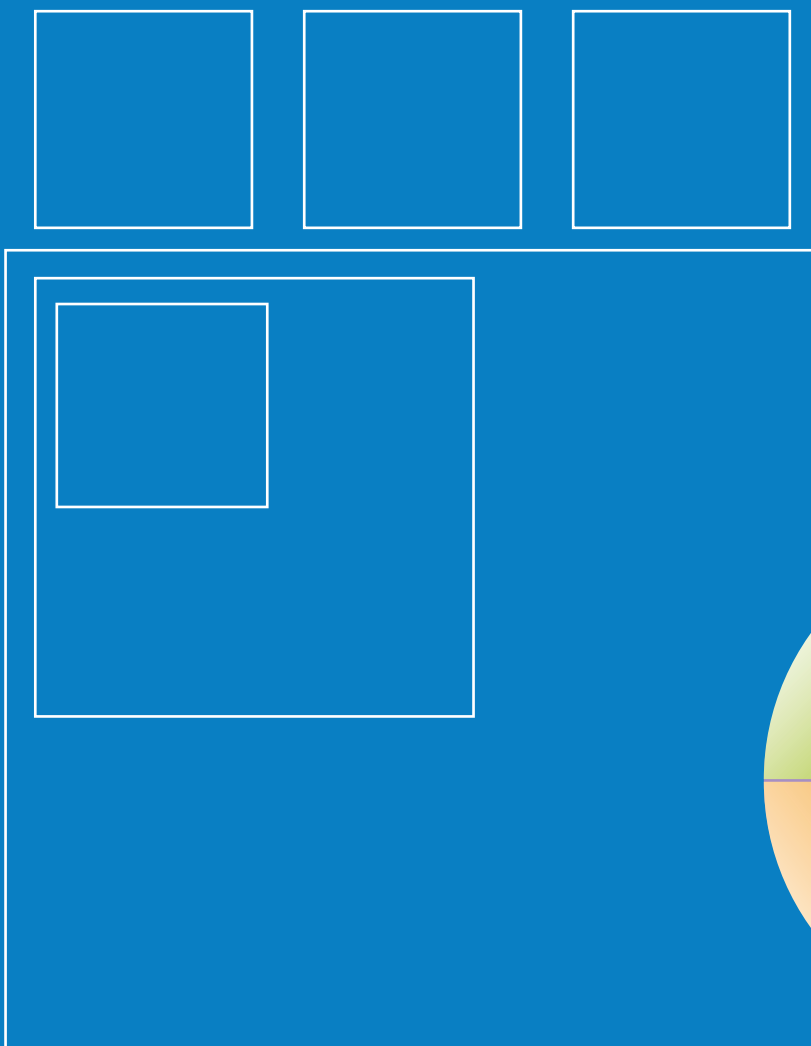


# THRIVE *Elaborated*

Second Edition

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A collaboration with

## 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 National Centre for Children and Families and The Tavistock and Portman NHS Foundation Trust.

## NOTE ON THE SECOND EDITION OF *THRIVE ELABORATED* (2015)

Please note that the content of the original *THRIVE ELABORATED* (2015) publication remains unchanged – apart from the addition of a 2016 foreword, updates to the reference list, and some small visual and formatting changes to illustrations.

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## FOREWORD: NOVEMBER 2016

### **THRIVE: a multi-agency initiative**

When we published our emerging ideas on a conceptual framework – *THRIVE: The AFC-Tavistock Model for CAMHS* (Wolpert et al., 2014) – we knew that our thinking would develop and we committed to providing regular updates. In November 2015, we published an updated version with greater elaboration on key points: *THRIVE Elaborated* (Wolpert et al., 2015).

For the second edition of *THRIVE Elaborated*, we have left the content of the framework unchanged. However, through this foreword we aim to address the most common question we get in relation to THRIVE: **“THRIVE reads as being very health focused, even though it professes to be a multi-agency framework. Can you clarify in what sense this is a genuinely multi-agency framework?”**

THRIVE was originally authored by professionals involved in mental health support for children and young people, all of whom came from a health background. We acknowledge that this was reflected in our language but stress that our vision was of genuine multi-agency work in this area. We now have co-authors from the world of education and social care, and have drawn on views from head teacher panels, CCG leads and local authority directors. We have also had input from Lorraine Khan of the Centre for Mental Health, for which we are very grateful. We hope that this will help us to communicate the framework using language that makes sense across agencies.

Below we highlight four key ways in which the THRIVE framework is inherently multi-agency:

#### **1. THRIVE endorses multi-agency definitions of mental health promoting practices**

THRIVE seeks to enhance awareness of the full range of mental health promoting practices (MHPP) and to facilitate a multi-agency approach to their use. For too long, practices to support the burgeoning and costly mental health needs across the UK have been conceived of only in terms of health interventions (Evans-Lacko et al., 2016; Ramon et al., 2011). Models of treatment and intervention have largely drawn on medical models within a very narrow set of parameters. This has led to increasingly sterile debates about the effectiveness of different modalities which focus on a very limited set of individual-focused options that are shorn of social context (e.g. talking therapies, psychoeducation, behaviour change and medication), and with diminishing differences in efficacy findings (Roth & Fonagy, 2013).

This approach is no longer tenable for a range of reasons. First, there is emerging and increasingly compelling evidence of a range of social and economic factors that affect mental health. These include poverty, poor housing, neighbourhood cohesion and national income inequality (Friedli, 2009). Second is the increasing recognition that more health care does not necessarily mean better mental health outcomes (Mulley, Richards, & Abbasi, 2015). Within the medical paradigm, less than 50% are likely to be substantially helped for many difficulties (Lambert, 2011). Third, there is a growing demand for a greater range of interventions that recognises the social contexts and individual preferences of individuals and communities (Camic & Chatterjee, 2013; Evans-Lacko, et al., 2016; Mulley, et al., 2015; Rogers & Pilgrim, 2014). Finally, the current economic climate means greater health care provision as a response to rising mental health need is simply not sustainable; the austerity agenda is itself acting as an important lever for a more radical reconceptualisation of what might help to promote positive mental health and wellbeing, and prevent or address mental health difficulties (e.g., Evans-Lacko et al., 2016). These factors have led to interest in different forms of mental health promoting practice beyond traditional health interventions, such as those supported by social prescribing (Maughan et al., 2016), or by the use of personal budgets (Glendinning et al., 2008).

Mental health support desperately needs a common language even to start to think about different forms of mental health promoting practice or offerings that go beyond a combination of one or more of the four current modalities: talking therapies, psychoeducation, behaviour change and medication. For example, emerging evidence of the impact of initiatives, such as volunteering, peer support and engagement in clubs, are currently not well considered in the literature. Additionally, the literature on social prescribing refers to “non-drug, non-health-service interventions” (Husk et al., 2016). THRIVE seeks to help by highlighting the need for the development of a common language not defined by health.

Within each category of THRIVE, a range of interventions may therefore be relevant beyond currently recognised “therapeutic approaches” delivered by “trained mental health professionals”. An important feature of the help offered is that it considers and draws on the network of services around the child, which maximises the young person’s potential for engagement and accommodates their individual preferences, where possible. Help can take the form of intervention in which any professional – mental health or not – takes responsibility for input directly with a specified individual or group related to a mental health need. <sup>1</sup>

The THRIVE definition of a mental health intervention is as follows:

1. Can you state what the mental health need(s)<sup>2</sup> is/are for the given child?
2. Are you working to address a mental health need?<sup>3</sup>
3. Are you clear what you are trying to achieve in relation to the mental health need?
4. Are you taking some responsibility for whether the goal in relation to the mental health need is achieved or not?

If the answer is yes to 1–4, then by THRIVE’s definition you are providing a mental health intervention regardless of who is providing it and in what context. For the intervention to be following best practice from a THRIVE perspective, we would add the following criteria:

5. Have you considered the evidence base and chosen an approach that best fits the needs of the child based on the latest evidence, and balanced with the preferences of those seeking help or support?
6. Have you collaboratively agreed with the child and/or carers what “goals” they want to achieve?
7. Are you reviewing your progress against the agreed goal and using this information to inform future decision making, including an appropriate time to end contact?

If the answer is yes to 1–7 above, then by THRIVE’s definition you are providing a best practice mental health intervention.

## **2. THRIVE encourages shared multi-agency responsibility for promoting “thriving”<sup>4</sup>**

All agencies share a responsibility to provide support proactively for the most vulnerable and high-risk children and young people. There is a strong (though not absolute) link between psychosocial adversity and mental health need. Vulnerable groups of children living in conditions of multiple adversity, often with experience of a

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1 This does not mean that wider interventions with less direct input from a professional (from any agency) may not also be relevant.

2 Defined as having a distinct problem identifiable on a mental health assessment tool, such as The Current View tool, which outlines 30 distinct child mental health difficulties.

3 This might be part of one of a number of issues being addressed – some or even the majority of which may not relate to mental health.

4 See pp. 17–18 for a full definition.

number of adverse life events, may need proactive support to ensure they get the most beneficial help available to them. A wide range of agencies, often usefully led by schools and social care, has a key role in outreach and motivational work that helps some young people's readiness to seek support. There is a shared responsibility of those in contact with children and families to promote awareness and understanding of the importance of good child and family mental health and wellbeing, and to promote family and child mental health and wellbeing actively, including specific interventions, as discussed previously.

There are many factors that may lead to the development of mental health difficulties in children and young people. The World Health Organisation categorises these into three broad areas:

- Social circumstances: such as loneliness, bereavement and neglect
- Environmental factors: such as injustice, discrimination and exposure to trauma
- Individual factors: such as cognitive/emotional immaturity and medical illness.

To address these factors requires an inter-governmental commitment and cross-agency strategy.

**Poverty and social inequality:** There is substantial evidence that poverty is a major risk factor for developing mental health problems in childhood. It is important that professionals across the multi-agency network are made aware of this evidence so that this is held in mind when planning preventative and mental health promoting input. There should also be a sensitivity and awareness of multi-agency provision and a wish to work collaboratively across agencies, including, for example, housing, social care and youth justice. It is crucial to consider this evidence and to seek to reduce child poverty in order to impact positively on mental health in the future.

**Trauma and maltreatment:** The harm caused by child maltreatment can have wide-ranging effects on the child or young person's emotional, psychological, behavioural and interpersonal functioning. Child trauma is also likely to have a negative effect on the quality of the close relationships a child is able to make now, in the future, and with their own children, thus making trauma an inter-generational issue. Reducing trauma and maltreatment may be one of the biggest primary prevention strategies available to us. The THRIVE model emphasises integrated training and continuing professional development across agencies in key issues such as this one.

**Social isolation and bullying:** The importance of having friends and feeling accepted by other children or young people of the same age cannot be overstated. Social isolation also means that a young person will have fewer resources available to help them deal with difficulties in their lives, as they will not be able to turn to those around them for advice or support.

**Promoting system-wide resilience:** Focusing on system-wide resilience is key to supporting "Thriving". For example, this will involve communities (including schools) and families in developing support systems and will help to build resilience at a system level.

### **3. THRIVE promotes multi-agency proactive "advice" and "help"**

There is a group of young people, and their parents/carers, who identify themselves as "Thriving", but are of concern to professional networks who firmly believe that areas of their lives are problematic and potentially harmful. From a therapeutic point of view, working with families where difficulties are minimised or denied is a very familiar situation; for example, when there is professional concern about abuse, neglect, domestic violence, poor school attendance or poor educational attainment. Such families may not be seeking help, and Getting Advice, Getting Help, Getting More Help or Risk Support may be proactively facilitated by specialist staff embedded in local authority services, such as social care or family support, where such families are often known. A liaison-consultation approach is often useful to get an understanding of the situation, and to advise

on which approaches might improve mental wellbeing. There may be an opportunity for joint home visits – with a social worker, for example. However, the mental health intervention in these situations may be best delivered by a non-health professional under supervision from a specialist mental health practitioner, with shared responsibility for the work.

A similar approach may be used with young people who are experiencing the transition to adulthood and do not or will not identify themselves as having a mental health problem. They may have a number of significant wellbeing issues which put them at risk of mental health problems in the longer term; for example, they may not be in education, employment or training (NEET) or they may be misusing substances. A holistic approach where young people are encouraged to access activities, engage in social enterprise, or get help with access to education and employment, will clearly improve general wellbeing, as well as mental wellbeing.

#### **4. THRIVE supports multi-agency clarity on endings as well as beginnings**

Organisations often have detailed processes for how people access their services, not least the eligibility and threshold criteria, referral forms or information requirements, triage processes and assessment paperwork. In contrast, the processes around leaving the service can lack clarity or be non-existent. THRIVE – and the Choice and Partnership Approach (CAPA) – emphasise the need for all agencies to consider the ending of service contact from the start of an intervention, including an emphasis on transparent conversations about how both those helping and those seeking help will know when “enough” help has been provided, and by which agencies. There needs to be clear consideration and an agreed understanding of what happens next.

We hope that this foreword will help those reading the THRIVE framework appreciate how THRIVE seeks to stress and promote the requirement for multi-agency input, which is essential for meeting the full range of mental health and wellbeing needs of children and young people in our communities.

*THRIVE Elaborated* (2016) authors

November 2016

## FOREWORD: NOVEMBER 2015

### **Introduction to *THRIVE Elaborated***

Since we published the *THRIVE: The AFC-Tavistock Model for CAMHS* a year ago in November 2014 it has generated a lot of interest. We are delighted by this.

We want to take this opportunity to clarify and elaborate as relevant, including addressing areas of potential confusion, as well as updating the document in light of our emerging thinking and elaboration of elements of the framework.

### **It is important to note that nothing relating to the central ideas of the framework has been changed.**

For those who have read the November 2014 document, what this document adds is:

- Further emphasis on how THRIVE, whilst it does not in itself provide a blueprint for implementation, is aligned to implementation models, including the Choice and Partnership Approach (CAPA) – addressed in a new section on THRIVE and implementation
- More detail and clearer elaboration of how THRIVE aligns with the payment systems work which was developed in parallel, both in terms of the needs-based groupings themselves but also in terms of the shared decision making principles that are at the heart of the work – addressed in a new section on THRIVE and payment system project development
- Greater elaboration of what is meant by Thriving and how this can be supported by services – addressed in a more detailed section on Thriving
- Further elaboration of a potential model for selection of outcome measurement and metrics

In the light of potential confusion caused by use of the term CAMHS (which has come to be associated with particular forms of provision such as specialist NHS provision), for this edition we are referring to “children and young people mental health services” to encompass the full range of provision to support mental health needs of young people across agencies and organisations.

In this edition we have made clearer the way THRIVE draws on and aligns with the thinking of the Choice and Partnership Approach (CAPA) and the Child Outcomes Research Consortium (CORC). We also emphasise how THRIVE is aligned to many key initiatives and shares principles, ethos and commitment with a wide range of professional organisations and associations’ missions and values. We continue to welcome feedback about these links, and are happy to incorporate into online resources as these are developed.

As ever we welcome comments and thoughts, and look forward to producing further elaboration based on learning from across the country and beyond in the coming years.

*Miranda Wolpert*

November 2015

On behalf of the THRIVE authors

## ACKNOWLEDGEMENTS FOR *THRIVE ELABORATED* (2015)

We want to thank many colleagues who have helped shape our thinking whilst in no way implicating them in any of the ideas presented below. These include colleagues who have been central to the development of models of children and young people mental health services including Peter Wilson, Richard Williams, Caroline Lindsey, Margaret Murphy, Peter Hindley, Ann York, Steve Kingsbury, Mick Cooper and others, and those that have led the way in adult mental health including Richard Layard and David Clark for their inspiration and support.

We would also like to thank our colleagues in the Department of Health, NHS England and Department for Education; in particular Kathryn Pugh, Anne O’Herlihy, Margaret Oates, Cathy James, Helen Kay, Karen Turner, Barbara Fittall, Sue Nowak, Jacqueline Cornish and Geraldine Strathdee for the many long discussions and intense debates over the years.

Thanks to colleagues who have helpfully commented on the current model include David Trickey, Jane Dutton, Rachel Surtees, Julia Smith, Isobel Fleming and members of the CYP IAPT service development group, in particular those parents and young people who bring expertise by experience.

Our thinking draws on work being undertaken as part of the payment systems work. Members of the Payment systems project group are: Panos Vostanis, Miranda Wolpert, Simon Young, Ben Ritchie, Isobel Fleming, Rob Senior, Ann York, Peter Martin, Roger Davies, Bruce Clark, Pat Howley, Lynne Howey. We also draw on discussions with those involved in advocating for young people and families including Sarah Brennan and colleagues from YoungMinds, Jane Sedgewick, Cathy Street and colleagues from GIFT, Yvonne Anderson and colleagues from Cernis and Kate Martin and colleagues from Common Room.

Members of the Child Outcomes Research Consortium (CORC) Committee were involved in developing ideas around the MINDFUL model of performance management and quality improvement. The CORC Committee comprises Miranda Wolpert, Ashley Wyatt, Tamsin Ford, Duncan Law, Julie Elliott, Ann York, Mick Atkinson, Alan Ovenden, Kate Martin and the CORC Team are Matt Barnard, Jenna Jacob, Kate Dalzell, Benjamin Ritchie, Andy Whale, Amy MacDougall, Elisa Napoleone, Victoria Zamperoni, Lily Levy, Sally Marriott, Craig Hamilton, Alison Ford, Deborah Sheppard and Danielle Antha.

As always, our work is enhanced by the design input of Slavi Savic and editing of Izzi Whelan.



## INTRODUCTION

As we noted in November 2014, children and young people mental health services<sup>1</sup> across England have never been so prominently in the spotlight. This has continued to be the case into 2015. In 2014, 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 (Health Committee, 2014). A government-sponsored taskforce (to which several of the authors contributed) resulted in the influential Future in Mind document jointly produced by the Department of Health and Department of Education (2015) and additional funds have been announced to support children and young people mental health services transformation in line with this document.

The Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre (AFC) published their suggested new model for children and young people mental health services, the *THRIVE: The AFC-Tavistock Model for CAMHS*<sup>2</sup>, in November 2014 (Wolpert, Harris et al., 2014). We stressed from the outset that whilst we felt that the THRIVE model offered a radical shift in the way that services are conceptualised and potentially delivered, along with suggestions for how they might be reviewed and improved. We were not presenting THRIVE as a “tried-and-tested one-size-fits-all implementation model”, but rather as a framework to allow for greater clarity of thought, planning and action.

We are continuing to share our thinking as it develops to help inform the current national debate on the future of children and young people mental health services and as a basis for future provision. This work is broader than the traditional CAMHS NHS delimited support and is based on a whole system approach encompassing education, social care and a range of partners.

**It is important to note that nothing relating to the central ideas of the framework has been changed.**

The current version of our thinking (*THRIVE Elaborated*) seeks to re-emphasise that whilst THRIVE does not in itself provide a blueprint for implementation it is aligned to implementation models including the Choice and Partnership Approach (CAPA) (York & Kingsbury, 2013).

This edition also provides more detail as to how THRIVE aligns with the payment systems work, which was developed in parallel and informed the development of aspects of the framework.

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1 In the light of potential confusion caused by use of the term CAMHS (which has come to be associated with particular forms of provision such as specialist NHS provision) for this edition we are referring to children and young people mental health services to encompass the full range of provision to support mental health needs of young people across agencies and organisations.

2 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 TO THE DEVELOPMENT OF THRIVE

### Children and Young People Mental Health Services in Context

Services to support child and adolescent mental health have grown from diverse roots. On the one hand, this 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 focused 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 (Wolpert, 2009).

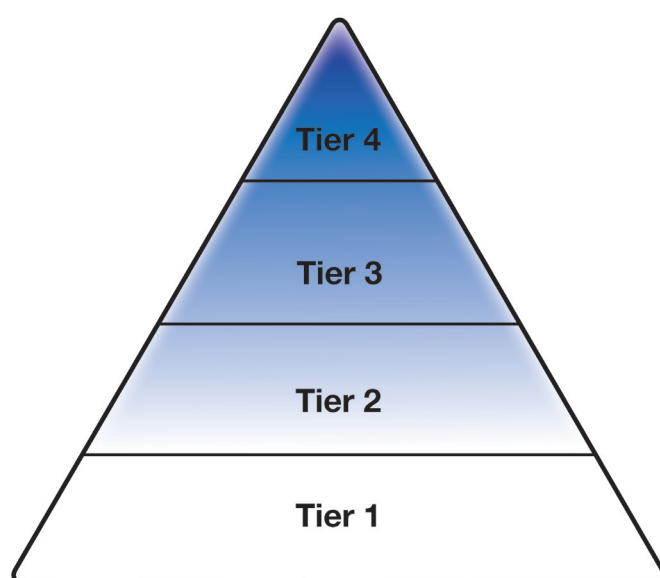
Children and young people mental health services are almost inevitably a smaller part of a bigger system, whether representing the child part of mental health or the mental health part of child services. Whilst there has in recent years been an increased policy focus on CAMHS specifically (National CAMHS Review, 2008), 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 (YoungMinds, 2013). The last UK epidemiological study suggested that at that time (ten years ago) less than 25% of those deemed 'in need' accessed support (Green, McGinnity, Meltzer, Ford, & Goodman, 2005).

Attempts have been made to conceptualise children and young people mental health services, the most long-lasting and influential of which a model dividing service provision into four tiers as outlined and described below (North East London NHS Foundation Trust, 2014):

**Tier 1:** 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:** specialised primary mental health workers (PMHWs) 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 and counselling service.



**Figure 1:**  
Four tiers of  
service provision

**Tier 3:** specialist multidisciplinary teams such as child and 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:** 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 (NHS Advisory Service, 1995) 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 (Bor, Dean, Najman, & Hayatbakhsh, 2014). 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) being apparent by the age of 18 (Campion, Bhugra, Bailey, & Marmot, 2013).

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 (Health Committee, 2014). Service providers report increased rates of self-harm referrals, and increased complexity and severity of presenting problems (Health Committee, 2014).

In terms of opportunities, there is increased provider coherence of what ideal children and young people mental health services might look like, with increased focus on work in schools and promotion of community and individual resilience (HeadStart, 2014), agreed sets of best practice standards collated by the service transformation initiative<sup>3</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<sup>4</sup>.

To enable this to happen there needs to be increasing alignment to shared standards of routine outcome measurement and performance management<sup>5</sup>.

A major opportunity for developing and refining thinking around children and young people mental health services came from the payment systems development work. This drew on the increasing evidence base in children and young people mental health services (Fonagy, 2002), emerging thinking around targeted payment systems to distinguish the needs of different groups of children, young people and families seeking help and support (NHS, 2013), and a determination to support service delivery based on both values and value (Fulford, 2004; Porter & Teisberg, 2006). The links between THRIVE and the Payment Systems project development are detailed on pp.12–16 below.

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

4 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.

5 Quality Network for Inpatient CAMHS, the Choice and Partnership Approach.

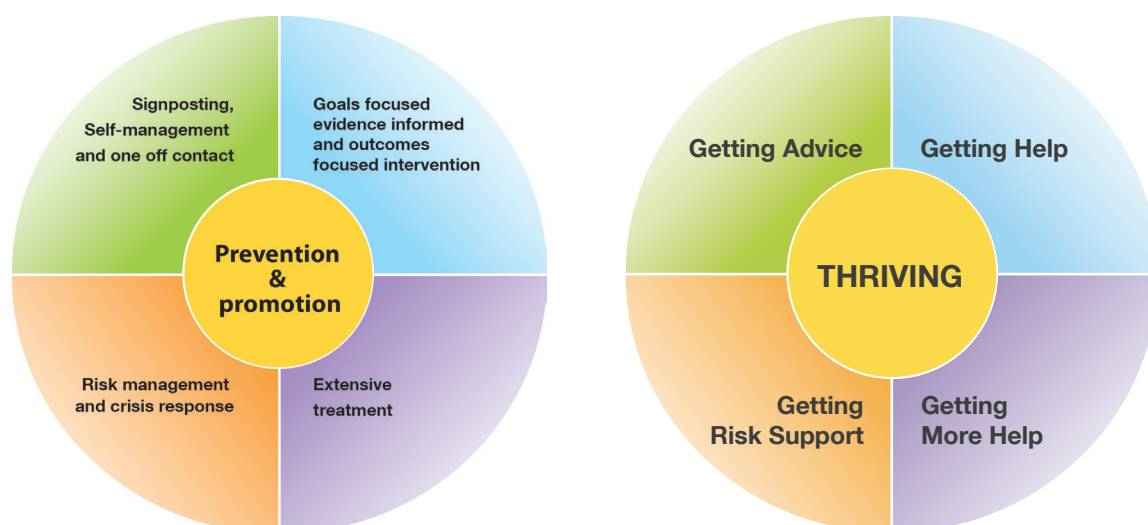
## THRIVE FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE MENTAL HEALTH SERVICES: A NECESSARY PARADIGM SHIFT?

We are proposing to replace the tiered model with a conceptualisation of a whole system approach that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The framework 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. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and families are active decision makers in the process of choosing the right approach. Rather than an escalator model of increasing severity or complexity, we suggest a framework 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 framework below conceptualises five needs-based groupings for young people with mental health issues and their families. The image on the left describes the input that is offered for each group; that on 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.

Each of the five groupings is distinct in terms of the:

- 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.



**Figure 2:**  
THRIVE framework

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

The groups are not distinguished by severity of need or type of problem. Although it is likely that certain problems or severities may be more common in some groups, there is no one-to-one relation between severity or type of problem and grouping. Rather, groupings are primarily organised around different supportive activities provided by children and young people mental health services in response to mental health needs and strongly influenced by client choice.

THRIVE focuses on clarity around need rather than prescription as to exact structures or interventions to meet those needs. The THRIVE categories are “needs-based groupings”: “Need is defined as the identified approach ... collaboratively agreed via a process of shared decision making between service provider and service user. It includes both judgement of the appropriateness of interventions offered and the informed choices of children, young people and their carers regarding the approach ... that is best for them, within the parameters and scope of the commissioned service,” (Wolpert et al., 2015, p.7).

Thus each person or family accessing services is entitled to the following respect agenda:

<b>As someone seeking help from a professional, I have a right to RESPECT</b>	
<b>Review</b>	<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>Effective Help</b>	<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</li> </ul>
<b>Select</b>	<ul style="list-style-type: none"> <li>• Make choices about what help I get when different evidence-based approaches exist</li> <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>Progress</b>	<ul style="list-style-type: none"> <li>• Be listened to and have my views taken into account</li> </ul>
<b>Expression</b>	<ul style="list-style-type: none"> <li>• Know how those supporting me understand the difficulties</li> </ul>
<b>Clarity</b>	<ul style="list-style-type: none"> <li>• Know what is happening to information about me</li> </ul>
<b>Transition Support</b>	<ul style="list-style-type: none"> <li>• Be supported to find further help if needed</li> </ul>

**Figure 3:** Respect agenda

## THRIVE AND IMPLEMENTATION

THRIVE is a framework that brings to bear some of the ideas that a number of us have had over many years based on our experience in providing, researching, using and change-managing systems related to supporting child and adolescent mental health, including our experience of what those accessing services tell us they want and need from services. THRIVE offers a set of principles and values to guide implementation but it is not itself a how-to guide nor does it provide a blueprint for implementation. We want neither to prescribe nor proscribe what implementation might look like locally – rather we are interested to learn from local models of implementation. In the light of this we have started to refer to THRIVE as a framework to try to emphasise this. We reiterate our wish, laid out in the November 2014 document, that we genuinely want to learn from local implementation and how the model has been applied across sectors. The author group see themselves as akin to a think tank organised around trying to address key aspects of service delivery using a number of key principles tested against what is known about service delivery and service use.

There are a number of initiatives and approaches that are aligned with THRIVE principles and which might support implementation of THRIVE:

- The Choice and Partnership Approach (CAPA) is a well-developed approach that many areas have found can aid implementation of the key principles of shared decision making and clarity of choice. The alignment of CAPA to THRIVE is discussed in more detail below. [www.capa.co.uk](http://www.capa.co.uk)
- Children and Young People Improving Access to Psychological Therapy (CYP IAPT) is being rolled out across the country and seeks to combine evidence-based practice with user involvement and rigorous outcome evaluation to embed best practice in child mental health. [www.cypiapt.org](http://www.cypiapt.org)
- The Child Outcomes Research Consortium (CORC) learning collaboration can aid alignment and integration of data and outcomes across agencies and organisations, and is seeking to support areas to develop and embed cross-sector outcomes. [www.corc.uk.net](http://www.corc.uk.net)
- Peer-review networks such as the Quality Network for Community CAMHS can aid embedding and consideration of key elements of practice. [www.rcpsych.ac.uk/quality/quality,accreditationaudit/communitycamhs.aspx](http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/communitycamhs.aspx)

An implementation group, i-THRIVE, has formed consisting of an initial partnership between AFC, Tavistock and Portman NHS Foundation Trust, UCLPartners and Dartmouth Center for Healthcare Delivery Science (US), drawing on support from a range of partners, including YoungMinds, CAPA and CORC. The purpose of i-THRIVE is to translate the THRIVE framework into a model of care, and to support sites implementing this model locally. In order to support shared decision making, which is core to THRIVE but which continues to present an implementation challenge, the group is seeking to combine THRIVE with specific tools developed in the US, in particular Options Grids™, and tools to assess extent of both collaboration and integration of services (CollaboRATE® and IntegRATE®).

i-THRIVE has recently been awarded NHS Innovation Accelerator status, led by Dr Anna Moore, and has launched the i-THRIVE Community of Interest. The programme is currently developing a range of tools to support local sites interested in adopting the model.

### THRIVE and CAPA

A key question we are often asked is “How does THRIVE relate to a Choice and Partnership Approach (CAPA)?” The THRIVE framework is consistent with a CAPA approach and draws on the rich learning from CAPA. CAPA also provides an important potential model of implementation of the principles within THRIVE. CAPA is used in children and young people mental health services and increasingly in adult mental health all over the world and includes a “how to” system in place that consists of 11 key components.

The ways in which CAPA and THRIVE align include:

- The THRIVE groupings align with those used in CAPA of choice (getting advice) and partnership (core partnership is equivalent to getting help, Specific partnership with getting more help and getting risk support). CAPA, like THRIVE, defines the groupings in terms of needs/choices of individuals, description of needs, skill mix and resources needed to support those choices.

- CAPA focuses on helping people make explicit choices about what may most benefit them and links this with clear evidence-based packages of care. A focus on being clear what the task is and how it is to be delivered and the agreement on the task alliance with the client is embedded in CAPA.
- One of CAPA's 11 key components is to change language to that which promotes strengths-based, collaborative work towards shared goals with young people and their families, thinking about skills needed, rather than access to a particular professional discipline. The THRIVE framework promotes this way of thinking by furthering the use of language to one that is helpful to young people and families and services.

CAPA addresses many areas the THRIVE framework does not address (nor necessarily endorse).

- Workforce and capacity planning. In particular, CAPA segments work so that skills and capacity can be properly identified and deployed. In addition CAPA identifies all the other types of work staff do in their job to allow capacity to be calculated.
- Consideration of staff training, for example in relation to language used with clients and with each other.

THRIVE emphasises aspects that are aligned but not synonymous with CAPA, including a more explicit and focused emphasis on:

- the difference between risk support and other forms of help. This includes being explicit about the role of children and young people mental health services, which is not about treatment, i.e. risk support is seen as the business of children and young people mental health services.
- the potential for treatment harm as well as the limitations of what can be achieved
- endings, even when significant change has not been achieved and focus on more explicit discussion of this with service users
- use of tools to support empowerment and shared decision making
- interagency ownership of the framework including cross-sector outcome measurement.



## THRIVE AND PAYMENT SYSTEM DEVELOPMENT

Payment systems attempts to capture a more complete picture of the work done by clinicians, and therefore its cost, in order to inform the development of a system by which payment, such as for children and young people mental health services, is determined according to need. The final report of the payment systems project was published in June 2015 (Wolpert, et al., 2015) and reports on the work are being produced (Vostanis, et al., 2015). The payment system work was jointly led by Miranda Wolpert (lead author for THRIVE) and Professor Panos Vostanis. Simon Young (Tavistock and Portman) chaired the steering group, working in close liaison with colleagues from South London and Maudsley Trust (Dr Gordana Milakovic and Dr Bruce Clark). Many others were also involved (see list of acknowledgements p.4)

Miranda Wolpert shared and updated thinking between the groups (THRIVE and Payment Systems) as the work progressed. Thus the emerging learning from the analysis of data from the Payment Systems Project, as it became publicly available, informed the thinking about the THRIVE needs-based groupings.

Perhaps not surprisingly given membership of the groups, the payment systems work was informed by many of the same values of the THRIVE authors – including a commitment to shared decision making wherever possible, and a wish to develop needs-based groupings that were meaningful to those providing and using services and not necessarily purely diagnostically driven (Wolpert, et al., 2015).

Three aspects of this data-analytic work from the Payment Systems project that particularly informed THRIVE are elaborated below. Their implications for each needs-based grouping within the THRIVE framework are outlined within each section as relevant (e.g. getting advice p.19, getting help p.21, getting more help p.22):

### **1. Analysis of resource use by those accessing outpatient CAMHS – existing data from the Child Outcomes Research Consortium (CORC) (2012-13)**

Using existing routinely collected data relating to children and young people mental health service users submitted by services who are part of the Child Outcomes Research Consortium (CORC) – a learning collaboration of the majority of services across England committed to using outcome measurement to improve and inform service delivery (Fleming, Jones, Bradley, & Wolpert, 2014), the payment systems group considered data from 38,794 periods of contact for children (0-18) from 107 clinical teams in 21 services, submitted to CORC between March 2012 and December 2013.

The analysis found that “the modal number of appointments was 1; almost a quarter (24%) of periods of contact were closed after the first appointment. The median number was 3, that is, half of all cases were closed after three appointments or fewer had been attended. The distribution was strongly positively skewed: 37.8% of all appointments were attended by the 5.25% most ‘resource-intensive’ patients, who attended more than 30 appointments each” (Wolpert, et al., 2015, p.21) Greater resource use was associated with greater clinician-rated severity (e.g. on CGAS – child global assessment scale) and some types of problems were more highly represented in the “resource-intensive” group such as eating disorders and psychosis. However it is important to note that there was great variability in terms of the amount of resource use, and type and severity of problem, and no correlation was possible to find in terms of any other indicators of need available in the dataset (Vostanis, et al., 2015; Wolpert, et al., 2015).

### **2. Analysis of resource use in relation to need by those accessing NHS outpatient CAMHS collected specifically as part of the Payment System Pilot Project (2012-14)**

In order to look more carefully at the factors that might account for the variations in resource use found above, pilot sites across the UK agreed to collect data using the Current View tool (Jones et al., 2013), to try to capture key information about case mix at the outset of contact. The tool is a one-page form completed at intervention outset. It was developed drawing on existing literature, and in consultation with both service providers and service users to try to capture key attributes of the young person and their family, in terms of presenting problem or context, that were thought likely to impact on either resource use or outcome (Jones, et al., 2013; Wolpert, et al., 2015). Clinicians in the pilot sites were trained to use the tool to promote consistency in use and item completion (<http://pbrcamhs.org/training/current-view-tool-training/>).



The Current View tool (see p.31, appendix 1 for copy of the tool) records:

- 30 presenting problems<sup>7</sup> (e.g. social anxiety, family relationship problems, carer management of child's behaviour)
- 4 contextual problems (relation to home, school, community, and service engagement)
- 2 education, employment or training issues (attendance and attainment),  
Each rated "None", "Mild", "Moderate", "Severe", or "Not known".
- 14 complexity factors (e.g. presence of learning disability, parental health issues, refugee status) Each rated "Yes", "No", or "Not known".

Data on resource use (in terms of number of contacts)<sup>8</sup> and on ending of contact were collected from 11 NHS outpatient CAMHS, amounting to some 4573 episodes of care with data that included Current View tool and resource use information.

Attempts were made to derive needs-based groupings bottom-up from the data using a variety of statistical techniques including: unsupervised cluster analysis (k-medoids cluster analysis) and supervised cluster analysis (regression trees) (Wolpert, et al., 2015, p.23) However, no stable or meaningful groupings were identified using these methods. In contrast, a "clinically driven classification approach" based on rigorous review of NICE guidance and clinical practice resulted in clinically meaningful groupings, which were as good as or better than statistical approaches (see algorithm development, below).

### **3. Development of an algorithm to potentially allocate children, young people and families to groupings.**

Two senior clinicians (consultant psychiatrist Professor Panos Vostanis and consultant psychologist Dr Roger Davies), both members of the payment systems group, independently reviewed the 15 existing NICE guidelines (11 specifically for children, and 4 for adults but with reference to children) in relation to factors affecting resource use (Vostanis, et al., 2015). From this analysis it was found that the NICE guidelines related largely to symptomatic severity and, to a lesser degree, impairment – but were not influenced or amended according to contextual factors in the children's or their families' lives. In light of this, an algorithm was developed that assigns children and young people mental health services clients to a NICE guidance category based on the presenting problems rated on the Current View tool. Because of the lack of consideration of contextual factors in the NICE guidance these elements on the Current View tool were not included in the algorithm, but it was hypothesised that these factors might account for additional variance in resource use within each grouping.

What emerged from this work was an algorithm that allocated children, young people and families accessing mental health services to three superordinate categories termed "getting advice" (analogous to the getting advice grouping in THRIVE), getting help (as the THRIVE grouping) and getting more help (as the THRIVE grouping). Within each of these categories there were subcategories (2 in getting advice, 13 in getting help and 4 in getting more help) leading to an overall set of 19 clusters (14 of which are guided by specific NICE guidance and 5 of which are not) within the Payment System model (Wolpert, et al., 2015). The implications of these categories and sub-categories for the THRIVE framework are discussed in more detail below. It should be noted at this point that risk support and thriving were not groupings identified by the Payment Systems work, though they were referred to in the final report to show how they could be aligned with the payment systems approach (Wolpert, et al., 2015).

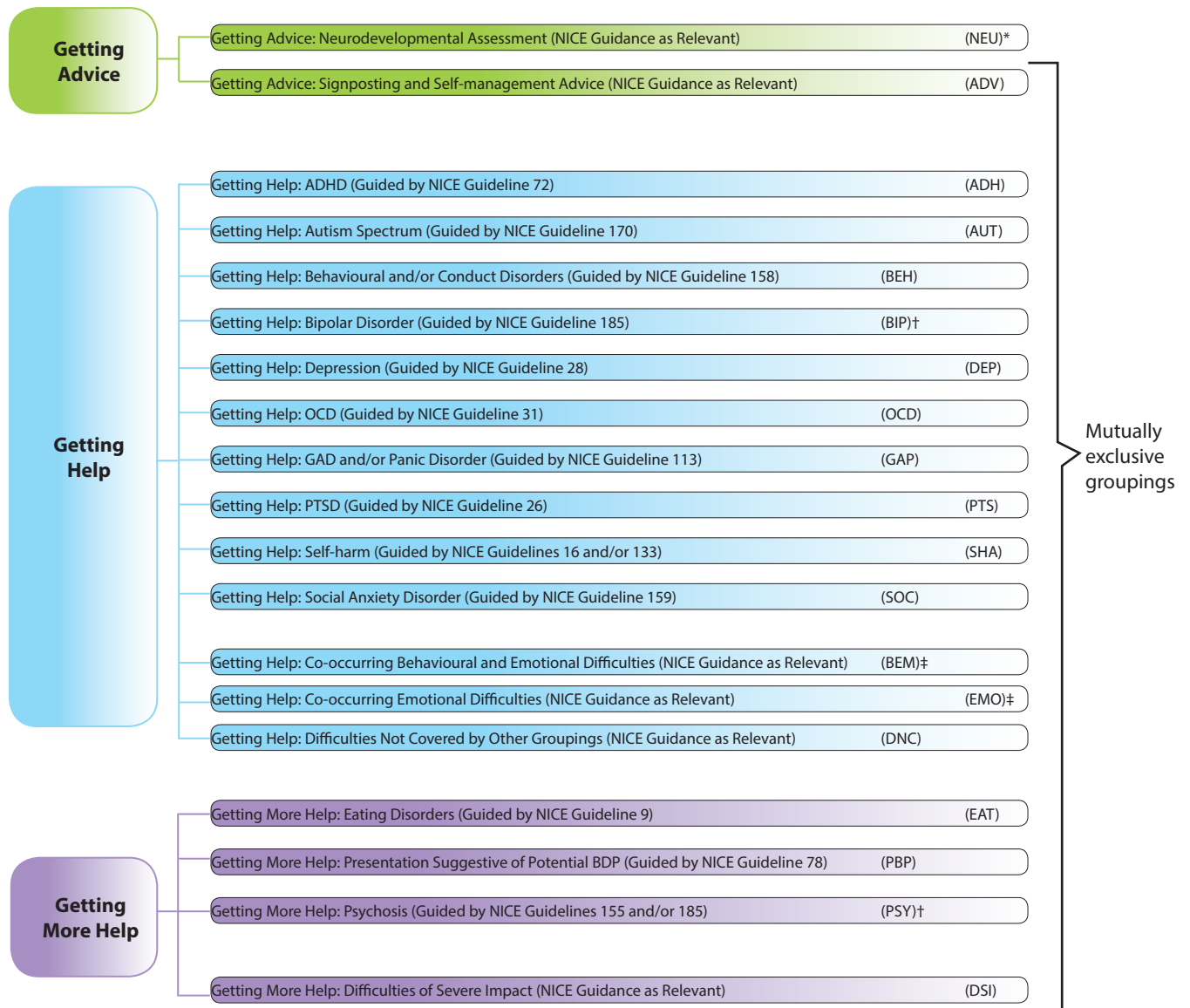
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7 Ratings need not imply a diagnosis.

8 Data quality on inpatient work was not sufficient to be included in the analysis.

'Super groupings'  
(n=3)

Needs-based groupings  
(n=19)



**Figure 4:**  
The payment systems groupings

The payment systems groupings are outlined in the figure above.

The exact algorithm can be found in the Payment Systems report (Wolpert, et al., 2015. Appendix C). Key elements are outlined overleaf.

1. To be potentially allocated to the getting advice needs-based grouping, children, young people and families had to have at maximum one problem rated as moderate, no problems rated as severe and no problems rated as potentially significant and enduring (such as psychosis or eating disorders) on the current view at outset. On this basis, 28% of the episodes of care were considered potentially appropriate to include in this grouping.
2. To be potentially allocated to the getting help needs-based grouping, children, young people and families had to have a signature problem rated as moderate or above, or one problem rated as severe. On this basis 60% of the episodes of care were considered potentially appropriate to include in this grouping. Of these about half (30% of all episodes of care) are estimated to be allocated to potentially benefiting from intervention guided by one of the ten NICE guidelines subsumed under “getting help”, while the other half belong to the three “co-occurring problem” groups (30% of all episodes of care).
3. To be potentially allocated to the getting more help needs-based grouping, children, young people and families had to have a difficulty that indicated likelihood of need for substantive resource use, such as eating disorders, psychotic symptoms, or multiple severe problems. On this basis, 10% of the episodes of care were considered potentially appropriate to include in this grouping. Of these, around a quarter are allocated by the algorithm to potentially benefit from help guided by one of the three NICE guidelines subsumed under “getting more help”, while the other three-quarters belong to the non-NICE specified “difficulties of severe impact” (8% of all episodes of care).

An important finding from the payment system work was that algorithm assignment did not fit neatly with actual resource use. This is consistent with findings in the development and analysis of other algorithm-based classifications. There was significant variability in actual resource use for children and young people and families potentially allocated to the groupings as outlined in Table 1 below.

**Table 1:** Predicted resource use for needs-based groupings, from payment systems project analysis

Needs-based groupings	Predicted % in grouping based on application of the algorithm	95% confidence interval of group percentage	Predicted average no. of sessions	95% confidence interval of estimated average appointments	Predicted % resource use for a typical service*	Informal confidence range for predicted resource use**
Getting advice	28%	27%-29%	6.2	4.6-8.4	24%	20%-29%
Getting help	61%	60%-62%	6.9	5.1-9.5	59%	53%-65%
Getting more help	11%	11%-12%	10.4	7.5-14.5	16%	13%-22%
Total	100%	--	7.2	6.6-7.8	100%	--

Note: The estimation of “% in grouping” is based on closed and open cases from 11 CAMH services (n=11,353). The estimation of “average number of sessions” is based on the sample of closed cases whose points of contact began between 1 September 2012 and 28 February 2013 (n=757). The latter sample was constructed in an attempt to minimise bias towards shorter periods of contact, which arises because data collection ended on 30 June 2014 (giving an overall data collection period of 22 months). Nonetheless, by definition no child in the data set attended NHS outpatient CAMHS for longer than 22 months. We therefore think that the predicted averages of numbers of sessions given in the table (as well as their confidence intervals) are underestimates.

\*Data only included face-to-face work as data quality for indirect work was too poor, so number of sessions is taken as proxy for resource use. No data was known about more or less expensive staff so each contact is treated as of equal resource use.

\*\*The confidence range of estimated percentage of appointments takes into account the uncertainty about the estimated percentage of service users in each grouping, as well as the uncertainty about the average number of appointments within each grouping. This is not a precise confidence interval.

Table 2 below sets out an entirely hypothetical allocation to groupings and allied resource use which draws on the analysis above but assumes resource use that follows tighter allocation to clusters and includes hypothesised use by groupings not addressed in the payment systems work but core to THRIVE: thriving and risk support (see elaboration sections p.17 and p.23 below).

**Table 2:** Hypothetical resource use in NHS outpatient CAMHS after implementing THRIVE

Needs-based groupings	Hypothetical % of episodes of care in grouping	Hypothetical average number of sessions	Hypothetical % resource use (direct appointments only)	Hypothetical % overall resource use
Getting advice <sup>1</sup>	30%	3	10%	8%
Getting help	60%	10	66%	56%
Getting more help	5%	30	16%	14%
Getting risk support	5%	15	8%	7%
Thriving	n/a	n/a	n/a	15%
Total	100%	9.2	100%	100%

Note: The predicted average number of sessions here was set to 9.2, which is similar to the average number of sessions observed in data collected by CORC. This is higher than the 7.2 observed in Payment Systems data (reported in Table 1), since Payment Systems data are biased toward shorter periods of contact.

It is crucial to note that Table 2 is entirely hypothetical. This framework must be tested and we do not want to make extravagant claims of cost savings without evidence. We hypothesised that targeting help may result in overall savings that would then free resources for community support, but this assumption is something to be tested as part of implementation trials.

One of the key tasks of THRIVE is to make more explicit how resource usage links to need and for this to be examined, considered and refined as part of ongoing implementation and framework development.

We now turn to a detailed discussion of each of the proposed needs-based groupings that make up the THRIVE framework.

<sup>9</sup> This includes neuro-psychological assessment thought to be relevant in around 3% of cases and assumed to be happening in addition to other elements.

## THRIVING

The grouping of “thriving” is often portrayed in the centre of the THRIVE model but could equally be portrayed as around the outside. It is perhaps worth nothing that this was how it was initially portrayed but then people complained the picture looked like a plughole - on such bases are pictorial representations of ideas moulded!

Thriving is included as a concept to indicate the wider community needs of the population supported by prevention and promotion initiatives. In our publication in November 2014 we did not include a detailed discussion of the needs of this grouping so we have started with a discussion of this grouping in this version.

**Context:** All those children, young people and families who do not currently need individualised mental health advice or help are considered to be thriving. This is based on the assumption that not everyone requires or would benefit from mental health interventions, and indeed offering specific mental health interventions which cut across individuals’ own strength and strategies may sometimes be iatrogenic.

This does not mean that those thriving in the community will not benefit from more general interventions to support mental health and wellbeing. The THRIVE framework would suggest this group should receive community initiatives that support mental wellness, emotional wellbeing and resilience of the whole population. This is an area of mental health support that some consider has been neglected by mental health professionals and commissioners over the years, but one where the potential impact could be great – by understanding the factors likely to lead to psychological harm, services can apply strategies to tackle these causes and prevent harm to individual children. This requires rigorous understanding of the environmental causes of potential harm to children and young people’s psychological health, and the active application of strategies to try to reduce or remove these as far as possible before they affect a child’s emotional wellbeing: primary prevention.

There are many factors that are known to increase the likelihood of the development of mental health difficulties in children and young people (World Health Organisation, 2012). These include individual factors such as: learning disability, physical health problems and sexuality; social factors such as poverty, poor education, and abuse and neglect; and environmental factors including injustice, discrimination, social and gender inequalities, and exposure to war and natural disasters.

The relationship between risk factors and mental health problems is complex, and the impact of exposure to the risk will vary from child to child – but all children exposed to potential causes of psychological harm will have an increased chance of developing mental health problems either in childhood or later in life.

**Data:** It is anticipated that at any one time around 80-90% of the total population of children and young people will fall into the needs-based grouping of thriving (based on Green et al’s (2005) view that around 10-20% of children and young people have problems significant enough to warrant specialist help).

**Resource:** There is no hard-and-fast rule for how much resource should be allocated to this category and as yet no economic evaluations that can robustly guide policy in this regard. Reports from current practice suggest that in many areas around 10-15% of the budget in children and young people mental health services is allocated to support community resilience programmes; consultation with teachers, health visitors and others; and other forms of intervention to support widespread wellbeing and mental health. It is anticipated that in any case-mix-adjusted payment system it is likely this work would need to be top sliced to be able to continue.

**Need:** Before reaching adulthood, all children and young people will experience many episodes of psychological distress. The quantity and impact of these events will depend largely on the environment in which the child lives, and the quality of care they receive from the people around them. For most children the distress they encounter will be mild and relatively short lived, and they will continue to thrive. For some children the impact of events will be so great that they will need more professional care and treatment. Despite the distress that negative events can cause it would not be helpful to try and remove all the emotional upset from a person’s life – in fact we know that these experiences, if not overwhelming, can help a person become more resilient and help them learn to manage bigger upsets later in life. To give children the best start in life it is important that systems promote emotionally healthy environments, and make every effort to prevent psychological harm. Child maltreatment is now known to be one of the biggest risk factors for children and young people developing mental health difficulties. Maltreatment can take a number of different forms, and can lead to a number of different outcomes. Selective prevention strategies that work with vulnerable families

and provide community-based interventions to build parenting skills and social support (e.g. mellow parenting (Puckering et al., 1999), help to build healthy protective attachments – particularly in the early years. This should be alongside the strengthening of child protection services to safeguard children more effectively in order to prevent maltreatment and trauma.

**Provision:** To promote thriving, the THRIVE framework expects that the system actively applies research evidence of the kind of interventions that are likely to reduce the risk of developing mental health difficulties and promote wellbeing and mental health. Opler et al (2010) define categories of prevention that might be seen to fit with the THRIVE framework of primary prevention: “1. **Universal prevention:** *Targeting the general public or a population group that has not been identified on basis of individual risk.* 2. **Selective prevention:** *Targeting individuals or populations subgroups who have biologic, psychological, or social factors placing them at a higher than average risk for developing mental disorders.*”

Services should also help increase awareness and promote psychological wellbeing and health at a whole community level – again through the application of evidence-based psychological approaches. There is much work to be done to expand the role of mental health professionals into this realm of mental health promotion (Knapp, McDaid, & Parsonage, 2011). This will involve awareness raising, consultation and training that is not necessarily focused on a particular child or family.

Examples of whole community approaches to promote psychological wellbeing include the ‘The Big Noise’, adapted from the ‘El Sistema’ movement (Tunstall, 2012). It encourages whole communities to become empowered and take an active role in their lives and community. The vehicle for this change is music, giving instruments to children and encouraging them to put on concerts, pulling together the community and fostering feelings of self-efficacy and wellbeing (Scottish Government Social Research, 2011). Whole school approaches include the Time 2 Talk project in Haringey, run by Nick Barnes and colleagues, which raises awareness about emotional wellbeing and mental health, and challenging mental health stigma.

## GETTING ADVICE

**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 (a £75-million project funded by the Big Lottery Fund), 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 increasingly becoming available and being used to support young people in their communities. There is increasing academic interest (e.g. community psychology) in how we can more effectively draw on strengths in families, schools and wider communities. School-based interventions have been shown to support mental health (Wong, Kady, Mewton, Sunderland, & Andrews, 2014), peer support can promote effective parenting (Day, Michelson, Thomson, Penney, & Draper, 2012) and integration of mental health in paediatric primary care can support community resilience (Rahman, Surkan, Cayetano, Rwagatare, & Dickson, 2013). The wider government policy can impact positively or negatively on the emotional wellbeing 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 CORC data as part of the payment systems development work (Wolpert, et al., 2015) as outlined above (p.12) found that the most frequently occurring (modal) number of sessions of young people and parents attending NHS outpatient CAMHS was one, with many being seen for less than three contacts. In the majority of these cases, where data were available, the clinician reported that the ending was by mutual agreement between the provider and young person or family members. Whilst it was not possible to determine from existing data whether the majority of these leave satisfied, nor how many are referred elsewhere, practitioner reports suggest 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:** In theory this is the likely least resource intensive (cheapest) of the needs-based groupings. However it should be noted that due to the variability in actual resource use of those who were provisionally allocated to this group in the payment system pilot data, the 28% potentially allocated consumed 24% of the total resources in the payment systems analysis (see p.15 above). If we assume that around 30% would benefit from only limited resource to allow coping and the average amount of resources used was equivalent to two face-to-face sessions then the amount of resource use would be equivalent to 8% of total resource given other assumptions outlined in Table 2 on p.16 above. It is important to note that this is only conjecture at the moment. This framework must be tested and we do not want to make extravagant claims of cost savings without evidence.

**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, however, 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 experienced decision making about how best to help people in this group and to help determine whose needs can be met by this approach.

Support within getting advice should build on existing family resources. In particular if the difficulty seems to be in a secure context then draw on these strengths. Coping is defined as there being sufficient resilience in person and community (context) so as not to be such high risk as to need intervention if not asking for more intervention.

Key elements of getting advice might include providing families with research or experience-based information related to the difficulties presented to the professional – information is relayed in such a way as to enhance the self-efficacy of the family and increase the chance of taking appropriate ameliorative action; using the interview to draw out the options available to the family and inviting the family to consider the pros and cons of each of the options; making suggestions for limited changes in aspects of the child's and family's routines; helping to identify extant proximal resources both within their social network or support agencies, voluntary groups etc.,

drawing on resources such as the Youth Wellbeing Directory<sup>10</sup> to identify relevant resources; an invitation for re-contacting the service is embedded in the offer of any advice if things do not improve or they deteriorate.

There are occasions where the young person or family may say they are “coping” and not seek further input, but the professional feels more input is required and the risks of intervention are outweighed by the risks of non-intervention. This would include occasions where there are major risks for the young person, such as of placement or school breakdown; there are significant concerns about deterioration or the context is not deemed safe for the young person or their family. If these factors applied then consideration should be given as to whether the needs of the young person and/or family should be more appropriately conceived of as falling into one of the other needs-based groupings such as getting help, getting more help or getting risk support.

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10 [www.youthwellbeingdirectory.co.uk](http://www.youthwellbeingdirectory.co.uk)



## GETTING HELP

**Context:** There is increasingly sophisticated evidence for what works with whom in which circumstances (Fonagy, 2002), and increasing agreement on how service providers can implement such approaches (NHS CYP IAPT, 2012), alongside embedding shared decision making to support patient preference (Mulley, Trimble, & Elwyn, 2012) and the use of rigorous monitoring of outcomes to guide choices both between different types of interventions and within interventions (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011). The latest evidence suggests that a significant minority of young people will not be “recovered” at the end of even the best evidence-based treatments.

**Data:** Analysis of data from the Payment Systems Project work (Department of Health, 2014; Wolpert, et al., 2015) (see above, pp.12-16, for fuller discussion) found that of the 60% of children, young people and families who had difficulties that appeared likely to benefit from goal-focused interventions under the heading of “getting help”, about half looked likely to be clearly aligned to specific NICE guidance and half were not clearly aligned, either because of co-morbidity or because the primary difficulty was not captured by NICE guidance, such as family relationship difficulties.

**Resource:** The average (mean) number of face-to-face contacts for episodes of care within the payment systems pilots was seven. It is hypothesised that the THRIVE model would support more clearly targeted work with some young people getting more intervention and others getting less. It is conjectured that the mean number of contacts for this group might rise (to e.g. 10 – see Table 2 on p.16) but with fewer young people being seen for extended periods of time if it were felt an intervention was not proving effective.

**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 but also where it was less clear which NICE guidance would guide practice.

**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) with a greater emphasis on ending an intervention if it was felt not to be working or if it was felt gains no longer outweighed costs or potential harms. It is our contention that health input in this group might draw on specialised technicians in different treatments, possibly allowing less expensive professionals to provide more procedurally defined interventions.

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.

## 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 NHS outpatient CAMHS data for payment systems found that “37.8% of all appointments were attended by the 5.25% most ‘resource-intensive’ patients, who attended more than 30 appointments each”, (Wolpert, et al., p.21) Key problems that were associated with larger amounts of contact included eating disorders and psychosis. It should be noted that there was great variation within the groups and that the analysis was not able to consider inpatient treatment. The payment system pilot work found the average number of appointments for those provisionally allocated by the algorithm to this group was around ten.

**Resource:** It is suggested that for some young people and families more extensive treatment is likely to be required and that these young people are likely to have most impairing difficulties such as those reflected in eating disorders and psychosis, though there may be many other issues that lead to significant impairment or requirement for more extensive input. It is hypothesised that the THRIVE framework may result in an average number of outpatient appointments of around 30 (see table 2 p. 16). However, 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. The THRIVE framework proposes that there may be some people currently allocated to this grouping who are not benefiting from intervention, and are being held in services solely because of concerns about risk and safeguarding. It is hypothesised that around half of the 10% of young people currently allocated to this group (as per the payment systems algorithm) might appropriately be reallocated to getting risk support.

**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 but again it may be that more procedurally defined interventions can be provided by less highly trained practitioners than may be needed for the decision making required for getting advice.

## 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 (Weisz et al., 2013). 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 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 – and our hypothesised estimate is that this group may account for 5% of all young people accessing services currently.

**Resource:** Practitioner reports suggest this group may require significant input; they certainly take up a lot of energy in terms of discussions within and between services. Some services report that they are 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 and 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 interagency collaboration (using approaches such as those recommended by AMBIT (Bevington, Fuggle, Fonagy, Target, & Asen, 2013) 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, although it is not a health treatment that is being offered, health staff must play their part in providing input to support and in some cases lead on risk support provision.

In terms of the support offered within this grouping, it would focus on supporting children and parents/carers during periods when they did not feel safe and were unable to take ameliorative action to regain safety. Service users would have access to support from someone whom they know, whom they had helped select and in whom they had confidence and trust, and who is responsible for coordination of the support backup-team (this could be anyone in the system, not necessarily a social care worker). Children and families would have an agreed written safety plan which they participated in drawing up and which explicitly lists agreed actions to be taken by everyone concerned (including the backup team). The aim of the support is to develop the children and families’ capacities for self-management of the emergent needs and the opportunity to exercise this capacity as rapidly as it is feasible to move people either into the getting advice, thriving or getting help/more help groupings as relevant.

## THRIVE AND OUTCOMES

It is suggested that the approach to outcome measurement for those implementing the framework should follow that suggested by Jacob et al (in press) and endorsed by the Payment Systems project team (Wolpert, et al., 2015).

This approach suggests that the personalised goal of the young person or family can helpfully point to a standardised measure that might also be helpful to track progress. Where possible a service should track a personalised goal, alongside a standardised outcome measure, as well as capture the young person or family's experience of the service.

For example, for a family with the goal of "having better family relationships", the service may want to track the family's progress using a personalised goal tool *and* select a standardised measure such as SCORE-15, if this is helpful to the family and practitioner.

In the light of analysis of goals brought by family members, the following five possible domains of measurement are suggested currently, in addition to measurement of whatever bespoke goal the service user identifies:

- symptom change
- greater understanding
- general wellbeing
- relationship enhancement
- impact on life.

The indicators in Table 3 are examples relating to the sort of goals agreed by children, young people and families accessing services. Any appropriate indicator can be used that is consistent with your service's policy. To note Goals Based Outcomes (Law & Jacob, 2015) may be useful in relation to the themes above and/or other bespoke goals agreed.

**Table 3:** Goal themes mapped to corresponding suggested outcome indicators<sup>11</sup>

Overarching theme	Agreed goal	Some possible outcome indicators that can be used
Relationship /interpersonal	Make more friends	Strengths and Difficulties Questionnaire (SDQ); Child Outcome Rating Scale (CORS)
	Have better family relationships	SCORE Index of Family Function and Change-15 (SCORE-15)
	Have less fights	Me and My School (M&MS)
	Better management of child's behaviour by parent	Brief Parental Self-Efficacy Scale (BPSES)
	Less symptoms PTSD	Impact of Events Scale (IES)
Coping with specific problems and symptoms	Less low mood	Strengths and Difficulties Questionnaire (SDQ) Revised Child Anxiety and Depression Scale (RCADS) How are things: Depression/low mood (PHQ-9)
	Manage intrusive thoughts and compulsive behaviours	OCD subscale of Revised Child Anxiety and Depression Scale (RCADS)
	Doing better at school	Number of days attending school; academic achievement
Personal functioning	Feeling happier	Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

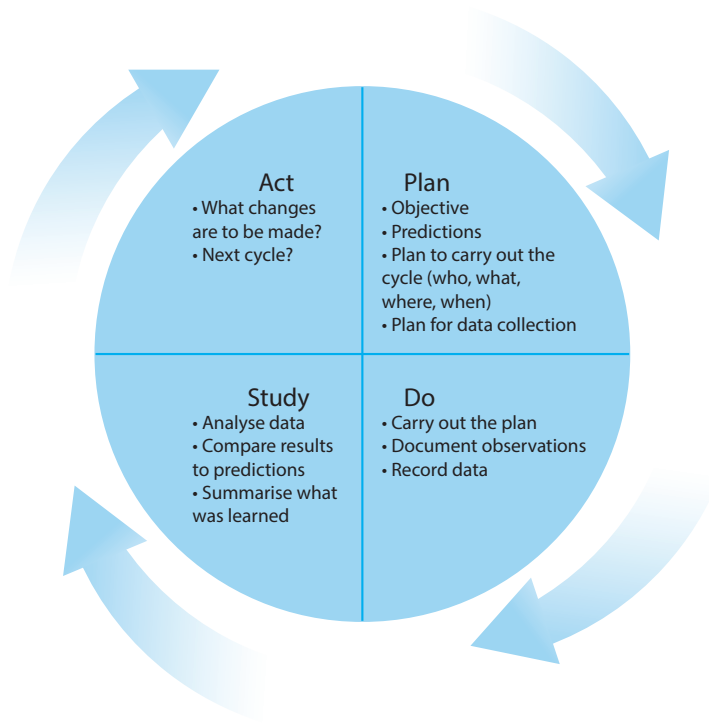
<sup>11</sup> Aspects of table derived from Jacob, Edbrooke-Childs, Law, et al. (2015). Goal frameworks taken from Jacob, Edbrooke-Childs, Holley, Law, & Wolpert, 2015.

## PERFORMANCE MANAGEMENT, QUALITY IMPROVEMENT AND THE THRIVE MODEL

We propose employing the MINDFUL approach to performance management (Wolpert, Deighton, et al., 2014) alongside the THRIVE model. This involves the consideration of multiple perspectives, interpretation focused on negative differences and use of directed discussions. Funnel plots should be used as a starting point to consider outliers, always keeping in mind an appreciation of uncertainty with learning collaborations of clinicians, commissioners and service users supporting data analyses.

This would require a seven-step process to **be applied separately to each of the five 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. in line with contract or commissioning intentions, commissioners, providers and service user representatives 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):
  - Thriving - e.g. community indicators of emotional wellbeing
  - Getting advice - 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:
  - Thriving - e.g. to include measures of self-assessed wellbeing
  - Getting advice - 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.
5. 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.
6. 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 plan, do, study, act (PDSA) cycles (see figure 5) and learning sets.



**Figure 5:**  
PDSA cycle

7. 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.
8. 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 across a range of sectors (health, education and social care).

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 health promotion, intervention and support in the years ahead.

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# APPENDIX 1: CURRENT VIEW TOOL

## Current View

CYP Name ..... Practitioner's Name ..... Please indicate your reason for completing this form:

DOB: ..... Practitioner's ID .....  First Contact

NHS ID: ..... Service Allocated Case Id .....  Changed Situation

Date: / / 20 Time: <sup>h</sup><sup>'</sup>  Changed Understanding

Provisional Problem Description		None	Mild	Moderate	Severe	Not known
1	Anxious away from caregivers (Separation anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Anxious in social situations (Social anxiety/phobia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Anxious generally (Generalized anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Compelled to do or think things (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Panics (Panic disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Avoids going out (Agoraphobia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Avoids specific things (Specific phobia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Repetitive problematic behaviours (Habit problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Depression/low mood (Depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Self-Harm (Self injury or self-harm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Extremes of mood (Bipolar disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Delusional beliefs and hallucinations (Psychosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Drug and alcohol difficulties (Substance abuse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Difficulties sitting still or concentrating (ADHD/Hyperactivity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Behavioural difficulties (CD or ODD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Poses risk to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Carer management of CYP behaviour (e.g., management of child)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Doesn't get to toilet in time (Elimination problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Disturbed by traumatic event (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Eating issues (Anorexia/Bulimia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Family relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Problems in attachment to parent/carers (Attachment problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Peer relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Persistent difficulties managing relationships with others (includes emerging personality disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Does not speak (Selective mutism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Gender discomfort issues (Gender identity disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Unexplained physical symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Unexplained developmental difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	Self-care Issues (includes medical care management, obesity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	Adjustment to health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SELECTED COMPLEXITY FACTORS	Yes	No	Not known	
1	Looked after child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Young carer status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Serious physical health issues (including chronic fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Pervasive Developmental Disorders (Autism/Asperger's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Neurological issues (e.g. Tics or Tourette's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Current protection plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Deemed "child in need" of social service input	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Refugee or asylum seeker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Experience of war, torture or trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Experience of abuse or neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Parental health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Contact with Youth Justice System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Living in financial difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTEXTUAL PROBLEMS					
	None	Mild	Moderate	Severe	Not known
HOME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SCHOOL, WORK or TRAINING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SERVICE ENGAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EDUCATION/EMPLOYMENT/TRAINING					
ATTENDANCE DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ATTAINMENT DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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