Child & Adolescent Psychiatry
19th Annual Trainee Conference
Poster Presentations
Nayyera Aslam
QI Project: Approaching Uncertainty With Innovation & Creativity

Dr Nayyera Aslam, ST2 CAMHS Psychiatry Trainee; Dr Ben Parker, Consultant Psychiatrist

Livewell Southwest

Background
The Covid-19 pandemic has created uncertainty in the higher education sector and accelerated the transition towards digital platforms as a primary resource of learning. Traditionally, third year medical students at the Peninsula Medical School are allocated ward based clinical placements, provided with an Orientation Guide and tasked with specific learning objectives. In pairs, students join the Child and Adolescent Mental Health Services (CAMHS) team for a week and follow a weekly schedule of events including: face to face outpatient clinics, multidisciplinary team meetings, ward rounds and clinical assessments. Following the Covid-19 outbreak, existing pedagogic practices need to be re-evaluated to help deliver a safer and sustainable CAMHS placement programme for third year medical students.

Aim
To evaluate the suitability and sustainability of virtual learning resources and e-learning tools implemented through the CAMHS Orientation Guide for third year medical students attending a 5 day placement in CAMHS.

Method
The traditional CAMHS Orientation Guide was redesigned with a timetable of virtual clinics and a range of self-study virtual learning tasks including; a) five online e-learning modules with computerised self-assessments, b) four written patient case studies with links to online resources and c) two video based learning tasks with questions (see Figure 1). A feedback questionnaire containing a mixture of nominal and continuous questions was included in the CAMHS Orientation Guide and each student was allocated a face-to-face feedback appointment to share their perspectives and experiences on the e-learning tasks and online activities. Data from the feedback questionnaires will be collected across four months during the first university trimester.

Results
Data collection for this QI project is currently in progress until December 2020. A 100% response rate for the questionnaires is anticipated. A univariate analysis will be performed on the responses provided to extrapolate meaningful evaluation of common themes, such as achievement of learning objectives, satisfaction with overall design, content and usefulness of e-learning resources implemented in the CAMHS Orientation Guide. A summary of outcomes and recommendations will be provided to Peninsula Medical School.

Discussion
The rapid migration to digital learning environments and use of remote online learning is now forecasted to have a significant role in the future of higher education. Delivering interactive digital content to students can be an effective alternative to traditional pedagogies, enrich the quality of educational experiences and bridge the potential gaps in learning. However, for third year medical students, observing face-to-face doctor-patient interactions cannot be substituted. A Mental State Examination (MSE) including assessment of verbal and non-verbal communication, behaviour and physical appearance can often be very difficult to interpret during video and telephone consultations between clinicians and patients. Self-paced virtual learning activities can also limit collaborative learning opportunities between students and create impersonal learning experiences.

Conclusion
The development and delivery of a successful and sustainable e-learning CAMHS Orientation Guide during and beyond the COVID-19 pandemic, necessitates careful and continuous evaluation of medical students’ expectations and experiences.
Rory Barr
Clinical Audit of recording height/weights in YPU

**Introduction**
- Working in 10 bed Young Persons Unit.
- Common reason for admission is eating disorder.
- Protocol defines where height and weights should be recorded, calculated and plotted.
- All separate entries for height/weights/BMI to be manually entered.
- Duplication of work in entering same information multiple times in different places.
- Benefits of duplication of data, and work?
- Risk of redundancy, more likely to introduce errors.

**1st loop steps**
- Identify relevant standards as defined by Edinburgh Eating Disorder Protocol for YPU.
- All notes for inpatients with Eating Disorder reviewed.
- Scored each set of notes against standards.

**Results of 1st loop**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Drug chart weight</td>
<td></td>
</tr>
<tr>
<td>Weekly weight chart admission</td>
<td></td>
</tr>
<tr>
<td>Investigations consent form - weight</td>
<td></td>
</tr>
<tr>
<td>Height admission form</td>
<td></td>
</tr>
<tr>
<td>Admission form - weight</td>
<td></td>
</tr>
<tr>
<td>70% (basically clinical note)</td>
<td></td>
</tr>
<tr>
<td>BMI calculated and plotted on chart</td>
<td></td>
</tr>
<tr>
<td>Weight plotted on chart</td>
<td></td>
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<tr>
<td>Height plotted on chart</td>
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</tbody>
</table>

**2nd loop steps**
- Repeat audit using new standards, looking at 7 rather than 9 data points, 3 of which were automatically calculated (as rather than entered for division).
- Scored against standards for all inpatients with eating disorder.

**Results of 2nd loop**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Drug chart weight</td>
<td></td>
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<tr>
<td>TRAM - adm height</td>
<td></td>
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<tr>
<td>TRAM - adm weight</td>
<td></td>
</tr>
<tr>
<td>70% (BMI)</td>
<td></td>
</tr>
<tr>
<td>BMI calculated and plotted on chart</td>
<td></td>
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<tr>
<td>Weight plotted on chart</td>
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<tr>
<td>Height plotted on chart</td>
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**Conclusions**
- Intervention led to significant improvements in meeting standards.
- Benefits include less duplication of data (and therefore clinician work), better accessibility of that data, and reduced risk of transcription errors.
- I suggest that we all recognise occasions where clinicians duplicate work, with no additional benefits, and examine if that process can be streamlined.

**Recommendations**

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Aim to input data only ONCE, unless duplicating leads to clear benefits.</td>
</tr>
<tr>
<td>Examine &quot;low hanging fruit&quot;, e.g., existing IT systems which can record and automatically calculate and display information like BMI for quick wins.</td>
</tr>
<tr>
<td>Work with colleagues to make sure any changes are discussed, understood, and agreed to maximise chances of achieving sustainable change.</td>
</tr>
<tr>
<td>Encourage spirit of innovation and curiosity within our teams, always looking for opportunities to improve.</td>
</tr>
</tbody>
</table>
Background
ADHD is a highly heritable developmental disorder. Young people with ADHD are at increased risk of alcohol misuse and are more likely to develop other substance misuse disorders. Studies have shown that the prevalence of individuals who met diagnostic criteria for a substance use disorder was 15% in those with ADHD, as opposed to 5.8% of those without this disorder. In addition, it is estimated that 25% of adolescents who have misused substances meet diagnostic criteria for ADHD. We know that the overlap between these disorders is not coincidental, indeed ADHD and substance misuse have both been described as disorders of disinhibition. This may suggest an underlying vulnerability that is shared between both disorders. Alternatively, features of ADHD, such as impulsivity, may increase the risk of initiating substance misuse. This project aimed to increase awareness of the links between ADHD and substance misuse, provide information and support for young people and their families.

Objectives
**Phase 1:** 20 ADHD patient records from the ADHD clinic list were selected using a random number generator. These charts were retrospectively reviewed using a pre-designed proforma to gather data including patient age, gender, diagnosis, comorbid conditions, history of substance Misuse, current substance misuse and treatment(s) offered. This provided an overview of the current provision for discussion and support specific to substance misuse issues in those with a diagnosis of ADHD.

**Phase 2:** Following literature search and linking in with the local substance misuse team; a substance misuse information leaflet was compiled. This leaflet provided information for young people and families detailing the links between ADHD and substance misuse, as well as supports available. This leaflet was distributed amongst a randomly selected cohort of patients attending ADHD clinic over a one month period. Patient satisfaction was assessed using a predesigned semi-structured questionnaire. Within the follow-up period we received 15 completed questionnaires.

Results
**Phase 1:** 40% of the ADHD cohort had documented co-morbidities, the most common being a diagnosis of Autism Spectrum Disorder. The mean age was 14.5 years and 80% of the cohort were male. 30% of individuals were currently misusing substances. All of these individuals were male. 20% had no documentation pertaining to substance misuse or not. Cannabis was the most common substance of misuse represented in two-thirds of current cases. This data identified a need for improved communication regarding substance misuse within the ADHD clinic.

**Phase 2:** 53% of respondents stated that the leaflet helped them to understand the problems ‘somewhat’, whilst 40% of respondents felt it helped ‘a great deal’. 93% respondents felt that the leaflet helped them to cope with problems better, either ‘somewhat’ or ‘a great deal’. All respondents stated that they would recommend the information leaflet to a friend or family member. Opportunity for free text was also offered. Within this written feedback, families welcomed the opportunity to initiate discussion around substance misuse, using the information leaflet as a guide.

Conclusion and Recommendations
In this cohort substance misuse in ADHD was common and potentially under-represented due to highlighted shortfalls in discussion of this issue at routine ADHD appointments. The introduction of this leaflet in the course of the QI project has opened up opportunities for discussion and further support for young people and families. Given the positive feedback, the leaflet will be provided to attendees of routine ADHD clinic appointments to facilitate discussion and allow opportunity for earlier intervention and support.

References
NICE. (2018). Attention Deficit Hyperactivity Disorder: Diagnosis and Management [Online]. https://www.nice.org.uk/guidance/ng157/chapter/recommendations
Naashoma Pereira Carvalho
Impact of COVID-19 in the management of Under-16s presenting to the acute hospital with self-harm

Naoshima Pereira Carvalho, Kim Pierson, Hadi Shaker-Naeeni
Hertfordshire Partnership NHS Foundation Trust

Introduction
Suicide remains the second most common cause of death among young people. Self-harm is an important indicator of distress and it requires appropriate, timely interventions. The aim was to assess the changes due to Covid-19 in the service response and compliance with NICE and RCPych guidelines for under 16s presenting to the acute hospital with self-harm.

Guidelines
In line with NICE guidance, young people under the age of 16 seen in the emergency department following acute self-harm presentations should be admitted overnight. Admission should be to a paediatric, adolescent or mental ward or to a designated unit. This is indicated regardless of the individual's chronological age so that comprehensive physical and psychological assessments can occur and management/crisis intervention can be planned and instigated.

Discussion
Of the 25 patients under 16 – in 2019, 24 were assessed by the Children’s Crisis Assessment and Treatment Team (C-CATT) and 1 was assessed by a junior doctor. In 2020, all were assessed by C-CATT as C-COCT, now functions 24/7 and provides patients presenting to the acute hospital. This change in operational hours for C-CATT was in response to the Covid-19 pandemic. 43% more young people (10-18 years) have presented to the acute hospital in September 2020.
A similar increase of 48% in young people under 16 was observed, with the proportions of the over and under 16 being quite similar in 2019 and 2020. However, the number of young people under 16 presenting with suicidal ideation increased by 133% which is well above the overall increase of 43% with nearly 4 in 10 (96/2120) versus nearly 2.5 in 10 (61/2120) presenting with suicidal ideation.

Conclusions
Increase in total presentations during Covid-19 pandemic by 48% may be due to multiple factors as shown in recent studies. Young people struggling to cope as they return to school after months of living through the Gor 19 crisis. Change in family dynamics with changes in parents' working circumstances; Parent and child anxieties about Covid-19 and wellbeing; Access to education and health services.

64% compliance with the guidelines on admission of under 16s with self-harm in 2020 fell to 26% in 2020. Likely factors for further study are:
- Patients and parents choice to be discharged during Covid-19.
- Limiting admissions to reduce the risk of exposure to Covid-19.

References
- RCPSych CRSSD: Managing self-harm in young people; NICE GUIDELINES for 19 Special issues for children and young people (under 16 years); Children’s Crisis Assessment & Treatment Team (C-CATT) Operational Policy; YOUNGANDNESS: Coronavirus: Impact on young people with mental health needs - Autumn 2020; Mental health of children and young people in England, 2020. Wave 3 follow-up to the 2017 survey.

Results

<table>
<thead>
<tr>
<th>Category</th>
<th>Sep 2019</th>
<th>Sep 2020</th>
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</thead>
<tbody>
<tr>
<td>0-18 Years with Mental Health Crisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 &amp; Over</td>
<td>47</td>
<td>67</td>
</tr>
<tr>
<td>Under 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 16 – Other mental health problems</td>
<td>47%</td>
<td>45%</td>
</tr>
<tr>
<td>Under 16 – suicidal ideation</td>
<td>55%</td>
<td>55%</td>
</tr>
<tr>
<td>Under 16 – self harm</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Under 16 with self harm - Discharged</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Under 16 with self harm – Admitted overnight</td>
<td>26%</td>
<td>26%</td>
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</tbody>
</table>

Not over 16 yrs 46%
Naomi Entwistle
The subject of rejected CAMHS referrals has been prominent in the media over the past few years. Data published by Public Health Scotland shows that referrals to CAMHS continue to rise and that around 1 in 5 referrals are rejected by the service. A Scotland-wide audit in 2018 found that families find rejected referrals distressing and frustrating, especially without a face-to-face assessment. Although 66% of rejected referrals included signposting, many families felt this was generic and unhelpful. 20% of survey respondents said that they had sought re-referral, although the study did not assess what proportion were subsequently accepted. The study has called for all young people referred to CAMHS to receive support from either CAMHS or another agency.

The Midlothian CAMHS team is a tier 3 CAMHS service in South East Scotland. Referrals may come from GPs, schools or social workers. All referrals are reviewed by two community mental health workers and allocated to a team and appointment, a choice appointment, or assessed as not suitable for CAMHS. Rejected referrals may be forwarded to another appropriate service or returned to the referrer. The referrer may be given information about other services and for the team’s consultation clinic, which allows professionals to seek advice about a young person without referrin CAMHS. This project looked at all referrals to the Midlothian CAMHS team over a 6 month period to ascertain how many young people whose referral had been rejected or re-directed were re-referred within the following 6 months. This included referrals both to the general CAMHS team and to the ADH team and assessment service.

**Objectives**

- Assess the proportion of referrals to the Midlothian CAMHS service which are not accepted and compare this to national data
- Assess the proportion of individuals who are re-referred within 6 months of their initial referral
- Compare rates of re-referral between those who are not accepted and those who are re-directed to other services
- Evaluate whether the provision of advice to the referrer or signposting to other services or organizations is effective in reducing re-referral rates

A report was obtained from the IT service detailing all referrals made to the sector CAMHS team within a 6 month period. The original referrals were then obtained from computerised records, along with the response letter that was sent if the young person was not accepted for further assessment. The outcomes of these referrals were coded as: returned without advice, advised about the consultation clinic, returned with signposting to non-NHS service (educational psychology, social work, Sleep Scotland or other sector counselling services), or redirected to another NHS service (community child health, paediatric liaison service, specialist trauma team or learning disability). Computerised records were then examined to assess the proportion of these individuals that were re-referred within 6 months and the subsequent outcome was documented.

**Method**

**Fig 2: Rejected referrals by type**

- **Total referrals:** 317
- **Urgent CAMHS:** 24 (7.6%)
- **Routine CAMHS:** 142 (44.9%)
- **ADHD:** 151 (47.4%)

**Fig 3: Outcome of initial referral at 6 months**

- **Accepted:** 49 (15.5%)
- **Not referred in 6m:** 17 (5.4%)
- **Referred and accepted:** 106 (33.5%)
- **Referred and rejected:** 146 (45.9%)

**Results**

- There were 317 referrals over the 6 month period, 87 of which were to general CAMHS and 13% for ADHD assessment.
- 19% of young people referred were not accepted for further assessment.
- 14% of referrals were marked as urgent. 90% of these referrals were accepted, and the remainder clearly did not meet the criteria.
- The most common reason for a referral to be rejected was for behavioural disturbance without evidence of accompanying mental illness. 77% of rejected referrals were signposted or redirected elsewhere: 30% to non-NHS services, 28% elsewhere in the NHS and 20% to the consultation clinic.
- 18% of rejected referrals were re-referred within 6 months, and 82% of these were accepted at the time of re-referral.
- Referrals were slightly more likely to be re-referred if they were given no advice at the point of rejection (23% of 18%), and less likely if signposted to a non-NHS service (4%). Of those who were redirected or signposted elsewhere, re-referrals were most likely to come from consultation clinic (33% of those signposted), paediatric liaison (10%) or CCG (17%), although these numbers were small in absolute terms.

**Fig 4: Rejected referrals by type**

- **Returned without signposting:** 100 (31.5%)
- **Signposted to non-NHS service:** 45 (14.2%)
- **Redirected to other NHS service:** 126 (39.6%)
- **Advised about consultation clinic:** 46 (14.5%)

**Fig 5: Proportion re-referred within 6m**

- **Returned without signposting:** 100 (31.5%)
- **Signposted to non-NHS service:** 45 (14.2%)
- **Redirected to other NHS service:** 126 (39.6%)
- **Advised about consultation clinic:** 46 (14.5%)

**Conclusions**

- The overall percentage of rejected referrals to this service is in line with the national average.
- A greater proportion of rejected referrals were signposted elsewhere than the national average (77% vs. 60%).
- It is important to provide referrers with clear guidelines for urgent referrals. All referrals that met these criteria were accepted for assessment.
- Consultation clinics are an effective method of supporting other professionals who work with children and young people and may help to prevent unnecessary re-referrals.
- It is important for clinicians who are reviewing referrals to have a clear understanding of services offered by other local services (NHS, government, and third sector). Appropriate signposting is effective in reducing re-referral rates.
- There is a significant gap in local tier 2 service provision, such as parenting courses and emotional regulation skills, as suggested by the proportion of rejected referrals related to behavioural disturbance without evidence of accompanying mental illness.

**Questions for further work**

- What are the re-referral rates beyond 6 months?
- What are the reasons for re-referrals being accepted: eg. more detailed referral, change in circumstances, deterioration in mental state, failure of previous recommendations?
- Does signposting affect long-term outcomes for young people as well as impacting re-referral rates?
- Are there any differences in outcome between young people whose referral was initially accepted and those whose referral is accepted at a later date?
- What is the subjective experience of referrers, young people and their families of the referral process?

**References**


**Acknowledgements**

Many thanks to Dr Nicky Cannon and the Midlothian CAMHS team.

Correspondence to: nemo.entwistle@nhslothian.scot.nhs.uk
Sundar Gnanavel
Introduction

- 50% of all psychiatric disorders start before the age of 14.
- Knowledge of developmental psychopathology is relevant for all psychiatric trainees, including non-child psychiatry trainees.
- The UEMS Psychiatry training requirements for the specialty of psychiatry states that training for all psychiatric sub-specialities should include exposure to psychiatric conditions throughout the life span.
- However, training in Child and Adolescent Psychiatry (CAP) is not mandatory in many national training programs for psychiatric trainees.
- Large variations in how CAP training is delivered in the national training programs are noted across Europe.

Aims and objectives

- To investigate the scope and the quality of training in child and adolescent psychiatry (CAP) in adult psychiatry training programmes across Europe.
- To explore the trainee perceived needs for training in CAP across Europe.

Methodology

- An online survey instrument was developed in consultation with members of CAP working group of EFPT through online panel discussions.
- This was peer reviewed by senior colleagues in child psychiatry across Europe.
- The survey instrument was developed composed of ten questions and would take approximately ten minutes to complete.
- It was pilot tested among selected participants.
- Later, it was distributed through the member organizations of the European Federation of Psychiatric Trainees (EFPT).
- Time frame for data collection: June-December 2019.
- Response rate: 65% (n=242)

Results

- Quality of the CAP training.
- Confidence in management of CAP patients.

Implications

- Significant variation in the scope, methods and quality of CAP training in adult psychiatry training programs across Europe from the trainee perspective.
- Need to harmonize and standardize child psychiatry training for psychiatric trainees in other sub-specialties across Europe.
Parul Jha
Telepsychiatry in CAMHS
Adapting to the Covid-19 Pandemic

What is Telepsychiatry?
Telepsychiatry is the delivery of mental healthcare services using technology, often using videoconferencing. Telepsychiatry can be used for a range of remote areas, improving access to care, reducing travel costs, and improving mental health outcomes through improved data sharing and research. Telepsychiatry can also help in reducing the healthcare costs and improving the healthcare system by making it more accessible.

Mini-case series demonstrating Telepsychiatry in CAMHS

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
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</thead>
<tbody>
<tr>
<td>Flexibility to attend appointments</td>
<td>Technical issues with hardware or software</td>
</tr>
<tr>
<td>Time-saving for patients</td>
<td>Limited access to after-hours care</td>
</tr>
<tr>
<td>Improved patient satisfaction</td>
<td>Patient privacy concerns</td>
</tr>
<tr>
<td>Increased access to care</td>
<td>Technical issues with hardware or software</td>
</tr>
</tbody>
</table>

Adapting to Telepsychiatry in CAMHS

- Setting up Video Conferencing
- Setting up Free-screening system
- Setting up a virtual environment for appropriate remote working

Teledermatology around the world

Trainee Experience of Telepsychiatry

- Online training & e-learning
- Allowing remote platforms to provide joint consultations
- Steps up in leadership & management roles
- Strain on mental health due to stress of Covid-19
- Strain on physical health due to isolation

Lessons from other countries

- Collaboration, participation and capacity building
- Investment needed to increase capacity
- Well-organized stakeholder collaboration
- Organizational and engagement tailored to context in which it works
- Tailored to local availability of resources, needs, strengths and weaknesses
- Education plan for upskilling, transferability and self-learning

Lessons to take forward

- Consider creative uses of new telepsychiatry platform for services
- Consider creating + implementing guidelines and “gold standard” for online platform
- Reflect on what is lost using this platform and ways of addressing it
Aneesa Karim
Treatment of Anorexia Nervosa in Young People with Autism: A Literature Review

Dr Anessa Karim
ST3 in Child and Adolescent Psychiatry
Adolescent Inpatient Unit, West of Scotland

Introduction
Previous research has suggested that there is a lack of representation of autistic traits in anorexia nervosa. There are implications for treatment options for young people with autism and autism. Young people with autism may find it more difficult to engage in psychological treatments for eating disorders due to cognitive and behavioural inflexibility, or communication difficulties. Researchers are therefore looking at other options for treatment.

Methods
This is a narrative review. Search was conducted in January 2023. Keywords used were “anorexia nervosa” combined with “autism” combined with “treatment.” Only published, peer-reviewed, full articles in English were included. Search of OVID (for Medicine, Psychiatry, PsychInfo, Embase and LIMIC databases) gave a result of 222 articles. 8 articles met the inclusion criteria. Searches of CINHAL gave a result of 12 articles. 3 articles met the exclusion criteria (as the redaction criteria had but been reviewed following OVID search).

Results
COGNITIVE REMEDIATION THERAPY (CRT)
- CRT was designed to improve cognitive flexibility and bigger picture thinking, encourage reflection on thinking styles and use awareness of cognitive styles in reality situations.
- Tischler et al. (2010) studied how 35 adult anorexia nervosa patients with high and low autistic traits related to 8 sessions of group CRT. Patients with low autistic traits had statistically significant better effect size improvements in cognitive rigidity and self-reported ability to change. Patients with high autistic traits showed no statistically significant improvements, suggesting that brief group format CRT might not be the best format for these individuals.
- Donald et al. (2018) conducted an observational study of the benefits of 8-10 sessions of individual CRT for adult patients with anorexia nervosa and high autistic features. Participants consisted of 35 adult females attended to an individual CRT program. A subgroup of 10 participants consisted of 8 patients with autistic traits (AG). The subgroup showed significant improvement in control of cognition and cognitive rigidity over time. This suggests that having high AG features may influence the effect of CRT on these outcomes. Following CRT treatment, all participants showed a significant improvement in control of cognition and cognitive flexibility scores.
- Donald et al. (2018) published a case study, describing the efficacy of 12 sessions of individual CRT in the treatment of a 21-year-old female patient with anorexia nervosa and ASD. Clinical and self-report data collected before and after CRT indicated improvements in cognitive flexibility and social coherence, alongside an increase in body shape index. This case study also demonstrated possible ways to adapt CRT to individual needs of patients with ASD.

IMPROVING EMOTIONAL IDENTIFICATION
- Cognitive remediation and emotion skills training (CREST) has developed as an extension to CRT, in order to target emotion processing over 8 sessions.
- Adelman et al. (2018) evaluated the effectiveness of CREST in individual and group format for adults with anorexia nervosa. Significant improvements were observed for patients’ alexithymia in individual formal. Self-reported ability to change significantly increased for patients in both interventions. Patients with high levels of autism symptoms scored high on social anxiety and alexithymia measures, but this did not affect response to treatment.
- Qualitative studies by Kimber et al. (2017, 2019) discussed adaptations that clinicians had made to treatment for adult patients with comorbid ASD and anorexia nervosa. Some clinicians noted that they would adapt their therapeutic approach to include more work on emotional identification. Patients reported that this would have been helpful for them.

ADAPTATIONS TO COMMUNICATION
- Kimber’s studies suggested that communication problems due to ASD made it more difficult to build a therapeutic relationship.
- Patients said that they were often seen as difficult or insensitive due to communication difficulties.
- Clinicians found that they had to adapt their own communication styles to meet the needs of the patient.

- It was noted that training for clinicians on communication in ASD may be helpful to improve patient experience of treatment.

DIETARY, SENSORIAL AND ENVIRONMENTAL CONSIDERATIONS
- Clinicians and patients in Kimber’s studies noted that patients with ASD may have difficulties about food which need to be considered in meal planning. Patients may need to be supported to consider sensory issues in meal planning, related to food and environment.
- Patients in Kimber’s 2019 study described how their sensory difficulties made regular treatment environments extremely challenging.

RECONSIDERING THE ROLE OF AUTISM
- Participants in Kimber’s 2019 study described how traits associated with their autism contributed to the development of their anorexia nervosa, but in ways not addressed by current treatment models. Interventions included thought patterns, sensory difficulties, social confidence, exercises as a method of stimulation, and the eating disorder acting as a special interest.
- Where clinicians recognised the presence of autistic traits and referred for CREST, the patient was a positive experience for patients. Clinicians enabled patients to understand and communicate which behaviours were related to their eating disorder, and which were related to their autism.
- In Kimber’s 2019 study, patients who recognised the role of their autism in their eating disorder and treatment.
- It was noted that patients experience eating to calm, such as sensory issues around food, may persist following recovery. Clinicians should therefore consider how their patient values recovery, and determine which behaviours can be targeted for change.

PHARMACOLOGICAL THERAPIES
- A case study by Freeman et al. (1998) described a 17-year-old girl with diagnoses of anorexia nervosa and high functioning autism, treated using a combination of an atypical antipsychotic and risperidone. This showed early symptom improvement during inpatient admission.
- Previous research has suggested the use of risperidone as a potential treatment enhancement in autism. Kim et al. (2014) studied this using double-blind, placebo-controlled within-subject crossover design. The subjects included 18 female inpatients with a mean age of 18 years (age range: 15-19 years). Excluded were those with co-morbid Axis I diagnosis (other than anorexia nervosa) and age below 16. Following a 6-week treatment period, the anorexia nervosa group showed significant reduction in attentional bias towards eating-related stimuli and body image stimuli. Effect of risperidone on response to body image stimuli was significantly correlated with high levels of autism spectrum communication traits in the anorexia nervosa group. In a randomised controlled trial by Hsu et al. (2016), 41 patients with anorexia nervosa from age 16, found that longer treatment administration of risperidone results in reduced eating concern and cognitive rigidity. Lower salivary cortisol levels also suggested diminished neuroendocrine stress responses to food eating. However, there were no significant differences in social anxiety, obsessive or autistic symptoms at follow-up.

Discussion
Lichtenstein suggests that treatment targeting cognitive features, common to anorexia nervosa and autism, can be effective. There has been interest in the use of CRT and CREST. However, more research is required in younger patient groups. Use of medications in experimental stages, with studies consisting as a role for spouses from age 16. Qualitative studies provide information on modifications to treatment which would be helpful.

Conclusions
This review highlights the need for a standardised, evidence-based approach to this patient group. A quality improvement project to address this is in progress in the Adolescent Inpatient Unit in West of Scotland.

References
Natasha Keyworth
Re-Audit of Starting Stimulant medication for Attention Deficit Hyperactivity Disorder: Are we screening for cardiac risk factors?

Dr Natasha Aswathorn, CTA, Dr Natasha Wadud, NIHR Clinical Lecturer; Dr Nadeem Suleman, Consultant Child and Adolescent Psychiatrist

Objective

To establish whether there have been improvements in meeting the standards of blood pressure (WHO guidelines) after initiating stimulant medications for ADHD. We were particularly interested in the assessment of cardiovascular deflections that may raise serious concerns. A repeat audit was undertaken to assess this.

The results compared to the original audit which was undertaken between 01/12/15 and 01/02/16.

Background

ADHD is a neurodevelopmental condition with an estimated prevalence rate of 2.5% in 10-18 year old young people. It can significantly affect the welfare of both the child and their family. Medications are recommended as the first treatment for severe ADHD and around 80% of children with ADHD, after non-pharmacological interventions have been tried. 1

Stimulant medications, including methylphenidate and amphetamines, are used to treat ADHD and act through stimulation of the sympathetic nervous system. However, research has been carried out into their cardiovascular effects. These medications are associated with small increases in blood pressure and heart rate. NICE recommends baseline monitoring to assess for any risk factors, before starting medication is initiated. This includes history taking, physical examination and an ECG. 1, 2

Method

Original audit:

A total of 27 children and young people referred to the local ADHD clinic from December 2015 to November 2017 was audited. A total of 20 notes were examined out of 62 eligible patients (8 sets of notes were unavailable).

Patient demographics, including age and gender, were the same as the medication and outcome data. NICE standards included were obtained from the NICE website. All data was collected and stored as a database by a wide range of doctors, from trainee doctors to consultants.

Repeat audit:

A total of 17 children and young people referred to the local ADHD clinic from January 16 to July 2017 were audited. A total of 17 notes were examined out of 25 eligible patients (8 sets of notes were unavailable).

Results

There were 21 children and in the original audit and 17 in the repeat audit (gap ranged from between 1 and 7 in the original audit (mean 3 and 7 in the repeat audit). There were 11 girls and 10 males. In the original audit and in 17 in the repeat audit (key):

- **Standard One**: Children should be assessed for a history of exercise syncope, syncope breathlessness and other cardiovascular symptoms. 49% 11/22 (49% 7/14) 1
- **Standard Two**: Baseline heart rate and blood pressure should be measured. 90% 19/21 (88% 12/14) 1
- **Standard Three**: Baseline height and weight should be measured. 77% 13/17 (78% 10/13) 1
- **Standard Four**: Baseline height, weight and blood pressure should be measured. 77% 13/17 (78% 10/13) 1
- **Standard Five**: Electrocardiogram examination of the cardiovascular system should be carried out. 80% 14/17 (80% 11/14) 1
- **Standard Six**: Electrocardiogram examination of the cardiovascular system should be carried out. 80% 14/17 (80% 11/14) 1
- **Standard Seven**: Baseline blood pressure and drug interaction (Lithium/ACE inhibitors) should be assessed. 82% 14/17 (82% 11/13) 1

NICE Standards 2018

- **Assessment history**: History of cardiovascular disease and family history of cardiac disease and sudden cardiac death.
- **Baseline blood pressure and heart rate**: Baseline blood pressure and heart rate should be recorded. 80%
- **Baseline height, weight and blood pressure**: Baseline height, weight and blood pressure should be measured. 77%
- **Family history of cardiac disease and sudden cardiac death**: Family history of cardiovascular disease should be assessed. 80%
- **Drug history**: Drug history should be obtained. 82%
- **Electrocardiogram examination**: Electrocardiogram examination of the cardiovascular system should be carried out. 80%

Conclusions and Recommendations

- There has been an improvement in screening for cardiovascular symptoms, family history of cardiac disease and sudden cardiac death.
- Some standards have not improved or have declined since the previous audit, in particular requesting an ECG if required.
- Height, weight, heart rate and blood pressure continue to be recorded, however measuring charts are not consistently used.
- A procedure will be devised to be used when initiating stimulant medication. It will exclude all other screening NICE standards.
- Training will be provided to all clinicians responsible for prescribing stimulant medications with no audits to ensure that standards are being met.

References

Gabriella Landy
Breaking down barriers in medical education

Aim
1. To adapt and deliver interactive CAMHS teaching virtually for UCL medical students following restrictions on face to face teaching.
2. To promote collaboration between paediatric and CAMHS specialities by co-creating undergraduate teaching sessions.

Methods
- Plan
  - Review “Child and Family health module” curriculum
  - Research virtual platforms
  - Develop new learning materials including role plays, polls and word clouds to enhance interactivity online.
- Do
  - 3 online sessions every 12 weeks to 60-120 students
  - Sessions delivered using Blackboard Collaborate, Mentimeter and Articulate Rise.
  - All sessions co-created and delivered with inter-professional dialogue.
- Study
  - Student feedback reviewed after every session with inter-professional faculty discussion.
- Act
  - Teaching materials reviewed and updated for next session.

Results
- Students said:
  - “Liked that there was more than one presenter sharing their experiences: made it engaging.”
  - “Open discussion really nice! Liked using menti, the videos and the word bubbles.”
  - “Involvement of different specialities was very informative.”

Successful collaboration from the pilot session enabled introduction of a ‘Mental Health week’ into the undergraduate paediatric curriculum further enhancing integration of paediatric and child and adolescent mental health training.

Conclusion
We plan to work through further PDSA cycles to continue to improve the quality of CAMHS teaching by remote delivery and embed changes. With online learning continuing indefinitely and students spending less time on the wards, promoting inter-professional collaboration in a virtual environment is increasingly important.

1. Paediatric regional and teaching venue, UCLMS.
2. Paediatrics registrar, Chelsea & Westminster Hospital.
3. CAMHS registrar, Tavistock & Portman NHS Foundation Trust.
4. CAMHS interested, Tavistock & Portman NHS Foundation Trust.
5. CAMHS interested, UCLMS.
6. CAMHS interested, UCLMS.
Rebecca Luxton and Kenneth Lee
CAMHS Keeping Safe Card: A Quality Improvement Project

Dr. Roderick Larsen, Dr. Kenneth Lee (Joint) and Victoria Jarvis (Team Manager)
Southwark Child & Family Service, South London and Maudsley NHS Foundation Trust

With thanks to CAMHS Council, at the Southwark CYP & Family Service

Problem Statement

The communication of safety information is a cornerstone of safety planning to address risk in mental health settings. Safety information includes advice on keeping the environment safe as well as who to contact for help in a crisis. In CAMHS settings, which have long waiting lists, it can be difficult to communicate this effectively. Safety information also needs to be developmentally appropriate for younger children under the age of 12. Studies have shown the importance of utilizing children's natural support systems to facilitate open communication about dangers, safety, and risk, and that parental involvement in the safety process is beneficial.

Aims

- To work with children and young people (CYP) in designing safety information in a child-friendly format
- To increase safety awareness as a mental health context and promote conversations on safety at home
- To increase parental awareness and confidence on environmental safety at home and how they can access help in a crisis

Quality Problem to Improve

To highlight 3 important aspects of safety planning:
1. Checking in on CYP's emotional state using a visual tool, the traffic lights system. This was chosen due to its simplicity, ease of use and visual appeal.
2. Environmental safety involves a plan for safe storage of medication in the household and other potentially harmful items which may be used by CYP to self-harm. An advisory clinical practice suggests that this message is often missed and that it would be helpful for a visual cue or reminder at home for parents to access.
3. CYP and parents find passing mental health support to other members of the family difficult. It is therefore important to provide information on how to access crisis lines in an easy, accessible and child-friendly way.

Method

In an effort to gain a better understanding of which safety information would be valued by young people and their families, we started with a focus group amongst the team. We then took this to the Southwark Child & Family CYP Council, to gain feedback and further suggestions from the CYP who use the service. These were then involved in the conception and design illustrations of the safety card. Once the first draft safety card was created, the team developed a pre-questionnaire to explore parents' knowledge and confidence in safety schemes and how to seek help if needed. Following this, the safety cards were distributed to families and followed up post-waste to assess the impact of the safety card on parental knowledge and confidence with regards to safety at home.

Results

Parents were asked to rate their confidence on a scale of 1-5 using the highest confidence before and after being given the CAMHS Keeping Safe Card.
- Q1: I'm confident in using the traffic light system to check in with how my child is feeling.
- Q2: I'm confident in my knowledge of what needs to be kept away to keep my child safe at home.
- Q3: I'm confident I would know who to contact for advice in an emergency e.g. overdose, mental health crises?

The total pre and post scores for each question was calculated and depicted in this line graph.

Discussion and Future plans

This quality improvement project succeeded in its aims to create a safety information card in collaboration with the CYP using the service. There was a notable increase in parental confidence levels across all domains.

Questionnaires were administered at initial appointments. Feedback was optional and therefore there may have been some selection bias through the parents who chose to return them. Posting out questionnaires prior to appointments would allow for anonymized feedback and reach a greater proportion of parents and feedback in addition, for the next cycle, it will be important to seek feedback from the young people using the service.

In the future it would be beneficial to consider collation of additional sources of support for CYP via other mediums, for example through apps. It would be also be useful to construct an age-appropriate safety information card for adolescent service users.

Parent Feedback

“I think it's a great card. It's child and parent friendly and a design that would happily have an influence. It's easy to understand and I'm confident I would have no problem using it.”
Amy McCulloch
Developing and Delivering a Pilot Psychiatry Teaching Programme to Refugee and Asylum-Seeking Doctors

Dr Jan Klimach & Dr Amy McCulloch
1. Greater Manchester Mental Health NHS Foundation Trust; 2. North West Broughts Healthcare NHS Foundation Trust
Correspondence: amy mcculloch@nhs.net

BACKGROUND REACHE North West is an education centre funded by Health Education England, which delivers comprehensive training and pastoral support for doctors who are refugees and asylum seekers.

METHOD We developed and delivered a psychiatry teaching programme to sit within the REACHE North West Curriculum. We covered key psychiatric presentations such as dementia, anxiety, bipolar disorder and schizophrenia. We also delivered psychiatry skills sessions covering mental state examination, risk assessment and use of section 52(1) of the Mental Health Act.

![Chart](image)

**Figure 2** — The number of sessions attended was positively correlated with the post-test score.

**Figure 1** — The average scores in the post-course evaluation

**4.65/5 for delivery**

**4.76/5 for organisation**

**4.88/5 for relevance to the PLAB tests**

CONCLUSIONS

The course was well received and considered useful by those who attended.

The course was enjoyable to run

Challenges to delivery included the fluid nature of the group and the wide variety in existing knowledge and experience

RESULTS Thirty-three doctors took part in the pilot teaching programme and we asked them to complete a short knowledge test before and after the course, plus an evaluation at the end of the course. The number of sessions attended was positively correlated with the post-test score. The average pre-course test score was 8.3/20 and the average post-course test score was 12.1/20. The feedback was predominantly positive and described the course as useful, interesting, relevant and helpful.

DISCUSSION The course was very well received and enjoyable to deliver. The challenges of delivering the programme included the fluid nature of the group (doctors join and leave the teaching programme throughout the year) and the wide variety of knowledge and experience of psychiatry within the group.

“Thank you for all information which you gave us. Well arranged course and well done.”

NEXT STEPS

An extended course based on the feedback received

Recruitment of additional speakers to cover a broader range of topics

Addition of practical skills sessions to allow attendees to practice communication skills, history taking and risk assessments.
Mary Parker
Clinical audit of prescribing for attention deficit hyperactivity disorder (ADHD) in children and young people services (CYPS)

Dr Elaine Martin, senior specialty doctor and Dr Mary Parker, ST6
Tees, Esk and Wear Valleys NHS Foundation Trust

Aims and hypothesis

The audit assessed if prescribing of ADHD medications, including third and fourth line, was compliant with:
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) prescribing guidelines
- NICE guideline NG87: Attention deficit hyperactivity disorder: diagnosis and management 2018 (updated 2019)

Methods

Information collected from medical records in four community teams (n=30)
Audit tool compiled from the Trust and NICE guidelines

Results

Areas of good practice included:
- Diagnostic recording
- Non-medical interventions
- Methylphenidate frontline
- Information provided
- Psychopharmacology
- Pre-treatment assessment

Issues identified:
- Where methylphenidate was not prescribed first line, parent/patient choice was an important factor in selection of second line medication

Evidence based practice:

The audit demonstrated that clinical practice had moved away from the previous NICE guidance CG72 (to prescribe atomoxetine second line) towards the prescription of lisdexamfetamine second line (75%) inline with the evidence base reflected in the NICE guidelines NG87, 2016 (updated 2019)

Evidence based approach instrumental in improving patient care

Trustwide audit planned to promote continuous improvement in patient care

Conclusions

This audit demonstrated that an evidence based approach has been instrumental in improving patient care illustrated by good practice in areas above, as well as good practice in consideration of patient choice.
Trustwide audit planned to promote continuous improvement in patient care.
Deepa Parry-Gupta
Comparing Burnout Symptom Rates Between Core and Specialty Trainee Psychiatrists in the North West Deanery

Core and Specialty Trainee Burnout Data Analysis

<table>
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<th>Question No</th>
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<th>CT SD</th>
<th>ST Mean</th>
<th>ST SD</th>
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</tbody>
</table>

References

Fifi Phang
Audit of Mental Health Service Transition from CAMHS in Royal Cornhill Hospital, Aberdeen

Dr Tze H Phang1, (CTA), Celine MacConnel2, Dr Anne Gilchrist3
1 Consultant in Psychiatry, 2Quality Improvement & Assurance Coordinator, 3CAMHS Consultant Psychiatrist
Royal Cornhill Hospital, NHS Grampian, Aberdeen, Scotland

Background
Care during transition for Young People (YP) into Adult Services can often be a complex process for service users and their families or carers. Currently, there is no collated data on patients transitioned from Child and Adolescent Mental Health Services (CAMHS) in Royal Cornhill Hospital, Aberdeen.

Aim: To identify how Mental Health Service Transition occurs within Aberdeen City against Scottish Government guidance

Results
- From CAMHS Database: 235
  - Turned 16 in 2018
  - From Aberdeen City
- Removal of: Duplicate cases, Never seen in CAMHS
  - 122 (100%)
- Seen by Adult Services before December 2019 (time of audit)
  - 38 (26%)
  - 89% (34) attended their Receiving Service follow up appointments
  - 17 (14%) Referred directly by CAMHS to Adult Services

Key Performance Indicators

Sub analysis of “via CAMHS” group
- 35% were identified prospectively and were asked if they would like to be transitioned.
- 59% did not appear to involve flexibility about age boundaries.
- 35% were asked if they would like to be transitioned.
- 69% had a full summary and all GPs were notified of transition.
- In 24% of cases joint transition meeting was offered and Receiving Service was visited.
- No evaluation form or transition documentation exist locally.
- 79% of YP or their family were made aware of indication of psychotropic medication by CAMHS clinician.
- All GPs were notified of transition through copy of correspondences.
- 53% of Receiving Services did not communicate appropriateness of referral. A case holder was not usually identified in the Receiving service but 82% were seen at least twice consecutively by the same Receiving service clinician.

Discussions
Proportion of patients undergoing transition is consistent with literature that 15–27% of CAMHS patients are transitioned from paediatric to Adult services (Colver 2019, Ogundeke 2012). Non-attendance at first appointments was similar to the NHS Scotland baseline ‘did not attend rate’ of 12.2% (National Services Scotland 2017). No evaluation were done as documentation did not exist locally at the time of audit. The transition documents recommended by the Scottish Government appeared lengthy and their direct application may not be time or cost effective to improve some of these processes.

Conclusions
1. Audit showed good service uptake with good transition practice already established in some areas but there is scope to improve.
2. Many young people in CAMHS services at age 18 are not directly transferred by CAMHS to adult services, but are referred by other routes into adult services within the next 1-2 years. The reasons for this and the patient journeys experienced by these young people needs further investigation.
3. Joint working by CAMHS and adult services could help identify scope for improvement.
Kavitha Ramamurthy
Neurofibromatosis 1 (NF1) is a common genetic disorder affecting 1 in 3000 people, caused by germline mutation of the NF1 tumour suppressor gene. It is a multisystem disorder primarily associated with cutaneous, orthopaedic and neurological manifestations. Cognitive impairments can affect up to 80%, behavioural difficulties such as ADHD in up to 50% and Autism Spectrum Disorder in 10-40% of children with NF1.

**Background**
- Neurofibromatosis 1 (NF1) is a common genetic disorder affecting 1 in 3000 people, caused by germline mutation of the NF1 tumour suppressor gene.
- It is a multisystem disorder primarily associated with cutaneous, orthopaedic and neurological manifestations.
- Cognitive impairments can affect up to 80%, behavioural difficulties such as ADHD in up to 50% and Autism Spectrum Disorder in 10-40% of children with NF1.

**Aim:** To examine multiple potential predictors (sex, age, inherited status, Socio-economic status, neurological problems, microdeletion) of variability in cognitive, behavioral and academic skills.

**Participants**
- Population of 206 children with NF1 coming from tertiary referral genetic regional centres.
- Inclusion criteria:
  - i) participants aged 4-18 years with a confirmed clinical and/or molecular diagnosis of NF1 based on the
  - National Institutes of Health Consensus Conference criteria
  - (ii) Availability of the verbal IQ scores

**Measures**
- Wechsler preschool and primary scale of intelligence – fourth edition (WPPSI-IV)7 and Wechsler Abbreviated Scale of Intelligence (WASI). Data from the Wechsler’s sub-scales was combined into Performance IQ, Verbal IQ and full scale IQ.
- Wechsler individual achievement test version II, and III
- Parent-rated Social Responsiveness Scale versions 1 and 2
- Parent-rated Conner’s questionnaires
- Social Economic Status (SES) was provided by standardized Index of Multiple Deprivation (score 1 to 10), derived from the participants’ postcodes (14) according to the official statistics (15)
- Comorbidities affecting the brain were divided into ‘gliomas’ or Neurological problem other than glioma

**Results**
- Mean age 9 years 8 months (SD 3 years and 1 month)
- Ratio Male/ female was (110/96) 1.14
- NF1 was inherited in 101/206, denovo in 102/206 and mutation status of 2 participants was not known.

**Table 1**
- Cognitive outcomes relative to normative peer in Z values comparing patient mean scores to the normative mean of 0. ***p<0.001; **p<0.01; *p<0.05.

**Conclusion**
- Relative to normative peers, this total sample demonstrated significantly lower scores in all domains.
- Age was only related to lower skills in reading and writing.
- Children who had at least one parent with NF1 were more likely to have lower verbal, perceptive and full-scale IQ and lower math skills.
- Higher Socioeconomic status was related with higher levels in verbal, perceptive, full-scale IQ, social skills and attention and a lower level of hyperactivity.
- Neurological problems such as epilepsy and hydrocephalia were related to lower levels in IQ and lower level in all academic skills.

**Clinical implications**
Our data suggest that those with neurological difficulties are at higher risk of cognitive impairments. Further, familial NF1 and those with lower SES are also at increased risk. Early interventions and remedial education may be targeted to these risk groups to prevent cognitive complication in children who are developing and learning.
Jake Rigby
Evaluation of Parent, Carer and School Satisfaction regarding Learning Disability Choice clinics located within Special Education Needs Schools

Dr Jake Rigby (CAMHS ST6), Dr Alyx Cavson (Psychiatry CT3) & Dr Lakshmi Ramasubramanian (Consultant Psychiatrist in Child and Adolescent Mental Health)

Alder Hey Children’s NHS Foundation Trust
jake.rigby@alderhey.nhs.uk

Background
What are Choice Appointments?
Choice appointments form part of the Choice and Partnership Approach (CAPA). This is based on the philosophy that the service user should be at the centre of services, and is designed to optimise accessibility and promote a team culture of flexibility and continuous service improvement. Alder Hey Children’s NHS Foundation Trust recently changed how Choice clinics are offered, from single point of access to localities. This restructure included alterations to how Choice appointments were offered out young people (YP) with learning disabilities and their parents/carers. In October 2018, Choice appointments were moved into Special Education Needs (SEN) school settings.

Aim
To evaluate parent, carer and school satisfaction regarding LD Choice clinics located within SEN schools.

Why?
Whilst, anecdotally, the new way of running the clinics appeared to be successful, it had not been formally evaluated. This audit was therefore developed to assess how satisfied the schools and parents/carers were regarding the new clinic set up, so as to give an indication as to whether this approach is acceptable to key stakeholders.

Method
Approval: Approval was sought from the Clinical Audit and Effectiveness Team at Alder Hey Children’s NHS Foundation Trust.
Sample: Data were collected from parents/carers of 8 YP attending LD choices from December 2019 to February 2020.

Audit Tool: The Experience of Service Questionnaire (formerly CHI ESQ) was given to parents and carers following their Choice assessment. A questionnaire was also given to the Special Educational Needs Co-ordinator (SENCO) at each school to complete.

Analysis: Quantitative data were analysed using descriptive statistics. Additional qualitative feedback was summarised to provide context.

Results

<table>
<thead>
<tr>
<th>Experience of Service</th>
<th>Certainly True</th>
<th>Partly True</th>
<th>Not True</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>I feel that people who have seen my child listened to me</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was easy to talk to the people who have seen my child</td>
<td>0.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was treated well by the people who have seen my child</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My worries and worries were taken seriously</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel the people here know how to help with the problems I have</td>
<td>0.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel I have been given enough information about the help available here</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that the people who have seen my child are working together to help with the problem</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The facilities here are comfortable (e.g. waiting area)</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The appointments are usually at a convenient time (e.g. do not interfere with school)</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is easy to get to the place where appointments are held</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is quiet easy to get to the place where appointments are held</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is quiet easy to get to the place where appointments are held</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have received similar help, I would recommend that he/she does the same</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall the help I have received here is good</td>
<td>1.00</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 1: Summary of Questionnaire Responses (n = 8)

Discussion
Feedback was mostly positive, and indicated that holding clinics at school, where appropriate, is beneficial for YP, parents and school. The results reflected that there was confidence in the professionals, but improvements could be made with regards to giving more information about the clinics. If the service chooses not to accept a patient, giving reasons why and a more comprehensive plan of who could help instead may be beneficial. Improvements could also be made with regards to contact with school prior to clinics being held. Interestingly, negative feedback was more commonly received following a referral not being accepted by the service compared with those that were accepted.

Recommendations
An information sheet, explaining what to expect from the CAPA approach, should be sent to YP and parents/carers prior to their Choice appointment. This should also signpost to additional community service and resources. Contact with schools should be made prior to clinics. Retrospective re-audit of a larger sample should be prioritised.

Standards
Standards were set by CAPA to what a Choice appointment should offer:

- The client should be given an opportunity to attend an appointment at a time and place to suit them.
- Extra effort should be made to facilitate access for more vulnerable people.
- The appointment should be inclusive.
- The clinician should show curiosity.
- The clinician should have the right skill set to offer the appointment.

Figure 1: Experience of Service Questionnaire
Anna Robinson
More than Medication!
Trainee Perspectives on Integrating Psychological Treatment into their Routine Practice

Aims: To ascertain trainee’s perceptions of integrating Cognitive Behavioural Therapy (CBT) techniques into their routine psychiatric appointments within a Community Child and Adolescent Mental Health Service (CAMHS).

Background: The Curriculum for Core and Higher Trainee Psychiatrists expects trainees to be able to deliver psychological treatment to patients. For most trainees gaining experience in these therapies is set apart from their routine work, further increasing the divide between the psychological and biological spheres in psychiatry.

Psychiatric trainees working within Barnet CAMHS are encouraged, and appropriately supervised, to enable them to integrate CBT techniques into their regular reviews. This can benefit patients waiting to start treatment with the psychology team, or augment the psychological input already received.

Methods: All trainees who have worked in the team within the last 3 years were asked to complete a survey regarding their experience of integrating CBT techniques into their clinical work.

Results: A total of 9 responses were received from the 10 trainees (3 Higher & 7 Core).

I utilised CBT techniques in my consultations

Prior to the placement:

- Nonexistent: 25%
- Sometimes: 40%
- Occasionally: 20%
- Often: 15%
- Always: 0%

Following the placement:

- Nonexistent: 30%
- Sometimes: 35%
- Occasionally: 15%
- Often: 15%
- Always: 5%

All respondents reported improved confidence utilising the CBT model. The majority of respondents perceived improved patient outcomes (85%) & relationships (75%).

I felt that my patients' outcomes were:

- Improved: 68%
- Stabilised: 12%
- Unchanged: 15%
- Declined: 5%

The majority (56%) reported that their was rarely or never insufficient time for additional aspects of psychiatric care.

Using CBT techniques left insufficient time for other aspects of psychiatric care

- Rarely: 25%
- Sometimes: 35%
- Occasionally: 25%
- Often: 10%
- Always: 5%

It was really helpful having something potentially curative and useful to “give” to patients in an assessment.

I felt more positive about the care I was giving my patients. I was able to provide an intervention & work with them to reduce their symptoms.

I sometimes felt limited by appointment time and frequency.

I have been able to apply similar techniques with some patients seen in A&E and clinic settings.

At first I was sometimes so focussed on getting the CBT “right” I wasn’t able to really listen & build a strong rapport with my patients.

I feel able to support patients without the use of so much medication.

Conclusions: This small study suggests that Psychiatry Trainees and CAMHS patients benefit from the use of psychological techniques within psychiatric consultations.

Dr Anna Robinson, Psychiatry Core Trainee, North Central London
Impact of COVID-19 on staff and young people within a Tier 3 CAMHS service

Dr Louisa Wilson (ST4), Jonathan Scott (CAMHS Participation Lead)
Somerset NHS Foundation Trust, CAMHS West

INTRODUCTION

The COVID-19 pandemic led to rapid changes being made throughout the healthcare system. Changes within Somerset CAMHS included:

- Introduction of two CAMHS Co-ordination Hubs across the county, each led by a Manager, Psychiatrist and other clinicians on-site (Duty 1, Duty 2, plus 1-2 additional clinicians).
- All other staff working from home.
- Twice daily Hub meetings which could be accessed by any staff requiring additional clinical advice or support.
- Face-to-face contact only if virtual interventions were not clinically appropriate (this was initially restricted to when an urgent response was needed, but later included when virtual working was not possible for therapeutic reasons).
- Only urgent and emergency referrals accepted initially; routine assessments re-started 15th June, with daily assessment appointments being made available.
- Introduction of online peer support groups.

A command-and-control approach was needed to allow services to adapt quickly and safely, but this gave little opportunity for consultation with staff and service users. We therefore invited staff and young people to take part in an online survey to share their experiences of CAMHS services during the pandemic. The aim was to identify how the changes were affecting young people’s ability to access and engage with services, and the impact that these changes were having on staff.

METHODS

A 10 question survey was sent out to all existing CAMHS service users within Somerset via their care coordinators. This survey was open for approx. 6 weeks (20th May to 6th July). A longer survey was sent out to all CAMHS West staff via email. This was open for approx. 2 weeks (4th June and 6th July). Questions were written to mirror those in the young people’s surveys, alongside additional questions covering clinical support, working environment and personal wellbeing. A mixture of multiple choice and free text questions was used in both surveys.

RESULTS

Clinicians and young people both felt that they were seeing each other less than usual (Figure 2) and that it was more difficult to engage in appointments (Figure 2). Staff found it particularly difficult to engage with young people with ASD (Figure 3). Despite these challenges, 78% of young people felt that they had been offered a service from CAMHS that was similar to or much better than usual (Figure 4).

Young people and clinicians were also in agreement that remote appointments and the home environment affected what was talked about in sessions (Figure 5). In particular, staff recognised that it difficult for young people to have a private uninterrupted space, that it was difficult to contain anxiety remotely, and that it was not appropriate to discuss trauma in young peoples’ home environments.

69% of staff agreed or strongly agreed that they felt well supported clinically whilst working remotely, and 87.6% of staff agreed or strongly agreed that they knew the best place for raising clinical concerns. However 26.6% of staff felt they were often managing risk on their own.

Staff wellbeing was affected both positively and negatively. For almost every area that some staff identified as being difficult, other staff noted a positive changes. Examples included:

- Feeling isolated vs. improved connection with colleagues.
- Blurring of boundaries between work and home, and having to balance them both simultaneously vs. having an improved work life balance.

CONCLUSIONS

The majority of young people felt they were getting a similar or better service from CAMHS compared with pre-lockdown, and staff largely felt supported clinically. It was not surprising to find that staff and young people were finding it difficult to engage in appointments for a number of reasons, but it was more surprising that staff noted the smallest change for young people displaying risky behaviours. This may be because these young people were still receiving face-to-face contact due to the level of risk involved. Also the Hub model of working encouraged closer links between CAMHS West and the Outreach Team. It is difficult to know which point in time respondents were reflecting back on when completing the survey. At the start of lockdown a young person may have been considered “seem” if they had a virtual appointment, but this may not have been the case at the time of the survey. It was also not possible to identify which particular service within CAMHS the young people were under. Young people needed to have access to the internet to reply to the survey, as well as the motivation to take part. This limits how generalizable the results can be, and also highlights the potential for “digital poverty” in the post-lockdown world.

NEXT STEPS

A working group has been formed within CAMHS West that alms to use QI methodology to:

- Embed the positive changes that have been identified into routine operations (Figure 6).
- Further identify what improvements can be made to services during the ongoing pandemic response.

Figure 6: Changes that staff and young people would like to continue.

- Virtual professional meetings
- Option for virtual appointments for young people
- Peer support groups
- Enhanced cross-team working

CONTACT DETAILS

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