

Innovating for Improvement

Developing and evaluating i-THRIVE grids for
supporting shared decision making in child
mental health care

The Tavistock and Portman NHS Foundation Trust



About the project

Project title: Developing and evaluating i-THRIVE grids to support shared decision making in child mental health care

Lead organisation: The Tavistock and Portman NHS Foundation Trust

Partner organisation: The Anna Freud National Centre for Children and Families, Dartmouth Center for Healthcare Delivery Science, UCLPartners.

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Contents

About the project.....	2
Part 1: Abstract	3
Part 2: Progress and outcomes.....	4
Part 3: Cost impact	11
Part 4: Learning from your project.....	13
Part 5: Sustainability and spread	16
Appendix 1: Resources and appendices.....	18

Part 1: Abstract

THRIVE (Wolpert et al., 2016) is a conceptual framework describing a whole-system, needs-led approach to CAMHS that moves away from the current tiers-based model. A central component of THRIVE is shared decision making (SDM). THRIVE is currently being implemented across the UK in a programme called i-THRIVE which uses an evidence-based approach to implementation. To help address difficulties with implementing SDM, i-THRIVE grids were developed using Dartmouth's methodology for developing Option Grid (OG) decision aids. The innovation was adapting the OGs to fit within a THRIVE needs-led system, as well as developing them for use with children and young people.

i-THRIVE grids were successfully implemented at one clinic at the Tavistock and Portman NHS Foundation Trust in London. Implementation resulted in:

- Parents reported higher experience of care, although this was not the case for young people.
- SDM for both young people and parents did not significantly change after grids were introduced. This may be because baseline readings were already high.
- Clinicians, young people and parents who used the grids liked them and found them useful.

Adapting grids to the THRIVE framework resulted in options being collapsed into hierarchical categories to not feel overwhelming to CYP and parents and the creation of grids for 'in' and 'outside' the NHS. We engaged clinicians in PDSA cycles which provided us with real time feedback resulting in better 'buy in'. Clinicians outlined other settings and appointments in which our grids had or could be used. Implementation at another clinic proved harder due to clinician resistance to changing practice (which could relate to already high levels of SDM) and logistical issues of data collection.

i-THRIVE grid champions have been identified in the Tavistock to promote sustainability, and grids are about to be rolled out to more clinics. As requested by clinicians, the grids will be electronically available from September and the Trust is looking at ways to build them into Carenotes.

Part 2: Progress and outcomes

THRIVE (Wolpert et al., 2016) is a theoretical framework developed by the Tavistock & Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families (AFNCCF). It describes a whole-system, needs-led approach that moves away from the current tiers-based model and focuses care around the needs of patients. It is currently being implemented across the UK in a program called i-THRIVE. Shared decision making (SDM) is a critical part of the approach but has proved difficult to implement. Option Grids (OGs) are SDM tools developed by Dartmouth that have been shown to help tackle this. i-THRIVE Grids are an innovation as OGs have been modified to make them suitable for children and young people (CYP) and for use in services that are implementing THRIVE.

The aim of the project was to improve the experience of CYP and families by implementing the OGs and enabling better SDM. We used:

- PDSA cycles to help with implementation
- 'CollaboRATE' to measure SDM
- The CHI-ESQ to measure patient experience
- We also measured if the use of our grids would affect modality of care or the types of services providing care

Grid Development (August 16 – January 17)

We successfully developed six i-THRIVE grids for low mood, difficulties sitting still and concentrating and self-harm (see Appendix). In line with THRIVE, these were split into getting help '*within*' and '*outside of the NHS*'. Expert Reference Groups (ERGs) were set up for each presenting difficulty (see stakeholders involved in Appendix B). Grid content was supplemented with research evidence or expert/stakeholder consensus when there was none (see Part 4: Lessons from developing the grids on how grids were innovated for improvement)

Depression: treatment options

Use this decision aid to help you and your healthcare professional talk about different ways to treat your depression. Most people will recover from an episode of depression. However, the first treatment may not work, and depression can come back.

Frequently Asked Questions ↓	Watchful waiting	Talk therapy	Medication
How does this treatment work?	This means no active treatment. You may see your clinician more often to check your symptoms, compare options and discuss your lifestyle and coping strategies.	Talk therapy works by helping you solve problems and clarify your thoughts. Treatment usually lasts 8 to 10 weeks, but can last longer. Therapy options include: In person: Meeting with a therapist every 1 to 2 weeks for 30 to 60 minutes. You may also do homework. On the computer: Using a program on your own or with your clinician's support.	Selective Serotonin Reuptake Inhibitors (SSRIs) are medications that help with symptoms. The pills are usually taken once a day. Treatment usually lasts for 6 to 12 months.
Will this treatment work?	23 out of every 100 people (23%) recover in 3 months through watchful waiting. 53 out of every 100 people (53%) recover in 1 year through watchful waiting.	In addition to the 23 out of every 100 people (23%) who recover through watchful waiting, another 14 out of every 100 people (14%) recover in 2 months with talk therapy. Computer programs work best when you check in regularly with your clinician. Combination therapy: In addition to the 23 out of every 100 people (23%) who recover through watchful waiting, another 26 out of every 100 people (26%) recover with a combination of SSRIs and talk therapy.	In addition to the 23 out of every 100 people (23%) who recover through watchful waiting, another 17 out of every 100 people (17%) recover in 1 month with SSRIs. Combination therapy: In addition to the 23 out of every 100 people (23%) who recover through watchful waiting, another 26 out of every 100 people (26%) recover with a combination of SSRIs and talk therapy.
What are the risks?	Watchful waiting can cause your symptoms to continue or get worse.	Talk therapy can cause discomfort, anxiety, and stress.	SSRIs can cause side effects. Nausea, diarrhea and drowsiness each affect up to 17 out of every 100 people (17%). Up to 13 out of every 100 people (13%) have sexual problems. Sweating, shaking, difficulty sleeping, and dry mouth are less common.
How much does this treatment cost?	Cost will depend on how often you visit your clinician and the type of visit. Work with your clinician and insurance company to check your costs.	In person: Prices will vary. Work with your therapist and insurance company to check your costs. On a computer: Some programs are free. "Mood Gym" is an example of a free online program: https://moodgym.anu.edu.au/	Without insurance: Prices will vary. In general, fluoxetine, citalopram, and paroxetine cost less than \$5 for a 30-day supply. Sertraline usually costs less than \$40 and escitalopram less than \$130 for a 30-day supply. With insurance: Prices will vary by plan. Work with your insurance company to check your costs and coverage.
Is there anything else I can do?	Exercise, healthy eating and visiting with friends can help with symptoms. Other resources may be available at your workplace, in your community or online.	Exercise, healthy eating and visiting with friends can help with symptoms. Other resources may be available at your workplace, in your community or online.	Exercise, healthy eating and visiting with friends can help with symptoms. Other resources may be available at your workplace, in your community or online.

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This Option Grid™ decision aid does not constitute medical advice, diagnosis, or treatment. See [Terms of Use](#) and [Privacy Policy](#) at www.optiongrid.org.

Figure 1: Traditional Option Grid



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.



Common Questions

What will this involve?

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.
This can include support with schoolwork, social skills, family events, or things personal to you.



This can involve focusing on your thoughts and feelings.
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.
Each session is usually about an hour long and may involve other family members.



This can involve taking medication to treat your symptoms. You will usually meet with a psychiatrist who can give you a prescription for medication.
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.



How will this help me get better?

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.



Talking therapies can help you think differently about situations in your life and improve how you feel.
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.



This medication works by increasing a chemical called serotonin in your brain. When your serotonin is low, this can lead to low mood.
These are often prescribed after a course of therapy or alongside a course of therapy.



Will I see the same people for the duration of this help or support?

You will usually see one person for this support.
This may not be the same person you see for your assessment.



You will usually see one person for this support.
This may not be the same person you see for your assessment.



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.



Are there risks or side effects from this type of help or support?



Talking about your difficulties can sometimes cause discomfort, anxiety or stress.
Tell the person you are talking to if you are experiencing these feelings.

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Tell the person you are talking to if you are experiencing these feelings.

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.

This decision aid does not constitute medical advice, diagnosis or treatment.
Version 1.6 (last updated 2/5/2017) Editors: Daniel Hayes, Rosa Town, Emilios LEMONIATIS, Anna Moore



Figure 2: i-THRIVE grid

Baseline data collection in Consultation and Resource (CAR) assessment clinics (November 16 – February 17)

Due to lower care plan completion of the start of the project, we created an audit form to capture baseline data (see Appendix C).

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 17– August 17)

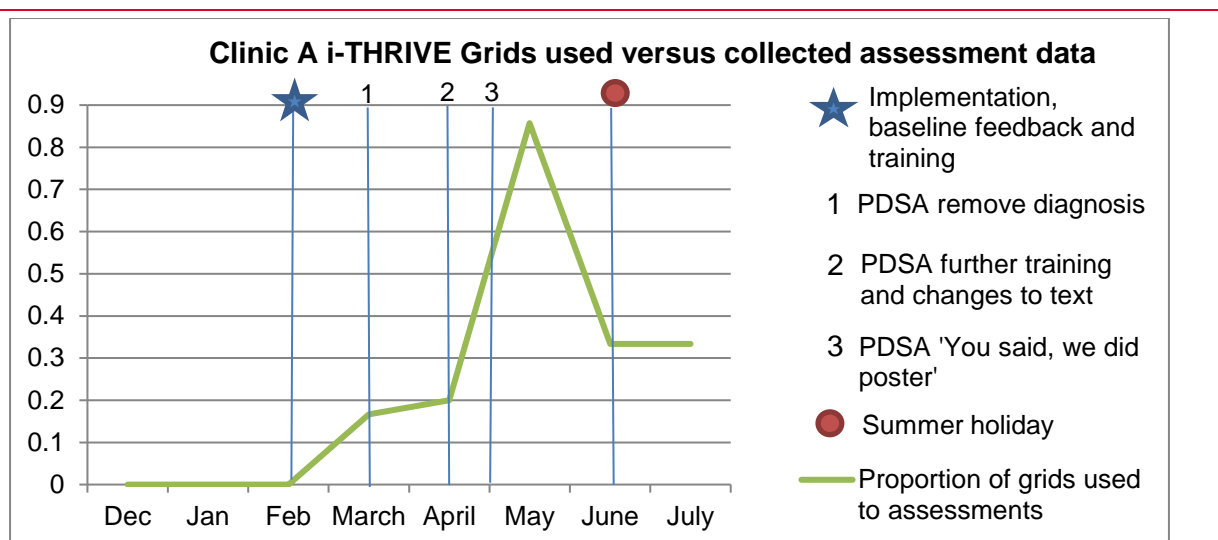
Two clinics (n=41 and n=26 respectively) took part in the refinement, piloting, and evaluation of the grids. Nine young people and parents used the grids in clinic one, and one parent used the grid in clinic two.

Grid usage by clinic

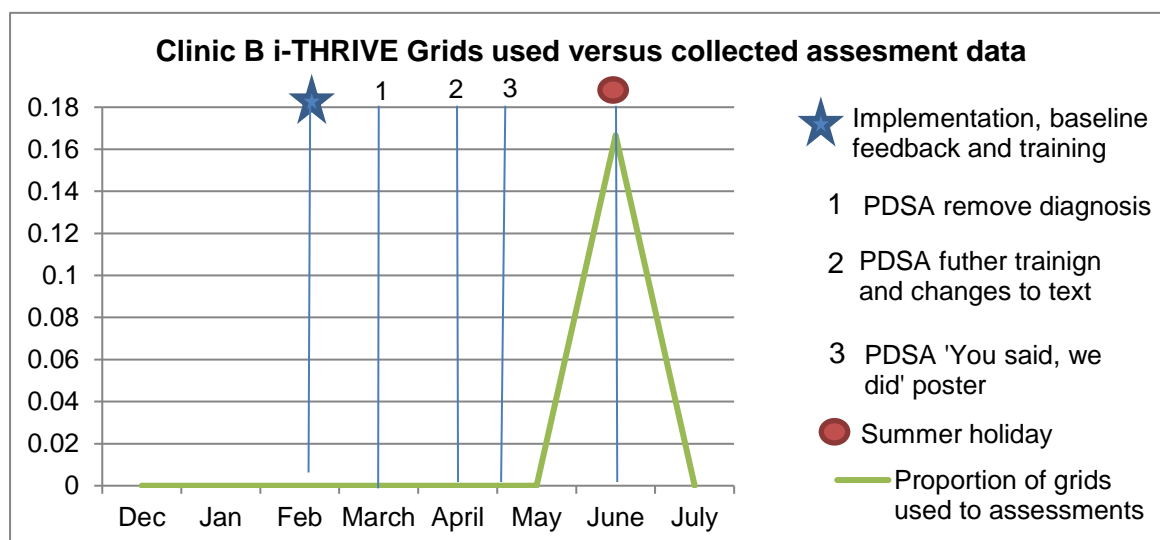
Clinicians were slow to adopt the grids in both teams, with one team ultimately being unsuccessful.

In Clinic A, grid usage increased after implementation when:

- Baseline feedback and training were given
- Diagnoses were replaced with presenting needs based difficulties
- Further training on i-THRIVE grids and text changes relating to reading age were added
- The introduction of the ‘You said, we did, poster’



In Clinic B, where grids were not successfully implemented, PDSA cycles did little to influence grid use. One grid was used in June.



Continued work with young people and parents

Continued iterative feedback was also sought from young people and parents. Grids were well liked by many in terms of colour, layout and design. Service users commented on the range of options they did not know were previously there: *'I didn't know all of these options were available'* with some asking to keep the grids to *'take to their next appointment'*. Some clarity over wording was suggested to help lower the reading age and was built this into the PDSA cycle.

Quantitative data

Rather than use SPC charts because of the lower numbers than originally expected, we decided to look at the impact of the grids comparing young people and families that used them to those that did not.

Comparison of scores (statistics, further interpretation, limitations and implications

are available in Appendix D)

CollaboRATE (Shared Decision Making)

- Implementation of the i-THRIVE grids did not significantly affect levels of shared decision making for parents or young people who used the grids and those that did not.

Experience of Care

- Implementation of the i-THRIVE grids did not significantly affect experience of care for young people who used the grids and those that did not. However, for parents, there was a significant increase in experience of care for those that used the grids compared with those that did not.

Modality of care

- Implementation of the i-THRIVE grids did not significantly affect the modality of care offered to CYP and families who used the grids and those that did not.

Clinician Type

- Use of i-THRIVE grids did not appear to be related to clinician role.

Qualitative data (A full account is provided in Appendix E)

Interviews were collected from six clinicians and one parent who had used the grids in their practice and one clinician who had not. Findings fall under 1) impact of grids and 2) implementation of grids.

Impact

Individuals described the grids as useful, reliable information sources about all available treatments. Grids were seen as multipurpose and helped to ‘*remind clinicians about things they may forget about*’ as well reminding the service user later: ‘*when they walk away they have something where it’s written down when they might not have fully taken in what you’ve said*’. For the parent, having access to the grids was empowering and helped to consolidate their knowledge. -- “*[The grid] gives you more... you can go into the meetings, the appointment armed with some knowledge.*”

Within the session, the i-THRIVE grids facilitated discussion about the different kinds of treatment options 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*”. Clinicians described how families were more involved in discussions around treatment which led parents to feel more satisfied and empowered “*In fact, I felt my partner and I were allowed to take ownership of the decision.*” The usefulness of the grids to families became apparent to clinicians when families requested more copies. -- “*I think what I was struck by is that the family specifically requested for 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*”.

One clinician highlighted that the grids did not change or impacted their session; however, they acknowledged this was “*because I don’t think that I fully integrated it into my practice*”. However, another who had better integrated the grids described how they ‘*felt a little bit naked, not having the grid*’ when discussing medication.

Implementation

The majority of clinicians thought that the i-THRIVE grids were easy to use, following PDSA cycles around wording. One clinician felt the grids reduced variability and created uniformity so that service users reliably received the same information.

However, clinicians described how they sometimes found the grids burdensome, as they added to an already packed schedule. *“When you are already feeling very full, it’s hard to have all these to add”*. Seeing the grids as not another thing to do or as ‘mandatory’, but instead as something that was flexible which could be used as appropriate was important. One clinician acknowledged that some colleagues felt that the grids may detract from their clinical expertise. This was raised in a team meeting at Clinic B – *“This doesn’t replace everything else... no one is telling you, you have to use it. It’s a tool to have, and actually, the family might find it helpful”*.

The grids were useful in the context of assessment clinics and clinicians also described other situations in which the i-THRIVE grids could have been used, including schools and A&E. Clinicians requested that the grids be available electronically – *“If they were electronic, for instance, I could just print them off myself. That would be the easiest thing”*.

It was important for clinicians that they felt they had the option to use the grids, and that they had the choice to participate as a team in the project from the outset. -- *“I would have like to have been asked rather than just told this was happening. Yes, 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”*.

Part 3: Cost impact

The CAR clinics at the Tavistock and Portman NHS Foundation Trust are funded through a range of contracts with CCGs and NHS England. The Consultation and Resource (CAR) clinics sit within this system and are used when it is not clear based off of referral information what would be an appropriate service or intervention.

A financial evaluation was not included as part of the project proposal. However, a high level review of costs has been undertaken by the wider i-THRIVE programme. These costs were calculated by assessing both actual operational costs and staff resource costs associated with grid usage. Key findings demonstrate that there is a minimal financial cost implication associated with embedding the OGs into routine practice:

- Additional costs linked to use of the i-THRIVE Grids in clinical practice are limited to the printing of resources (e.g. hard copies of the grids) only. This cost is not necessarily always a new cost but could be instead of other resources that would have been printed before use of the grids was adopted (e.g. information leaflets). Thus the cost is minimal.
- Clinicians use the grids within their existing consultation time so there are no additional staff resources or time incurred as a result of the use of the grids with young people and their families. Use of the grids has been demonstrated as not impacting on time elsewhere and clinician feedback indicated that grid use did not increase session length.
- Training and engagement around the use of the i-THRIVE grids took place in established team meetings or at the clinics themselves as part of the clinician discussion slots. No additional time or resources are needed from staff in order to use the i-THRIVE grids. For new clinicians to be trained in grid use, a short information sheet and interactive video are in the process of being developed and have been built into pre-existing project costs. After this point, these will be hosted on the i-THRIVE website and will be freely available to all. The i-THRIVE Partnership has committed to the maintenance of any grids developed (see below).
- As further training was requested by both teams in SDM, it may be beneficial to train more teams in SDM and how to use i-THRIVE grids. This is not a required cost but would be beneficial and may have a wider impact on grid usage and subsequent cost savings. The i-THRIVE Partnership Board and Academy are looking into costing for sites to 'buy in' training associated with the SDM and grids.

At a higher level, should the use of i-THRIVE Grids spread to other i-THRIVE sites, we would expect that while there would be no reduction in costs of commissioning we would expect to be able to increase the number of CYP who are able to access care for the same commissioning budget. It is not possible to quantify these currently and they are the subject of a large-scale evaluation which is currently underway as part of a scaling up bid (funded by the Health Foundation), However we expect this to be achieved by:

- Increased signposting to alternative services (third sector), self-help, and self-care.
- Increased uptake of alternative modalities for evidence-based interventions

(digital, peer support)

- Clearer distinction between help and support, and with this a more appropriate use of professionals' time.

Additional expenditure is expected for the maintenance of the i-THRIVE grids. After two years the grids must be reviewed in line with Dartmouth methodology and any amendments made based on changes to clinical practice and/or options available. The costs would be staff time (Project Manager and Research Assistant) and costs associated with hosting ERGs and patient and parent involvement and are estimated at £5-£10k. The i-THRIVE programme has committed to the maintenance of any grids developed.

Part 4: Learning from your project

Lessons from Developing the Grids

Adapting grids to make them 'THRIVE like'

Traditionally OGs were developed for clinical settings. One key challenge was modifying these for use within a needs-based system that includes non-clinical settings (e.g. 3rd sector). There was also a tension of including options with differing levels of evidence. Originally it was planned that we would have five grids over two decision points (see Appendix F). However, consultation with Dartmouth demonstrated that this would not work as different options may be available for each presenting difficulty (e.g. different medications) and these would need to be outlined to help CYP make 'preference-sensitive' decisions. To fit the grids within a THRIVE framework, it was decided to have help in the NHS, which corresponded to NICE guidelines and available research evidence, and help outside the NHS which would be used for signposting and risk support.

What to put in the grids

Feedback from stakeholders was that first appointments can feel overwhelming to service users due to the amount of information they receive. With a vast range of options available, we needed to condense options into categories to make them more manageable. Different options were tried, but condensing based on type of overarching treatment approach (e.g. peer support) was preferred by stakeholders. Feedback from piloting confirmed that this format were usable and not overwhelming

Importance of co-production

The majority of stakeholders highlighted design and content issues that needed to be made 'CYP friendly'. Thus, grids content and design were co-produced with CYP and parents. Pilot feedback from CYP, parents and clinicians suggests that the new CYP-friendly format was preferable to the old format, with particular appreciation for the simplified language and multiple colours/graphics.

Implementation Lessons

Enablers

- A key policy driver was 'Future in Mind', which mentions THRIVE and emphasizes the importance of SDM with CYP. This provided a 'foothold' with senior staff and managers as the project was closely aligned with guidance from an influential, well-known report and could help with patient outcomes.
- 'Piggybacking' of existing structures. The Tavistock was implementing THRIVE on their Carenotes electronic records system during grid implementation. This dovetailed with our project, as there was already staff buy-in. The grids were therefore seen as part of THRIVE rather another project 'to do'.

- Insider support. Project implementation was vastly aided by clinician champions. Advantages of this included having someone to champion the project in the implementation team's absence and insider knowledge of team dynamics and structure (e.g. identification of silverbacks, laggards, and knowledge of when it was best to introduce grids).
- Providing feedback loops enhances clinician buy-in. "You said, we did" posters (see Appendix G) were created to keep staff informed of changes they requested and whether they could be implemented (and if not, why). Clinicians responded positively to this and said they felt listened to, and we noticed more interest and ownership in the grids after this poster was in place.
- Ongoing engagement through effective, tailored and continuous communication, which promoted buy-in with clinicians, service users, and carers/parents. Tavistock clinicians were targeted through the Tavistock newsletter and team meetings, whilst parents, CYP, and other organisations were reached through Twitter and blog posts. A wider group of professionals were targeted via the i-THRIVE Community of Practice events. This has resulted in much interest from other clinicians/teams/organisations who wish to use the grids when they go live in September.

Challenges

- Data collection challenges: A decision made at the Trust level not to make CollaboRATE a routine outcome measure meant that researchers diverted resources to focus on collecting this measure. This meant we had to focus on two clinics rather than Trust-wide implementation. Clinics were selected based on the types of difficulties likely to be seen there, however it became apparent that low numbers of young people were passing through these clinics. Further investigation revealed some individuals were seen in the same clinic but outside set appointment times. Working with admin staff helped us identify and target some of these appointments.
- Logistical challenges: CYP and parents did not need to return to waiting rooms in Clinic B after the appointment, so catching them to collect measures was difficult. Two strategies which helped with this was asking clinicians to send individuals back to the waiting room after their session, and introducing ourselves to the individuals in the waiting room prior to their appointment.
- Low usage of some grids: Few CYP were eligible for the 'difficulties sitting still and concentrating (ADHD)' grid. It was discovered these were either diverted to another hospital at intake or sometimes seen outside of CAR clinics. We worked with intake staff to identify cases which may be applicable outside CAR clinics and contacted the hospital where CYP were diverted for grid feedback. Unfortunately, they were unable to provide input due to their own transformation changes. Early on it is important to work with intake and informatics where the project will be targeted (rather than more generally) to

understand the makeup of service users.

- Grids being seen as a burden: clinicians already believed they were good at SDM and viewed the grids as another thing to do and fill out. The implementation team attended team meetings at the start of grid implementation to discuss this. Whilst analysis of baseline data did show high levels of SDM in both Clinic A and B, team discussion was encouraged around differences between young people and parents on SDM and satisfaction. The grids were also introduced to teams and it was emphasized that they did not have to fill anything additional out. This helped in Clinic A, but did little to change attitudes in Clinic B.
- Clinician grid use was also hampered by diagnoses (e.g. depression) originally being present on the grids. Whilst we worked with many clinicians during grid development, once in clinics there was pushback as clinicians often did not assign a formal diagnosis after the first assessment session. In response to this, we removed the diagnoses and replaced them with descriptions from the Current View Tool (e.g. low mood). A key learning point from this was that it was important to actively and obviously engage clinicians in the process of refinement of i-THRIVE grids and to make it clear that their suggestions were being taken seriously and implemented where possible.

Part 5: Sustainability and spread

Sustainability within the Tavistock

Our work in establishing sustainability at the Tavistock & Portman is ongoing. As outlined in implementation challenges, the lack of electronic availability of the grids has inhibited some clinicians from using them. From September, all grids will be available electronically for clinicians to download and save to their documents/desktop as needed. A video and manual (currently under construction) accompanying the grids will be available for clinicians. These will detail the grids' purpose, how to use them, and address some commonly asked FAQs.

As the Tavistock is one of the developers of THRIVE and an i-THRIVE accelerator site, we are linking the grids in with further ongoing work (such as the recruitment of a THRIVE clinician for assessment and intake) which will help to embed the project. In addition to this, both teams have a designated i-THRIVE clinical champion within the clinic responsible for championing the project from September to keep the project going in the implementation teams absence.

The Senior Management at the Tavistock has requested a meeting with the Project Manager to further discuss sustainability. Initial conversations with the Associate Clinical Director have already established that a fruitful avenue would be to incorporate grid use into care-plans on Carenotes. This will not only build grids into clinical practice but also act as a prompt for clinicians and allow informatics to track usage over time. Further conversations around whether an 'admin champion' would be helpful to ensure that hard copies of the grids are available within clinics for clinicians who feel they are too busy/don't have enough time to print them out. Both of these topics will be discussed with senior management in September.

Spread

The key mechanism for spread and dissemination will be via the i-THRIVE Community of Practice, which is a community of sites currently implementing THRIVE. It represents over 72 CCGs and almost 50% of the CYP in England live within the range of a site implementing THRIVE. The i-THRIVE grids are being integrated into the i-THRIVE Approach to Implementation which is followed by implementing sites. The i-THRIVE Partnership Board (partnership between Anna Freud Centre, Tavistock, Dartmouth and UCLP) will remain responsible for the upkeep of the i-THRIVE Grids.

We have experienced a wealth of interest and recognition from organisations regarding this project. Grids have been disseminated in a variety of formats including Twitter, the Huffington Post (http://www.huffingtonpost.co.uk/rosa-town/ithrive_b_16686372.html) and three conferences (International Association for Youth Mental Health, International Shared Decision Making, and the Society of Psychotherapy Research) which will be discussed further below.

Presenting grids at the i-THRIVE Community of Practice event in Manchester generated a lot of interest from other i-THRIVE sites who are keen to trial the new grids when they go live in September. The grids will be freely available from the i-THRIVE website (www.implementingTHRIVE.org) and i-THRIVE grid case studies will be created and feature on the website. We have also had confirmation that one i-THRIVE trust (NELFT) will be trialling and evaluating i-THRIVE grids within their sites as part of a Scaling Up bid, supported by the i-THRIVE Programme (funded by the Health Foundation) and championed by the i-THRIVE clinician embedded in the site.

We have presented a talk and a poster at the International Shared Decision Making (ISDM) conference about the i-THRIVE grids and will be attending the International Association for Youth Mental Health conference to present a poster about the grids. At ISDM, our presentation and poster generated a lot of interest from researchers, clinicians and teachers who viewed the grids as a valuable step forward in improving shared decision making in child mental health care. When the grids go live on the i-THRIVE website this autumn, we will be sending emails to all of our contacts about the grids as well as monitoring traffic on the i-THRIVE website to see where the grids are generating interest. We are also in the process of drafting two papers about i-THRIVE grids (related to development and testing).

Clinicians at the Anna Freud Centre on the masters courses with a clinical component have expressed interest in using the low mood grids as part of their course to help facilitate shared decision making and person-centred care. The Project Manager, who will be staying on at the AFNCCF, will deliver a lecture on these in the Spring Term, and will liaise with clinicians who are running the practical components of the course to see how the grids can be used practically. It is hoped that including this as part of training will help to embed these tools early in practice, as well as helping with spread as students then go into clinical teams for placements.

Much of this project is replicable. As indicated by clinicians, the grids can be used in a variety of contexts not just the clinical setting. This could be educational or community settings as long as a responsible adult with some knowledge of children's mental health could be there to support the young person. Our learning from the project would be useful for anyone attempting to implement an intervention within CAMHS or a similar setting. However, the grids that mention medication might need to be limited to a clinical setting only, while the "outside the NHS" grids could be used more widely. This was our thinking when we separated the presenting difficulties on the grids to interventions "within the NHS" and "outside the NHS".

Appendix 1: Resources and appendices

Appendix A: i-THRIVE grids













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.



Common Questions

Common Questions	Practical Support	Talking Therapies	Anti-depressants
What will this involve?	<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> 
How will this help me get better?	<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> 
Will I see the same people for the duration of this help or support?	<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> 
Are there risks or side effects from this type of help or support?	<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>

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Low mood:
Support outside 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	Reading Support (psycho-education)	Peer or Community Support	Telephone Support	Counselling	Computer-based CBT (CCBT)
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.)



Anna Freud National Centre for Children and Families
The Tavistock and Portman NHS Foundation Trust

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Use this tool to help you, your parent or carer, and a therapist decide about getting support for difficulties sitting still or concentrating.

Note: You may want to try other types of help and support alongside the ones that are listed here. The evidence suggests that combining multiple types of support for behavioural difficulties (for example, parent training, child school support, individual child work, and child medication) may be more likely to help than one type of support alone.



Common Questions

<p>What will this involve?</p>	<p>This usually involves talking with a therapist about your experience of your difficulties.</p> <p>Your therapist might help you practice situations and learn new ways to focus and concentrate.</p> 	<p>This involves taking medication to treat your symptoms.</p> <p>Methylphenidate (commonly known as Ritalin) can be taken in two ways. The first is taking a tablet once in the morning. The second is taking a tablet a few times a day.</p> <p>This medication can be taken only on school days and does not have to be taken over the weekend.</p>	<p>This involves taking medication to treat your symptoms.</p> <p>Atomoxetine (commonly known as Strattera) can be taken as a capsule one to two times a day, and the full effects can take 4-6 weeks.</p> <p>This medication needs to be taken every day.</p> 
<p>How will this help me get better?</p>	<p>It may be helpful for you to practice situations with a therapist and learn ways to focus and concentrate better.</p>	<p>Stimulant medication usually works by increasing the activity in the areas of your brain that help to control your attention and behaviour.</p>	<p>Non-stimulant medication usually works by increasing a chemical in your brain that helps you concentrate and control your impulses.</p>
<p>Are there common risks or side effects to this type of help or support?</p> 	<p>Talking about your difficulties can sometimes cause worry or stress.</p> <p>Tell the person you are talking to if you are experiencing these feelings.</p>	<p>Very common side effects of Methylphenidate include insomnia, nervousness and headaches.</p> <p>This can affect your ability to do highly skilled tasks (like driving).</p> <p>It is very rare, but sometimes young people taking this medication think about self-harm and/or suicide.</p> <p>Very rarely, serious liver problems can occur while taking this.</p> <p>Talk to your doctor about other side effects</p>	<p>Very common side effects of Atomoxetine include decreased appetite, headaches, sleepiness, abdominal pain, feeling sick, and increased blood pressure and/or heartrate.</p> <p>It is uncommon, but sometimes young people think about self-harm or suicide while taking this medication. Rarely, serious liver problems can occur while taking this.</p> <p>Talk to your doctor about other side effects.</p>
<p>What are the long-term outcomes?</p>	<p>The evidence shows that you are more likely to have better long-term outcomes with one of these treatments for these difficulties than without any treatment.</p> <p>In most cases, treatment is continued for as long as it is helping.</p> 		
<p>Will I see the same people for the duration of this help or support?</p>	<p>You will likely see the same person for your therapy.</p> <p>This may not be the same person you see for your assessment.</p> 	<p>Your psychiatrist will probably prescribe you a small amount of this medication at first. It is then likely that you will be seen by your psychiatrist and/or a member of the team for regular check-ups to make sure the treatment is working and to check for side effects.</p> 	

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Difficulties sitting still or concentrating (Parent or Carer):
Support outside of the NHS



Use this tool to help you and a therapist decide about getting support for your child's difficulties sitting still or concentrating.

Note: You may want to try other types of help and support alongside the ones that are listed here. Evidence suggests that combining multiple types of support for behavioural difficulties (for example, parent training, child school support, individual child work, and child medication) may be more likely to help than one type of support alone.

Parent Support Groups

Parent Training

School Support

Common Questions	Parent Support Groups	Parent Training	School Support
What will this involve?	Groups are usually run by volunteers in places like a community centre or a church. They can take place 1-2 times a month and can involve other parents of children who have difficulties sitting still or concentrating. 	You (and your partner, if appropriate) will usually meet once a week for 2-3 hours to receive parent training. These trainings last from 3-12 weeks and may involve other parents of children who have difficulty sitting still or concentrating. 	This can involve speaking with your child's school to ensure that your child is given extra support. 
What will happen?	These groups can offer a safe space for parents to support each other and share information. Parents or carers can share stories of parenting their children and provide each other with support and advice. 	These trainings can help you manage and better understand your child's behaviour. You will learn a combination of good behavioural management skills and background information about ADHD. 	The SENCO (special education needs coordinator) at your child's school can work with you to come up with a plan that meets your child's needs. 
How will this help my child?	You could find out ways to manage your child's behaviour and help your child have the best quality of life. 	This could help you learn new and different skills that can help you with parenting your child. Using these skills may help improve your child's behaviour. 	This could include the creation of an individualised education plan for your child, behavioural modifications, and/or extra teaching support and guidance, all of which might help your child to sit still and concentrate at school. 
Will I see the same people?	The people who come to and run these meetings can change. 	You will usually have one leader for the whole of the programme. 	You will not necessarily see a therapist for this type of support. 
How can I access this support?	Ask a therapist what is available in your local area. You can also find support group listings online. 	Common programmes include: the Incredible Years - Webster Stratton, 1-2-3 Magic, Parenting with Love and Limits, and Triple P (Positive Parenting Programme). Ask a therapist or GP what is available in your area.	A therapist can help to facilitate this support. You can also speak with your child's school directly. 

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

Note: You may want to try other types of help and support alongside the ones that are listed here. Changes to diet, exercise and lifestyle could also help to improve your symptoms, although there is not enough evidence about this to be sure.



Common Questions

<p>What will this involve?</p>	<p>You will usually meet weekly with a therapist who can help you understand your difficulties, solve problems, and set goals. They will create an action plan with you and give you activities to complete. This can involve learning practical strategies that may help you feel better.</p> <p>You may receive support with school work, social skills, family events, or things personal to you.</p> 	<p>You (and sometimes your parent or carer or other family members) will meet a few times a month with a therapist who can help you understand the difficulties you are going through.</p> <p>There will likely be a focus on your relationships to each other (and your environment) and how this affects your feelings and behaviour.</p> 	<p>You will usually meet weekly with a therapist who can teach you coping strategies to keep you from feeling like you need to harm yourself. This can involve focusing on your thoughts and feelings and how they can affect the way you act.</p> <p>Group Talking Therapy will give you the opportunity to talk with other young people who are experiencing difficulties similar to you.</p> 
<p>How will this help me feel better?</p>	<p>This support may help you learn about self harm and the reasons why you self harm. You will be given practical strategies for managing your feelings that may help you feel better.</p> 	<p>This support may help you to think about your difficulties in relation to your family and to learn new ways to help each other.</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>Will I see the same people for the duration of this support?</p>	<p>You will usually see one person for this type of support. This may not be the same person you see for your assessment.</p> 	<p>You will usually see one person for this type of support. This may not be the same person you see for your assessment.</p> <p>Your family members might be invited to attend some or all of your sessions.</p> 	<p>You will usually see one person for this type of support. This may not be the same person you see for your assessment.</p> <p>Your family members might be invited to attend some of your sessions.</p> 
<p>Are there risks or side effects from this type of support?</p>	<p>Talking about your difficulties can sometimes cause discomfort, anxiety or stress. Tell the person you are talking to if you are experiencing these feelings.</p> 		

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

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?	<p>This involves reading information about self harm and understanding more about your difficulties.</p> 	<p>This involves either you or your parent or carer calling a telephone number and speaking to someone who can listen to you and provide you with information and advice.</p> 	<p>This involves talking with a counsellor who can listen to you, support you and help you understand your feelings.</p> 
How will this help me feel better?	<p>You may learn tips to cope with the feelings that lead you to self harm. You might also find out new ways to understand your thoughts and feelings.</p> 	<p>Talking to someone about your difficulties may help you to work through the reasons why you self harm. This may also help you to see things more clearly and to think about what your options are.</p> 	<p>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.</p> 
Will I see the same people for the duration of this support?	<p>This support can usually be done on your own or your parent or carer may be able to help you.</p> 	<p>There will probably be a different person on the line each time you call.</p> 	<p>It is likely that you will talk to the same person for this support.</p> 
Are there risks or side effects from this type of support?	<p>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.</p> <p>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.</p>		
Where can I get this support?	<p>Online or through reading material (See back of page.)</p> 	<p>On the phone (See back of page.)</p> 	<p>In person or online (See back of page.)</p> 

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Appendix B: i-THRIVE grids stakeholders

- Young people with lived experience of the presenting difficulty
- Parents of young people with lived experience of the presenting difficulty
- The project team
- The wider i-THRIVE implementation team
- THRIVE authors
- Clinicians (in and out of the Tavistock) with expertise for that presenting difficulty
- Individuals in education, voluntary and third sector organisations
Commissioners

Appendix C: Assessment clinic template

i-THRIVE QI project

	Adult	CYP
Clinic		
Date		
Patient ID		
Age/Gender/Ethnicity* if both parents indicate		
Current concerns/presenting problems		
Goals/Aims		
Proposed intervention		
Modality of care		
Category of Care (Thrive Group)		
SDM measure (1 – understand)		
SDM measure (2 – listen to things)		
SDM measure (3 – include what matters most)		
ESQ score (_____)		
Seen by:		

Appendix D: Statistics, interpretation, limitations and implications

Parents

- **CollaboRATE score**

After baseline, shared decision making did not significantly differ between parents who used the i-THRIVE grids (Mdn =9.00) and those that did not (Mdn =8.67), U = 82.00, z = -1.24, p=.215, r= -.21

- **Experience of care survey (CHI-ESQ)**

After baseline, experience of care did significantly differ between parents who used the i-THRIVE grids (Mdn = 10.50) and those that did not (Mdn =9.00), U = 52.00, z = -2.05, p<.05, r= -.36

Children and young people

- **CollaboRATE score**

After baseline, shared decision making did not significantly differ between CYP who used the i-THRIVE grids (Mdn =8.00) and those that did not (Mdn = 8.17), U = 81.00, z = -.01, p=.99, r= -.00

- **Experience of care survey (CHI-ESQ)**

After baseline, experience of care did significantly differ between CYP who used the i-THRIVE grids (Mdn =10.00) and those that did not (Mdn =9.00), U = 61.00, z = -.84, p=.40, r= -.16

- **Signposting and grid use**

A chi-square test for independence was calculated to examine the relationship between services signposted to and whether i-THRIVE grids were used. No significant interaction was found ($X^2 (3) = 2.72, p = .44$)

- **Clinician role and grid use**

A chi-square test for independence was calculated to examine the relationship between clinician role and whether i-THRIVE grids were used. No significant interaction was found ($X^2 (3) = 2.83, p = .50$)

Findings should be treated cautiously due to the small sample size (N=10) of individuals that used i-THRIVE grids. However a few implications should be noted:

- No change to modality of care may be because CYP are screened during intake prior to getting a CAR clinic appointment. Help out of NHS (quadrant one) i-THRIVE grids may need to be implemented earlier (e.g. at intake screening) for signposting. Alternatively, as few clinicians signposted out, it may be that training is required for clinicians to understand the value of different modalities of care.

- There were ceiling effects on the CollaboRATE measure at clinics. This is not surprising since these are part of the site where THRIVE was developed. If other sites plan to trial this, a larger sample in a more diverse setting would help evaluate whether i-THRIVE grids affect SDM.
- It appears that psychiatrists were more likely to use the grids, whilst no social workers used the grids. Psychiatrists could be seen as useful champions, whilst more work should be conducted into why social workers did not use i-THRIVE grids.

Appendix E: Qualitative data

A top-down thematic coding structure was used to identify themes related to the impact and implementation of i-THRIVE grids at the Tavistock. Within these overarching categories, a bottom-up approach was used to identify themes that emerged from these data (Braun & Clarke 2006).

Impact

Clinicians described how i-THRIVE grids served as useful, reliable information sources about all of the treatments they could offer young people and their families. They explained how the grids had helped to remind them about out-of-NHS or signposting opportunities, which they might have otherwise forgotten about in the session. – *“For some families with particular difficulties, all they might need is some kind of self-help. I think [the grids are] useful in bringing attention to things that, as a therapist, you are more likely to forget about. For me, that would be likely reading support.”* (Clinician 2) For parents, having access to this information on the grids was empowering and helped to consolidate their knowledge. – *“[The grid] gives you more... you can go into the meetings, the appointment armed with some knowledge.”* (Parent 1). This clearly displayed information on both sides facilitated an informed discussion about treatment options. *“It was really helpful for me to have the information, set out logically, and I think then once you’ve got it all in front of you, you can then let the patient know.”* (Clinician 1)

Clinicians found the information on the back of the out-of-NHS grids particularly useful for signposting, as it was laid out clearly with phone numbers and websites. – *“We’re often sort of wanting to guide people to useful sources, you know, good, reliable sources of information and it’s helpful to have that to hand about that specific issue, rather than me sort of having to scabble about and write things down for people.”* (Clinician 4). However the backs which contained source of further support were not seen as visually appealing as the front *“the front side is very user-friendly, or more user-friendly than the support list on the back”* (Clinician 6)

Clinicians also found it reassuring that they could give families something tangible to take home and digest after their session. -- *“I think because within the context of the meeting with the family, you can verbally explain things but often they are really highly aroused and anxious in the moment. We always do try and explain what something might involve, but it’s nice that when they walk away they have something where it’s written down when they might not have fully taken in what you’ve said.”* (Clinician 2)

Within the session, the i-THRIVE grids facilitated discussion about the different kinds of treatment options that were available. -- *“The parents came with a view of one kind of medication ... that they’d heard about and they’d read about on Mumsnet. But with the grid, we were able to have quite a bit of conversation about the different types of medication that were available.”* (Clinician 1) as well as acting as an aid to discuss things already tried: *“they [parent and young person] found it really useful to help them think outside of what treatments they’d already used, because it was much more, I suppose, of a helpful aid for him [young person] Clinician 6. Clinicians described how these conversations aided shared decision making, as families were more involved in discussions around treatment. “I think it is useful to have the information clearly there with their options and I think it’s good for the young people to sort of feel that they’re part of the decision-making process rather than things just being done to them.”* (Clinician 4) This in turn led parents to feel more satisfied with the decision that they ultimately made about treatment. -- *“I: So after you left, did you feel satisfied with the decision? P: Yes ... In fact, I felt my partner and I were allowed us to take ownership of the decision.”* (Parent 1)

Clinicians described how having the information as it is on the grids can be containing for some families -- particularly those who may be experiencing heightened anxiety. *“I particularly like that people come in talking about something very serious, and this doesn’t necessarily take away from that, but in having something that looks as it does, there is something quite approachable about the grid. ... There is something that helps, perhaps, to bring some containment to a consultation whereby people might be feeling quite anxious.”* (Clinician 2)

The grids also had the potential to clear up misconceptions that families might have about certain aspects of treatment. -- *“People have lots of misconceptions about [antidepressants], the most common one being, is it addictive, and am I never going to be able to get off it, and does it mean that I’m crazy. So, I think it’s quite nice on the grid that it’s there, equal to and with practical support, talking therapies and antidepressants. It’s sort of saying all of these are equal, and can be used at different times.”* (Clinician 3)

Clinician described how some families specifically requested the grids, which indicated that families found them useful. -- *“I think what I was struck by is that the family specifically requested for 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.”* (Clinician 2) However, clinicians worried that the “one size fits all” approach of the grids may not be appropriate for some families with complex difficulties. *“One of the things is that there is always going to be a difficulty with using something like a grid. There are so many levels of not one size fits all. There is the service context, there is the family context, the preference; obviously, that’s what the grid is about. But that means the different columns are more or less relevant for people.”* (Clinician 2)

Implementation

In terms of the implementation of i-THRIVE grids within the Tavistock, clinicians explained how the CAR assessment clinic arrangement at Clinic A was uniquely suited to using the grids. -- *“What happens in this particular assessment clinic is that we have a break. That fits really nicely with these thrive grids in one sense in that it*

is a bit of reading to do and you could give somebody something to walk away with. That's a nice thing because they can digest it in their own time. But equally it may facilitate their thinking during break time." (Clinician 2) This may shed light on why the other Tavistock clinic did not use the grids, as their assessment clinic did not include a break.

While acknowledging that the grids were useful in the context of assessments, clinicians described other situations in which the i-THRIVE grids would also be helpful, e.g., in a parent/GP letter after diagnosis or when a young person was considering a new or different treatment option -- *"There's always going to be different times when you want to bring the grids in, I think, not just the initial assessment."* (Clinician 3)

Clinicians explained that the grids as being a useful tool for creating uniformity of practice within the trust amongst clinicians of varying levels of experience. *"I think they can be very beneficial. As people progress in their careers, or as people have worked in a service for a longer amount of time, you do become aware much more of resources. But equally this is a useful orientation tool and it helps you to help people to think about what they might benefit from and what their options are."* (Clinician 2)

Clinicians also mentioned other settings in which the grids might be helpful. One clinician has used it in a school based setting: *"I used one in schools...with a mum who was concerned about low mood"* (Clinician 6). Other clinicians posted grids could be helpful in other areas. This included A&E settings (in the case of self harm), schools, and specialist clinics (in the case of ADHD). -- *"What I was going to suggest is that the self-harm one, probably the key place where you want that is in A&E departments.... Most of the people I see who are acutely self-harming are coming into A&E, and that's the kind of... for people who present with self-harm, that's often going to be their first presentation, so that it would be really nice on an evening, or a weekend, to be able to give them this grid in that situation."* (Clinician 3)

While clinicians generally viewed the grids as a helpful tool, there was some concern that the grids were burdensome to clinicians. *"I think it's a thing that you are giving them on paper, because it's not in any way, shape or form an outcome measure. But people come for one hour and it's another thing that is given. When you are already feeling very full, it's hard to have all these add-ons – if they'd feel like an add-on rather than a relief for families."* (Clinician 2)

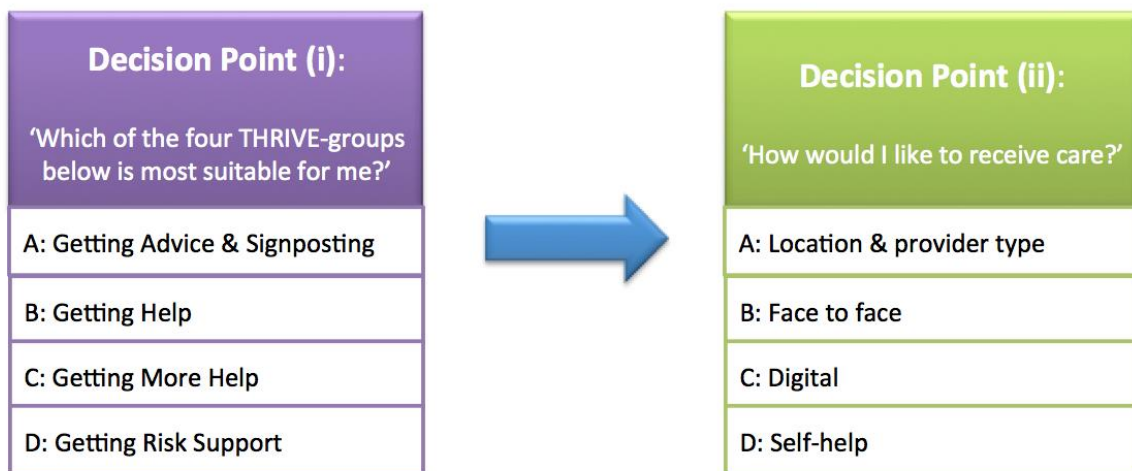
It was especially important to clinicians that they felt they had the option to use the grids or not to use them. In Clinic B where there was some resistance to the project, clinicians may have felt that they had to use the grids or change their practice. This was highlighted by one clinician who defended the grids after a training session – *"I think when [the researcher] left, the discussion continued and I said, "This doesn't replace everything else... no one is telling you, you have to use it. It's a tool to have, and actually, the family might find it helpful, whether you do or don't. It's not just about you. It's about what the family might find helpful."* (Clinician 6).

It was also important to interviewees that teams should have a choice to participate in the project -- *"I would have like to have been asked rather than just told this was happening. Yes, 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” (Clinician 4).

A potential barrier to implementation outlined by two clinicians was that they did not always have paper copies of the grids to hand when they needed them or know where to find them. Having electronic copies on their desktops or a website would be helpful – “if they were electronic, for instance, I could just print them off myself. That would be the easiest thing” (Clinician 6).

Appendix F: Original decision points



Appendix G: One of the 'You said we did posters' in Clinic A

