



Developing and piloting i-THRIVE grids

Daniel Hayes, Rosa Town and Emiliios Lemoniatis have developed and piloted six new decision aids for improving shared decision making in children and young people’s mental health. This case study looks at the development, implementation and evaluation of this tool, and what they learned.

The problem

A recent rapid internal audit of the Children and Young People Improving Access to Psychological Therapies Service Transformation Programme¹ revealed that most young people and parents do not feel involved in decisions about their care and treatment. Decision aids, which are tools designed to facilitate shared decision making (SDM) between practitioners and clients, have been shown to be effective in improving SDM. Dartmouth’s [Option Grids™](#) are one type of decision aid that has been shown to increase shared decision making in other healthcare settings.

What we did

As part of a Health Foundation Innovating for Improvement grant, the Tavistock and Portman NHS Foundation Trust in collaboration with Anna Freud National Centre for Children and Families adapted Option Grids™ so that treatment decisions fitted within the THRIVE whole-system, needs-led framework (Wolpert et al., 2016). We named this new tool “i-THRIVE Grids” as they have been developed for and within THRIVE-like settings.

Grid development (August 2016 – January 2017)

We successfully developed six i-THRIVE grids for low mood, difficulties sitting still and concentrating, and self-harm. In line with the THRIVE conceptual framework, these were split between getting help ‘within’ or ‘outside’ of the NHS. Expert Reference Groups (ERGs) were set up for each presenting difficulty. Grid content was

supplemented with research evidence, or expert/stakeholder consensus when research was sparse.

Piloting of the grids took place in two CAMHS teams within the Tavistock and Portman NHS Foundation Trust. Baseline data collected from both teams indicated these clinics already had high levels of SDM at the start of the project. However, there was still some room to improve, particularly as young people gave lower scores than parents on the SDM measure, CollaboRATE (Elwyn et al., 2013)², across both clinics.

Table 1: Baseline data from clinics

Measure	Clinic A n= 21	Clinic B n= 13
SDM (CollaboRATE)	-	-
Total out of nine		
<i>Parent</i>	7.94	8.38
<i>Young Person</i>	7.21	7.13
Experience of Care (ESQ)	-	-
Total out of 12		
<i>Parent</i>	9.78	9.15
<i>Young Person</i>	7.57	8.43

Piloting/refining the grids (March 2017 – August 2017)

The two CAMHS teams (Clinic A and Clinic B) took part in the refinement, piloting, and evaluation of the grids. Of 41 young people and families seen at Clinic A and 26 young people and families at seen Clinic B, nine

¹ [Children and Young People’s IAPT- Rapid Internal Audit National Report](#). September 2015.

² G. Elwyn, PJ. Barr, SW, Grande. R. Thompson, T. Walsh, EM, Ozanne (2013) Developing

CollaboRATE: A fast and frugal patient-reported measure of shared decision making in clinical encounters. Patient Education and Counseling 93(1), 102-107.

people used the grids in Clinic A and one person used a grid in Clinic B.

Grid usage by clinic

Clinicians were initially hesitant to adopt the grids in both teams. However, we saw gradual improvement in grid usage after each of our five PSDA (Plan Do Study Act) cycles, which were as follows:

1. Baseline feedback and training were given to clinicians
2. Diagnoses (e.g. "Depression") on the grids were replaced with more generic descriptions of difficulties (e.g. "Low mood")
3. Further training on i-THRIVE grids was provided to clinicians
4. Text on the grids was altered to be more CYP friendly
5. A 'You said, we did' poster was introduced to both clinics detailing the rationale behind changes made to the grids

Continued work with young people and parents

We sought continuous iterative feedback from young people and parents throughout the course of this project. One source of feedback was our ERG meetings with of young people with experience of depression, ADHD and/or self-harm. Young people stated that they liked the colours, layout and design of the grids, particularly after we employed a graphic designer to improve the grids. Some clarity over wording was suggested by young people, which led to our decision to lower the reading age on the grids. We were particularly struck by several young people's comments that they wished they had had something like the grids when they first sought help for their difficulties.

Quantitative findings

In August 2017, after five months of implementation, we compared baseline and follow-up data on grid usage across several measures. We found that parents who had used i-THRIVE grids in an assessments session reported significantly

better experience of care on the CHI-ESQ than parents who had not used the grids.

However, no significant difference between baseline and follow-up was found regarding parent or young person SDM on CollaboRATE, young person experience of care on the CHI-ESQ, or modality of intervention received. Ceiling effects of baseline measures and screening out of cases that could have used the grids (e.g. potential ADHD cases sent to specialist clinics) prior to assessment could account for this.

Qualitative data

Interviews were collected from six clinicians and one parent who had used the grids in practice and one clinician who had not used the grids. Findings have been separated between 1) impact of grids and 2) implementation of grids.

Impact

Interviewees described the grids as useful, reliable information sources that accurately covered the range of available treatments. Clinicians described how the grids helped to remind them about things they may forget about outside of the NHS. Clinicians described how the grids also served a purpose outside of the clinical encounter, as they could remind service users of the treatments available to them after their appointment.

"When they walk away they have something where it's written down when they might not have fully taken in what you've said."

The parent we interviewed echoed this sentiment and explained that having access to the grids was empowering.

"[The grid] gives you more... you can go into the meetings, the appointment armed with some knowledge."

Within the session, participants described how use of the i-THRIVE grids uniquely enhanced and facilitated discussion around

the different treatment options that were available.

“The parents came with a view of one kind of medication ... But with the grid, we were able to have quite a bit of conversation about the different types of medication”

In line with previous research indicating that decision aids can increase service user satisfaction, the parent we interviewed explained how the grids allowed her to make the decision that was right for her family.

“In fact, I felt my partner and I were allowed to take ownership of the decision.”

Clinicians commented on young people and parents’ desire for the grids and how service users saw the grids as intrinsically useful.

“I think what I was struck by is that the family specifically requested more grids. The dad wanted a grid, and I thought that was indicative that it was something that they thought was a useful component of the conversation that we had”.

Implementation

Most clinicians felt that the i-THRIVE grids were easy to use and that they did not detract from practice. One clinician explained that the grids reduced variability and created uniformity so that service users reliably received the same information.

However, some clinicians described how the grids seemed burdensome and “mandatory”, and that this added to their already packed schedule.

“When you are already feeling very full, it’s hard to have all these to add.”

Other clinicians believed the grids were not burdensome, as they were flexible and could be used whenever a clinician felt they were appropriate.

“This doesn’t replace everything else... no one is telling you, you have to use [the grids]. It’s a tool to have, and actually, the family might find it helpful”

Clinicians found the grids useful in the context of assessment clinics, as this was when options for treatment were often discussed. Clinicians described other situations in which the i-THRIVE grids could also be useful, including schools and A&E.

Clinicians requested that the grids be available electronically to make them more accessible.

“If they were electronic, for instance, I could just print them off myself. That would be the easiest thing”.

One clinician described how it would have been preferable to have had the choice to participate as a team in the project from the outset, rather than feeling that it was mandated from on high.

“I would have liked to have been asked rather than just told this was happening. Just to have been consulted from the outset and it may have been sort of decided at a more senior level. But I think the teams and the staff that are actually going to have to be doing it need to be involved a bit more from the outset.”

What we learned

- To adapt the grids to fit into a new needs-based system, it was necessary to move away from NICE guidelines to include other types of care and support.
- Collaboration and coproduction with young people and parents was essential in getting the look and feel of the grids right.
- Due to a wide array of similar treatment options, which was overwhelming to parents and young people, we found it was more effective to collapse

treatments into hierarchical categories on the grids.

- Consistency, time and considerable effort were necessary to engage staff members in the project, who initially saw the introduction of the grids as burdensome. This was greatly aided by embedding a researcher within the assessment clinic, creating a 'You said, we did' poster and having an informal feedback loop between staff and the research team. This allowed for coproduction between staff and researchers.
- We found it challenging to recruit young people and families to use the grids from the assessment clinics. These clinics had very few ADHD cases, as due to local pathways they were often rerouted to another specialist clinic at intake. There were also fewer total incoming assessment cases than we had anticipated. In future, this could be improved by mapping the service pathway and looking at data regarding the service's

service user presenting difficulties before grid implementation.

Next Steps

At the site of the pilot, the i-THRIVE grids will be available electronically, incorporated into the Carenotes system, and will continue to be used in other clinics and appointments.


The six grids will be available through the i-THRIVE Community of Practice, currently covering 72 CCGs. The North East London Foundation Trust (NELFT) is at the forefront of this exciting work as they will have the opportunity to trial and evaluate i-THRIVE grids within their services from autumn 2017.

For further information, please contact:

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i-THRIVE Grid for Low Mood: Support within the NHS




Low mood
Support in the NHS


Use this tool to help you, your parent or carer and a therapist decide about getting support for low mood.

Note: You may want to try other types of help and support alongside the ones that are listed here. There is evidence that combining CBT with medication is more likely to help than either talking therapy or medication alone. Changes to diet, exercise and lifestyle could also help to improve your symptoms, although there is not enough evidence about this to be sure.
















Practical Support




Talking Therapies




Anti-depressants

Common Questions			
<p>What will this involve?</p>	<p>This can involve learning practical strategies that may help you feel better. You will usually meet weekly with a therapist who can help you understand your difficulties, set goals, create an action plan, and give you activities to complete.</p> <p>This can include support with schoolwork, social skills, family events, or things personal to you.</p> 	<p>This can involve focusing on your thoughts and feelings.</p> <p>You will usually meet weekly with a therapist who can offer you a space to talk about and understand your feelings and the difficulties in your life.</p> <p>Each session is usually about an hour long and may involve other family members.</p> 	<p>This can involve taking medication to treat your symptoms. You will usually meet with a psychiatrist who can give you a prescription for medication.</p> <p>The most common medication for depression is called an SSRI. There is evidence the SSRI Fluoxetine can help young people with low mood. This is usually taken once daily as a capsule, liquid or tablet.</p> 
<p>How will this help me get better?</p>	<p>This support may help you learn about low mood. You will be given practical strategies for managing your feelings that may help you feel better.</p> 	<p>Talking therapies can help you think differently about situations in your life and improve how you feel.</p> <p>Different types of talking therapy focus on different things in your life like your relationships with others, your past experiences, or negative thoughts you might be having.</p> 	<p>This medication works by increasing a chemical called serotonin in your brain. When your serotonin is low, this can lead to low mood.</p> <p>These are often prescribed after a course of therapy or alongside a course of therapy.</p> 
<p>Will I see the same people for the duration of this help or support?</p>	<p>You will usually see one person for this support.</p> <p>This may not be the same person you see for your assessment.</p> 	<p>You will usually see one person for this support.</p> <p>This may not be the same person you see for your assessment.</p> 	<p>You will usually have a height, weight, blood pressure, pulse and mental health assessment. Then, a member of the team will regularly check up with you to make sure the treatment is working and to check for side effects.</p> 
<p>Are there risks or side effects from this type of help or support?</p> 	<p>Talking about your difficulties can sometimes cause discomfort, anxiety or stress.</p> <p>Tell the person you are talking to if you are experiencing these feelings.</p>	<p>Talking about your difficulties can sometimes cause discomfort, anxiety or stress.</p> <p>Tell the person you are talking to if you are experiencing these feelings.</p>	<p>Very common side effects of Fluoxetine include insomnia, headache, diarrhoea, nausea and fatigue. There is a small risk of self-harm, suicidal thoughts and hostility which will need to be monitored. Talk to your doctor about other side effects.</p>








This decision aid does not constitute medical advice, diagnosis or treatment.
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Anna Freud
National Centre for Children and Families



i-THRIVE Grid for Low Mood: Support outside of the NHS

		Use this tool to help you and your parent or carer decide about getting support for low mood.			Note: You may want to try other types of help and support alongside the ones that are listed here. There is not much evidence about these types of support, but you may find that they help you feel better.	
						
Common Questions						
What will this involve?	This involves reading information about low mood and understanding more about your difficulties.	This involves activities like drama, sport or art. Families can sometimes also be a part of these activities.	This involves calling a telephone number and speaking with someone who can listen to you and provide you with information and advice.	This involves talking with a counsellor who can listen to you, support you and help you understand your feelings.	This involves working through a computer programme either on your own or with a therapist.	
How will this help me feel better?	You may learn tips to feel less stressed, worried or sad. You might also find out new ways to understand your thoughts and feelings.	You may meet other people at these events who are experiencing similar difficulties. This could help you make new friends and learn strategies to tackle challenges in your life.	Talking to someone about your difficulties may help you to work through your worries and/or sadness. This may also help you see things more clearly and think about what your options are.	Meeting with a counsellor in a safe and regular space may help you to talk about, better cope with, and eventually overcome your difficulties. It might take more than one session to start feeling better.	You may find out how to understand and overcome your difficulties by breaking them down into manageable parts. You may also learn how to change negative thoughts and patterns of thinking and behaving.	
Will I see the same people for the duration of this support?	This support can usually be done on your own or your parent or carer may be able to help you.	These groups are usually run by the same person.	There will probably be a different person on the line each time you call.	It is likely that you will see the same person for this support.	It is likely that you will see the same person for this support.	
Are there risks or side effects from this type of support?	 There is not enough evidence to know for sure if these types of support will have side effects. Talking, reading or thinking about your difficulties might cause worry or stress. Making changes in the way you think about things or do things may also be hard, and you might feel worse before you start to feel better. Tell someone if you are having these feelings. If you are finding it too hard to use this support on your own, it may be a sign that you should ask for more support.					
Where can I get this support?	Online or through reading material/books (See back of page.)	At community or faith centres, online, or at school (See back of page.)	On the phone (See back of page.)	In person or online (See back of page.)	Online or at a venue that offers this type of support (See back of page.)	

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