



i-THRIVE Q&A

Ilse Lee, i-THRIVE Research Officer caught up with Lisa Weldrick, Team Leader for the CAMHS crisis team in Hull and East Riding, Humber NHS Foundation Trust about how she is implementing the THRIVE framework (Wolpert et al., 2016) in services for children and young people.

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Q: What has been your role in implementing THRIVE?

A: I am a team leader within Hull and East Riding Crisis Team. The whole service is implementing the i-THRIVE model and my particular interest is in the 'Getting Risk Support' needs-based group.

Q: How long have you been working on it? When did you start the THRIVE journey?

A: The crisis team initially started being set up two years ago and i-THRIVE was getting more known at that time. We had adopted CYP-IAPT in the community teams and THRIVE fits together with this. I started my role in looking at 'Getting Risk Support' and how we link with partner agencies and move away from being CAMHS focused.

Q: Can you tell me more about the crisis team?

A: The crisis team was launched as a 24/7 service in January 2016, although work started on developing the model and recruiting people about two years ago. A 24/7 crisis service for children and young people is rare across the country. The push to have a 24/7 crisis service was driven by a local desire to have a consistent service across night and day. Historically, there used to be an inpatient unit for children and young people in the Hull and East Riding area. It used to close at the weekends because we generally wanted young people to be at home with their families. When the commissioning arrangements made it mandatory for inpatient units to be 24/7 it was decided instead to have intensive intervention teams with the aim of preventing the need for admission to inpatient wards. There was still a gap for a crisis service however because the work of the intensive intervention team was all pre-planned. There is the feeling that the crisis team prevents emergency admissions, but there is not the data to support this yet.

The crisis team is made up of 12 nurses. Before the crisis team was introduced, CAMHS practitioners often felt quite isolated in managing risk and complex presentations and wanted this to change quite urgently. The crisis team wanted to look more closely at how risk was being shared between professionals. A multi-disciplinary team meeting takes place once a week and is a space for the team to share concerns about any of their current cases. Psychiatry, psychology, nursing and systemic therapists are represented at these meetings and we develop a plan for the child or young person. It would be ideal if the team was multi-agency, but this is not yet the case.

Q: How do you work with the wider system to support children and young people?

A: We have been working with other agencies from the beginning, for example the out of hours social care service. We would do joint visits on the evenings and weekends with the emergency team. We developed robust systems for people in custody and we got good responses from the police when asking for joint visits. We worked to reduce the number of



section 136s and are being proactive about the support we offer. We have worked with education too although it's been more difficult because this is usually required for longer term work and education is more linked into the community teams. The crisis team works closely with Mind with their supported accommodation for young people. Feedback from residential homes indicates that the difference between a young person settling in and not settling in can be the presence of a robust crisis plan.

Hull have funded a full-time psychologist for the crisis team with a role in consultation to the wider system. We are doing some work about what this consultation will look like. The psychologist is picking up on young people who don't fit with traditional CAMHS. They may not attend appointments or are hard to engage. The psychologist works with the system around the child to support them. He is very skilled in what he does and there will need to be some succession planning to work out the skills and knowledge required for the role. He works to help professionals and parents/carers understand a young person's behaviour and other people's roles in supporting the young person. A crisis provides an opportune time to tap into families and professionals because they want help at that point and the psychologist works with them to develop a shared crisis plan for the young person and their family.

Q: How is THRIVE implementation structured locally?

A: i-THRIVE underpins several aspects of local transformation. There are many local initiatives supporting young people at pre-CAMHS threshold in the community and in schools. We have implemented a pathway model for care which involves seven different pathways for eating disorders, low mood, anxiety, deliberate self-harm, ADHD, trauma and autistic spectrum disorders. The pathways are joined up with multi-professional teams.

Q: What are some of the barriers you have faced in implementing THRIVE so far?

A: There is still a huge pressure on core CAMHS. Roughly six out of the ten people we see in the crisis team have a need for ongoing CAMHS intervention but there is a delay in transitioning young people to core CAMHS due to their service demands. There is the perception of a dividing line between core CAMHS and the crisis team because people like the immediate help from the crisis team and then get frustrated that it takes a long time to be seen in core CAMHS. We need to somehow get the message across to children and young people that we are all part of the same service.

It would be nice to be able to do some intensive follow-up with children and young people and it would be interesting to be able to track a few cases beyond their interaction with the crisis team and receive feedback from the agencies.

Q: What are some of the facilitators you have faced so far?

A: The patience from CAMHS in developing the model for the crisis team has been important for its development over the last two years. Feedback from families has been useful. Families complete the friends and family's test on an iPad at their last contact with the crisis team. We send out follow up Experience of Service Questionnaires after sending families a letter summarising the joint work which has been undertaken with them. An example of the feedback we received early on was that parents and carers did not feel included enough in the work of the crisis team. One reason for this might have been some staff coming from adult mental health crisis teams where it is more usual for the family to take a back seat. Involvement of parents and carers was then looked at more closely and



trainings were provided to the crisis team staff. Now families are included in plans wherever possible.

Q: What has been the area so far which has required the biggest culture change in implementing THRIVE?

A: Some of the culture change has been evident when talking to social care, it appears the message of mental health being everyone's business is now well accepted.

Q: What are you focusing on in the next six months?

A: Humber NHS Foundation Trust won a contract to provide a new inpatient unit. This is in the development stage at the moment. We will be thinking about the role of the crisis team in relation to the new inpatient unit, which is likely to be around gatekeeping and discharge. There will soon be a review of the crisis team now that we are two years in. The review will cover the skills of the crisis team staff and the time they spend with children and young people. The crisis team have identified a growing need for support for young people with emerging personality disorder and will be working on developing their approach to meeting this need.

We will also be doing a piece of work on analysing the referrals the crisis team receives and understanding the reasons for referrals.

If you would like to take part in a Q&A to share your experiences in relation to implementing THRIVE and using the i-THRIVE approach to implementation, please get in touch with Bethan Morris at bethan.morris@annafreud.org.