

## **Title Page**

### **Title:**

Co-developing a Participation-Led Evaluation Framework for THRIVE-Aligned CYP Mental Health Services: A Mixed-Methods Method-Development Study

### **Authors and affiliations:**

- Dr Ana Draper, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK
- Maristelle Preece, Mindworks Surrey, Mole Business Park, 18, off Ronson Way, Randalls Rd, Leatherhead KT22 7AD
- Dr Tessa Crombie, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK
- Sophia Shepherd, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK
- Zuzanna Malecka, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK
- Socayna Moudiab, The Tavistock and Portman NHS Foundation Trust, Tavistock Centre, London, UK

### **Corresponding author:**

Dr Ana Draper

The Tavistock and Portman NHS Foundation Trust

Tavistock Centre, 120 Belsize Lane, London NW3 5BA

Email: [adraper@tavi-port.nhs.uk](mailto:adraper@tavi-port.nhs.uk)

### **Authors' contributions**

AD (Ana Draper) led the study design, overall supervision, and drafting of the manuscript. MP (Maristelle Preece) contributed to data analysis, interpretation, and manuscript development. TC (Tessa Crombie), SS (Sophia Shepherd), ZM (Zuzanna Malecka), and SM (Socayna Moudiab) supported data collection, literature review, and refinement of the manuscript.

### **Running head:**

Embedding user experience as part of THRIVE system change

### **Keywords:**

THRIVE; participation; children and young people; ESQ; quality improvement; mixed methods; method development; mental health

## **Abstract**

This paper reports on a method-development study that aimed to design and implement a participatory, THRIVE-aligned evaluation framework across a large children and young people's mental health (CYP MH) alliance. Existing Experience of Service Questionnaires (ESQs) varied across providers, limiting comparability and weakening the capacity for system-level learning. In response, we developed a co-produced Minimum Data Set (MDS) through a multi-stage process involving Quality Improvement (QI), dialogical practice, and rights-based participation principles informed by the Lundy Model of Participation (2007). Over 2,500 ESQs collected across five quarters were analysed using descriptive statistics and thematic analysis (Braun & Clarke, 2006).

Findings show consistently high relational quality (mean 4.6–4.7/5) and over 90% agreement that needs were met. However, challenges persisted regarding waiting times, session length, and parental engagement. The co-production process strengthened the legitimacy and credibility of the evaluation approach, embedding CYP voice in both the design and interpretation of data. The study demonstrates that evaluation methods themselves can operate as mechanisms for THRIVE-consistent system change, cultivating participation, shared decision-making, and relational accountability (Wolpert et al., 2019; Seikkula & Arnkil, 2016).

## Introduction

The THRIVE Framework (Wolpert et al., 2019) advocates a shift away from deficit-oriented CAMHS models toward needs-led, collaborative, and participatory approaches to supporting children and young people's mental health (CYP MH). Implementing THRIVE at system level requires evaluative infrastructure capable of capturing relational quality, shared decision-making, and outcomes that matter to CYP and families—not only clinical outputs. However, evaluation tools used in routine practice rarely meet these expectations and often lack consistency across complex provider landscapes (Batty et al., 2013).

The Mindworks Surrey partnership—a multi-agency alliance between NHS and voluntary sector providers—identified substantial variation in ESQs used across services. Variation impeded comparison, hindered service learning, and risked minimising young people's voices (Tisdall, 2015). In response, we undertook a method-development study designed to create a shared, participatory, THRIVE-aligned evaluative process.

Our methodological framework drew on:

1. **Quality Improvement (QI)** (Langley et al., 2009) to iteratively build, test, and embed processes.
2. **Dialogical practice** (Seikkula & Arnkil, 2016) to promote relational accountability.
3. **Standardised Experience of Service Questionnaires (ESQs)** (Brown et al., 2014) to capture comparable user-experience data.
4. **The Lundy Model of Participation** (2007) to ensure ethical, rights-based involvement of CYP in shaping the evaluation.

Rather than evaluating services directly, this study evaluates the *development of the method* used to capture service experience—a crucial distinction. Our aim was to understand:

How can a participatory, THRIVE-aligned evaluation method be developed and embedded across a multi-agency CYP mental health alliance?

## Evaluation Design (Method Development)

This was a mixed-methods method-development study following the conceptual tradition of Greene et al. (1989). The aim was to design, test, and refine an evaluation

process that aligned with THRIVE principles and operationalised CYP participation meaningfully and ethically.

## 1. Quality Improvement Approach

QI cycles (Langley et al., 2009; NHS Improvement, 2018) guided the development of a standardised evaluation method. Early PDSA cycles revealed:

- multiple ESQ versions
- inconsistent administration
- limited feedback loops
- low carer participation

These findings shaped the design of the Minimum Data Set (MDS) and the creation of shared collection cycles.

## 2. Dialogical Practice

Dialogical principles ensured that discussion with CYP and families was open, reflective, and relational. Consistent with Shotter (2015), meaning was seen as co-constructed, not extracted. This approach supported:

- collaborative question refinement
- re-design of language for accessibility
- exploration of “why” behind numerical ratings

## 3. ESQ Standardisation

Research emphasises the value of ESQ tools in benchmarking satisfaction and relational quality (Brown et al., 2014; Wolpert et al., 2016). However, their effectiveness depends on consistent application and alignment with participatory principles. To achieve this, all ESQs from across the alliance were mapped and synthesised. The most used and most meaningful items—validated through consultations—formed the basis of the MDS.

## 4. Lundy Model: Embedding Participation

The Lundy Model (2007) provides a rights-based structure for participation, emphasising space, voice, audience, and influence. Operationalisation included:

- **space:** accessible consultations; CYP-friendly formats
- **voice:** youth-led phrasing of questions; open text boxes
- **audience:** governance processes mandated review of feedback

- **influence:** CYP feedback directly shaped QI cycles

### **Triangulation**

Triangulation was guided by Farmer et al. (2006) to strengthen validity. We integrated:

- QI data
- quantitative ESQ scores
- thematic analysis of free text
- Lundy participation checks

This ensured the method captured both measurable trends and relational nuance.

### **Data Collection**

Three development stages were undertaken:

1. **Mapping existing tools** across NHS and voluntary sector providers.
2. **Synthesising common domains** and identifying gaps (e.g., participation, endings, waiting).
3. **Co-production of the MDS** via multi-agency focus groups including CYP.

The MDS included domains on listening, needs-meeting, goal-setting, accessibility, and relational quality.

ESQs were completed at discharge. Data were collected quarterly (Q2 2023/24–Q3 2024/25).

**Sample:** 2,500+ responses; 70–75% from CYP.

### **Analysis**

#### **Quantitative Analysis**

Descriptive statistics identified trends in:

- satisfaction
- needs met
- goal-setting
- relational experience
- waiting support

## **Qualitative Analysis**

Thematic analysis followed Braun and Clarke (2006). Themes were mapped against THRIVE and QI priorities.

## **Participation Checks**

Each stage was reviewed against Lundy's four participation domains to ensure procedural and ethical soundness.

## **Findings**

### **Quantitative Findings**

- **Overall satisfaction:** 4.6–4.7/5
- **Would use service again:** 4.6–4.8/5
- **Listening:** consistently 9.0–9.2/10
- **Needs met:** >90% agreement
- **Shared goals:** ~90%
- **Waiting support:** highly variable; one major dip (55%)

Carer participation remained low (~25%), consistent with national patterns (O'Reilly & Lester, 2017).

### **Qualitative Findings**

#### **Strengths**

- high relational quality
- feeling listened to
- helpful strategies
- valuing activities/games
- strong rapport with staff

#### **Challenges**

- desire for longer/more sessions
- inconsistent communication while waiting
- session endings feeling abrupt
- parental desire for more involvement

- accessibility issues (school, transport)

### **Participation Reflections**

CYP repeatedly described appreciating:

- choice
- collaborative goal-setting
- being asked what mattered to them

However, they wanted clearer explanations of processes, especially around endings.

### **Discussion**

This method-development study demonstrates that co-producing an evaluation framework can itself act as an intervention that strengthens THRIVE implementation. Developing the MDS required collaboration, transparency, and dialogue—processes that align with THRIVE values and shift organisational culture.

### **Methodological Contribution**

The study contributes:

1. **A replicable participatory evaluation method** for multi-agency CYP MH systems.
2. **Evidence that standardisation can coexist with participation**, rather than displace it.
3. **A demonstration that evaluation tools shape service culture** (Dixon-Woods & Martin, 2016).
4. **A triangulation strategy integrating QI, narrative, and participatory evidence.**

### **Key Tensions Identified**

- **Standardisation vs. local flexibility**
- **CYP voice vs. carer voice**
- **Positive scores vs. deeper systemic challenges**
- **High satisfaction vs. waiting pressures**

These tensions reflect national patterns in CAMHS transformation (Children's Commissioner, 2021).

## **Representativeness**

Lack of demographic data limits equity analysis—a concern widely identified in routine outcome measurement literature (Batty et al., 2013).

## **Limitations**

- self-selection response bias
- incomplete demographic data
- limited parental engagement
- discharge-only feedback (no longitudinal perspective)
- ESQ data requiring triangulation with other participatory streams

## **Future Directions**

- routine demographic capture
- increased carer engagement strategies
- longitudinal follow-up evaluation
- integration of digital data-collection tools, including exploring AI-assisted thematic analysis
- ongoing review of the MDS to ensure relevance

## **Conclusion**

This study shows that developing an evaluation method is not merely a technical exercise but a participatory, relational, and cultural process that mirrors the values of THRIVE. By co-producing a shared MDS grounded in dialogical and rights-based approaches, the alliance created an evaluation framework that is credible, meaningful, and capable of driving system learning.

Embedding such approaches requires sustained commitment, transparent feedback loops, and continued attention to equity. As CYP MH systems nationally strive for integrated, participatory models of care, this method-development process provides a transferable model for how evaluation can act as a driver—not just a measure—of change.

## References

- Batty, M.J. et al. (2013) 'Implementing routine outcome measures in child and adolescent mental health services', *Child and Adolescent Mental Health*, 18(2), pp. 82–87.
- Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101.
- Brown, A. et al. (2014) 'Satisfaction in child and adolescent mental health services', *Administration and Policy in Mental Health*, 41(4), pp. 434–446.
- Children's Commissioner (2021) *The state of children's mental health services 2020/21*. London.
- Dixon-Woods, M. and Martin, G.P. (2016) 'Does quality improvement improve quality?', *Future Hospital Journal*, 3(3), pp. 191–194.
- Farmer, T. et al. (2006) 'Developing and implementing a triangulation protocol', *Qualitative Health Research*, 16(3), pp. 377–394.
- Flick, U. (2018) *An Introduction to Qualitative Research*. 6th ed. London: Sage.
- Greene, J.C., Caracelli, V.J. and Graham, W.F. (1989) 'Toward a conceptual framework for mixed-method evaluation designs', *Educational Evaluation and Policy Analysis*, 11(3), pp. 255–274.
- Langley, G.J. et al. (2009) *The Improvement Guide*. Jossey-Bass.
- Lundy, L. (2007) "'Voice" is not enough', *British Educational Research Journal*, 33(6), pp. 927–942.
- NHS Improvement (2018) *Quality Improvement: Theory and Practice*. London.
- O'Reilly, M. and Lester, J.N. (2017) 'Examining mental health services for CYP in the UK', *Journal of Health Psychology*, 22(2), pp. 158–168.
- Seikkula, J. and Arnkil, T.E. (2017) *Open Dialogues and Anticipations*. Helsinki.
- Shotter, J. (2015) 'Dialogic Responsiveness in Living Speech', *Journal of Constructivist Psychology*, 28(4), pp. 327–340.
- Tisdall, E.K.M. (2015) 'CYP participation: voices in and of social research', *Social Inclusion*, 3(6), pp. 134