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How can services be improved to effectively address the mental health of vulnerable children and young people?☆

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ABSTRACT

This discussion article describes a Child and Adolescent Mental Health Service (CAMHS) in the United Kingdom developed to meet the mental health needs of children and young people particularly those vulnerable children and young people at risk of actual or potential harm through child abuse and neglect, but may not be therapy ready. The aim was to improve the level of access to CAMHS for vulnerable groups and the quality and effectiveness of services for children, young people and their families.The model of service delivery is underpinned by the THRIVE Framework for System Change (THRIVE) which builds on the resilience of families and the skills of the workers who have the closest relationships with them. The article describes how a redesign was accomplished in the London Borough of Camden between 2016- 2018 to do this. Qualitative evidence of the positive impact of the changes for service users and key workers and quantitative evidence of the increased service capacity are presented. Challenges and opportunities provided by the new service model are discussed

1. UK government policy

Adverse Childhood Experiences (ACEs) such as abuse, neglect and dysfunctional home environments are associated with emotional and behavioural disorders, externalizing and internalizing problems relating to peers, physical health problems and poorer social outcomes across the life course (Bellis, 2015; Felitti, 1998). In some cases, these behavioural problems are manifestations of lasting changes to the structure and functioning of the brain (Glaser, 2000). Child Maltreatment, domestic violence or disasters are all forms of toxic stress that can negatively affect brain development. The changes to the brain's structure and chemical activity include decreased size and connectivity resulting in cognitive, behavioural and emotional difficulties. Article 19 of the Uanited Nation's Convention on the Rights of the Child states that children and young people who have been the subject of abuse and neglect have the right to care and support to overcome these difficulties (OHCHR, 2019). As it is clear that psychological presentations are likely to be linked to the co-occurrence of different types of abuse (Finkelhor, Ormrod, Turner, Shattuck, & Hamby, 2005; Finkelhor, Turner, Shattuck, & Hamby, 2015), the challenge for mental health professionals is how to intervene and help families, children and young people who have complex histories of abuse, neglect, trauma and violence in a way that meets their and their families' needs.

The UK has a national health service funded by general taxation. Clinical Commissioning Groups (CCG) are organizations set up by

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a 2012 statute in England with the responsibility to plan health care services for their local areas. The CCG hold the budgets and can choose the services they will contract and the service providers who will deliver these. The CCG work with local mental health services providers and Local Authority social services which have duties to provide welfare services, to improve access to and effectiveness of mental health services. National strategy is currently focused on waiting times, service accessibility and the development of integrated models of service delivery.

Over the last three years, the UK government has focused on addressing the mental health needs of children and young people, recognizing the specific needs of those who have suffered traumatic experiences and have abusive histories (NHS England, 2015b, 2015b). The UK Government (UK Government, 2019) asserted its commitment to improving Child and Adolescent Mental Health Services (CAMHS) for children and young people by 2021 by increased expenditure and the development of new models of service delivery (modernization) to improve access, reach and quality. The modernization includes the development of work across partner organizations including public health, education, publicly funded social care and private or charitable organizations in an integrated way. Services are required to meet needs using practices that have been shown to work through either through evidence-based practice or a practice-base with routine collection of outcome measures also considered as evidence.

The data on access to and experience of Child and Adolescent Mental Health Services (CAMHS) is limited (Care Quality Commission, 2018). However, the data collected across England suggests that 1 in 4 young people receive the help they need (NHS England, 2015b, 2015b). Clinic-based community CAMHS are often not accessed by the most vulnerable families, children and young people or those who have multiple psychosocial problems and /or lack of trust in professionals (Care Quality Commission, 2017). If they do access CAMHS, they may wait a long time before receiving help because of lengthy waiting lists (Green, 2005). Once accessed, the effectiveness of CAMHS for children and young people is variable with 2 in 5 of those accessing it getting better and 1 in 10 getting worse (Wolpert, Jacob, Whale, Calderon, & Edbrook-Childs, 2016). There is an important group of young people and families for whom evidence based treatments are either not chosen by the family or have not proven effective when applied (Cooper, 2016).

The need for new models of service delivery is supported by evidence from England that suggests that only 33 % of children and young people will be recovered after the best evidence- based treatment available and some children and young people do not benefit at all (Care Quality Commission, 2017). Internationally, evidence-based practice (EBP) holds out the hope of improving the effectiveness of interventions because large-scale efficacy trials have shown that psychological interventions are robust and durable for several disorders (Roth & Fonagy, 2005) However, implementation science (Fixsen, Blase, Friedman, F, & W, 2005) suggests that interventions developed and tested in a controlled research setting do not translate easily into other established settings including clinical contexts (Aarons, Hurlburt, & Horwitz, 2011; Fixsen, Blase, & Van Dyke, 2011) (Mitchell, 2011), especially where presenting problems are more complex and the context uncontrolled. Even when the issues surrounding implementation are considered, for a third of children and adolescents no evidence-based intervention will be identifiable (Chorpita et al., 2002; Chorpita, Becker, & Daleiden, 2007a; Chorpita, Becker, & Daleiden, 2007b). This is often the case for children and adolescents who most need help – those with complex family histories of intergenerational trauma and violence. The definition of EBP has been revisited (California Evidence Based Practice Clearinghouse for Child Welfare, 2015), and the scope of eligible evidence expanded by including interventions evaluated as effective in selected trials. “Evidence-informed practice” (Saini & Shlonsky, 2012) and “feedback-informed practice” (Miller, 2013) are terms used to describe practices validated through research and practice-based evidence through clinical feedback

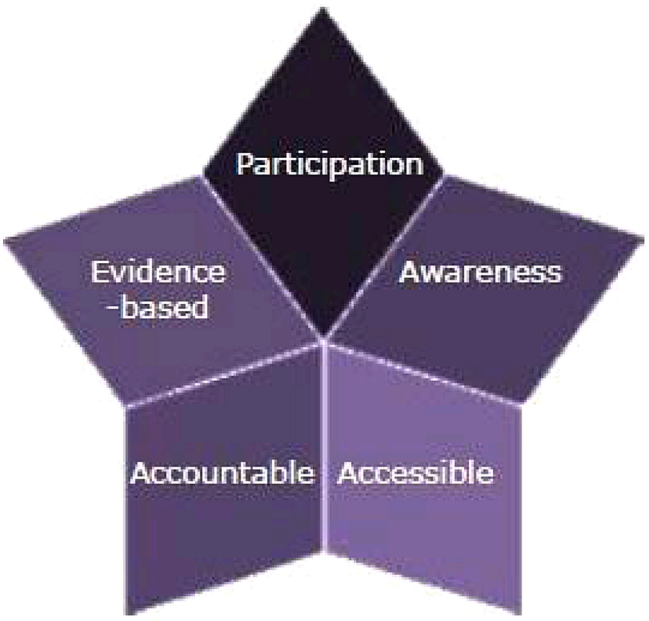


Fig. 1. Children and Young People Increasing Access to Psychological Therapies Principles.

from service users (Miller, 2013).

The THRIVE Framework for System Change (Wolpert et al., 2019) was developed in 2014 to address some shortcomings of existing service delivery models, in a collaboration between the Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families. Specifically, those shortcomings were (1) insufficient access, (2) lack of crisis care in the community leading to children and young people being treated far away from home, and (3) a lack of treatment for children and young people who do not fit into clear diagnostic categories or who do not engage with clinic-based services. The framework, which is now widely used in the UK, has since gone through revisions in 2016 and 2019 to extend its multi-agency integrated focus.

THRIVE seeks to provide an integrated, person-centred and needs-led approach to delivering mental health services for children, young people and families who are who are empowered to be actively involved in decisions about their care. The aim of this paper is to illustrate its application and outline some improved service outcomes for users and staff, in order to provide an international audience a reference to explore the framework's relevance to service improvement where there is a need for interagency communication and collaboration for effective mental health support for vulnerable families young people and children.

2. The THRIVE Framework for System Change and service transformation

The THRIVE (Wolpert et al., 2019) Framework for System Change offers a radical needs-based reconceptualization of service delivery. It is a conceptual framework that incorporates the principles of, and builds on, the UK's government's initiative of Increasing Access to Psychological Therapies for Children and Young People (CYP- IAPT) (Badham, 2011) (Fig. 1). CYP-IAPT (CYPIAPT, 2019) principles emphasize the importance of using evidence-informed practice, outcome monitoring and user feedback to ensure interventions meet needs.

THRIVE emphasizes that the decision on how best to support children and young people's mental health cannot be based purely on their diagnosis or presenting symptoms. It stresses the importance of drawing on the evidence base, alongside being transparent about the limitations of treatment, and explicitly engaging children and their families in shared decision- making about the type of help or support they need. THRIVE promotes the principle that all those involved in the delivery of care across health, education, social care and the voluntary sector work closely with one another to meet these needs, agreeing on aims, and reviewing progress with a common language and framework. THRIVE brings together all interventions relevant to mental health and wellbeing, recognizing that there are relevant interventions beyond those evidence-based therapeutic approaches delivered by trained mental health professionals (Wolpert et al., 2016).

THRIVE divides the population into 5 needs-based groupings (Fig. 2). Needs basis is determined by (1) what the young person and family want, (2) what a professional can provide, and (3) what the professional judges is best for the young person or family. It creates coherent and resource-efficient communities of support for children, young people and families and uses language that everyone can understand. "Help" in the model is defined as "an intervention in which any professional – mental health or other – takes responsibility for input directly with a specified individual or group related to a mental health need" (Wolpert et al., 2019). A best practice mental health intervention under the THRIVE Framework requires an agency to determine: (1) whether the "Help" they are providing is mental health support and (2) whether the support fits into a category of best practice. "Help" qualifies as a mental health support if: (1) the mental health need is clearly stated, (2) the mental health need is being addressed, (3) there is a clear goal in terms of what the intervention is trying to achieve, and (4) the provider is taking some responsibility for whether the goal is achieved or not. The intervention can be considered best practice if it: (1) has considered the evidence base and chosen an approach that best fits the needs of the child balanced with the preferences of those seeking help or support, (2) goals were collaboratively agreed with the child and/or carers, and (3) progress against goals are reviewed and the information is used against future decision making including deciding about endings.

The five categories are:

Thriving – children and young people who are doing well and do not need individualised advice or support.

Getting Advice – children and young people who need advice and signposting. They might have mild or temporary difficulties or fluctuating or ongoing severe difficulties. They are managing their own health and do not want goals-based specialist input. When not in crisis, these children and young people can be managed with minimal resource input, self-support or in the community with digital input.

Getting Help – children and young people who need focused goal-based help, targeted work with a specific goal – for example Trauma focused cognitive behaviour therapy (TF-CBT), Eye Movement Desensitization Reprocessing (EMDR), CBT for anxiety and depression. The remit of the work is clear and there is an end point. The clinician and user know when the end point is achieved and what to do if it is not achieved.

Getting More Help – those who need more extensive and specialised goal-based help because they have complex needs and may have significant difficulties functioning in several different domains such as children and young people with complex trauma or attachment difficulties or coexisting Autistic Spectrum disorders – modular intervention, extended periods family therapy and psychotherapy might fall into this category depending on the time scale.

Getting Risk Support – for children, young people and families who are unable to make use of psychological help but are still at risk. Mental health professionals then become part of a multi-agency network that includes social services and other welfare agencies (housing, employment, children centers) who are involved in supporting and managing this risk.

The children, young people and families in receipt of Risk Support are also frequently known to social welfare, are vulnerable and at risk of child abuse and neglect. In the Risk Support model, they are being helped by a network of professionals who act as a team around a key worker or lead professional. Risk Support is the most relevant quadrant to the rethinking of services for vulnerable

Fig. 2. THRIVE and thse needs-based approach informing Camden Services.

families, young people and children who have complex multi-agency networks and experience difficulties in engaging in mental health support. The key worker, with the supervision of a mental health professional, provides enhanced management of risk, as someone that the family trusts. The key-worker co-ordinates the multi-agency input and provides emotional support, but not in a goal focused therapeutic form of engagement. A key worker can be a teaching assistant, a behaviour support worker, youth worker family or support worker, or a lead professional responsible for coordinating the multi-agency input but also providing.

The principles of the THRIVE Framework are translated by sites into local models of care known as i-THRIVE. The aim is to move to the delivery of a population health model for children and young people's mental health. Sites are supported through implementation via an "i-THRIVE tool kit" and an the "i-THRIVE Academy" (i-THRIVE, 2019), a set of learning and development modules created for cross-sector professionals that support children and young people's mental health. i-THRIVE Grids are an important tool in collaborative decision-making in the Getting Help and Getting More Help quadrants (i-THRIVE, 2019). These are adaptations of Dartmouth Institutes Option Grids (Option Grid, 2017) co-created with service users and experienced clinicians to outline the treatment options for selected mental health presentations. Along the horizontal axis are the treatment options (peer support, bibliotherapy, psychoeducation, therapy, medication etc) and inside the grid boxes are responses to questions regarding (1) what the treatment involves, (2) how will it make the young person feel better, (3) will they see the same person during the intervention, (4) the risks and side effects, and (5) where they can get the support. The Grids address presentations including low mood, self-harm and attention deficit disorder and are endorsed by the UK's National Institute for Health and Care Excellence (NICE)[1] . THRIVE reduces the number of children and young people passed from one agency to another via inter agency transfers by reducing inappropriate referrals and promoting a greater transparency around mental health care, progress and appropriateness of services. This in turn is intended to promote more effective and efficient services with greater user satisfaction.

[1] NICE is an independent organization set up by the UK government to provide guidance to health and social care professionals to ensure that the treatment they provide is based on the best evidence.

3. Redesign of service in the London borough of Camden

3.1. Background

A collaborative systemic approach to helping children with Adverse Childhood Experiences, including joint health and social welfare budgeting is essential to providing services that meet need (Wave Trust, 2018). Service innovation in Camden was enabled by collaborative working between the CCG, the mental health service provider and between the Local Authority[2] . A joint commissioning model manages one budget including income from the Health Budget through the CCG and the social care budget through the Local Authority collaborative working. A joint budget fosters an understanding of the importance of a specific CAMHS offer to the most vulnerable and hard to reach children, young people and families in the borough.

3.2. CAMHS service in Camden

The Tavistock and Portman is the largest provider of community CAMHS services in Camden. Camden CAMHS has a history of providing clinical expertise through consultation to social work and other Local Authority services (child welfare, youth offending services, education). However, in the past a lack of integration between CAMHS and Local Authority services meant that families with multiple problems or conflicting appointments with different agencies were passed between agencies and were not accessing an integrated multidisciplinary service.

Co-location of CAMHS professionals with individual agencies had improved working relationships between practitioners. However, Local Authority staff would still refer vulnerable families where children were felt to be at risk, but did not engage with social workers CAMHS in the hope that specialist CAMHS clinicians and psychiatrists would be able to 'fix' the problems that they felt unable to address within their service. Frustration and a lack of trust towards the CAMHS developed because some vulnerable families did not attend clinic-based appointments available and were therefore discharged for non-attendance in line with CAMHS policy. The CAMHS clinicians in turn wasted time trying to "treat" families, young people and children who did not want treatment but needed support. THRIVE was implemented in Camden to increase access and efficiency of care for all children, young people and families by improving: (1) appropriateness of mental health services through co-construction with young people and families to reduce non- attendance, (2) communication between provider agencies, and (3) capacity for appropriate care in the system. Improved capacity in the system is achieved through improved integration leading to a reduction in transfers between providers and streamlining of professional's time through Risk Support strategies. THRIVE's emphasis in working in partnership with families, children and young people improves the relationship with professionals and emphasizes more preventative work to reduce risk and the need to escalate to formal, monitored Child Protection Plans[3] detailing the ways in which a child or young person need to be kept safe including how his or her health and development is to be promoted.

3.3. Service Re-design in Camden: an example of implementing thrive

The steps to implementation included (1) a new shared vision for the mental health service provision, (2) integration of services provided in each of the THRIVE groupings, (3) providing staff with the skills to implement the new ways of working, (4) providing the infrastructure to implement integrated working within the CAMHS system, and (5) using the "Risk Support" model to mainstream CAMHS perspective into key worker's thinking and relationships with non-therapy ready families who in the past might have been referred to CAMHS and take unnecessary clinical time to engage.

3.4. Developing a vision

Providing an integrated needs-based service for young people's mental health requires a multi-agency approach with a shared vision. Providers across mental health, social welfare and education used workshops to develop this, which was that services would be delivered by partnership working, produced with young people and their families, and be "flexible, proactive and evidence-informed".

3.5. Restructuring the CAMHS provision

CAMHS provision was restructured so all teams could act in an integrated manner under a single management structure and one Community (as opposed to Hospital) CAMHS. Restructured services were clustered around need, allowing staff to work together to developing specific clinical practice expertise.

CAMHS expanded their clinics into schools and doctors' surgeries, increasing the number of venues for children, young people and families to access them. CAMHS teams and clinician's services based in Local Authority agencies were reorganized into two multidisciplinary services and a community crisis intervention team. The Complex Needs Service (CNS) composed of two teams, one providing input to a small group of Looked after Children (LAC) and another providing expert assessments when cases go into court

[2] The Local Authority is the government organization responsible for the social services, welfare services and education services for the local area.

[3] A child protection plan is a plan drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need.

proceedings. A larger Whole Family Service (WFS) provides CAMHS to a Social Work Division and a new Resilience and Prevention Division. WFS is made up of two CAMHS teams. The Whole Family Team for children over five years (WFT) and the Whole Family Team with Perinatal Specialism (WFTP) for children under five years old. WFS staff are co-located with the Local Authority Camden Multi-Agency Safeguarding Hub,[4] Child in Need and Child Protection social workers,[5] Early Help family workers,[6] Special Educational Needs and Children's Centres as well as Pupil Referral Units (PRUS)[7] and Youth Offending Service (YOS). Staff spend 60 % of their time integrated into an allocated agency and 40 % providing a service as a multi-disciplinary team. The same families and young people often present in the YOS and PRUs and have a younger sibling under 5 who is known to a social work key worker and CAMHS clinician providing Risk Support. Having clinicians linked into the services but part of the same team allows the families, children and young people to be tracked more effectively and to provide the family with holistic support. The crisis intervention team was created to perform assertive outreach for children and young people of secondary school age who might otherwise have been referred to inpatient units. All three non-clinic teams can provide outreach community appointments to vulnerable families unable to make use of clinic appointments. These restructured services cluster around need, allowing staff to develop specific clinical practice.

All teams deliver interventions that fall into the "Getting Advice", "Getting Help" and "Getting More Help" quadrants. Evidence-based, guideline-informed interventions are encouraged and Local Authority services for vulnerable families are exploring the use of 47 of The Children Act 1989, and happens when a child is regarded to be suffering, or likely to suffer, significant harm and is subject to timescales education modular interventions to provide interventions in the "Getting Help" and "Getting More Help" quadrants. Modular approaches acknowledge that not all families need all the modules of a specific program and that clinical decision-making and feedback or evidence is essential to designing effective needs-based interventions combining modules (Chorpita et al., 2007a, 2007b; Chorpita, 2015). A modular parent's group based on combining mindfulness and mentalization modules has been used locally and evaluated. Both the WFS and CNS services provide extensive "Risk Support" to professionals, which has transformed the mental health support of vulnerable families involved with multiple agencies, improving capacity in the clinics to see appropriate referrals.

The leadership team for Camden CAMHS meets periodically composed of five team managers from the community, crisis and Local Authority teams. This allows cases to be jointly case-managed across different CAMHS teams or transferred from one CAMHS team to another without a referral process. This allows children, young people and families to benefit from the expertise from different parts of the Camden CAMHS at the same time, in whichever configuration best meets their needs.

3.6. Training professionals

The effective implementation of the "Risk Support" component of THRIVE relied on training staff in the Local Authority agencies and CAMHS staff. Camden Social Services Division commissioned the Tavistock and Portman to train Camden Local Authority staff in a model of reflective practice to increase their understanding of family dynamics and help them recognize that not all problems will be solved by a referral to CAMHS. This programme facilitated partnership working with families promoting Local Authority social workers, with CAMHS professional support, adopting a position of curiosity and understanding to combat blame and judgement.

CAMHS clinicians were also trained in evidence-based models of consultation and indirect work such as "AMBIT" to add to their Risk Support consultation skills (Bevington & Fuggle, 2012). This helped triage users who will benefit from direct therapeutic interventions and those whose needs would be met best by a multi-agency risk support plan. AMBIT is a mentalization-based, multi--modal approach to delivering services to vulnerable young people with networks of professionals providing services. AMBIT manages risks by organizing a team around a key worker who has an attachment to the young person. The model offers techniques to help workers think about complex and highly emotionally charged situations in meetings called "Thinking Togethers", encouraging active planning and understanding of the perspective of the young person and their family, mentalizing the worker's states of mind, and then returning to pragmatic action plans to address the difficulties.

3.7. Infrastructure changes

Prior to the re-organization, CAMHS clinicians recorded their notes on different information systems depending on whether they were based on the Local Authority or in a Community CAMHS setting. Under THRIVE all records are held in the same electronic record system, "Care Notes", so that when a request for help with a case comes in to one part of the service, it can see the work undertaken by others. Service users no longer experience unnecessary delays and do not need to retell their stories to different teams. In the re-organized model, vulnerable families have access to a multi-disciplinary team of CAMHS practitioners who track families over the life cycle, reducing duplication and retaining the families' history within the service. In the system all interventions are monitored and evaluated using outcome measures and user feedback. Communication at leadership level has been enhanced, with the service lead and

[4] Multi-agency safeguarding hubs are structures designed to facilitate information-sharing and decision-making on a multi-agency basis often, though not always, through co-locating staff from the local authority, health agencies and the police.

[5] A child in need plan operates under section 17 of The Children Act 1989 and doesn't have statutory framework for the timescales of the intervention. A child protection plan operates under section

[6] Early help covers a broad range of services and support that are brought in before any formal interventions to help children, young people and families in need achieve good outcomes.

[7] A Pupil Referral Unit is an alternative education provision which is specifically organized to provide education for children who are not able to attend school and may not otherwise receive suitable

team managers engaging with leadership at different levels of the multi-agency system.

4. Evaluation methodology

In order to evaluate the impact of THRIVE on service delivery in terms of user experience and service efficiency and effectiveness, qualitative and quantitative evaluations were carried out.

4.1. Quantitative analysis of data on the electronic record system

All patient data, activity and outcomes measures are entered on the Care Notes Electronic Record System (ESR). Care Notes has been developed to address the needs of the community and mental health services and child health services, to support planning, manage, record and analyze care across a range of settings. Reports are produced and analyzed by service leads. The data collected includes number of appointments, waiting times, client satisfaction and change in scores on the session by session outcome monitoring measures. A distinction is made between clinic-based appointments and community assertive outreach appointments both of which showed an increase in the period being evaluated when THRIVE was implemented. The data was used to quantify the increased capacity in the system as result of the implementation.

4.2. Service evaluation: interviews with service users and feedback from staff

In 2017, an independent service evaluation was undertaken to explore the experience of service users involved with two or more agencies across Health and the Local Authority over the period 2017−2018. The experience of users accessing the integrated multi-agency Risk Support approach through a key worker was explored where it involved two or more agencies and compared to those who accessed multiple single agencies that were not coordinated by a keyworker. The evaluation was undertaken using a simple four question instrument "IntegRATE" (Elwyn, Thompson, John, & Grande, 2015) followed by an extended interview to obtain qualitative data. To further explore users experiences. The methodology of the study is reported in detail elsewhere (Solomon, Burcham, & Lewis, 2018). The four integRATE questions asked were

- How often did you have to explain something because people did not share information with each other?
- How often were you confused because people gave you conflicting information or advice?
- How often did you feel uncomfortable because people did not get along with each other?
- How often were you unclear whose job it was to deal with a specific question or concern?

The extended interview transcripts were analysed using a grounded theory approach (Pidgeon & Henwood, 1996), to develop a framework for understanding participants' experiences. In terms of ethical considerations, the data was collected as part of a service evaluation project and participants were assured that the data would be used anonymously and confidentially but consent was given for publication in aggregate. The participants had the right to withdraw at any time. The full results of the evaluation can be found in a published study (Solomon et al., 2018).

An additional evaluation process was through short feedback questionnaires sent to Heads of Service in the Local Authority to cascade down to staff working alongside CAMHS clinicians. The forms asked about staff and key workers who were supported by CAMHS staff under the new "Risk Support" co-located service model. Key workers and staff were asked about (1) the nature of their involvement with CAMHS (2) what they need support with, and (3) what they most appreciate about CAMHS.

5. Service evaluation outcomes

5.1. Quantitative outcomes from the analysis of data from the Electronic Record System

Data collected over the two years when THRIVE was implemented is shown in Table 1. The beginning of services transformation was in July 2016. Data was taken from base April 2016 to March 2017 and compared to data collected from April 2017 to March 2018, The data collected suggests an increase in number of appointments and cases seen in the year after THRIVE was implemented from

Table 1
Performance and Quality – Improving Access and Waiting Times whilst maintaining high levels.

of satisfaction		
Measurement	2016 to 2017	2017 to 2018
Number of first appointments	306	408
Number of cases worked with	1045	1363
Number of community appointments	2143	2423
Number of clinic appointments	3010	4662
Average waiting time referral to treatment (2nd appt.)	3.4 weeks	2.6 weeks
% Request to Treatment within 8 weeks	93	98
Good experience of service	98	94

3010 to 4662 clinic appointments (Getting Help and Getting More Help) and from 2143 to 2423 community appointments (crisis teams, Local Authority teams, school appointments). Thus, in the period evaluated there were 1932 more appointments and the changes were cost neutral. Staff were redeployed and no new staff recruited with the restructuring. The average waiting time decreased from 3.4 weeks to 2.6 weeks. This was without a significant change in the experience of service rated as "good" 98 % of cases in 2016/2017 and 95 % "good" in 2017/2018. Using THRIVE, Camden exceeds national access targets for children and young people accessing help, support and treatment, and achieves high levels of satisfaction from service users.

5.2. Results of service evaluation using questionnaire and interview data

5.2.1. Outcomes for service users

A range of services were asked to identify users of multi-agency provision. These were residents living in a particular local authority area, who had engagement with two or more agencies in the previous three months as part of a multi-agency intervention. Participants were contacted by their key worker or professional from each referring service, to gain verbal consent for them to be contacted. A total of 98 potential participants were referred. 90 answered the four integRATE questions, and of those 38 agreed to take part in an extended face to face interview. Of those who answered the integrate instrument 34 Interview participants were female and four were male; 35 were parents, one was a foster carer and two were young people. Participants' ages ranged from 15 to 58 with an average age of 39 years old. 24 % were receiving a service from two agencies, 53 % were receiving support from 3 or 4 agencies and 22 % were receiving support from 5 or 6 agencies.

The quantitative data for the integRATE measure is presented in Table 2 and a detailed discussion of these results is presented elsewhere (Solomon et al., 2018). The most common issue reported was participants having to 'do or explain something' due to professionals not sharing information with each other adequately. The significant implications of this resulting need to repeat was articulated in many of the interviews. Significant numbers also reported feeling confused as a result of receiving conflicting information or advice from different professionals, and being unclear about the distinct roles of different professionals in their networks.

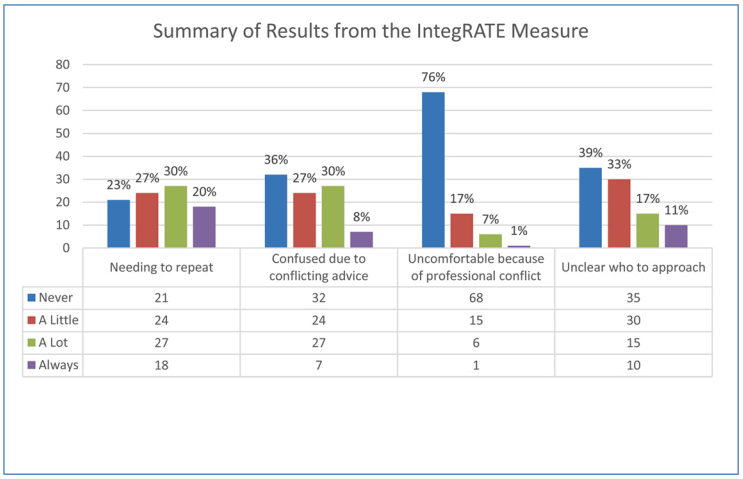
However, as the researchers point out, the integRATE measure is less useful than the qualitative data in evaluating the effect of the co-located multi-agency Risk support approach as the measure misses a key element of the experience of service users in this sample, namely the importance of having, or not having, a key worker (Solomon et al., 2018).

The analysis of the extended questionnaire data showed that families using multiple single services complained about having to repeat their stories, trying to get professionals to talk to each other and feeling "pushed around from one service to another". They complained that agencies failed to integrate properly and work effectively as a team. Conversely, those using the newly integrated and co-located services who had been allocated a keyworker had noticed that communication between professionals was good and they were very positive about the keyworker system. This suggests a positive impact of integration on service user experience. One service user commented "When I have a keyworker, I feel she asks questions that I am probably too afraid to ask". Another participant commented that keyworkers could advocate "We knew that we could absolutely rely on (keyworker) to be an advocate for (our son)". Keyworkers were described as people that could be "trusted" to act as sources of "knowledge" and act as a bridge between them and other professionals. Key workers and lead professionals emerged as vital to facilitate access to health, build and maintain trusting relationships and facilitating authentic, transparent communication between service users and agencies. The most common finding is the importance of having a key worker or lead professional, someone who can build a trusting relationship, navigate complex arrays of services and agencies, and knows how to get families and users the help they need. Participants also highlighted issues regarding the need for coordinating multi-agency work, and the value of key workers who take responsibility for this. Again, this finding echoes the previous findings cited above. When facing the apparently very common challenge of having to repeat their stories multiple times, participants again highlighted the value of key workers who take responsibility for sharing information with other professionals, with the service user's consent. The implication is that service users tell their stories just once, to an audience of one, whose responsibility then is to share with multi-agency networks. This keeps to a minimum the possibility of being 're-traumatised' by having to tell one's story repeatedly. The issues relating to different aspects of identity mostly seem to be helped by trusting relationships with key workers or lead professionals. When such a trusting relationship exists, service users are more able to be authentic. People have less need to present a 'fake self' to resist coercion. When the relationship includes the key worker's ability to 'change register', communicating clearly with the user as well as with professional colleagues, 'translating' across different language 'gaps' where necessary, then users have the experience of their key worker sharing power, reducing the perceived gap in status, and helping to 'humanise' what can often feel an intimidating professional network. This includes the service user feeling that their voice is represented, being validated professionally by their key worker. Participants reported that working with co-located services helped with the challenges of co-ordination and with effective sharing of information. The sense of community that can counter-act feelings of isolation was also highlighted by those receiving support from co-located services.

5.3. Outcomes for staff

Feedback from the questionnaires suggested that CAMHS staff presence at reflective practice case discussions and Thinking Together consultations were highly valued. CAMHS staff facilitation and support of the Camden model of social work was appreciated, introducing curiosity about families' experiences and fostered collaboration between social work staff and families. The feedback from keyworkers who had supervision from CAMHS workers as part of Risk Support for families that were "not therapy ready" include statements such as "I really do find all the clinical advice helpful, especially with feeling confident exploring mental health issues with clients" and "The relationship with clinical staff is so valued; I am a better person and support worker because of them". The feedback

Table 2
Results of the evaluation of the IntegRATE Model.



suggested that CAMHS professionals played an essential role in helping keyworkers develop their confidence and resilience to give families a more joined-up experience. CAMHS staff presence at child protection conferences and core group meetings was also highlighted as valuable. Some staff did express concern that because the CAMHS data was now on one ESR and not recorded on the Local Authority systems, data about families was no longer available to them, and this may mean their systems do not always have the most up-to-date information about risk.

6. Discussion

The quantitative ESR data suggests that the redesigned service using the THRIVE Framework of System Change has resulted in an increase in the capacity in the system which has extension improved access for both clinic and community appointments. The clinic-based appointments can be delivered on several sites by clinicians from all teams to children, young people and families who are engaged in interventions falling in the "Getting help or Getting more help" quadrants. These interventions may be evidence-informed, modular, in individual, family or group format. The community appointments reflect outreach in the community, schools and homes for those families who do not access the clinic, some of which may be "Risk Support" where the CAMHS clinician may visit with the keyworker. The substantial increase in the number of appointments cannot be attributed to any increase in staff as the redesign was cost neutral with no new staff being recruited. The hypothesis is that a more effective use of resources, less duplication and less time wasted in referrals bouncing between agencies has led to an increase capacity in the system. New ways of working such as Risk Support, providing

CAMHS input through the keyworker likely avoids repeat referrals to CAMHS for families that will not benefit from CAMHS interventions as well as enhancing the experience of families through less repetition. This in turn would reduce inappropriate referrals to clinics of families who are not "therapy ready" and increase capacity for appointments, reduce waiting times and increase access for those families who want and needs direct therapeutic help. The decreased waiting times enhance user experience and likely reduce the risk of families going into crisis.

The qualitative data interview and questionnaire data suggests improved user and staff experience of the new integrated model. The evaluation suggests that co-location in Local Authority settings developed trust between professionals and agencies so improving service users' experience. Co-located Local Authority and CAMHS staff have become a multi-agency system that is truly integrated and has been described in the qualitative evaluation as "a community of practitioners". The CAMHS staff remain part of the network for these families supporting realistically modest multi-agency goals set in collaboration with families, mainstreaming CAMHS thinking through the network. In practice, much of the CAMHS leadership capacity is directed at maintaining and supporting multi-agency relationships, and CAMHS leadership have played a lead role in modelling and influencing the development of the integrated system by being transparent and open with colleagues, showing integrity, supporting reflective practice.

This experience suggests that families building trust and engagement with a key worker can be a bridge for them into formal services. The key worker can work alongside the CAMHS professional for a time and facilitate this transition. The building of a trusting relationship is likely to be essential for families, children and young people who have histories of complex trauma and abuse. Successful changes in their psychological difficulties cannot be achieved without this trust and containment which is essential if they are to learn new adaptive skills such as self-regulation, process trauma and rebuild family relationships (Brom, Pat-Horenczyk, & Ford, 2009).

Clearly, the interpretation of the data has its limitation and further studies could be done to enhance our understanding of the impact of changes of working practices on the increase in capacity and effectiveness of CAMHS provision. Furthermore, during the period when THRIVE was being implemented, the multi-agency services provided data using an outcome framework that looks at

multiple domains of change for families fitting the criteria for "Troubled" (multi- problem). There were improvements demonstrated for the families in terms of (1) reduced reported domestic violence incidents, (2) reduction in cases meeting safeguarding[8] criteria (the criteria did not change during this period) and (3) improved educational attainment.

Improvements in health were not analysed due to lack of joined up reporting systems but reported overall quality of life clearly improved. In the future, it would be interesting to see whether the changes in multi-agency working and service delivery linked to THRIVE contribute to this overall improvement in quality of life. Furthermore, whilst we have focused here on the implementation of a whole system approach, we recognise that other non- British, even English situations may be different.

The THRIVE Framework can be applied in any context to categorise the interventions available to support the mental health needs of children and young people and the collaborative approach can be used to ensure needs are met and services are used effectively. Certain principles embodied in the framework could be used to enhance any mental health services such as (1) the need for an integrated approach using the language of "Help" understood across agencies (2) the recognition of different ways of providing valuable mental health support for vulnerable families (3) the focus on wellbeing and categorizing different interventions according to need not symptom severity (4) the Risk Support or team around the keyworker approach where mental health clinicians can work indirectly providing expertise through key workers..

Risk Support and indirect working to mainstream mental health support is especially important in contexts where mental health professionals are scarce and there is a need to reach a large population.

The implementation of this approach has had its challenges and has been supported by the collaboration between different agencies, commissioners and providers, as well as a relatively high levels of resources available to CAMHS in Camden. It has required training to achieve a change in mind-set and ways of working both in CAMHS clinicians and staff referring into the services. Clinicians had to learn that they could be equally effective working through others as they could doing direct therapeutic work. During the transition, some agencies expressed feelings of loss regarding "their CAMHS worker" becoming part of another team, rather than "belonging" to them.

At the practice level, providing Risk Support has highlighted difficulties with knowing when to close cases, given that cases known to the Local Authority can present with high levels of risk for extended periods, and CAMHS practitioners may be required as part of the professional network during this time. Another, area of difficulty has been data recording.

Whilst there have been advantages to the CAMHS service integration of having all data on the same ESR, Local Authority Agencies have expressed concerns about not having this data recorded on their systems. This has required negotiation and protocols around information sharing including duplication in terms of uploading documents on two systems which increasing workload for already busy CAMHS clinicians.

However, independent indicators suggest the potential of THRIVE to transform service in Camden and the UK. The value of the redesign in terms of providing more accessible services and more psychologically informed management of vulnerable and high-risk families who may not access CAMHS directly has been recognized by independent evaluating bodies. The summary of the 2017 safeguarding inspection of the London Borough of Camden by England's Office for Standards in Education, Children's Services and Skills (OFSTED)[9] wrote that the availability of CAMHS staff has allowed social workers to explore and implement imaginative and bold approaches with families. CAMHS staff work with senior social workers in the Local Authority to explore and implement more creative solutions to manage the most complex families (Ofsted, 2018). The Care Quality Commission[10] recently rated the services as outstanding in the area of "effectiveness" which reflects users experience of the care they are receiving (CQC, 2018).

Since the successful implementation, interest in the THRIVE Framework and the opportunities it provides to integrate the help and support required to meet the needs of children, young people and their families has grown and there is now a community of practice (organizations and local areas) using the national i-Thrive program that includes 99 local areas and covers 63 % of children and young people in England (AnnaFreud, 2019; i-THRIVE, 2019).

7. Conclusions

The preliminary data suggests that the THRIVE informed services re-design in Camden resulted in a more effective and comprehensive CAMHS offer to vulnerable, children, young people and their families at risk that is based on their need and ability to engage with services. Those who cannot access CAMHS directly benefit from CAMHS-informed interventions from co-located non-CAMHS staff. Co-located CAMHS staff build resilient relationships with staff of other agencies and facilitate an integrated approach to case management, interventions tailored to a user's needs and CAMHS-informed thinking and solutions for families who do not want or seem ready for the intensity of a therapeutic relationships. The CAMHS workers have developed expertise in providing Risk Support to those children, young people and families unable to benefit from CAMHS treatment at that point, but who remain a significant concern/risk. Many of these children and young people have spent years in CAMHS without engaging or improving. In the new system these cases are managed within the multi-agency service, realistic conservative outcomes are agreed, and the network holds a collective responsibility.

Our experience suggests that CAMHS staff can influence the decisions made by the various stakeholders and providers with a

[8] Safeguarding refers to a child's and young person's rights to be kept safe from harm

[9] Ofsted is the Office for Standards in Education, Children's Services and Skills. Ofsted inspects services providing education and skills using a standard framework. Osted also inspects and regulates services that care for children and young people.

[10] The Care Quality Commission is the independent regulator of all health and social care services in England.

substantial impact on the lives of children, young people and families. The expertise of a small number of highly trained professionals is reaching a larger number of children and young people through other trusted professionals. The restructured CAMHS allows for a better use of resources, reduced waiting times and a focus on interventions that are suited to meet different needs in different contexts. The implementation of THRIVE has been important in allowing the services described to continue to evolve, to meet need and to build resilience of staff and service users. In this way, the rights of vulnerable and at-risk children and young people to receive care and support to meet their mental health needs is being continually improved. The expansion of the framework across the UK and the new approach to defining mental health treatment and support suggests that THRIVE has the potential to transform services for vulnerable children, young people and families where there is need to integrate care across providers in a needs focused way in a number of different contexts, nationally and internationally.

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