Health and Social Services Department

Child and Adolescent Mental Health Service (CAMHS)

Liberte House

19-23 La Motte Street

St Helier

JE2 4SY

23rd October 2018

Dear Tom Leveridge,

Following our recent conversation please find the written submission of the CAMHS team to the scrutiny panel. We welcome your interest in services available to young people with mental health problems in Jersey. Before addressing the questions raised online and sharing our thoughts in relation to the survey we would like to give a snapshot of the work undertaken by our team over the past two years.

The CAMHS team continues to be extremely busy in its efforts to meet the high level of demand placed upon it in a context in which the incidence of mental health difficulties presenting in young people continues to rise and there are a range of gaps in the provision of mental health services, particularly at Tier 2 and Tier 4 level.

1. Current provision

What do we offer?

In 2017 Camhs received 544 new referrals to the service. To date in 2018 we have received 436 referrals. Nearly half of these referrals to the service were crisis related or urgent and required a response within 48 hours.

We process all new referrals on a daily basis and allocate each new referral either to an urgent duty assessment which is carried out within the day the referral arrives, a routine initial assessment, or signpost to a more appropriate service. Once young people are assessed there is then a wait for them to be allocated to a clinician for treatment. We aim for this wait to be up to 6 weeks when there is some psychiatric risk in the presentation and approximately six months when there are no mental health risk issues. However, over the past six months we have had to prioritise work with high risk clients and we have not been able to meet these targets.

We offer a range of therapeutic modalities:-

- Duty risk assessments and risk management
- Cognitive behavioural therapy
- Cognitive analytical therapy
- Systemic therapy
- Psychodynamic therapy
- Medication
- Mellow parenting group work
- New Forest parenting programme for parents with children with ADHD
- Consultation and advice to other professionals

Young people with complex difficulties are offered more intensive packages of care which can include individual therapy, family therapy and psychiatric input. Where necessary they are admitted to Robin ward or to Orchard House and our staff support the delivery of care in these inpatient settings. Where appropriate family's needs are met by a sole clinician.

Some young people are offered long –term interventions such as those in the ADHD clinic and some young people who present with developmental disorders, severe OCD, severe eating disorders, and severe attachment difficulties can be offered several years of work

We have two FTE Consultant Child & Adolescent Psychiatrists, 0.6 Associate specialist (fixed term) 4 FTE Clinical Psychologists, 2 Family Therapists, 0.5 art

psychotherapist, 1 CAMHS social worker, 3.5 nursing staff , 1 Assistant Psychologist and 3 vacant nursing posts and a vacant manager post.

3 people man a very busy admin and reception area

Duty risk assessments

When young people who are new or existing clients present with urgent psychiatric concerns these are managed by our two duty nursing staff with support from colleagues across the team. The level of demand on these workers has increased as there has been sustained rise in the number of young people who present with thoughts or plans of suicide.

For those young people with the most significant risks an inpatient admission may be required and therapeutic plans for these young people can be very time consuming in that we need to offer support to the staff on the paediatric ward, alongside therapeutic input to parents and the young person and liaison with schools. On three occasions this year we have had to transfer patients to UK adolescent psychiatric units and these cases have required substantial amounts of time to be invested in them.

ADHD pathway

19 young people are currently being assessed for ADHD and 155 have been diagnosed. They are offered medication which needs regular review and the New Forest parenting programme. 1 nurse offers this work alongside psychiatry and an Assistant Psychologist

All other pathways.

This leaves 8.5 therapists to support 402 families where young people are experiencing:-
Anxiety
PTSD
Depression
Deliberate self-harm

Developmental disorders

Attachment disorders

Eating disorders

Gender identity dysphoria

Paediatric problems

Your questions

1. **What are the current trends in mental health in Jersey**

- A sustained and significant increase in young people presenting with risky mental health presentations including suicide attempts, psychosis and eating disorders

- Nearly half of all referrals over the past two years have required an urgent duty response and been responded to within a week.

- This increase in demand to attend to young people with risky presentations has led to an increase in waiting times for the other families presenting to our service

- Young people who are involved with the children's service have had a greater degree of advocacy and rightly social workers are asking for a high level of involvement from mental health practitioners for their service users. We are trying to balance this demand alongside the needs of other groups of service users.

2. **What progress has the States of Jersey made on implementing its mental health strategy in 2015**

The themes of this strategy were:-

- Securing joint working across the mental health system
- Developing the workforce
- Awareness raising prevention early help and support for young people and children

- Improving the money flow in the system to follow the service user
- Enabling workplace mental health intervention
- Building educational approaches to recovery
- Improving the service environment
- Developing mental health service in the criminal justice system
- Establishing outcomes quality and measurement
- Culture and leadership

In terms of a self-appraisal we would argue that our strengths are:-

We work on a daily basis with colleagues across all agencies including working with community and voluntary sectors.

Our clinicians all have specialist skills and access a range of continuing professional development opportunities.

We have contributed towards awareness raising through joint working with Youthful Minds (MIND Jersey) in the training and work they provide directly to young people in schools. They have been a partner in our own service development and have had their members sitting on our interview panels for new staff.

New resources have been allocated to provide two primary mental health worker and a trainee parent infant psychotherapy post.

We have developed a more robust system for collating data on our work including contributing to the NHS benchmarking for CAMHS. This has allowed us to compare our work to other jurisdictions in the United Kingdom.

Improving service environment – we have relocated premises. We have had mixed feedback as to the success of this move. Contentious issues are parking, co-location with the children's service, and lack of privacy.

We have taken an active role in contributing to the suicide prevention program which was identified as part of the Mental Health Strategy including providing trainers towards the identified program for frontline staff.

Areas that have not been addressed

Developing the workforce – since 2015 we have had a senior post removed from our team, a Consultant Clinical Psychologist, and have struggled to recruit to three nursing posts. Salaries are not sufficiently competitive to attract candidates from the UK to move to Jersey. People accept posts and then decline them once

they have visited estate agents and understand the poor quality of accommodation that they can afford. Despite the Always On Nursing Recruitment Campaign undertaken in 2016, we have not been successful in recruiting suitably qualified nurses on a permanent basis.

Culture and leadership – regular changes in the leadership team are unsettling and lead to frustration as history is lost and much time is spent focusing on structural changes rather than attending to business as usual and clinical governance.

There is no dedicated forensic mental health input for young people who offend a group known to be at elevated risk of experiencing mental health difficulties.

4) What support is in place to ensure the organisations that provide mental health services are able to work in partnership in the best interest of the individual concerned?

We are unsure what this question means, if it means how are we supported to work in partnership with families then our programme of continuing professional development allows staff to refresh and build their clinical skills to promote best practice in working with families. For example, we have recently had whole team training in risk assessment and cognitive analytical therapy and staff access training to support their specialist roles.

5) What are the potential risk and benefits of separating child and adult mental health services? How could any potential risks be mitigated?

We have always been a small part of a larger organisation with high expectations placed upon what it is possible for us to deliver. We are unclear as to how it will improve service provision for us to sit under a children's umbrella. We need to maintain professional links with our colleagues in health. Tier 3 camhs services are traditionally viewed as health services as they offer medication, support for inpatient treatment, nursing and therapeutic interventions.

We are concerned about how the support that we receive from the health department will be replicated under the new organisational structure, however as

the new structure is not yet in place we are not yet clear as to how these concerns will be addressed.

The vision that has been shared with us of a one stop shop for children and families we do not believe to be an attractive idea for families. Parents have fed back to us that they are concerned that we are now in the same building as the children's service. We need an independent identity, this is a small island service users have little choice in where they go for support. For some families the thought of entering a building full of social workers leaves them feeling anxious and for those who struggle with trust ask us if we are independent.

6 What examples of best practice are available from other jurisdictions that Jersey could learn from?

In the UK a comprehensive CAMHS service is thought about using a Tiered model of service (see appendix). Our team was originally set up as a community Tier 3 CAMHS team, over the past few years there has been a sustained increase in the risks presented to the team and the lack of tier 4 provision has become a stark difficulty for us as a team. We note in your online survey that you are asking families to tick whether they have accessed community or inpatient camhs. Inpatient camhs does not exist. We are one team a small community team which is trying very hard to meet the needs of a diverse group of people and we fear leaving many people feeling dissatisfied with us and compromising our own health under the pressure that we are experiencing.

When the scrutiny panel investigated mental health services in 2014 there was discussion as to whether an inpatient provision for young people with mental health difficulties was required. At this time there were insufficient numbers of young people to warrant offering such a provision but this situation has now changed and needs to be considered.

Another service model developed to help shape camhs services in the UK is the THRIVE model which originates from the Anna Freud Centre in London (see attachment sent with this letter.) The visual image designed to illustrate this model offers a simple way of understanding why we as a team are finding it hard to meet demand. We are a small team and we are offering both risk support and specialised mental health interventions from the same pool of resources. The

need for risk support has grown in such a dramatic and sustained way that capacity to offer therapeutic input is reduced.

We welcome further discussion with you on this paper or any other issues

Kind regards

Dr Laura Posner Consultant Clinical Psychologist & Dr Catherin Keep Consultant Child & Adolescent Psychiatrist, written in collaboration with the CAMHS team

Appendix 1

The tier model is explained in further detail below

CAMH service tiers

Children and young people who are experiencing difficulties that could be related to their mental health are usually first identified within Tier 1 services, for example by a teacher, GP or health visitor . Similarly, parents/carers who identify that their child is experiencing difficulties will usually first seek help from services at that level. Children and young people with an identified need may be subsequently referred into specialist CAMH services (falling within Tiers 2–4) for assessment and intervention if necessary.

In Scotland, CAMH services are generally delivered through a tiered model of service organisation, as shown in the diagram below:
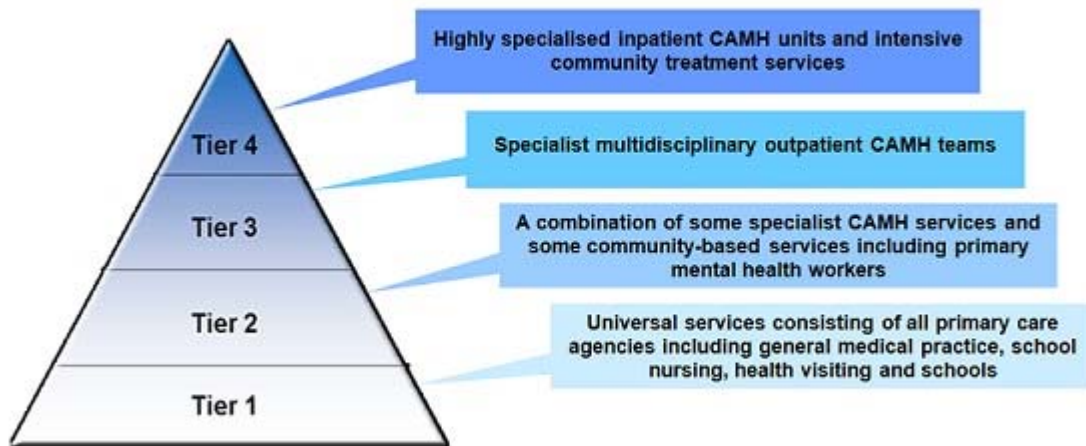
The following describes in more detail the services provided at each tier of CAMH service operation.

Tier 1

Child and adolescent mental health services at Tier 1 are provided by practitioners working in universal services who are not mental health specialists. This includes:

- GPs
- health visitors
- school nurses
- teachers
- social workers, and
- youth justice workers and voluntary agencies.

Tier 1 practitioners are able to offer general advice and treatment for less severe problems. They contribute towards mental health promotion, identify problems early in the child or young person's development and refer to more specialist services.

Tier 2

Mental health practitioners at Tier 2 level tend to be CAMH specialists working in teams in community and primary care settings (although many will also work as part of Tier 3 services). They can include, for example:

- mental health professionals employed to deliver primary mental health work, and
- psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Tier 2 practitioners offer consultation to families and other practitioners. They identify severe or complex needs requiring more specialist intervention, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1 level.

Tier 3

Tier 3 services are usually multidisciplniary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Team members are likely to include:

- child and adolescent psychiatrists
- social workers
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
- occupational therapists, and
- art, music and drama therapists.

Tier 4

Tier 4 encompasses essential tertiary level services such as intensive community treatment services, day units and inpatient units. These are generally services for the small number of children and young people who are deemed to be at greatest risk (of rapidly declining mental health or serious self-harm) and/or who require a period of intensive input for the purposes of assessment and/or treatment. Team members will come from the same professional groups as listed for Tier 3. A consultant child and adolescent psychiatrist or clinical psychologist is likely to have the clinical responsibility for overseeing the assessment, treatment and care for each Tier 4 patient.
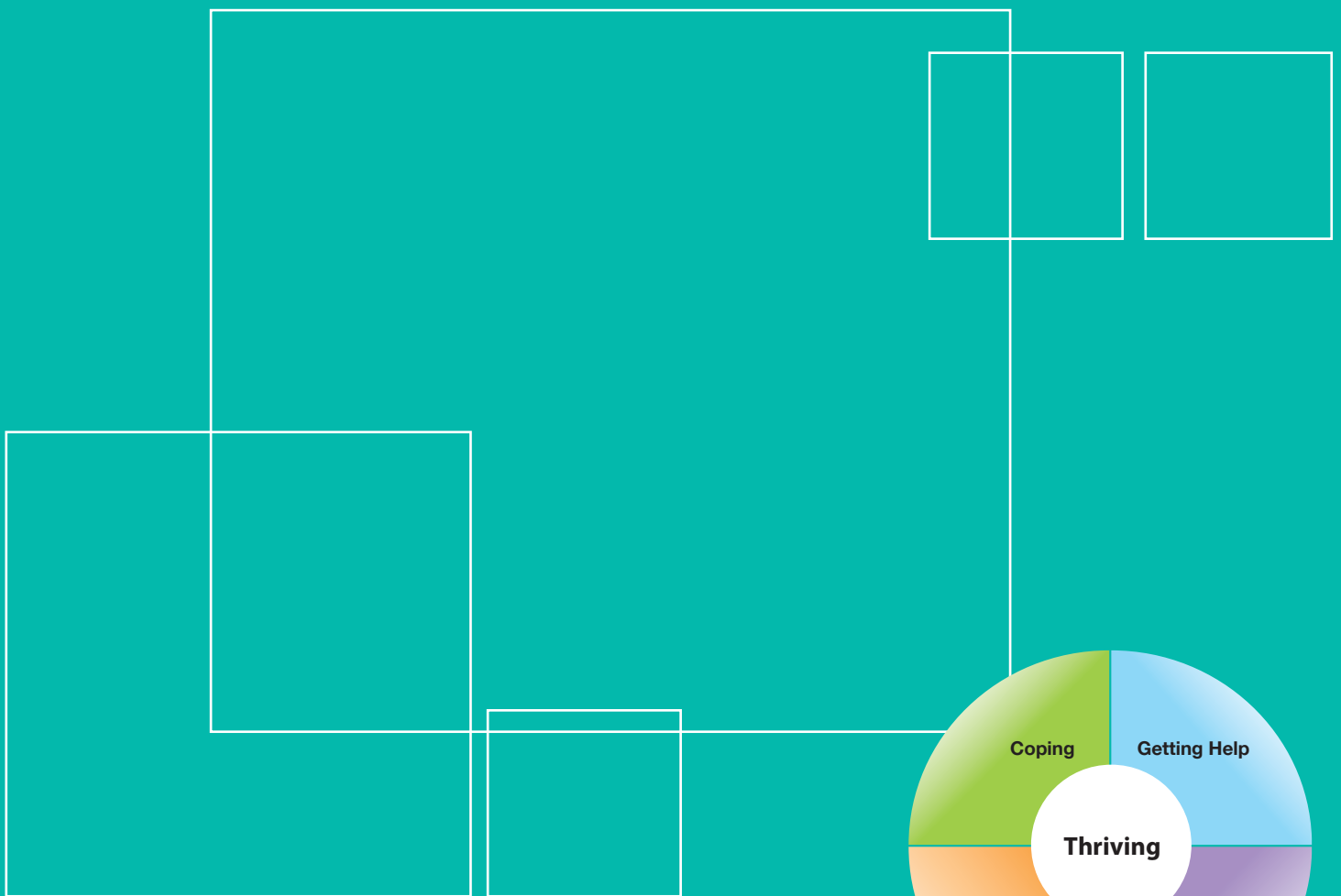
Mental health scrutiny panel

Date Created ▾

THRIVE

The AFC–Tavistock Model for CAMHS

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Coping

Getting Help

Thriving

Getting Risk
Support

Getting
More Help

Disclaimer

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

Press
CAMHS

ACKNOWLEDGEMENTS

INTRODUCTION

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

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

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

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

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

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

BACKGROUND

CAMHS in context

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

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

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

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

Tier 1: consists of non-specialist primary care workers such as school nurses and health visitors working with, for instance, common problems of childhood such as sleeping difficulties or feeding problems.
Tier 2: consists of specialised Primary Mental Health Workers (PMHW's) offering support to other professionals around child development; assessment and treatment in problems in primary care, such as family work, bereavement, parenting groups etc. This also includes Substance Misuse & Counselling Services.
Tier 3: consist of specialist multidisciplinary teams such as Child & Adolescent Mental Health Teams based in a local clinic. Problems dealt with here would be problems too complicated to be dealt with at tier 2 e.g. assessment of development problems, autism, hyperactivity, depression, early onset psychosis.
Tier 4: consists of specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.
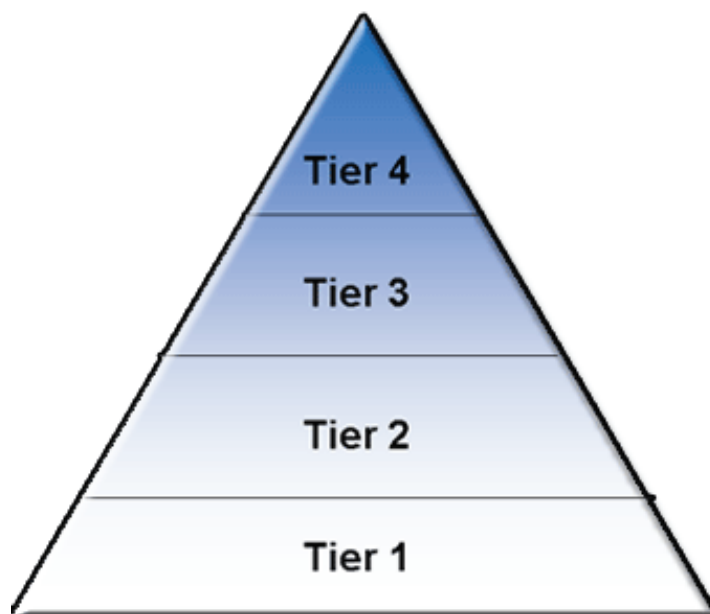
This model was very useful at its time of development in 1995(7) for helping differentiate between the forms of support that might be available to children and young people, but has increasingly been critiqued (including by its developers) for leading to a reification of service divisions. As we will argue below, we feel that the THRIVE model offers a more helpful conceptualisation to address the challenge and opportunities of the current situation.

Current context: challenges and opportunities

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

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

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

2   The Children and Young Peoples' Improving Access to Psychological Therapies Programme.
3   Quality Network for Community CAMHS, Child Outcomes Research Consortium, Youth Association, Royal College of Psychiatrists, Association for Family Therapy and Systemic Practice, British Association for Behavioural and Cognitive Therapies and British Association for Counselling and Psychotherapy.
4   Quality Network for Inpatient CAMHS, The Choice and Partnership Approach.
5   Child Mental Health Informatics Network

THRIVE MODEL FOR CAMHS: A NECESSARY PARADIGM SHIFT?

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

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

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

THRIVE model
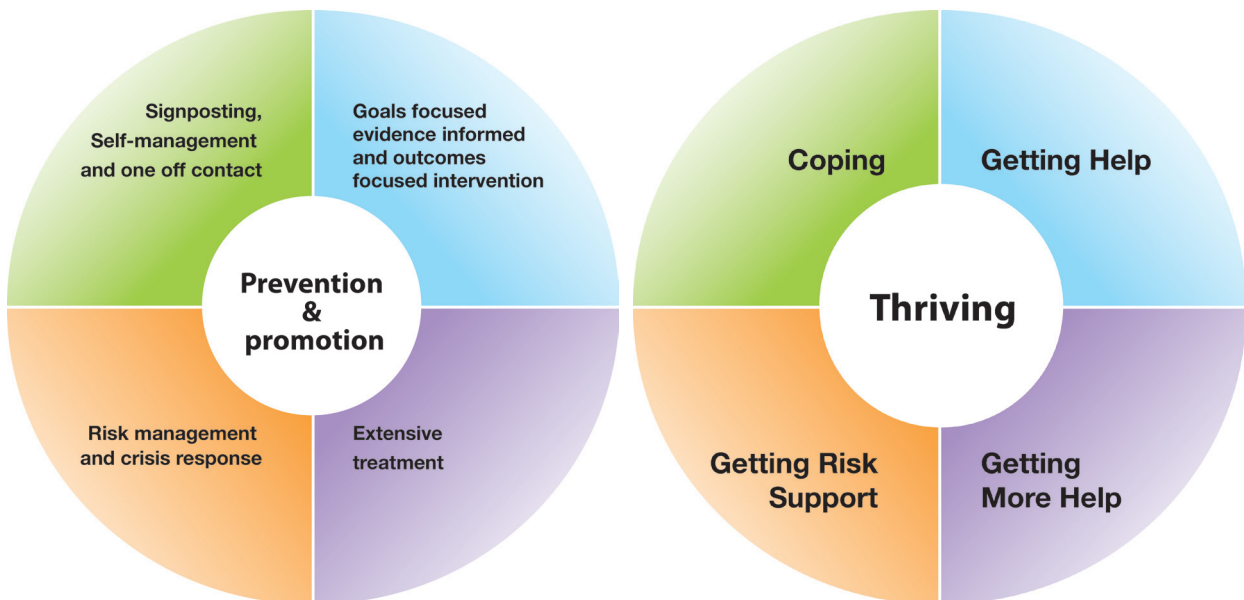
Each of the four groupings is distinct in terms of:

Needs and/or choices of the individuals within each group[6]

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

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

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

Coping

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

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

Resource: The payment systems project group are currently suggesting this group might be the first (likely cheapest) of three clusters for payment system (see below for other clusters)(18).

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

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

Getting Help

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

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

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

Need: This grouping comprises those children, young people and families who would benefit from focussed, 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 National Institute for Health and Care Excellence (NICE) guidance and where there are interventions that might help.

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

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

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

Getting more help

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

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

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

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

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

Getting risk support

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

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

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

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

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

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

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

Thriving

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

PERFORMANCE MANAGEMENT, QUALITY IMPROVEMENT AND THE THRIVE MODEL

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

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

1. At regular time periods e.g. every three years commissioners and providers and service user reps would jointly agree high-level key quality indicators in areas of weakness relating to that particular aspect of THRIVE, using a mix of process and outcome measures (based on CORC annual reports and/or other sources of information):

   - Coping - e.g. access to online support/levels of resilience
   - Getting help - e.g. access to NICE interventions/levels of recovery or reliable change
   - Getting more help - e.g. length of inpatient stay/functioning
   - Getting risk support - e.g. response to A&E admissions/management of crises

2. Data about children and families involved, activities and outcomes would be collected routinely to help shape service provision. Measures and approaches to support this would be tailored to each element of the THRIVE model:

   - Coping - e.g. to include measures of resilience
   - Getting help - e.g. to include measures of symptom change
   - Getting more help - e.g. to include measures of impact on life
   - Getting risk support - e.g. to include measures of risk management

3. Leads for each area of provision would collate information relevant to the key performance indicators (KPIs) regularly (e.g. monthly) and feed this information back to staff. Data will be considered relative to others involved in similar THRIVE activity using appropriate statistical analyses.

4. Where there is information that suggests outcomes, or activities that vary significantly from others in a negative way, then that group of staff will be supported to explore if variation is warranted using the Queensland evidence pyramid.

   These explorations should include directed discussions in which the team are invited to consider, if these differences were unwarranted, what they would do differently using the MINDFUL approach.

5. Staff groups are encouraged to trial improvements aimed at addressing unwarranted variation and enhancing service quality. This may involve the use of statistical process control methodology such as run charts to consider and review improvements and impact on patient care and use of "plan–do–study–act" (PDSA) cycles and learning sets.

6. Quarterly meetings of users, commissioners and providers will review progress against KPIs for each of the elements of the THRIVE model separately, spreading any learning and improvements across the service

7. Annual review of the whole system to enable any relevant adjustments to be made to contracts or specifications.

CONCLUSION

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

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

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

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

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