

### **What is a welcome meeting?**

As soon as possible after admission (usually within a week) we invite family and/or other significant people from life outside hospital to come to the unit and join the young person in meeting with staff. The meeting is organised around the availability of the family. For each welcome meeting we gather as many people as we can from the MDT to meet with the family. On our unit welcome meetings are facilitated by the family therapist and the consultant psychiatrist makes it a priority to attend. Where a family therapist is not available we suggest that the welcome meeting is facilitated by a member of the team who can help the family to ask their questions without being the person to answer them.

We welcome our guests warmly and offer drinks. After introducing everyone present we explain the welcome meeting (let's call our young person 'Tom'):

*This is your meeting ... so we can all meet each other and you can ask us anything you need to know about this place and what happens here; and so you can tell us anything we need to know while we are looking after Tom. Then we can talk about how we will all keep in touch while Tom is here and, Tom, you can show your visitors around if you want to. There are quite a lot of people here and that's because we wanted you to meet us all and because we hope that, between us, we can answer any questions you might have. But we know that lots of people find big meetings difficult so this doesn't have to be a long meeting and, Tom, you can take a break any time you want – you can come and go from the meeting as often as you like.*

### **Our questions**

We have devised a series of questions to structure the meeting, although the facilitator's job is to make sure the meeting is responsive to the particular concerns of each young person and their family. The questions, addressed to the young person and his family are:

- What do you need to know about the unit and what happens here? What's most important to you? *We think this question marks a significant difference from most interactions with professionals, in that **they** get to ask **us** the questions!*
- What do we need to know while we are looking after Tom? (e.g. special needs or preferences, talents or interests, goals in life). *With this question we are positioning the young person and his family as having expertise about Tom that we want to learn from. And we are signalling that we will be working together, sharing knowledge and expertise.*
- While Tom is here, is there anything you would like us to pay attention to or help with? *With this question we are seeking a 'commission' from the young person and family (things they would like our help with) and laying the foundations for a collaborative relationship.*
- How are we all going to keep in touch?

As the family ask their questions the facilitator invites different members of the MDT to respond, according to their particular knowledge; and family members are invited to ask follow-up questions and to share their own views alongside those of the professionals. We acknowledge any differences that emerge, respecting these without pressing for agreement. Professionals are discouraged from asking for information from families that isn't spontaneously offered, though they might let the family know they would be pleased to meet at another time to hear more.

### **Benefits of welcome meetings**

We have noted a number of outcomes linked to welcome meetings:

- Families, with very occasional exceptions, express very positive views of the unit and are more supportive of the young person's treatment.
- Seeing his family/ significant people respectfully welcomed and involved, the young person is more able to make a connection between his stay in the unit and his preferred future outside hospital.
- Staff of the unit have a better understanding of the young person's family context and are able to forge on-going constructive contact with the family.
- Young person, family and professionals are able to establish shared goals and work collaboratively even where there are differences of opinion.

There are very few formal complaints received as family and staff form relationships in which differences can be spoken about and resolved or tolerated and respected.

Discharge planning is quicker and more successful because we are engaging with the 'world outside hospital' from the beginning.

#### **Comments from patient and carers:**

**Young person:** "Having my family at the meeting meant they were involved and I was not alone".

**Parent:** "This is my child's second admission to hospital. It would have made such a difference to me to have had a welcome meeting that last time. I had never been in a place like this before and I found it really hard; it's so different from the normal hospital. I didn't feel welcomed that time and a welcome meeting would have helped a lot. It's great to be able to put names to faces and I feel much more welcome this time. I have noticed the nurses are generally more friendly when I visit or even when I just ring up. Keep doing the welcome meetings!"

**Nurse:** "The Welcome meetings in my opinion are one of the best projects to be

implemented in the service in recent years. It is definitely something I think should be integrated into normal practice."

#### **References**

- Bownas, J. & Wilson, E. (2012) *Context*, 9-14
- Dimond, C. and Chiweda, D. (2011) *Journal of Forensic Psychiatry and Psychology* Vol 22, 2, 283-306 [claire.dimond@nhs.net](mailto:claire.dimond@nhs.net)

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### **International Membership**

QNIC and QNCC continue to enjoy an international presence during this cycle:

#### **QNIC**

Ireland:

- Eist Linn
- Linn Dara
- St Josephs Adolescent Unit
- Willow Grove
- Galway

Norway:

- Oslo General Adolescent Unit
- Oslo Acute Adolescent Unit

Turkey:

- Dokuz Eylul University CAMHS Inpatient Unit

Estonia:

- Inpatient Unit for Children
- Inpatient Unit for Adolescents (Tartu)
- Inpatient Unit for Adolescents (Tallinn)

#### **QNCC**

Estonia:

- Outpatient service in the Parnu Region

Dubai:

- Camali Clinic, Dubai Healthcare City

Iceland:

- National University Hospital of Iceland

## QNIC Annual Forum

June 17<sup>th</sup> saw the QNIC Annual Forum take place, this year in the beautiful city of York. Over 150 professionals, peer reviewers and young people attended the day of presentations and workshops, culminating in an exciting debate and wine reception. Our new chair Paul Abeles opened the day by celebrating 15 years of QNIC, and was followed by a project update by Harriet Clarke highlighting the promising preliminary results of another years peer reviews. It is particularly encouraging to see that once again our membership has grown, with another three units joining us including one service from Australia!

The key note speech was delivered this year by James Downs, a young adult with lived experience of CAMHS. Through his touching and honest portrayal, the audience was given a unique insight into CAMHS through the eyes of a service user, an insight that highlighted most of all the importance of considering the views the young person when approaching their treatment.

The conference then split into one of three pre-lunch workshops covering a variety of subjects. Philippa Beale and Nicky Maund from the Riverside Adolescent unit discussed



*The QNIC Team at the Annual Forum  
June 17th 2016*

*Left to right: Tom Johnstone, Andrew Gordon,  
Jasmin Halvey, Hannah Craig, Harriet Clarke,  
Emily Lesnik, Izzy Avery-Phipps, Peter Thompson*

the importance of involving parents in the treatment of young people when possible, whilst Marjorie Goold, Louise Smith and Dr Anjan Mandara from Maple Ward in Chester considered the alternatives to hospital admission. Our young person advisors also contributed a session, with Hannah Stevenson and Izzy Avery-Phipps asking how internet and mobile phone use should be controlled within a unit.

After lunch, three more workshops took place continuing to discuss contemporary issues and experiences within CAMHS treatment. Cheryl Smith and Carol Reffin from St Andrews in Northampton looked at balancing risk and vulnerability within secure ASD units, and Barbra Sowa from The Wells Unit in London talked about how engaging young people to look after their bodies can also contribute to helping them look after their minds. Finally, Vince Hesketh and Tina Gutbrod from The Croft Child and Family Unit shared their experiences of working with parents who they themselves had experienced complex trauma, and the impact it has on their child's treatment.

The day was rounded off with the infamous QNIC debate, this time titled: '*This house believes that there is no place for seclusion within CAHM services*'. Supporting the motion was Andrew Gordon, a young person's advisor and debate veteran, who squared off against Jane Whittaker, Consultant Psychiatrist and Chair of CCQI CAMHS Accreditation Committee. From the outset, it was clear Jane had her work cut out for her, with a significant majority of the audience supporting the motion. Throughout the debate, her idealism tried to pick away at Andrew's pragmatism, insisting that seclusion is only considered necessary because professionals are unwilling to consider some of the effective if slightly challenging alternatives. Andrew countered that it was naive to assume these alternatives are always going to be practical, and that seclusion is an important last resort to ensure the safety of staff and patients in

very difficult circumstances. Ultimately, this support of seclusion did maintain its audience majority by the end of the debate, although Jane did deserve some credit for managing to convert a few opinions along the way.

Many thanks to all who took part and attended; it was a pleasure to see so many professionals keen to get involved in the project and contribute to the discussions, particularly to those who had to travel from abroad to come. We are already putting together ideas for next year's forum, this time back in London, and look forward to seeing you all there.

**Tom Johnstone**, *Project Worker, QNIC*

## **Staff Wellbeing**

We are a Tier 3 CAMHS service based in Norwich as part of the Norfolk and Suffolk NHS Foundation Trust. Our Trust has undergone substantial changes and this is resonated across the country in terms of limited resources and increased demand. We all try our best to deliver the highest quality of care to our patients which can have an impact on our own emotional wellbeing.

As a part of raising staff wellbeing a group of enthusiastic clinicians have created a staff wellbeing resource which is available in our communal room. Members of staff usually meet there for coffee, lunch and team meetings. It is an ideal place for staff to catch up with each other and discuss various dilemmas.

We took inspiration from 'The Five Ways to Wellbeing': a set of evidence-based actions shown to promote people's wellbeing, developed from the UK government's Foresight Project on Mental Capacity and Wellbeing. The five steps are: Connect, Be Active, Take Notice, Keep Learning and Give. These are simple things we aim to remind ourselves and put into practice through communal activities.



*Staff Wellbeing Space*

Our resource base is very simple but highly effective. We have set up a mindfulness corner, where ideas and inspirations are posted.

These include mindfulness quotes, graphics and suggestions for activities. We also have communal activities such as coloring and jigsaws that the staff can engage in whilst focusing on how they feel and help them relax. This has become very popular and gives staff chance to unwind even briefly, which helps in their wellbeing.

Feedback from the idea has been overwhelmingly positive:

*"I never used to see jigsaw puzzles in this way. I think I will do them more now!"* – Dr Ayat Ali, CT3

*"It's very calming. I think it also helps with team camaraderie as it gets us excited about a common goal."* – Dr David Tesh, GPST

*"I think it's very cathartic!"* – Carl Fendick, Mental Health Practitioner

We have also used a similar model in the waiting room to help parents, carers and siblings to learn about mindfulness in a fun and engaging manner. We are very proud of the initiative taken by our colleagues to help us remain 'mindful' and not 'mind-full'.

**Dr Nishi Puri**, *Consultant Child and Adolescent Psychiatrist*  
**Dr Gregom Sng**, *FY2 doctor*

## Design Competition!

**Our next competition is to design the front cover of our QNCC standard revision document. This should include the network name (pictured top right) and make it clear that it is for the standards revision, but other than that it is entirely up to you! The brighter and more colourful the better!**

### **How to Apply:**

Please send your design along with these details; first name, age, unit you're from or service you visit

**By Email:** [thomas.johnstone@rcpsych.ac.uk](mailto:thomas.johnstone@rcpsych.ac.uk)

**By post:** Tom Johnstone, 21 Prescott Street, London, E1 8BB

**1st Prize: £20  
voucher**

**2 Runner-Up Prizes**

**The competition closes on September 1st  
2016**

**Conditions:** The page must include the network name 'Quality Network for Community CAMHS' in order to qualify for consideration.

**Disclaimer:** The winner will have their front cover printed in our next newsletter with their first name and age ONLY. The name of their unit/service will NOT be printed in the issue but we ask for this information so we know where to send the prize. The winner's unit/service will be notified by email, and staff will be expected to forward on their prize. We reserve the right to amend the price or close the competition at any time.

## QNIC Routine Outcome Measurement Service

**"Reliable, routine outcome measurement and data collection is a complex task that is only just beginning to be undertaken by many services. Ultimately, improving outcomes for children and young people is what matters most." - National CAMHS**

Since mid-2007, QNIC has offered an effective means of ensuring consistent and appropriate use of outcome data across CAMHS services nationwide.

### What is it?

QNIC ROM compiles, monitors and analyses outcome data collected at admission and discharge, as well as at 6-week intervals.

### Who can use it?

ROM is available to all QNIC member services free of charge.

### Why is it helpful?

QNIC standards 2.7.1-2.7.9 address in detail the routine use of validated outcome measures in order to monitor young people's progress and challenges effectively. The tools and guidance ROM provides allow units to meet these standards and obtain tangible evidence of the support they are offering.

### How do we know which data to collect?

ROM comprises data from a number of different outcome tools, including:

- Health of the Nation Scales for Children and Adolescents—HoNOSCA (Gowers et al., 1999)
- Children's Global Assessment Scale—CGAS (Schaffer et al., 1983)
- Strengths and Difficulties Questionnaire—SDQ (Goodman, 1998)
- Eating Disorders Examination Questionnaire—EDQ (Fairburn et al., 1994)
- Diagnostic specific tools (e.g. Beck Hopelessness Scale) - we encourage the use of these specific scales and will endeavour to support this data collection upon request

Baseline variables and the CAMHS measure of satisfaction are also included to account for heterogeneity within and between units.

### What happens to our data?

Once data has been collected over the course of a year, it can be uploaded onto our online data bank, SNAP, or sent directly in the form of an excel document. It can then be analysed by the ROM team and presented

in the form of a report. All names are excluded from the database and anonymity is maintained strictly.

### What do we get from it?

Once your data has been compiled and analysed, you will receive a personalised report containing graphical and statistical information. This document is considered a valued form of evidence when demonstrating quality improvement and can also provide reassurance to young people, parents, and carers.

As well as individual reports, all units' ROM data is comprised in our Annual Report, allowing members to compare outcomes with other, similar services.

### How can we sign up?

Training days will now be held at regular intervals to enrol more units onto the service. If your unit is a member of QNIC and wishes to use our ROM service, please contact Hannah Moore at [hannah.moore@rcpsych.ac.uk](mailto:hannah.moore@rcpsych.ac.uk). If you are not yet a member of QNIC and want to find out more about joining the network, please email Harriet Clarke at [harriet.clarke@rcpsych.ac.uk](mailto:harriet.clarke@rcpsych.ac.uk).

**Want to share your work or present your recent findings to a wide audience?**

**Submit an article for our next newsletter!**

Published twice a year, our newsletter reaches thousands of clinicians working in CAMHS nationwide! Articles can be as short as 700 words, comprising an introduction, main body, and conclusion.

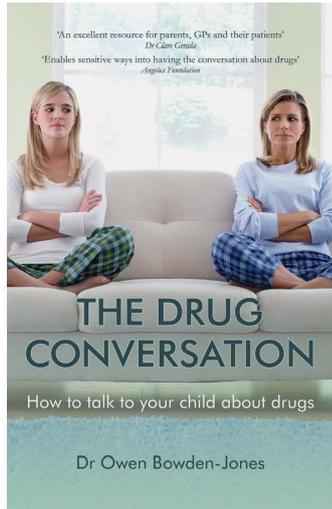
If you would like to submit an article, please send a short paragraph describing your topic to [harriet.clarke@rcpsych.ac.uk](mailto:harriet.clarke@rcpsych.ac.uk)

New book from the Royal College of Psychiatrists

# The Drug Conversation

How to talk to your child about drugs

By Dr Owen Bowden-Jones



"How can I drug test my child?" "I've just found drugs in their room, what should I do?"

*The Drug Conversation* is a guide for parents about how to raise the thorny issue of drugs with their children. It will help you begin a useful conversation about drugs with your child.

The book provides information on the different types of drugs available, their attractions and harms, how they work in the brain, and who uses them and why. It covers issues such as how to detect drug use, drug testing, synthetic drugs ('legal highs'), accessing help, effective treatments and what to expect from professional medical services.

*The Drug Conversation* also gives practical advice on how to prepare for and have a conversation about drugs with your child – including examples of actual conversations between parents and children. Case studies from the author's own clinical practice are used to illustrate the main points.

All parents will need this book at some stage. It will help you to feel properly informed about drugs, more confident in talking to your child, more able to keep drug-related problems from developing and better equipped to tackle problems if they do arise.

May 2016, paperback, 180 pages, ISBN 978-1-909726-57-4, price £12.99  
(RCPsych members' price: £11.70)

[www.rcpsych.ac.uk/thedrugconversation](http://www.rcpsych.ac.uk/thedrugconversation)

## About the author

Dr Owen Bowden-Jones is a psychiatrist and researcher with over 20 years' experience helping people with drug and alcohol problems. A father himself, he firmly believes all parents need reliable information to support an effective conversation about drugs.



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**Online ordering:** [www.rcpsych.ac.uk/books](http://www.rcpsych.ac.uk/books)

**RCPsych members** get a 10% discount.

(Please note pre-payment is required before any items can be sent.)

Book Title	Quantity	Price
<i>The Drug Conversation</i>		£12.99

**Total £**

**Airmail @ £4 per book.** (Postage and packing is free in the UK, and for surface mail to overseas destinations)

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The College's Data Protection Statement can be viewed at: [www.rcpsych.ac.uk/dataprotection](http://www.rcpsych.ac.uk/dataprotection)

Buy online at: [www.rcpsych.ac.uk/thedrugconversation](http://www.rcpsych.ac.uk/thedrugconversation)

Code: **CCQI**