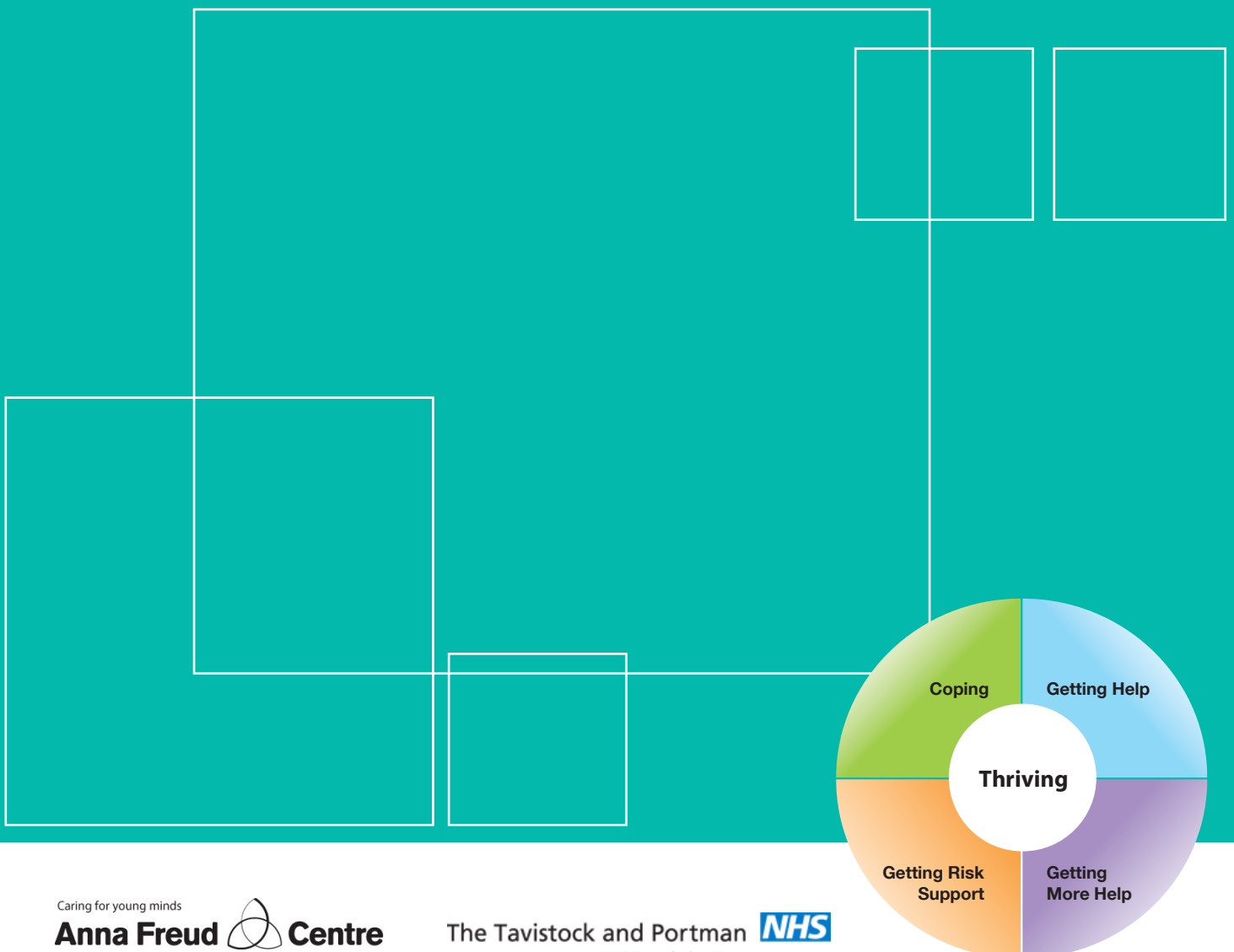


# THRIVE

## The AFC–Tavistock Model for CAMHS

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## Disclaimer

All ideas in this paper and related to this model are independent of any organisational affiliations, committee membership or other official capacities of any of the authors, other than their roles within the Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust.

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## INTRODUCTION

Child and Adolescent Mental Health Services (CAMHS) across England have never been so prominently in the spotlight. The recent publication of the Health Committee quoted a government minister as describing services as “dysfunctional” and the committee referred to “serious and deeply ingrained problems” with respect to commissioning<sup>1</sup>. A Government-sponsored taskforce (to which several of the authors are contributing) is in progress, the Department for Education is planning a mental health strategy for schools, and the Royal College of Psychiatrists’ Child and Adolescent Mental Health Faculty has scheduled a Commission on Values in CAMHS for next year.

The Tavistock and Portman NHS Foundation Trust (The Tavistock) and the Anna Freud Centre (AFC) have been collectively and individually considering what CAMHS could and should look like for some time.

In 2014, we formed a consortium to further develop and refine a new model for CAMHS based on our shared thinking in this area: this is now known as the THRIVE model<sup>1</sup>. In this document, we lay out the key aspects.

We are sharing our thinking as it develops to help inform the current national debate on the future of CAMHS and as a basis for future provision. We are not presenting THRIVE as a tried and tested one-size-fits-all implementation model, nor is the language and terminology for different groups fixed at this point. Whilst AFC and Tavistock do have thoughts on implementation in particular contexts, this paper does not purport to be a how-to guide.

We feel that the THRIVE model offers a radical shift in the way that services are conceptualised and potentially delivered, along with suggestions for how they might be reviewed and improved. Through wider discussion, planning and, in time, the commissioning processes, the model will appropriately undergo refinements and developments as to how it can be applied to local contexts.

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<sup>1</sup> We are aware there are a number of initiatives across the country which use “Thrive” in their title. We use the term to reflect our core commitment to young people “thriving” and to represent our commitment to provision that is Timely, Helpful, Respectful, Innovative, Values-based and Efficient.

## BACKGROUND

### **CAMHS in context**

Services to support child and adolescent mental health (collectively called CAMHS) have grown from diverse roots. On the one hand, CAMHS provision is the descendant of the child guidance movement of the 1920s onwards which sought to support child wellbeing and deal with problems before they became significant. On the other hand, its antecedents lie in medical psychiatry which focussed on mental illness and serious problems. There is a third element which has increased in prominence in recent years: the necessity of managing risk for some of the most troubled children and young people in the community. In many ways, this tension between promoting wellbeing (where education language and metaphors are dominant), treating illness (health language and metaphors dominate) and managing risk (social care language and metaphors dominate) still lies at the heart of debate over service provision(2).

CAMHS is almost inevitably a smaller part of a bigger system, whether representing the child part of mental health or the mental health part of child services. Whilst there has in recent years been an increased policy focus on CAMHS specifically(3), the tendency for CAMHS to be an afterthought to wider policy or funding initiatives remains. Differences in language and philosophy between the wider systems (health, education, social care) make cross-agency working hard and agreement on coordinated policies challenging.

Historically underfunded, and vulnerable to cuts because of its location within larger systems, the more recent context of austerity has resulted in extensive disinvestment in services, with 25% cuts reported in some areas in 2013(4). The last UK epidemiological study suggested that at that time (ten years ago) less than 25% of those deemed 'in need' accessed support(5).

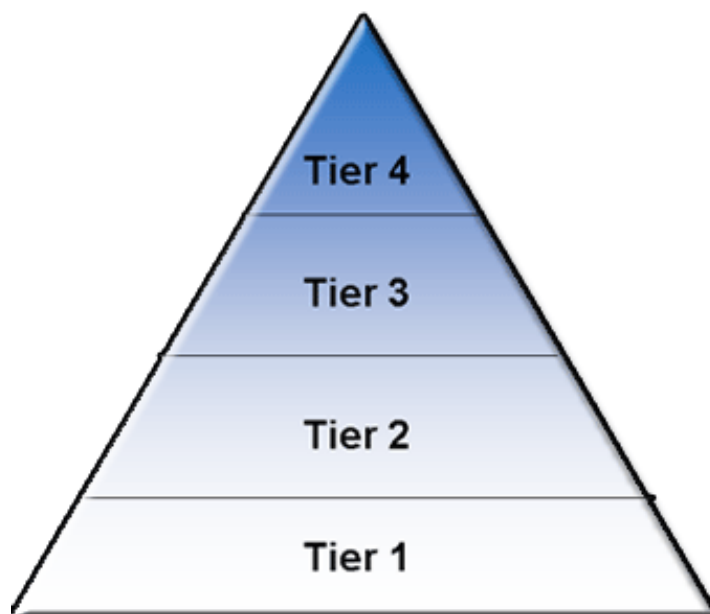
Attempts have been made to conceptualise CAMHS, the most long-lasting and influential of which a model dividing service provision into four tiers as outlined and described below:(6)

**Tier 1:** consists of non-specialist primary care workers such as school nurses and health visitors working with, for instance, common problems of childhood such as sleeping difficulties or feeding problems.

**Tier 2:** consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services.

**Tier 3:** consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems too complicated to be dealt with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis.

**Tier 4:** consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.



This model was very useful at its time of development in 1995(7) for helping differentiate between the forms of support that might be available to children and young people, but has increasingly been critiqued (including by its developers) for leading to a reification of service divisions. As we will argue below, we feel that the THRIVE model offers a more helpful conceptualisation to address the challenge and opportunities of the current situation.

### **Current context: challenges and opportunities**

There is evidence of extensive and rising need in key groups, such as the increasing rates of young women with emotional problems and increasing numbers of young people presenting with self-harm.(8) There is also increasing policy acceptance of the long term consequences of ongoing difficulties, including significant impact on employment, physical and mental health, with the oft-quoted figure of 66-75% of adult mental illnesses (excluding dementia) starting by the age of 18.(9)

Recent audits have found increases in average waiting times to first appointment in specialist mental health provision for children and young people (up to 15 weeks in some areas) and that less than half of all providers (40%) reported providing crisis access (2013). Service providers report increased rates of self-harm referrals and increased complexity and severity of presenting problems (2014).

In terms of opportunities, there is increased provider coherence on what an ideal CAMHS might look like, with increased focus on work in schools and promotion of community and individual resilience(10), agreed sets of best practice standards collated by the service transformation initiative CYP IAPT,<sup>2</sup> shared sign-up to a vision of personalisation of care aligned with use of evidence and rigorous review of outcomes with buy-in from a range of professional and other groups (QNCC, CORC, YA, RCPsych, AFT, BABCP, BACP)<sup>3</sup>. There is increasing alignment to shared standards of routine outcome measurement and performance management (CORC,QNCC,QNIC,CAPA)<sup>4</sup>, management of flow (CAPA) and meaningful use of data across systems (C/MHIN)<sup>5</sup>. There is also an increasing evidence base in CAMHS (11) and emerging thinking around targeted payment systems to distinguish the needs of different groups of children, young people and families seeking help and support (12) and to support both values-based and value-based service delivery(13, 14).

2 The Children and Young Peoples' Improving Access to Psychological Therapies Programme.

3 Quality Network for Community CAMHS, Child Outcomes Research Consortium, Youth Association, Royal College of Psychiatrists, Association for Family Therapy and Systemic Practice, British Association for Behavioural and Cognitive Therapies and British Association for Counselling and Psychotherapy.

4 Quality Network for Inpatient CAMHS, The Choice and Partnership Approach.

5 Child Mental Health Informatics Network

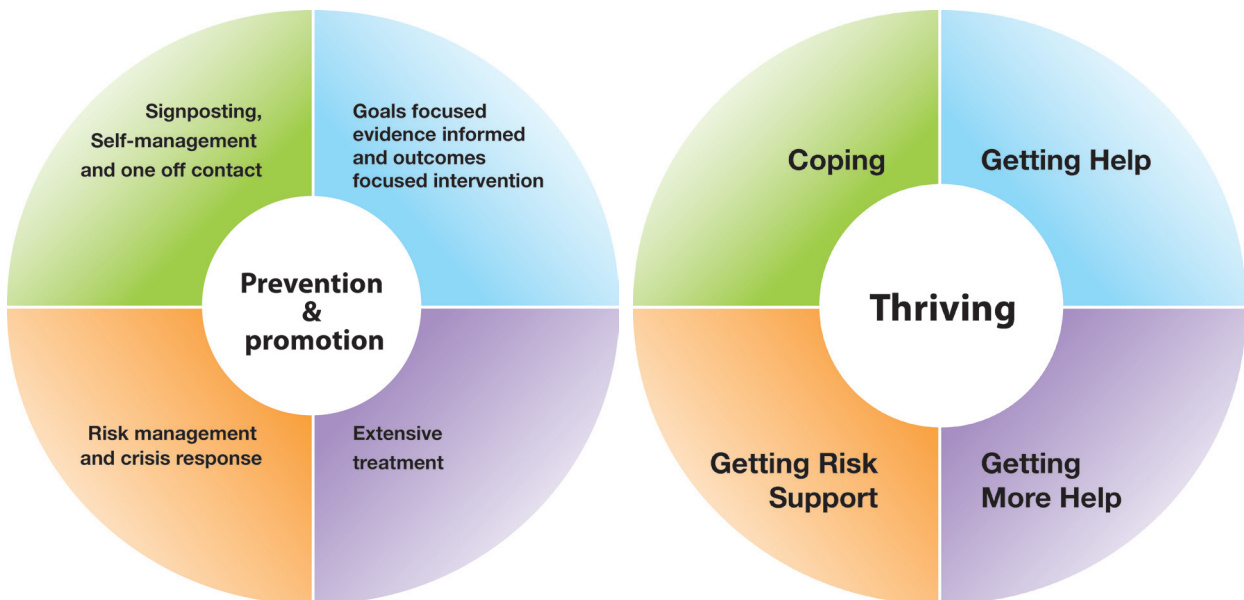
## THRIVE MODEL FOR CAMHS: A NECESSARY PARADIGM SHIFT?

We are proposing to replace the tiered model with a conceptualisation that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The model outlines groups of children and young people and the sort of support they may need and tries to draw a clearer distinction between treatment on the one hand and support on the other. Rather than an escalator model of increasing severity or complexity, we suggest a model that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices.

The THRIVE model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community.

The image to the left describes the input that offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service use.

### THRIVE model



Each of the four groupings is distinct in terms of:

Needs and/or choices of the individuals within each group<sup>6</sup>

- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group
- The groups are not distinguished by severity of need or type of problem.

The middle designation of "thriving" is included to indicate the wider community needs of the population supported by prevention and promotion initiatives.

<sup>6</sup> Where need is taken to refer to "the minimum resource required to exhaust capacity to benefit" and choice is taken to refer to the shared decision making between a young person or family member and those providing help and support.

## Coping

**Context:** There is an increased interest in the promotion of resilience, to build the ability of a community (school/family) to prevent, support and intervene successfully in mental health issues. Initiatives such as Headstart (£75 million funded by Big Lottery), the Penn Resilience programme and others seek to help young people and families to help themselves. A proliferation of digitally based support (e.g. via email, phone and web) is becoming increasingly available and being used to support young people in their communities. There is increasing academic interest (e.g. community psychology) on how we can more effectively draw on strengths in families, schools and wider communities. School-based interventions have been shown to support mental health,(15) peer support can promote effective parenting(16) and integration of mental health in paediatric primary care can support community resilience(17). The wider government policy can impact positively or negatively on the emotional well-being of the child within the family – the government initiative to have a Family Impact Assessment of all government policy is welcomed if it proves effective.

**Data:** Analysis of CAMHS data as part of the development of payment systems clusters (18) suggests that many (indeed the modal number) of young people and parents attending CAMHS attend only once, with many being seen for less than three contacts. Data would indicate that the majority of these leave the service through mutual agreement between the provider and young person or family members. Whilst it is not possible to determine from existing data whether the majority of these leave satisfied, nor how many are referred elsewhere, practitioner reports at least a proportion of this group find relatively few contacts, even one single contact, enough to normalise their behaviour, reassure families that they are doing the right things to resolve the problem without the need for extra help and to signpost sources of support.

**Resource:** The payment systems project group are currently suggesting this group might be the first (likely cheapest) of three clusters for payment system (see below for other clusters).

**Need:** Within this grouping would be children, young people and families adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support. This group may also include those with chronic, fluctuating or ongoing severe difficulties, for which they are choosing to manage their own health and/or are on the road to recovery.

**Provision:** The THRIVE model of provision would suggest that wherever possible, this provision should be provided within education or community settings, with education often (though not always) the lead provider and educational language (a language of wellness) as the key language used. It is our contention that health input in this group should involve some of our most experienced workforce, to provide experience decision making about how best to help people in this group and to help determine whose needs can be met by this approach.

## Getting Help

**Context:** There is increasingly sophisticated evidence for what works with whom in what circumstances(11) and increasing agreement on how service providers can implement such approaches(19) alongside embedding shared decision making to support patient preference(20) and the use of rigorous monitoring of outcomes to guide treatment choices(21).The latest evidence suggests that only 33% of young people will be “recovered” at the end of even the best evidence-based treatments.

**Data:** Analysis of CAMHS data for payment systems has found that the majority of children and young people seen in CAMHS are seen for less than twelve face-to-face meetings, whether in schools, clinics or the community.

**Resource:** The payment systems project group are currently suggesting this group might be the second (middle costing) of three clusters for payment system (see below and above for other clusters).

**Need:** This grouping comprises those children, young people and families who would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved. This grouping would include children and young people with difficulties that fell within the remit of NICE guidance and where there are interventions that might help.



**Provision:** The THRIVE model of provision would suggest that, wherever possible, provision for this group should be provided with health as the lead provider and using a health language (a language of treatment and health outcomes). It is our contention that health input in this group might draw on specialised technicians in different treatments.


The most radical element of what we are suggesting is that treatment would involve explicit agreement at the outset as to what a successful outcome would look like, how likely this was to occur by a specific date, and what would happen if this was not achieved in a reasonable timeframe.

To aid best use of specialist provision it may be helpful to consider use of explicit charters for children and families such as the example below:

As someone seeking help from a professional, I have a right to:

## RESPECT

<b>R</b> EVIEW	<ul style="list-style-type: none"> <li>Know what options are available</li> <li>Know the pros and cons of the different options</li> </ul>
<b>E</b> FFECTIVE HELP	<ul style="list-style-type: none"> <li>Know the evidence for the help and support being suggested</li> <li>Know if there are different types of help that may be effective</li> <li>Know what is expected from me or others for the treatment to be effective</li> </ul>
<b>S</b> ELECT	<ul style="list-style-type: none"> <li>Make choices about what help I get when different evidence-based approaches exist</li> </ul>
<b>P</b> ROGRESS	<ul style="list-style-type: none"> <li>Be involved in setting and reviewing goals</li> <li>Know how soon and to what extent things are likely to improve</li> <li>Agree what will happen if things don't get better</li> </ul>
<b>E</b> XPRESSION	<ul style="list-style-type: none"> <li>Be listened to and have my views taken into account</li> </ul>
<b>C</b> LARITY	<ul style="list-style-type: none"> <li>Know how those supporting me understand the difficulties</li> <li>Know what is happening to information about me</li> </ul>
<b>T</b> RANSITION SUPPORT	<ul style="list-style-type: none"> <li>Be supported to find further help if needed</li> </ul>



## Getting more help

**Context:** There is emerging consensus that some conditions are likely to require extensive or intensive treatment for young people to benefit. In particular, young people with psychosis, eating disorders and emerging personality disorders are likely to require significant input.

**Data:** Analysis of CAMHS data for payment systems found that only a very small percentage of children seen in CAMHS receive more than 12 contacts with a large variation in amount of resource use within this group.

**Resource:** The payment systems group are currently suggesting this group might be the final (most expensive) of three clusters for payment system (see above for other clusters). It is recognised that, for some of these young people, individual agreements with commissioners will be needed to arrange payment as the range of costs within this group are so wide.

**Need:** This grouping comprises those young people and families who would benefit from extensive long-term treatment which may include inpatient care, but may also include extensive outpatient provision.

**Provision:** The THRIVE model of provision would suggest that wherever possible, provision for this group should be provided with health as the lead provider and using a health language (that is a language of treatment and health outcomes). It is our contention that health input in this group should involve specialised health workers in different treatment.

## Getting risk support

**Context:** This is perhaps the most contentious aspect of the THRIVE model and has certainly been the need/choice group we have found it hardest to agree a simple heading for. We posit that even the best interventions are limited in effectiveness. As noted above, a substantial minority of children and young people do not improve,

even with the best practice currently available in the world(22). There has, perhaps, in the past been a belief (strongly held by service providers themselves) that everyone must be helped by a service and if they are not then that is an unacceptable failure.

The THRIVE model suggests that there be an explicit recognition of the needs of children, young people and families where there is no current health treatment available, but they remain at risk to themselves or others.

**Data:** On current data sources available it is not possible to disaggregate this group from the three other groups within the THRIVE model, which are proposed to be used for future payment systems. It is likely that many, though not all, of this group will be subsumed within the getting more help group above (the most costly grouping for payment).

**Resource:** Practitioner report suggests this group may require significant input; they certainly take up a lot of energy in terms of discussions within and between services. Some services are report currently distinguishing members of this group as a group of children, young people and families who may be termed “not ready” for treatment, or in need of ongoing monitoring. It may be that many are currently being offered intensive treatment for which they are failing to attend appointments or making no progress in terms of agreed outcomes. It is suggested that over time this group may be disaggregated as a distinct grouping for payment systems.

**Need:** This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children, young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference, who self-harm or who have emerging personality disorders or ongoing issues that have not yet responded to treatment.

**Provision:** The THRIVE model of provision would suggest that, for this group, there needs to be close inter-agency collaboration (using approaches such as those recommended by AMBIT to allow common language and approaches between agencies) and clarity as to who is leading. Social care may often be the lead agency and the language of social care (risk and support) is likely to be dominant. Health input should be from staff trained to work with this group and skilled in shared thinking with colleagues in social care, but with explicit understanding that it is not a health treatment that is being offered.

## Thriving

This is the state we are all seeking to achieve! Services are and should be helping with prevention, promotion, awareness raising work in the community to support this and may involve consultation and training that is not focussed on particular children or families. It is likely that such work will need to be funded separately from any payment system based on per-head payments as these are community-focussed and public health-focussed interventions.

# PERFORMANCE MANAGEMENT, QUALITY IMPROVEMENT AND THE THRIVE MODEL

We propose employing the MINDFUL approach to performance management(23) alongside the THRIVE model.

This involves a seven step process which would be **applied separately to each of the four groups of need or choice included in the THRIVE model**, with the relevant lead funder/commissioner for each leading on the review.

1. At regular time periods e.g. every three years commissioners and providers and service user reps would jointly agree high-level key quality indicators in areas of weakness relating to that particular aspect of THRIVE, using a mix of process and outcome measures (based on CORC annual reports and/or other sources of information):
  - Coping - e.g. access to online support/levels of resilience
  - Getting help - e.g. access to NICE interventions/levels of recovery or reliable change
  - Getting more help - e.g. length of inpatient stay/functioning
  - Getting risk support - e.g. response to A&E admissions/management of crises
2. Data about children and families involved, activities and outcomes would be collected routinely to help shape service provision. Measures and approaches to support this would be tailored to each element of the THRIVE model:
  - Coping - e.g. to include measures of resilience
  - Getting help - e.g. to include measures of symptom change
  - Getting more help - e.g. to include measures of impact on life
  - Getting risk support - e.g. to include measures of risk management
3. Leads for each area of provision would collate information relevant to the KPIs regularly (e.g. monthly) and feed this information back to staff. Data will be considered relative to others involved in similar THRIVE activity using appropriate statistical analyses.
4. Where there is information that suggests outcomes, or activities that vary significantly from others in a negative way, then that group of staff will be supported to explore if variation is warranted using the Queensland evidence pyramid.

These explorations should include directed discussions in which the team are invited to consider, if these differences were unwarranted, what they would do differently using the MINDFUL approach.
5. Staff groups are encouraged to trial improvements aimed at addressing unwarranted variation and enhancing service quality. This may involve the use of statistical process control methodology such as run charts to consider and review improvements and impact on patient care and use of PDSA cycles and learning sets.
6. Quarterly meetings of users, commissioners and providers will review progress against KPIs for each of the elements of the THRIVE model separately, spreading any learning and improvements across the service
7. Annual review of the whole system to enable any relevant adjustments to be made to contracts or specifications.

## CONCLUSION

The THRIVE model offers a way forward for child and adolescent mental health provision. Distinguishing different groups in terms of their needs and/or choices enables:

- greater clarity about agency leadership
- greater clarity on skill mix required
- potential for more targeted funding
- potential for more transparent discussion between providers and users
- options for more targeted performance management
- options for more targeted quality improvement
- alignment with emerging payment systems
- alignment with best practice in child mental health.

To reiterate, we are not presenting THRIVE as a tried and tested one-size-fits-all implementation model, nor is the language and terminology for different groups fixed at this point. Whilst AFC and Tavistock do have thoughts on implementation in particular contexts, this paper does not purport to be a how-to guide. Rather, we are sharing our developing thinking at this point to contribute to current national debate because we feel that this may help form a way forward for future provision.

We hope that the thinking underpinning this model may become embedded across the UK and beyond to point the way forward for child and adolescent mental health promotion, intervention and support in the years ahead.

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