Q&A with Dr Rachel James, i-THRIVE Clinical Lead

Dr Rachel James is a Consultant Clinical Psychologist and an Associate Clinical Director at the Tavistock and Portman NHS Foundation Trust. Rachel is an author of the *THRIVE Framework* (Wolpert et al., 2016) and is the Clinical Lead for the i-THRIVE Programme.

Q: How would you describe your role as Clinical Lead for the i-THRIVE Programme?
A: I assist the i-THRIVE Community of Practice sites to implement the THRIVE principles in a way that meets the needs of those sites. I am passionate about equity of access, and support sites to develop their local knowledge and understanding of the principles that underpin THRIVE by sharing learning from other sites across the nation who have successfully put elements of the THRIVE framework into practice. I support them to develop their local knowledge and explore through this collaborative approach how the challenges they face can be overcome, learning from others' experiences. This helps sites have a realistic understanding of the practicalities involved in whole service transformation. The differences across sites in terms of their populations, local communities and geographical landscape mean that each local area can face unique challenges. What works in inner London is unlikely to meet the needs of more rural areas, such as Lincolnshire or Cornwall, so it's about how we work with the site to support them apply the principles in a way that meets the needs of their local population.

Q: Are there any common misconceptions about the THRIVE framework?
A: A common misconception is that the THRIVE framework just replaces the tiered system with different language. It can sometimes be hard for people to conceptualise what i-THRIVE is trying to work towards, which is building capacity in all the children's workforce whatever sector or service they work within, so that the emotional health and wellbeing needs of children and young people can be identified and met in a timely way. We need to think holistically about health and wellbeing, and consider broader contextual issues such as the impact of housing, parental health and well-being, and poverty. We want to build capacity in the entire children's workforce to identify vulnerable children and intervene in meaningful ways that make a positive difference. System-wide consideration needs to be given to the potential risk of strategies in one domain inadvertently undermining positive outcomes in another. For example, key performance indicators (KPI's) which incentivise direct contacts with children, young people and their families may inadvertently de-incentivise capacity building work in another part of the system.

Q: From a care point of view, what's different about the THRIVE framework?
A: The THRIVE framework tries to move away from diagnosis-driven systems towards thinking about "need" in collaboration with the child and their family. Shared decisions are reached with regards to how best to meet the identified needs, taking into consideration the usual safeguarding and legal frameworks. Young people and families need support to make informed decisions about what support is available, and what the evidence-base tells us. For example, one young person with obsessive compulsive disorder might decide they don't want medication and that they want a CBT programme that they can do at home, while another might decide that a trial of medication alongside face-to-face CBT is best for them, and yet another may decide to manage their recurrent symptoms independently after having previously received a treatment. Meeting the needs of children and young people, whilst also

ensuring shared decision-making, requires skilled assessment. We need to ensure that we avoid potentially colluding with a young person's or families view of the world that is potentially unhelpful to them, and ensure they are fully informed of the range of support and treatment options available to them. Part of the challenge of increasing shared decision making is ensuring there aren't perverse incentives to reduce referrals to CAMHS by young people opting out of receiving an intervention. There needs to be work to ensure the young person's view is supported by the best evidence so they can make genuine and informed decisions about their treatment or support options.

Q: What have you noticed from your experiences of presenting i-THRIVE at local engagement events?

A: Whilst each site is unique, common themes have emerged across different sites, some of which are driven by government agendas around areas such as waiting times, and initiatives such as *Future In Mind*. It is clear that people have a real desire to make a positive difference in the child mental health landscape. Implementing THRIVE can sometimes be viewed as *another* thing that sites must do on top of all the government driven targets, when actually the THRIVE framework can be used to pull together all of the various strands and initiatives. i-THRIVE can help with those government levers but it is not the panacea; there has to be good resourcing to allow children and their families to access good quality services in an equitable way.

I think a key challenge relates to the fact that the traditional single-agency model of Child and Adolescent Mental Health Services (CAMHS) is not really appropriate anymore. There has been growth across the country in the number of sectors providing child and adolescent mental health care. A solely NHS offer is far too narrow to offer a comprehensive and diverse range of resources, and it is clearly not a case of one-size fits all children, young people and their families. Most people working in CAMHS know this, hence why there are in-reach and out-reach services, and multi-disciplinary and multi-agency teams. We need to think more holistically about who provides child and adolescent mental health care across systems to enable us to retain the more specialist CAMHS professionals and resources for those who most need them.

The THRIVE framework is centred on improving mental health and wellbeing and preventing problems escalating, alongside promoting holistic family mental health and wellbeing. When we're working at an engagement level with sites it can be quite hard to shift away from the traditional CAMHS view. As the demand on services has led to some CAMHS imposing strict thresholds, there isn't equitable access for all children and young people. Helping organisations that don't have a traditional role in supporting children and young people's mental health to see that they have a valuable contribution to make, and that they can deliver a high-quality intervention can be really helpful. It may mean that young people don't need to use more specialist services because they can instead be supported by their community, such as through faith organisations, local football or other sport or leisure clubs, or extended family networks.

A lot of the work at the beginning of the implementation of THRIVE is to get all the multi-agency organisations together. The first stage is helping professionals across the system see the importance of coming together, and understanding that everyone has a valuable contribution to make in improving children and young people's emotional health and well-being. Working together gives strength to the resources already available, and provides an

opportunity to build capacity within the system. We have to make best use of the resources available. There are a variety of fantastic examples from different sites showing that a genuine focus on working collaboratively across the system in a holistic way can lead to better outcomes for children and young people. A number of these have been written up as case studies, and can be found here.

There are a number of issues that vary across different localities. For example, in different parts of the country there are strong voluntary sector initiatives and collaborative working practices, and in other parts there are very few. That presents a real challenge in supporting local services to start thinking about how to provide a more holistic offer to promote genuine child and family wellbeing, when there are perhaps big gaps in the local offer. The gaps aren't the same in different parts of the country, so although there are common problems, they present unique challenges for each site.

Q: In what way can using the i-THRIVE Grids, the shared decision making tool developed by i-THRIVE, help a service to become more aligned to the THRIVE framework?

A: The i-THRIVE Grids help practitioners to maintain a more neutral position on the options available to a young person based on the research evidence. As a practitioner myself, I know that my own training and experiences can influence my practice, meaning that even though you think you're facilitating shared decision making, it's not as neutral as it could be. The i-THRIVE Grids provide young people and their family with something concrete that they can take away for further discussion if they choose to do that, and helps to build awareness of the variety of options available to them. The grids also support the idea of self-management as a positive option. Just because a young person is meeting with a practitioner at one moment in time it doesn't mean they will need to do so in the longer term. They could be supported by social prescribing initiatives, or by other Strategies Not Accompanied by a Professional (SNAP). It's a helpful way to explore whether the young person could make use of different initiatives and strategies, and to draw on support available within their network and/or their local community.

When they experience significant challenges or difficult life events some young people will inevitably need more specialist support, but we also know that the needs of most young people can be met within their local community. The i-THRIVE Grids help children and young people understand from the outset that there are a wide range of resources available to them, and that not everything works for everyone. The skill of the practitioner is key in ensuring that significant mental health needs are not missed. We want to ensure that the grids are used in a way that supports evidence-based practice, whilst simultaneously ensuring that they do not negate the need for a comprehensive assessment.

Q: Which areas of the THRIVE framework do services find challenging?

A: A lot of work has taken place to promote good mental health and wellbeing and preventing mental health difficulties. Sites often describe challenges in the development of system-wide approaches to building resilience. Children and young people need to be supported across all sectors to develop their skills and resources to cope with adversity and life's challenges in a way that genuinely promotes Thriving. Resilience building is complex and involves developing children and young people's knowledge about where to access and negotiate help and support, and how to make use of it to meet their needs in culturally meaningful ways.

Promoting “Thriving”, and preventing mental health difficulties is an area where we will be sharing more learning from different sites to support new sites. Perhaps as a result of the more traditional single-agency CAMHS offer, new sites are often very strong within the Getting Help and Getting More Help needs-based groupings, which have also been supported through national initiatives, such as CYP-IAPT. The Getting Advice and Signposting and Getting Risk Support needs-based groupings have emerged as potentially challenging aspects due to the need for good multi-agency working. At the time of writing the THRIVE framework, there was little reliable data about which children and young people would fall within the Getting Risk Support needs based grouping. These were often young people who had been held in CAMHS for years, and although they caused a lot of worry in the system, were making limited, if any, progress. It was identified early on that this needs-based grouping would be a challenge for sites to identify and meet the needs of. More recently, challenges with the Getting Advice and Signposting needs-based grouping have come to the fore. There is some common ground with Getting Risk Support in terms of them both really needing a multi-agency offer. To provide Getting Advice and Signposting with shared decision making at the core, the offer really needs to be holistic, cross-sector, and diverse – we know that what works for one person might not work for another. There has to be multiagency collaboration across the public and voluntary sectors, with shared responsibility and accountability to enable a true Getting Advice and Signposting offer, in a similar way to Risk Support. Complex relationships between sectors and services in local areas can sometimes be a barrier to this.

Q: Can the principles of the THRIVE framework be applied to other populations?

A: It’s a little bit of an unknown because THRIVE was developed in the context of child and adolescent mental health services, but we have had feedback from sites that the framework makes sense for a range of populations such as dementia, physical health and learning disabilities. As yet, we don’t know whether the framework is helpful for those different populations but it seems to make sense to people. We are beginning to see evidence that the THRIVE framework has advantages in child mental health in increasing access and reducing inequalities, and in meeting the needs of children and young people in a location that suits them. We’re keen to support the thinking and share the learning from sites who are applying the framework to different populations. If local areas are applying the THRIVE framework or principles to different populations then they are encouraged to get in touch with the i-THRIVE team to enable us to help share their learning, if the local site would like to do so.

Q: As the lead for the i-THRIVE Academy were there particular learnings that you took away from each of the modules?

A: The shared decision-making module was really helpful, bringing people together from different providers, disciplines and geographical areas to consider what is at the core of the THRIVE framework. Participants held different definitions and understandings of what shared decision making is, and identified that children, young people and their families are also likely to have a different view to those held by practitioners. A key learning point I took away was about the importance of transparency in the decision-making process, and the ways in which using the i-THRIVE Grids can help to empower children and young people by facilitating open decision-making. Practitioners do work hard to ensure they are engaging in shared decision-making. However, it is important to reflect on whether children and young people are genuinely being empowered, or whether our own biases, experiences and beliefs might be shaping the conversations we have.

During the Getting Advice and Signposting module, I became mindful of the potential for services to inadvertently reinforce the difficulties for marginalised groups in accessing evidence based treatments. We all work with diverse populations and face a genuine need to ensure equitable access. In striving to be inclusive, it is important to identify potential hidden biases in the services that we're offering. It is crucial that shared decision making does not further marginalise vulnerable groups. For example, some vulnerable groups may be at greater risk of opting out of active support or treatment, and whilst that might be ok on the one hand, it could also create significant inequalities. We must ensure that everyone's needs are met and that there are not inequalities in the uptake of support offered - we really do need to work to mitigate against such potential unintended outcomes. Ultimately shared decision making does not negate our duty as professionals to ensure everyone has a tailored intervention or approach that we believe will help improve their outcomes.

A key learning point I took away from the Risk Support module relates to the challenges in having true shared accountability and responsibility across sectors. Different infrastructures and data systems across social care, health, education and the voluntary sector create challenges for the delivery of Risk Support, which greatly benefits from co-located workers and good communication across agencies. Some local areas are doing an amazing job of working collaboratively despite these barriers and are delivering risk support in a way that keeps children and young people supported through very challenging circumstances by sharing responsibility, often reducing anxiety within professional networks.

I think a key light bulb moment for me in the When to Stop Treatment module related to the different approaches within physical health and mental health regarding expectations of "getting better". Over twenty years ago, when I was completing my clinical training, clinicians were strongly encouraged to think about what else could be offered if treatments were not demonstrating improvements. Of course it is completely correct to do that, but not at the expense of endless resources, as that has the potential to restrict equitable access to services for all. We do need to keep in mind the evidence base which tells us that not everyone shows the same improvements. Some young people do not make improvements despite the really good quality interventions offered. This academy module helped participants consider how to have these discussions from the beginning, in the same way that you would with someone who is about to have a knee replacement operation for example. All potential outcomes are clearly outlined at the beginning for a patient undergoing surgery, including the chances for improvement and any risks involved, and I think that this is something we could benefit from within mental health. It is important that children and families share responsibility for change so that if the support offered isn't facilitating an improvement, there can be a conversation about what else might help to support positive change that is reasonable and practical to offer.

Throughout all of the academy modules, I was inspired by how participants were genuinely stimulated to take back their learning to share with their teams. For new approaches to be embedded locally there has to be local follow up and engagement across all levels. In practice, this presents a real challenge, and informed the design of the i-THRIVE Academy training modules to ensure it builds capacity and makes a sustainable difference to support system-wide transformation, ensuring that improving children and young people's emotional health and well-being is everybody's business.

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