THRIVE, payment systems and outcomes

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http://www.annafreud.org/data/files/CAMHS_EBPU/Publications_and_Resources/Thrive031214.pdf

The THRIVE Model

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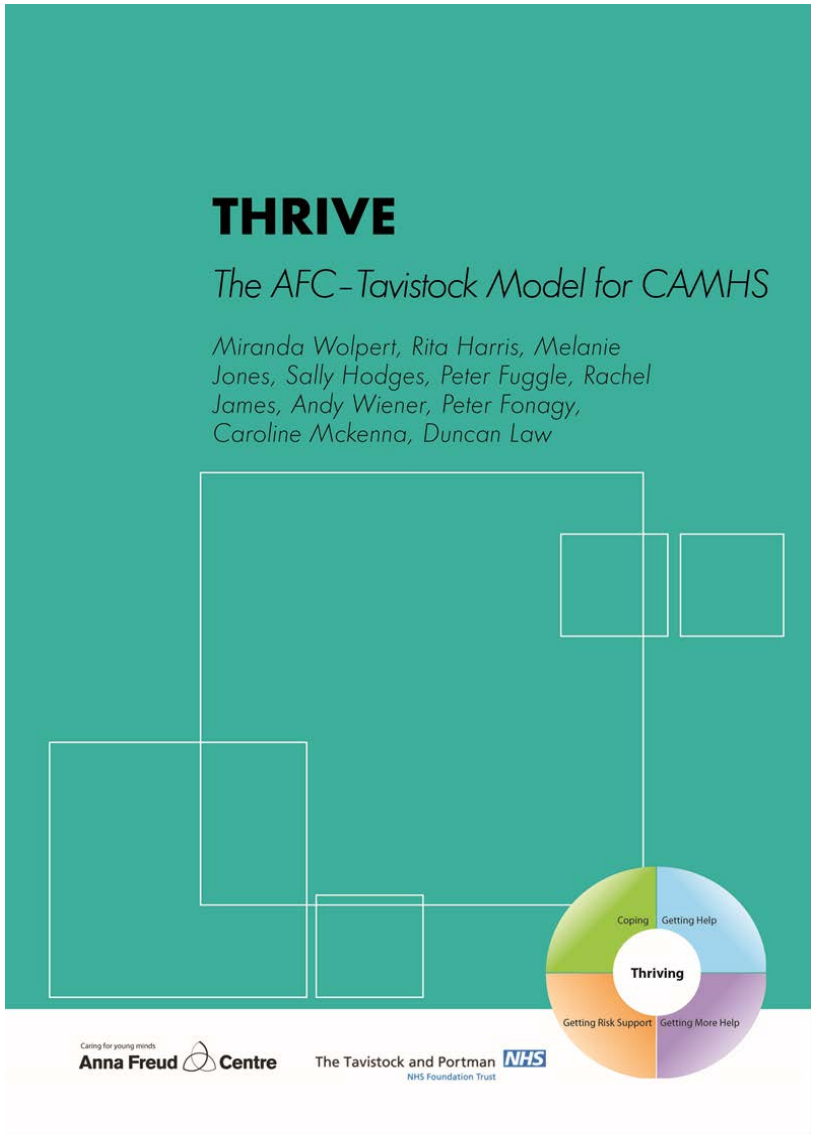

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History: The origins of CAMHS

The child guidance movement

- From the 1920s
- Support child wellbeing
- Deal with problems before that become significant

Educational lexicon

Psychiatry

- Focused on mental illness and severe mental health problems

Health lexicon

Management of risk

- More a recent perspective
- Focus on most troubling young people
- Risk to themselves or others

Social care lexicon

- Different languages: difficult cross-agency work
- Historically underfunded
  - Current austerity context resulted in cuts up to 25%
- The last UK epidemiological study (10 years ago) shows
  - Less than 25% of those deemed in need accessed support

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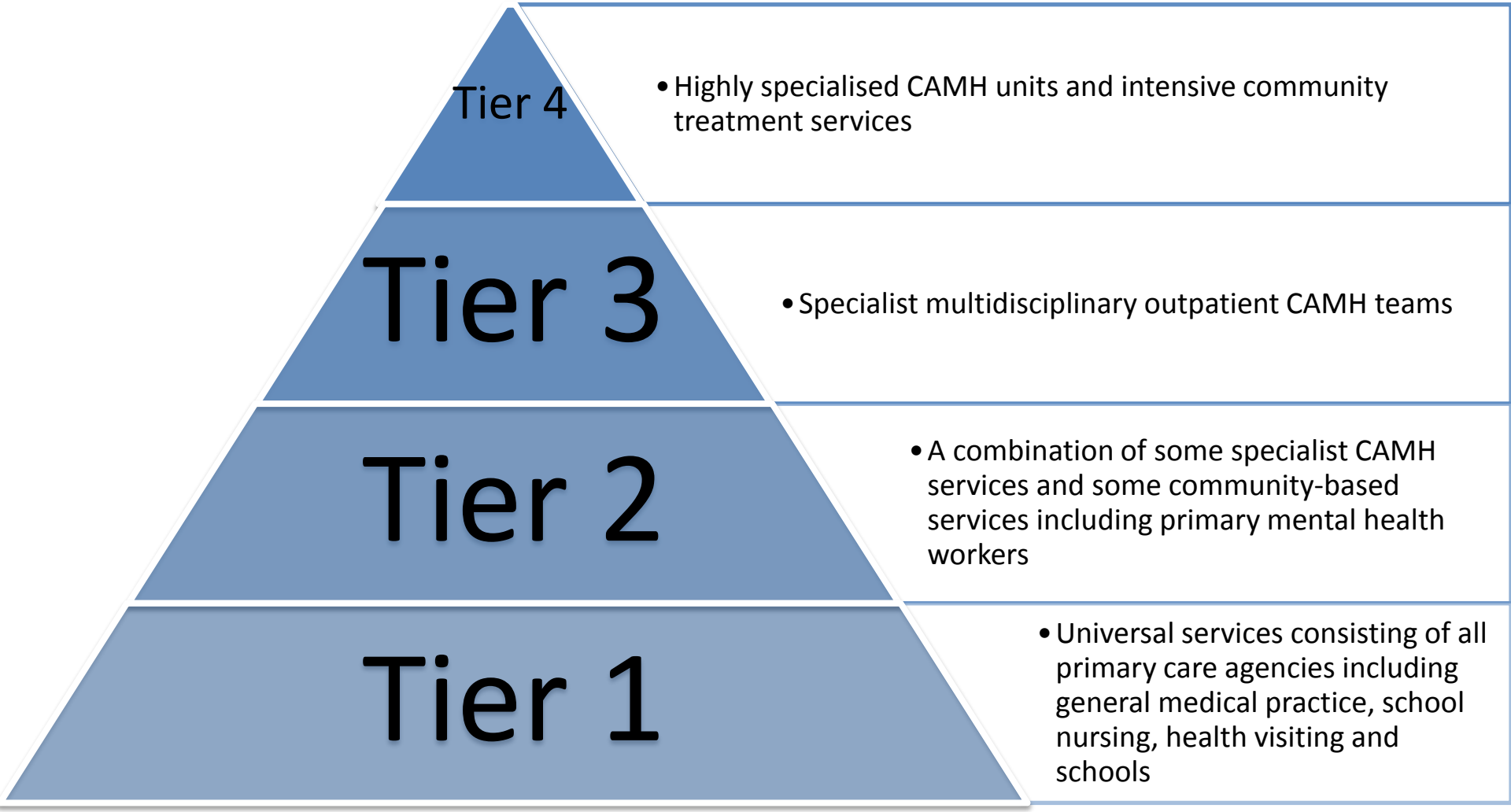
Current model of provision



Criticised, even by its same developers for leading to a reification of service divisions

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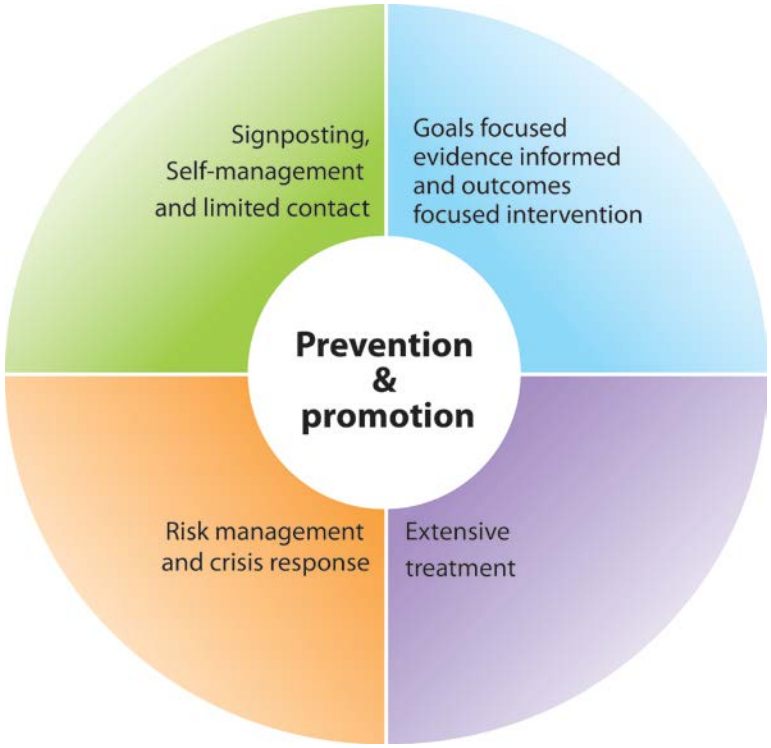
The THRIVE Model

Attempts at drawing a clearer distinction than before between:

- **treatment** and **support**
- **self-management** and **intervention**



We are aware there are a number of initiatives across the country who use "Thrive" in their title. We use the term to reflect our core commitment to young people "thriving" and to represent our commitment to provision that is Timely, Helpful, Respectful, Innovative, Values-based and Efficient.

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Coping/Getting Advice

Context

- Increased interest in self-management and promotion of resilience
- Proliferation of digitally based support
- Development of programmes that help YP and families to help themselves
  - Headstart (£75m funded by Big Lottery)
  - Penn Resilience Program
- Increasing academic interest: positive psychology
  - School-based interventions support mental health
  - Peer support can promote effective parenting
  - Integration of mental health in paediatric primary care supports community resilience

Data

- Many (the modal number) of young people attending CAMHS attend **only once**
  - Many are seen for less than 3 contacts
  - Lack of information about the destiny of those users
  - Practitioners report that short contact is enough for many of these users

Resource

- This group accounts for about 30% of YP and families accessing CAMHS
- Accounts for small precentage of CAMHS provision cost
  - It is the cheapest group

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Coping/Getting Advice

Need

- These are the YP and their families adjusting to life circumstances
- Mild or temporary difficulties
- Capable of community or self-support
- Or chronic, fluctuating or ongoing severe difficulties for which they decided to manage their own health

Provision

- The THRIVE Model suggests: provision within educational or community settings
  - Education as lead provider
  - The education language is a language of wellness
  - Health input coming from experienced health workers who support and diagnose

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Getting help

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Getting help

Context
- Increasingly sophisticated evidence on what works for whom in what circumstances
- Increasing agreement on how service providers can implement those approaches
  - Shared decision making to support patient preference
  - Rigorous use of ROMs
- 33% of YP will be “recovered” even after the best evidence-based interventions

Data
- Majority of children in CAMHS are seen for 12 or less face-to-face meeting
- The data does not show yet how many of them are successfully completed
- The great majority are seen in the community or ambulatory clinics.

Resource
- This group accounts for about **55%** of YP and families currently accessing CAMHS
- Pbr analyses suggest this is a middle costing service in the payment system

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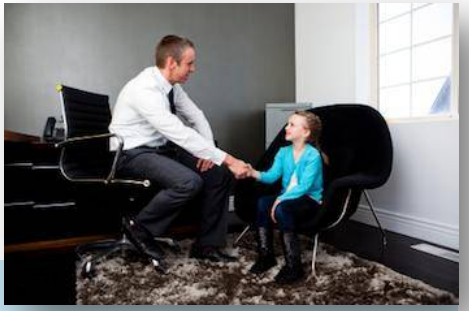
Getting help



Need

- This group would benefit from focused, evidence-based treatment
  - Clear aims
  - Ways to evaluate the aim has been achieved
- This group falls into the scope of NICE guidance
  - Around **45%** of families in this group fall into one NICE guidance
  - The rest of families have multiple problems

Provision

- The THRIVE Model suggests: health services as main providers
  - Language of treatments and outcomes
  - Health input should involve specialised technician in different treatments
- Explicit charters for children and families:
  - Treatment should involve explicit agreement at the outset as to what success would look like
  - How would success occur and when
  - What happens if there's no success

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Getting more help

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Getting more help

Need

- This group represents those YP and families who would benefit from extensive long term treatment
  - Inpatient care
  - Extensive outpatient interventions

Provision

- The THRIVE Model suggests: health as main provider
  - Language of health: treatment and health outcomes
  - Health input consists in health workers specialised in different treatments

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Getting Risk Support

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Getting Risk Support

Context

- The most contentious aspect of the model
- A substantial minority do not improve, not even with the best EBPs (33%)
- There must be an explicit recognition of the needs of young people and their families where there is no current treatment available and they remain at risk.

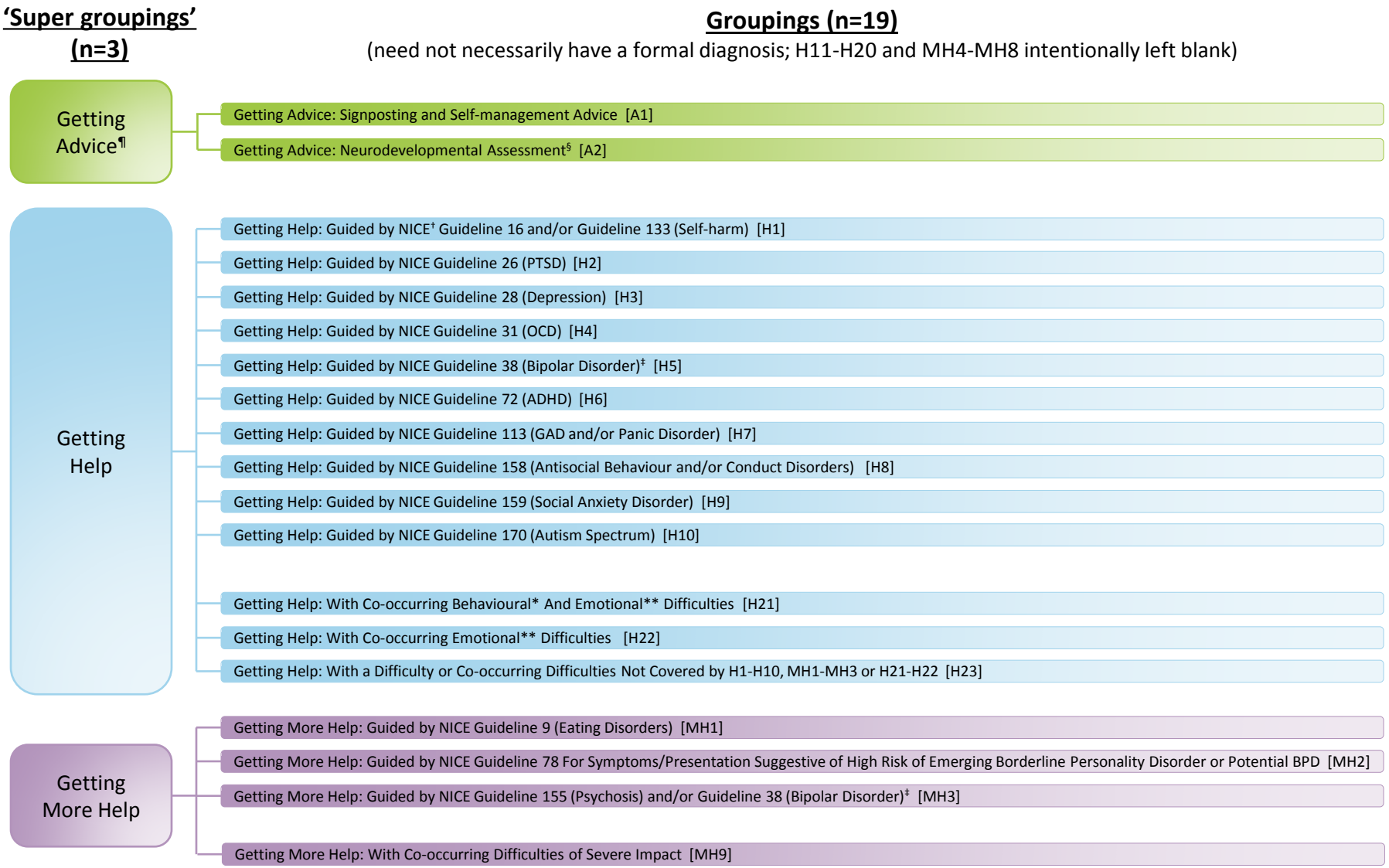
Data

- No data:
  - Impossible to disaggregate this group from the other three
  - Many of this group will be subsumed within the “getting more help” group (the most costly one)

Resource

- This group might require significant input
- Many services increasingly recognise this group as
  - Not ready for treatment
  - In need of ongoing monitoring
- The might have been offered high intensity treatment, but they are missing appointments, or making no progress.
- This group should be disaggregated within the Payments System

Proposed groupings (draft 08/04/15)



¶ Advice may be guided by the relevant parts of National Institute for Health and Care Excellence (NICE) guidelines.
§ A child can be in the grouping 'Getting Advice: Neurodevelopmental Assessment' (A2) at the same time as being in one of the other groupings. Apart from A2 all other groupings are mutually exclusive.
† 'NICE' is the acronym for the National Institute for Health and Care Excellence, which provides guidance and advice to improve health and social care (www.nice.org.uk).
‡ If extremes of mood or bipolar disorder have moderate impact on functioning (at individual or family level) and/or distress consider grouping H5; if they have severe impact consider grouping MH3.
* Behavioural difficulties (Conduct Disorder or Oppositional Defiant Disorder).
** For the purpose of grouping assignment emotional difficulties are defined as: Depression/low mood (Depression); Panics (Panic Disorder); Anxious generally (Generalized anxiety); Compelled to do or think things (OCD); Anxious in social situations (Social anxiety/phobia); Anxious away from caregivers (Separation anxiety); Avoids going out (Agoraphobia); Avoids specific things (Specific phobia).

Illustrative indication of relative grouping sizes based on analysis of Current View data collected Sep 2012-June 2014¶

Draft groupings	Percentage of periods of contact in sample§
Getting Advice: Signposting and Self-management Advice [A1]	30 %
Getting Advice: Neurodevelopmental Assessment [A2]	3 %
Getting Help: Guided by NICE Guideline 16 and/or Guideline 133 (Self-harm) [H1]	6 %
Getting Help: Guided by NICE Guideline 26 (PTSD) [H2]	2 %
Getting Help: Guided by NICE Guideline 28 (Depression) [H3]	6 %
Getting Help: Guided by NICE Guideline 31 (OCD) [H4]	1 %
Getting Help: Guided by NICE Guideline 38 (Bipolar Disorder) [H5]	1 %
Getting Help: Guided by NICE Guideline 72 (ADHD) [H6]	6 %
Getting Help: Guided by NICE Guideline 113 (GAD and/or Panic Disorder) [H7]	4 %
Getting Help: Guided by NICE Guideline 158 (Antisocial Behaviour and/or Conduct Disorders) [H8]	5 %
Getting Help: Guided by NICE Guideline 159 (Social Anxiety Disorder) [H9]	2 %
Getting Help: Guided by NICE Guideline 170 (Autism Spectrum) [H10]	2 %
Getting Help: With Co-occurring Behavioural* And Emotional** Difficulties [H21]	2 %
Getting Help: With Co-occurring Emotional** Difficulties [H22]	8 %
Getting Help: With a Difficulty or Co-occurring Difficulties Not Covered by H1-H10, MH1-MH3 or H21-H22 [H23]	16 %
Getting More Help: Guided by NICE Guideline 9 (Eating Disorders) [MH1]	1 %
Getting More Help: Guided by NICE Guideline 155 (Psychosis) and/or Guideline 38 (Bipolar Disorder) [MH3]	1 %
Getting More Help: With Co-occurring Difficulties of Severe Impact [MH9]	8 %

¶ Total sample size: 4573 periods of contact in the community (i.e. does not include inpatient periods of contact) from 11 CAMH services. Data were collected between September 2012 and June 2014. Current View tools were usually completed after the first contact within a period of contact.

§ Percentages sum to more than 100%, because each group has been rounded to the nearest whole percentage, and because a child can be in the grouping 'Getting Advice: Neurodevelopmental Assessment' (A2) at the same time as being in one of the other groupings. Apart from A2 all other groupings are mutually exclusive.

* Behavioural difficulties (Conduct Disorder or Oppositional Defiant Disorder).

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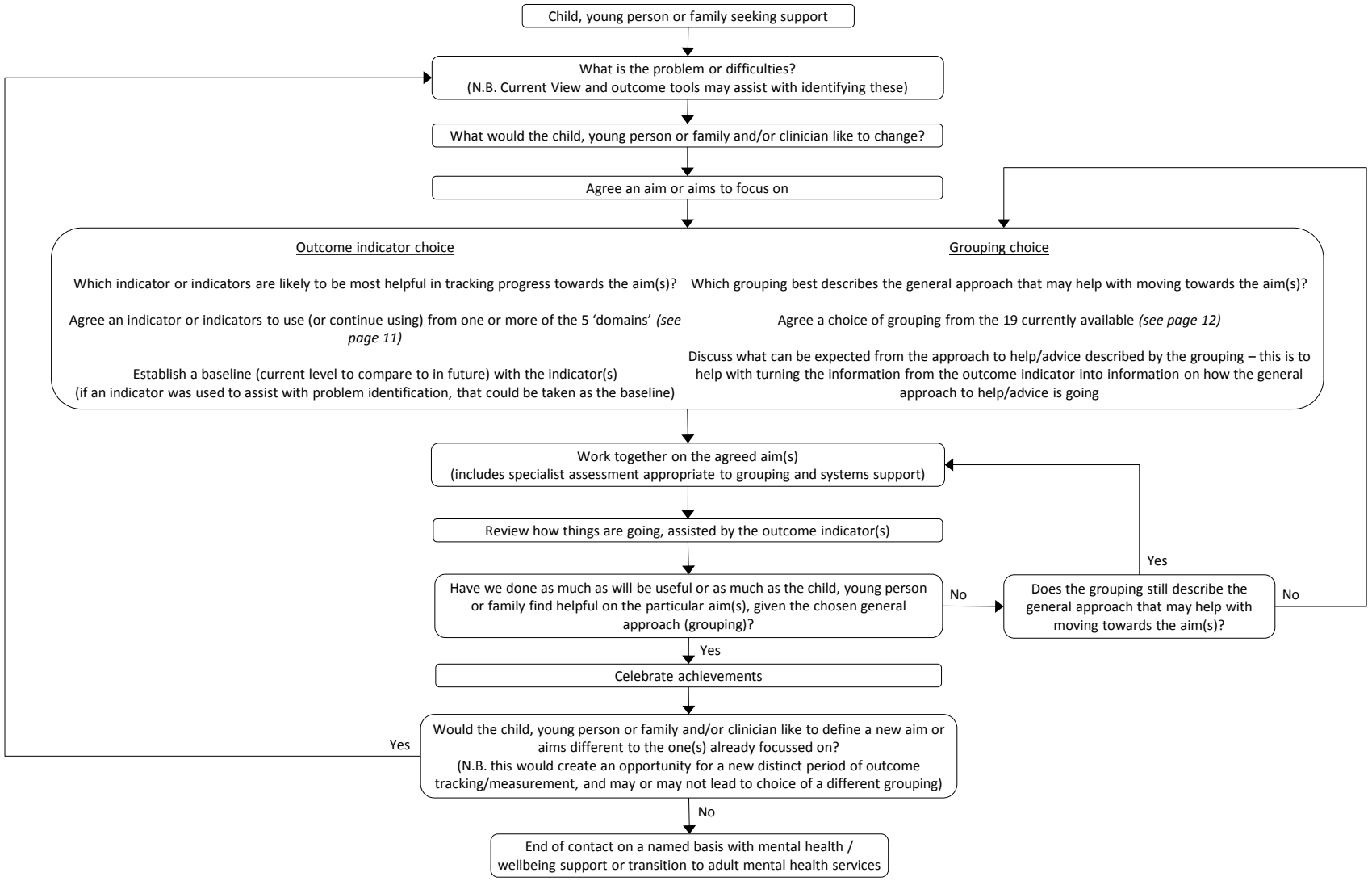
Flow chart of agreeing aims and choosing an indicator and grouping to help move towards them (draft 08/04/15)



References: Wolpert, Law et al (2014) Guide to Using Outcomes and Feedback Tools with Children, Young People and Families; Chorpita and Weisz (2009) MATCH-ADTC: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

Considerations for outcome indicator choice

- For advice on using outcomes and feedback tools with children, young people and families please refer to:
  - Child Outcomes Research Consortium (CORC) www.corc.uk.net
  - Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) www.cypiapt.org
  - Quality Network for Inpatient CAMHS (QNIC) www.rcpsych.ac.uk

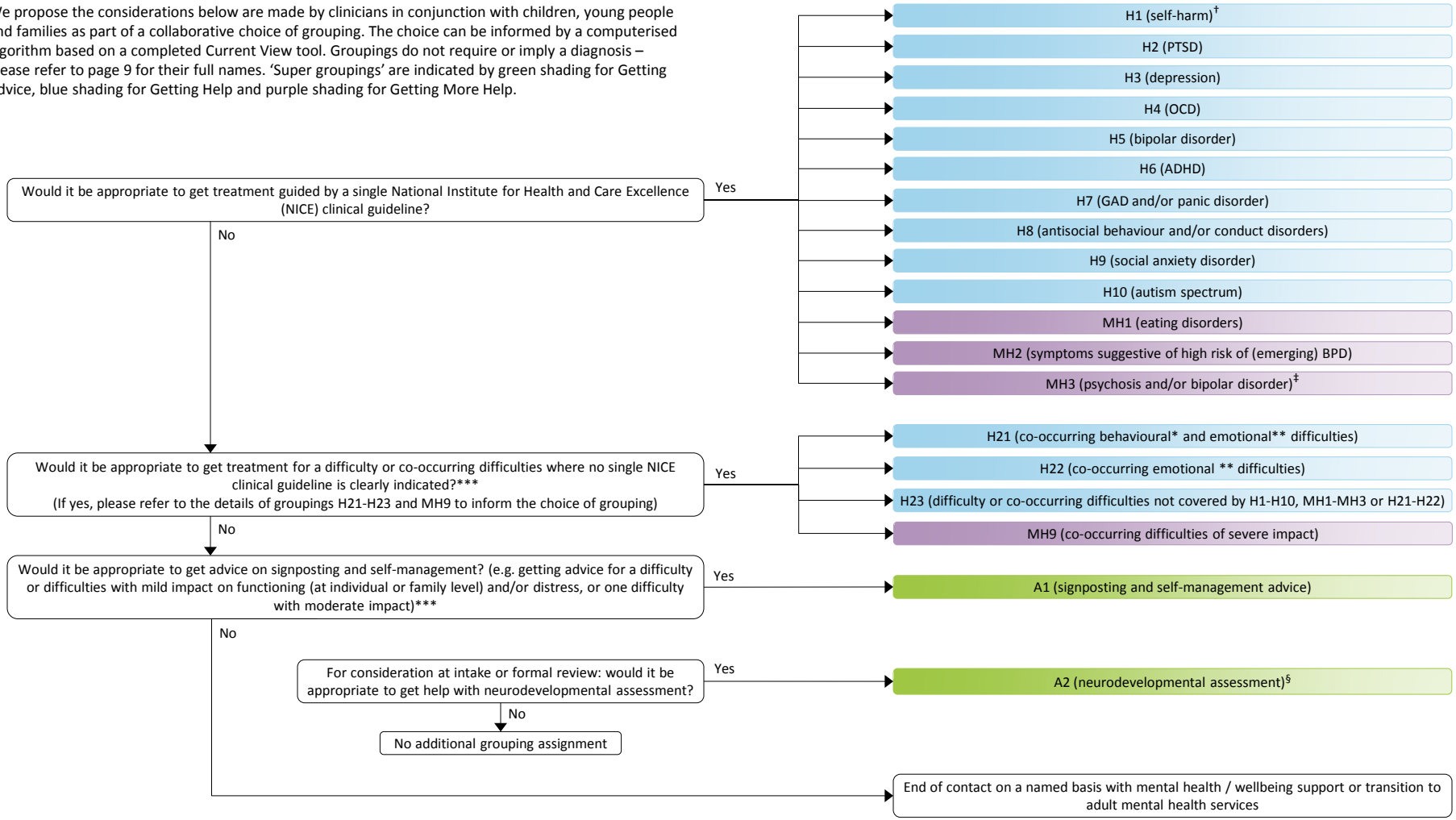
- It may be useful to consider 5 general 'domains' from which specific indicators can be chosen:

Domains (may overlap)	Domain description	Example of indicator
Bespoke goals	What I/we would like to achieve	Goals based outcome (GBO)
General wellbeing	How things are generally	Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)
Symptoms	How things are specifically	Social Phobia Subscale of Revised Child Anxiety and Depression Scale
Impact on life	How school, work, home life, friendships or relationships are affected	Attendance or attainment with regard to education, employment and training
Experience of service	Would I recommend to a friend	CHI Experience of Service Questionnaire (CHI-ESQ)

Reference: Wolpert (2014) PROMs in Child and Adolescent Mental Health. Presentation at: Patient-reported outcome measures (PROMs) research conference, The King's Fund, 18/11/14.

Considerations for grouping choice (draft 08/04/15)

We propose the considerations below are made by clinicians in conjunction with children, young people and families as part of a collaborative choice of grouping. The choice can be informed by a computerised algorithm based on a completed Current View tool. Groupings do not require or imply a diagnosis – please refer to page 9 for their full names. 'Super groupings' are indicated by green shading for Getting Advice, blue shading for Getting Help and purple shading for Getting More Help.



† Help may be guided by one or both of NICE guidelines 16 and 133.
‡ Help may be guided by one or both of NICE guidelines 155 and 38.
* Behavioural difficulties (Conduct Disorder or Oppositional Defiant Disorder).
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*** Difficulties under consideration: Anxious away from caregivers (Separation anxiety); Anxious in social situations (Social anxiety/phobia); Anxious generally (Generalized anxiety); Compelled to do or think things (OCD); Panics (Panic disorder); Avoids going out (Agoraphobia); Avoids specific things (Specific phobia); Repetitive problematic behaviours (Habit problems); Depression/low mood (Depression); Self-Harm (Self injury or self-harm); Extremes of mood (Bipolar disorder); Delusional beliefs and hallucinations (Psychosis); Drug and alcohol difficulties (Substance abuse); Difficulties sitting still or concentrating (ADHD/Hyperactivity); Behavioural difficulties (CD or ODD); Poses risk to others; Carer management of CYP behaviour (e.g., management of child); Doesn't get to toilet in time (Elimination problems); Disturbed by traumatic event (PTSD); Eating issues (Anorexia/Bulimia); Family relationship difficulties; Problems in attachment to parent/carer (Attachment problems); Peer relationship difficulties; Persistent difficulties managing relationships with others (includes emerging personality disorder); Does not speak (Selective mutism); Gender discomfort issues (Gender identity disorder); Unexplained physical symptoms; Unexplained developmental difficulties; Self-care Issues (includes medical care management, obesity); Adjustment to health issues.
§ A child can be in the grouping 'Getting Advice: Neurodevelopmental Assessment' (A2) at the same time as being in one of the other groupings. Apart from A2 all other groupings are mutually exclusive.

Example of assigning to cluster: Getting advice

Hypothesised Need	Care package elements	Possible algorithm (based on "current view" tool)	Example of shared decision potentially overriding algorithm
Adjusting to life circumstances Temporary or mild difficulties Managing chronic difficulties	Signposting Self-management support Choice appointment	No problem rated more than mild A single problem on CV form rated moderate that does not fit any NICE guidance	Severe difficulties but choose self management Concern about depression agree to wait

Choosing: Getting Advice vs Getting Help

	Getting help from a mental health specialist	Coping without help from a mental health specialist
Will it help?	Studies have found that seeing someone with specialist training using a NICE recommended approach at 1 year follow up % of people are no longer depressed, x% get more depressed and x% stay the same.	Activities such as exercise, talking friends and family and ensuring good sleeping and eating patterns can all help lift mood. Without treatment studies have found % of people are no longer depressed, x% get more depressed and x% stay the same.
How long will it take to get better	Generally recommendation is around x meetings but this varies for individuals	x% get better within x months
Will I get worse again ?	Around x % get depressed again within 1 year	Around x % get depressed again within 1 year
What are the risks	If you choose medication as part of your care package there may be side effects You may be asked to come to meetings in school time	Things get worse without effective input
Will it hurt?	Sometimes you will be asked to do things that seem hard e.g. getting up and doing activities or speak about things that are painful and upsetting but the people helping you are trained to help you do these things.	Friends and family are likely to want to help but are not trained and sometimes when people are not sure what to say or do they can say things that feel hurtful or insensitive or advise things that are not helpful.

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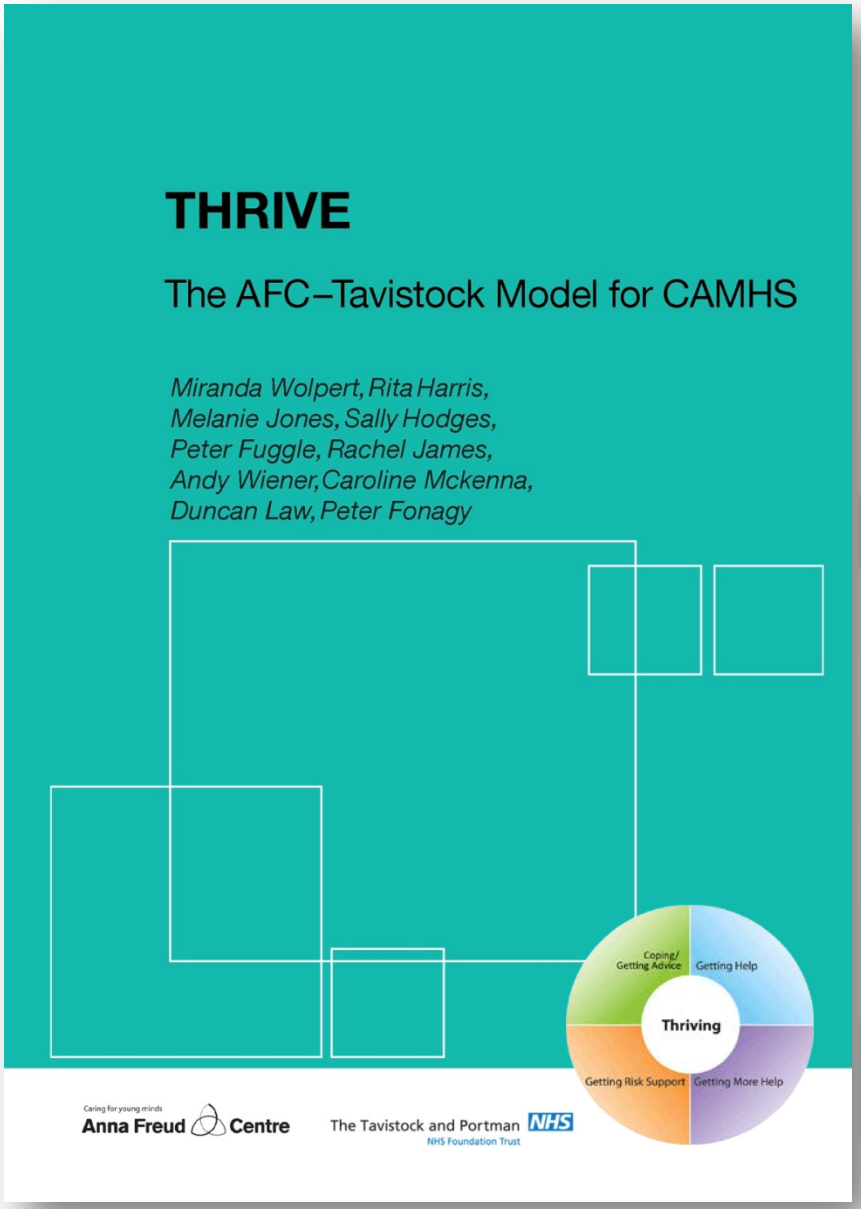

- Alignment with best practice in child mental health
- Alignment with emerging payment systems
- Options for more targeted quality improvement
- Greater clarity about agency leadership
- Potential for more targeted funding
- Options for more targeted performance management
- Potential for more transparent discussion between providers and users