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REFORM MODELS FOR CHILDREN AND YOUNG PEOPLE MENTAL HEALTH SERVICES IN THE UK: EVALUATION OF THE 0-19 MODEL'S EARLY INTERVENTION APPROACH (Vol.1)

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of
Philosophy in Health Sciences

November 2020
University of Warwick
Warwick Medical School, Department of Health Science



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It is said that no man is an island. This thesis is dedicated to all those rocks that were surrounding me (you know who you are) and who given so much support, encouragement and their time during this PhD project and in everything else. On your solid foundations I can stand firm and strong, able to deal with life and live it to its full potential.

“And now here is my secret, a very simple secret: It is only with the heart that one can see rightly; what is essential is invisible to the eye. The most beautiful things in the world cannot be seen or touched, they are felt with the heart”

Antoine de Saint-Exupéry, [The Little Prince](#)

Acknowledgments:

I would like to acknowledge the help and support of many people throughout this PhD project and the production of this thesis.

Firstly, I would like to thank my supervisors, Professor Max Birchwood and Dr Andy Thompson, for providing me with the opportunity to undertake this PhD project. I am very grateful (and always will be) for their guidance and the patience they have shown during the last three years. Their knowledge, experience and guidance were invaluable. I would also like to thank all staff from Warwick Medical School. They were supportive and welcoming throughout this PhD project. My special thank goes to Desiree Stewart. Desiree was always there when needed and provided help with all administrative matters for this project. I would additionally like to thank Samantha Plumb, whose help was very much appreciated, as well as her continuous support. Similarly, many thanks goes to Francesca Meneghetti (Grazie mille, care Francesca) and Sean Barret (Sean, I am still waiting to see your long-promised guitar gig) for their continuous support through this PhD.

Secondly, I would also like to express my sincere gratitude to Michele Underwood, from whom I learned a lot about research development and teaching practice. I would also like to thank the lovely Researcher Development team (Dr David Swan, Dr Claire French, Kate Mahoney and Tina Janssen) and the Doctoral College for their support and advice, and for providing an excellent working environment. Similarly, I would like to thank the Warwick Medical School Clinical Based Learning teams for their continuous support and wonderful (and stimulating) teaching environment.

Thirdly, I express my gratitude to the Solihull Clinical Commissioner Julie Hackett, who made this PhD project possible, and for her continuous support and help provided. I am also thankful for the support of the Solihull CCG and Birmingham and Solihull Mental Health Foundation Trust, who provided the funding for this PhD project. The Solar Service has been an invaluable partner throughout this PhD project. Therefore, a big thank-you goes to Elain Murray, Dr Harvey Tagger, Liam Laughton, Emmalene Garratt and Steve Harris. Similarly, all other Solar

staff members at the Bishop Wilson and Freshfield clinics deserve a big thank-you. I spent three lovely years working with them, and their help and support were much appreciated. Without all the support of the Solar staff, this PhD project would not be possible.

Equally, I would like to express my sincere gratitude to all interviewed participants who took part in this research project and for sharing their time, experiences and feelings about the topic. Without their participation, this PhD thesis and its findings would not be possible.

Fourthly, my wholehearted thanks goes to my family (parents and sister) for their support during the last three years. Also, a massive thank goes to Barbara and Andrew for their support, help and for making the “final push” possible. Most of all, I would like to thank my partner Andrew for his patience, support and help provided. Similarly, like all PhD students’ partners, he became an expert unwittingly in this topic.

Last (but not least), my gratitude goes to all other PhD students in the Farmhouse. A big thank-you goes to Dr Ines Kander and Dr Julia Gauly for their lovely support, friendship, and helpful advice (especially when things got difficult). I would also like to express my particular gratitude to Latoya Clarke and (now officially Dr) Muna Dubad who always made me smile (even when things were going south). Also, a big thank-you goes to Julia Welsh for her “counselling skills” and support. I’m also very thankful to Farah, Helen, Marie, Becky, Zain, Omar, Tommer, Sara, Maartjee, and Sarah for their support and advice, as this PhD experience would not have been the same without them.

It was such a privilege and joy to work with you all. Thank-you all.

Declaration

This thesis is submitted to the University of Warwick in support of my application for the degree of *Doctor of Philosophy*. The thesis was composed by myself and was not submitted in any previous application for any other degree.

List of publication including submitted papers

Journal articles:

- ❑ Vusio, F., Thompson, A., Birchwood, M., & Clarke, L. (2019). Experiences and satisfaction of children, young people and their parents with alternative mental health models to inpatient settings: a systematic review. *European child & adolescent psychiatry*, 1-13, 29(12), 1621-1633.
- ❑ Vusio, F., Thompson, A., Laughton, L., & Birchwood, M. (2020). After the storm, Solar comes out: A new service model for children and adolescent mental health. *Early Intervention in Psychiatry*.

Dissemination (Conference presentations):

- Vusio, F., Thompson, A. & Birchwood, M. (10/2019) Lego Serious Play applied to Children and Young people's Mental Health: Oral presentation at the International Qualitative research on Mental Health 2020, Valletta, Malta (Cancelled due to Covid19)
- Vusio, F., Thompson, A. & Birchwood, M. (10/2019) Lego Serious Play applied to Children and Young people's Mental Health: Poster Presentation at the International Association of Youth Mental Health 2019, Brisbane, Australia
- Vusio, F., Thompson, A. & Birchwood, M. (10/2019) Presentation of the novel 0-19 model: Poster Presentation at the International Association of Youth Mental Health 2019, Brisbane, Australia
- Vusio, F., Thompson, A. & Birchwood, M. (10/2019) Experiences and satisfaction of children, young people and their parents with alternative mental health models to inpatient settings: Poster Presentation at the International Association of Youth Mental Health 2019, Brisbane, Australia
- Vusio, F., Thompson, A. & Birchwood, M. (06/2018) Youth Mental Health Crisis models - Presented at Warwick Research Student Skills Programme Conference. Awarded both "Best Medicine Poster presentation" and "Best overall poster"

Abstract

Background: Prevalence data both in global and UK contexts shows an early onset of mental health issues in early adolescence, supporting the need for effective early intervention and prevention services to prevent escalation of young people's mental health and to facilitate their recovery. If these disorders are not treated or prevented early, they may well persist into adulthood. However, the current state of children and adolescent mental health services in the UK, and the main weaknesses (e.g. barriers to access) associated with children and young people mental health provision, prevents attempts of early intervention and prevention. To deal with these weaknesses a range of different policies was brought in the UK to improve overall mental health services and their provision to meet CYP needs. A gradual and visible step have been taken since implementing these policies to re-transform existing service provision, paving the way for newly introduced service models in the UK (i.e. 0-25, 16-24 and 0-19 models). Therefore, this research aimed to use the exemplar of a newly developed and retransformed model and its crisis service component for children and young people aged 0-19 in England to assess the accessibility and acceptability of this model for its service users, professionals and parents. In addition, this research also aimed to understand the impact of the model on local community.

Methods: A mixed-methods approach was conducted which involved: 1) a systematic review of the experiences and satisfaction of children, young people and their families with alternative models of mental health care; 2) a qualitative study of stakeholders' perceptions of the accessibility and acceptability of the 0-19 model; 3) a novel application of the qualitative Lego Serious Play approach to understanding young people's perceptions of the accessibility and acceptability of the 0-19 model; 4) a mixed-methods study of the duty/triage line to understand its accessibility, effectiveness and acceptability; 5) a quantitative study that analysed the crisis pathway and inspected its effectiveness as well as relapse and recovery rates post-crisis discharge; 6) a qualitative study exploring stakeholders' perception regarding accessibility and acceptability of the 0-19 crisis component; 7) a qualitative study with local professional community stakeholders to understand the impact of the model on its local

community; and 8) a qualitative study that explored parental and CYP journeys through mental health crisis and the crisis service.

Results: This research found that the 0-19 model has particular strengths, such as partnerships with the voluntary sector, the presence of a crisis service within the model that prevents and reduces the need for hospitalisation, being considered by its service users as an alternative to more clinical settings, and most importantly being both community orientated and youth-friendly. In addition, children, young people and their parents' experiences of mental health crisis journeys supported the need for early intervention and prevention models similar to the 0-19 model and identified a preference for community-based treatments. On the other hand, the research also identified a number of weaknesses of the 0-19 model such as inaccessibility of service locations (i.e. clinics), long waiting times, lack of adequate resources (e.g. staff), extensive use of signposting, the need to retell personal stories, a lack of therapeutic alliances and discontinuity of staff care. The weakest parts of the 0-19 model were identified as its psychiatric services and its third sector partner – Autism West Midlands.

Conclusion: The 0-19 model is a bold attempt to improve CYP mental health services and their provision. However, despite some of the strengths of the model, major weaknesses of the model remain persistent and similar to other retransformed models of CYP mental health in the UK. However, the 0-19 model is a positive step forward, and as such may be further developed by focusing on turning its weaknesses to its strengths. The strengths and weaknesses of this PhD project and potential implications on further research and clinical practice are discussed in the thesis summary.

Impact of Covid-19 on this PhD and the final research activities

This PhD project consisted of three separate research work packages. Work packages one and two were completed before the outbreak of COVID-19. The third work package was only partially completed due to the disruption caused by Covid-19.

Although the initial qualitative research activities of work package three were completed by December 2019, the Covid-19 pandemic impacted recruitment for administering the ReQuest recovery outcome measure, which was intended to be conducted from January to June 2020. As a result, the impact of COVID-19 also affected the last qualitative research activity that was supposed to follow the administration of the outcome measures to understand parental perceptions of their children's recovery from the mental health crisis. All attempts to mitigate this situation failed, as the service did not want to risk exposing participants and the researcher to a potential situation where they could become infected with COVID-19.

List of Abbreviations

ADoC	Average Duration of Crisis Care
AMHS	Adult Mental Health Services
CAMHS	Children and Adolescent Mental Health Services
CRHTT	Crisis Resolution Home Treatment Team
CRT	Crisis Resolution Team
CYP	Children and Young People
DoC	Duration of Crisis Care
DNA	Did Not Attend
FIM	Future in Mind
FTB	Forward Thinking Birmingham
FyFW-MH	Five-year Forward View for Mental Health
IAPT	Improving Access to Psychological Therapies
ICOS	Intensive Community Outreach Team
LSP	Lego® Serious Play®
LTP	Local Transformation Plan
MHC	Mental Health Crisis
MMAT	Mixed-Method Appraisal Tool
NHS	National Health Service
NI	Northern Ireland
PIS	Participant Information Sheet
RAID	Rapid Assessment Interface and Discharge
UK	United Kingdom
YP	Young People
WHO	World Health Organisation
WP	Work Package

Chapter 1: Setting the scene – Structure and Background of this project

1.1 Chapter outline

This introductory chapter starts with a general overview of the thesis and provides a rationale for the need for this research project. This chapter also discusses the background context and rationale for the reform of mental health services for Young people (YP) in the UK, which will introduce the magnitude of mental health issues facing Children and Young People (CYP) with a specific focus on the prevalence rates of self-harm, suicide, depression and anxiety both worldwide and in the UK. The current context of UK mental health service provision and the associated weaknesses of the CAMHS/young adult models will then be discussed.

The justification for the transformation of CAMHS and the UK policy context that sets out measures to improve and strengthen the delivery of CYP mental health services will then be introduced, followed by a presentation of the potential barriers that may hinder the transformation process. This chapter also outlines the rationale for early intervention and prevention services and explores definitions of CYP mental health crises. This chapter will also explore the development and responses of mental health crisis services, while introducing and discussing recovery processes and CYP post-crisis relapse rates. Finally, the gaps identified in the literature review will be presented and discussed.

1.2 Overview of the thesis

1.2.1 Purpose of the study

The purpose of this research project was to explore stakeholders' perceptions and experiences of accessibility and acceptability of retransformed mental health service models in response to recent UK policies. Therefore, the 0-19 model was used as an exemplar of a model of successful transformation to understand the degree to which this model impacts its local community and

how much it contributes towards solving a number of existing weaknesses of CAMHS in the UK. Since the 0-19 model works in partnership with both statutory and voluntary sectors, has a community-based setting that provides early intervention, crisis resolution, and a youth-friendly service environment, it is an exemplar of a unique service model in the UK worth investigating further.

The literature review identified many gaps within mental health crisis provision for CYP within the UK. For example, a lack of understanding of CYP and their families' experiences of mental health crisis journeys, their recovery, the impact that crisis has on overall family functioning, a lack of knowledge about how effective these CYP crisis models are, and most importantly, what constitutes effective crisis pathways. Therefore, to fill these gaps in the literature, the predominant focus of this project was on the 0-19 crisis service, which acts as a gatekeeper to hospital admission, and as such, promotes home treatments, which improve recovery rates faster than for those in acute/inpatient wards, for the majority of CYP patients. (McDougal et.al, 2008). Furthermore, the 0-19 model and its crisis service operate in line with recommendations made by the Crisis Concordat (Signatories, 2014) in which mental health crisis service must support the recovery process, as well as prevention and increasing CYP resilience against future crises. Therefore, it is important to investigate how effective the 0-19 crisis service is in achieving recovery and building CYP resilience to prevent future crises and readmissions back to the crisis or other mental health services.

This research project was envisaged as a comprehensive case-study evaluation of a 0-19 model and its crisis service. In addition, this project used the 0-19 model and its crisis service provision to answer all identified gaps in the literature review, and to understand how this theoretical model meets the number of recently developed policies within the UK. As this is an exploratory and pragmatic project, a mixed-method design was seen as an appropriate way to generate new knowledge. It was also crucial to discuss the findings from this project in the broader UK context to address a number of gaps identified in the literature review and to ensure that findings will be useful and relevant to both local and national context.

1.2.2 Structure of the thesis

An overall outline of this thesis is provided in Table 1. The literature review focuses on the main issues in the current CYP mental health service provision, including: 1) an overview of global and the UK CYP mental health prevalence data; 2) The existent policy context and rationale for the transformation of CYP mental health services; 3) Theoretical basis and rationale for early intervention and prevention models; 4) Theoretical basis of CYP mental health crisis and introduction of mental health crisis models in the UK; and 5) the main identified gaps and limitation in the existing research literature.

The main body of this thesis includes a conducted systematic review and five qualitative studies, out of which, the one study described a novel utilisation of the Lego® Serious Play® in the mental health service and their evaluation process that has never been previously conducted in the mental health research. In addition, one quantitative study looked into the effectiveness of Solar's crisis service and its pathways, while another study looked into the effectiveness of the duty-triage telephone service within the Solar model. Each of these studies was made as standalone studies interlinked with the literature review presented in chapter one, while each study had their own research questions, findings, strengths and limitations, and made conclusions.

The thesis summary section aims to answer the initial research questions posed in the chapter 3 and synthesises the main findings of all research studies to address the accessibility, acceptability and effectiveness of the overall 0-19 model and its crisis component. The last parts of the discussion chapter will introduce the status of the current reform of the CAMHS services and outline a set of recommendations for commissioners and policymakers.

Table 1. Thesis structure map

Chapter	Title	Description
1.	Introduction (Thesis structure, Literature review and identified gaps)	<u>Chapter 1</u> will initially introduce the overall thesis, its purpose and structure. The main findings from the literature review will then be presented with a focus on youth mental health prevalence data for worldwide and UK contexts. As part of the literature review, the current condition of CAMHS services within the UK will then be discussed. The rationale and justification for the much-needed transformation of CAMHS services within the UK will then be outlined with specific emphasis on the UK policies that govern the transformation of the CAMHS service provision and act as facilitators for the development of new CYP mental health models. The need for early intervention, prevention and recovery models will be discussed, while identified gaps in the existing literature will be presented. Besides, this chapter will also introduce and define the concept of a mental health crisis and introduce the current mental health crisis service provision for CYP in the UK.
2.	The theoretical model as solution for identified gaps	In <u>chapter 2</u> , a theoretical 0-19 model will be described as a solution for all identified gaps in chapter 1 and in line with other available models in the UK and worldwide. Initially, the Solihull research setting will be described in this chapter, to present an overview of the area where the 0-19 model and its crisis component operate, with respect to the geographical area, CYP population description, prevalence rates of mental health disorders, and the policy context. This chapter will also introduce and explain the roles and responsibilities of the 0-19 model and its crisis service component
3.	The main methodology	<u>Chapter 3</u> introduces the main aims, objectives and research questions that govern all research activities for this PhD project. The logic model will also be discussed alongside three work packages and their related research activities. The mixed-methods approach will then be introduced alongside its rationale and justification. The last part of this chapter will cover research governance, funding and ethics applications.
4.	Systematic Review	<u>Chapter 4</u> will introduce a comprehensive systematic review to address the gaps in the existing literature and to inform the direction of the overall PhD project. Initially, the main aims and objective of this review, together with the searching strategy and methodology used will be discussed. The data synthesis and main findings will then be followed, explored and discussed further. The last part of this chapter will address the strengths and weaknesses of this systematic review and its conclusions.
5.	Stakeholders perceptions of the 0-19 model	<u>Chapter 5</u> represents one of the first research activities that investigated CYP, parents and staff perceptions of the 0-19 model's accessibility, acceptability and the overall stakeholder's satisfaction with the Solar service. This chapter will initially cover the aims and research questions. The main sampling, recruitment and data collection methods will then be presented. Aside from the main methods, this chapter will also introduce the template analysis and provide a rationale and justification for the choice of

		<p>this qualitative approach to analysis. The final template for the analysis of qualitative data will be presented in this chapter. Participant demographics and ethical considerations will also be discussed further. The main findings will then be outlined for the four main themes identified from the participants' transcripts. All findings will also be examined in relation to existing literature. Lastly, in addition to its conclusions, this chapter will also cover the main strengths and limitation of this review.</p>
6.	<p>Children and young people's perceptions of the 0-19 model by utilising the Lego® Serious Play® approach</p>	<p><u>Chapter 6</u> introduces a novel Lego® Serious Play® approach to understand CYP's experiences of access and treatment in the Solar service and their satisfaction with the overall model and its service provision. Initially, the need for qualitative research, as well as the need for participatory research will be outlined and justified. A methodological overview of the LSP approach will then be introduced, followed by an explanation of the methodological steps taken during recruitment. The rationale and justification for using the thematic analysis approach will also be discussed, followed by the presentation of the main findings. These findings were grouped around five main themes captured from participants Lego models and their story narratives. These findings will also be discussed in the context of the existing literature. A reflection on the use of the LSP method will then be presented, followed by the introduction of strengths and weaknesses of the study, and its conclusions.</p>
7.	<p>Gatekeeping towards crisis</p>	<p><u>Chapter 7</u> will initially introduce and define the role of the duty workers in the Solar service, followed by presenting the main aims of this study. This segment of the study was mixed-methods in its design. The qualitative thematic analysis of the Solar staff's perceptions will be followed by the presentation of three emerging themes that looked at the impact of the duty line on accessibility, identified barriers and benefits of the duty line. Once all the main findings are introduced, they will then be discussed in relation to other available literature. Lastly, the chapter will add the strengths and weaknesses of this study and its conclusion.</p>
8	<p>Effectiveness of the crisis pathways</p>	<p><u>Chapter 8</u> aims to provide information on the effectiveness and accessibility of the 0-19 crisis service and is the main quantitative segment of this thesis. Initially, the primary methodology will be introduced in this chapter, followed by the overall analysis of the service data and their interpretations. Once all the main findings are presented, the outcomes will be compared with the available research evidence to understand how the data informs us of the current accessibility and effectiveness of the crisis service.</p>
9	<p>Stakeholders perceptions of the 0-19 model's crisis component</p>	<p><u>Chapter 9</u> investigated CYP, parents and staff's perceptions of the 0-19 model regarding the crisis component's accessibility, acceptability and the overall stakeholder's satisfaction with the crisis service. Initially, this chapter will cover the aims and research questions. The main methods for sampling, recruitment and data collection will then be presented. Besides the main methods, the final template that aided the analysis of qualitative data will be presented. Participant demographics and ethical considerations will also be further discussed. The main findings</p>

		will then be outlined for the five main themes identified in the transcripts of the participants. All findings will also be examined in relation to existing literature. Lastly, this chapter will also cover the main strengths and limitations of this study, in addition to its conclusion.
10	Impact of the 0-19 model and its crisis component on the local community	<u>Chapter 10</u> investigated local community perceptions of the Solar model's accessibility, acceptability and the overall stakeholder's satisfaction with the Solar service and its crisis component. The aim of this study was also to understand the impact of the Solar service and its crisis team on the local community. Initially, this chapter will cover the aims and research questions. The main methods for sampling, recruitment and data collection will then be presented. The final template that has contributed to the analysis of qualitative data will then be presented. The main findings will then be outlined for the five main themes identified in the transcripts of the participants. Towards the end of the chapter, the main findings are discussed. These findings were also compared with the existing literature, covering the main strengths and limitations of this study and the conclusions of the study.
11	Young people and parental journeys through a crisis and beyond	<u>Chapter 11</u> investigates the parental and CYP experiences of their journey through the crisis service and the impact of a mental health crisis on the overall family functioning. Initially, we outlined the main aims of the study, followed by a presentation of the main methodology that will include research ethics, recruitment, data collection, participants, and data analysis using the template approach. The main findings will then be outlined with respect to the four main themes identified in the transcripts of the participants. All findings will also be examined in relation to existing literature. Lastly, this chapter will also cover the main strengths and limitations of this study, in addition to its conclusion.
12	Thesis summary	<u>Chapter 12</u> is the final chapter of this thesis, which summarises all the findings of this research project and how they address previously identified gaps in the literature as well as research questions. The discussion chapter will consider how these findings can be applied to improve mental health service provision for CYP. A list of recommendations will be provided to inform public and policymakers on how the Solar service can improve its mental health provision. In addition, the aim of this chapter is to reflect on the overall quality of research conducted throughout this PhD project and to provide a summary of the newly identified or remaining gaps in the existing literature. Lastly, the final part of this chapter will consider the contributions of this project to the overall crisis service provision and the mental health system for CYP in the UK.

1.3 Literature review: Why children and adolescent mental health services are essential for children and young people today

1.3.1 Epidemiology of mental health disorders in children and young people worldwide

The majority of adult and recurring mental health disorders are rooted in early childhood, adolescence and young adulthood (Fusar-Poli, 2019a). Adverse mental health in CYP is recognised as a global problem, with 10% - 20% of CYP suffering from mental health disorders globally (Kieling et al., 2011; World Health Organisation, 2016). Similarly, a meta-analysis review showed a high prevalence of 13.4% of CYP affected by any mental health disorders globally (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). Similar prevalence of CYP mental health disorders ranged in other studies from 12% to 15% worldwide for periods between 1985 and 2012 (Kessler & Bromet, 2013; Roberts, Attkisson, & Rosenblatt, 1998; Verhulst et al., 2003). Therefore, it is evident that the WHO estimate of the prevalence of CYP mental health illness could be well within the suggested range.

Furthermore, evidence from a study conducted in 2005 indicated that 50% of the adult population manifested mental health difficulties before reaching the age of 14, while 75% manifested some mental health disorder by the age of 24 (Kessler et al., 2005). Likewise, a review conducted in 2011 showed that the onset of mental health symptoms in YP occurred by the age of 25 in 75% of cases (McGorry, Purcell, Goldstone, & Amminger, 2011). Another study reported that 80% of YP diagnosed with mental health difficulties at the age of 26 had previously been diagnosed with a mental health disorder since the age of 11 (Fusar-Poli, 2019a; Jones, 2013). Furthermore, 50% and 74% of 26 year-olds diagnosed with mental health difficulties were diagnosed with a mental health condition before they reached their 15th and 18th birthdays, respectively (Fusar-Poli, 2019a; Jones, 2013). Indeed, findings from these studies show that mental health disorders have early onset of the symptoms that could persist through adulthood into chronic mental health conditions.

However, at the time of writing this thesis, the global prevalence data for CYP experiencing mental health crisis were not officially published in any form. Nevertheless, a range of scientific

evidence informs about the worldwide prevalence of anxiety, depression, suicide and self-harm that are often associated with mental health crisis presentations. For example, back in 2001, the prevalence of depression in children was less than 1%, and rapidly rises throughout adolescence (Green, McGinnity, Meltzer, Ford, & Goodman, 2005; Kessler, Avenevoli, & Merikangas, 2001). However, a previously mentioned meta-analysis review estimated that global prevalence of CYP anxiety disorders in 2015 was 6.5%, while 2.6% of CYP suffer from any depressive disorders and 1.3% from major depressive disorder (Polanczyk et al., 2015). Similarly, another study reported that unipolar depressive disorder may also affect 4-5% of mid to late adolescents worldwide (Thapar, Collishaw, Pine, & Thapar, 2012). However, depression in adolescents is a significant risk factor for suicide, and the second-to-third leading cause of death in this age group, with more than 50% of YP suicide victims reported having depressive disorder at the time of death (Hawton, 2009; Windfuhr et al., 2008). Depression is well-linked with pre-puberty and adolescent-onset and can easily persist into adulthood (Hagan et al., 2015; Jones, 2013). Similar early onset is evident in the case of anxiety disorders (Goodyer, 2001).

Equally, suicide and self-harm are also recognised as major worldwide public health issue especially in the adolescent population who experience high self-harm rates, while findings from some studies showed that approximately 10% of YP reported engaging in self-harm globally (Madge et al., 2008). Additionally, suicide in YP population is classified as the second most common cause of death in YP age 15-29 in 2016 and represented 8.5% of all YP deaths around the world (Cha et al., 2018; Hawton, Saunders, & O'Connor, 2012; World Health Organisation, 2019).

Similar high prevalence rates of YP suicide are evident in Europe, where the suicide of YP age 10-19 is considered as the most frequent cause of death (Bilsen, 2018). Likewise, Bilsen (2018) study showed that suicide is the most prevalent cause of death for young females aged 15-19. Moreover, according to one report, suicide is also the leading cause of death in both young men and women aged 15-35 (Edwards, 2018). Suicide ideation prevalence data show that 19.8 to 24 % of adolescents experience suicide ideation after the age of 10, and this ideation remains high until the age of 17 (Edwards, 2018). Conversely, CYP who experienced suicide

ideation during early adolescence may attempt suicide around the age of 12, and risk for suicide remains high and prevalent in mid-to-late adolescence (Cha et al., 2018).

The research evidence highlights the existence of a link between suicide and the presence of other mental health disorders, where 90% of adolescents who committed suicide suffered from at least one mental health disorder (Bridge, Goldstein, & Brent, 2006; Gould, 2001; Pelkonen & Marttunen, 2003). Additionally, the presence of mental health disorders accounts for a 47% to 74% increase in the CYP suicide risk (Bilsen, 2018). YP who are affected by eating disorders, such as anorexia nervosa, are also at higher risk of suicide (Bridge et al., 2006). Furthermore, gender has also been identified as a risk factor of depression and suicide in YP. Previous attempts of suicide were evident in 25%-33% of all suicide attempts and were more prevalent in young male adolescents than in young females, while 1-6% of all YP attempted suicides in YP resulted in death within the first year (Bilsen, 2018). Conversely, depression was 50-65% more prevalent in suicide cases of young females than males (Bilsen, 2018).

Likewise, the high comorbidity prevalence between affective disorders and substance abuse precipitates suicide ideation and increases the risk of death by suicide (Bilsen, 2018). Also, as seen from previous studies, there is a strong link present between previous attempts of suicide, history of self-harm and suicide (Cooper, Kapur, Webb, Lawlor, & Guthrie, 2005). However, the risk of suicide was associated mainly with self-inflicting harm and less with the degree of active suicide ideation. Therefore, it is evident that the presence of comorbidity of mental health disorders significantly precipitates YP suicide risk.

1.3.2 Epidemiology of mental health disorders in children and young people in the UK

The last conducted survey in 2004, in the UK on the prevalence of CYP mental health disorders, showed that approximately 10% of CYP suffer from some form of mental health disorder (Longfield & Lennon, 2017; Office for National Statistics, 2004). However, in 2018, NHS Digital released a new report that showed that 12.8% of CYP aged 5-19 had at least one mental health-related diagnosis in 2017 in England, UK (NHS Digital, 2018).

From the NHS data, 10% of young females reported experiencing emotional disorder in comparison to 6.2% of boys (NHS Digital, 2018). For all genders, a higher prevalence of anxiety disorders was reported (7.2%) in comparison to a prevalence of 2.1% for depressive disorders (NHS Digital, 2018). Besides, it is evident that the prevalence of mental health difficulties in 5–15-year-olds in England had increased since 1999 when the prevalence was 9.7%, to 10.1% in 2004, and 11.1% in 2017, with an increase of emotional disorders in 2017 compared to behavioural disorders in both boys and girls

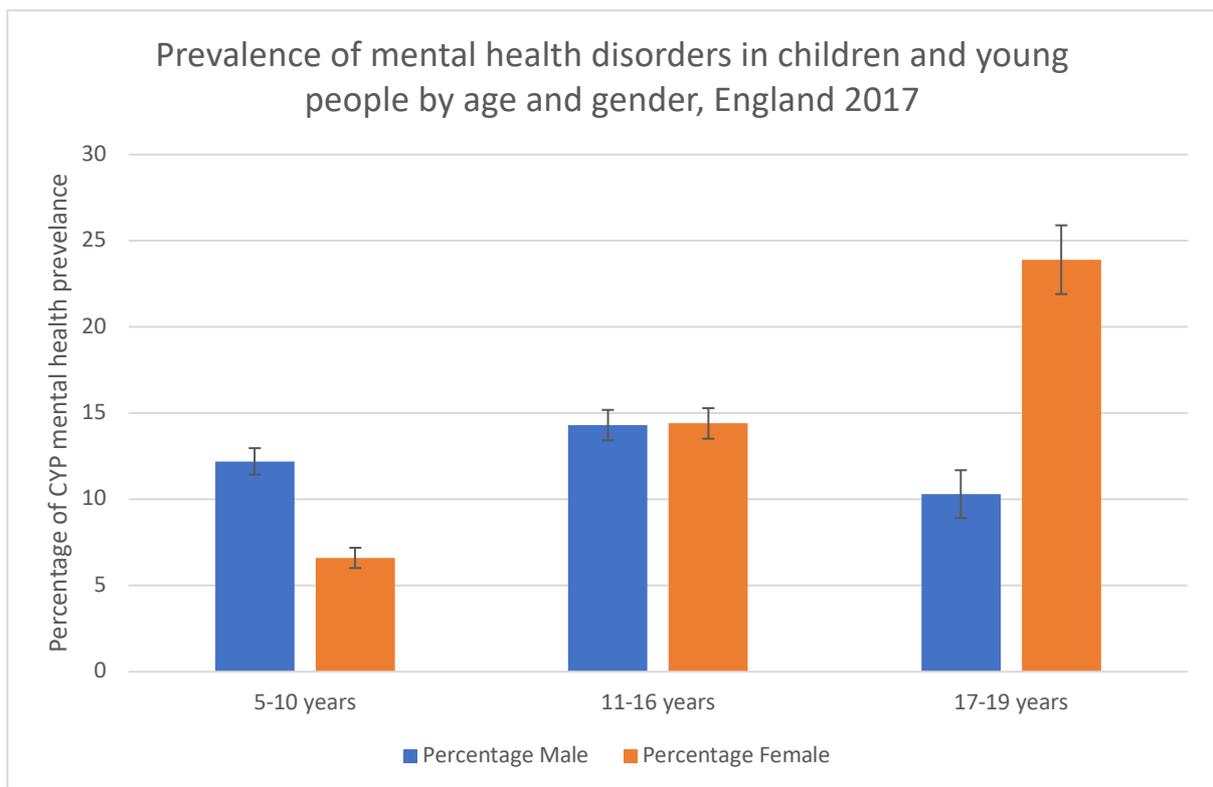


Fig 1. Prevalence of mental health disorders in CYP by age and gender in England 2017 (NHS Digital, 2018)

A report on the prevalence of mental health amongst individuals aged 16-74 estimated the overall rate of common mental health problems for YP between 16-24 was one in six (McManus, Bebbington, Jenkins, & Brugha, 2016). For the 16-24 age group, the prevalence of common mental health disorders was three times higher in young women (26.0%) than in young men (9.01%). In addition, this report also highlighted that 24.6% of young females and 14.7% of young males aged 16-24 displayed signs of anxiety and depression (McManus et al., 2016).

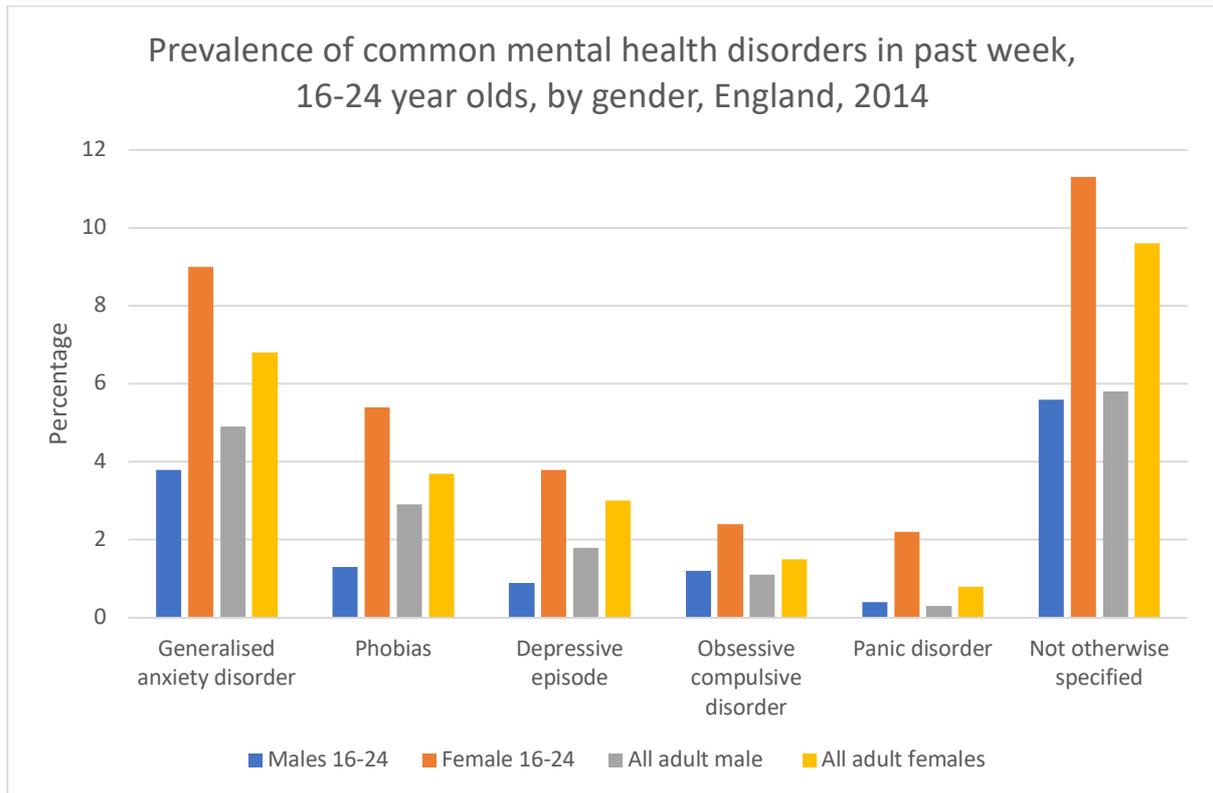


Fig 2. Prevalence of common mental health disorders among 16-24-year-olds, by gender in England 2014. Adapted from McManus et al., (2016)

It should be noted that other devolved governments in the UK did not release any similar prevalence data to show the prevalence of youth mental health disorders in Scotland, Wales and Northern Ireland (NI). However, some reports indicated that the prevalence of CYP mental health disorders in Wales is similar to the prevalence in England. For example, 1 in 10 CYP aged 5-16 in Wales experienced a diagnosable mental health disorder, while 10% to 15% of young adolescents experienced depression (National Assembly for Wales, 2018). Similarly, in Scotland, it was estimated that 10% of CYP in 2003 experienced mental health difficulties (Murphy, 2016). Similarly, one Scottish survey (SALUS) in 2015 used a sample of CYP school children age 13 and 15 to show the prevalence of mental health disorders of CYP in Scotland (Murphy, 2016). The report's findings showed that young females age 15 were more likely to experience borderline or abnormal emotional problems in comparison to any other sub-group (Murphy, 2016; Scottish Government, 2017).

Similar reports have also shown that more than 20% of YP in NI are affected with significant mental health difficulties by the time they reach 18 years of age (Department of Health; Social

Services & Public Safety, 2010; Department of Health; Social services and Public safety, 2015; Khan, 2016a). In terms of scale and complexity of mental health problems, several reports also indicated an increase in the prevalence of CYP mental health disorders in NI (Niccy, 2017). Moreover, another report estimated that in NI, CYP experienced up to 25% higher rates of mental health illnesses compared to other parts of the UK (McClelland, 2006). There is, however, an evident lack of epidemiological research and CYP mental health illness prevalence data in NI (Niccy, 2017).

Considering all available prevalence data from the sources mentioned above, it is evident that a significant proportion of YPs aged 10-24 will develop symptoms of mental health illness in the UK during the early to mid-adolescence. It is also evident that young women are more likely to have mental health difficulties than young men. However, it is crucial to note that the above-mentioned estimates of mental health difficulties may vary depending on the type of measurement and the age of the sample used (Hagell, Shah, & Coleman, 2019). Lastly, more epidemiological studies are needed to be conducted to understand the prevalence rates across all parts of the UK.

Prevalence of self-harm, suicide, depression, and anxiety in YP in the UK

In the UK, self-harm is one of the most common mental health presentations among CYP aged 11-25 that often leads to suicide ideation (Hagell et al., 2019). In recent years, several attempts have been made to understand the prevalence of self-harm and suicide in the UK. For example, a report showed that 22% of 15 year-olds reported engaging in self-harm, of whom 32% of young girls and 11% of young boys reported self-harm at least once a month or more (Brooks, Magnusson, Klemmer, Spencer, & Morgan, 2015). Similar findings were evident in another survey that found that 1 in 4 (25.7%) young women reported self-inflicted injuries from self-cutting, compared to 1 in 10 (9.7%) young men (McManus et al., 2016). Additionally, the European CASE study also found that 15.5% of CYP in England, aged 13 to 18 years of age reported engaging in self-harm (Madge et al., 2011). The study found that the onset of the self-harm had begun at the age of 13. In contrast, another study found that 54.9% of young females aged 13 to 15 were self-harmed (Morey, Mellon, Dailami, Verne, & Tapp, 2017). However, the

rates of self-harm in YP aged 16-24 double and tripled for young men and women, respectively, between 2000 and 2014 (Figure 3) in England and Wales (McManus et al., 2016).

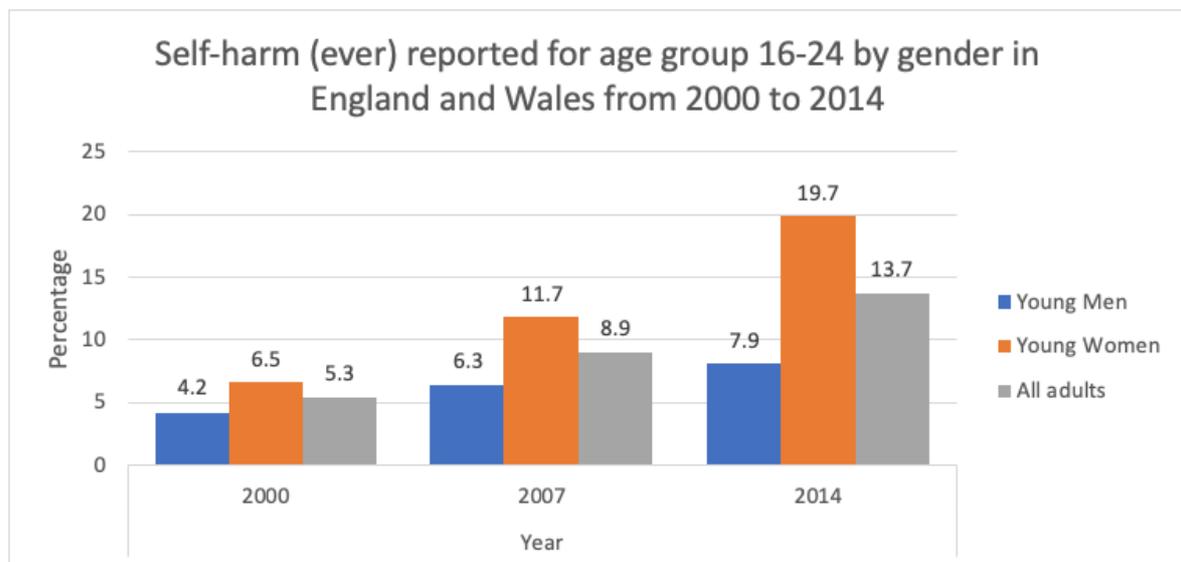


Fig 3. Self-harm reported for the age group 16-24 by gender in England in Wales between 2000-2014. Adapted from McManus et al., (2016)

These prevalence data again show higher susceptibility of young females for self-harm compared to their male peers, other studies have found that young males are more susceptible to active suicide ideation. For example, data from the Office for National Statistics (ONS) (Figure 4) showed that age-specific suicide rates in the UK between 1981 and 2017 for YPs aged 15-19 and 20-24 were much higher for young males aged 20-24 compared to young females of the same age range (ONS, 2019).

Similarly, the Adult Psychiatry Morbidity Survey showed that young men aged 16-24 had similar suicide rates to men aged 25 and over (approximately 8%), while suicide was much higher in the same-age young females' group (approximately 13%) (McManus et al., 2016). Lastly, it is also important to note that when UK suicide rates for YP aged 10-24 were compared with other countries in 2016, the UK had the seventh-lowest for YP aged 15-19, eighth-lowest for YP age 20-24, and the third-lowest rates for the age group 10-14 (Institute for Health Metrics and Evaluation, 2018).

Moreover, ONS data (Figure 4) showed that the number of suicides among young men and young females aged 20-24 has been relatively stable since 2005. However, it is also evident that the number of suicide rates of young males/females aged 15-19 is increasing. In addition, 2017 data showed that suicide rates of young men aged 20-24 were 11.4 per 100,000, compared with 7.1 in the 15-19 age group. Much lower suicide rates of 3.9 per 100,000 were evident in young women aged 20-24, while those in the 15-19 age group were 3.5

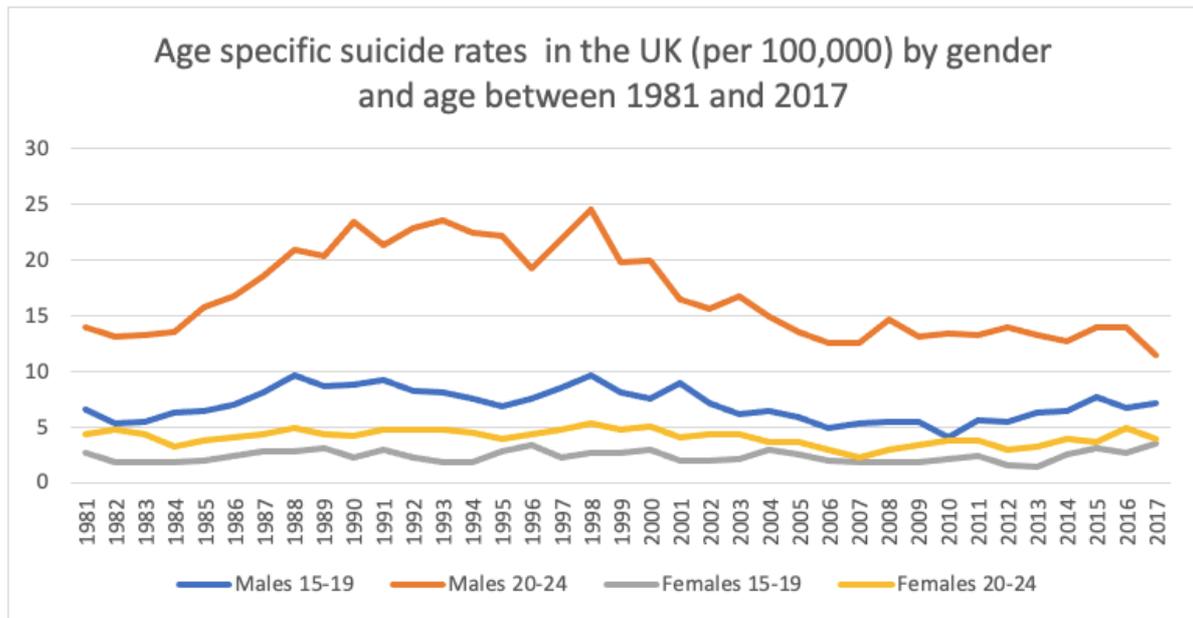


Fig 4. Age-specific suicide rates in the UK (per 100,000) by age and gender between 1981-2017. Adapted from Office for National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency Suicides in the UK (2018)

Regarding the prevalence of anxiety and depression among CYP aged 10-24 in the UK, it is evident that a significant portion of CYP within that age range will experience symptoms of anxiety, depression or comorbidity of both disorders at some point throughout their early to the late adolescent developmental trajectory (Hagell et al., 2019). From ONS and SALUS data, it is evident that young women tend to be more affected by anxiety and depression than young men. However, similar to self-harm and suicide, these estimates of anxiety and depression may vary depending on the type of measurements and age of the sample. Likewise, the Adult Psychiatric Morbidity survey also reported that 24.6% of young women and 14.7% of young men aged 16-24 reported being affected by anxiety and depressive disorders (McManus et al., 2016). What is evident from this report is that most young women between the ages of 16 and 24 are at high risk of developing emotional difficulties. On the other hand, NHS Digital survey

found that young women tend to be more affected by any emotional difficulties than young men in England, especially in the periods between ages of 17 and 19 years (NHS Digital, 2018). However, even for ages between 11 and 16, young women still tend to have a higher prevalence of emotional disorders compared to their male peers of the same age (Figure 5), while males tend to experience more emotional disorders between the ages of 5 and 10 compared to young females (NHS Digital, 2018).

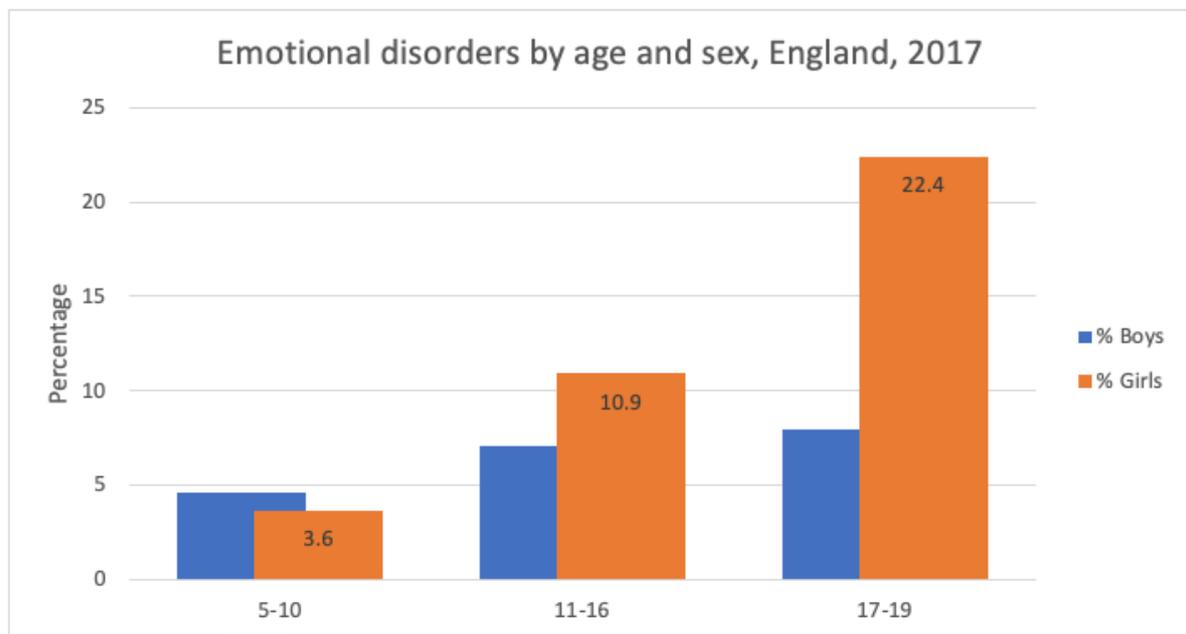


Fig 5. Emotional disorders by age and gender in England in 2017. Adapted from NHS Digital Mental health of Children and Young People in England survey (2017)

In line with the data on the overall prevalence of CYP mental health disorders in the UK, it is therefore evident that young females are at a greater risk of developing emotional disorders and experiencing self-harm. Young men, on the other hand, tend to be more engaged in active suicide ideation. These prevalence data support the notion that youth mental health difficulties stem from early adolescence and may persist through mid to late adolescence. However, these mental health issues are one of the most prevalent reasons for possible mental health crisis experiences that may well lead to hospital and A&E admission in the UK.

Hospitalisation rates for CYP due to mental health reasons

A small number of YP hospitalisations in the UK are attributed to self-harm and suicide attempts (Hagell et al., 2019). However, suicide attempts, self-harm and overdose are still the key reasons for the hospital admission. Still, these high numbers indicate that YP are experiencing distress with their mental health, as self-poisoning is the most common acute medical presentation in the UK (Camidge, Wood, & Bateman, 2003).

Public Health England published a report that showed that the peak hospital admission for YP (Figure 6) due to overdose was 15 years of age for young women which represents 3,861 admissions, compared to total 34,271 hospital admissions for YP due to self-poisoning in the 10-24 age group in 2017/2018 (NHS Digital, 2018).

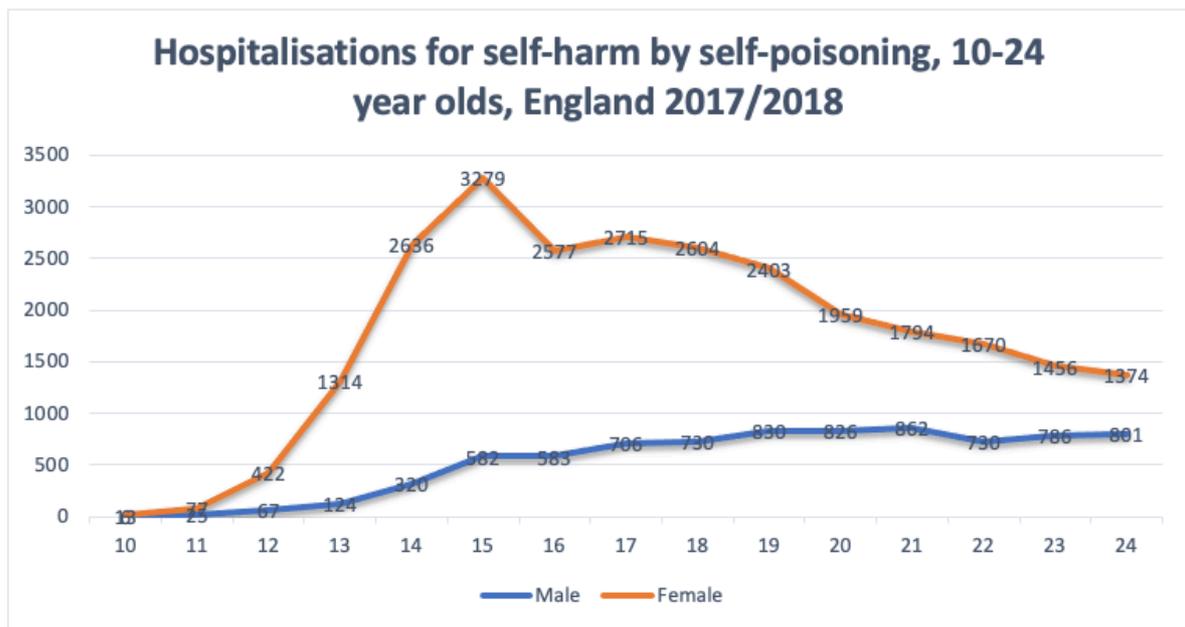


Fig 6. Hospitalisation rates for self-harm by self-poisoning of CYP 10-24-year-olds in England 2017/2018. Source: Public Health England (2019) Hospital admissions as a result of intentional self-poisoning by young people (10-24 years)

A similar pattern is also evident for YPs aged 10-24 with respect to suicide rates per 100,000 population. The Public Health England also compared self-harm hospital admissions between 2011/2012 and 2017/2018 (Figure 7) with a visible increase in YP hospital admission in age groups between 10-14 and 15-19, compared to 20-24.

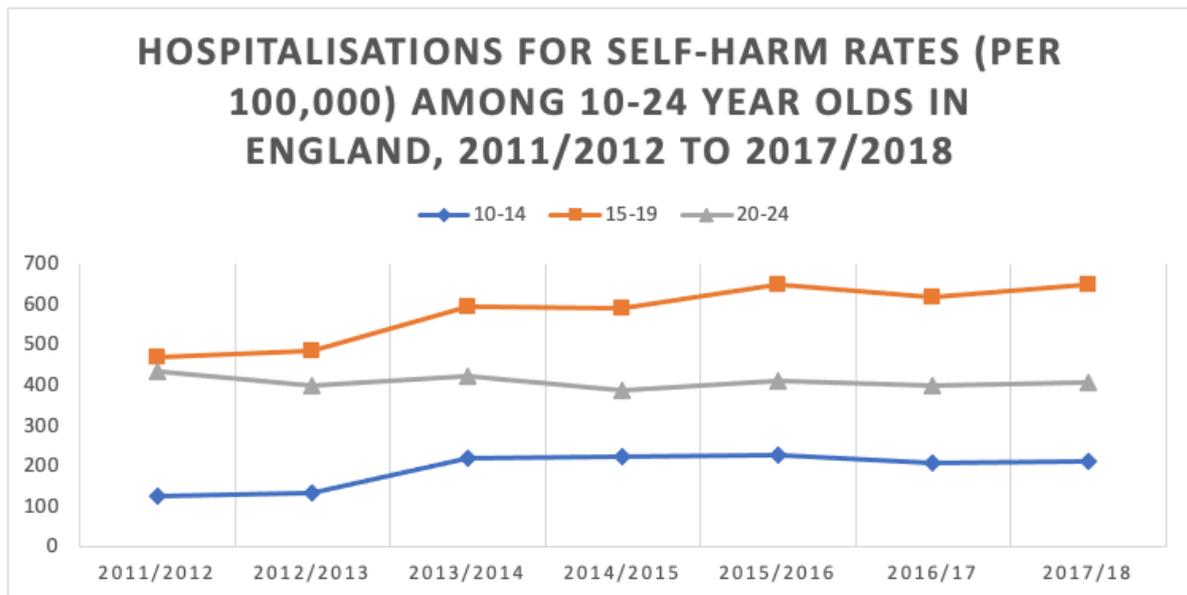


Fig 7. Hospitalisation for self-harm rates (per 100,000) among 10-24-year-old in England for 2011/2012 – 2017/2018. Source: Public Health England Fingertips: Hospital Episode Statistics 2017/18

Aside from self-harm or self-poisoning, additional reasons for hospital admission of YP may be linked to eating disorders. For example, the Health and Social Care Information Centre reported in 2014 that half of YP hospital admission between the ages of 10 and 19 were due to eating disorders (Hagell et al., 2019).

Again, as seen above, the evidence shows that younger women are more affected by self-harm, self-poisoning and eating disorders which ultimately lead to hospital admission compared to male peers. In contrast, young men tend to experience more hospitalisation due to self-poisoning towards older adolescents' years, while the rate of self-poisoning in young women tends to gradually decline during the period of adolescence. However, one study found that CYP from more deprived backgrounds are more likely to be admitted to hospital or inpatient settings due to their mental health compared to more prosperous areas (Hargreaves, Marbini, & Viner, 2012). Similarly, the figures published by Public Health of England (Figure 8) showed the largest number of admissions for YP aged 10-24 in 2017/2018 was for 15-year-old young women. These YPs experienced hospital admission primarily due to anorexia, which accounts for a larger proportion of admissions, although bulimia is more common in the population (Hagell et al., 2019).

However, it is crucial to highlight that most of the data are difficult to access, as these reports only include data for ages 0-19 or 16-59. Epidemiological studies involving CYP age 0-25 are therefore clearly needed, as it is evident that the first onset of mental health difficulties occurs in this particular age range. However, it is evident from most research literature that despite the high prevalence of CYP mental health disorders, there are clear weaknesses in the current CYP CAMHS service provision in the UK (House of Commons Health Committee, 2015). These weaknesses will be discussed further in the following section.

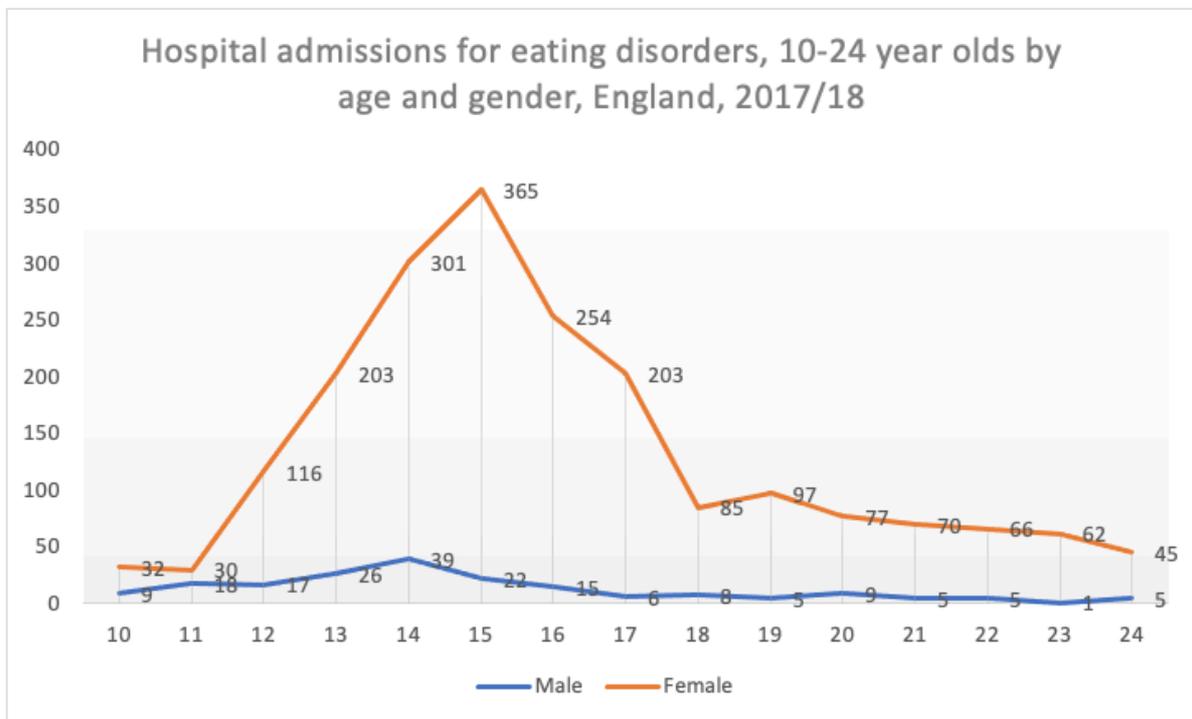


Fig 8. Hospital Admissions for eating disorders, 10-24-year-olds by age and gender in England 2017/2018. Figure adapted from Public Health England (2019)

1.3.3 The current condition of Children and Adolescent Mental Health services in the UK

CAMHS in the UK has been described as “possibly the biggest single area of weakness in NHS provision at the moment” (Hunt,2017). This further acknowledges the recent calls for the transformation of the current CAMHS provision (Department of Health, 2015). These calls for change are supported not only by professionals and experts in the field but also by CYP and their families (Department of Health, 2015). There is also prominent scientific recognition of the weaknesses of the current CAMHS models (Care Quality Commission, 2017b; the Royal

College of Nursing, 2017). In particular, delayed access to CAMHS provision (Hetrick, Bailey, Smith, Malla, Mathias, Singh, O'Reilly, Verma, Benoit, & Fleming, 2017), barriers to access (Abdinasir & Pona, 2015), fragmented provision (Caroline Mitchell, Mcmillan, & Hagan, 2017), and complicated care pathways (Plaistow et al., 2014) are some of the main weaknesses of the current CAMHS provision. In addition to these weaknesses, a lack of early intervention, prevention and recovery models (Lamb & Murphy, 2013), and inadequate quality of crisis care provision were identified as points requiring urgent transformation (Department of Health, 2015).

Furthermore, many CYP face difficulties transitioning from CAMHS to Adult Mental Health Services (AMHS). Most CAMHS users transition to AMHS is based on their age, rather than actual need (Lamb & Murphy, 2013). Similarly, even before transitioning, CYP who experience crisis are admitted to adult wards, or other inappropriate environments for their age or level of need (Care Quality Commission, 2017a). This may indicate that the current traditional form of CAMHS provision may struggle to meet their service users' needs, potentially leading to problematic and unpleasant CYP experiences (The Health Committee, 2014). Consequently, unattractive service provision may result in help avoidance behaviours (Singh & Tuomainen, 2015) and higher 'Did Not Attend' (DNA) statistics (Islam et al., 2016), which may further affect engagement with mental health services (Compton, 2005; NHS England - Healthy London Partnership, 2016), and increase the need for crisis intervention (Bhugra, Harding, & Lippett, 2004; Hawke, Cleverley, Settapani, Rice, & Henderson, 2017).

Despite the high prevalence of CYP-related mental health disorders in the UK, the rate of CYP help-seeking rates are declining. This is supported by a high treatment gap, with up to 55% of adolescents with mental health needs aged 12-15 years not receiving CAMHS care (Knapp et al., 2015). The treatment gap is similar for 16-20-year olds, while it is as high as 64% for 21-25-year-olds (Knapp et al., 2015). A survey also found that 35% of YPs requiring mental health services had no contact with them (Salaheddin & Mason, 2016). While some CAMHS are unable to provide the needed help to CYP, some CYP may be reluctant to engage with CAMHS (Salaheddin and Mason, 2016). A possible explanation for CYP's lack of engagement is unattractive mental health provision for CYP, fears of stigma, and the presence of multiple barriers for access to needed care (Caroline Mitchell, McMillan, & Hagan, 2017). The

aforementioned prevalence data also support the notion that adult mental health stem from untreated and undiagnosed mental health issues that have already occurred in childhood and adolescence (Merikangas, Nakamura, & Kessler, 2009; Office for National Statistics, 2004). Therefore, there is a clear need to intervene early in childhood before the problem escalates into a chronic condition later in adulthood. Early intervention models are potentially cost-effective and efficient methods to identify and prevent CYP mental health problems from escalation further. However, the current state of CAMHS service provision, high prevalence rates of mental health disorders among CYP age 5-25 and lack of appropriate funding of CAMHS service are clear indicators that many CAMHS models need transformation to be effective and clinically efficient at both preventing and treating CYP mental health illness.

A context and rationale for reform of current CAMHS mental health provision for CYP

Both the CYP mental health prevalence data and the current status of CAMHS provision presented in sections 1.3.1 and 1.3.2 are clear indicators for the transformation of existing CAMHS models in the UK. Additional evidence supporting service reform comes from the 'Future in Mind' (Department of Health, 2015) and the 'State of the Nation' (Firth, 2016) reports. Both publications acknowledged the existence of 'treatment gaps' as well as inconstant and sporadic service provision. Mental health stigma can exacerbate the problem by preventing CYP or their families from seeking early help before ill mental health further escalate, potentially to the point of crisis (Frith, 2016b; Place2Be, 2016).

Aside from stigma, funding for CAMHS can be seen as a contributing factor to the treatment gap. The NHS currently allocates up to 0.7% of its budget to fund CYP mental health services (Frith, 2016b; Youngminds, 2018a). However, due to a lack of transparency with the NHS data, it is difficult to approximate the NHS' exact mental health funding (Frith, 2016b). Therefore, a higher level of transparency within CAMHS would contribute to better care standards (NHS England, 2015). In addition, a higher demands, and subsequent higher thresholds for referral reduced access to more specialised mental health treatments (Frith, 2016b). The high acceptance threshold resulted in a rejection rate of 23% for referred CYP to CAMHS in 2016, while a recent report shows that the CAMHS rejection rate for referrals may be closer to 26% (Frith, 2016b).

Moreover, transition between CAMHS and AMHS has potentially detrimental consequences for CYP and their mental health (Department of Health, 2015), and for a large number of CYPs, *“transition is poorly planned, poorly executed and poorly experienced”* (Singh et al., 2010). Therefore, it is important to address and close the service gap, as breaking the continuity of care cycle can jeopardise the effectiveness of the early intervention in dealing with a long-term chronic condition (Birchwood & Singh, 2013). Additionally, a 2014 survey raised concerns about the current state of mental health crisis provision and the severe lack of out-of-working hours care provision (Fellow-Smith, Hindley, & Hughes, 2016). This survey also highlighted the out-of-area placement of CYP and their placement in inappropriate adult wards (Fellow-Smith, Hindley, & Hughes, 2016). However, in crisis management, it is crucial to maintain a balance between community crisis care and inpatient hospital beds. The lack of community crisis care can have a negative impact on in-patient hospital treatment, by making their beds occupied with cases that could be easily prevented and treated in community care settings (Tyrer & Johnson, 2011). This particular situation may cause CYP to be treated in an adult inpatient setting or to be sent miles away from their home area (Frith, 2016b).

1.3.4 Steps towards reform of current CAMHS provision for CYP – Overview of UK’s policy context

The report of the House of Commons Health Committee showed how serious existing problems with the provision of CYP mental health services in England are (House of Commons Health Committee, 2014, 2015). The report identified problems ranging from poorly planned and executed transitions of YP from CAMHS to AMHS, along with the waiting times that further deteriorate CYP mental health, issues with access to CAMHS, and inadequate data collection and management (House of Commons Health Committee, 2015; The Health Committee, 2014).

In addition, due to high rate of mental health prevalence, increased demand for mental health service, and rise in complex mental health presentations, CAMHS have struggled to meet the high demand . This has resulted in CAMHS services raising the threshold for access while at the same time being under-staffed and under-resourced, and unable to deliver effective and sustainable care (Care Quality Commission, 2017b). Additionally, the lack of joint commissioning has resulted in unclear pathways of care and lack of adequate CYP services (Care Quality Commission, 2017b).

In order to mitigate the increase in demand, many services have reacted by raising their eligibility criteria for acceptance and admissions thresholds, resulting in large numbers of CYPs reaching crisis points and placing massive pressures to urgent and emergency settings that easily become overwhelmed (Care Quality Commission, 2017b).

Therefore, since 2014 significant changes have been made to the national policy context to improve the provision of CYP mental health services in the UK and to ensure that mental health services and their provision are effective and accessible to support CYP mental health problems. Moreover, CYP mental health was recognised as a national priority, and a number of key policies and reviews were produced between 2014 and 2019 to improve CAMHS services at both national and local levels (Figure 9).

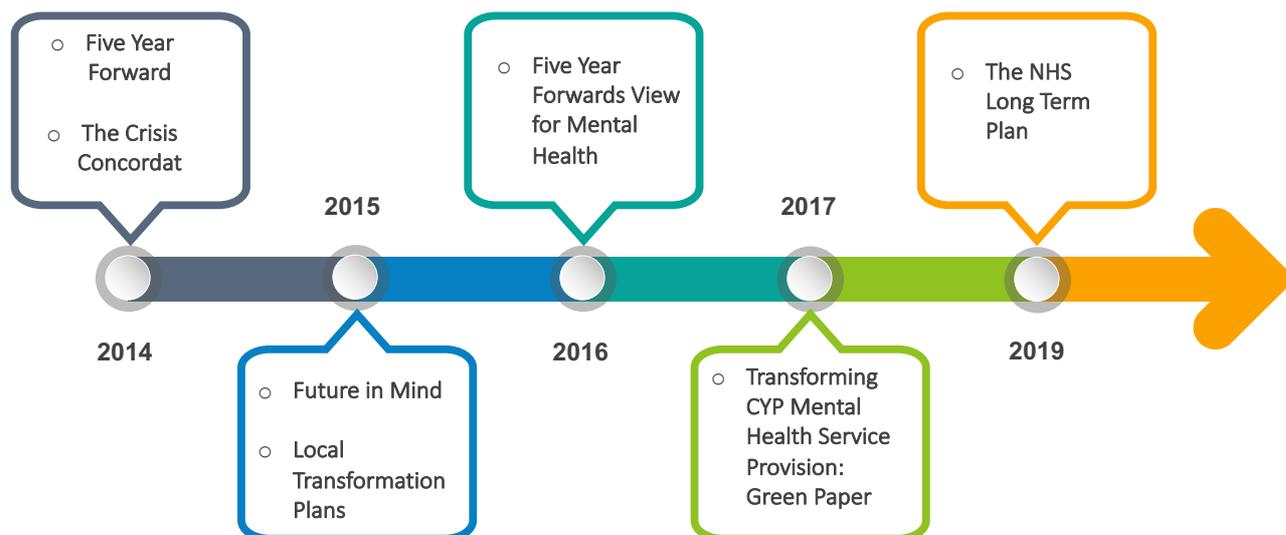


Fig 9. Timeline overview of key CYP mental health policies in the UK (2014-2019)

Five Year Forward View (2014)

Published in 2014 by NHS England, this policy document established a vision of how the future NHS services should be adapted and changed to meet the needs of service users (NHS England, 2014). The main focus of this report was on prevention and creation of integrated services that will allow for the creation of new community care models that will make it easier to adapt to serve and meet local population needs while at the same time putting service users in control of their health (NHS England, 2014). The Five-Year Forward View policy proposed the overarching implementation of following standards: clear direction for the future development of NHS service models; removal of barriers to care; moving away from “one size fits all” care models; implementation of multidisciplinary community care; integration of primary and acute care systems; redesign and integration of urgent and emergency care services; local leadership and regional flexibility and restoration and maintenance of financial balance (Care Quality Commission, 2017b; NHS England, 2014).

The Crisis Concordat (2014)

In 2014, a national agreement was established between 27 services and agencies involved in the care and support of people in a mental health crisis to improve their mental health outcomes as well as crisis pathways. The Crisis Concordat (Mental Health Crisis Concordat,

2014) provided a thorough definition of what mental health crisis pathway should encompass, suggesting key four stages that should be integrated into the crisis pathway:

- Access to support before reaching a crisis point, with emphasis on providing crisis support 24/7 to individuals who are close to reaching a mental health crisis. Prompt access to mental health crisis support may prevent further deterioration of mental health and escalation of the crisis
- Urgent and emergency access to crisis care, explaining the need for a swift crisis assessment and for all individuals who have experienced a mental health crisis. Mental health crisis should be considered to be similar to any physical health emergency
- Quality of treatment and care while in crisis focuses on providing the necessary support and treatment to patients with respect, while at the same time providing effective treatment that will improve patient recovery in the setting where patient feel comfortable
- Promoting recovery and prevention of future crises is the final but important stage of mental health crisis pathway, which highlights the importance of creating such mental health crisis service that will actively support patients in their recovery process and help them to learn how to prevent future crises.

The main highlight of the concordat is in the joint work with a range of national and local organisations to prevent crises from occurring in the first place, by using early intervention and prevention to meet the needs of people in a mental health crisis and enabling them to recovery (Crisis Care Concordat, 2018).

Future in Mind (2015)

A document published in 2015 by the Department of Health, Future in Mind (FIM) sets out the main goals for improving CYP mental health services by 2020 (Care Quality Commission, 2017b). The FIM supports evidence-based mental health practices with precise and efficient pathways to community-based care, including home treatments (Department of Health, 2015). Besides clear pathways, the FIM also contains further 48 recommendations, which can be summarised in five fundamental themes: early intervention, prevention and promotion of resilience; a system without tiers; better access to mental health provision; increase in level

and quality of accountability; and transparency; improvement in care for those who need it and workforce development (Care Quality Commission, 2017b; Department of Health, 2015). The document states that these themes will contribute to a reduction in the need for hospital admission, A&E's and acute care, as well as improvement in the effectiveness of the overall provision of mental health by 2020 (Care Quality Commission, 2017b).

Local Transformation Plans (LTP) for Children and Young People's Mental Health and Wellbeing (2015)

The Local Transformation Plans (LTPs) are a response to the recommendations of the Future in Mind, with guidance for the implementation by 2020 of much-needed developments in CYP mental health provision (NHS England, 2015). The LTP clearly states that CYP transformation should be locally led so that it can take into account individual CYP needs, in diverse local regions, as initially recommended by the FIM (Department of Health, 2015; NHS England, 2015). To achieve this, both statutory, private and charitable organisations will have to work in cooperation with CYP and their families to transform existing services into evidence-based and youth-friendly practices (NHS England, 2015). Also, local areas have the autonomy to prioritise which of the 123 proposed LTP plans are more urgent for transformation based on their consultations with CYP and their families (NHS England, 2015).

Five Year Forward View for Mental Health (FyFV-MH) (2016)

Informed by the recommendations of the Future in Mind, NHS England adopted 'The FyFV-MH' (Khan, 2016b) which sets out a transformation plan for existing services. This plan aims to reshape provision so that CYP mental health services provide timely and seven-day access to evidence-based practices, integrated mental health care, early intervention and prevention, and the provision of mental health care in a stigma-free and integrated environment (Department of Health, 2015). It also recommends the implementation of new models of CYP mental health provision that will improve the effectiveness of the provision and increase investment in both mental health and crisis services (National Institute for Health and Care Excellence, 2016). However, in 2018 all the Party Parliamentary Group on Mental Health launched an inquiry with the aim of understanding the progress made since the implementation and of the FyFV-MH (Youngminds, 2018b). The report showed that FyFV-MH

was able to make progress in implementing and boosting funding for IAPT and Early Intervention services for psychosis (All party parliamentary group, 2018). However, despite the view that the policy was “*a step in the right direction*”, it was also evident from the report that many gaps still remain, such as a lack of mental health support for children under five years of age, racial disparities in access to mental health services, and a lack of coverage of mental health crisis provision for CYP (All party parliamentary group, 2018). The report made a number of recommendations such as: the need for more investment in the prevention of CYP mental health disorders and the improvement of their recovery from mental health disorders; additional resources that should be directed to CYP mental health services that support complex CYP mental health needs; recognition of adverse childhood experiences on CYP mental health for the future mental health policies and need for 24/7 support from mental health crisis services for CYP mental health crisis (All party parliamentary group, 2018; Youngminds, 2018b).

Transforming Children and Young People’s Mental Health Provision: Green Paper (2017)

The recently published “Green Paper” is the government’s latest response to issues with CYP mental health and CAMHS provision (Department of Health and Education, 2017). The Green paper aims to improve early intervention and prevention by establishing mental health support teams that will be present in the schools and colleges and deliver low-intensity therapy to CYP as needed to prevent further escalation of their mental health while also acting as a link between educational settings and CAMHS (Whitney & Hutchinson, 2020a). In addition, the Green paper’s primary objective is to ensure shorter waiting times for CYPs needing access to mental health services (Secretary of State for Health and Education, 2017). According to the Green Paper, all CYP should be assessed and treated by CAMHS within four weeks of referral (Whitney & Hutchinson, 2020a). However, the four-week period placed by the government is ambiguous as it is unclear whether this specified period relates to the time for assessment or time for starting treatment (Whitney & Hutchinson, 2020a). Conversely, in reality, for many CAMHS services and mental health providers, an assessment appointment is considered to be the first appointment, and most reports point to a significant delay between the assessment and the actual start of treatment, while for other providers, the assessment is considered to be the start of the treatment (Whitney & Hutchinson, 2020a). Furthermore, the document also

indicates that there is a great need to improve the provision of mental health for YP aged 16-25, with an emphasis on the prevention of mental health illness, and an increase in support both for CYP and their families (Secretary of State for Health and Education, 2017). However, the current document is only a starting point for much-needed change, which, according to the British Psychological Society is a *“late and insufficient response to more urgent pressing issues with current funding and the state of CYP mental health provision”* (BPS, 2017). It is also evident that these mental health support teams serving schools will not cover the whole of the UK until 2022-2023, while there may be still a wide variation in how these teams operate in different geographical areas in the UK after 2023 (Whitney & Hutchinson, 2020a).

The NHS Long Term Plan (2019)

The Long-Term plan was created and published in 2019 as a response to the Future in Mind and FyFV-MH policy reports aimed at expanding and improving access to mental health services closer to CYP homes in an attempt to reduce waiting times and delays in providing more specialised mental health care in accordance with YP needs (NHS England, 2019b) By 2023/2024, NHS England plans to improve access for CYP aged 0-25 at their educational settings, improve existing mental health crisis service provision and implement 24/7 crisis support, along with appropriate community home-based treatments (NHS England, 2019b). In addition, CYP affected by Eating Disorders will have a similar 95% referral to treatment standards as planned to be achieved in 2020/2021. More importantly, it is clear that this plan also committed to addressing YP’s transitional gaps by implementing more 0-25 models to prevent “cliff-edge” transitions from CAMHS to AMHS (NHS England, 2019b).

The Long-Term plan also aims to shift care models to more preventive care, closer integration of community services, better coordination of urgent and emergency care to reduce the pressures on A&E’s (Alderwick & Dixon, 2019). Additional improvements are also evident in this plan to address more priority issues such as mental health and dealing with inequalities regarding the accessibility of mental health services (Alderwick & Dixon, 2019). Although the long-term plan is ambitious in its scope, the question remains as to whether the NHS can deliver on its committed plans?

Barriers and Challenges with the transformation of current CAMHS service provision

Despite visible steps towards transforming CYP mental health care in the UK, there are significant barriers that could affect the successful implementation of mental health and crisis provision. Some of the challenges currently facing CYP mental health services include lack of support for early interventions; fragmented services; commissioning challenges; difficulty involving hard-to-reach patients and complex co-morbidity with crisis services and creating appropriate and timely crisis care settings (CAMHS Benchmarking report, 2013; NHS England, 2015).

The Education Policy Institute has also published a transformation performance report, which established the effectiveness of CAMHS services in the UK in improving CYP mental health services based on transformation plans and the Future in Mind recommendations. The results of this report show that 73% of Clinical Commissioning Groups (CCG) failed in their attempts to achieve given targets for required improvement (Firth, 2017). The report also highlighted a wide variation in the quality of local transformation plans, issues related with the funding distribution, referrals to specialised services deemed inappropriate and difficulties in receiving timely treatment due to waiting times (Crenna-Jennings & Hutchinson, 2018).

A number of different research studies have highlighted gaps such as data availability and transparency issues that are perceived as key barriers to improving CYP mental health service (Care Quality Commission, 2017b). The Education Institute also reported that in 2018 it was difficult to assess whether there were any new improvements with CAMHS services since the implementation of the policies mentioned above (Crenna-Jennings & Hutchinson, 2018). However, similar issues have also been evident in the recent report, showing that the median waiting time from referral to start of the treatment has decreased by 11 days since 2015 in 2018-2019 (Whitney & Hutchinson, 2020a). However, CYP were forced to wait for an average two months to receive treatment, which is still double the amount of time of the four-week standard as proposed by the government (Whitney & Hutchinson, 2020a). These data confirm that despite significant UK government expenditure on CAMHS since 2015, the current CAMHS system continues to fail to meet CYP mental health needs nationwide (Whitney & Hutchinson, 2020a).

Despite a wide range of UK policies from 2014 until now , it remains evident that there are still some gaps in the provision of CYP mental health services and there is a need to overcome these gaps. Although there is a wide-recognised need for early intervention and prevention of CYP mental health services in the community, there are still gaps in the nationwide service delivery that will meet CYP's ever-changing mental health needs. Previously introduced global and UK prevalence data support the need for more early intervention and prevention service models to address CYP mental health needs between 0-25 years. As a result, the implementation of the NHS Long-term plan could potentially be a viable way to ensure that CYP receive appropriately funded CAMHS services that will address their mental health and emotional needs within that given age range. Indeed, early intervention and prevention services have the potential to prevent the escalation of CYP mental health issues to long-term and chronic conditions. These services' benefits are evident and will be further explored in the following section.

1.3.5 Early intervention and prevention

Scientific evidence has well recognised early intervening and preventing of CYP mental health illnesses as a key element in minimising or reducing the impact of any potentially serious CYP mental health disorders (Colizzi, Lasalvia, & Ruggeri, 2020). Early Intervention and prevention can be defined as a set of appropriate actions taken to prevent or identify particular mental health problems before they escalate further by reducing the risk factors and increasing CYP protective factors (Early Intervention Foundation, 2017). The main focus of early intervention and prevention is to identify 'at risk' CYP groups that may develop some form of mental health illness during their developmental trajectory (UK Parliament, 2013). Thus, early screening and detection interventions can help develop more effective pathways of care that act (rather than react) by taking action long before specific mental health disorders become a chronic and life-long issue while preventing the onset of mental health disorders at their roots (Marmot et al., 2008).

This particular strategy also involves family members to help them learn how to support their children and provide them with a set of skills and knowledge to manage mental health issues (Early Intervention Foundation, 2017). Therefore, early intervention and prevention are considered a co-operative approach based on a multi-level and holistic approach (Early Intervention Foundation, 2017). Additionally, this strategy is seen as a cost-effective strategy that has the potential to improve the quality of life of CYP and their families and prevent mental health conditions from becoming chronic by intervening before a crisis point (Early Intervention Foundation, 2017). Early intervention and prevention can also be tailored to provide personalised care at specific stages of CYP illness and therefore, meet individual needs (Schleidgen, Klingler, Bertram, Rogowski, & Marckmann, 2013).

Furthermore, early intervention and prevention models are usually categorised as universal or targeted services that are equally important for CYP mental health (Adolescent Psychiatry Committee AACAP US, 2017). Universal models are types of services designed to facilitate prevention and identify the particular presence of initial signs and symptoms of mental health issues in CYP, as well as their families (Care Quality Commission, 2017a).

Despite the apparent need for early intervention and prevention service in the UK as seen from previous sections, the lack of early intervention and prevention services in the local communities across the country is also evident. Although early intervention and prevention received more support and recognition from the government, many services still lack funding (Khan, 2016a). This may lead to a situation where CYP are unable to access adequate early support or help, what can consequently further deteriorate their mental health, lead to relapse and further increase demands for hospital admissions and crisis services (The Kings Fund, 2015). However, the potential of these services is recognised by the implementation of various CYP mental health services models such as 0-25 (Birchwood et al., 2018), 0-19 (Vusio, Thompson, Laughton, & Birchwood, 2020), 12-25 (Muir et al., 2009; O’Keeffe, O’Reilly, O’Brien, Buckley, & Illback, 2015) and Early intervention psychosis services (McGorry, Bates, & Birchwood, 2013) both in the UK and worldwide. Based on all the evidence presented in this chapter, there is a clear need to continue developing and improving CYP mental health service models capable of implementing early intervention and prevention strategies to improve CYP mental health and wellbeing.

1.3.6 What is a mental health crisis?

The term ‘Mental Health Crisis’ (MHC) is well-defined as a response, limited in time to specific adverse situations or life events (Caplan, 1961; Caplan & Caplan, 2000). It is a response that leads to overwhelmingly high levels of distress for affected individuals, making people unable to cope daily with a particular situation or source of crisis (Caplan, 1961). Alternatively, MHC can be defined as ‘a mental health breaking point’, or a situation where people cannot control their emotions or behaviours, and cope with a crisis source (Hubbeling & Bertram, 2012). Most psychiatrists define MHC as a medical emergency (Smith & Leon, 2001).

As a result, an individual affected by mental health crisis may often exhibit unusual behaviours such as feeling paranoid, hearing voices or hurt itself or others nearby (NHS East of England Clinical Networks, 2017). MHC cannot be observed as a mental health disorder or illness (Paton et al., 2016a). Instead, a crisis occurs more as a short-term acute response to particular overwhelming stimuli, event or source, due to disruption of the psychological balance or homeostasis and lack of coping mechanisms (NHS East of England Clinical Networks, 2017;

Paton et al., 2016a). Therefore, it is important to emphasise that, despite age, socio-economic status, or culture, everyone can experience an MHC, and it may occur to all individuals several times throughout their lives (Smith & Leon, 2001). Despite the possibility that anyone can experience an MHC, MHC experience is closely linked to an individual perception of the situation that causes a crisis in the first place. This is particularly important for CYP crisis service, as CYP may have different symptoms of the crisis compared to adults as a crisis for one person is not necessarily a crisis for another person (NHS East of England Clinical Networks, 2017; Smith & Leon, 2001).

Young people and mental health crisis

For YP, MHC can be experienced as a part of an ongoing mental health problem that contributes to MHC due to combination of various external or internal factors (Smith & Leon, 2001). Alternatively, some YP may experience distress before self-harm what can result in an escalation of their mental health to a crisis, while others may reach crisis after losing control over their lives or in this case self-harm, leading to increased levels of distress and concerns about their safety (Smith & Leon, 2001). Other YP can also experience mental health crisis due to underlying psychiatric disorders such as psychosis, depression and eating disorders, or due to culmination of a range of adverse life circumstances such as family breakdowns, chronic illness or bereavement (Smith & Leon, 2001). However, research evidence suggests that most YP with MHC presentations are those who attend urgent and emergency settings due to underlying psychosis, depression, self-harm, overdose and eating disorders (Street, 2000). Therefore, it is evident that MHC in YP can be observed as both social and psychiatric perspective of crisis, as social crisis such as homelessness or experience of being bullied can trigger a psychiatric crisis, while a psychiatric crisis can result in homelessness or experiences of education difficulties which can also cause a social crisis (Smith & Leon, 2001). However, most YP who experience MHC have reported issues with accessing crisis intervention and support services, and many of YP only come to the attention of these services when YPs already experience breaking points (Smith & Leon, 2001).

Mental health crisis services and crisis care

One can define mental health crisis service as any type of mental health service capable of responding quickly to an individual experiencing a mental health crisis with short-term intervention to help an individual to overcome their breaking point (NHS East of England Clinical Networks, 2017). These types of mental health services are available both as statutory or voluntary provision, classified as “Tier 3.5”; Paediatric Liaison Teams; 24/7 Crisis services with home treatments and Intensive Community CAMHS service (see Table 2) (NHS East of England Clinical Networks, 2017). These types of mental health crisis provision have the overall aim of providing a person-centred approach, based on an appropriate assessment with the least restrictive support available while promoting patient self-management of their mental health. Such mental health crisis services should be governed by working effectively in a multi-agency environment, where services can learn from experience (NHS East of England Clinical Networks, 2017).

As a result, crisis services should work towards understanding the nature of the presented crisis, its causes and severity (NHS East of England Clinical Networks, 2017). Although most of these services were initially developed for the adult population, they may be useful in designing conceptual models of crisis services specifically for CYP mental health needs. However, it is important to highlight that Crisis Resolution Teams (CRTs) started in the UK in 2000 with very limited evidence base (Hubbeling & Bertram, 2012), which is still limited today, especially for CYP under the age of 0-25. Nevertheless, research evidence shows that these services are still a better alternative to acute in-patient settings (Vusio, Thompson, Birchwood, & Clarke, 2019).

Table 2. An overview of existing Crisis services for both CYP and adult population in the UK

Model	Description	Source
Paediatric Liaison Teams (PLS)	PLS provide assessments in urgent and emergency situations such as self-harm or overdose. They also provide support with the management of mental health in cases of chronic physical and mental health conditions. PLS are embedded in acute hospital settings providing crisis assessments through multidisciplinary liaison and offering interventions to avoid or reduce the need for inpatient admission.	NHS East of England, 2017
24/7 Crisis Care Home Treatment Teams (CHTT)	CHTTs manage and risk assess YP with complex mental health needs with the aim of reducing the length of stay in an inpatient setting (i.e. facilitating early discharge from inpatient units) and supporting post-discharge from inpatient units to YP and preventing readmissions or relapse of mental health crises. Some CHTT are successful with YP's treatment engagement that would not otherwise engage in help-seeking from inpatient or outpatient services.	NHS East of England, 2017
Tier 3.5 or Tier 3+ Teams	Crisis services offering assessment, intervention and support to YP experiencing complex mental health issues. The initial assessment may be offered in A&E, Hospital or community settings. Following assessment and support and appropriate intervention are offered to YP at their local community and homes to ensure their safety and that their mental health needs are met.	NHS East of England, 2017
Assertive Outreach Teams (AOT)	Team working within the community to prevent hospital/psychiatric admission, while trying to deliver YP assessment, treatment and signposting in their own home. Their holistic approach allows AOT to support not only YP but also their families in coping and managing YP mental health issues while preventing the possibility of mental health crisis relapse.	NHS East of England, 2017
Crisis Houses	Teams located in community settings, fully trained and staffed to deal with mental health crises that admit patients who would otherwise be admitted to in-patient settings. These teams are representing alternatives to psychiatric hospital admission. Limited research indicates that this alternative is more cost-effective than hospital admission and more acceptable to its service users.	Thornicroft and Tansella, 2004
Mobile Crisis Resolution and Home-Treatment Teams (CRHTT)	Community mental health implemented to offer assessment for YP in a mental health crisis and providing YP with short but intensive treatment at YP homes. Some evidence suggests that these teams may reduce duration and length of stay in hospital and instead provide regular home visits and community-based treatment.	Thornicroft and Tansella, 2004
Crisis Telephone lines and support	Often, they operate as a part of Crisis Intervention teams or voluntary sectors, working throughout the week, while some operate at night and weekends. The telephone support lines act as a point of access to the service and to receive immediate support in case of a mental health crisis.	Smith and Leon, 2001

Mental health crisis pathways of care

According to Future in Mind (2015), mental health crisis pathway should be clear and based on the best evidence-based practice to prevent unnecessary admissions of CYP into A&Es or hospital settings (Department of Health, 2015). However, the Crisis Concordat (Mental Health Crisis Concordat, 2014) provides a definition of what mental health crisis pathway should encompass using key four stages that should be integrated into crisis pathway:

- Access to support before reaching crisis point
- Urgent and emergency access to crisis care,
- Quality of treatment and care whilst in crisis
- Promoting recovery and prevention of future crisis

However, in their review, Paton et al. (2016) indicated that the above-mentioned elements of crisis pathway are limited due to the lack of methodologically led mental health crisis care evaluations. Evidence from high-quality studies would reduce “vagueness” and point to models that are most effective and efficient with appropriate crisis interventions for individuals experiencing a mental health crisis (Paton et al., 2016a).

Appropriate crisis intervention is underpinned by a sound crisis plan to improve CYP coping in the crisis and maximising their resilience to future crises (NIMH, 2018). This can also prevent a relapse leading to a “revolving door syndrome” where CYP are readmitted back to a crisis service or hospitalisation (Wise, 2017). However, the effectiveness of crisis pathways or crisis services can be challenging to determine, primarily because there is high variability between existing crisis services and their pathways (Fellow-Smith, 2016). Moreover, research on the effectiveness of CYP crisis services and their pathways has been lacking (Fellow-Smith, 2016).

Furthermore, the National Collaboration Centre for Mental Health (NCCMH) is tasked with developing a guideline for CYP mental health crisis care pathways based on the best evidence-based practices (Cotgrove, 2018). Once published, this guideline should define what is effective and efficient mental health crisis pathways and describe how to meet the needs of CYPs in a mental health crisis (Cotgrove, 2018).

1.3.7 Relapse and recovery

It is realistic to expect that most CYP will recover after being discharged from mental health or crisis services (Department of Health Australia, 2009). However, it is also realistic to expect that a certain percentage of CYP will experience periodic relapses of their mental health problems after discharge (Department of Health, Australia, 2009). Our knowledge of CYP relapse rates is underpinned by psychiatric studies of inpatient discharge and predicted rates of re-admission and relapse (Geller et al., 2001). Literature evidence suggests that most readmissions (81%) occur within 90 days of acute-care hospital discharge (Blader, 2004a). The risk of relapse is highest within the first 12 months of being discharged from acute/inpatient care (Majid et al., 2016). Moreover, recovery from the mental health crisis is an essential step towards understanding factors that govern the crisis itself and predicting and preventing the possibility of future crisis or relapse (NIMH, 2018). Alternatively, mental health crisis services should be focused on teaching CYP how to self-manage their condition, provide change and learning opportunities for successful future self-management (East of England, 2017). CYP who would be successful in self-managing their condition could easily be taught to recognise particular triggers or early signs that precipitate crisis or potential relapse, reducing, therefore, their future needs for accessing acute, inpatient or crisis care settings (NHS East of England Clinical Networks, 2017).

1.3.8 Identified gaps in the literature

In this chapter, seven gaps in the existing literature have been identified that the next chapters in this thesis will further try to answer to fill these gaps in our existing knowledge.

Lack of knowledge about the acceptability and effectiveness of alternative retransformed CYP mental health models within the UK

Despite some evidence that some retransformed CAMHS services meet the UK's policies (McGorry et al., 2013), there is still a lack of research evidence regarding their effectiveness. The literature review showed that some of the worldwide models such as Irish Jigsaw (O'Keeffe et al., 2015) and Australian Headspace (Hilferty et al., 2015) have some evidence regarding

their effectiveness. However, this literature review failed to identify any articles that reported how much these alternatives and retransformed models in the UK are accessible, acceptable and effective. Similarly, there is also an evident gap in our understanding of how much CYP and their parents are satisfied with these newly reformed models. Likewise, there is also evident gaps in our understanding of how much these new retransformed models can be considered as potential solutions for key issues with existing CAMHS in the UK, as mentioned earlier in this chapter.

Lack of knowledge about existing CYP mental health crisis models within the UK

A systematic review by Shepperd et al. (2009) was one of the first in the UK to explore alternatives to inpatient and acute care. Home-based crisis interventions were found to produce a slight improvement for CYP undergoing a crisis, with insufficient evidence to assess the effectiveness of these alternatives to acute/inpatient care (Shepperd et al., 2009). The systematic review concluded *“The evidence we now have provides very little guidance for the development of these types of services”* (Shepperd et al., 2009). Another systematic review (Paton et al., 2016) examined four main objectives by following the recommendations stated in the Crisis Concordat (2016). It identified only one systematic review (Shepperd et al., 2009) that examined CYP mental health crisis services, with predominantly low-quality evidence (Paton et al., 2016). However, the review made by Paton et al (2016) identified current gaps in access to support, before reaching a crisis point and urgent or emergency access to the crisis (Paton et al., 2016,). Review by Paton et al (2016) is one of the most comprehensive systematic reviews of the current mental health crisis provision. According to Paton et al (2016), more studies are needed to assess the clinical effectiveness of crisis care and post-discharge experience. At present, there is no accurate representation of the availability and effectiveness of CYP mental health crisis care models available in the UK.

Lack of CYP experiential findings of navigating the mental health crisis services in the UK

This literature review showed that there is currently a lack of research literature in the UK specifically addressing the experiences of CYP and their parents travelling through crisis services, from the point of referral to the point of discharge from mental health crisis services.

To the best of knowledge, this literature review was unable to identify any studies describing CYP/parental experiences of navigating through the UK or worldwide mental health crisis services models.

Lack of professional service users' experiential findings of the accessibility and acceptability of crisis service provision for CYP

Similar to the aforementioned gap, this literature review was unable to identify any research evidence on the experiences of CYP, their parents/carers and local community professionals with accessibility and acceptability of mental health crisis services in the UK. In addition, since patient satisfaction is an important outcome measure (Hubbeling & Bertram, 2012), stakeholders satisfaction with CYP 's mental health crisis provision was also identified as an evident gap in the existing literature.

Gap in understanding the roots and impact of the mental health crisis on the overall family and their functioning

Despite some evidence from the other studies, there is still insufficient evidence to understand the primary roots of a mental health crisis, the impact on the individual affected by the breaking point, the impact of the CYP crisis on the family and their overall functioning. This gap was also evident in the review by Paton et.al. (2016), who recommended that future research should look into access to mental health support prior to reaching a mental health crisis. Therefore, we need to understand the causes of mental health crisis and initial CYP help-seeking to inform actions of early intervention and prevention services.

Relapse and rates of the resilience of children and young people after being discharged from crisis services

There is a lack of research evidence on recovery and relapse rates with either CYP or adult populations following discharge from mental health crisis services (Paton et al., 2016a). Relapse prevention models are needed, specifically designed for CYP after being discharged from crisis services. Moreover, there is a gap in quantitative/qualitative research that addresses CYP relapse and resilience rates after being discharged from crisis services. Most of

the literature on relapse and re-admission of patients in mental health crisis back into the service is from acute and psychiatric admissions for the adult population (Werbelloff et al., 2017). However, we still do not know how good crisis services are in terms of improving resilience and recovery in CYP, as well as prevalence rates of CYP relapse post-crisis discharge.

Lack of research evidence of the effectiveness of crisis mental health services

Finally, there is a lack of published and methodologically led service evaluations from existing CYP mental health crisis services. Due to limited evidence on the effectiveness of CYP crisis services, it is crucial to *“combine rigorous measures of service provision and an appropriate set of outcome measures to establish the effectiveness of the crisis services for CYP”* (NHS East of England Clinical Networks, 2017). This should ensure that the crisis pathways are both effective and efficient.

1.3.9 Chapter summary

This chapter introduced the purpose and structure of the thesis and set the scene by outlining the mental health prevalence data for CYP in national and international contexts. Prevalence data showed early onset of mental health issues in early adolescence, further supporting the need for early intervention to prevent escalation of YP mental health and facilitate recovery. This chapter also introduced the current condition of CAMHS services in the UK and the main weaknesses associated with the CYP's mental health provision. A range of barriers to access and potential facilitators (i.e., therapeutic alliances) to help-seeking behaviours were examined. This also set the stage for outlining a range of different policies brought forward in the UK to improve overall mental health services and their provision to meet CYP needs. A gradual step has been taken since implementing these policies to re-transform existing service provision, paving the way for newly introduced service models in the UK (i.e., 0-25, 16-24 and 0-19 models). The importance of early intervention and prevention was introduced in the last part of this chapter, along with defining mental health crisis, and outlining existing CYP crisis models in the UK. The concept of mental health crisis pathways was also introduced, as well as definitions of recovery and relapse. The main conclusion of the literature review showed that mental health crisis models for CYP can promote the least restrictive treatment in the community, act as the gatekeepers for admission and improve recovery rates. However, a number of gaps in our understanding of mental health crisis provision for CYP in the UK were evident.

Chapter 2: The 0-19 model and its adaption to the population of Solihull, UK

2.1 Chapter outline

The previous chapter introduced CYP mental health prevalence rates, both in the UK and worldwide, and provided an overview of the current state of CAMHS services in the UK. The previous chapter also highlighted a number of weaknesses in the existing CAMHS system, as well as gaps in the research literature, and provided the rationale for the transformation of these services. This chapter will introduce the exemplar 0-19 model called ‘Solar’, which is based in Solihull in the UK, and will discuss its potential for improving mental health services in the UK. Initially, the demographics of Solihull will be discussed, along with the rates of mental health disorders in the area and the local policy context. Once a research setting is established, the rationale for commissioning the 0-19 model will be discussed. The final part of this chapter will introduce the evolution of the 0-19 model and its crisis service and outline their organisation, roles, and responsibilities.

This chapter was published in *Early Interventions in Psychiatry* journal in abbreviated form (Vusio et al., 2020) prior to submission of the thesis. The published article is included in **Appendix-1**.

2.2 The Solihull population and setting

In the West Midlands, Solihull is one of the most affluent towns in a local, regional, and national context (Solihull Observatory, 2019). Solihull is also located next to Birmingham, and is close to Warwick and Coventry (Solihull Observatory, 2019). Because of its proximity to Birmingham, the UK’s second-largest city, Solihull has experienced a further increase in the diverse ethnic population, which currently comprises 11% of the total Solihull population since 2011 (Solihull Observatory, 2019).

However, Solihull is less diverse than Birmingham and the rest of England, but there is a noticeable rise in the high proportion of YP from a BME background, which currently represents 17% of those aged 15 and younger (Solihull Observatory, 2019).

Fig 11. Location of the Solihull borough in the England. (Source: IoD2019 Interactive Dashboard – Local authority focus)



Moreover, Solihull is also one of England’s least deprived areas, with highly localised pockets of deprived areas primarily clustered in the borough’s northern areas. The LSOA measures show that Solihull ranks in the fourth quintile nationally (Solihull Observatory, 2019). By comparison, IMD figures showed that in 2019 Solihull was 32nd least deprived borough in England, or second top quintile nationally between 2007-2019 (Solihull Metropolitan Borough, 2019a). Since 2012 some parts of North Solihull borough have been identified as lagging significantly behind the rest of the Solihull (Figure 12). These northern areas of the borough were at the bottom of the LSOA 25 % nationally deprived areas. Thus, there was an evident need to regenerate these areas to reduce inequalities and bridge the prosperity gaps in Solihull, as it was evident that more than half of young children in the North Solihull lived in poverty in this regeneration zone (Solihull council 2012).



Fig 12. Solihull aggregate prosperity geographical areas. (Solihull council 2012)

As can be seen from figure 13, the northern and the western parts of Solihull remains the borough’s most deprived area. The left map shows comparisons with the national quintiles of IMD scores in 2015; the darkest coloured areas were some of the most deprived areas in England (Public Health England, 2018). The figure also shows the population percentage living in these areas at each level of deprivation. In contrast, the map on the right shows the differences in deprivation compared to local quintiles of IMD scores (Public Health England, 2018)

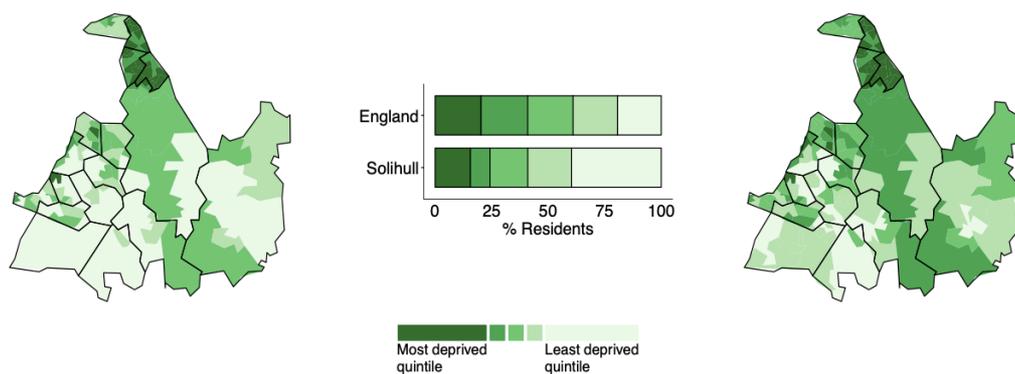


Fig 13. Deprivation in the Solihull borough (Public Health England, 2018)

2.2.1 CYP Population and demographics

ONS data also shows that Solihull has the proportion of CYP in-line with the rest of England and the West Midlands (Table 3). Future predictions estimate that between 2018-2038 the number of CYP aged 0-15 will rise by 7.1% (Table 4).

Table 3 - Solihull population estimates according to age. Source: ONS Mid-Year Population Estimates (2018)

All People aged:	Solihull population numbers	% Population		
		Solihull	England	West Midlands
0-15	42,004	19.5%	19.2%	19.7%
16-64	127,679	59.4%	62.6%	61.9%
65+	45,226	21.0%	18.2%	18.5%
All People	214,909			

ONS data (Figure 14) estimated that Solihull had 214,909 residents in 2018, an increase of 0-5% of individuals compared to 2017. Between 2008 and 2018, Solihull’s population grew by 4.9%. The CYP population in the 0-25 age group makes up 27.3% of the overall Solihull population; for the 0-19 age group the figure is 22.5% (n=51,440) with a slightly higher number of males (n=26,620) compared to females (n=24,820) (Public Health England,2020)

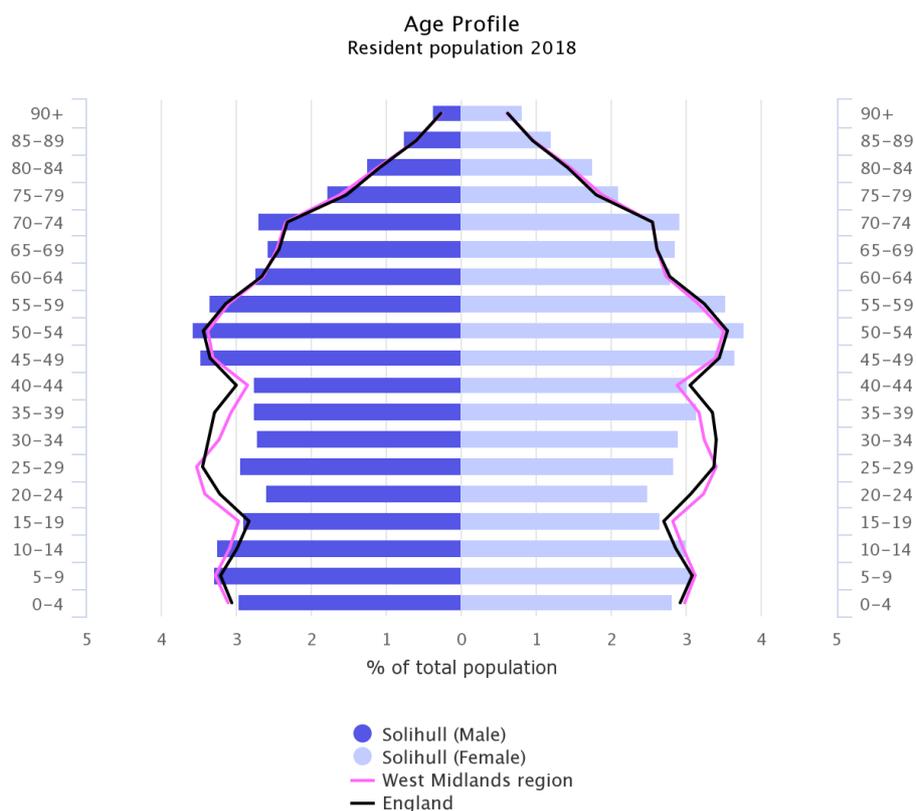


Fig 14. Solihull Resident population age profile (2018)(Source: Public Health England,2020)

Table 4 - Solihull CYP Population Projection changes for CYP aged 0-15. Source: ONS Sub-National Population projections (2016)

Year	Population	% change over the decade
2018	42,004	
2028	44,330	5.50%
2038	45,037	1.60%

2.2.2 Children in poverty

The Children in Low-Income Families Local Measure of relative poverty developed by the HM Revenue and Customs (HMRC) aims to capture the percentage of CYP who fall below the national poverty line. This measure is defined as the percentage of CYP who live in household with an income less than 60% of the UK average (median) income, or in other words, CYP who live below the national poverty line (Solihull Observatory, 2019). The 2016 HMRC reported that 6,740 children aged 0-15 in Solihull live in low-income families representing 15.3% of children in Solihull area (Table 5) (Public Health England, 2018; Solihull Observatory, 2019). This figure is below the UK (17.3%) and West Midlands (20.2%) averages. Out of the 15.3% of CYP in Solihull, most CYP (73%) live in a one parent’s low-income household, while 27% were living in a two-parent household. HMRC data also found that 17% of young children aged 0-4 are likely to live in poverty, followed by 14% of 5-10-year-olds, 12% 11-15-year-olds and 8% of 16-19-year-olds (Solihull Observatory, 2019).

Table 5 - Children in Low-Income Families in 2016 by the age of child. Source: HRMC and Solihull Observatory (2019)

Age of Child	Solihull Children	Child Poverty Rate	
		Solihull	UK
0-4	2,155	17%	18%
5-10	2,265	14%	16%
11-15	1,530	12%	16%
16-19	795	8%	10%

54% of children in Solihull live under the poverty line in the three most deprived areas in North Solihull, where the child poverty rate is 33% compared to 9% in the rest of the Solihull borough (Solihull Observatory, 2019). Furthermore, the number of children in low-income families in Solihull increased by 6% between 2015 and 2016, which is consistent with the trend observed in the rest of England and the West Midlands over the same period (Figure 15) (Solihull Observatory, 2019). LSOA and IMD figures show that there are still significant gaps in inequality in Solihull, with estimates that 1 in 6 CYPs are currently live in relative poverty (Solihull CCG, 2015).

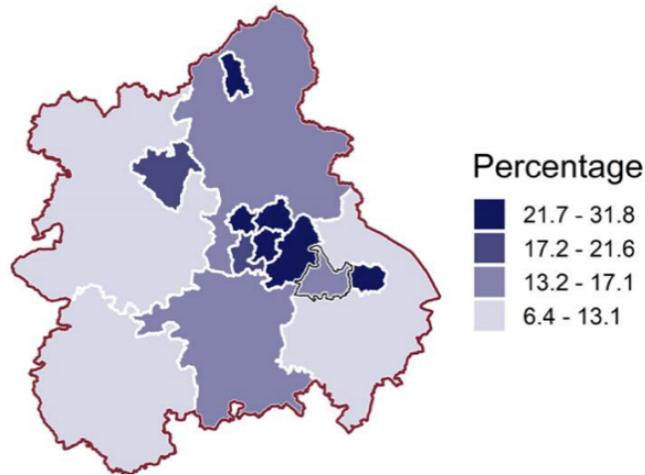


Fig 15. Map of the relative levels of children in relative poverty in Solihull and West Midlands. Source: (Public Health England, 2020)

2.3 The mental health and wellbeing of young people in Solihull

Solihull as a borough follows similar prevalence rates as the rest of England, and thus this increase in national prevalence is consistent with rising demand for the Solihull’s 0-19 model. For example, the number of referrals to the Solar service increased by 50% between 2015/2016 and 2017/2018. Similarly, the number of new referrals to CAMHS services increased visibly by 54% between 2017 and 2018 (Figure 16), compared to the same period between 2016 and 2017 (Solihull Metropolitan Borough,2019)

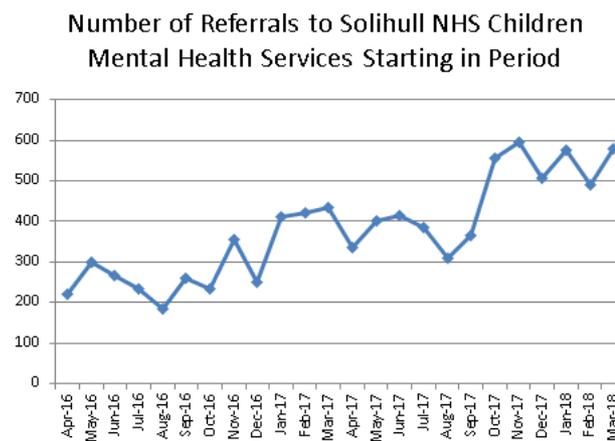


Fig 16. Number of referrals to Solihull NHS CAMHS 2016-2018 (Solihull Metropolitan Borough,2019)

High CYP hospital admission rates (Figure 17) also support high referral and help-seeking rates in Solihull for mental health reasons, which in 2016/2017 was 93.5 per 100,000, which was above average compared to the rest of England (81.5 per 100,000). Solihull hospitalisation rates were higher for males compared to females, with Solihull young people hospitalisation rates are among the highest in England (Solihull Metropolitan Borough, 2019b).

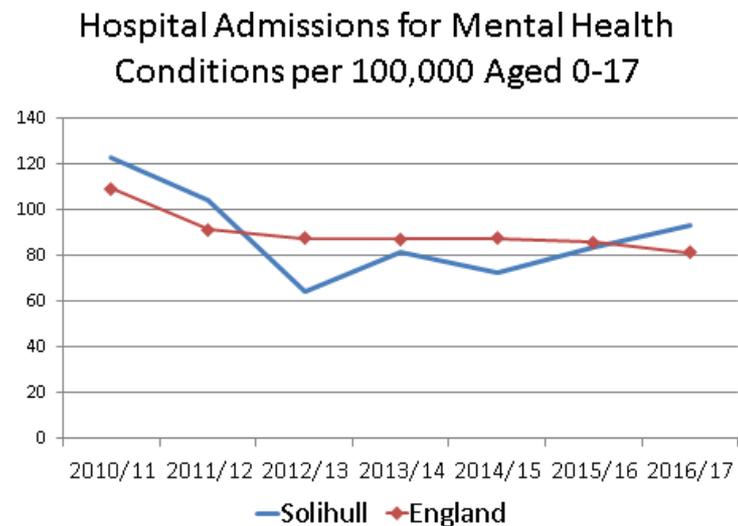


Fig 17. Hospital admission for mental health conditions per 100,000 CYP aged 0-17 in 2016/2017. Source: Solihull Metropolitan Borough, (2019b)

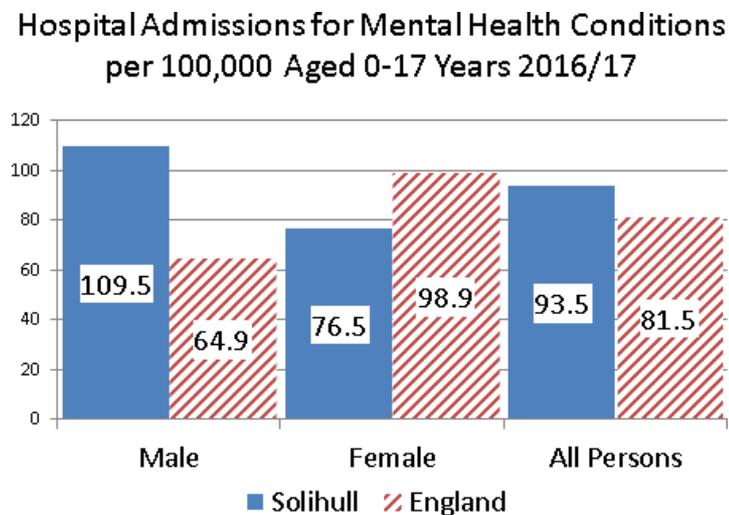


Fig 18. Hospital Admission for Mental Health conditions per 100,000 for CYP aged 0-17 between 2010/11 and 2016/17 (Source: Solihull Metropolitan Borough, 2019b)

Historically, Solihull had lower hospital admission rates, especially in periods between 2011-2013 when there was a sharp drop in 0-17-year-old hospital admissions for mental health-related issues (Solihull Metropolitan Borough, 2019b). However, this trend shifted to a 45%

increase (Figure 18) in CYP hospital admissions between the period of 2013 and 2017 (Solihull Metropolitan Borough, 2019b). In 2018/2019 the annual hospital admission rate for mental health related conditions per 100,000 for CYP aged 0-17 was 85.2 in Solihull, which was similar to the national English average of 88.3 (Public Health England, 2020). As mentioned earlier, there is a high prevalence rate of CYP hospitalisation in the Solihull, and these rates have increased in recent years with evident admissions numbers of young women and those YPs aged 15-19 (Solihull Metropolitan Borough, 2019b). For example, for CYP 10-19-year-olds in 2016/2017, it is evident that within this age group hospital admissions due to self-harm were lower than the English average but are higher for the 0-25 age range in the Solihull (Figure 19). Moreover, it is also evident that self-harm hospitalisation rates for YPs aged 20-24 are significantly higher than the average self-harm hospital admissions rates in the rest of England. Similarly, recent data also showed that 170 CYP hospital admissions (local value of 493.0) aged 10-24 were due to self-harm in Solihull last year, relatively higher than average rate of 444.0 for England (Public Health England, 2020).

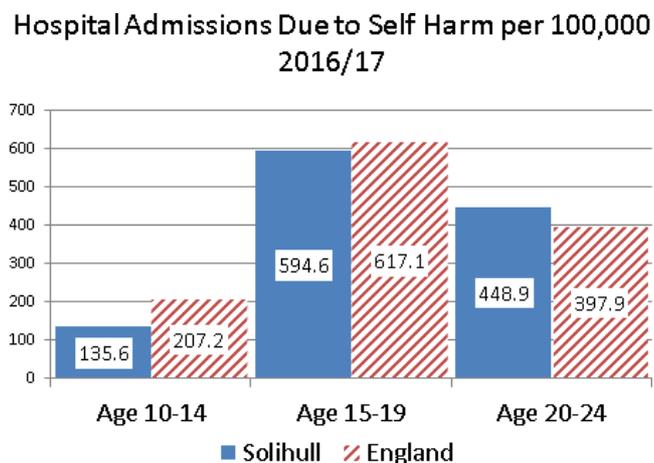


Fig 19. Hospital Admission due to Self-Harm per 100.000 2016/17 (Source: Solihull Metropolitan Borough, 2019b)

This fluctuating trend is visible in recent years and is on an upward trend for 15-19-year-olds admitted to a hospital due to self-harm (Figure 20).

Hospital Admissions Due to Self Harm per 100,000 Aged 15-19

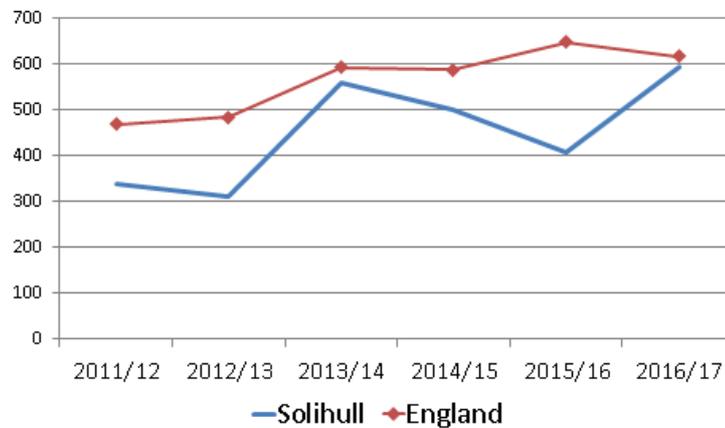


Fig 20. Hospital Admission due to self-harm per 100,000 for CYP aged 15-19 (Source: Solihull Metropolitan Borough, 2019b)

One possible explanation for such high prevalence rates in Solihull is due to deprivation, inequality, and CYP living in poverty. White ethnicity may also be a factor since it is associated with a higher risk of self-harm and subsequent hospital admission (Solihull observatory, 2019), while Solihull has a higher proportion of 0–15-year-olds who identify as white (83%) compared to the overall proportion in England (Solihull observatory 2019).

2.4 Policy context in Solihull

Significant progress has been made in improving mental health and physical care for Solihull residents since 2011, knowing that good health is not consistent across Solihull and some resident’s health has been significantly below acceptable levels (NHS Solihull CCG, 2016). In order to improve the lives of residents of Solihull, the Health and Wellbeing Strategy was initiated in 2012 based on the Marmot Framework that was found to be valuable for effective improvement and reduction of health inequalities. The Marmot Review was crucial to the recognition of the social environment as a determinant of health, and the acknowledgement of inequalities in the socio-economic distribution of health (Marmot et al., 2010). It also led to the identification of health and wellbeing priorities by the Joint Strategic Needs Assessment (2012-2019) and the Early help Needs Assessment (2014-2016) (NHS Solihull CCG, 2016). These priorities were based on an understanding of a broader range of factors such as social,

environmental and economical over which individuals often lack (or have very little) control and are thus the main determinants of individual health (NHS Solihull CCG, 2016).

Furthermore, Birmingham and Solihull's health and care systems have joined forces to develop a Sustainability Transformation Plan (STP) to address care services' quality gaps that potentially have a positive effect on residents' health and wellbeing, while complying with NHS FyFV national policy (NHS Solihull CCG, 2016). The Solihull council recognised the need for a collaborative approach with STP to make a difference and substantial changes to the lives of Solihull residents and give every child the best start in life (NHS Solihull CCG, 2016). This policy continued to focus on the local "place-based" and "life-course" approach and kept working in partnership with STP to deliver its renewed strategy (2019-2022) with three additional emphases on maternity, childhood, and adolescence; adulthood and work; ageing and later life (NHS Solihull CCG, 2019). Efforts are focused on the continuation of regeneration in the most deprived North Solihull areas, and reductions of hospital admissions for CYP with mental health difficulties (NHS Solihull CCG, 2019).

2.5 Rational for retransformation of previous CAMHS service and new service design

The former Solihull CAMHS service model 0-17 was run in collaboration with several different providers under a four-tier system (Solihull CCG, 2015). However, a 2014 review of Solihull CAMHS showed very little evidence of the existence of the whole-system approach between prevention and more specialised services, lack of support between primary and specialised mental health service, and lack of an integrated partnership between statutory and voluntary sectors (Solihull CCG, 2015).

Several additional factors also indicated that the previous CAHMS model needed service transformation. These included no defined early intervention/prevention procedures, the existence of barriers to accessibility, the lack of 24-hour crisis service, and the transition of YP to AMHS based on age rather than individual needs (Solihull CCG, 2015).

Moreover, during the previous model of care, the gap between services was evident as CAMHS provided a service up to 17 years, while the AMHS provided a service from 18 years onwards (Solihull CCG, 2015). The service had had 1194 referrals in 2014, with an overall acceptance rate of 55% (662 patients) and waiting times of six to nine weeks on average (Solihull CCG, 2015). More importantly, feedback obtained from CYP and their families highlighted previous service's inaccessibility and inefficiency (Solihull CCG, 2015). Therefore, these factors were clear indicators that the 0-17 model did not meet CYP's mental health needs and was very much in need of transformation.

Foundations for the new 0-19 model were laid in 2014 before the UK government officially published national policies in *Future in Mind* and *FyFV-MH* (Vusio et al., 2020). However, in 2015, Solihull council began retransforming its CAMHS model, guided by recommendations from these two policies and in collaboration with Birmingham and Solihull Mental Health Fund Trust (BSMHFT) (Solihull CCG, 2015). The main goal of this transformation was to design and create an all-inclusive system to meet CYP's needs while working in partnership with both statutory and voluntary sectors to deliver the early intervention, prevention and resilience development in the familiar, stigma-free and community-based environment (Solihull CCG, 2015). Moreover, the transformation also had a goal to remove "cliff-edge" transitions for CYP moving to AMHS and improve their transitional outcomes (Solihull CCG, 2015). The newly formed transition process was structured to allow choice and flexibility to CYP needs instead of being guided by age cut-off (Vusio et al., 2020). The innovative transition element of this service model is its flexibility to support CYP up to the age of 21 if their initial transition is unsuccessful or if CYP are not ready to make a transitional step at the age of 19 (Vusio et al., 2020).

The transformation resulted in the development of an integrated-whole system that moves away from a high acceptance threshold service to an emotional and wellbeing mental health service (Vusio et al., 2020). The new service model aims to provide better access to CYP's mental health needs and a community-based model that works in partnership with both statutory and voluntary sectors as recommended by national policies and guided by local needs (Vusio et al., 2020).

2.6 Structure and organisation of the 0-19 model

The main aims of the 0-19 model are to meet the emotional wellbeing and mental health needs of CYP, and support service users to leave the service once they are ready to make their transitional step (Solihull CCG, 2015). The entire set of Solar's aims is listed in box 1.

2.6.1 Involvement of CYP in the 0-19 model's values and structure

Since its conception, the 0-19 model has been engaged in co-production and joint-decision making with the local CYP population to ensure that the newly commissioned service is attractive to CYP (Vusio et al., 2020). Collaboration between CYP and the service has resulted in several improvements to the model, such as the decision made with CYP to rename the 0-19 model to Solar service that "*brightens young futures*" (Vusio et al., 2020). In co-production with CYP, to create more youth-friendly service environments, service settings were made to look less clinical and more appealing to their service users. Service users were also significant contributors to the development of "Your journey through the Solar" publication (Solar, 2016) aimed at informing other CYPs who have never been engaged with Solar service what their journey through the Solar system may look like (Vusio et al., 2020).

In addition, CYP service users also participated in the recruitment of new staff members. The Solar service is also engaged in the annual "You in mind" conference to gain feedback from its service users and the opinions of their families on what needs to be changed and improved with the existing service or its provision (Vusio et al., 2020). Indeed, the involvement of the service stakeholders in service organisation and design has contributed to a better service environment that not only seek to meet the service users' needs but also actively involves them in attempts to adapt the model and its service provision to encompass ever-changing CYP mental health needs.

- Provide and use a Single Point of Access (SPOA) while providing advice and information on emotional wellbeing and mental health services in Solihull and online;
- Enable timely access, innovative provision and a friendly environment for its service users and their families;
- Provide service users with a choice of evidence-based practices and treatments that are appropriate for CYP with mental health problems;
- Provide services that address and meet the mental health and multiple complex CYP needs;
- Provide more intensive community services and provision for CYP who are at risk of being admitted to in-patient services due to poor mental health;
- Provide specialised assessments and therapeutic interventions for looked after and adopted CYP with a range of emotional and mental health problems and work with foster carers, social workers and a range of other stakeholders;
- Create and provide a safe environment for CYP for assessment, treatment, and support, including those CYP sectioned under 135 and 136 of the Mental Health Act;
- Provide and offer appropriate out-of-hours advice and assessment for CYP presenting at the hospital or in the community with deliberate self-harm, overdose or CYP suffering from serious mental health illnesses, and liaise with the medical and hospital wards in cases when CYP are being admitted to inpatient settings to accelerate their discharge or onward referral as and when appropriate;
- Involve parents and CYP in their care, while providing jargon-free information about the nature of their problems and the different interventions and options available to them, agreeing on the goals of interventions with them; provide them with written assessment and plans, while taking into account their own mental health needs of CYP and the family unit; supporting access to appropriate adult services when required and provide support to parents and carers to understand and manage their children's needs, while promoting and building resilience to sustain recovery and prevent future relapses;
- Work closely with primary and community health services, and wider children's services, including schools and a wide range of agencies, to ensure effective and holistic multi-agency approach in working with CYP using the Solar Service, including those Look after of adopted CYP;
- Publish jargon-free and plain English information about emotional wellbeing and mental health services in Solihull, so that CYP, their families and professionals can understand what services are available to them and how to access them, including web-based resources;
- Work with partners to deliver training for professionals across the Children's Workforce;
- Manage and provide a range of the Solihull's parenting programs and co-delivered them in cooperation with parents and partners;
- Ensure excellent customer service and experience to service users at transition points from acceptance until discharge from Solar, and on return to community-based mental health service upon discharge from inpatient settings. This includes ensuring that all CYPs have written and agreeable discharge plan at the discharge point;
- Ensure that YP have positive experiences of transition between providers and that the agreed transition protocol has been followed, followed by check after six months to make sure that the transition has proceeded smoothly;
- Measure the effectiveness of the Service, regarding the impact that Solar has on its service users, their families and the local community, and further develop evidence-based practices that will inform future service development and service provision;
- Work together with CYPs and families to design and create care pathways, and involve them in evaluation and feedback, and to monitor their complaints;
- Ensure that the Solar Service meets the expected NHS and public sectors standards regarding staff, their development, and professional growth and to provide reports to local and national organisations when needed.

2.6.2 The Solar service organisational structure

As an emotional and wellbeing mental health service, Solar uses a multidisciplinary and early intervention approach to assess and treat its service users who experience a range of mental health difficulties in the least restrictive and community-based settings (Vusio et al., 2020). To successfully achieve these activities, the model works in partnership with the NHS CAMHS service operated by BSMHFT, the Primary Mental Health Service (PMHS) run by Barnardo's, and Autism West Midlands (AWM), which provides additional support for learning disabilities and education for CYP and their families (Vusio et al., 2020). The overarching component working in cooperation with all three partners is a crisis-home treatment service, which acts as a gatekeeper for the prevention of hospitalisation and providing crisis resolution treatment and management of mental health crises in community-based settings (Vusio et al., 2020). All staff from these services work together under the same umbrella of the Solar service, supported by a number of additional services such as "looked after children", parental and infant mental health, eating disorders, learning disability service and physical health service (Vusio et al., 2020).

A single service-wide governance arrangement ensures a coherent organisational structure and a consistent approach without gaps in-between services through which CYP may fall (Vusio et al., 2020). This service arrangement and partnership with voluntary and statutory sectors incorporated into its organisational structure makes Solar an innovative model (Figure 21). Furthermore, the Solar partnership ensures that service users are not exposed to long waiting times for other externally located services, unless necessary, while creating a system that is safe, effective and responsiveness to service user's mental health needs by providing an adequate level of care (Vusio et al., 2020). According to the 0-19 model, the organisation structure and approach of this service reduced treatment delays and non-attendance to appointments. Also, as CYP have to tell their stories only once, they move rapidly between different parts of the Solar system as recommended by the Future in Mind publication (Department of Health, 2015; Vusio et al., 2020).

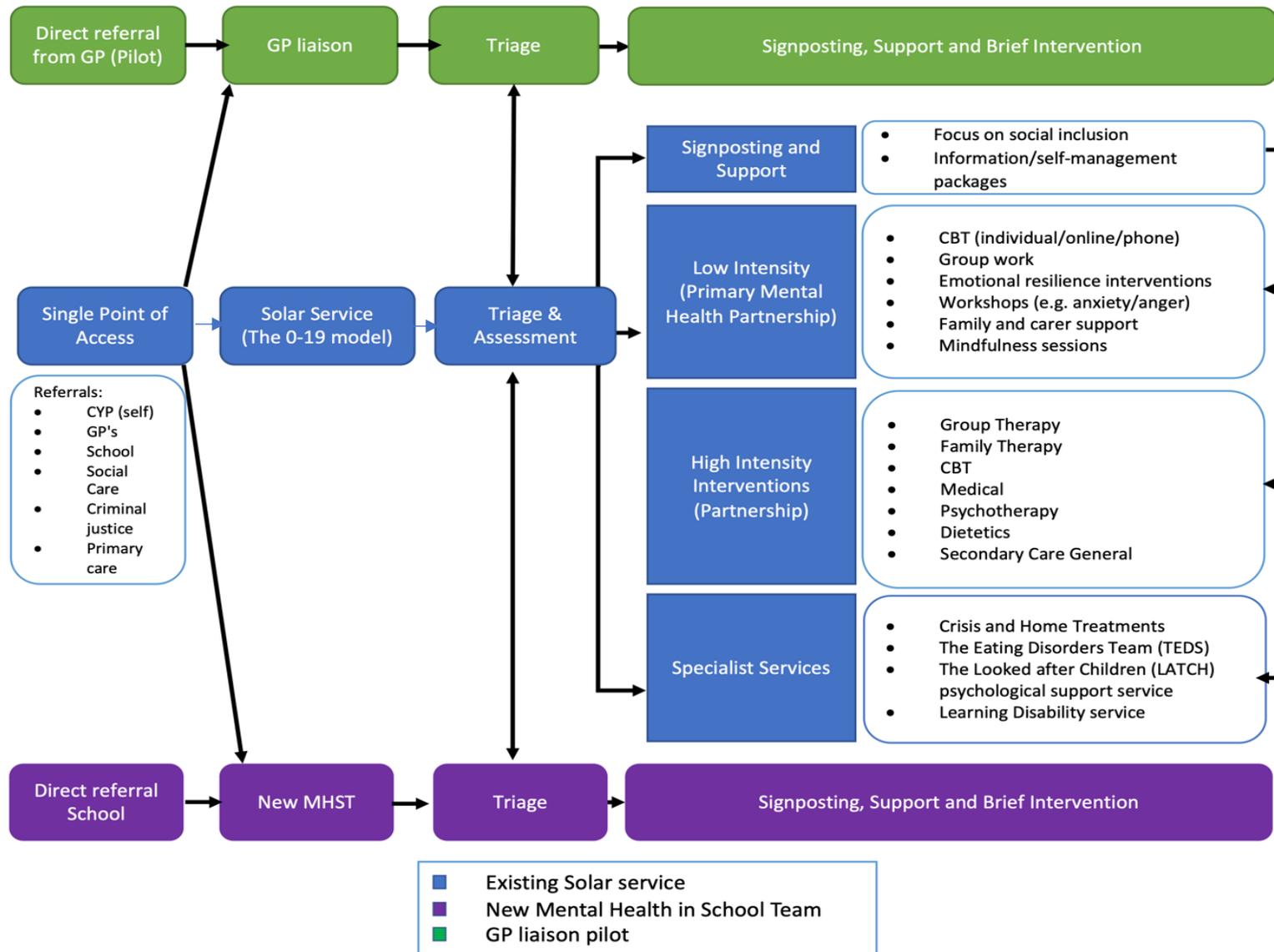


Fig 21. The Solar service organisation structure Source: Vusio et al., (2020)

2.6.3 No-tiers service

Since its commission in 2015, the Solar service has gradually moved away from a tier-based system, merging CAMHS with PMHS into a single point of access (SPOA), which contributes to the reduction of transition points (Solihull CCG, 2017). Implementation of the SPOA has allowed the service a more coordinated and coherent approach with referrals and also opened up direct pathways for CYP to self-refer to Solar, thus reducing the need for CYP to be referred by other services or their GPs, while leading to improved flow through the system (Vusio et al., 2020). Therefore, the SPOA enables service users and their families to provide more information on CYP symptoms and presented problems, and for the service to understand what the service users' expectations are (Vusio et al., 2020).

The SPOA has allowed the implementation of a transformational model of engagement and multidisciplinary assessment, also known as CAPA, enabling CYP and their parents to participate in shared decision-making on suitability and treatment preference, with an aim to improve service users satisfaction, flow through the Solar system, and efficiency and reductions with waiting times (Vusio et al., 2020; York & Kingsbury, 2013). Besides, the use of a single RIO software patient information records across the Solar service has helped create a fluid movement of service users throughout the Solar system, and it has opened up a possibility that service users can be treated at the same time by multiple practitioners in Solar (Vusio et al., 2020). Maintaining constant CYP flow throughout the Solar service is crucial to Solar's normal day-to-day operations due to increased demand for Solar service provision since the model was introduced in Solihull in 2015 (Vusio et al., 2020).

2.6.4 CYP journey through the Solar model

Referral process and initial screening

A service user may be either referred to the Solar service by their GP, educational provider, carer or parent, or by self-referral to the service. All new Solar referrals are reviewed regularly by a multidisciplinary group of experienced mental health practitioners (Vusio et al., 2020).

Triage

Upon completion of the initial screening, the Solar service initiates a triage (assessment) for information gathering purposes, risk assessing and establishing initial contact with service users and their referrers. All service users are redirected to more specialised pathways or treatment delivered by one of the Solar service partners according to their level of needs (Vusio et al., 2020).

Assessment

When CYP mental health difficulties are more complex, Solar will thoroughly assess CYP within six weeks of receiving and accepting the referral. These CYP will be urgently risk assessed, and a management plan will be produced, followed by additional assessments and formulation (formulation can be defined as a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioural problems) (Vusio et al., 2020).

Treatment at Solar

The decision about what appropriate treatment will be delivered to service users usually depends on the outcomes of the initial assessment. Before starting treatment, CYPs work in cooperation with its clinician to create an individual care plan that is tailored to meet the individual's specific needs and to establish what goals an individual wants to achieve together with the care team to reach recovery (Vusio et al., 2020). Both parties will agree collaboratively about what particular treatment is suitable for the individual. In Solar, treatment usually occurs in an individual, group, or family environment, while in cases of substance misuse, these are dealt with in the Solar service by using a harm-reduction model in both individual and family settings (Logan & Marlatt, 2010; Vusio et al., 2020).

Transitioning point

Before YP reach the transition point, Solar starts working with YP to understand whether they are ready to leave the service and to make the transition process as smooth as possible by linking with AMHS and continuing supporting YP until they are fully prepared for transition at the pace that suits YP needs (Vusio et al., 2020). A pre-transition questionnaire is given to YP at the beginning of the transition process to understand how much YP are ready for the service provider change, and to provide AMHS baseline information (Solihull CCG, 2018; Vusio et al., 2020). Apart from this questionnaire, each YP is provided with a transitional guide that informs them about the overall transition process, while the second questionnaire is given to YP after the transition to AMHS to confirm whether YP mental health needs are met by AMHS (Vusio et al., 2020). In the situation where AMHS is not the right fit for an individual, or where an individual is not adequately prepared for the transition, YP can continue to receive Solar support until they reach the age of 21 (Vusio et al., 2020). All YP who are unsuccessful with initial attempts of transitioning to AMHS will be gradually prepared for their second attempt if needed (Vusio et al., 2020).

Solaris (Solar's outreach)

In response to the recent government's "Green Paper", Solar introduced a Solaris support for educational settings in Solihull that are further supported by the Mental Health Support Teams trailblazer to achieve "a whole school approach" as recommended by the UK government (Department of Health and & Department of Education, 2018; Vusio et al., 2020). Introduction of Solaris added local educational settings as Solar's partners. The main goal of Solaris is to work together with educational settings to early identify CYP with emerging mental health problems or emotional needs and to implement early intervention and prevention strategies to ensure that local CYP receive adequate help and support before their mental health escalates further (Solihull CCG, 2019; Vusio et al., 2020). To support these CYP needs, Solaris in cooperation with Solar offers a range of brief low intensity, goal-focused, and group therapies to CYP and their families (Vusio et al., 2020). A similar trailblazer has been introduced with GP practices and is currently underway (Vusio et al., 2020).

The 0-19 model's staffing structure

The Solar model's staffing structure has changed significantly since its inception in 2015 (Figure 22). This change was aided by an increase in funding from the local transformation fund, which enabled the creation of additional posts and the further development of specific parts of the model, such as the inclusion of the Eating Disorder Service, and the Crisis Service (Solihull CCG, 2018).

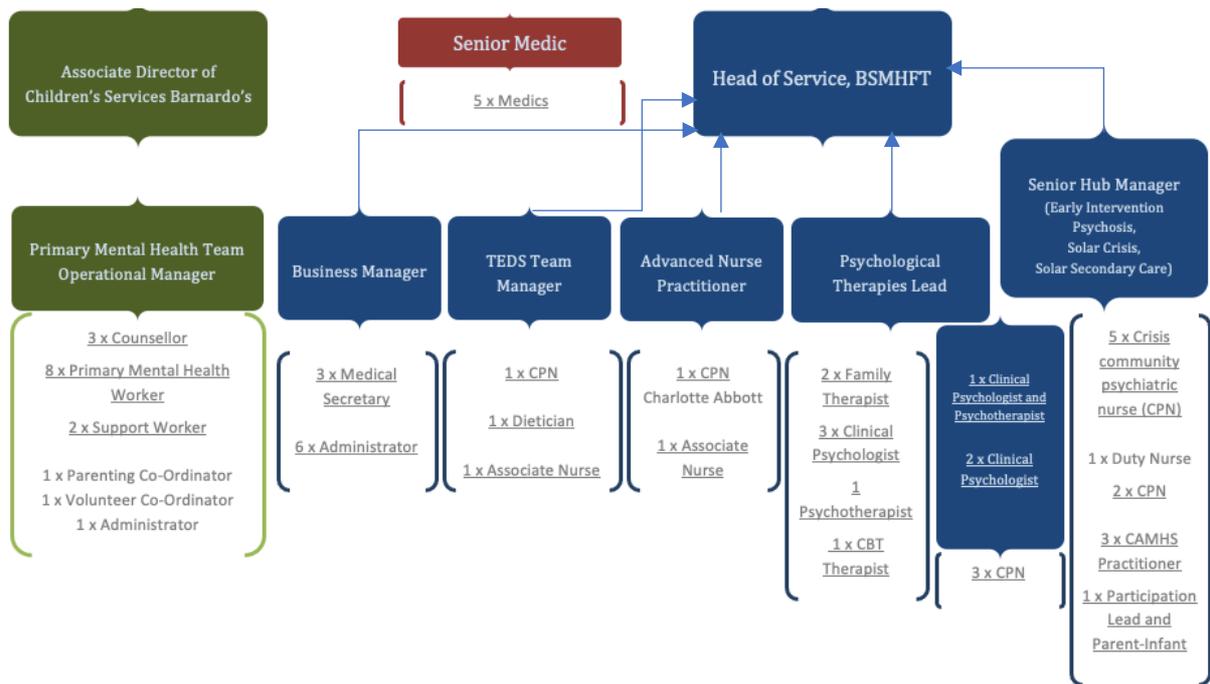


Fig 22. Initial Solar's staffing structure between 2015 and 2017

The model currently serves a population of approximately 45 000 CYP and is undergoing further development; staff numbers are reviewed on an annual basis (Solihull CCG, 2018). The demand for the service and the number of service users are factors that contribute to the local transformation funding plans (Solihull CCG, 2018). As shown in figure 23, the 0-19 models staffing establishment defines the core and additional staff within the service, which is regularly reviewed and adjusted.

Solar Staffing Baseline – as per CAMHS Benchmarking data		
Total WTE across Solar 59.84		
BSMHFT		
WTE	Banding (AFC)	Role
3.6	Medical - Psychiatrist	Consultant Psychiatrist
0.2	Medical – Other	Other Medical
0.1	8c	Therapist
1.71	8b	Psychotherapy
1	8b	Therapist
3.6	8a	Clinical Psychology
0.6	8a	Psychotherapy
2.6	7	Operational Management
2.45	7	Nursing
11.7	6	Nursing
1	6	Social Worker
1	5	Allied Health Professional
1	5	Admin
2	4	Nursing Associates
4.48	4	Admin
2	3	Admin
1	2	Admin
40.04	Total	
Barnardo's		
WTE	Banding*(close to AFC as possible)	Role
1	7	Operational Management
2	6	Therapists
7.6	5	Therapists / AHP
7	4	Trainee Therapist / AHP
1	4	Parenting Co-Ordinator (Admin/Clerical)
0.6	3	Volunteer Co-Ordinator (Admin/Clerical)
0.8	3	Admin (Vacant)
0.6	2	Admin
19.8	Total	
*(although employed on different paygrades and terms and conditions)		

Fig 23. Solar Staffing structure in 2019 (Source: Solihull CCG, 2018)

2.6.7 Solar's crisis resolution service

When Solar was commissioned in 2014/2015, the CYP crisis service was at its foundations. Initially, the Intensive Community Outreach team (ICOS) was responsible for managing all CYPs with crisis presentations, while delivering both an acute and a crisis pathway to enable easier access for service users and their families (Solihull CCG, 2015). The ICOS had four main functions (Table 6) including providing rapid response for urgent assessments, intervening to presented CYP crises with short intensive interventions, providing CYP with long-term intensive outreach support and acting as a gatekeeper towards hospital admissions (Solihull CCG, 2015). Besides, the Solihull CCG also intended to integrate the ICOS with the BSMHFT's RAID (Rapid Assessment, Interface and Discharge) team to provide comprehensive 24/7 crisis intervention service, enabling the exchange and the sharing of expertise, knowledge and experiences between two teams (Solihull CCG, 2015). The initial crisis service was based at the Freshfields clinic, and during 2015/2016, the ICOS intervened to provide crisis help to an average of 1-2 CYP a week (63 CYP in total)(Solihull CCG, 2015). In contrast, the service aimed to improve the overall crisis provision by using Vanguard funds to accelerate the crisis provision to allow for better standards of crisis care, such as to see CYP within one hour of presentation and assess CYP within four hour period (Solihull CCG, 2017).

However, since 2017, Solar's crisis component has shown improvement, largely due to the Vanguard funding that helped transform the crisis service and increased its capacity to provide crisis service provision seven days a week between 8 am and 8 pm. These improvements also included the introduction of a crisis telephone line to ensure that service users and their families have quick access to crisis support (Solihull CCG, 2018).

Table 6 - ICOS's four main functions . Source: Adapted from Solihull LTP (2015)

Rapid Response	<u>Timeframe:</u> Same day assessment according to the assessed risk and meeting ICOS criteria
	<u>The criteria</u> for acceptance for ICOS: <ul style="list-style-type: none"> • Presentation of major mental health illness such as major mood disorder, chronic anxiety or psychosis • Evidence of suicidal thoughts or behaviours • Evidence of chronic eating disorder
Crisis Intervention	<u>Treatment:</u> Brief crisis intervention to contain the crisis and directed towards stabilisation of crisis and CYP mental health and wellbeing
	<u>Four main pathways:</u> <ul style="list-style-type: none"> • Primary mental health or voluntary agency support • ICOS intensive community treatment (i.e. at home) • Long-term follow-up and treatment at the outpatient facility (i.e. Bishop Wilson or Freshfields clinics) • High specialist – inpatient admission in case if community treatment failed to create positive outcomes
Outreach function	Provision of the ICOS team within the community and liaison with GP's, Paediatricians, and range of agencies, including links with Police, Social Services, Place of safety, Street Triage, A&E's and Rapid Assessment Interface and Discharge Service (RAID)
Stepped Transition	The ICOS acted as a gatekeeper to hospital admission, preventing inappropriate admissions, facilitating early discharge where needed or facilitating admission to inpatient units when required in cooperation with tier 4 services. The ICOS continued to follow up CYP during and after discharge from inpatient units.

Additionally, in cooperation with the neighbouring 0-25 service model, a separate out-of-hours crisis service provision is provided to ensure that there are no gaps in crisis provision and that CYP in crisis are being seen and triaged within one hour of referral, and fully assessed within four-hours during regular working times. In addition, FTB's 0-25 model covers out-of-working hours support (Solihull CCG, 2017, 2018; Vusio et al., 2020). The increase in team's capacity is also evident in the numbers of CYPs accepted by the crisis team. For example, the crisis team received 350 referrals in the 2017/2018, of which 256 were unknown to the Solar service (Solihull CCG, 2018). A similar increase in demand for crisis support and treatment was evident

between 2018 and 2019, showing a total of 344 CYP referrals to Solar crisis team (Solihull CCG, 2019).

The crisis team is a fully nurse-led team that also receives support from other parts of the Solar model (e.g. psychiatrist or clinical psychologist). Since 2019 the crisis team has also been enhanced by an additional team member who supports the team with their ASD and learning disability expertise. It will contribute to existing home and community treatment; crisis support over the phone and support in both Solar's clinics. The crisis team also has the benefit of being closely tied to the rest of the Solar service, as it prepares CYP for gradual and ongoing further support from other mental health professionals within the model once they are stabilised and ready to move on from the crisis team.

2.8 Chapter summary

This chapter provided an overview of the local context in which the 0-19 model and its crisis component operate in terms of the Solihull borough geographical position, economic and prosperity data, including deprivation, CYP population and demographics. It also provided an overview of the mental health of CYP in Solihull and the mental health policy context as a facilitator of change and improvement of local health and wellbeing. The chapter also introduced the previous 0-17 model and outlined why the transformation of the previous model was needed. The structure and organisational framework of the current 0-19 model and its crisis service were then introduced.

Chapter 3: Overview of research aims, questions and methodology

3.1 Chapter outline

The previous chapter introduced and described the 0-19 model and its crisis service as a possible solution to a number of identified issues with the existing UK CAMHS service provision covered in Chapter 1. This chapter describes the main research aims of this PhD project, which was designed as a mixed-methods study and organised around three distinctive and integrated work packages: (1) a mixed-method systematic review; (2) a prospective mixed-methods evaluation of the 0-19 model and its crisis service; and (3) a mixed-method retrospective study of service user's experiences of mental health crises, and their journeys through the 0-19 model. The main research aims and questions that underpinned this project will be presented initially in this chapter, followed by the introduction of a logic model that provides a figurative overview of key assumptions, methods and findings across the three work packages. The next section of this chapter will discuss the rationale for a mixed-method approach and provide a brief overview of the project's work packages. The last sections of this chapter will discuss the ethics, funding and research governance related to this project.

3.2 Main research aims and questions

The main aim of this PhD project was to assess the degree to which the 0-19 model and its crisis component are accessible, acceptable and effective. The secondary aims of the project were to investigate (1) the impact of the model on its local community; (2) the impact of a mental health crisis on CYP, families and family functioning; and (3) the degree of CYP recovery post-crisis discharge. Specific research questions underpinning this research will be presented separately for each work package in subsequent sections.

3.3 Rationale for the logic model

In order to provide a clear narrative and conceptual summary of the main research assumptions, a logic model was developed as a visual representation of the aims, objectives

and outcomes that guided this research project. A logic model is a narrative or visual demonstration of the desired project outcomes based on the underlying assumptions that all research activities are expected to achieve specific outcomes. Logic models are widely used in complex evaluations, and interventions.

A logic model is a system approach for communicating the path to a desired result that demonstrates a sequence of cause-and-effect relationships (Millar, Simeone, & Carnevale, 2001). The logic model provides a simpler way to demonstrate, evaluate and refine the hypothesis of research projects and the “theory of change” to understand how the particular model described in the logic model works (Millar et al., 2001).

The logic model, according to the Kellogg Foundation (2004), can be defined as the “*depiction of how an organisation does its work, the theory and the assumptions underlying the program*” (Kellogg, 2004). Similarly, Reneger and Titcomb (2004) described the logic model as a graphical representation of the program’s “*resources, activities and intended outcomes that identify program theory and function*” (Renger & Titcomb, 2002). Kaplan and Garrett (2005) defined the logic model more scientifically; stating that the logic model aids hypothesis testing for a particular project evaluation (Kaplan & Garrett, 2005). The logic model, therefore, represents logical relationships between project resources, activities, outputs and outcomes related to specific problem or situation, which can lead to a set of short, intermediate and long-term outcomes.

For this project’s logic model (Figure 24), short-term outcomes represent possible changes and improvements that the 0-19 model could expect within the first two years since the research evaluation was conducted. The intermediate outcomes represent the expected results from previous short-term outcomes. Lastly, long-term outcomes represent possible changes and improvements to the 0-19 model within 3-5 years of the research evaluation.

Although the logic model is an appropriate tool to better understand the 0-19 model, its design and implementation, the main benefit of the logic model for this project is its ability to identify and measure results. As this research study investigated the 0-19 model and its crisis component, the logic model was a useful tool for its evaluation, as it produced valuable

research evaluation data and highlighted the appropriate sequence for data collection, analysis and their outcomes. Besides, this tool was a useful way to identify the theoretical assumptions of the 0-19 model and its crisis component, as well as to evaluate the model's practices and the degree to which this model aligns its practices with theoretical assumptions.

This logic model can be used as a map to guide other service models that want to replicate the 0-19 model or adapt its components to their unique situations. The logic model has the potential to perform "reality testing" (Patton 1997), to establish whether the 0-19 model and its crisis component do what we think the model should do in theory (Reneger and Titcomb 2002, p4). Therefore, this approach was considered an appropriate framework to be used for this particular research project.

3.3.1 Logic model for this project

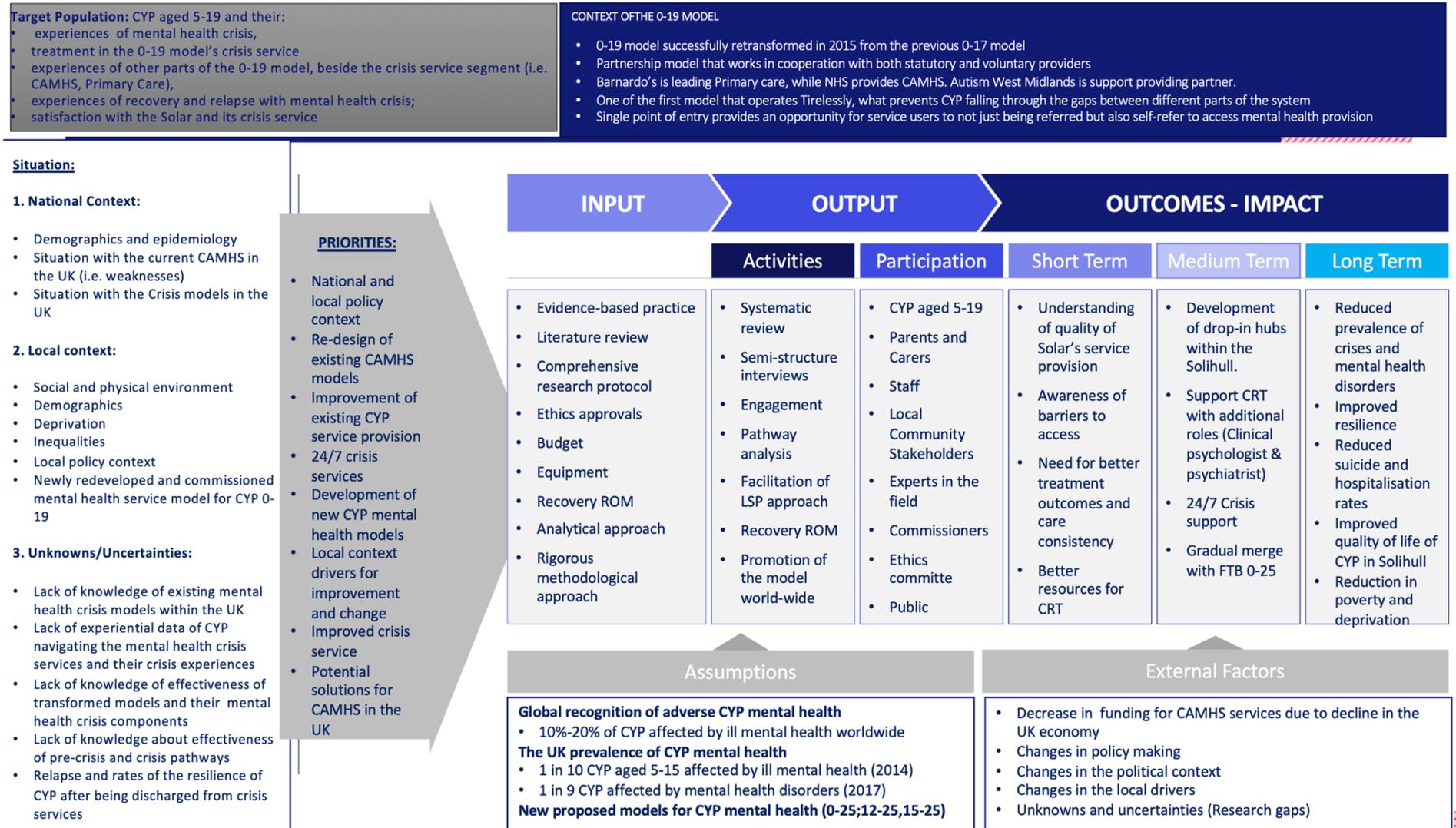


Fig 24. Logic model describing the context and processes of the PhD project evaluation of the 0-19 model and its crisis service

The logic model (figure 24) was developed after the systematic review (Appendix 25) and formalised as data was collected. All outcomes of the logic model were treated as assumptions. The logic model in this chapter represents the final and more succinct version of the initially created logic model and its full explanation can be seen below:

- The **assumption** box explains the underlying theory of mental health prevalence rates both in the UK and around the world, in addition to the existence of similar integrated models in the UK and globally, which are retransformed and improved CAMHS
- The upper parts of the logic model provide the **context** for the 0-19 model, and the project's targeted population (i.e., CYP).
- The lower left-hand segment of the model describes **the current situation** and context in which the 0-19 model operates by considering both national and local contexts, as well as a number of uncertainties (i.e., research gaps).
- The **priorities** in this logic model are the justification for the design and implementation of this PhD's research inputs and activities as outlined in the corresponding section of the logic model
- The **input** section of the model describes what was invested in this project so that a range of outputs could be generated through a range of activities (i.e., interviews, focus groups) for the facilitation of the engagement of a number of stakeholders crucial to the success of the project, and the targeted population as outlined in the very top left part of the model.
- A range of **activities** and **participation** of stakeholders lead to **short-term** outcomes (assumptions) that outline what changes the 0-19 model needs to make in terms of knowledge, awareness, skills, and resources to improve its service provision and meet the needs of the local CYP population
- When the 0-19 model applies these changes, the effect may lead to changes in the behaviour of staff, the model's practices, improved internal policies and procedures, and the implementation of new parts of the service provision that have been identified as weakness from the activities section of the logic model.
- Once the 0-19 model applies both short-term and medium-term outcomes, improved service provision may lead to **long-term** outcomes and changes in the initially proposed situation box (the left part of the logic model).
- In other words, when long-term conditions change, the result will also affect changes in the Solihull mental health care environment, social conditions, economic decisions, and improved mental health of the 0-19 CYP population within Solihull, and may contribute to the improvement of national policies, and CAMHS services. It may also enable to turn outlined research gaps (uncertainties) into new knowledge that will change the situation as described at the beginning of the model (i.e., situation box).
- However, all these outcomes, particularly in the medium and long-term may be potentially hindered by a range of external influences that the 0-19 model has little or no control over, such as the impact of the declining UK economy on service funding, changes in national or local priorities and policymaking, and epidemic outbreaks such as COVID-19.

3.4 Rationale for a mixed-method design

All three-research work packages in this project used a mixed-methods approach. The main rationale for choosing a mixed-methods design for the three work packages was its well-established use in health and social sciences due to its pragmatic nature to investigate particular phenomena (Curry & Nunez-Smith, 2015). Having a pragmatic approach was necessary for this project, as the research questions guided the overall research activities. For example, a quantitative approach was crucial to investigate the effectiveness of the crisis service and crisis pathway, while a qualitative approach was needed to understand the experiences of stakeholders with the overall 0-19 model and its crisis service. However, both approaches have their advantages and disadvantages, but if applied together they can complement each other (Bölte, 2014).

In addition, the ability of a mixed-methods approach to combine qualitative and quantitative research may contribute to a more in-depth understanding of a particular research phenomenon (Johnson, Onwuegbuzie, & Turner, 2007). Besides, the mixed methods approach also helped to triangulate the findings of both qualitative and quantitative approaches. It, therefore, helped to strengthen the credibility of the main findings. Indeed, a combination of quantitative and qualitative approaches may provide a more robust understanding of the accessibility, acceptability and effectiveness of mental health services than either approach used alone (Robins et al., 2008).

3.4.1 Mixed-methods research challenges

One of the biggest challenges in mixed-methods research is how to incorporate “qualitative” and “quantitative” epistemologies that are often viewed in more traditional research as separate disciplines in social science and health research, as their underlying philosophical principles may conflict with each other (Robins et al., 2008). However, researchers are increasingly using mixed-methods approaches to answer research questions at hand, while “epistemological wars” between “positivism” versus “interpretivism” and “inductivism” versus “reductivism” are seen more as a distraction (Curry & Nunez-Smith, 2015). A multi-viewpoint

approach to mixed-method research can also be supported by pragmatism as knowledge is always based on experience, and our perception of the world is underpinned by our social and life experiences (Morgan, 2014). The main potential of pragmatism is its ability to empower and engage communities and provide evidence at the micro and macro level of discourse (Kaushik & Walsh, 2019). Therefore, the rigour and strength of the chosen methods remain crucial regardless of their epistemological grounding (Curry & Nunez-Smith, 2015). Equally, this research project considered the rigour and strength of each research component (study) addressed in the following chapters before all the studies were brought (integrated) together and discussed in relation to each other and the research questions. Lastly, to ensure that this mixed-method study was valid and reliable, a mixed-method appraisal framework (Curry & Nunez-Smith, 2015) was used in the final discussion chapter to scrutinise the strengths and limitations of the overall mixed-method approach used in this project.

3.4 Work packages

This project consisted of three work packages: (1) a systematic review; (2) a prospective mixed-methods evaluation of the 0-19 model and its crisis service; and (3) a mixed-methods retrospective study of service users' experiences of mental health crises, their journeys through the 0-19 model and its crisis service, and a personal post-crisis recovery assessment (Figure 25).

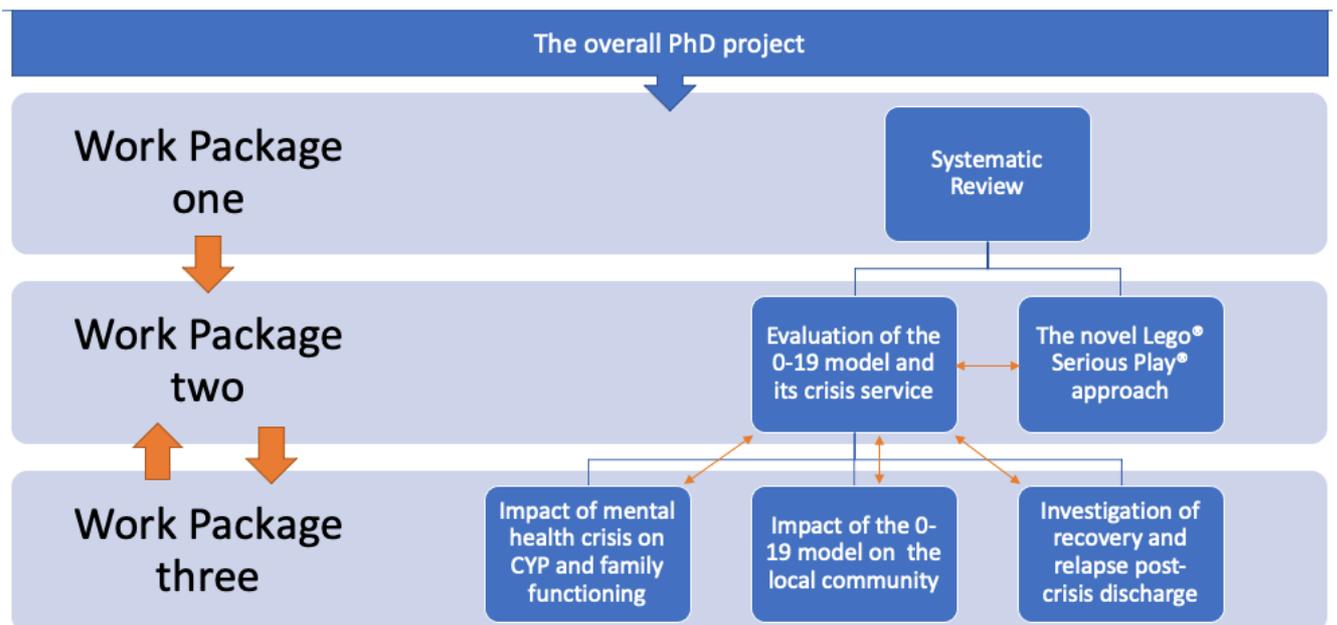


Fig 25. An overview of all three work packages and their relations to each other

3.3.1 Work package one – Systematic Review of CYP urgent and emergency care

Since this project is predominantly focused on the crisis segment of the 0-19 model, it was important to understand what other urgent and emergency alternatives to inpatient setting exist in the UK and worldwide. Another rationale for the systematic review was to gain an understanding of the experiences of parents and service users with crisis service providers and their degree of satisfaction. Despite some attempts to synthesise the alternatives for urgent and emergency inpatient admission (Kwok, Yuan, & Ougrin, 2016; Paton et al., 2016a; Shepperd et al., 2009), there were no known systematic reviews that also included CYP and parental experiences of access to and satisfaction with these alternatives. Therefore, work package one can be described as a review of CYP crisis care models in the UK and worldwide, as well as a synthesis of experiences of parents and CYP who previously accessed these urgent and emergency community-based alternatives to inpatient settings.

The main aims of the systematic review:

- ❑ To understand what urgent and emergency alternatives exist to inpatient settings
- ❑ To examine what interventions these alternatives use
- ❑ To understand CYP and parental experiences of accessibility and satisfaction with these alternatives.

The systematic review research questions:

1. What are the experiences and satisfaction of CYP and their parents, with mental health crisis services or alternatives to inpatient settings?
2. What are the identified interventions that can be applied to CYP in urgent and emergency environments?
3. Besides well-known and established models, are there any newly developed alternative models to inpatient or emergency department admissions for CYP experiencing mental health crisis?

In the synthesis of available literature, systematic reviews are regarded as a golden standard, representing a more structured, rigorous and replicable alternative to literature reviews (Noble & Smith, 2018). The main advantages of systematic reviews are their transparency and need for rigorous protocols that can be published to PROSPERO, which describes the process of undertaking a review (Eagly & Wood, 1994; Stewart, Moher, & Shekelle, 2012). The use of the standardised PRISM reporting system also helps to establish minimum criteria and items to be reported in each systematic review, accompanied by a flow chart showing the steps taken (Moher, Liberati, Tetzlaff, & Altman, 2010). Lastly, it is important to highlight that standardising the systematic reviews process helps to reduce the risk of bias, especially since the introduction of the AMSTAR checklist that assesses the quality of systematic reviews and the risk of bias (Shea et al., 2009).

For this project, a systematic review was conducted to gather available research literature, and critically evaluate all of the included articles to synthesise the evidence for this study to create an accurate and reliable understanding of research gaps and different evidence-based findings and practices (Noble & Smith, 2018). Besides, the systematic review findings also helped to direct this project's research activities, its aims, and research questions for work packages 2 and 3.

3.3.2 Work Package two – The prospective evaluation of the 0-19 model and its crisis service

This primary focus of the prospective evaluation was on the 0-19 crisis service, as this project was commissioned by the Solihull CCG to evaluate the effectiveness of the crisis service. It was agreed with the Solar service that this project would undertake research activities to observe the attitudes of stakeholders towards accessibility and satisfaction with the overall Solar service.

The main aims of the work package 2 were:

- ❑ To ascertain the accessibility and acceptability of the overall 0-19 model and its crisis service
- ❑ To ascertain the effectiveness of the crisis pathway

The Work package 2 research questions:

1. How effective, accessible and acceptable is the crisis provision of the 0-19 model?
2. How effective is the 0-19 crisis pathway to admission for CYP?
3. Is 0-19 crisis model effective in reducing A&E and acute admission or out of area placements?

4. What are the stakeholder's experiences with the overall Solar service?
5. How accessible Solar is to CYP and what are perceived barriers related to accessibility and acceptability of the 0-19 model?
6. What is stakeholders satisfaction with the overall 0-19 model's service provision?

As can be seen from figure 26, this work package consisted of two interconnected phases:

1. Evaluation of the 0-19 model's crisis service using a mixed-methods approach
2. Qualitative evaluation of the overall 0-19 model

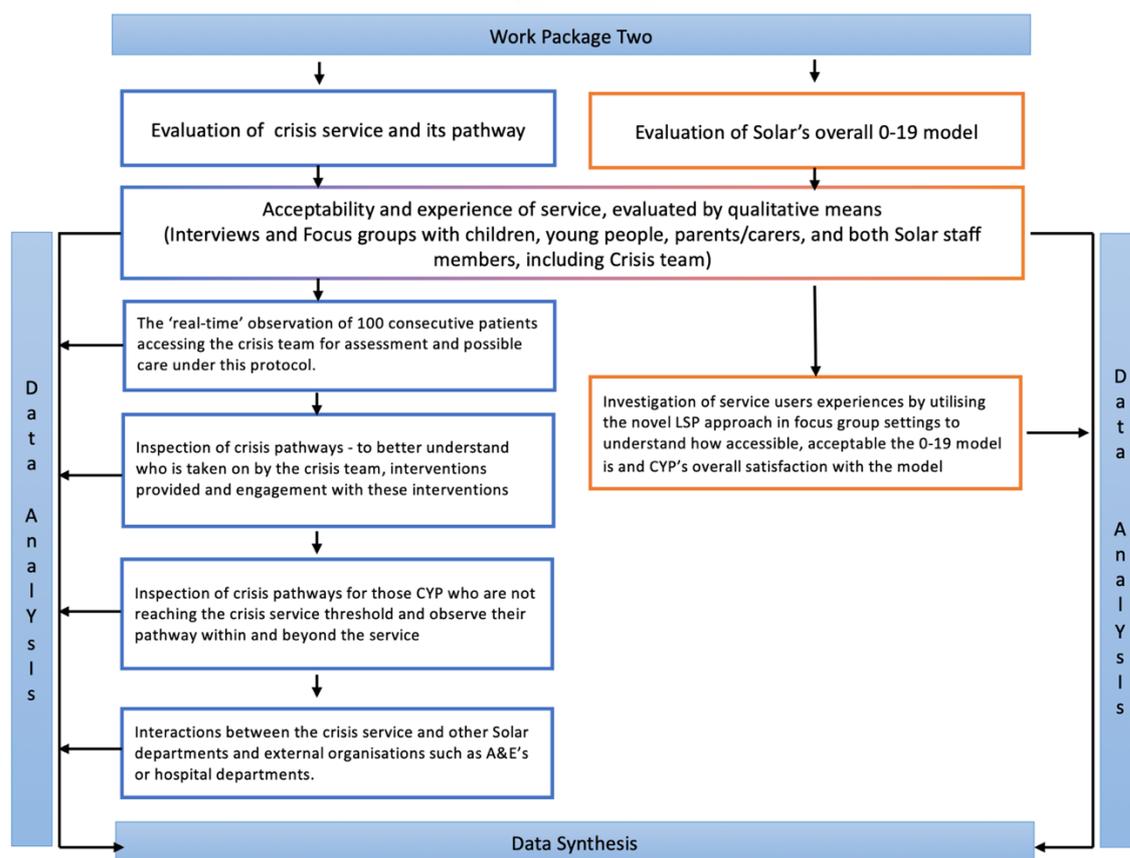


Fig 26. An overview of the planned research activities of the work package two

Phase 1: Evaluation of the 0-19 model's crisis service using a mixed-methods approach

Chapter 1 introduced a range of gaps that currently represent uncertainties, especially regarding what constitutes an effective crisis pathway for CYP. In addition, the review by Paton et al., (2016) also concluded that the evidence on the effectiveness of the crisis pathway is limited due to the lack of methodologically led crisis care evolutions. Similarly, the NCCMH was tasked with developing a guideline specifically for CYP mental health crisis pathways based on the best evidence-based practice to define what is effective and efficient mental health crisis pathway (Cotgrove, 2018). However, there is still a lack of published evidence to define what is an effective pathway for CYP mental health crisis services.

As can be seen from Figures 25 and 26, work package two predominately focused its attention on the 0-19 model's crisis service and its crisis pathway. A prospective eight-months investigation of all service users' journeys through the crisis service from the point of referral

to the point of discharge was conducted to understand where CYP came from, the key delays and time spent in the crisis pathway (Figure 27). Also, during this period, CYP who relapsed and were re-admitted back to the crisis care were followed, as well as those CYP who did not reach the crisis service threshold. The researcher also conducted an audit of the duty triage (pre-crisis) segment by reviewing patient records data in the RIO system and day-to-day duty nurse diaries.

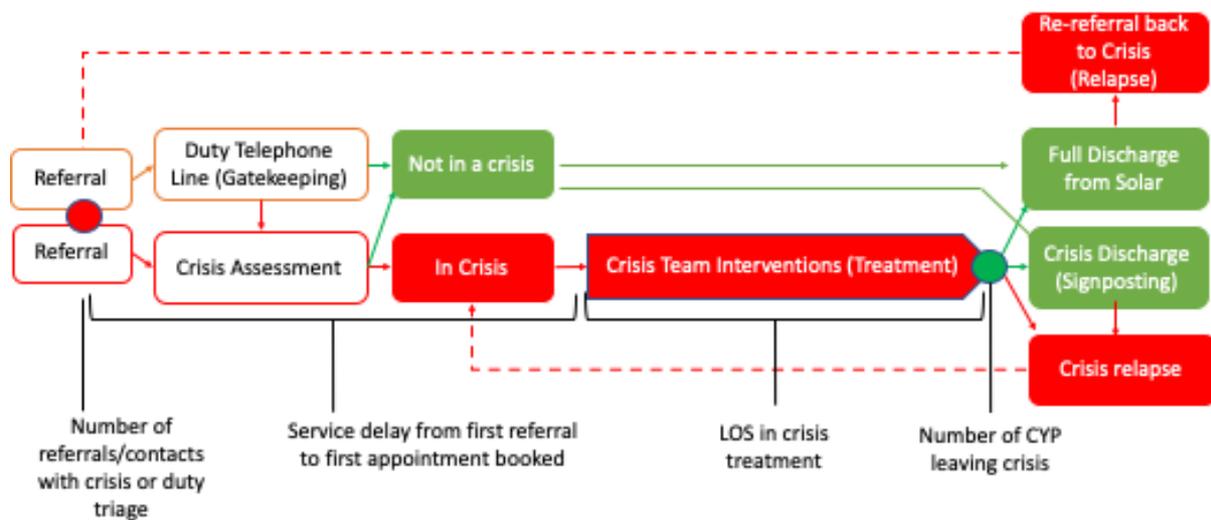


Fig 27. - Process of investigating the effectiveness of the crisis pathway in the 0-19 model

All these quantitative research activities were complemented by a qualitative analysis of stakeholder's perceptions of the accessibility and acceptability of 0-19 crisis service. The rationale for a need for qualitative investigation was provided in chapter 1, which also highlighted the lack of experiential data on CYP and their parents navigating crisis services. To the best knowledge, this project was unable to identify any studies describing CYP/parental experiences of navigating through the UK or worldwide mental health crisis services models. Therefore, there was a clear need to obtain experiential data from a range of stakeholders involved with the 0-19 crisis service to understand how accessible and acceptable the crisis service is, and how satisfied stakeholders are with their crisis care. Patients satisfaction has been well established in the literature as an important outcome measure (Hubbeling & Bertram, 2012). Therefore, Work Package 2 aimed at understanding the experiences of not only CYP and their parents, but also staff members regarding the crisis service and its provision.

Phase 2 – Qualitative evaluation of the overall 0-19 model

In order to understand the CYP's, their parents and staff's perspectives, attitudes and experiences with the 0-19 model, a semi-structured interview schedule was developed to encompass questions about both the 0-19 model and its crisis service. This approach allowed us to interview participants who had both experiences with Solar and its crisis service, as well as participants who had exposure only to Solar or its crisis service. The additional and separate segment that focused only on the 0-19 model was conducted in the form of two focus groups with service users (CYP) following the Lego® Serious Play® (LSP) a novel approach to qualitative research that has never been attempted previously in the context of mental health research. The findings from these focus groups represent, therefore a novel research knowledge that reflects not only the attitudes and experiences of CYP with the 0-19 model but also a reflection on the use of the LSP approach. Thus, this phase may provide an in-depth understanding of CYP's individual experiences and attitudes, that may be implemented in future mental health research and clinical practices. A general overview of all planned qualitative research activities is provided in figure 28, while a more detailed description of all the research activities used in this research project is provided in chapters 5,6 and 9.

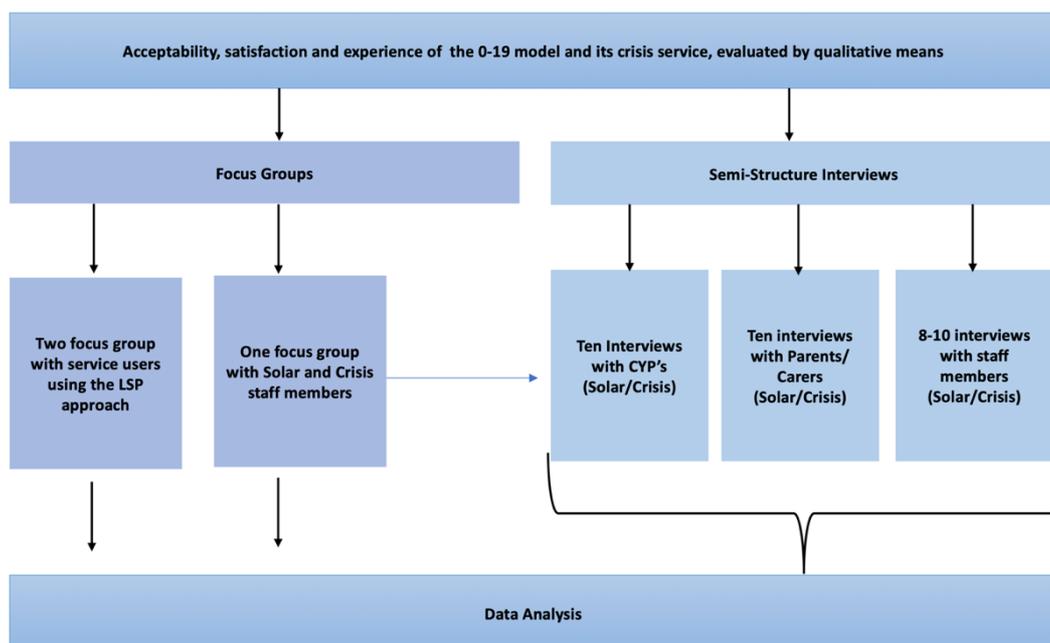


Fig 28. An outline of the main planned qualitative activities of the work package two

3.3.3 Work package three – The retrospective mixed-methods study of CYP crisis recovery post-crisis discharge

The last work package was designed to gain a deeper understanding of experiences with the 0-19 model’s crisis service from a wide range of service users and local professional community stakeholders. Work package three also focused on the 0-19 model’s crisis service to understand how much crisis service has helped CYP develop resilience and assess the personal degree of post-crisis discharge CYP recovery. This overall package was envisaged as a mixed methodology study and figure 29 summarises the key research components of this package.

The main aims of the work package 3 were:

- ❑ To assess the effectiveness of the crisis service and its service provision
- ❑ To understand mental health crisis experiences of CYP and their parents and the impact of a mental health crisis on family functioning
- ❑ To establish the overall impact of the 0-19 model on the local community

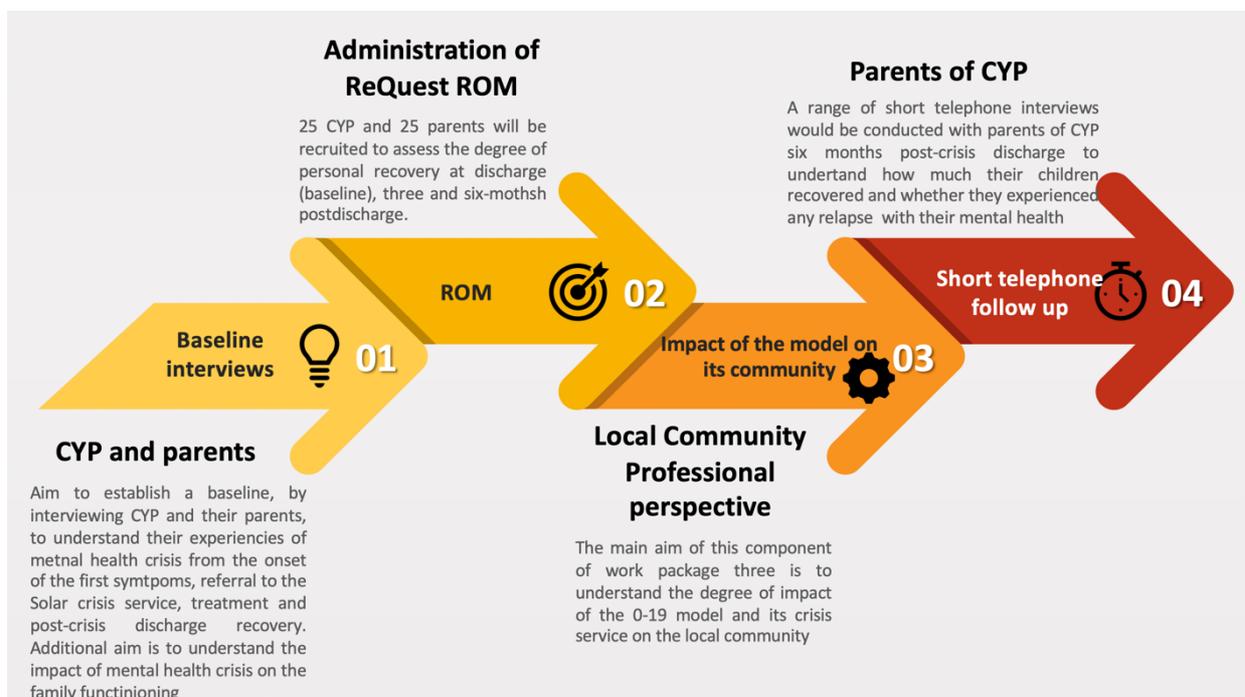


Fig 29. The overview of planned research components of the work package three

The Work package 3 research questions:

1. Is the 0-19 crisis service model successful at improving recovery and resilience of children and young people, six months after their discharge from the service?
 - a. How effective is the 0-19 crisis model in reducing relapse rates of children and young people post-discharge?
 - b. How effective is the 0-19 crisis pathway to admission for children and young people?
2. What was YP and their family's journey through the Solar's crisis service, and their perceptions of its accessibility and acceptability?
 - a. What are the main sources and triggers of a mental health crisis for CYP?
 - b. What is the impact of the YP mental health crisis on parents, siblings and overall family functioning?
 - c. What was the personal perception of recovery and satisfaction with the overall crisis treatment?
3. What are the perceptions and attitudes of local professional stakeholders regarding the impact of the 0-19 model and its crisis service in their community?

3.3.3.1 ReQuest outcome measure (quantitative component - ROM)

The quantitative component of this work package envisaged the use of the ReQuest outcome measure to assess the degree of personal CYP recovery following discharge from the crisis service. Figure 30 outlines the process of administration of the ReQuest outcome measures. Since Solar crisis service does not officially measure the outcomes of their interventions through outcome measures, the researcher obtained permission from the University of Surrey to use the ReQuest outcome measure for this PhD project to determine the degree of recovery of CYP post-discharge and to establish how effective Solar crisis service is in facilitating the recovery of CYP who experienced mental health crisis post-discharge.

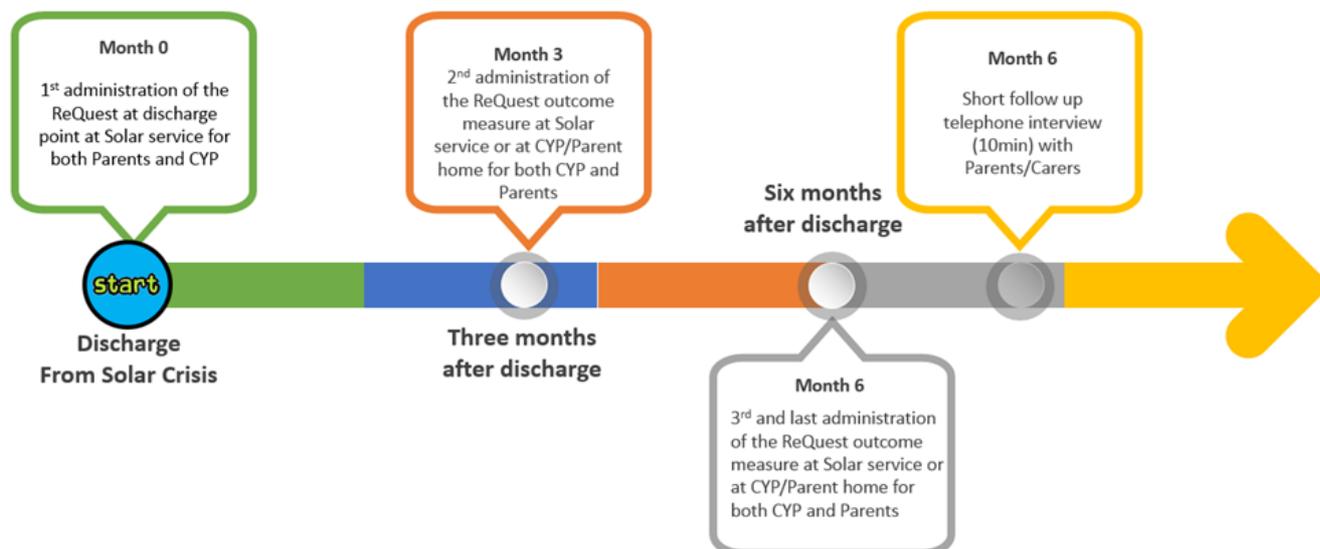


Fig 30. The planned administration procedure of the ReQuest outcome measure

The main rationale for using recovery-based measure is that “they can provide a more holistic picture of the effectiveness of services by capturing dimensions that symptom-focused measures do not” (John, Jeffries, Acuna-Rivera, Warren, & Simonds, 2015).

The ReQuest recovery measure has two distinctive questionnaires, designed to assess the CYP recovery rates and additional measure to establish the CYP recovery rates perceived by their parents and carers (John et al., 2015). This recovery outcome measure has showed good psychometric properties, good validity, and reliability (John et al. 2015). As such, this recovery measure has the potential for routine administration within CAMHS. Another study investigated the use of ReQuest-YP in inpatient settings found similar psychometric properties (Bentley, Bucci, & Hartley, 2019). The authors of this study found that the ReQuest demonstrated good internal consistency, test-retest reliability and sensitivity to change, in addition to being a relevant and acceptable outcome measure for YP (Bentley et al., 2019). Also, Quantitative outcome measures are an important part of the research project and quality measurement. However, outcome measures alone are insufficient (Cotgrove, 2018); to see the full picture, combining outcome measures with the experiential data obtained using the qualitative methodology is crucial.

The PhD student completed work packages one and two before the outbreak of COVID-19. However, due to the onset of COVID-19 outbreak, the doctoral student only partially completed the third work package. The initial qualitative research activities of work package three such as baseline interviews and the impact of the 0-19 model on the local community were fully completed. Due to Covid-19 outbreak, the recruitment process for administration of the outcome measure ended in January 2020. Initially, the outcome measure was planned to be administrated between the end of January 2020 and the end of July 2020. The ReQuest outcome measure, and short telephone follow up after post-administration of the outcome measure were the only parts of the work package three affected by Covid-19 outbreak and the country's widespread lockdown. **Therefore, this thesis does not include these two components.** All attempts to mitigate this situation failed, as the service did not want to risk exposing the participants and the researcher to a potential situation in which they could become infected with COVID-19.

Infobox 2. Impact of Covid-19 on the work package 3

3.3.3.2 Qualitative components of the work package 3

The qualitative components of this work package were designed to investigate:

1. **Semi-structured interviews** to understand the five CYP experiences of mental health crises from the first onset of symptoms, referral to Solar crisis service, treatment by the crisis team and post-crisis discharge, and the degree of their recovery. In addition, five parents were recruited to understand their perspectives on their children's mental health crisis journey, as well as the impact of a mental health crisis on the overall family functioning.
2. **Impact of the Solar and its crisis service on the local community** aimed to understand the impact of the 0-19 model and its crisis component on the community in Solihull. Eight professional local community stakeholders were recruited from a range of different educational, urgent, and emergency settings.

3. **Short telephone interviews** were planned to be conducted with 25 CYP and 25 parents following successful completion of administration of ReQuest outcome measure (six months after discharge) to assess the personal recovery of individuals after being discharged from Solar crisis service. These interviews aimed to understand whether CYP had fully recovered from mental health crises and whether they had a relapse with their mental health. This would allow us to capture the effectiveness of the crisis service in developing resilience, prevention of relapse and post-discharge experiences of service users. However, due to the outbreak as described in the box 2, this segment of work package three was not completed.

3.3.4 Funding, Ethics approvals, and research governance

This PhD project was funded by Solihull Clinical Commissioning Group (CCG). For work package one, the following approval for the systematic review protocol was granted:

- ❑ PROSPERO ID: CRD42019110875

For all research activities in the work package two, following ethics approval was granted by:

- ❑ The University of Warwick Biomedical Science Research Ethics Committee (BSREC) REGO-2018-2294 (**Appendix 3**)
- ❑ Birmingham and Solihull Mental Health Foundation Trust approved the research protocol and issued the letter of access for the researcher (**Appendix 4**)

For all research activities in the work package three, ethics approval was granted by:

- ❑ The HRA NHS Edgbaston Research Ethics Committee (Rec ref. 19/WM/0018) (**Appendix 5**)
- ❑ The research study was sponsored by the University of Warwick (SC.06/18-19) (**Appendix 6**)

It is important to emphasise that recruitment and all research activities (In work packages 2 and 3) did not start until the official approvals had been received from the appropriate ethics body.

3.3.4.1 Participant wellbeing during recruitment and interviews, and research governance

Once the necessary approval was granted to the research protocol, participant recruitment officially started. During the design phase of the study, recruitment and interview phases, the researcher adhered to the "Code of Human Research Ethics" (British Psychological Society, 2014). All participants signed the consent form, and the researcher provided them with copies of the PIS and consent form for their records. During the pre-interview and interview, the researcher provided a full explanation of what the study purpose was and what the interview would involve. The researcher answered any question and assured all participants that their responses would be anonymised to protect their identities. The researcher removed any identification label from transcripts that could be used to identify individuals. During the recruitment and interview phases, interviewees in this study were not subjected to any emotional or psychological distress.

At the beginning of each interview, the researcher informed all participants about their confidentiality rights. Also, the researcher reminded the participants that they had the right to stop the interview at any time, and not answer any question they considered inappropriate. Likewise, the researcher reminded participants of their rights to request the exclusion of their responses and demographic data from the study. No participant in any part of the project exercised that right.

For all qualitative data studies, non-identifiable data obtained from participants or their parents, such as consent forms, audio recordings, interview transcripts and field notes were kept in a secured filing cabinet, while electronic data was securely stored on the University of Warwick's encrypted network. Even though the researcher used an encrypted digital recorder, once all audio files had been transferred to the authorised transcription company, Appen, the audio data on the recorder was deleted. The researcher removed any identification labels from the transcript that could potentially be used to identify individuals and replaced those with pseudo-IDs. The collection of demographic data was limited to only necessary as advised by the BSREC ethics committee and BSMHFT research and innovation department.

For the quantitative data collection phase, the researcher received the necessary anonymised datasets from the BSMHFT data analyst team. It is important to highlight that both quantitative and qualitative data were stored and handled in accordance with GDPR and the University of Warwick's and BSMHFT's policies to preserve participants confidentiality and anonymity.

3.5 Chapter summary

This chapter discussed the overall aims of the PhD project and described the main aims and research questions that all research activities in this project sought to address. A rationale for the use of a mixed-method design has also been provided, in addition to a summary of all three research work packages and their aims, research questions and a brief description of each work package. A detailed description of each study and its findings are given in chapters 4 - 10, while chapter 11 reflects on the integration of the key findings from each study and general discussion on how these findings address the research questions raised in this chapter. Lastly, it is important to highlight that two components of work package three were impacted by the Covid-19 pandemic, which consequently prevented the researcher of completing them, and therefore, they are excluded from the results chapters.

Chapter 4: Experiences and satisfaction of children, young people and their parents with alternative mental health models to inpatient settings: a systematic review

4.1 Chapter outline

In this chapter, evidence from six different journal databases was systematically reviewed to understand the experiences and satisfaction of CYP and their parents with alternative mental health models to inpatient settings. The review also identified several newly developed alternative models for CYP experiencing a mental health crisis that represents an alternative to more restrictive treatment in inpatient settings, as well as a range of interventions that can be applied to CYP in urgent and emergency environments. In this review, all research activities were aligned with the overall logic model and its corresponding activity section presented in the previous chapter.

Initially, a brief background and the main aim of the systematic review will be provided, followed by the presentation of the main methodology aimed at explaining the search strategy applied to six databases, the eligibility criteria used for the inclusion and exclusion of journal articles, the selection of articles included in this review and their quality assessment, as well as data extraction procedure and data synthesis. The result section will then be presented, and the main findings of this systematic review will be explained. The findings are then discussed and compared with other literature findings. Finally, the strengths and weaknesses of the review will be outlined.

The review (Vusio et al., 2019) was published in the European Child and Adolescent Psychiatry journal prior to the submission of this thesis. This chapter is an amended version of the original review (**Appendix-2**).

4.2 Background and the main aims

As explained in Chapter 1, the high national prevalence of CYP mental health illness in the UK, weaknesses in the current CAMHS provision, the presence of barriers to accessibility, unattractive service provision and an increase in rates of CYP help-seeking have placed considerable pressures on urgent and emergency settings in the UK. In order to reduce these pressures on these settings, research evidence suggests using alternative models that will intervene early to prevent escalation of CYP mental health and decrease pressures on urgent and emergency settings by developing community-based models and less restrictive treatments. These alternative models would act as gatekeepers for the inpatient admission of CYP and would also help develop more cost-effective services.

Three conducted systematic reviews between 2009 and 2016 identified a range of alternative models, both in the UK and around the world, designed to prevent CYP admission to urgent and emergency settings (Table 7).

Table 7 - Community-based alternative models to inpatient setting identified from previously conducted systematic reviews

Model	Description	Source
Multisystemic therapy (MST)	Community-based, family-centred, ecological oriented therapy approach delivered to individuals and families with 24/7 access. Most of the therapeutic approaches used are family therapy, behavioural therapy, CBT, crisis intervention with aftercare plans and peer support. Some CYP behaviours improved with MST.	Shepperd et al.,2009
Day hospitals (patient treatment)	These models are intended in some studies for the treatment of eating disorders. One review found that these alternative models are effective and achieve a similar outcome as inpatient admissions. Also, this alternative was considered cost-effective.	Shepperd et al.,2009 Kwok et al. 2016
Intensive specialist outpatient services	Represents a holistic approach that provides CYP treatment as well as counselling for parents on behavioural management. The model is mainly known for its treatment of eating disorders in a community setting, in the UK, using motivational interviewing, CBT, dietary therapy and medication for CYP, while the multidisciplinary team delivers treatment. CYP who received these services did not improve any more than CYP who did not.	Shepperd et al.,2009
Family preservation (wraparound) services Intensive (aka Home-Based crisis interventions)	The main aim of this model is to prevent the out-of-area placement of CYP at high risk of hospital admission while attempting to meet a range of CYPs and their family needs. The model delivers a range of interventions such as CBT, anger management and respite. Services are available 24/7. Small improvements were evident in CYP once they have been discharged from this intervention.	Shepperd et al.,2009

Intensive Home Treatment	A child and family-centred approach aimed to decrease an individual's psychiatric presentations and problem-solving. Family therapy and crisis interventions are provided. CYP who received these services did not improve any more than CYP who did not.	Shepperd et al.,2009
Intensive Case Management (ICM)	A package of care that used an assertive community treatment and outreach model and a case management model. Effective in reducing the length of hospital stay and improving the retention of care, but less consistency was evident with improving the quality of life. A meta-analysis of the UK trails showed no evidence of a reduction in the average length of hospital stay or improvement in the quality of life. Likewise, the review also found that ICM showed evidence that it was not clinically and cost-effective, while service users expressed satisfaction with this model.	Paton et al. 2016
Temporary residential care (Crisis houses)	CYP live in a community-based temporary residence that is not urgent or emergency setting. Similar lack of evidence has been identified as in the case of the foster care provision. However, these models are recommended by NICE as an alternative to hospitalisation and may benefit service users in crisis due to a more personal approach and calmer environment.	Shepperd et al.,2009 Paton et al., 2016
Therapeutic foster care provision	A community-based model designed for CYP affected by mental health issues that enables them to live with specially trained foster parents for a short time. The review found no randomised evidence comparing this alternative to inpatient settings or other alternative models.	Shepperd et al.,2009
Early Intervention for psychosis services (EIPS)	EIPS models are based on early intervention and prevention, while evidence has shown that these models are effective in promoting recovery and reducing the duration of untreated psychosis. Also, CBT intervention for psychosis resulted in moderate-to-high evidence of effectiveness in a reduction in relapse, readmission and symptoms related outcomes.	Paton et al. 2016
Assertive outreach (AO)	AO is the community-based model that ensures the delivery of repeated visits to service users where service users are not present within the clinic, telephone calls to family members in the event of service users non-compliance or reluctance to meet with the CRT.	Shepperd et al.,2009
Crisis Resolution and home treatments (CRHT)	Were created as a gatekeeper to prevent admission to inpatient settings and reduce pressures to A&E and hospital wards. These models are both clinically and cost-effective. CRHTs use assertive engagement strategies to assess patients in person. However, the review found that the quality of evidence was considered low due to lack of evidence, high heterogeneity and high risk of bias.	Paton et al. 2016
Telephone crisis line (Triage)	Most of the evidence supports telephone triage that screens through referrals and diverts crisis teams where needed. However, the review failed to find evidence describing the effectiveness of telephone triage on access before reaching a crisis point.	Paton et al. 2016
Supported Discharge Services (SDS)	Were created to facilitate and support early hospital discharge and treating patients in a community-based or home settings.	Kwok et al. 2016

The review by Sheppard et al., (2009) concluded that there is a lack of high-quality evidence to understand these model's true potential as suitable alternatives to urgent and emergency admissions. However, the review concluded that these models could be considered as an

alternative to inpatient settings, although limited understanding of the evidence provides for further development of these alternatives (Shepperd et al., 2009; Vusio et al., 2019).

A similar conclusion was also drawn from another review, which concluded that these models varied largely in organisation and structure, with limited methodological evidence (low to very low) of their clinical effectiveness (Paton et al., 2016b; Vusio et al., 2019). Likewise, the review by Kwok et al.,(2016) also agreed that Intensive Community models showed a lack of support for their effectiveness as an alternative to urgent and emergency settings (Kwok et al., 2016; Vusio et al., 2019).

What can be seen from this literature background is that some steps have been taken in the right direction to create and improve alternatives to urgent and emergency settings (Vusio et al., 2019). However, despite some evidence that these models may be seen as suitable alternatives to restrictive settings, it is also evident that there is a lack of evidence regarding their effectiveness (Vusio et al., 2019). In addition, some of these reviews reported general satisfaction with these alternatives, but none of these reviews investigated the experiences of CYP and their families while receiving treatment from these alternatives (Vusio et al., 2019). As a result, there is still a lack of experiential evidence of the experiences of service users, as well as a lack of knowledge whether any new model have emerged out of these alternatives and whether these models have developed new interventions or treatments that may help to reduce or prevent urgent or emergency admissions.

This systematic review was therefore conducted to explore the following research questions: (1) What are the experiences and satisfaction of CYP and their parents, with mental health crisis services or alternatives to inpatient settings? (2) What are the identified interventions that can be applied to CYP in urgent and emergency settings? (3) In addition to well-established and well-known models, are there new emerging alternatives models to inpatient or emergency department admissions for CYP experiencing mental health crisis? (Vusio et al., 2019).

4.3 Methodology

This systematic review was carried out and reported in accordance with the PRISMA guideline (Moher et al., 2010). The systematic review protocol for this review has been submitted and approved by PROSPERO (CRD42019110875).

4.3.1 Searching strategy

The searching strategy was expanded from previously conducted systematic reviews (Kwok et al., 2016; Paton et al., 2016b; Shepperd et al., 2009). The researcher developed the search strategy by combining terms ‘*alternatives to inpatient settings*’, ‘*urgent and emergency mental health provision*’, ‘*children and young people*’, and ‘*patient satisfaction*’ (Table 8) (Vusio et al., 2019). The searching strategy was applied on Ovid (Medline, Psychinfo, and Embase), Scopus; Web of Science; CINAHL and ASSIA databases.

‘Parents’ were not directly used in the search strategy, as initial searches that included ‘parents’ generated very (overwhelmingly) broad results that focused primarily on parental/adult mental health and their experiences of AMHS. Instead, the terms “*user experience OR subjective experience*” were used to encompass parents’ experiences. The search strategy was created in cooperation with a University of Warwick librarian who specialises in medicine and psychology literature.

Table 8 - Example of searching strategy (applied to Ovid Medline)

Term 1 (and)	Term 2 (and)	Term 3 (and)	Term 4
((Child OR adolescen\$ OR youth\$ OR teenage\$ OR ‘young people’)	(mental health crisis OR mental health crises OR (mental health emergency OR mental health emergencies) OR (psychiatric adj (crisis OR crises OR emergenc* OR acute OR intensive)) OR (mental\$ adj disorder\$) OR (mental\$ adj ill\$) OR psychopathology)	(ambulatory care OR residential treatment OR home care service\$ OR psychiatric hospital* OR community mental health service* OR inpatient* OR community service* OR wraparound OR psychotherapy OR early intervention OR crisis intervention OR foster home care OR continuity of patient care OR (alternative adj (inpatient or in-patient)) OR assertive community treatment* OR mobile mental health crisis OR (multi-systemic or mult-systemic) OR virtual mental health OR respite centre OR outpatient treatment OR child\$ mental health service\$ OR mental health treatment* OR mental health hospital admission OR mental health treatment outcome*)	(user experience OR subjective experience OR patient satisfaction OR patient perspective))

The final re-run of the searching strategy was completed in June 2019 with no additional articles identified. In addition to the searching strategy, forward and backward manual searches applied to the studies that met the inclusion criteria were carried out in this review. The backward searches helped to identify and examine the references cited in the articles, while forward-searching strategy allowed to identify any recent publications made by authors of studies that met the inclusion criteria after the publication of their article.

4.3.2 Eligibility

- Studies published between January 1990 and December 2018
- Studies describing CYP experiences with mental health crises or acute mental health
- Studies describing the experiences of parents or caregivers of CYP who have experienced mental health crises or acute mental health
- Studies describing models and interventions applied to both mental health crises and alternatives to inpatient settings or improving inpatient admission and reducing the length of stay

Infobox 3. Criteria for inclusion of articles

- Studies that involved patients over 25 years of age or reported perceptions of staff
- Other systematic reviews; book chapters; dissertations; grey literature; and articles on young offenders and learning disabilities were also excluded
- Studies published in languages other than English were also excluded

Infobox 4. Criteria for the exclusion of articles

4.3.3 Study selection

All articles obtained from the seven electronic databases were transferred into the software 'Rayyan' (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016) for further analysis. After removing all duplicates, two researchers (FV and LC) independently screened titles and abstracts. Any study meeting the inclusion criteria were examined independently by two researchers (FV and LC). Any disagreement between the researchers was dealt with by involving a third party. The decision of a third-party (AT) was considered final.

4.3.4 Quality assessment and risk of bias

The quality of the articles included was assessed by the Mixed Methods Appraisal Tool (Hong et al., 2018a). The MMAT is deemed as a critical appraisal tool that is appropriate for mixed-method studies or qualitative and quantitative studies (Hong et al., 2018b). According to Hong et al. (2018b) the MMAT tool “*permits to appraise the methodological quality of five categories to studies: qualitative research, randomised controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies*” (Hong et al., 2018b). As recommended by Hong et al. (Hong et al., 2018b), and due to the lack of research evidence in this particular area this systematic review did not exclude studies with low methodological quality.

Appraised studies were divided into three categories according to their quality:

- Low (meeting minimum criteria)
- Medium (meeting three of four criteria)
- High (meeting all five MMAT criteria)

If any of the studies did not meet the MMAT minimum screening criteria (Hong et al., 2018a), the study was included and reported, but without the MMAT screening result. We found only two papers that did not meet the MMAT minimum screening criteria (Hart, Blincow, & Thomas, 2008; Kaplan & Racussen, 2013).

4.3.5 Extraction of data

The data extraction form was initially developed and tested on a smaller sample of studies and was later used on the 19 identified articles. Two reviewers (FV and LC) independently carried out the extraction of data. The results of the review are divided into four main themes as shown in table 9, with the following data extraction information: author; year of publication; country of origin; model or intervention name; study design; age and sample size; key findings; outcomes and satisfaction.

4.3.6 Data synthesis

The review adopted a three-stage narrative synthesis approach as described by Popay et al. (Popay et al., 2006). The first stage began with the development of a preliminary synthesis of the findings of the included studies. In the second stage, it was recommended to explore relationships both within and between studies, while the third stage required a robustness assessment of the synthesis. The systematic review found that all included studies had significant variations with their methodologies, and therefore a meta-analysis was not conducted. However, the qualitative studies were analysed by themes and subthemes.

4.4 Results

4.4.1 The selection of studies

A total of 477 articles were identified by using the created searching strategy, out of which 23 additional articles were identified using manual searches of reference lists. After all duplicates were removed, 235 articles were excluded, while 260 articles were selected for full-text examination (Vusio et al., 2019). The main reasons for excluding these articles were due to lack of relevance to CYP mental health, non-CYP study populations, and a focus on inpatient settings (Figure 31).

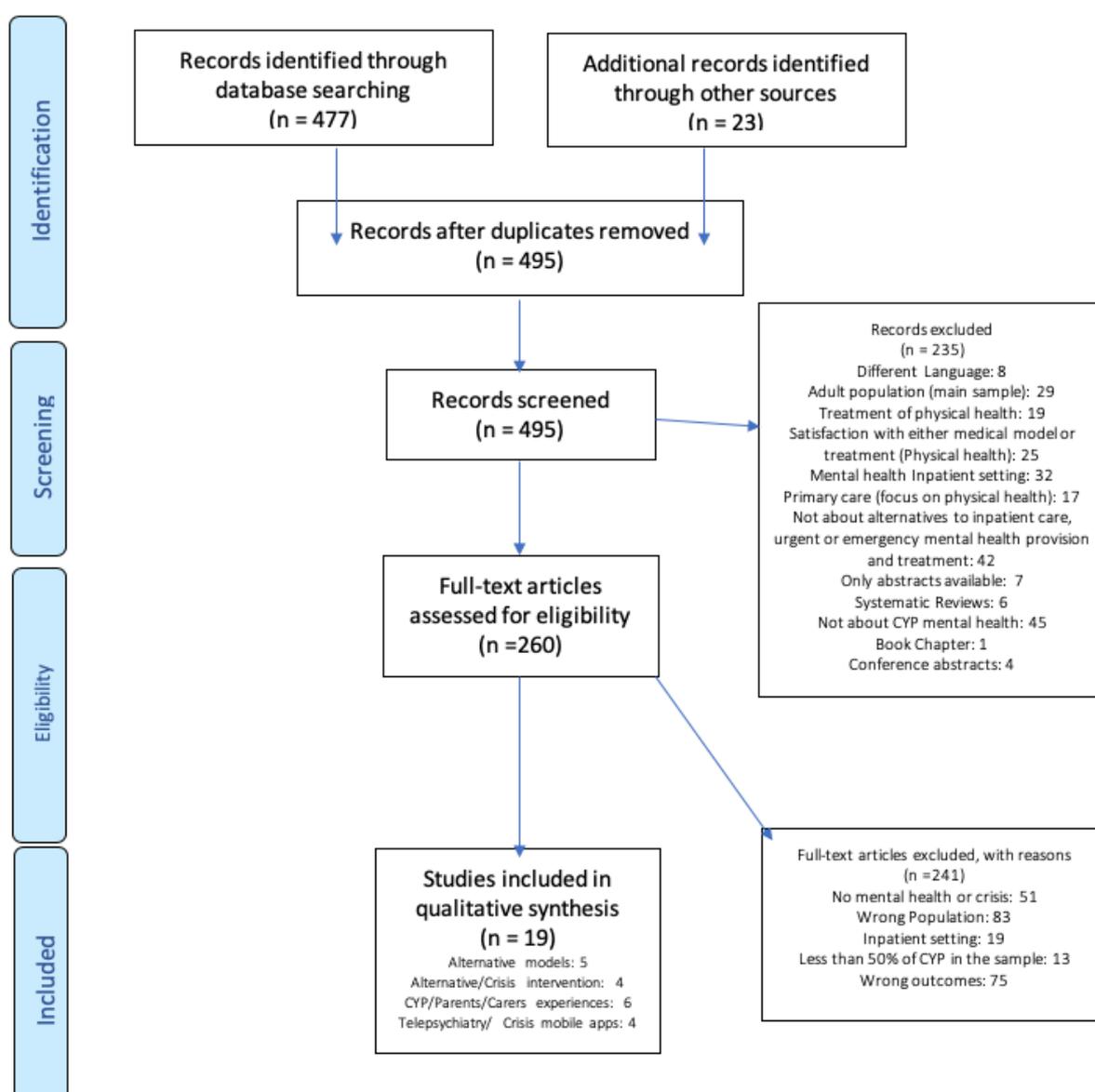


Fig 31. Prisma flowchart selection process

Of the 260 articles that were thoroughly reviewed, 19 articles were independently selected for inclusion by two reviewers (FV and LC). There were no disagreements between reviewers. The complete selection process is presented in the PRISMA flow chart (Moher et al., 2010) (Figure 31).

The 19 studies included in this review were from five different countries; eight studies came from the UK (Albert & Simpson, 2015; Hart et al., 2008; Kaplan & Racussen, 2013; Ougrin et al., 2018; Pardi & Willis, 2018; Pycroft, Wallis, Bigg, & Webster, 2015; Sfar-Gandoura, Ryan, & Melvin, 2017; Wright, Roberts, Redmond, Davies, & Varley, 2016), five from the US (Asarnow, Berk, Hughes, & Anderson, 2015; Cordell & Snowden, 2015; Ginnis, White, Ross, & Wharff, 2013; Narendorf et al., 2017; Thomas et al., 2018), three from Australia (Brennan et al., 2016; M Olasoji, Maude, & McCauley, 2017; Ospina-Pinillos et al., 2018), two from Canada (Roberts, Hu, Axas, & Repetti, 2017; Sukhera, Lynch, Wardrop, & Miller, 2017) and one from Denmark (Andreasson et al., 2017). Eight studies utilised a qualitative methodology (Albert & Simpson, 2015; Brennan et al., 2016; Narendorf et al., 2017; M Olasoji et al., 2017; Ospina-Pinillos et al., 2018; Pardi & Willis, 2018; Pycroft et al., 2015; Sukhera et al., 2017) and two studies were based on a qualitative case study approach (Ginnis et al., 2013; Hart et al., 2008). On the other hand, three studies followed a quantitative descriptive approach (Roberts et al., 2017; Sfar-Gandoura et al., 2017; Thomas et al., 2018), while one study had a mixed-methods design (Wright et al., 2016). Two studies followed an RCT design (Asarnow et al., 2015; Ougrin et al., 2018) and two studies were non-randomised with their methodological approach (Cordell & Snowden, 2015; Kaplan & Racussen, 2013). Finally, one study was identified as an RCT protocol (Andreasson et al., 2017). Only three studies (Albert & Simpson, 2015; Brennan et al., 2016; M Olasoji et al., 2017) included experiential data from parents and relatives while remaining studies involved only CYP aged 0-25. The size of the CYP sample in the included articles ranged from 5 to 1397. Detailed information on the included studies can be found in table 9.

4.4.3 Synthesis of results

The final sample consisted of 19 articles included in this review, which provided outcome evidence in the following four domains: alternative models (Kaplan & Racussen, 2013; Ougrin et al., 2018; Pardi & Willis, 2018; Sfar-Gandoura et al., 2017; Wright et al., 2016); interventions

applied to Crisis (Asarnow et al., 2015; Cordell & Snowden, 2015; Ginnis et al., 2013; Hart et al., 2008); telepsychiatry and mobile applications applied to mental health crisis (Andreasson et al., 2017; Ospina-Pinillos et al., 2018; Roberts et al., 2017; Thomas et al., 2018); and experience and satisfaction with mental health crisis provision (Albert & Simpson, 2015; Brennan et al., 2016; Narendorf et al., 2017; M Olasoji et al., 2017; Pycroft et al., 2015; Sukhera et al., 2017).

Table 9 - Details of included studies according to the author (year,) study design, sample characteristics, intervention details, and a summary of the main findings

Author(s)/Study design/ MMAT	Model name / Participants Sample	Model description / Interventions	Key findings / Satisfaction / Outcome measures
<p>Sfar-Gandoura, Ryan & Melvin (2017)</p> <p>Study Design: Nonrandomised, observational study MMAT Score: Moderate</p>	<p>Models Name: ADHD one-stop-shop (drop-in) Location: UK, East Midlands, Leicester City Number of participants: N=62 AGE: M= 10.87 (Range 6-18 yrs.) CYP Gender: 14.8% male and 85.2% female. Parental gender: 80.3% mothers, 12.1% fathers and 4.9% other relatives CYP medical condition: ADHD</p>	<p>Model description: Nurse-led, multi-agency drop-in clinic. Created to improve access, flexibility, efficiency and satisfaction. The main aim is to reduce waiting times for CYP experiencing a crisis. The intervention provided: Combination of medication therapy, crisis intervention, psychosocial intervention and behavioural support</p>	<p>KEY Findings: The majority of CYP attended the clinic at three monthly intervals - safe and adequate monitoring of ADHD medications. The clinic improved accessibility and flexibility of services. A significant reduction in the waiting time is evident from identified crisis to being seen. An increase in contact with nursing staff reduced the number of time medics spent with CYP. A reduction in the amount of time CYP spent away from work/school. SATISFACTION: Improvement in CYP experiences compared to the traditional clinical model. CYP felt that the service was flexible to their needs, compared to previous clinics, p=0.009</p>
<p>Pardi and Willis (2018)</p> <p>Study Design: Qualitative (focus groups /interviews) with Purposive sampling MMAT Score: Moderate</p>	<p>Models name: Clubhouse model Models Location: London, UK Number of participants: 5 AGE: M=23 (16-25) CYP Gender: 2 Males and 3 Females CYP medical condition: Range of conditions</p>	<p>Model description: Recovery orientated, participatory communities in which people with mental health diagnoses can take part in the running of the clubhouse Intervention provided: No official interventions provided, only signposting to appropriate mental health service</p>	<p>Key findings: Previous studies found that clubhouse attendance resulted in fewer hospital admissions. Use of clubhouses as alternatives to A&E, where appropriate, may reduce pressures on mental health services. A need for qualified staff in the clubhouse to help young people with a mental health crisis. Sense of personal change and social improvement experienced. Highlighted benefits of the model: collaborative approach, flexibility and a preventative role in reducing the mental health crisis. This model may be beneficial if it is capable of reducing dependence on crisis services for some young people. SATISFACTION: Preference of participants to use clubhouse over mental health or crisis services, where possible. The more positive experience of the clubhouse model than other mental health services, due to not feel judged or youth input being more valued.</p>
<p>Wright, Roberts, Redmond, Davies & Varley (2016)</p> <p>Study Design: Mixed-Methods (Survey plus Qualitative interviews) MMAT Score: Moderate</p>	<p>Models name: York Community Model Model Location: UK, Yorkshire, York Number of participants: Not reported AGE: 0-18; plus, transition teams 18-25 CYP Gender: Not reported CYP medical condition: Range of conditions</p>	<p>Model description: Accessible and smooth care pathways with a single point of referral access. The initial assessment is locality-based with multiagency and multidisciplinary, triage systems. The service is closely integrated across levels of need. CYP do not fall into gaps between services. Referral to more specialised services is made where necessary. The intervention provided: Various range of interventions</p>	<p>Key findings: Model emphasise the importance of social and emotional development and psychological functioning of CYP. The model creates conditions where a child's needs can be addressed on a day-to-day basis rather than through a "clinic-based model". An innovative model with a single point of referral, based on a multi-disciplinary and multiagency triage system. Integration across the level of needs with no gaps in which CYP could fall. The partnership between voluntary and statutory agencies and integrated collaboration. SATISFACTION: Not reported</p>
<p>Kaplan & Racussen (2013)</p> <p>Study Design: Narrative description (Case study) MMAT Score: Not applicable</p>	<p>Models name: The New Beginnings crisis recovery model - Not currently operational Models location: London, UK Number of participants: Not reported AGE: 13-18 CYP Gender: Not reported CYP medical condition: Range of conditions</p>	<p>Model description: A recovery model that was developed to reduce 80% of all admissions duration of less than 42 days on average. The model may be suitable for use by community services dealing with YP in crisis. The model works on the premise that a stable problem becomes a crisis through disorganisation and disempowerment. The intervention provided: Managing disorganisation; Systemic functional analysis of the presenting problem; and change required; Agreeing on the minimum change(s); Empowerment and Enhancing motivation</p>	<p>KEY Findings: Initially devised for an inpatient setting, this model may be adapted for use by community services to manage crises and reduce the need for inpatient admissions. The model aimed to improve CYP satisfaction and accessibility. The model's way of managing the referral, assessment and experience of a mental health crisis has advantages beyond a short length of stay, and recommend it for improvement of accessibility, patient empowerment, and the specialist community care. OUTCOME MEASURES: The CGAS changes between admission and discharge was 32 to 48 for 'psychotic patients' and 40 to 52 for 'suicide ideation' patients, with 25% CYP achieving this in a stay of less than 14 days SATISFACTION: A patients satisfaction was favourable with summated satisfaction scores well above 80%.</p>
<p>Ougrin et al., (2018)</p> <p>Study Design: Mixed-Methods: Single-blind, patient-level, parallel-group, RCT MMAT Score: Moderate</p>	<p>Models name: Supported Discharge Service (SDS) Models location: South London NHS Trust, UK Number of participants: 106 AGE: M=16.23 (12-17) CYP Gender: Not reported CYP medical condition: Psychiatric emergencies (psychosis and self-harm)</p>	<p>Model description: The SDS teams operated 8:00 to 20:00 with out-of-hours 24/7 cover available if required. The intervention provided: Intensive case management, home treatment, day care in the hospital setting or any combination of the three according to need.</p>	<p>KEY Findings: Improved school reintegration with SDS compared with usual care, with similar clinical and patient satisfaction outcomes, as shown in previous studies. The proportion of service users with self-harm episodes was reduced. Intensive community treatment models may be viewed as an alternative to usual inpatient care. SDS could be cautiously considered for implementation by other treatment centres. OUTCOME MEASURES: Hospital use at six months was significantly lower in the SDS group than in care as usual group (unadjusted median 34 IQR 17-63 vs 50 days, 19-125, p=0.04). The ratio of mean total inpatient days for care as usual to SDS was 1.67 (95% CI 1.02-2.81, p=0.04), while decreasing to 1.65 (0.99-2.77, p=0.057) when corrected for differences in the use of hospital before randomisation. The CGAS and SDQ scores did not differ between groups SATISFACTION: Satisfaction with the services did not differ</p>

Author(s)/ Study design/ MMAT	Intervention name / Participants Sample	Intervention description	Key findings / Satisfaction / Outcome measures
<p>Ginnis, White, Ross & Wharff (2015)</p> <p>Study Design: a case study (Qualitative narrative) MMAT Score: Low</p>	<p>Intervention name: Family-Based Crisis Intervention (FBCI) Country: US Number of participants: 1 AGE: 15 CYP Gender: Female CYP medical condition: Suicide ideation</p>	<p>Intervention description: A psychiatric intervention, used to optimise care for suicidal adolescents and their families in the ED. The FBCI is a combination of natural support and traditional outpatient mental health services, aimed to provide clinically indicated treatment and to avoid hospitalisation. The intervention provided/duration: Following the initial assessment, the core components of FBCI are utilised to stabilise the patient and to explore all treatment options with the family (Range of different therapies applied which are part of FBCI). Few hours of intervention, followed by telephone follow up and community treatments</p>	<p>KEY Findings: The FBCI is a model of care for suicidal adolescents that may be a viable alternative to traditional ED care that views inpatient care as an endpoint. Patient's case demonstrates that with acute family intervention in the ED, an adolescent can be safely discharged to home care. The patient was able to engage in a less restrictive form of treatment and acquire treatment more expeditiously than if the patient had awaited inpatient admission. The patient received immediate treatment for its acute symptoms, avoided unnecessary use of limited ED and inpatient resources, and returned home. Patient's discharge plan included intensive follow-up services. The FBCI represents a paradigm shift away from traditional emergency psychiatry practice. The goal of FBCI is to help the patient and family/caregivers engage in crisis intervention to reduce patients suicidality SATISFACTION: Both patient and parents reported improved individual and family functioning, and satisfaction.</p>
<p>Hart, Blincow & Thomas (2008)</p> <p>Study Design: Qualitative (Case study) MMAT Score: Not applicable</p>	<p>Intervention name: Resilient Therapy (RT) Country: UK Number of participants: 1 AGE: 10 CYP Gender: 1 Female CYP medical condition: Mental Health Crisis,</p>	<p>Intervention description: The RT is designed to meet the needs of CYP who experienced crisis by providing them with an insights and analytical tools that help carers and practitioners and rapport. The framework provided by RT helps practitioners to design and carry out interventions that enhance resilience in CYP. It offers a user-friendly account of evidence-based strategies that can be merged in an application to one specific context. The intervention provided/duration: In the magic box, each section is represented as a compartment or remedy rack: Basics, Belonging, Learning, Coping and Core Self.</p>	<p>KEY Findings: The Resilient Therapy (RT) helps practitioners to design and carry out interventions that enhance resilience in young people. The RT is reflexive, aimed at individual practitioners themselves as well as CYP children and their families. The RT an outcome-focused strategic approach to meet the needs of children. The intervention is designed to improve children's functioning and can be applied by individual workers, parents and young people in many different contexts. The metaphorical language of "ordinary magic", "spells" and "potions" appeals to parents and CYP, reducing the need for the complex language of resilience mechanisms and outcomes. The RT achieved positive outcomes; however, further details were unreported . SATISFACTION: Not reported</p>
<p>Asarnow, Berk, Hughes & Anderson (2015)</p> <p>Study Design: RCT MMAT Score: Moderate</p>	<p>Intervention name: The Safety Program (SAFETY = Safe Alternatives for Teens & Youth) Country: US Number of participants: 35 AGE: M=14.89 (Young people age 11-18) CYP Gender: Female (predominantly) CYP medical condition: 46% multiple suicide attempts, 57% NSSI, 40% major depressive disorder (MDD), 62.5% met DISC criteria; 50% reported current severe depressive symptoms</p>	<p>Intervention description: The Safety is a brief intervention designed for ED's for suicide-attempting youths. It is a 12-week trial of the SAFETY Program; a CBT family intervention designed to increase safety and reduce suicide-attempt (SA) risk. The family emphasis also aimed to increase parent motivation and decrease family treatment barriers. Intervention provided/duration: In 12 weeks, youth received a mean of 10.14 sessions, SD= 4.63. Most youths (57%) received 9-13 sessions. Range of different therapeutically approaches applied</p>	<p>Key findings: Safety, feasibility, and benefits of the SAFETY intervention is described in this study. Results support the need for a larger RCT to further evaluate efficacy and effectiveness. Suicide-attempting youth are at high-risk for repeat attempts and continuing mental health problems. Results support the value of an RCT to evaluate further the SAFETY intervention Outcomes measures were evaluated at baseline, 3-and 6-month follow-ups. The study used a range of outcome measures in month three assessment. In the month six parent telephone-interviews included the DISC suicidal ideation and attempt items, and SACA questions assessing ER visits, hospitalisations, and residential placements. SATISFACTION: Treatment satisfaction was high in youths and parents. Mean satisfaction ratings were 4.07 (SD=1.11) and 4.1 (SD=0.79) for parents and youths, respectively, on a scale of 1 to 5 (5= very satisfied).</p>
<p>Cordell & Snowden (2015)</p> <p>Study Design: Secondary observational – quantitative MMAT Score: Moderate</p>	<p>Intervention name: Clinical measure of emotional distress dispositions - The Child and Adolescent Needs and Strengths Mental Health (CANS) Country: US Number of participants:1397 AGE: M age= 12.8 (3.1) CYP Gender: Female CYP N= 425; Male CYP N=972 CYP medical condition: crisis, anxiety, anger, or depression</p>	<p>Intervention description: CANS is a comprehensive, intervention-oriented instrument for assessing children with emotional and behavioural health care needs. A widely employed, psychometrically favourably evaluated assessment for problem evaluation and treatment planning. Intervention provided: At least six months with a range of different therapeutic approaches ranging from crisis intervention, wraparound or residential</p>	<p>KEY Findings: Assessment of youth crisis events in residential and community settings. Results showed the presence of strong associations for YP's anger control and frustration management, a weaker correlation for anxiety/anxious disposition, and no significant association for irritability/poor self-control problems. This is an important finding as it validates the ability to identify emotional distress presented early within treatment in the clinical setting. Aggregate emotional distress differences for YP in school, probation, wraparound, residential, or community mental health programming contributed a little beyond emotional distress differences among individual YP. Clinically measured emotional distress dispositions prompted significant behavioural disruption for YP in residential care as well as in community services, and they can be detected early in treatment for guiding remedial efforts, considering that a broad definition of crisis events was adopted for this study. SATISFACTION: Unreported</p>

Author(s) /Study design/ MMAT	TMH application name / Participants Sample	Tele-mental Health description	Key findings / Satisfaction / Outcome measures
<p>Andreasson et al., (2017)</p> <p>Study Design: Study protocol for a randomized controlled trial</p> <p>MMAT Score: Low</p>	<p>TMH Name: Myplan – mobile phone application</p> <p>Location: Denmark</p> <p>Number of participants: 546 participants, 273 in each arm, will be recruited.</p> <p>AGE: CYP – no age restrictions</p> <p>CYP Gender: Not recruited yet</p> <p>CYP medical condition: Risk of Suicide ideation and Mental Health crisis</p>	<p>Model description: The Myplan helps patients to continue working with their suicidal triggers, coping strategies, and developing a new strategy in the app, as well as continuously revising existing ones. The range of additional features is presented (map function with the current location and the nearest ED as a help in a crisis situation, direct phone links to selected contacts, or virtual hope box).</p> <p>Technology application: Experimental intervention: the safety plan provided as the app My Plan, or Treatment as Usual</p> <p>Duration: 12 months</p>	<p>Purpose of the study: The purpose of the trial was “to investigate if this app, compared to a plan delivered by paper, can reduce suicide ideation, as measured with the Beck Suicide Ideation Scale (BSS), after 12 month’s intervention in patients referred to Suicide Prevention Clinics”. The study hypothesis was that an app-based safety plan would be more effective compared to a paper-based version, based on its availability and accessibility of mobile phone technology.</p> <p>Outcomes measures: The fact that suicidal ideation fluctuates over time for many patients indicates that a tool such as Myplan, which is available at most times, might be a highly relevant resource for people at risk of suicide. The Beck Suicide Ideation Scale (BSS 21-items) will be used. Secondary outcomes were hopelessness (measured by the Beck Hopelessness Scale, BHS) and depressive symptoms (using the Major Depression Inventory, MDI); these were measured before participants entered the trial and post-discharge participation at months 3, 6, 9, and 12.</p> <p>SATISFACTION: App/ user satisfaction will be measured by a modified user satisfaction the Client Satisfaction Questionnaire (CSQ-8)</p>
<p>Ospina-Pinillos et al., (2018)</p> <p>Study Design: Qualitative (PPI)</p> <p>MMAT Score: Moderate</p>	<p>Models name: Mental Health eClinic (MHeC)</p> <p>Models Location: Australia</p> <p>Number of participants: 18 participant in stage 1; 9 participants in stage 2</p> <p>AGE: 16-25</p> <p>CYP Gender: There was equal gender participation, and 78% (14/18) were aged between 18 and 25 years.</p> <p>CYP medical condition: Service users of the Headspace</p>	<p>Technology description: An attempt to develop the Mental Health eClinic (a Web-based mental health clinic) to improve timely access, and better quality of CYP mental health care</p> <p>Technology application: Video conferencing was found to be as reliable as face-to-face assessments. Example: Synergy is a Web-based modular platform linking integrated and interoperable resources while operating through existing health providers to promote access to high-quality and cost-effective mental health services</p> <p>Duration: 12 months</p>	<p>Key findings: This study utilized an innovative approach to the development of a web-based mental health clinic for young people. The first time that a Web-based clinic has been conceptualised and code signed through an iterative cycle with end-users. The main components of this system ensure that young people seeking help can find what they need within one system.</p> <p>Outcomes: One of the strengths of the system is that it integrates new and emerging technologies with the traditional face-to-face process. Several studies emphasise that screening alone is insufficient for connecting end-users with the necessary resources for effective treatment</p> <p>SATISFACTION: Unreported</p>
<p>Roberts et al., (2017)</p> <p>Study Design: Prospective study (Quantitative)</p> <p>MMAT Score: Moderate</p>	<p>Models name: Telepsychiatry</p> <p>Model Location: Canada</p> <p>Number of participants: N=120</p> <p>AGE: The average age of patients was 14</p> <p>CYP Gender: 67% of the sample were females</p> <p>CYP medical condition: High % with no assigned disorders and a higher % diagnosed with adjustment disorder</p>	<p>Technology description: Videoconferencing was found to be as reliable as face-to-face assessments, and more cost-effective. Telepsychiatry may serve as a user-friendly, efficient, and cost-effective method of providing mental health services to rural and remote communities</p> <p>Intervention provided: utilisation of video-conference in assessment and treatment</p> <p>Duration: 12 months</p>	<p>Key findings: Telepsychiatry is acceptable to patients and families for safe emergency assessment and follow-up, reducing unnecessary travel to urban centres. Longer time outcomes are needed to establish the validity of telepsychiatry for emergency assessments. Telepsychiatry may serve as a user-friendly, efficient, and cost-effective method of providing mental health services to rural and remote communities</p> <p>Outcomes: no further mental health services required, brief (up to 4 weeks) follow-up in CAMHUCC, referral to the local CMHA, referral to other outpatient clinics in the CYP division, or hospital admission.</p> <p>SATISFACTION: Patients reported a high degree of satisfaction with the use of telepsychiatry and the majority stated that the model was user friendly, and that they are willing to re-access the service in the future.</p>
<p>Thomas et al., (2018)</p> <p>Study Design: Cross-sectional, pre-post design</p> <p>MMAT Score: Moderate</p>	<p>Models name: Telepsychiatry</p> <p>Model Location: USA</p> <p>Number of participants: N=494</p> <p>AGE: M= 13.1-13.3 (Range 1-19)</p> <p>CYP Gender: Unreported</p> <p>CYP medical condition: Presentation with a behavioural health complaint that was not immediately life-threatening (Suicide, Self-Harm, Depression, Anxiety or Psychosis)</p>	<p>Technology description: Videoconferencing was found to be as reliable as face-to-face assessments, and more cost-effective. Telepsychiatry may serve as a user-friendly, efficient, and cost-effective method of providing mental health services to rural and remote communities</p> <p>Intervention provided: ED length of stay, disposition/discharge, and hospital system charges. Satisfaction surveys for telepsychiatry consultations were completed by providers and parents or carers.</p> <p>Duration: Short stay (5-8 hours)</p>	<p>Key findings: Compared to children who received usual care, children who received telepsychiatry consultations had a significantly shorter median length of stay (5.5 hours and 8.3 hours, respectively, p=001). Telepsychiatry is a dominant strategy over the care as usual for paediatric psychiatric emergency consultations presenting to an EDs, meaning that it should be adopted because it saves resources (lower charges) and time (improved efficiency). This study showed that telepsychiatry video consultation improved access to specialised services, and increased capacity of the service while promoting the delivery of appropriate care in geographically dispersed settings.</p> <p>SATISFACTION: Providers and patient caregivers reported high satisfaction with the overall acceptability, effectiveness, and efficiency of telepsychiatry. Patients, parents or carers, and ED providers all rated the services highly satisfactory.</p>

Author(s) / Study design/ MMAT	Participants Sample	Main Themes identified	Key findings
<p>Brennan et al., (2016)</p> <p><u>Study Design:</u> Qualitative, Thematic Analysis</p> <p><u>MMAT Score:</u> Moderate</p>	<p><u>Location:</u> Australia</p> <p><u>Number of participants:</u> 9</p> <p><u>AGE:</u> M= 65.78 years (SD = 7.45).</p> <p><u>Participant Gender:</u> All females</p> <p><u>Relation to patient:</u> Eight were mothers one spouse</p>	<p>Dissatisfaction with the service responses</p> <p>Negative/ inconsistent experiences exacerbated carer burden</p> <p>Sense of isolation</p> <p>Diminished confidence/trust in the support services</p> <p>Reluctance to involve with mental health service again</p> <p>Carer suffering (due to relative mental health crises)</p> <p>Need for recognition of carers experiences and appropriate support</p>	<p>The study explored carer’s perception and experiences of accessing crisis services and their responses. The four themes emerged from carers discussions: Carer suffering, inconsistent experiences with crisis services, desire for collaborative responses, and carer burden related to trust in services. These findings highlighted the need for professionals to recognise carers’ experiences and offer appropriate support. Priorities for crisis responses for carers were accessibility, rapid response times, and involvement, recognition and communication with carers during and following the crisis response. Carers expressed dissatisfaction with the service responses, which indirectly increased the pressures of caring and the risk of escalation of further crises. Conversely, negative and inconsistent experiences exacerbated carer burden, leaving carers isolated and with loss of confidence in the support services. If a carer had bad experienced from a particular service, it is less likely that they would be reluctant to involve them again.</p>
<p>Albert & Simpson (2015)</p> <p><u>Study Design:</u> Qualitative, Interpretative phenomenological analysis (IPA) method.</p> <p><u>MMAT Score:</u> High</p>	<p><u>Location:</u> UK</p> <p><u>Number of participants:</u>8</p> <p><u>AGE:</u></p> <p><u>Participant Gender:</u> All females</p> <p><u>Relation to patient:</u> Majority were mothers of the person with the mental illness, but also one daughter and one sister took part</p>	<p>Traumatic, terrifying and rejection experiences</p> <p>Complex feelings of guilt and loyalty</p> <p>Feelings of being abandoned, isolated and unsupported</p> <p>“double deprivation”</p> <p>Negative perceptions of crisis services</p> <p>Need to be acknowledged</p> <p>Feelings that society is not tolerating mental health crises</p>	<p>The relationship between mental health services and carers was the most prominent theme. When services acknowledge there is a crisis, the response to it is seen by the carers as ineffectual. The discrepancy between services in recognising a crisis and the experience of non-responsiveness left the carers feeling abandoned. Carers experienced ‘double deprivation’ as a result of not receiving support from professionals and protecting them from the effects of a crisis. The caring experiences in crisis invoked complex feelings of guilt and loyalty Caring was described as a terrifying experience.</p>
<p>Olasoji, Maude & McCauley (2017)</p> <p><u>Study Design:</u> Qualitative, descriptive design using a theoretical approach</p> <p><u>MMAT Score:</u> High</p>	<p><u>Location:</u> Australia</p> <p><u>Number of participants:</u>19</p> <p><u>AGE:</u> M=63.3 (Range: 40-76)</p> <p><u>Participant Gender:</u> 80% female (n=14) and 20% male (n=5).</p> <p><u>Relation to patient:</u> mothers (n=13); fathers (n=4) and other relatives (n=2)</p>	<p>Experiences of battling through the system</p> <p>Lost in maze</p> <p>“not sick enough” or “not in the crisis”</p> <p>Need to develop coping mechanisms and become more assertive</p> <p>Feelings of frustration, distress and anxious</p> <p>Felt tossed between services and not taken seriously</p>	<p>Carers were often denied access to crisis treatment due to their relative’s illness being classified as “not in crisis”, “not suitable’ or “not sick enough”. This often led to feelings of frustration, distress and severe anxiety. This study provides insight into the specific nature of such difficulties. There are needs for a clear definition of what constitutes a mental health crisis and signposting for carers when their relatives are in such situations. Appropriate support must be given to carers, especially during the period when their relatives are experiencing a crisis. Some participants reported positive experiences with the service provider, which led to good outcomes, while others highlighted negative experiences. The main issues raised by the carers were lack of communication, confidentiality, involvement with care planning, and not being listen to by health professionals.</p>
<p>Pycroft et al., (2013)</p> <p><u>Study Design:</u> Qualitative, Interpretative Phenomenological Analysis</p> <p><u>MMAT Score:</u> High</p>	<p><u>Location:</u> UK</p> <p><u>Number of participants:</u>6 CYP</p> <p><u>AGE:</u> M=17.33 (Range: 15-21)</p> <p><u>Participant Gender:</u> 50:50 ration male to female</p>	<p>In crisis and out of control</p> <p>Lack of information and understanding</p> <p>Problem with services</p> <p>Need for safe expression of feelings, ongoing support</p> <p>Need for staff to show that they care and shared decision making</p> <p>Barriers to help-seeking</p>	<p>The research identified three super-ordinate themes that reflected CYP experiences of receiving the UAT provision: in crisis and out of control, new helping relationships and building new lives. What emerged from these interviews were rich data that gave an insight into how service users experienced their journeys through the services: study findings both support and add to the existing research in this area.</p>
<p>Sukhera, Lynch, Wardrop & Miller (2017)</p> <p><u>Study Design:</u> Qualitative, Constructivist grounded theory</p> <p><u>MMAT Score:</u> High</p>	<p><u>Location:</u> Canada</p> <p><u>Number of participants:</u> 25 (16 CYP and 9 Parents/Carers)</p> <p><u>AGE:</u> Unknown</p> <p><u>Participant Gender:</u> Unknown</p>	<p>Sense of powerlessness and exclusion</p> <p>Issues of waiting times and waiting lists</p> <p>Lack of choice and engagement</p> <p>Difficult experiences whilst being treated for crisis</p> <p>Stigma</p> <p>Need for the therapeutic alliance</p> <p>Feeling of being judged, burden, frustrated</p>	<p>Difficulties that participants encounter in the current mental health system such as wait times, crisis-driven services, and feelings of powerlessness and exclusion among service users and caregivers. Study participants described problems with the current systems, and they also had innovative ideas about how to transform the system. A need for more flexibility emerged as a key finding along with the concept of immediate real-time services as a necessary shift from the traditional medical model. Solutions Include an Adaptive Recovery-oriented and Real-Time System of Care that Integrates hospital and Community Sectors. These services should also be community-based with a strong relationship between the hospital and the community</p>
<p>Narendorf et al., (2017)</p> <p><u>Study Design:</u> Qualitative, Open coded analysis</p> <p><u>MMAT Score:</u> Moderate</p>	<p><u>Location:</u> USA</p> <p><u>Number of participants:</u> 55 CYP</p> <p><u>AGE:</u> M=22.5 (Range: 18-25)</p> <p><u>Participant Gender:</u> 45% female (n = 25)</p>	<p>Fear of opening up and fear of stigma</p> <p>Importance of being listened and respected</p> <p>Barriers to treatment; Personal barriers; Barriers to others</p> <p>Experiences of treatment positive and negative</p> <p>Challenges of treatment</p>	<p>Main findings are clustered as: provider-related factors, treatment-related factors and environmental factors. Provider-related factors were the most frequently discussed and emerged as the most prominent aspect of both positive and negative treatment experiences. Similarly, participants described provider interactions and skills that shaped their experiences of treatment. The environment was frequently described, especially in inpatient settings. Findings highlight the importance of providers in both inpatient and outpatient care systems in producing positive experiences that may increase the engagement of young adults into psychiatric care and reduce future crisis visits. The stigma about seeking services combined with fear of opening up was highlighted barriers to seeking treatment.</p>

4.4.4 Alternative models to urgent and emergency settings

This systematic review identified five alternative models based in the UK.

York Model

The York model is fully integrated, a multidisciplinary and community-based model that works in partnership with the statutory and voluntary agencies to provide multiagency provision for CYP within the UK (Wright et al., 2016). The key benefits of this model are its accessibility, single point of entry, responsiveness, 24/7 crisis care for CYP, and fully integrated service which enables smooth navigation through care pathways for CYP (Vusio et al., 2019; Wright et al., 2016). Such aspects of the model minimise the need for re-referrals, since all services are closely integrated, thus preventing CYP from falling through the gaps between the services (Wright et al., 2016).

The One-Stop-Shop model

The One-Stop-Shop model takes a similar multiagency approach whilst being a nurse-led drop-in clinic for CYP who are affected by ADHD (Sfar-Gandoura et al., 2017). Although similar 'one-stop-shop' models are known and widespread in the UK, this particular model is innovative, as it allows a reduction in waiting time for CYP who are experiencing a crisis, with rapid access to appropriate crisis help, flexibility with care, and has improved efficiency and CYP satisfaction (Sfar-Gandoura et al., 2017).

The 'New Beginnings' crisis recovery model

The 'New Beginnings' crisis recovery model (Kaplan & Racussen, 2013) was developed as a recovery model used in inpatient settings, with a recovery-orientated and a flexible approach. The recovery model is founded on the idea that continuous exposure to a persistent problem contributes to a crisis (Kaplan & Racussen, 2013). In order to resolve CYP crisis, the model used a range of interventions to stabilise CYP by managing their disorganisation; applied systemic functional analysis of presented problems and identified the systemic functional analysis of

change required (Kaplan & Racussen, 2013; Vusio et al., 2019). However, the model no longer operates (Kaplan & Racussen, 2013). The crisis recovery model shows the potential to be adapted in community-based crisis settings to reduce the need for inpatient settings (Kaplan & Racussen, 2013).

The Support Discharge Service (SDS)

The Supported Discharge Service is a model comprised of intensive and assertive community treatment that shows a promising reduction in the need for inpatient admission, and self-harm rates and improved school reintegration in comparison to care as usual (Ougrin et al., 2018; Vusio et al., 2019). The use of the SDS community models may help in reducing a need for hospital or A&E admissions. The SDS model may be a useful alternative to the inpatient setting, but a degree of caution is needed if the SDS is applied to other treatment models (Ougrin et al., 2018).

The UK Club House model

The UK Club House model is a non-clinical and complementary model that may represent a non-clinical alternative to both inpatient setting and crisis services (Pardi & Willis, 2018). The Clubhouse model is a community-based mental health service and the mental health recovery model that supports YPs with complex mental health needs while helping them (YP) to reintegrate back into society (McKay, Nugent, Johnsen, Eaton, & Lidz, 2018; Pardi & Willis, 2018). One study found that, in some cases, the use of clubhouses can be an appropriate alternative to acute and emergency settings (Pardi & Willis, 2018). Even though the model is based in non-clinical and community settings and is not part of the NHS system, the model functions more like a charity organisation. The Club House model successfully signposts individuals to appropriate mental health services where and when needed. Moreover, this fluid and flexible approach of the model helps with early intervention and prevention of CYP in crisis. This particular model could also potentially bridge the gap in the transition of CYP between CAMHS and AMHS services (Pardi & Willis, 2018). However, there is a clear need to investigate further the fidelity of the clubhouse model (McKay et al., 2018; Vusio et al., 2019).

4.4.5 CYP Satisfaction with alternative models

Regarding service users satisfaction, the One Stop Shop model (Sfar-Gandoura et al., 2017) highlighted increased service users satisfaction and positive service experiences, as well as accessibility and flexibility compared to the previous service model in use. Similar positive CYP satisfaction with service provision is evident in the case of the Recovery model (Kaplan & Racussen, 2013), while CYP satisfaction in the case of the SDS did not differ from the care as usual (Ougrin et al., 2018). For the York model, CYP satisfaction data were not reported (Wright et al., 2016). Regarding the club house model, YP expressed more positive experiences than with other mental health services they had received (Pardi & Willis, 2018).

4.4.6 Urgent and emergency interventions

This review identified several interventions for the urgent and emergency care, three of which came from the USA (Asarnow et al., 2015; Cordell & Snowden, 2015; Ginnis et al., 2013) and one from the UK (Hart et al., 2008) respectively. The Family-Based Crisis Intervention (FBCI) (Ginnis et al., 2013) was initially developed for the Emergency Departments (ED) to prevent hospital admission, and provide patients and their families with a stabilisation intervention and signposting or treatment in the community-based setting, thereby avoiding hospital admission (Ginnis et al., 2013).

Similarly, the SAFETY program (Asarnow et al., 2015) is the brief CBT family intervention, devised for ED's for treating suicide-attempt in YP. Phase 1 of the study reported support for the safety, feasibility, and benefits of the SAFETY intervention, with statistically significant improvements in measures of hopelessness, suicidal behaviour, depression, and youth social adjustment in the intervention group (Asarnow et al., 2015; Vusio et al., 2019). However, further evaluation of the efficacy and effectiveness of the intervention is needed. In contrast, Resilient Therapy (RT) (Hart et al., 2008) represents an outcome-focused approach towards creating and improving the resilience of CYP and their families (Vusio et al., 2019). This therapy approach is devised to improve the functioning of CYP and is also a reflexive tool that can be applied in many different contexts (Hart et al., 2008; Vusio et al., 2019). The main advantage of the RT is an adapted language that can be easy to understand by CYP, as the intervention

uses simplified terms such as potions, magic, remedies and spells that service users can easily comprehend.

Finally, the clinical measure of emotional distress dispositions is an assessment of CYP crisis events in both residential, inpatient and community settings using the Child and Adolescent Needs and Strengths (CANS) intervention-oriented instrument (Cordell & Snowden, 2015). The findings of this study highlighted that the disposition of emotional distress could be measured clinically, and could be a valuable tool for assessing and early detecting CYP behavioural disruption in both residential and community settings (Cordell & Snowden, 2015; Vusio et al., 2019).

4.4.7 Satisfaction of CYP and their parents with crisis interventions

Two studies reported limited CYPs satisfaction and improvement in outcomes (Asarnow et al., 2015; Ginnis et al., 2013). CYP and their parents reported high satisfaction rates associated with their SAFETY intervention treatment (Asarnow et al., 2015). Similarly, the study that utilised the FBCI intervention stated that patients and parents reported an improvement in both individual and family functioning (Ginnis et al., 2013).

4.4.8 Tele Mental Health (TMH) - Telepsychiatry and mobile application solutions applied to urgent and emergency care

Four studies investigated TMH applications for urgent and emergency care. A Canadian study (Roberts et al., 2017) found that tele mental health is both a reliable and cost-effective method of assessment and follow up in rural areas. Similarly, an American study (Thomas et al., 2018) stated that the use of telepsychiatry demonstrated operational and clinical efficiency in ED's by improving access to speciality health care services, and increasing system capacity in remote and rural areas (Thomas et al., 2018). Anderson et al., (2017) suggest in an RCT protocol that the use of a CYP self-management application for those experiencing a mental health crisis may help

An Australian project (Ospina-Pinillos et al., 2018), which reported on the first eMental Health clinic for YP, noted a similar potential for early intervention and prevention of escalation of YP's mental health into a crisis.

4.4.9 Satisfaction with the application of TMH

Two studies reported high satisfaction with the use of telepsychiatry (Roberts et al., 2017; Thomas et al., 2018). Telepsychiatry is perceived as CYP-friendly with a high degree of CYP and Parental acceptability, and improved service experience (Roberts et al., 2017). Similar high outcomes in terms of parental and staff satisfaction with TMH acceptability, effectiveness and efficiency were reported in the US study (Thomas et al., 2018).

4.5 Parental and CYP experiences of accessing mental health crisis services

Three studies (Albert & Simpson, 2015; Brennan et al., 2016; Olasoji et al., 2017) focussed predominantly on the parents, caregivers and relatives of individuals experiencing a mental health crisis, while two other studies (Narendorf et al., 2017; Pycroft et al., 2015) focussed mainly on the CYP experiences of undergoing crisis care. One further study looked at the experiences of both CYP and Parents (Sukhera et al., 2017). The synthesis resulted in 68 themes, from which five related domains were derived: barriers; emotions and emotional reactions; experiences; needs and what appropriate crisis service should be (Vusio et al., 2019). The overarching themes between CYP, parents or caregivers' experiences were identified and summarised (Table 11).

4.5.1 Summary of qualitative findings:

4.5.1.1 Barriers:

CYPs reported two accessibility barriers, which prevented them from successfully engaging in mental health crisis services and achieving positive mental health outcomes, while parents reported eight barriers to accessibility. A combination of stigma and fear of opening up acted

as barriers for CYP, hindering engagement or contributing to disengagement from future contacts with mental health services (Narendorf et al., 2017). By contrast, there are more evident barriers for parents, caregivers, or relatives of CYP who receive mental health crisis services. For example, lack of communication between parents and crisis service providers was evident in all three articles and was also one of the main reasons for parents dissatisfaction (Brennan et al., 2016; Olasoji et al., 2017). This is related to other subthemes such as the lack of participation in care planning; the perception that parental observations and experiences are not heard or taken into account (Vusio et al., 2019). In two studies, parents and carers reported that they felt they received inadequate support from the mental health crisis provider (Albert & Simpson, 2015; Brennan et al., 2016).

4.5.1.2 Emotional reactions associated with the child's crisis

The findings of this theme revealed the complex, and sometimes similar emotional reactions reported by both CYP and parents, such as the sense of powerlessness, frustration, anxiety or worry. These feelings are often the results of access barriers and uncertainty due to lack of information and appropriate engagement with a service provider (Narendorf et al., 2017; Vusio et al., 2019). Furthermore, parents reported experiences of high carers burden due to dealing with CYPs that experienced both a mental health crisis and a crisis treatment at the same time. High levels of carer burden often contributed to a sense of suffering, isolation, and feelings of being abandoned by crisis providers while travelling through the crisis care system (Sukhera et al., 2017; Vusio et al., 2019).

Table 11 - Summary of the main themes from included articles. Adapted from Visio et al., (2019)

Theme	Parents/Carers/Relatives	Children and Young People
Barriers	<ul style="list-style-type: none"> • Lack of communication from providers • Inadequate support from crisis services • Fear of confidentiality breaches • Lack of involvement with care planning • Concerns over the inconsistency of crisis services establishing whether their children are in crisis or not • Perception not being listened to • Concerns that their parental experiences and observations are not taken into account • Reluctance to become involved with help-seeking 	<ul style="list-style-type: none"> ▪ Fear of opening up with crisis services ▪ Stigma about seeking help from crisis services
Emotions and emotional reactions	<ul style="list-style-type: none"> • <u>Powerlessness</u> • <u>Exclusion</u> • <u>Frustration</u> • <u>Great anxiety</u> • <u>Worry</u> • Sense of isolation • Suffering • Complex feelings of guilt and loyalty • Feeling abandoned 	<ul style="list-style-type: none"> ▪ Powerlessness ▪ <u>Exclusion</u> ▪ <u>Frustration</u> ▪ <u>Anxiety</u> ▪ <u>Worry</u> ▪ Fear of opening-up ▪ The feeling of not knowing
Experiences	<ul style="list-style-type: none"> • <u>Lack of understanding</u> • <u>The sense of being lost</u> • <u>Not being listened or understood</u> • <u>Felt often tossed between the crisis assessment services</u> • <u>Lack of choice</u> • Traumatic and Terrifying experiences • The sense of battling through the overall experience • Experience of rejection • Being told that a child has not relapsed • <u>Frequent changes of staff members</u> • 'Double deprivation' by not receiving appropriate support • Being told child not in crisis 	<ul style="list-style-type: none"> ▪ <u>Lack of understanding</u> ▪ <u>The sense of being lost</u> ▪ <u>Not being listened or understood</u> ▪ <u>Felt often tossed between the crisis assessment services</u> ▪ <u>Lack of choice</u> ▪ Struggle to get appropriate help or any help from a crisis ▪ Disengagement ▪ Being Judged ▪ Being honest perceived as damning ▪ Difficult experiences ▪ <u>Lack of therapeutic alliance with crisis staff.</u> ▪ Short appointments seen as negative experiences ▪ <u>Frequent changes in the staff members</u> ▪ <u>Telling their problem more than once (story)</u> ▪ In crisis and out of control
Needs	<ul style="list-style-type: none"> • <u>Need to be respected and listened by crisis providers</u> • Need to be more assertive • Need to battle through the crisis services • Need to be signposted to appropriate parental help or support network • Need to develop a coping mechanism to deal with both CYP crisis and mental health crisis services 	<ul style="list-style-type: none"> ▪ <u>Need to be respected and listened by crisis providers</u> ▪ A need to be treated as a human being ▪ A need for safe expression of feelings ▪ Need for crisis providers to show that they care

4.5.1.3 Experiences with crisis services

Both positive and negative service users' experiences with crisis services were expressed in all six articles. Moreover, lack of understanding or choice, coupled with a sense of being lost in the system due to being thrown between different crisis assessment services and not being listened or understood were commonly expressed experiences by both parents and CYP. Besides, staff changes are often reported both in CYP and parental experiences that have also had an impact on their therapeutic alliance and created a need to re-tell their stories on multiple occasions (Sukhera et al., 2017).

Additionally, parents and carers often described their experiences as traumatic or terrifying (Albert & Simpson, 2015), while most parents reported on several occasions being rejected by crisis services due to services perception that their children are not in crisis (Albert & Simpson, 2015; Olasoji et al., 2017). The best way to summarise the experiences of parents would be to describe their travelling through crisis services as 'battling through the system' (Olasoji et al., 2017). CYP shared similar experiences, characterising their experiences as difficult, 'in crisis and out of control', struggling to get suitable help from the crisis services, and being judged by the crisis staff (Pycroft et al., 2015; Sukhera et al., 2017). Besides, short appointments were often perceived as negative experiences while being honest to a service staff was perceived as damning (Narendorf et al., 2017; Sukhera et al., 2017). Most of these factors contributed to some CYPs to disengage from crisis services (Narendorf et al., 2017; Sukhera et al., 2017).

4.5.1.4 Needs

Both CYP and parents have identified the range of different needs that crisis services need to meet such as a need to be listened to and treated with respect (Narendorf et al., 2017; Olasoji et al., 2017; Sukhera et al., 2017). Furthermore, parents discussed a set of different needs that most parents must have to successfully deal with crisis services such as the development of a coping mechanism for dealing with both CYP crisis and mental health crisis services, and need to become more assertive (Olasoji et al., 2017).

Additionally, parents expressed that the crisis of their child has a negative impact not only on parents but also on the whole family functioning (Brennan et al., 2016). Crisis services should therefore signpost whole families to appropriate family or parental support networks (Brennan et al., 2016). In CYP cases, the need to be taken seriously, to be treated as human beings and shown that crisis staff do care for them was evident from their responses (Narendorf et al., 2017; Pycroft et al., 2015; Sukhera et al., 2017).

4.5.1.5 CYP and Parental perception of what appropriate crisis service should be:

Both parents and CYP expressed positive experiences of being treated in the community setting (Brennan et al., 2016; Narendorf et al., 2017). CYP and Parental views were that mental health services should be all encompassed under one roof, with excellent links between hospital and community, with different hubs across the community, using a flexible (non-traditional medical model) approach that emphasises early prevention and recovery (Sukhera et al., 2017; Vusio et al., 2019).

Table 12 - Service users' perceptions of what appropriate crisis services should be. Adapted from Vusio et al., (2019)

THEME	PARENTS CYP
APPROPRIATE CRISIS SERVICE SHOULD BE:	<ul style="list-style-type: none"> ○ Community-based with a strong relationship between the hospital and the community to provide services ○ In an ideal world, there would not be any such thing as different mental health agencies, it would just be one cohesive thing, and maybe there would be different locations ○ A need for greater flexibility emerged as a key finding along with the concept of immediate real-time services as a necessary shift from the traditional medical model ○ Authentic youth/caregiver engagement and delivery of services through a flexible, real-time system of care that emphasises prevention and recovery-oriented community-based services ○ Solution: Adaptive Recovery-oriented and Real-Time System of Care That Integrates hospital and Community Sectors

4.6 Discussion:

This review aimed to evaluate and summarise research evidence on alternative models of inpatient settings, as well as the interventions used for urgent and emergency mental health treatment and satisfaction of CYP and their parents with alternative models of inpatient settings. The review identified 19 studies, which were divided into four main themes: alternative models; interventions applied to mental health crisis; telepsychiatry and mobile applications for urgent and emergency mental health help; and CYP and parental satisfaction and experiences of accessing urgent and emergency mental health services (Vusio et al., 2019).

The review found a very limited number of studies that looked at newly formed alternatives to inpatient settings or models that could be used for mental health crisis services. Similarly, the research literature on the accessibility, acceptability, and satisfaction of CYP and their parents was scarce. On the other hand, the review found an increase in the use of the internet and mobile solutions aimed at creating more accessible e-mental health services and products for CYP who are at the risk of experiencing mental health crises. Finally, a small number of interventions were identified in this review, which showed the potential for their application in the mental health crisis settings, and in the recovery and reduction of urgent and emergency admissions.

4.6.1 Alternative models

This systematic review found some evidence of the suitability of alternative models for inpatient settings such as the York and the One-Stop-Shop models (Sfar-Gandoura et al., 2017; Wright et al., 2016) that offered a promising, less restrictive alternative services compared to more restrictive hospital-based CYP treatments. Both models are responsive to CYP needs and provide a single point of access, as well as 24/7 crisis support and interventions for CYPs experiencing mental health crises, and most importantly, they operate by adhering to the recommendations from the FyFV-MH (Mental Health Taskforce, 2016) and Future in Mind (Department of Health, 2015) policies. In addition, these two models have accessible and integrated pathways that are covered by a multidisciplinary team working in partnership with statutory and voluntary agencies, which also ensure much smoother navigation experiences

for CYP through these models' pathways of care (Wright et al., 2016). Similarly, the support discharge service and the recovery model have been developed to provide CYP treatment in the community-based settings, to address individual needs and to provide a less restrictive form of treatment closer to CYP's homes.

Parents and CYP experiential findings in this review supported these alternative models, by showing a preference for community-based treatment compared to treatment delivered in urgent and emergency settings (Sukhera et al., 2017). Therefore, these findings are well supported with the findings of other reviews that also highlighted that mental health treatments should be provided in the least restrictive environments such as community-based settings (Kwok et al., 2016; Paton et al., 2016b; Shepperd et al., 2009).

One non-clinical model stood out from the other reviewed and more clinical alternatives, largely due to the Club house's improved performance in reducing unnecessary CYP hospitalisation compared to other alternative clinical models. Similar findings have been reported by another review that identified the potential of these models to reduce YP readmissions to inpatients settings (McKay et al., 2018). Some studies found the similar potential of the Clubhouse models to reduce CYP's reliance on urgent and emergency services and improvement in the YP transitioning experiences from one provider to another (Pardi & Willis, 2018). However, due to the non-clinical nature of these models and the lack of more empirical evidence of the effectiveness of the Clubhouse models, these models can therefore be viewed more as complementary alternatives to the other identified models in this review, and to crisis services and inpatients settings. Despite their potential and usefulness, further investigations and sound methodological evolutions are required to understand the fidelity of these models (McKay et al., 2018).

Regarding the service user's satisfaction with these four models, it was evident that CYP reported higher satisfaction rates with these alternatives and more positive treatment outcomes. The higher CYPs satisfaction evident in the case of the Clubhouse models, was largely due to YP's perception that they were not judged and they were taken seriously by this environment (Pardi & Willis, 2018). These findings are well in line with the report from the

review that associated the positive CYP experiences with better treatment outcomes and higher engagement rates of both CYP and parents with alternative models (Kwok et al., 2016).

However, since not all studies have carried out formal qualitative investigations to understand the perceptions of service users regarding the acceptability of these alternative models, satisfaction reports need to be carefully considered. This lack of qualitative findings is well supported by the review by Shepperd et. al (2009), which concluded that there was a significant lack of qualitative experiential evidence regarding the acceptability of these alternative models to inpatients settings investigated. This corresponds with the results of this systematic review which showed that there is still an evidence gap in our understanding of what constitutes adequate treatment or intervention for CYP who experience mental health crises. Additionally, the findings of this review also highlight parental reports of a number of barriers to accessibility of crisis services such as children deemed as not being in crisis or not suitable for crisis intervention, despite clearly being in distress (Albert & Simpson, 2015; Brennan et al., 2016; Olasoji et al., 2017). This review also found that parents were concerned about the conflicting diagnosis of clinicians and their inability to recognise the presence of mental health crises (Albert & Simpson, 2015; Brennan et al., 2016). There is therefore a clear need to define what constitutes a mental health crisis, and what criteria patients need to meet to be classified as being in a crisis (Olasoji et al., 2017).

4.6.2 Urgent and emergency interventions applied to a mental health crisis

This systematic review identified a range of interventions that may be applied in mental health crisis interventions for CYP such as the “SAFETY program” and the “Family-based crisis intervention”, which are both short-term treatment interventions, designed to be delivered in community-based services, as well as urgent and emergency settings. The utilisation of these interventions may therefore reduce urgent and emergency admission of CYP, as well as decrease the caregiver burden, and improve the functioning of CYP and the overall service users satisfaction. These findings are consistent with the findings from other studies that have shown that more favourable treatment outcomes and faster recovery are evident when treatment encompasses the entire family (Albert & Simpson, 2015; Asarnow et al., 2015; Campbell, 2004; Ginnis et al., 2013).

4.6.3 Telepsychiatry-mental health and mobile solutions for urgent and emergency settings

This review identified several new mobile and web solutions for TMH. The TMH models are well-established and well-regarded in modern healthcare for those areas where patients are considered to be living in rural or geographically remote areas (Gloff, LeNoue, Novins, & Myers, 2015). These solutions represent a lifeline for these patients, while the implementation of these applications in the urgent and emergency settings may reduce the pressures to these settings and provide more timely access to much-needed help.

Some evidence from a previously conducted systematic review found that TMH was considered to be ineffective and inefficient methods for urgent and emergency settings, despite being considered promising (Adolescent Psychiatry Committee AACAP US, 2017; Martin et al., 2011; National Collaborating Centre for Mental Health, 2014). However, more recent evidence indicates that TMH models do have feasibility, acceptability and higher rates of CYP satisfaction (National Collaborating Centre for Mental Health, 2014). The recent development of technology also precipitated the use of mobile applications and web solutions that have also found a way to be used in urgent and emergency settings, such as e-Mental health and Myplan. The use of these technological approaches has been linked to potential benefits such as improving accessibility, reducing waiting times, and improving the quality of mental health service provisions. The findings of this review are consistent with the findings of a meta-analysis that concluded that TMH applications are a viable means of providing mental health support to its service users (Fedele, Cushing, Fritz, Amaro, & Ortega, 2017).

4.6.4 CYP and parental experiences

The last part of this review focused on the service users' experiential data of access and satisfaction with mental health crisis services and alternative models to inpatient settings. The findings of this review showed the existence of a range of barriers to access to mental health crisis services, which resulted in service users' disengagement from these services. Similar findings were evident in a previously conducted review (Shepperd et al., 2009), as well as other studies that showed that the existence of barriers to accessibility of mental health services

could significantly impact the engagement of CYP and their parents (British Medical Association, 2017). Furthermore, most service users reported a lack of communication and crisis support, which resulted in increased carers burden and a loss of confidence in crisis providers, which also reinforced service users' decisions not to engage further in help-seeking with mental health crisis providers; a pattern that is also reported in other studies (Brennan et al., 2016; Olasoji et al., 2017; Olasoji, Maude, & McCauley, 2016).

Furthermore, both CYP and parents experiential data in this review showed that mental health crisis experiences could produce traumatic and often stressful experiences and a range of negative emotional reactions. Frequent staff changes may also be a reason for service users' worry, as these changes have a negative impact on the rapport between service users and mental health staff, but also force service users to re-tell their stories on multiple occasions, which can contribute to future disengagements from help-seeking. The existing policies are clear that CYPs should tell their problems and background story only once (Department of Health, 2015).

However, if service users are adequately supported throughout their crisis treatment and taken seriously in every step of the way, their experiences of treatment and help-seeking may improve, which may help to reduce their negative emotional reactions and experiences. This improved experience may lead to positive outcomes and impact on the rapport (therapeutic alliance), which is the strongest predictor of positive treatment outcomes (Newhill, Safran, & Muran, 2003).

4.7 Strengths and limitations

The key strength of this systematic review is the integration of the service users' views and their experiences of accessibility, acceptability and satisfaction with alternative models for urgent and emergency settings, as well as the identification of a number of additional models, interventions and mobile and web solutions that can be applied to urgent and emergency settings. To our best knowledge, no previous conducted reviews reported similar findings and experiential data on alternatives to inpatients settings. In addition, this review used a searching

strategy that resulted in a consistent number of identified articles throughout several additional searches.

On the other hand, several identified articles from German, Swedish and Norwegian countries have not been assessed, since the initial protocol only took into account articles published in the English language. Therefore, this focus on only English literature alone can be seen as a limitation of the review. Lastly, all qualitative studies included reported a small number of participants, and as a result, these qualitative findings may not be generalised to the broader population. Additionally, identified articles mainly included mothers and females, with very low participation of father and males.

4.8 Implication for future research:

The remaining gap in the literature is linked to experiential data on CYP's journey through crisis services, especially in the UK. Another gap is associated with the experiential data of males and fathers. There is also a need for more mixed-method studies to look into the accessibility, acceptability and satisfaction of CYP and their families with alternative models to inpatient settings.

4.9 Chapter summary

This review aimed to evaluate and summarise research evidence on alternative models of inpatient settings, as well as the interventions used for urgent and emergency mental health treatment, and satisfaction of CYP and their parents with alternative models of inpatient settings. This review identified 19 studies which were synthesised using a narrative approach. The findings indicate that some CYP may benefit from alternative models to urgent and emergency settings. The CYP satisfaction findings support alternative models compared to usual care provision. These findings correspond well with other conducted reviews. The experiential findings of this review showed that parents experienced significant care burden, as well as being compromised by a range of negative emotional reactions as a consequence of engagement with crisis services. The service users' experiences pointed out to the presence of a number of barriers to accessibility of these services that can impact the engagement of CYP with service providers and their future help-seeking behaviours. In addition, the review also showed that a number of interventions could be applied to CYP urgent and emergency alternatives, but there is still lack of research evidence that describes what the most appropriate intervention for CYP in a mental health crisis is. Similarly, the TMH interventions showed promising results that can be applied to mental health crisis interventions, as well as urgent and emergency settings.

Chapter 5: Stakeholders' perception of the 0-19 model

5.1 Chapter outline

The previous chapter presented a systematic review and synthesis of the literature on the alternative models to urgent and emergency settings while identifying experiences of CYP and their parents regarding the accessibility of these alternatives. In this chapter, the main aim is to understand staff, CYP service users, and parental perceptions regarding how accessible and acceptable the Solar service is. Initially, the main aims and objectives of this research are discussed, alongside the methodology. The recruitment and data collection procedures are then explained and discussed. The template analysis method will then be justified. The main findings from one focus group with Solar's staff members and a range of interviews with staff and service users will be presented and discussed. Finally, all research activities presented in this chapter are aligned with the 'activity section' of the logic model presented in chapter 3.

5.2 Study aims

As the Solar service model is unique in the UK, it is crucial to explore the main stakeholders' perceptions regarding their experiences of accessibility and acceptability of the overall model and their satisfaction with received service provision. Apart from understanding these perceptions, this study aimed to fill the gap in the existing literature (chapter 1). Evidently, there is a lack of available evidence regarding qualitative research that explores perceptions and attitude of staff, service users and their parents with newly retransformed CYP mental health services in the UK. Hence, the main aim of this study was to understand how stakeholders perceive accessibility, acceptability of the Solar service. This study included the following research questions:

1. What are the stakeholder's experiences with the overall Solar service?
2. How accessible Solar is to CYP and what are perceived barriers related to accessibility and acceptability of the 0-19 model?
3. What are stakeholder's satisfaction with the overall 0-19 model's service provision?

Traditionally, many research studies used qualitative methods to gain insight and understanding of patients' and staff members' experiences and perspectives of local healthcare provision and the degree to which this provision meets their needs. Qualitative research methods offer flexibility and the ability to empower interviewees to speak openly and in their own words about their lived experiences (Braun & Clarke, 2006; NHS England, 2017). Also, using semi-structured interviews often helps to facilitate participants' reflection and provide researchers with a new perspective on participants' views (NHS England, 2017). Therefore, qualitative semi-structured interviews are a well-supported way to achieve the aforementioned aims of this study.

5.3 Methods

5.3.1 Sampling

Most research literature differentiate between two sampling types – probability and purposive sampling (Nash, 2014). While probability sampling relies heavily on a random selection of research participants, purposive sampling does not rely on random participants selection (Nash, 2014). Instead, participants are chosen based on their professional experiences, lived experiences, and their specialist knowledge. Researchers often use purposive sampling in under-researched areas to generate more exploratory data from a specific population (LoBiondo-Wood, Haber, & Krainovich-Miller, 2006).

In this study, the purposive sampling strategy was employed, mainly to capture stakeholders' experiences with the Solar model. As the Solar service is unique in the UK with its service provision, it was essential to capture staff experiences, their specialist knowledge, and practices. Apart from staff experiences, the most crucial factor that this study needed to achieve was to understand CYP's lived experiences with mental health difficulties and their parents who supported their children throughout their treatment. Moreover, given the current lack of qualitative studies of stakeholder's perspectives on newly developed or retransformed mental health provision for CYP, the researcher believed that it was vital to also include professional staff opinions.

The involvement of service users, carers and staff members is crucial to improve the quality of mental health services (Greenaway, 2013). Therefore, understanding their degree of satisfaction with the model was important, since the patient's satisfaction is a crucial indicator of service effectiveness (Rossberg & Friis, 2004). On the other hand, staff perceptions of their working environment were also needed, to gain an understanding of their satisfaction. Without staff input and their experience of working in the model, this study might fail to capture and understand factors linked to the accessibility of the model. Poor working environments are associated with high staff burnout, reduced staff satisfaction and high staff turnover, which can impact patient satisfaction and accessibility of the services (Rossberg & Friis, 2004).

- The recent CYP experience of Mental Health Crisis (Currently not in the crisis) or experience of being treated in the 0-19 model
- Aged 6 to 19
- Have the capacity to provide informed consent to participate
- Ability to converse in the English language
- Ability to read and write

Infobox 5. Eligibility criteria for CYP

- To be parent, carer or foster carers of CYP aged 6 to 19
- Have a child who recently experienced a mental health difficulty
- Aged 18-67
- Have the capacity to provide informed consent to participate
- Ability to converse in the English language
- Ability to read and write

Infobox 6. Eligibility criteria for Parents and carers

- Experience of working with CAMHS, Crisis teams or experience of referring CYP to crisis services
- Employee of Solar
- Aged 18-67
- Have the capacity to provide informed consent to participate
- Ability to converse in the English language

Infobox 7. Eligibility criteria for clinical staff

5.3.2 Recruitment methods and consent procedure

Solar's Staff recruitment

The recruitment started by contacting the Solar service manager and clinical leads to discuss the availability of their staff for the focus group and subsequent interviews, as well as providing clinical managers with an electronic invitation letter for the staff (**APPENDIX-7**) and participant information sheet (**APPENDIX-8**).

The researcher recruited all staff members using a purposive sample from two main sites of Solar's Bishop Wilson and Freshfields clinic. The researcher recruited all participants for the focus group after their weekly MDT meeting at Bishop Wilson clinic. Staff members who volunteered to participate in the focus group were provided with two printed versions of the consent forms (**APPENDIX-9**), demographic questioners (**APPENDIX-10**) and Participant information sheet (PIS) (**APPENDIX-8**). Before the official start of the focus group, a copy of these documents was returned to the researcher while participants kept a second copy for their records.

Similarly, in cooperation with clinical leads, all interview participants were recruited over the four weeks. The researcher conducted all interviews at both service locations – Bishop Wilson and Freshfields clinic. The researcher organised all interview dates in cooperation with each staff member according to their availability and the availability of treatment rooms that were used for interviews.

Recruitment of CYP and their parents

The researcher initially contacted participants via health care professionals involved in their care. All CYP participants in a crisis were excluded from participation, whereas recruitment focused predominantly on CYP already discharged from the Solar or its crisis service. Additionally, a small sample of CYP still receiving crisis support was recruited, yet they were

ready to be discharged soon by the crisis team. A small sample of CYP from other parts of Solar, which had previously experienced a mental health crisis, was also recruited.

Both CYP and parents were informed by their health care worker about the purpose of the research and offered a copy of PIS (**APPENDIX 14&14a**) and “Expression of interest form” (**APPENDIX-13a**). If service users were interested in receiving more information about the project and wished to participate in the study, service users and their parents would fill out this form, and their care worker passed this form to the researcher. The researcher contacted only those participants who wanted to receive more information about the study. Where participants were under 16, the initial contact was established with their parent. The researcher sought parental approval that their child can be contacted and participate in the interview. If participants were happy to participate in an interview, the researcher agreed with participants convenient day/time, usually following their usual visit to Bishop Wilson or Freshfields clinic to avoid extra travelling time for the CYP and their families. If alternative arrangement were needed, the researcher offered participants an opportunity to be interviewed via telephone or at the participant’s home, whichever was more convenient for participants.

5.3.3 Data Collection

Staff focus group

Staff participants received all necessary documents (**APPENDICES 8-10**) and given 10 minutes for completing them. During this time, all participants’ questions were answered. The researcher also emphasised to the participants the importance of confidentiality and non-disclosure of any personal or sensitive information before the focus group officially started. The researcher informed all participants that the focus group would be recorded for the transcription purposes, and what will happen with recording post-transcription. All participants agreed to be recorded verbally and on the consent forms.

The focus group took the format of the semi-structured interview that followed the designed interview schedule (**APPENDIX-11**) to ensure that all participants had equal opportunities to be heard. The researcher double-checked that all participants did filled-out all necessary forms correctly and remained available for any additional questions before all participants were dismissed.

Staff interviews

On the interview day, the researcher provided two copies of the necessary forms to each participant (**APPENDICES 8-10**) and answered any questions that participants had before the interview started. An interview schedule was developed mainly for service staff members (**APPENDIX-12**).

A copy of the PIS and consent form remained with participants while original documents were returned to the researcher who double-checked that the necessary information had been filled correctly. Before the interview began, the researcher reminded participants of the confidentiality and anonymity and non-disclosure of sensitive information. The researcher also reminded participants that interviews would be audio-recorded for transcription purposes and explained what will happen to the audio recording post-transcription. All interviewed participants agreed both in writing and verbally to be recorded. The researcher also informed all participants that he would take notes in his research diary during the interview. The duration of interviews ranged from **30 minutes to 68 minutes**, with an average duration of **52:58 minutes**. After the interviews, the researcher remained available to answer any further questions that the participants had.

CYP Interviews

The researcher conducted half of all interviews with CYP participants at clinics Bishop Wilson and Freshfields, while another half over the phone. Usually, all interviews with CYP would occur before or after their regular appointments with Solar staff. On the other hand, the researcher arranged phone interviews in cooperation with CYP and their parents.

On the day of the interview, the researcher provided two copies of necessary forms (**APPENDICES 14-15**) to each CYP participant. A copy of the PIS and consent form remained with participants. In contrast, the participant's original documents were returned to the researcher who double-checked that all necessary information was correctly inputted. In case when the researcher interviewed participants over the phone, the researcher read the content of the consent form to participants, asking for audio-recorded participant's response.

The researcher developed the CYP participants' interview schedule (**APPENDIX-16**). The interview started once the participant had completed all necessary documentation, and all the participant's questions were answered. When the researcher conducted phone interviews, an interview started when a participant gave consent and when a participant consented to all components of the consent form. The researcher alerted participants about confidentiality and anonymity as well as non-disclosure of any sensitive information. Also, the researcher reminded participants that the interview would be audio-recorded, but only for transcription purposes and explained the transcription procedure as outline in section 5.4.3.2. Interview duration ranged from **11 minutes** to **32 minutes**, with a **23:22 minutes** average interview duration

Interviews with parents

Similarly, half of the parents were interviewed in the Solar service clinical spaces, while the other half over the phone. The recruitment procedure followed a similar approach to CYP. The researcher interviewed some parents while they were waiting for their child to have their treatment in the clinic, while others came to the clinic individually. The researcher provided all participants with a copy of the PIS and consent form. In contrast, the other copy of the form signed by a participant was kept by the researcher, alongside demographic form (**APPENDICES 18-20**). In case when the researcher conducted telephone interviews with parents, the researcher read to the participants' consent form for a participant to give their consent.

The researcher developed an interview schedule for parents' participants (**APPENDIX-21**). The interview started once when the participant completed all necessary documentation, and all

participants questions were answered. When the researcher interviewed participants over the phone, the interview started once a participant agreed to participate. Parental interviews followed the identical procedure as outlined in the previous CYP section regarding confidentiality, anonymity, and audio recording. Interview duration ranged from 18 **minutes** to **54 minutes**, with an average interview **39:47 minutes interview**.

Post-interview tasks

Once the focus group or interviews were completed, all participants signed forms were stored in a secure filing cabinet at the University of Warwick, Medical school. The researcher sent to Appen all audio recording for transcription. For all participants interviewed by telephone, a copy of the PIS and consent form was sent to the participant's home address at the end of the interview. Appen transcribed all audio recordings, while the researcher double-checked received transcripts for their accuracy.

5.3.4 Participants

Staff

All participants were drawn from two separate multidisciplinary teams– NHS and Barnardo’s. The researcher included a wide range of professions in this sample. The most recruited participant came from a White British background, followed by Black Caribbean and British Asian background (table 13).

Table 13 - Ethnicity of staff members involved in interviews and a focus group

Ethnic group	Focus Group	Interviews	Total
White British	6	4	10
White Asian British	1	1	2
Asian	0	2	2
Black British Caribbean	1	3	4

All participants were recruited by using purposive sampling, which facilitated the recruitment of participants with a wide range of experiences in the Solar service (table 14).

Table 14 - Staff Demographic information (Age, Length of Work in Solar and Length of work in mental health)

	N	Male	Female	Age range	Length of work in Solar	Duration of work in mental health
Focus Group	8	1	7	20-62 ($\mu=34$ yrs.)	6 months – 3 years ($\mu=1.13$ yrs.)	6 months – 15 years ($\mu=8.8$ yrs.)
Interviews	10	1	9	26-41 ($\mu=31.6$ yrs.)	9 months – 12 years ($\mu=3.45$ yrs.)	3.4 years – 15 years ($\mu=8.57$ yrs.)

CYP

Recruitment of CYP was carried out in cooperation with their clinical staff involved in their care and was guided by risk assessments that showed whether CYP were ready to participate in the study. The initial decision regarding the suitability of CYP for participation was made by the clinical staff who initially approached the participants to introduce them to the research study. Throughout the recruitment stage, we identified a variety of CYPs from ethnic and minority backgrounds. However, recruiting participants from any other than White British background was difficult. Most CYP or CYP parents from non-white backgrounds did not accept to participate in this study. Only one individual came from other than White British background (table 15).

Table 15 - CYP interviewees demographics (Age and Ethnicity)

	N	Male	Female	Age range
Interviews	10	3	7	12-18 ($\mu=15.3$ yrs.)

Ethnic group	Participants
White British	9
Black British Caribbean	1

Parents

With the cooperation of the crisis team, four parents were recruited through an initial contact between the researcher and CYP parents. The researcher recruited six service participants through research posters and recruitment flyers. However, as with CYP recruitment, recruiting parents from other ethnicities was challenging, as most parents from a BME background refused participation. Therefore, the primary parental sample is all consisted of a White British background (Table 16).

Table 16 - Parent interviewees demographics (Age and Ethnicity)

	N	Male	Female	Age range
Interviews	10	1	9	35-60 ($\mu=45.25$ yrs.)
Ethnic group			Participants	
White British			10	

5.3.5 Data preparation for analysis

All audio recordings from both focus group and interviews were transcribed verbatim by externally approved by both the University of Warwick and BSMHFT transcription service—Appen. Once Appen transcribed all audio files, the researcher reviewed all transcripts for accuracy and assigned all transcripts with a unique pseudo-identifier matching the participant’s consent form. At this stage, the researcher started familiarising himself with the transcription content. The transcripts data analysis was based on the process described by King (2004) and the principles of the template analysis (King, 2004a, 2004b).

5.3.6 Template Analysis

The researcher chose template analysis as the main qualitative analysis method for this PhD project. King (2004) developed a specific approach based on the thematic analysis of transcripts.

“The essence of template analysis is that the researcher produces a list of codes (‘template’) representing themes identified in their textual data”(King, Cassell, & Symon, 2004).

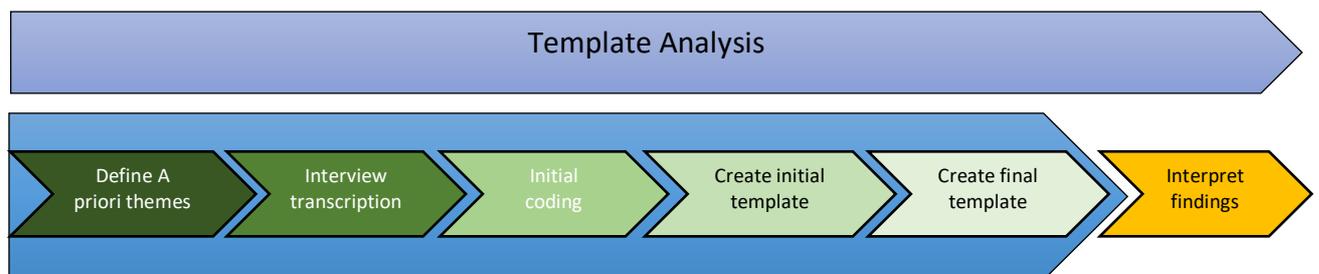


Fig 32. Overview of the template analysis. Adapted from Cerimagic (2014) and King (2004a)

The first step in template analysis begins even before the interviews or focus groups are conducted. The researcher started template analysis by establishing several a-priori themes based on research questions as well as previous assumptions from the existing literature that helped to develop an interview schedule. King (2004) recommends using the interview schedule as the initial foundation for the development of a-priori themes. Therefore, taking King's recommendation, the a-priori themes in this study were developed in combination between qualitative results of the systematic review in chapter four and the interview schedule.

Once interviews were transcribed, the researcher began familiarising himself with the raw data present in the transcripts. The researcher read through all captured transcripts from focus groups and interviews. During this step, the researcher applied preliminary data coding to all transcripts. The Nvivo 2019 software was used for the coding procedure.

Coding procedure

The template analysis coding process is identical to thematic analysis approaches (Brooks & King, 2014). Coding can be described as a process of attaching a series of labels (codes) to transcripts sections that are important to interpretation and related to research questions (Brooks & King, 2014). Codes can be interpretative or descriptive. While interpretive codes are more difficult to interpret clearly, descriptive codes are more self-explanatory and easier for interpretation (Brooks & King, 2014).

The initial coding procedure was used on parts of transcripts, mostly corresponding to research questions and previously developed A-priori theme. In case when there was no A-priori theme that would fit particular parts of transcripts, the existing A-priori theme was modified. Alternatively, a new A-priori theme was developed.

Furthermore, the most prominent feature of template analysis is its hierarchical organisation of codes in different levels based on which codes represent more general (higher-level) or more specific (lower-level) themes (King, 2004a; King et al., 2004).

The approach towards developing the final template

Template development is not a separate step; but occurs throughout the analysis of the transcripts (King et al., 2004). The researcher created an initial template before recruitment commenced. The template was further refined during initial coding and finalised after completing all coding. The main reason why the researcher refined the template on three separate occasions was due to a recommendation from King (2004), which stated:

“The researcher must work systematically through the full set of transcripts, identifying sections of text which are relevant to the project's aims, and marking them with one or more appropriate code(s) from the initial template. In the course of this, inadequacies in the initial template will be revealed, requiring changes of various kinds. It is through these that template develops to its final form” (King,2004).

Therefore, the researcher applied five main types of modification to the initial template: deletion, insertion, changing scope and changing high-order classification as suggested by (King et al., 2004).

Table 17 - Five main types of modification to the initial template. Adapted from King et al., (2014)

Modification type	
Deletion	Represents removal of any code defined in the initial template, that has no particular purpose or function in the final template
Insertion	Addition of any code that is relevant to research questions and that emerges from participants transcribed responses but has not been covered by A-priori code
Change of scope	Re-definition of the existing code because the code is too broad or too narrow
Change of order	Changing code position in a higher or lower category (theme or subtheme)

A modification was done primarily to produce a better and clearer final template. Once all coding was applied and completed on all analysed transcripts in NVivo 2019, all codes were transferred to Microsoft Word template, allowing the researcher to combine codes into specific and overarching related themes. All codes and themes were subject to verification process by two academic supervisors. Discussions between the researcher and academic supervisors helped create the final template (Box 8). The final template formed a basis for the interpretation of all interviews and the focus group and their findings.

The researcher structured an interpretation of findings around the main themes that grouped A-priori with emergent themes to produce chronological flow throughout the findings section.

Ethical consideration

Biomedical and Scientific Research Ethics committee (BSREC) REGO-2018-2294 (Appendix-3) approved the research protocol. The study received evaluation approval/permission from the BSMHFT research and innovation department (Appendices 4&4a). The full description of ethics and research governance can be found in chapter 3, section 3.3.4.1

5.4 The main findings

1. Integrative theme – The Solar service as a lifeline [E]
2. Views of service users and staff about the conceptual basis of the model [E]
 - 2.1 Empowering service [E]
 - 2.2 Youth-friendly service [A]
 - 2.2.1 The physical aspect of the clinics [E]
 - 2.3 Accessibility [A]
 - 2.4 Therapeutic alliance (Rapport) [A]
 - 2.5 Partnership based model [A]
3. Experience of using the service: CYP and parent’s perspectives [A]
 - 3.1 Referral process and ease of access [A]
 - 3.1.1 Barriers to access [E]
 - 3.2 Integrated community service model [A]
 - 1.1.1. Solar partnership [A]
 - 1.1.2. Youth-friendly service [A]
 - 3.3 Engagement with the service provider [E]
 - 3.4 Service users’ needs [E]
 - 3.4.1 *Being listened to and taken seriously* [E]
 - 3.4.2 *Continuity of care and therapeutic alliance* [E]
 - 3.4.3 *Assertiveness* [E]
 - 3.4.4 *Need for timely treatment* [E]
 - 3.5 Personal assessment of treatment outcomes [A]
4. The experience of providing the service: Staff perspectives [A]
 - 4.1 Solar partnership [E]
 - 4.2 Accessibility of the model (Ease of access) [A]
 - 2.2.1 *Barriers to access* [E]
 - 4.3 Meeting service users’ needs [E]
 - 2.3.1 *Being listened to and taken seriously* [E]
 - 2.3.2 *Continuity of care* [E]
 - 2.3.3 *A need for timely access for a treatment* [A]

[A] A-priori theme
[E] Emergent theme

Table 18 - Quotation codes

Quotation codes:	Interpretation
SSSI	Staff semi-structured interviews
SFG	Staff focus group
CYP	CYP interview responses
PC	Parents and carers responses

5.4.1 The Solar service as a lifeline

CYP

Most CYP reported the need for the local service, which serves their mental health needs. For example, participant CYP101 stated a “clear “need for the Solar model. Equally, participant CYP100 reported that the model is “a really good service” while stating their satisfaction with the model: “I’m glad it’s there”.

Staff

The similar perception of Solar was also evident in staff responses. Some staff members described Solar as a service that “matters” and is “needed” in its local community, while others felt that the model is “a lifeline” for both CYP and their families. The main rationale why the Solar model is perceived as a lifeline is primarily due to its community base that offers a range of different therapies delivered by several diverse professionals within a fully patient-orientated multidisciplinary team.

Parents/Carers

Similar to CYP and staff members responses, parents also had similar perceptions of Solar being a lifeline for the community. Most parents stated a clear preference for the service compared to other alternatives such as hospitals. For example, PC119 noted that the Solar service provided to them “much better options for my child”. Moreover, the availability of Solar in the local community for PC119 meant avoiding stressful hospital or clinical settings and being treated in a more “relaxing setting”. However, most parents agreed that the existence of the

Solar and its crisis service in the community was a lifeline for families, as help is available if needed. It is clear from all participants’ responses that the presence of the Solar service in the local community was of importance to them. There is also evident a clear preference among participants for community-based treatment compared to other more clinical environments. Indeed, the Solar service may be seen as a community lifeline.

Table 19 - The Solar service as a lifeline theme and example quotes

Participants	Quotes in the support of the theme
CYP	<i>“I think a lot of people would benefit from the kind of things that they have at Solar. Because I know a lot of young people struggle with mental illnesses and I think it would be nice for them to know that they can go somewhere locally” (CYP103).</i>
Parent	<i>“The main help Solar and Crisis gives you as a parent is simply knowing that they’re there and accessible. So that if something really bad is happening, you don’t feel you have to deal with it on your own. They are the lifeline” (PC116).</i>
Staff	<i>“We are all about the community and teamwork at Solar. I think the team here is brilliant, absolutely amazing” (SSSI110)</i>

5.4.2 Views of service users and staff about the conceptual basis of the 0-19 model

In this theme, the views of different groups (service users, parents, and staff) regarding the validity of the multiagency community model (i.e the conceptual basis of the Solar model) will be presented.

5.4.2.1 Empowerment

CYP

Most CYP felt that Solar empowers them and their families. For example, some CYPs agreed that the service allows them to voice their concerns and problems. For example, participant CYP101 shared that they were “*encouraged*” by the service to express what the participant “*kept deep inside*”. A similar experience was shared by CYP105, who also had “*an opportunity*” to communicate their “*thoughts*” to Solar staff. Most CYP liked the idea of being able to voice their concerns about treatment and tailor treatment to their specific individual needs.

Staff

Solar staff also perceived the service as an environment that allows CYP to openly discuss and express issues that they experienced with their mental health. Solar has often been referred to as a service that listens to its service users. All staff members felt that Solar “*empowers*” both CYP and their families as the service allows them to voice out their concerns.

Parents

Some parents also reported that Solar had provided them with an opportunity to voice out their concerns. All parents expressed the need to be listened to and taken seriously as crucial. What can be seen from most interviewees’ responses is that Solar is a service that both empowers and encourages CYP and their parents to communicate their needs for the service to meet them.

Table 20 - Empowerment theme and quotes in support

Participants	Quote in support
CYP	<i>"So, with the person that I have now, I talk to her about feeling worried about moving forwards, the crutch of having a support there. So, she's reassured me now that it's (inaudible) when I want it to finish"</i> (CYP103)
Parent	<i>"...to me it's really important, that somebody sat there and listened and took on board "what I had to say"</i> (PC113).
Staff	<i>"It is somewhere that they (CYP and their families) can be heard, someone to listen."</i> (SSSI104)

5.4.2.2 Youth-friendly service

CYP

The vital part emerging from most CYP interviews was their perceptions of Solar as a youth-friendly service. The majority of participants described the service as youth-friendly due to the sense of safety, respectful staff members who listen to them and the environment that encourages YP to engage and participate with the service to improve their mental health. For example, CYP100 perceived Solar as youth-friendly *"without a shadow of a doubt"*. Similarly, participant CYP102 not only recognised the Solar service as youth-friendly but more importantly, the service was perceived as *"a safe space"* where the participant feels *"quite conformable"*.

Staff

Most staff interviewees believed that Solar *"is trying"* to be a youth-friendly service. SSSI104 reported that during the last five years *"young people did contribute and help Solar to design and improve the service to be as much as possible youth-friendly"*.

However, to fully become the youth-friendly service, Solar depends mostly on the engagement and feedback obtained from CYP. For example, SSSI108 stated how important is CYP engagement and feedback are for the service to be fully youth-friendly environment:

“It is important to get that feedback directly from young people in terms of what they want from the service and develop it on that, not just to make assumptions about what we think they might say is youth-friendly” (SSSI108)

However, while staff felt that the Bishop Wilson clinic is a more youth-friendly and appropriate environment for CYP, all staff were of the opinion that the Freshfield clinic may not be “a very good fit for purpose” and is an inappropriate setting for children, largely due to its proximity to the two adult units.

Parents

Parents had similar perceptions of Solar as youth friendly. Most of the parents who had experiences with the previous 0-17 model indicated that the 0-19 model changed massively. All parents welcomed this change as it made the service look less clinical, more comfortable, inviting, and most importantly, youth friendly. For example, PC115 stated that Solar is well-designed “for children and young people” and is more attractive to its service users by being “laid out well”. From participants responses, Solar is trying to be a youth-friendly service to provide their service users with a safe and inviting space. Compared with the previous 0-17 model, it is evident that the Solar model is evolving towards becoming more youth-friendly service.

Subtheme 1 – The physical aspect of clinics

CYP

Some CYP felt that service environment itself contributed to a sense of youth-friendliness. All CYP appreciated service efforts to make both clinics as less clinical as possible. For example, most CYP reported that the colourful environment made services much more “inviting” and “welcoming”. For instance, CYP104 stated that the Solar service is a “better environment”,

mainly because of its “colourful environment” perceived as “very inviting”. The use of more colourful therapeutic space helped make CYP feel more relaxed in the services, which contributed to better engagement.

Staff

All staff members believed that an inviting and relaxed environment was crucial for CYP to feel welcomed and to engage with the service. According to SSSI108, the physical environment of the Solar service enabled “young people to be at ease and relaxed enough to open up and be honest about how they feel and get support with that”.

Parents

Most parents compared their previous experiences of other services and clinics, including GP practices to the current Solar service environment. Interviewees thought that Solar provides more “relaxing”, “calm” and “inviting” environment in comparison with other alternative settings.

It is evident from interviewees responses that the physical environment plays a significant role towards youth-friendliness and prevention of exposing service users to more clinical settings that are unattractive to CYPs. Unattractive service provision may affect CYP future engagement with the model. Therefore, by providing service users with CYP friendly environment, the model has tried to ensure that their service provision is attractive enough, what also may help with the facilitation of CYP’s further (future) engagement with the provider.

Table 21 - Importance of appealing clinical setting and example quotes

Participants	Quote in support
CYP	<i>“Yeah, it was nice, and it was, like, quite relaxing, it was not like a hospice or anything like that, it was, like, colourful, very inviting and relaxing. It made me want to come back” (CYP108)</i>
Parent	<i>“I think the (Bishop Wilson) building itself is actually great, it’s very relaxed, it’s very calm, and very clean. We have been to other counselling places where it’s just like an office block with plain, grey walls, not inviting. Whereas that place is very bright, it’s very airy, it is inviting” (PC119)</i>

5.4.2.3 Accessibility

CYP

For most CYP, the primary source of referral was made by GPs. Aside from GP referrals, CYP participants also reported that their parents or educational provider made an initial referral to Solar. In some cases, both parental and educational referrals were made simultaneously.

Table 22 - Source of referral of interviewed CYP participants

Source of referral	Evidence from quotes:
School	<ul style="list-style-type: none"> • “School referred me to Solar” (CTP101)
Parental referral	<ul style="list-style-type: none"> • “Mum referred me to Solar” (CYP100)
GP	<ul style="list-style-type: none"> • “My GP sent me on to come to Solar” (CYP102) • “I think I was referred to by my doctor, yeah” (CYP105) • “So, I decided to go to the doctors, and then they transferred me over to Solar” (CYP106)
Joint referral (parental and school)	<ul style="list-style-type: none"> • “My mum and the school made referral” (CYP109)

During the interviews, most CYP expressed how easy it was to be referred to Solar, while other CYP said that it was just “Okay” process. Only one participant reported that access was “complicated”.

Staff

All staff interviewees believed that the Solar model significantly improved access to the service from its conception. According to participant SFG6, even now the service is “trying to improve access” and further “reducing waiting times”. Other participants shared a similar view that since the service implemented self-referral route, accessibility has greatly improved “and helped with faster access to Solar” as reported by participant SSSI104. Similarly, participant SSSI103 stated that self-referral pathways helped with accessibility, largely “by removing GP as a middleman”. The self-referral route brought Solar some definite benefits, such as the possibility of seeing CYP at home, school or over the phone.

“There is self-referral route from Young People/Parents, from schools, GP's and other professionals. I think that accessibility is really good, actually and I think they (CYP), sometimes they don't always need to be seen, but they can be spoken to on the phone and I think some Young People find that really helpful” (SSSI110)

5.4.2.4 Therapeutic alliance (Rapport)

Solar staff and CYP highlighted the therapeutic alliance and continuity of care as additional factors that improve engagement and collaborative practice of service users with Solar’s clinicians. Therapeutic alliance, regardless of the type of therapy used by clinicians, is one of the most significant predictors of clinical outcomes. It is therefore understandable why a good rapport is something that both CYP and their families want to get out of the service.

CYP

Most CYP interviewees responses indicated that they did not have problems with consistency of care or lack of therapeutic alliance.

Staff

Most staff members reported that initially when Solar was commissioned, there was an evident high turnover of staff, which also affected the therapeutic alliance with CYPs. Similarly, other staff interviewees also reported that since its commission, the Solar service gradually evolved and improved staff retention what also positively reflected on the therapeutic alliance between service users and staff members. Indeed, the therapeutic alliance is a crucial predictor of positive treatment outcomes.

Table 23 - Therapeutic alliance theme and example quotes

Participants	Quote in support
CYP	<i>“To be fair, I’ve been pretty alright with that (therapeutic alliance). I’ve been stuck with, well not stuck with but I’ve been partnered with the same person (staff) near enough” (CYP101)</i>

<p>Staff</p>	<p><i>“High staff turnover was an initial problem as CYP want more stability. Before CYP were seeing a lot of different faces, which was difficult, but now things improved” (SSSI108)</i></p>
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5.4.2.5 Partnership based model

CYP

All CYP interviewees reported that partnership between CAMHS and voluntary agencies was something that helped them to overcome their mental health issues. For example, CYP107 reported that one of the positive aspects of the Solar partnership is *“that you do not need to look for help outside of Solar, as all the help is there in the Solar service”*.

Staff

When staff were asked how much their service feels joined, all the staff members shared the same views that Solar currently feel joined. However, it is clear from participants’ reflections, that this sense of partnership was absent in the early years when Solar was recommissioned. Therefore, the Solar model has evolved over the years. This Solar evolution was summarised by participant SM103 who supported the notion that the service feels more integrated. However, according to participant 103, there is definite room for improvements.

Parents

Most interviewed parents welcomed NHS, Barnardo’s and Autism West Midlands (AWM) partnership as something that is needed and helpful. The partnership was perceived as beneficial as both statutory and voluntary sectors incorporated in the Solar service a multidisciplinary set of diverse skills, expertise, and experiences. All parents praised the service for offering all the necessary service provision under the one roof, preventing the need for re-referrals to other services. Equally, PC114 felt that partnership *“does work”*, primarily because of their *“multidisciplinary team effort”*.

Table 24 - Therapeutic alliance theme and example quotes

Participants	Quote in support
Parents	<i>"But I think if you've got it all, in my eyes, if it's all under one roof, the services are all in one place it's, in my opinion, it's positive that they're all together, yeah". (PC113)</i>
Staff	<i>"Solar feels joined more now than before. More fluid, but there is a room for improvement. Core CAMHS is good with Primary Care. We can approach them and sit down together to discuss cases. There is no attitude like this is not ours; it's yours and deals with it" (SSSI 103).</i>

5.4.3 Experience of using the service: CYP and parent's perspectives?

In this theme, the experiences of service users and parents with the Solar model will be explored to understand how their experiences (i.e how model works in the reality) deviated from the conceptual basis of the model.

5.4.3.1 Referral process and ease of access

When CYP and their parents seek support and access to appropriate treatment from community mental health services, their perceptions of accessibility of these services will be based primarily on how easy it was to access a service provider, the speed of their referral process, and their first contact with a provider. Therefore, in this subtheme, CYP and parents described their referral process to Solar, their initial sources of referral and personal perceptions of ease of access to Solar.

CYP

In the previous section, most CYP reported that it was easy to access the service. However, not all CYPs had easy referral experiences. For example, CYP106 related their referral experiences as *"complicated"* mainly due to the error that Solar made with their referral. Because of this error, CYP106 stated that the process of referral and acceptance was *"not easy at all"*. However, according to CYP106, once the participant was accepted into the Solar service, things became *"much easier"*. Only one CYP participant experienced the initial process of being

referred to Solar and accepted as “horrible”. Recently, CYP107 participant experienced a new Solar referral, which they felt was “much better experience” than their initial Solar access.

Table 25 - CYP experiences of access to Solar service

Access experience	Evidence from quotes:
Easy	<ul style="list-style-type: none"> • “It was easy referral.” (CYP102) • “How easy it was? ... It, it was...” (CYP105) • “It was an okay process, and it was an easy referral...” (CYP109)
Complicated	<ul style="list-style-type: none"> • “It was complicated because of, obviously, you know, like going to talk to them, then, you know, they’re making that mistake, which happens. That was why it was complicated, but after that one they actually like, I actually got somewhere. It became easier, but before that it wasn’t as easy” (CYP106)
Improved access	<ul style="list-style-type: none"> • “Back then, horrific, absolutely horrific access. It’s only been the last couple of years that it has worked for me. But before hand and just with previous experience with them, it hadn’t been good at all until more recently. I’ve been under them (Solar) since I was 12” (CYP107)

Parents

Most parents reported that an educational provider was the main source of referral of their children to Solar, followed by GP and hospital referral (Table 26). Interestingly, there were only two direct parental referrals into the Solar service. Only one referral came from the A&E. However, most of these referrals were described by parents as “long” and “not overly pleasant” experiences, often followed by “long waiting” and “uncertainty”. Consequently, failure to receive timely help caused a further decline with some children’s mental health.

Table 26 - Source of referral of interviewed participants children

Source of referral	Parents participant’s ID
Educational setting (School or College)	PC111; PC114
Parental referral	PC112; PC115
GP	PC118
A&E	PC120
Children’s Hospital	PC112

Subtheme 2 – Barriers to access

CYP

Most CYP felt that the only barrier to access to Solar was the service's inaccessible locations. For example, participant CYP105 suggested it would be better if Solar had "*more hubs*" across Solihull, allowing easier access for CYP from all areas of the borough. The similar perception that service locations may pose a barrier to access was also evident in CYP responses. For example, most CYP felt that services as such were far where they live. Therefore, the northern part of the service was suitable for CYP living near the Bishop Wilson service, while southern parts of the service were more suitable for CYP in the Knowle area. All CYP who are not from either part of the Solihull borough expressed difficulties in getting to the service as the poor public transport connections between two services take an hour and half of their journey. Participant CYP109 stated that their drive to the Bishop Wilson clinic "*was about 20 minutes*".

Parents

Likewise, some parents felt that Solar should improve its presence in the Solihull borough, as at the moment the service provision is inaccessible. All parents felt that the Solar service should have smaller hubs scattered around Solihull, which would make Solar much more accessible to all Solihull residents.

On the other hand, all parents reported that Solar is currently underfunded, and more funding is needed to employ more staff members, create more additional hubs in the Solihull area and reduce waiting times to acceptable timeframe. Therefore, most parents associated lack of staff members with barriers to accessibility. According to parents, the Solar service should be larger and cover more of the Solihull borough area. For example, one parent reported a preference for employing more staff in Solar. This parent hoped that "*more staff members*" within the service would also reduce a need for waiting for treatment and make "*waiting lists short*".

Table 27 - Barriers to access theme and example quotes

Participants	Quote in support
CYP	<i>"In terms of the location it's quite far. When I first went (Bishop Wilson) there it was kind of a bit hard to find things, like, kind of concealed in a way next to a school. It was like part of the same building; I think except that it was partitioned. The Bishop Wilson was just a bit far from where I lived" (CYP 105)</i>
Parent	<p><i>"Barriers. I think other than the fact that sometimes young people find the building difficult to access, they might be discharge because of that. But if you could work around that, or maybe have, like, a drop-in hub or something that's neutral that's not going to frighten kids or maybe perhaps reduce their anxiety, I think. (PC114)</i></p> <p><i>"I'd like to see it bigger, helping more kids. I'd like to see it much bigger, employ much more staff. There is waiting times, I know that I know there is waiting times, it'll be nice to see a lot more people working here to help a lot more." (PC112)</i></p> <p><i>"Solar needs to be bigger and I think there should be a lot more locations, so people haven't got to travel extremely far and obviously more people working for Solar. So, bigger buildings to accommodate more staff members and more children" (PC113)</i></p>

What is evident from all stakeholders' responses is the need for more accessibility in terms of service locations, adequately resourced by the staff numbers. Ultimately, this could increase better service engagement, reduce waiting times, and improve the overall provision of mental health services within the Solihull.

5.4.3.2 Integrated community service model

Subtheme 3 – Solar partnership

In this subtheme, parent participants reflected on their experiences with the Solar partnership, which is a collaboration between statutory (NHS CAMHS) and voluntary sectors (Barnardo's and Autism West Midlands).

Parents

As seen from the previous theme, most parents welcomed NHS, Barnardo's and Autism West Midlands (AWM) partnership as something that is needed and helpful. Besides, most parents stated that they were more familiar with the NHS and Barnardo's segments. However, six out of ten parents who believed their children needed help from AWM to manage their learning

or developmental difficulties felt that AWM is the Solar’s “weakest link”, largely due to its invisibility, limited provision of support and involvement. For example, PC112 stated that the ‘invisibility’ and lack of AWM presence in the service was evident. Consequently, despite the need for AWM and its services, most parents and their children instead turn to CAMHS and Barnardo’s partners for help.

Similarly, PC111 reported that there was a lack of involvement of AWM in the Solar service. Besides, the participant explained that AWM could play a crucial role in Solar to help bridge the gap in the service provision for learning disabilities. If properly addressed, this particular gap could reduce the workload and waiting times for the remaining parts of the Solar service. Moreover, all parents reported their initial degree of confusion with the Solar partnership. This confusion stemmed from not knowing how Solar works and fears that partners would work independently rather than collaboratively. However, PC114 stated that despite all partners working within Solar, they still had different ways and approaches to work. PC114 suggested a more coherent approach between all partners.

Table 28 - Partnership subtheme and example quotes

Participants	Quote in support
Parent	<p><i>“I don’t know because I don’t see their involvement (AWM), so I’m not really sure they’re fully involved. I’ll rather stick with Barnardo’s and NHS” (PC112)</i></p> <p><i>“I don’t see any Autism West Midland involvement. I don’t see their involvement at all in the whole Solar thing, and I do think they could probably relieve some of the burden of NHS and Barnardo’s. I don’t see where they are, where they are making an impact or helping any children or families. You know, I just don’t have any contact with them, I don’t see any literature from them on the walls. There might be, I haven’t spotted it. You know, so actually, I don’t have any ideas as to what their involvement is with the service. I know, that they’re involved but I don’t know what that involvement looks like or what they offer” (PC111)</i></p> <p><i>“They all work differently, or they’ve all got different strategies in how they look after that person. It could be better if it was more uniformed, or they came together.” (PC114)</i></p>

Subtheme 4 - Youth-Friendly Service

CYP

In the previous theme, most CYP participants described Solar as a youth-friendly service. However, three YP participants reported that although Solar is youth-friendly, the service as such is predominantly '*geared*' to children, and less to young people. Therefore, according to CYP 100,107 and 109, the Solar service was perceived as youth-friendly "*but to a degree*". These participants distinguished between Freshfields clinic, which was more teenage-friendly, while clinic Bishop Wilson was more characterised as a child-friendly space. The similar perception was reported by CYP100 and CYP103, who believed that Bishop Wilson was more suited to young children than young people.

Despite some CYP's perception that the Solar service is more child-oriented, all participants generally expressed the view that Solar is considered as a youth-friendly service that meets CYP needs. The service as such provides CYP with a more relaxed environment than other more clinical alternatives.

Parents

Parents had similar perceptions of Solar as youth-friendly. However, it is interesting to note that all parents reported a higher preference for the Bishop Wilson clinic; this environment was perceived as more youth-friendly and less clinical. The Freshfields clinic was, however, characterised as '*clinical*', but improved from the way the building looked before. Moreover, there was an interesting observation during interviews with parents about the Freshfields clinic. While parents reported a higher preference for the Bishop Wilson clinic, their children's preference was the opposite. According to parents' responses, the reasons why their children preferred Freshfields over Bishop Wilson were mainly due to the size of the clinic.

Table 29 - Youth-friendly service subtheme and example quotes

Participants	Quote in support
CYP	<p><i>"Here (Freshfields clinic) you don't see many young children; you see more young children at Bishop Wilson" (CYP107)</i></p> <p><i>"Service is youth-friendly ...the environment didn't bother me, clearly geared towards children but, I don't care" (CYP100)</i></p> <p><i>"I think it's just quite a calm environment, so yeah I think so. The first time I came into the waiting area, I was a bit worried that I felt a bit too old. I think a lot of it seems quite young children orientated, but I think that's mainly just the waiting area" (CYP103)</i></p>
Parents	<p><i>"Solar is not like a clinic or a hospital. No, it's really nice. Freshfields is still quite clinical. But I know there's other services that run from there, so it's ...The one at Freshfields is quite small, which can be hard for like children, because it's quite closed in. But the one at Bishop Wilson is nice." (PC118)</i></p>

5.4.3.3 Engagement with the service provider

In this theme, the reflections of CYP and parents on their engagement with the service provider in terms of joint (collaborative) decision-making and the rapport between CYP and clinicians involved in their care is explored.

CYP

The importance of engagement and collaborative work was evident in CYP responses. All CYP considered their relationship with service staff to be more of a collaborative process that needed to maximise the benefits of treatment. All CYP reported the importance of being able to understand what the staff are trying to communicate to them. This was especially pronounced among those who sought more involvement with their care and more independence with decision making. For example, CYP109 reported on their experience of disagreement with the psychiatrist's decision on the need for medication. The YP had expressed their concerns to the staff that they wanted to explore other alternative options instead of taking the most invasive action. Participant CYP109 raised concerns about the psychiatrist being dismissive as well as applying pressure on YP and their parents to start taking

medication, despite the patient’s resistance to that idea. Instead of taking medication, CYP109 suggested exploring other therapeutic solutions and leaving medication as the last option.

Parents

Some parents also reported that their child had experienced lack of connection with the clinician (i.e. disengagement). Most of these disengagements were the result of not being listened to or taken seriously by Solar. On the other hand, most of the parents who had positive experiences of being taken seriously and being actively listened to reported improved engagement with the Solar staff members. As a result, this enhanced engagement, helped to form a collaborative work that was crucial and necessary for the benefit of the child and helped their recovery. For example, participant PC116 reported that they “*never felt not being listened to*” by the Solar staff. Participant PC116 added that all treatment decisions were made in “*collaboration with (family)us*”.

Table 30 - Engagement theme and example quotes

Participants	Quote in support
CYP	<p><i>“I think the good thing is the Crisis Team and Solar, they use similar methods, so you can go from one to the other. So, with medication as well, they’ve always said it’s up to me whether or not I want to take it, and how much I want to take. They’ve never said I have to take it, also I think it, there’s been a lot of decisions have gone to me, I think yeah” (CYP103)</i></p> <p><i>“Obviously I’m not a very academic person, so when somebody explains something to me, sometimes they’ll have to explain it twice just so I can understand. But I would ask for that from them and they would do, they would do that. She (staff member) ’ll tell us, she’ll ask, basically do like a little review, a little like thing to see where we’re at. And if this is, and I’ll say a few things that I think need to be addressed with her, and talk about, and then, you know, we try and put all of that in into the work.” (CYP106)</i></p> <p><i>“They, at first they wanted to put me on antidepressants which I didn’t want to go onto, so we, like, declined that, but we said <could we go into the group instead?>. “When they went straight to trying to give me antidepressants before looking more into it and spending more time on it. I think that they should try more things rather than going straight to the antidepressants. I think they should try the courses and then try anything they can before prescribing medicine. The psychiatrist was trying to prescribe them to me, did put pressure on me to take them. She (psychiatrist) was more taking to my dad, she didn’t really speak to me as such, it was more to my dad saying that, <She needs to>.” (CYP109)</i></p>
Parents	<p><i>“So now he (child) just doesn’t really speak, so he doesn’t really engage with the staff. My daughter does to a degree” (PC111)</i></p>

“(Son) He closed up very much, because he couldn’t, there was no connection with psychiatrist, nothing at all. He found it very difficult, and very stressful” (PC118)

“...it was very much sort of not telling her what they were doing, it was working with her and, you know, and asking her how she felt about what they were suggesting and then they would follow it up with how that it works”(PC120)

5.4.3.4 Service users’ needs

Subtheme 5 - Being listened to and taken seriously

CYP

All CYP reported that they needed to be listened to and taken seriously. Most CYP conveyed positive experiences with being listened to. However, some CYP reported their negative experiences of not being listened to or taken seriously by the Solar service. For example, participant CYP105 felt being “*patronised*” and treated “*as a child*” during their treatment. Participant CYP109 also felt that the psychiatrist “*did listen*”, but “*not as much*” and “*not every time*”. Some CYP participants felt greatly affected by not being taken seriously or not being listened to by Solar’s staff. Consequently, these experiences affected their involvement with service staff and their therapeutic alliance. Most of these problems were associated with psychiatrists.

Parents

Likewise, most of the parents’ responded that they were not being listened to and taken seriously. This issue was the most important one for all parents. Most parents reported that mental health professionals should take their concerns and thoughts seriously, as most parents naturally observe the behaviour of their children and can provide much in-depth information about their symptoms and behavioural changes. However, half of the interviewed parents described staff members as insensitive, dismissive, uninvolved, or tending to ignore service users due to lack of time. However, few parents indicated that frequent changes in staff members led to different experiences, some of which did not take their concerns into account.

Table 31 - Being listened to subtheme and example quotes

Participants	Quote in support
CYP	<i>"She understood how I was feeling, and she listened to what I was saying". (CYP101)</i>
Parents	<i>"I didn't think that the psychiatrist listened to what he said, and he thought the psychiatrist just talked over him and ignored what he, what he was saying about how he felt. The only problem that we did have with a member of staff was that my child didn't feel listened to" (PC111)</i> <i>"But then it, I felt that we weren't being listened to, or S wasn't being listened to, or he wasn't able to, he wasn't able to say to, to this certain person (doctor) how he actually felt And I found his Doctor [name], who is lovely, just wasn't on his level, and didn't actually get what we needed. And I felt, at this particular meeting we weren't being listened to. And it was almost we felt a bit dismissed, nothing's going to change, she (doctor) wasn't offering any sort of, new help, any sort of support for us. Just increase the medication, which I really wasn't happy about. We felt like we didn't want to go back again" (PC118)</i>

Subtheme 6 - Continuity of care and therapeutic alliance (rapport)

CYP

Similarly, most CYP interviewees acknowledged the lack of consistency with their care and the impact this had on their therapeutic alliance. Most CYPs characterised this issue as uncomfortable, as they needed to repeat the same story to new staff members. Besides, CYP also stated that it is not easy to open up to a brand-new staff member who is a stranger. All CYP interviewees expressed a preference for working with only one member of staff. On the other hand, other CYP did not have problems with consistency of care or lack of therapeutic alliances.

Parents

Most parents reported concerns about the frequent staff changes and lack of therapeutic alliance in the Solar service, which negatively affected the continuity of care of their children. Most parents reported having contact with more than one staff member who had been

involved in their child’s care during the time their children were being treated in Solar. However, the experiences of the continuity of care of most parents and staff members varied considerably among participants. Most parents complained about lack of continuity of care and a therapeutic alliance with Solar psychiatrists. Indeed, most parents reported that their child had between three and five different psychiatrists during their journey through the Solar service. All parents felt that continuity of care and a therapeutic alliance were important for a positive outcome in their child’s treatment. This was particularly important in cases of CYP affected by ASD, which requires routine and familiarity with care providers. Parent PC111 stated that a large amount of “*uncertainty*” and “*anxiety*” arises from staff members leaving in “*the middle of the therapeutic process*”. Similarly, PC114 felt that frequent changes of psychiatrists contributed to “*different*” and often “*conflicting*” diagnoses for their child’s mental health. Indeed, labelling CYP with different diagnoses can contribute to stigma or stereotypes, and hinder the overall CYP recovery process (Frith,2016) .

Table 32 - Continuity of care and therapeutic alliance subtheme and example quotes

Participants	Quote in support
CYP	<p><i>“I do now. But previously, no. I have never really found anyone that I’ve gelled with, that I feel that I can actually work with. It chops and changes a lot. I’ve been under so many people, and things like the psychiatrists, they’re always changing, there’s somebody leaving, someone new. It’s a nightmare because how are we supposed to be expected to open up and be comfortable enough if it’s a new person every time? Yeah, I think psychiatrists are the worst, let me count, probably about six of them that I’ve had, possibly seven under the service.” (CYP107)</i></p> <p><i>“To be fair, I’ve been pretty alright with that. I know that the staff changes around a lot, but I’ve been stuck with, well not stuck with but I’ve been partnered with the same person near enough” (CYP101)</i></p>
Parents	<p><i>“My son has gone through one, two, three, three different psychiatrists. And he’s now on his fourth person. So, he’s gone through four people in a couple of years. Which isn’t great, especially when they’re autistic, cause they don’t build relationships with people well” (PC111)</i></p> <p><i>“I know there’s stuff, there’s a lot of, high level turnover, they have a lot of locums, I know it’s difficult to, to recruit and to keep psychiatrists. But my daughter, she’s had one, two, three, she’s had five psychiatrists. Every doctor that she’s seen had some positives, but they’ve all had some negative side. All psychiatrists were trying to label my child with different diagnoses. And conflict of, conflict of diagnosis, would that be right word?” (PC114)</i></p>

Subtheme 7 - Assertiveness

The need for assertiveness emerged primarily from CYP and parents/carers interviews and was equally prevalent.

CYP

As CYP105 mentioned, to have more timely access to treatment, it was necessary to develop assertiveness and pro-active approach. The same experiences of assertiveness were also reported by CYP106, who had similar experiences with the need to chase up the service to get treatment. Other CYP also confirmed that their parents often tried to chase up the service to find out when they were due to receive treatment from Solar. This need for assertiveness was also evident in most of the parent's responses, especially during the referral phase.

Parents

Most parents experienced this initial process as '*battling through*' experience. The idea of parents taking proactive steps to help their children were prominent in parental responses. It is interesting to note that all parents openly admitted that they were desperate because they did not know where to seek help or what other alternatives exists. For example, PC112 stated that they did not know "*who to contact for help?*". Likewise, PC120 reported not knowing "*who else I could go to*" to get help for their child. Consequently, some parents were forced to develop assertiveness to cope with the situation. The need to become more assertive was seen as necessary, especially when parents exhausted all other options. Additionally, some parents have expressed the need to learn as much as possible about the Solar model and the entire mental health system to ensure that their children received the best possible help.

Not only was there a need for assertiveness in the initial steps of being referred to the service, but this particular need also continued to be expressed in the later stages, once their children were part of the Solar service.

Table 33 - Assertiveness subtheme and example quotes

Participants	Quote in support
CYP	<i>"...So, I thought <Oh God, what's going on?>. So, we were phoning them to get that sorted. And they finally got me a counsellor, quite quickly actually". (CYP105)</i>
Parents	<p><i>"...but it's certainly with a lot of pushing from me to be able to get support and help. See I, you know, if I need to know something I'll phone up and ask them. I won't sit back and wait for somebody to tell me. I'd been asking for a long time before we finally got an appointment to see this, the psychiatrist. I do question whether if I wasn't on the phone asking the questions whether I'd get told the answers." (PC111)</i></p> <p><i>"I've been very proactive, so I've gone on two, three courses... and I've tried to learn all about the medication and learn about the side effects, trying to build strategies...And for, I think you'll find that as you interview your other participants or whatever they're called, you'll find that a lot of parents with kids that are on the spectrum need to be assertive to get any help for their children" (PC114)</i></p> <p><i>"I just bypassed everything and rang L straight up and said, <What can I do?>. And she said, <You can self-refer her. I can pick her up on my workload.> She was really helpful, so we didn't have much waiting time with my daughter, really" (PC112)</i></p>

Subtheme 8 - A need for timely treatment

Parents

All interviewed parents reported experiences of waiting to get access to Solar, while some parents expressed dissatisfaction with how much time their children have spent waiting for treatment. Most parents reported waiting times ranging from a few months for group therapy, a few months for an assessment and almost a year to be seen by psychiatrists. Most negative reactions were reported for waiting to be seen by psychiatrists. Several parents stated that the timeframe to be seen by a psychiatrist was between a minimum of six months to one year. Similar experience of waiting was also reported by participant PC117: *"I think it's been about four or five months. She's waited, she's on a waiting list to have like group work"*. Besides waiting for the treatment, parent PC112 stated that every part of their journey through the Solar service was marked by a need for waiting. The need for waiting also increased parental worries and contributed to confusion, uncertainty, and a sense of not knowing what is going on. Only one participant expressed satisfaction with the direct provision of treatments and

quick service responsiveness. The main rationale behind this responsiveness was due to the safeguarding issues.

CYP

A similar impact of anxiety and worry due to waiting times, uncertainty and ‘not knowing’ was also evident in some CYP interviewees’ responses, especially those regarding waiting times for psychiatric treatments. For example, CYP101 stated that they had a nine-month wait, during which they had no contact with the psychiatrist involved in their care. However, during that time CYP101 reported receiving support from a clinical psychologist. Waiting experiences were also reported by other CYP participants who recalled waiting more than a few weeks to receive treatment from the Solar service. The waiting times for some participants was between one and six months. For example, participants CYP108 stated they had to “*wait quite a while*”, about “*two months waiting*”. All CYP interviewees who had a long time to get treatment indicated that the time period had precipitated their worry and increased anxiety about not knowing what is going on and when they will receive treatment. Therefore, it is clear from all participants’ responses that CYP are exposed to long waiting times and lack of accessibility.

Table 34 - Need for accessibility subtheme and example of quotes

Participants	Quote in support
Parents	<p><i>"Quite a while, I mean, I'll give you an example, we haven't seen a psychiatrist since, gosh, September, and we're not seeing her 'til May". (PC114)</i></p> <p><i>"We were a bit jammy, so the wait for my son, it was a little bit of a while, it wasn't too long, a few month, a couple of months, something like that, and for his assessment, and then it was probably about six months before he actually got to see a counsellor" (PC112)</i></p> <p><i>"Oh crikey, I think it's probably about a year for my daughter. I can't remember how long it was when my son was referred. We had to wait because she sees the counsellor, but we needed her to see a psychiatrist, and that was a long wait. I'd been asking for a long time before we finally got an appointment to see this, the psychiatrist. And I'm not actually sure what's happening now, because the psychiatrist that she saw has now left, so I'm not sure whether she will see another psychiatrist, or whether she's just been signed off from the psychiatrist and just under the counsellor. I'm not really sure what's happening" (PC111)</i></p>
CYP	<p><i>"With Solar, the only problem I can think of is seeing a doctor (psychiatrist). I was meant to see her in January, I think it was, and I still have not seen her yet". (CYP101)</i></p>

"Because I didn't know what was going on, but as the days went by it was like, <Oh, we'll wait tomorrow, you know, they might, you know, send us a letter or give us a call>. It just got to the point where I just couldn't wait, I couldn't wait any longer, I had to phone them up and say, <Look, what's going on here?>. I had a good six months of not having any communication, nothing from them. So, I thought <Oh God, what's going on?>" (CYP105)

5.4.3.5 Treatment outcomes

CYP

When CYP were asked about their assessment of their recovery once discharged from Solar, most CYP reported the degree of improvement with their mental health. However, most CYP reported during interviews that it is still too early to tell if their mental health has improved and if they have fully recovered. Nonetheless, three CYP stated that despite progress; specific issues still needed to be addressed. Although most CYP were pleased to be discharged from the Solar service, one participant had a different opinion. CYP103 stated that they believed they had been discharged prematurely from the Solar service, which contributed to later readmission to Solar. The participant felt they had been discharged despite not being ready to leave the service and its support.

Parents

Similarly, parents reported positive and negative changes to their children's mental health during and after treatment. Mostly, the parents described these experiences as *"Rollercoaster ride"* as the mental health of their child showed improvement or decline, depending on the life circumstances. However, some parents reported positive treatment outcomes for their children that were evident once they were discharged from the Solar service. In contrast, one parent reported a decline in their child's mental health due to ineffective Solar psychiatric treatment. A parent described that during the last few years of receiving inadequate treatment, things had made their child's mental health worse, to the point where the child believed that they were *"irreparable"* and *"can't get better"*.

Table 35 - Treatment outcomes subtheme and example quotes

Participants	Quote in support
CYP	<p><i>"Yeah, I mean like little things, as I say, but there is one big thing that still needs to be resolved, and that is the thing that I have, I wanted to sort out from the start." (CYP106)</i></p> <p><i>"I think quite a while ago, so maybe November, the first time I'd been there, I was discharged from somebody before I quite felt like I was ready to lose that support, I think. So, I think that was probably the only bad time I've had" (CYP103)</i></p>
Parents	<p><i>"My, they're kind of like rollercoasters, really, they kind of go up and down depending on what's going on in their lives. For my son, I'm at the moment unsure, and he's more isolated, he doesn't speak to anybody. So, his mental health is definitely declining at the moment. My daughter's, if I look back on how it was six months ago when she was still in mainstream, to how it is now, it's a massive, massive improvement." (PC111)</i></p> <p><i>" Her school attendance got much better, and she started to be motivated to work towards her exams again." (PC116)</i></p> <p><i>"[name] has not necessarily got better, he's actually got worse before he's got better, but I feel that Dr [name] needed to see that before she could put things into practice, you know. I think the years that, the couple of years that we've been with Doctor [name], it's, he just feels frustrated, and that we've not got anywhere at all. Which has made [name] sad himself, and made him think he's irreparable, in that he can't, he's with a, a specialist doctor, a consultant, he can't get better" (PC118)</i></p>

5.4.4 The experience of providing the service: A staff perspective

In this theme, staff members' experiences with the Solar model is explored to understand how their experiences (i.e how model works in the reality) deviated from the conceptual basis of the model.

5.4.4.1 Solar partnership

Staff in theme two stated the importance of partnership as well as its developmental evolution to an improved integration. What was evident from all staff responses was that not all parts of the Solar partnership are integrated equally. For example, participant SSSI107 felt that *"NHS and Barnardo's are better integrated than AWM"*. Participant SSSI104 stated that *"AWM is the Solar's least integrated part"* and that this partner is *"the weakest link in the overall*

partnership". Similarly, all other staff interviewees reported that the least joined part of the Solar service is the AWM. Although most staff members are aware of AWM's limited presence in Solar, there is still a persistent perception among staff that AWM's role is limited, separated from the rest of the service and absent. One of the main reasons why most of the staff members believed that there should be more involvement from AWM, as many CYP referrals received were affected by ASD, which would benefit more from receiving AWM support. Besides, the other parts of the Solar service were perceived to be closer together. As participant SSSI105 explained, Barnardo's, the Crisis team and CAMHS "*feel much joined*" than the service's other parts. Nevertheless, all interviewees agreed that the partnership is beneficial for the Solar service.

Table 36 - Partnership theme and example quotes

Participants	Quote in support
Staff	<p><i>Oh, I think Barnardo's it's more, much more integrated now. So, I think at first it, it felt a little bit like them and us, but now I think it is good. I think there could be ways of improving that, which I think they started to do. I've been in Core CAMHS and I offer supervision to people in Barnardo's and I think the cross working and joint working is good. (SSSI107)</i></p> <p><i>"Autism West Midlands, I think that has felt a little bit absent." (SSSI107)</i></p> <p><i>"The rest of the partnership is good. Autism West Midlands is the weak link. It's just that bit with Autism West Midlands part is that's missing." (SSSI104)</i></p> <p><i>"Autism West Midlands, I think that has felt a little bit absent. There is a need for their involvement, more involvement. Absolutely. Because there are lots of young people who have comorbid ASD in mental health diagnosis, so definitely that is one thing I can categorically say that needs to be" (SSSI102)</i></p>

5.4.4.2 Accessibility of the model (Ease of access)

In theme two, most staff felt that the Solar service had improved access thanks to the self-referral route that brought many benefits to the service. However, from staff reports it was evident the presence of other factors that may hinder the accessibility of the Solar model. For example, according to participant SFG6 the main accessibility issue is that the service lacks "*enough staff*" with the right training. The issue highlighted by participant SFG6 is associated with a lack of human resources to meet the growing demand for service provision and accessibility improvement. Moreover, participant SSSI109 reported that the service accepts

more CYP on its workload than the service is “*capable of dealing with*”. Consequently, taking more CYP than service can deal with can negatively reflect on the staff who reported being overwhelmed by their caseloads. Similarly, participant SSSI110 reported that Solar did not accept a large number of CYP due to not meeting criteria. However, this participant believed that the service accepts more than it can in terms of staff numbers, skills, and training. Lastly, SSSI107 suggested that “*maybe locations*” of the Solar services “*for some families*” could also affect accessibility to Solar. Several other staff members also felt that service locations could pose a barrier to accessibility.

Table 37 - Accessibility theme and example quotes

Participants	Quote in support of the theme
Staff	<p>“<i>Being too busy and overwhelmed with the numbers of CYP cases are also affecting access.</i>” (SFG1)</p> <p>“<i>There’s loads of people that we signpost. I think as a service we accept quite a bit, but we don’t have the right staff numbers, skills set and support to deliver it. Or it’s very limited what you can do, but then I haven’t been trained in that, so if I start saying <Yeah, we can do this, this and this> then actually that’s me working unethically and unsafely, because I’ve not been trained</i> (SM110)</p>

Subtheme 9 - Barriers to access

Regarding the appropriateness of Solar’s locations, most of the staff interviewees felt that both locations of the Solar service were not very accessible to CYP. These locations described by participants were not easily accessible by public transport and could lead to a lengthy journey for parents and their children who did not drive or were on a low income. Some staff members supported this perception that the service locations were a barrier to access. For example, participant SSSI108 suggested that both the location of clinics and “*getting to the services is struggle and barrier*”. Similarly, SSSI106 felt that Freshfields clinic might not be an ideal setting for CYP, while participant SSSI103 suggested expanding the Solar service in Solihull may contribute to improvement in the model’s accessibility.

Another clinic in the Solihull centre could potentially remove the barrier to service location and accessibility. The similar idea that Solar should expand further came from participant SSSI104

who also felt that the current model is “*not widespread enough*”, as most service users would like “*a much closer service across the borough*”. SSSI105 also reported that an additional hub is needed, mainly due to poor public transport links that do not allow easy access to the service for CYP and their parents. Besides, participant SSSI105 felt that the current service locations could pose a barrier and affect DNA rates, so the idea of having a drop-in hub could be more plausible for CYP and their parents.

Apart from service locations, staff members reflected on the current levels of staff in the service that does not meet CYP’s increased demand for the mental health provision. This staff shortage affects the overall service provision. As a result, employees were unable to deal effectively with the amount of workload, which forced employees to work over the weekends and more than contracted. Similar opinions came from other interviewed staff members who also reported that current workload levels were not sustainable with existing staff numbers. Some staff members believed that increased funding could help address this issue. Staff also perceived Solar’s lack of more specialised professions as a barrier, as the service received large amounts of CYP cases with autism or learning disabilities and staff did not have sufficient skills or competencies to deal with the influx of these cases. Participant SSSI102 felt that this lack of more highly specialised professionals should support the need for Solar to recruit additional staff members that would cover this barrier.

From the responses of interviewees, staff also shared similar opinions regarding barriers to access, as did parents and some CYP. Mainly locations, lack of staff and model not being widespread in the Solihull were reported as barriers between all interviewees.

Table 38 - Barriers to access subtheme and example quotes

Participants	Quotes in support of the theme
Staff	<p>"We've got Freshfields, but it's a small base, it's not a very good fit for purpose "(SSSI103)</p> <p>"I don't think Freshfields building is big enough for TEDS and Choice. And I think limited to how many people you can see at Freshfields, and I don't think Freshfields is an ideal setting for children when you've got the two adult mental health units opposite" (SSSI106)</p> <p>"So, to expand again, we could expand and have another Solar in the south of the borough" (SSSI103)</p> <p>"...if parents don't drive, if they've got work commitments, it's difficult to get them into sessions. So, I feel like even though it's a lovely building, sometimes it is a little bit hard to get to, especially from public transport. And then I think that parents are relying on taxis which again if you're from a low-income family that's going to cause problems. But then I feel that the clinic at Freshfields, that's too far out. So, I think something more centralised would be more appropriate, maybe having three hubs would help." (SSSI105)</p> <p>"People work on the weekends, and it is not very healthy. This amount of workload is not healthy, as well as the number of people working to deal with the workload." (SFG8)</p> <p>"Funding is a barrier. The demand on the service is increasing, the staffing levels can't, don't match that. So it is that balance, the more you raise profile of the service, the more people will be aware of it and need that support. Funding (increase) could help with staffing. (SSI 108)</p> <p>"it's very limited what you can do, but then I haven't been trained in that". (SSSI110)</p> <p>"We need more specialised workers geared this way, that's what I think. Because of the lack of it, becomes a barrier for CYP." (SSSI102)</p> <p>"Lack of doctors and not having enough medics is also a barrier to access. Medical reviews and delays in doing it - not meeting timescale is also highlighted as a barrier, as this is increasing the waiting time for CYP and causing issues such as increased pressure on the rest of the Solar staff, but also causes relapse and CYP becoming unwell." (SFG1)</p>

5.4.4.3 Meeting service users' needs

Subtheme 10 - Being listened to and taken seriously

All staff involved in interviews and the focus group reported that all CYP and their families want to be listened to and taken seriously.

"Families wants to feel supported, to feel listened to and for the things to change." (SSSI101)

Likewise, participant SSI105 also felt that all service users want to be "listened to and understood".

Subtheme 11 - Continuity of care and therapeutic alliance

The therapeutic alliance and continuity of care were highlighted by Solar staff as additional need that improves engagement of service users with Solar. Therapeutic alliance, regardless of the type of therapy used by clinicians, is one of the most significant predictors of clinical outcomes. It is therefore understandable why good rapport is something that both CYP and their families want to get out of the service. Also, building a rapport eliminates the need to tell a personal story on a number of occasions.

However, it can be seen from participants responses that the high turnover of staff members has an impact on the therapeutic relationship between CYP and clinicians, as well as on the continuity and consistency of care.

"I think they (service users) want clinicians that are experienced, that can form good therapeutic relationships that will listen to their views and offer that sense of consistency. Because I think what happens at the moment is young people will come in for an initial assessment, see one clinician and be passed to another clinician, and then maybe another clinician, and there isn't that sense of continuity of care and need for therapeutic alliance. (SSSI107)

Subtheme 12 - A need for timely access to a treatment

All staff interviewees recognised accessibility and delivery of the most appropriate treatment as a crucial need that all service users and their families are looking for from Solar. However, other staff members also reported the need for parents and CYP to be seen as quickly as possible. The need for an accessible service and its flexibility have been evident throughout participants responses. However, most of these responses indicated that the Solar service does not provide timely access, as CYP are still subjected to specific waiting time to receive appropriate treatment. A similar opinion was shared by participant SSSI105 who felt that waiting lists for treatments raise concerns for CYP and parents. Similarly, participant SSSI110 stated that waiting for access to treatment could also cause CYP mental health to escalate into a mental health crisis. Therefore, CYP must be given timely access to appropriate support. All staff interviewees agreed that Solar should be more accessible and flexible to the service users' needs. All CYP should be seen as quickly as possible to prevent their mental health from escalating and the possibility of developing a mental health crisis.

Table 39 - A need for accessibility subtheme and example quotes

Participants	Quotes in support of the theme
<p>Staff</p>	<p><i>"I think that they (parents) want their child to be seen as quickly as possible and to have the most appropriate treatment to help them." (SSSI101)</i></p> <p><i>"They want service which is accessible. They would like to know, what they can get on the end of the phone and have their needs met straight away. They don't want to wait for the service. In Solar, that's not the case - you need to wait for the service. Hope is that you don't have to wait long". (SSSI103)</i></p> <p><i>"And I think they want quick access. I think the waiting list it causes a big concern for a lot of parents and young people". (SSSI105)</i></p> <p><i>"So, for example, the lady I was speaking to yesterday, she reckons her child hasn't ate properly in the last three weeks, okay. So, there is a choice appointment, okay, so we're getting quicker, like, offering choice appointments within two, three weeks. But then what will happen is they'll go on a waiting list depending on what the outcome is, but that waiting list can be anything up to six months. But that child needs help now do you understand? So, by the time six months comes, things have probably escalated. It could have become a crisis." (SSSI110)</i></p>

5.5 Discussion

This study aimed to investigate key stakeholders' perceptions regarding the acceptability and accessibility of Solar and its service provision. The main findings were structured around the main themes identified through the use of the template analysis. Four main themes for the 0-19 model were included in the final template: (1) The Solar Service as a lifeline (2) Views of service users and staff about the conceptual basis of the model, (3) Experience of using the service: CYP and parent's perspectives? and (4) The experience of providing the service: Staff perspectives.

The commissioning of the Solar model is a bold attempt to reform services for CYP. All interviewed stakeholders felt that that this model is the way forward. At the same time, staff showed a strong belief in it and all stakeholders endorsed the decision that this should be a partnership between the statutory (NHS) and voluntary sector (Barnardo's and AWM).

Similarly, other research literature has highlighted that there is an increasing recognition to involve the more voluntary organisation in developing effective mental health service provision and pathways of care in partnership with statutory agencies (Care Quality Commission, 2017; Lester et al., 2008). Such partnerships can address some of the system-wide priorities, such as prevention, community-based care delivery and meeting CYP's unmet needs (Addicott, 2013). Therefore, the Solar partnership is one of many examples of retransformed mental health models that fully utilised partnership approach in its organisation and structure to jointly deliver effective, high-quality, and patient-centred care between statutory and voluntary sectors. Similarly, the neighbouring FTB service model offers a youth-based mental health service that provides an integrated pathway of care between the statutory and voluntary sectors (Fusar-Poli, 2019b). However, evaluation of the model showed that despite the FTB was welcomed by CYP, parents and local stakeholders; the model was largely compromised by increased demand that surpassed the model's capacity and its evident lack of resources (Birchwood et al., 2018b; Vusio et al., 2020). Besides, evaluation raised serious questions regarding how the democratic models is and its level of true shared power and decision making (Birchwood et al., 2018b).

Furthermore, the Solar model was regarded as a 'lifeline' for CYP by service users, parents and staff members. The finding of this study is consistent with findings of a recent systematic review that showed that most YP and parents expressed the need for more community-based models to provide mental health treatments in the least restrictive and community-based environments (Vusio, Thompson, Birchwood, & Clarke, 2019). Similarly, another review found that most CYP expressed a preference for treatment in community mental health settings, mainly due to the flexibility of services to meet individual YP needs (Plaistow et al., 2014).

Research evidence shows that several other well-established worldwide community-based mental health models also play a vital role in their communities (McGorry, Bates, & Birchwood, 2013). For example, both Headspace and Orygen in Australia serve local community mental health needs for YP aged 12-25 and 15-25, respectively (Burns & Birrell, 2014). Similarly, the Jigsaw in Ireland is designed to provide early intervention to YP aged 12-25 to meet their mild to moderate mental health needs in community-based settings (O'Reilly, Illback, Peiper, O'Keeffe, & Clayton, 2015). What all three models have in common is their multidisciplinary and fully patient-oriented approach to early intervention and prevention in community-based settings (McGorry et al., 2013; O'Reilly et al., 2015). Likewise, the Solar service displays many similarities with the aforementioned models and therefore can be perceived as a community lifeline.

Furthermore, service users and parents also felt positive about the youth-friendly ethos of the Solar model; many felt the clinics were modern, and welcoming. The importance of the need for youth-friendly services is well established and recommended by WHO, which has developed a framework for youth-friendly services (World Health Organisation, 2012). According to the WHO, there are clear benefits from making the mental health service more youth-friendly, such as improved use of services, increased engagement and satisfaction (World Health Organisation, 2012).

The CYP response in this study showed that they see Solar as a safe space where they feel respected and valued. Similar findings were also found in the review, which concluded that the essence of the youth-friendly services is the provision of safe space where YP can feel respected and valued in a judgment-free environment (Hawke et al., 2017; McGorry & Mei,

2018). In contrast, staff reported that the Freshfield clinic is not an ideal setting for children due to the two adult units opposite. However, from the findings of this study, most YP preferred the Freshfield clinic and considered it more youth-friendly compared to the Bishop Wilson clinic, which was perceived more as child-orientated.

Similarly, a study has warned that services should keep in mind that there is a need for a balance between professional and youth-oriented décor, as some YP may not enjoy a youth-orientated service environment (Muir et al., 2012). Youth-friendly space should also be available within the service that might help YP to destress (Hawke et al., 2017). However, the YP participant's responses show that there is no such space in the Solar service. Instead, YP share the waiting room with other children. Lastly, giving YP a chance to make the service environment their own is the most important aspect of the youth-friendly mental health services, as YP appreciate having an impact on their service environments (Hawke et al., 2017; Persson et al., 2017a). The findings of this study well supported this level of CYP engagement in the Solar service.

On the other hand, the findings of this study showed that there were many issues and caveats with the Solar model; namely barriers to access, long waiting lists and service pressure. Moreover, it was clear from staff responses that the model was heavily reliant upon 'signposting'. Also, staff were aware of this issue and saw the irony of the waiting list for an early intervention focused service.

Similar research evidence suggests that at every stage of their journey, YP can face numerous barriers to access to mental health services (Young Minds, 2018). For example, the existence of high service thresholds may also affect the accessibility of mental health services, as some staff members have stated in the findings of this study. A report highlighted that due to the high acceptance threshold for services, YP with mental health difficulties often struggle to get any help from mental health services (Young Minds, 2018). A rise in demand for mental health services may explain the rationale for the high referral threshold, which consequently forces services to accept fewer referrals, and prioritises those CYP with higher levels of need (Firth, 2016). High service acceptance thresholds set to cope with increasing referral pressures can often mask the lack of mental health service capacity, which can negatively reflect on YP's

mental health and contribute to their mental health problems progressing to long-term and chronic problems (Firth, 2016).

Similarly, according to the findings of this study, locations of mental health services have been reported in other research studies as an additional source of barriers to access. A systematic review found that easily accessible location such as schools, community walk-in clinics and easy to get hubs are an effective way to increase CYP access to mental health services and these may ensure better engagement with service providers (Anderson et al., 2017).

Similarly, in another study, YP expressed their view that service provision should be made available in locations that are more accessible to youth and allow independent access (Plaistow et al., 2014). YP viewed services with an outreach function and delivery of home treatments as favourable (Plaistow et al., 2014) as it is visible from the findings of this study. YP in other studies have expressed the desire to have suitable working hours and convenient geographical locations near public transport at the point of delivery of mental health treatment and support (Fusar-Poli, 2019b; McCann & Lubman, 2012). Therefore, the service location as such can play a vital role as facilitator or inhibitor of CYP engagement with mental health services (McCann & Lubman, 2012).

Similarly, another study also noted a better engagement with their service due to a more accessible location and availability of convenient drop-in hubs for YP (Sfar-Gandoura et al., 2017). Besides, a range of research evidence has shown that “One Stop Shops” and Drop-in clinics improve YP and vulnerable groups’ accessibility and engagement with service providers (Sfar-Gandoura et al., 2017). Therefore, there are clear benefits from such services that other studies have reported, such as meeting CYP needs at “*the right place and right time*”, providing support and treatment in more appropriate settings (Austerberry et al., 2008; World Health Organisation, 2012). One example of the UK drop-in service offering such community-based services in a convenient location is the Forward Thinking Birmingham’s (FTB) Pause drop-in clinic (Fusar-Poli, 2019b).

The lack of accessibility identified in this study is well consistent with the findings from many other studies that linked the lack of accessibility of services to resource capacity limitations

(i.e. lack of funding). For example, one study reported their service limitations due to lack of funding to undertake assessments and limits to service sustainability (Hetrick, Bailey, Smith, Malla, Mathias, Singh, O'Reilly, Verma, Benoit, Fleming, et al., 2017). Similarly, other NHS trusts also struggle to staff existing services, while the lack of available staff affects service delivery, accessibility and waiting times (Quirk, Crank, Carter, Leahy, & Copeland, 2018). Mental health service staff should therefore be considered as a resource needed for normal service operations and worth investing in (The Royal College of Physicians, 2015).

Furthermore, it is evident from this study that there is a lot of tensions at the referral-access interface, with many parents felt that they had to fight/battle for access and be assertive, despite the much-heralded open access system. The need for parental assertiveness was also reported in another study, which found that carers became assertive when faced with difficulties accessing mental health services for their children (Fargas-Malet & McSherry, 2018). Therefore, findings of this study demonstrated a need for the development of assertiveness and pro-activity, as evident from service users' responses. As a result, more assertive parents and YP may achieve faster access to needed treatments. Such findings resemble other research evidence. For example, one study reported a parental need to develop assertiveness to ensure that their children receive the best possible care (Olasoji, Maude, & McCauley, 2017). Moreover, in this study, most parents reported that their assertiveness was not their natural inclination. Instead, parents were often forced to develop it, which is also consistent with the findings of Olasoji et al., (2017) study.

Secondly, from the findings of this study, it was not always clear that CYP were being listened to and taken seriously. Similar findings from this study were supported by the review, which found that YP tend to engage more in help-seeking if they feel listened to and respected, while not being taken seriously often reduced YP's ability to engage more with mental health providers (Radez et al., 2020). However, it is essential to acknowledge that all YP tend to appreciate the staff who allow YP to be heard and take YP views seriously (Young Minds, 2006), which is also evident from the findings of the current study.

However, more research studies report that CYP are not often involved in joint decision-making regarding their treatments, while their concerns and goals often remain unheard (Gondek,

Edbrooke-Childs, Fink, Deighton, & Wolpert, 2016). Also, two other studies reported that CYP shared similar experiences of not being listened to, being patronised, or experienced a lack of staff engagement with CYP (Idenfors, Kullgren, & Renberg, 2015; Wadman et al., 2018). These two studies also found that treatment staff often imposed their professional opinions on CYP rather than listening to CYP concerns (Idenfors et al., 2015; Wadman et al., 2018). Thus, the findings of this study, therefore, correspond well to other research evidence.

Similarly, continuity of care was of concern among CYP and parents because of high staff turnover, especially among psychiatrists and led to reports of individual CYP receiving multiple diagnoses and conflicting advice. These findings are well aligned with other research evidence that has established a therapeutic alliance and continuity of care as the foundation for modern mental health care, as well as an indicator of quality of care (Thornicroft, 2000; Thornicroft & Tansella, 2004). Both service users and professionals have well supported the need for therapeutic alliance and continuity of care, and their lack is often associated with patient dissatisfaction or disengagement (Jones et al., 2009; Waibel, Henao, Aller, Vargas, & Vázquez, 2012). For example, the development of a therapeutic alliance is strongly associated with engagement and genuine participation of CYP with mental health service providers (Rickwood, Deane, & Wilson, 2007). Similar research evidence shows that therapeutic alliance can be improved and strengthened when CYP are being listened to, respected, valued and treated with dignity (Kazdin, Marciano, & Whitley, 2005; Marcell & Halpern-Felsher, 2007; Rickwood et al., 2007). However, continuity of care can be hindered when service users experience long waiting times for treatment, are transferred between different services or staff members, or do not experience enough progress with their treatment (Ådnanes & Steihaug, 2013).

Thirdly, it was also evident from stakeholders' responses that treatment delivery was perceived as another issue. Most parents/CYP reported waiting within the service for substantial amounts of time to receive treatment, especially to be seen by psychiatrists. However, all service users reported satisfaction with their treatment once delivered. Additionally, some parents described their children's treatment outcomes and processes as a "rollercoaster" ride, and these findings are consistent with the findings of another study (Gallagher & Schlösser, 2015). Similar to our findings, another study also reported the patient's dissatisfaction with the end-of-treatment, and the desire for more extended support (Gallagher & Schlösser, 2015).

Similarly, a large body of evidence shows the close interaction between YP satisfaction with the care and treatment outcomes (Rickwood et al., 2017; Watsford, Rickwood, & Vanags, 2013). Likewise, another study noted that there is an association between dissatisfaction, poor treatment outcomes, termination of treatment and disagreements between YP, their parents and professionals regarding their care (Day, Michelson, & Hassan, 2011). Therefore, YP's satisfaction with their care they receive is an important indicator of clinical effectiveness (Brown et al., 2014). YP satisfaction remains crucial, as it may contribute to lower dropout rates, promote service engagement and contribute to future help-seeking behaviours (Davison, Zamperoni, & Stain, 2017; De Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013)

Furthermore, both staff and parents felt that AWM involvement with the rest of the Solar service was more peripheral and needed reviewing. This raises questions about the effectiveness of AWM involvement with the Solar partnership.

Similar concerns also appeared in other literature. For example, one report highlighted the existence of significant barriers to effective partnership work, including a lack of understanding of roles, responsibilities, management and delivery of care (Addicott, 2013). Similarly, another report highlighted that voluntary sectors in a partnership are often more vulnerable to funding and administrative constraints (Care Quality Commission, 2017; National Children's Bureau, 2016). Consequently, limited AWM engagement in the Solar model may be associated with the limited funding or contractual constraints that prevent the AWM from becoming more involved with the Solar model. Similarly, a study by Lester et al. (2008) found investment in a partnership as a barrier. This barrier was described from the perspective of time and resources needed to make partnerships work, as many voluntary partners had limited capacity to create a more significant impact on the overall partnership and to develop longer-term plans.

Therefore, a particular lack of joint work approach may explain the staff's perception that the AWM is the least-joined partner in the overall Solar partnership. However, it is important to recognise that partnership approaches do not work with "one size fits all", and each partnership must adapt to the specific needs of each area in which they perform their service provision (Care Quality Commission, 2017).

5.6 Strengths and limitations

The main strength of this study is its qualitative orientation towards understanding stakeholder perceptions and experiences with the Solar model. Since Solar is a unique model in the UK, understanding the accessibility, acceptability and satisfaction of service users and their experiences with this service and its provision was crucial. However, a small sample of CYP and their parents can be seen as a weakness of the study. Despite all efforts having been made to reduce the impact of selection bias, it is difficult to conclude with certainty whether the full range of experiences of the service have been captured. For example, the inclusion/exclusion criteria required by the ethics committee may have resulted in the study failing to capture the full range of experiences of individuals with more severe and ongoing mental health difficulties. Similarly, cultural, and socio-economic factors may have influenced the willingness of prospective participants to take part in the study. Likewise, it is highly possible that parents of children who were not accepted by the service, or patients who were discharged due to DNA may have different perceptions and experiences than those parents and CYP recruited in this sample. Subsequently, findings from this study cannot be generalised to the pool of potential service users and the entire UK population. Additionally, since all participants were recruited in the relatively small geographical area, the findings of this study may only represent local experiences and perceptions.

The additional limitation was that most of the parents were females while recruiting fathers (males) proved to be very difficult. Since the Solar model encompasses a wide range of patients in that age bracket, this research mainly explored YP perceptions. Similarly, this study did not manage to recruit parents of children between 1-5 years of age and capture their views and experiences with Solar. Lastly, it is also important to highlight that AWM has only one devoted worker who is not based in the Solar service. The researcher attempted to recruit this individual to participate in the research, but without success. Therefore, this study recognises that AWM involvement was needed to get a real perspective of why there is a limited engagement of AWM and why other stakeholders shared perception of AWM as a peripheral part of the overall partnership with limited impact.

5.7. Future research

Given the apparent lack of experiential research with newly retransformed CYP mental health services, looking at other retransformed models and gaining experiences of service users and their families with accessibility and acceptability of these models is crucial for future research. Furthermore, future research should also seek to obtain views from different groups on the validity of the multiagency community mental health models for CYP. Moreover, the experiences of service users do not present a strong picture of a uniformly positive response, which given the evidence of a lack of training, especially for ASD, suggests that a formal study is needed to determine how effective Solar is with different groups of patients. Future research should also focus on the experiences of fathers and their perspectives of retransformed models, as this study showed a predominant representation of mothers.

5.8 Chapter summary

This chapter qualitatively investigated the accessibility and acceptability of the Solar service from the perspective of CYP, staff and parents. Many stakeholders felt that Solar was an improvement over the previous model and welcomed the partnerships with third sector parties. Additionally, many interviewees felt that Solar is a community lifeline to service users and their families. Most service users felt positive about the youth-friendly ethos of the service and the design of its clinics. Furthermore, most stakeholders felt the self-referral pathway was helpful, and stated a clear preference for community-based treatment over more clinical alternatives. On the other hand, many stakeholders identified a range of barriers to Solar's accessibility, including poorly accessible service locations, and a lack of staff and resources. Many also felt long waiting times, especially for psychiatric referrals, created accessibility issues for the service. Parents specifically reported a need to be assertive for their children to receive timely access to care, while some staff members raised concerns over a high use of 'signposting'. Most interviewees felt the main weaknesses of Solar lay in its psychiatry services, while the least integrated partner of Solar was perceived as AWM. Finally, service users expressed mixed experiences with treatment outcomes.

Chapter 6: Children and young people's perceptions of the 0-19 model by utilising the Lego® Serious Play® approach

6.1 Chapter summary

The previous chapter aimed to understand the perceptions of CYP, their parents and staff members of the 0-19 model regarding the accessibility and acceptability of the Solar service. In this chapter, a novel use of the Lego® Serious Play® (LSP) methodological approach applied to a CYP mental health 0-19 model will be described. Initially, the importance of participatory research will be discussed, followed by the introduction of the main LSP methodology. Recruitment and data collection procedures are then explained and discussed in the context of the application of the LSP methodology in a CYP mental health environment. The application of thematic analysis to the analysis of the data will then be justified and expanded further.

The main findings from two focus groups with the service users of 0-19 model will be presented. These findings will be compared with findings obtained from a range of interviews conducted with the 0-19 model's staff members, parents and service users from chapter 5. Therefore, this chapter aims to understand CYP's perceptions of accessibility, acceptability, and satisfaction with the overall 0-19 model and its service provision. Besides the main findings, this chapter also reflected on the research experience of using this novel application of the LSP methodological approach. This reflection assesses the effectiveness of the LSP and its potential future use in other mental health research and service evaluations with CYP populations. All related research activities in this chapter are well aligned with the activity section of the logic model outlined in chapter 3.

6.2 Study aims

As the 0-19 model is a unique and novel service in the UK, it is important to explore service users' insights, experiences and perceptions of the model's strengths and weaknesses. Obtaining these may help towards a better understanding of their lived experiences with accessibility, acceptability, and satisfaction with the Solar model. Ultimately, gaining a better

awareness of CYP experiences may also help to identify gaps in the model or its service provision. Consequently, this may contribute towards better service provision that is more acceptable to CYP and truly meets their mental health needs. However, at the moment, there is an evidence gap in our understanding of CYP experiences with newly created or retransformed mental health community service models for CYP in the UK, as previously mentioned in chapter 1.

In order to explore CYP's engagement experiences with the novel Solar model, a qualitative approach was chosen primarily because of a limited amount of evidence from other qualitative studies exploring attitudes and experiences of CYP with their retransformed community mental health services in the UK. The additional rationale for using a qualitative approach in this study was its ability to generate rich CYP narratives to convey their lived experiences. In order to capture these narratives, it was essential to create flexible qualitative approach (design) that focuses on the shared construction of meaning between the researcher and the participants, and participants' empowerment without creating power imbalances between parties (Bassett, 2010). In order to investigate this, the study used a novel qualitative methodological approach based on the principles of the LSP methodology to meet participatory research needs.

The aim of this study was, therefore, to answer the following research questions:

- What is the stakeholders' perception of the 0-19 model's accessibility and acceptability?
- What is the overall satisfaction of the stakeholders with the 0-19 model and its service provision?

6.3 A need for participatory research

In order to fully understand CYP perceptions of accessibility, acceptability and their satisfaction with the Solar model, this study recognised a need for participatory research and CYP active participation. Most researchers in the field of CYP mental health use traditional data collection methodological approaches to obtain both qualitative and quantitative data. However, there

is an evident lack of participatory, creative, innovative and inclusive methodological approaches that are capable of facilitating self-expression and improving participant engagement with researchers (Dixon, 2016; Veale, 2005).

For example, traditional qualitative methodologies such as semi-structured interviews or focus groups are heavily reliant on the passive participation of CYP with the research process for the method to yield success (Veale, 2005). Moreover, in these processes, CYP often lack the opportunity to properly engage, analyse and represent their opinions and perceptions and convey their lived experiences (Veale, 2005). Furthermore, these methods are often not appropriately adapted to suit CYP capacities or competencies (Hendrick, 2008). Consequently, most research that is not participatory often fails to understand CYP realities and their experiences fully (Veale, 2005).

The main strength of participatory research does not lie in the extraction of data from participants responses. Instead, the research process should be considered as a transformational process that facilitates both the generation of knowledge and reciprocal learning through interaction between researchers and CYP (Borda, Reason, & Bradbury, 2001; Veale, 2005). Also, most research that involves CYP in active participation states that research which is accessible, engaging and robust, should also be fun for CYP participants (Carter & Ford, 2013). The use of research that is fun for CYP participants can be viewed as a 'serious' undertaking (Carter & Ford, 2013). Therefore, the use of the LSP approach stemmed from a need for participatory research, as improved participation may also help to introduce 'serious play' into the research domain with CYP.

Nevertheless, it is important to emphasise that in this study, we actively involved and encouraged participatory research, as recommended by Dixon (2017). This approach may remove any power-imbalances and smooth overdominance of CYP, which may help to create a more collaborative and inclusive process, not just between researcher and CYP, but also amongst CYP. Indeed, the utilisation of participatory research may allow for more empowerment, diversity, equality, inclusion, and collaboration between all engaged parties. Therefore, in order to fully explore CYP lived experiences with the 0-19 model and capture rich

CYP narratives, the researcher believed that qualitative study utilising the LSP methods was a useful way of allowing active CYP participation with the research process.

6.4. Methodological overview of Lego® Serious Play®

The LSP methodology utilises Lego bricks to provide a problem-solving solution (Gauntlett, 2013). Initially, this methodology was created for business environments to improve overall team performance and help generate innovation (Wouters & van Hoof, 2017). As such, according to Wouters & van Hoof (2017), the main benefit of LSP is its ability to promote and encourage reflection processes, which consequently enables more dialogue and engagement between involved participants.

Similar perceptions regarding the benefits of LSP was expressed by Hinthorne & Schneider (2017), who believed that LSP has successfully demonstrated an ability to stimulate critical thinking, reflection and interaction between participants effectively (Hinthorne & Schneider, 2012). Nevertheless, the LSP method is viewed as a feedback tool that has widely been utilised across different industries (Swann, 2011), healthcare providers (Murphy, Jordan, Hunter, Cooney, & Casey, 2015), education (Lotts, 2016; Montesa-Andres, Garrigós-Simón, & Narangajavana, 2014) and research settings (Barton & James, 2017; Hansen, Mabogunje, & Haase, 2009; Sheard et al., 2019).

Besides, there has been an increased use of the LSP methodology in a range of research settings that aim to use LSP as a means for generating different ideas and perceptions both creatively and interactively (Wouters & van Hoof, 2017). However, despite the potential of LSP to “express everything”, this particular methodology and its application to date has received little consideration as a feasible methodological tool from the broader research community. As such, it is rarely found in social and health sciences research designs (Swann, 2011). Nevertheless, several studies successfully demonstrated the effectiveness of LSP in service design and evaluations, and the successful utilisation of this methodology in NHS and healthcare settings (Dixon, 2016; Swann, 2011; Wouters & van Hoof, 2017).

The core advantage of the LSP method lies in constructed metaphors that are the main building blocks of an individual's narrative, which participants develop through engaging in the Lego building activity. Therefore, this 'hands-on' approach can capture an individual's 'hand-mind' connections which allows them to 'think through their fingers' while developing models and metaphors that will make the story or narrative behind the constructed model (Ackermann, Gauntlett, & Weckstrom, 2009; Gauntlett, 2007). Besides, research evidence shows that this approach where participants first build the model (scenario) with Lego bricks, followed by an explanation of the model through the story or narrative, offers better insight and comprehensive understanding of participant's real-life experiences, including feelings, relationships, aspirations, expectations and perceptions of an individual within a group (Dixon, 2009; Swann, 2011). Also, the LSP enables and promotes the empowerment of participants in the research, as creating something palpable diverting both the balance of power and locus of control from researchers to participants (Dixon, 2009).

Although this research study has utilised more traditional thematic approaches with data analysis from obtained qualitative data, we also employed visual research methods (Claudia Mitchell, 2011) and metaphorical modelling based on the principles of LSP methodology (Dixon, 2016; Gauntlett, 2013). The use of metaphors helped both the researcher and other CYP participants to gain insight into the storyteller thinking process, as well as highlighted themes that were visible from the told stories. The main rationale behind the use of LSP methodology in this project lies in its creative nature that enables an individual's active participation and engagement in a more personal and inclusive manner.

For this study, it is proposed that the models built by CYP participants would act as conduits to facilitate engagement of other CYP and promoted discussion which helped with the joint exploration of CYP experiences with accessibility, acceptability, and satisfaction with the 0-19 model and its service provision.

6.4.1 LSP methodological process

The LSP methodology has a well-developed a six-step process, as outlined in figure 33 (adapted from the LEGO® Group).

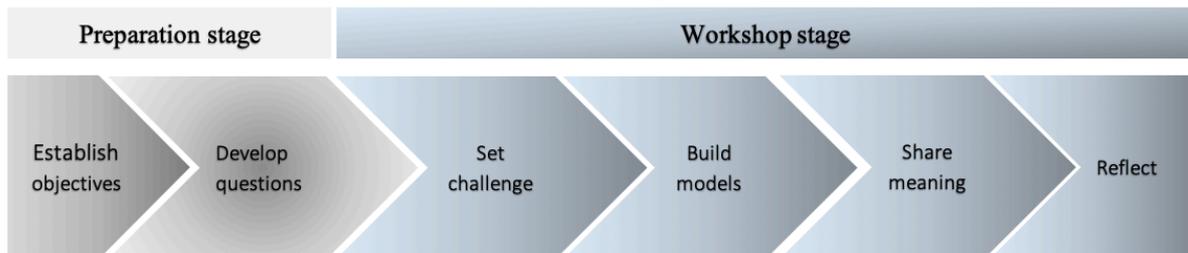


Fig 33. Six-step process of Lego Serious Play methodology

The initial two stages preceded the workshop stage. In the first stage, clear objectives needed to be developed to guide the LSP workshop. In the second stage, the researcher created questions that represented the main foundation for the building process. According to the authors, developing the right set of build questions is key for a successful LSP workshop (Gauntlett, 2010). Once these two stages were developed, the researcher engaged with participant in workshops. The previously developed questions were used as building directions for workshop participants as a set of instructions that guided their models and consequently, their answers (i.e. the researcher sets up the challenge for participants). During the building stage, participants were engaged in the construction of their models using various Lego bricks that represented their reflections on the earlier posed questions (or challenges). During this stage, participants also started to think about metaphors and narratives that explained the overall model (i.e. give meaning to their models). In the fifth stage, all participants shared their narratives (or stories) behind their built models. The group of participants collectively explored each model and their meanings. In the last stage, the group reflected on the models they constructed and sought deeper layers of insight (i.e. learning from each other).

6.5 Methods

6.5.1 Eligibility criteria

All YP were eligible to be included in focus groups if they satisfied following inclusion criteria: a recent experience of mental health issues; active service users of the 0-19 model; aged between 10-19; have capacity to provide informed consent to participate; have the ability to read, write and converse in the English language.

6.5.2 Recruitment

All participants were recruited from the primary location of the Solar service, Bishop Wilson clinic. The recruitment of CYP for the LSP sessions was challenging and took more time than initially predicted. Initially, three separate LSP sessions were conducted. Despite recruitment efforts from both clinicians and the researcher, the initial sessions failed to attract any CYP participants. To overcome this initial challenge, the researcher, in cooperation with a clinical psychologist, co-produced the LSP session as a part of the treatment group therapy. The LSP sessions were conducted in the last session of a treatment block to improve the chances of CYP and parental availability.

As recommended by the University ethics and Solar staff, only CYP that were deemed as 'ready for discharge' were considered for focus groups, as this approach reduced interference of the research study with CYP therapeutic process and impact on their mental health. The researcher was introduced to CYP at their first group therapy session by a clinical psychologist to enable the service users to be familiarised with the researcher. This initial contact helped service users to understand the purpose of the project and why their involvement is needed. During the initial group therapy session, the researcher provided CYP with all necessary documents. Participant information sheets (PIS) and consent forms (**Appendices 13-15**) were given to the CYP.

Also, the researcher met with and introduced himself to CYP parents. All parents were provided with copies of the consent forms and PIS (**Appendices 15a**) as most CYP participants were younger than 16 years of age.

6.5.3 Participants

A total of seven CYP participated in two LSP focus groups. A purposive sampling strategy was employed to capture broader CYP experiences with the 0-19 Solar service. All participants were active service users of the Solar service and were recruited from the service's low-intensity group therapy, which comprised of a wide range of CYP with different experiences of the Solar model.

Only one participant was classified as an adult (i.e. 16 years of age or above) and consented independently, without the need for parental consent. The remaining six participants were younger than 16 and parental consent was provided in addition to their own.

Demographic data from all CYP participants were kept at a minimum as recommended by the BSREC ethic committee. As visible from table 40, the focus groups comprised of four female and three male participants. Six participants identified as having white British ethnicity, while one identified as black British-Caribbean. At the time of the focus groups, all participants were ready to be discharged from the 0-19 model. Two participants had previously been treated in the Solar crisis team, while no participants had experienced relapse with their mental health.

Table 40 - Participants demographics

Demographic questioner	Number of participants
<input type="checkbox"/> Gender	
Male	3
Female	4
<input type="checkbox"/> Ethnicity:	
White British	6
Black British-Caribbean	1
<input type="checkbox"/> Age:	
10-12	2
13-14	3
15-16	2
16-19	0
<input type="checkbox"/> Treated in the 0-19 model:	
Yes	7
<input type="checkbox"/> Previously treated in the 0-19 crisis service:	
Yes	2
No	5
<input type="checkbox"/> Experience of crisis relapse	
No	7

6.5.3 Data collection

On the day of focus groups, all participants, and parents when parental consent was required, were given a consent form to fill out before their involvement, in addition to information documents (Appendices 13-15a) and given 10 minutes to complete them. During this time, all participants and parents were also allowed to ask questions. Once all consent forms had been completed and signed, the researcher provided participants and their parents with additional copies of PIS forms and consent forms for their records. The researcher then double-checked that all necessary forms had been completed correctly.

Before the focus group started, the importance of confidentiality and non-disclosure of any personal or sensitive information was emphasised to all participants. All participants were informed that the focus group would be recorded for transcription purposes, and once their words had been successfully transcribed, the audio recordings would be destroyed. All participants agreed to be recorded.

The role of the researcher was predominantly to facilitate the focus group session with the LSP tools. At the same time, participants took full control over the narrative, overall building session and following discussion. This approach helped participants to build a rapport with the researcher, as the researcher was on the same level as participants.

The participants had 120 minutes to answer the two following questions using the Lego bricks and models:

1. Describe your experience with the Solar service and its service provision?
2. How would you like to see the future of the Solar service and its service provision?

Even though the usual LSP methodological approach advises 3-6 hours of participant engagement and participation, we believed that this would not be possible in this research setting. As most of the participants were under the age of 16, it was felt that it would be challenging to maintain their motivation and concentration for any period longer than 120 minutes. Therefore, the researcher used a modified version of the LSP methodology, as employed by Wouter et al. (2017), which was adapted for 90-120-minute periods. Both focus groups were structured to allow for two short breaks after 50 and 95 minutes. All participants were in the same room and they had 45 minutes to build their models and answer the first question. During this time, CYP only interacted with facilitator and supporting staff. Once this was completed, CYP had a break. During this break, the CYP were provided with refreshments. Once CYP were ready to continue the researcher again reminded participants on the aspect of confidentiality and non-disclosure of sensitive information. Once every participant had their turn in explaining their models, a group discussion lasting 10 minutes followed, during which CYP interacted with each other. In this discussion, all participants reflected on their experiences and how similar or different they were in comparison with their peers' experiences. The second stage of the focus group commenced once all CYP expressed their willingness to continue with building the models to answer the second posed question. Participants had 45 minutes to make the second model, and once finished, another break followed by an explanation of CYP models with discussion. The LSP focus groups lasted for 80 and 115 minutes in total. The shorter focus group was the one with only two participants.

Task	Description	Planned Duration
Introductory exercise	A one-minute task given to CYP participants as a warm-up exercise to build a duck with only six pieces of Lego bricks. Once participants built a duck, they were instructed to remove two bricks and rebuild a duck with only four remaining bricks within one minute period.	5 minutes
Evaluation of perceptions	CYP were instructed to build their models that would answer the question "Describe your experience with the 0-19 service model?"	35 minutes
Reflection and discussion	CYP participant explained their models by using metaphors and stories. CYP held small discussion around different models and different experiences.	10 minutes
Refreshment break	CYP were given a break from the activities	10 minutes
Envisioning the future of the service	CYP were instructed to build their models that would answer the question "How would you like to see the future the 0-19 service model?"	35 minutes
Break	CYP were given a break from the activities	5 minutes
Reflection and discussion	CYP participant explained their models by using metaphors and stories. CYP held small discussion around their views of how the future 0-19 model should look like.	10 minutes

Fig 34. Facilitator guide for the LSP sessions

6.5.4 Post-focus group tasks

The researcher remained available for any additional questions that participants had before all participants left. Once the focus group was finished, all signed and completed forms were stored at the University of Warwick, Medical school in a secure filing cabinet, while the audio recording was sent for transcription.

6.5.5 Data preparation for analysis

The audio recordings from both focus group were transcribed verbatim by the transcription service, Appen, which is approved by both the University of Warwick and BSMHFT. Once the audio files had been transcribed, all transcripts were reviewed by the researcher for accuracy. Each transcribed log was assigned a unique pseudo identifier, which corresponded to the participant's consent form. The data analysis conducted on the transcripts was based on the thematic analysis and process described by Braun and Clarke (2006).

6.5.6 Thematic Analysis

Thematic analysis is widely employed in psychological and social science research to gain an understanding of particular social phenomena (Frost, 2011) while being one of the most utilised methods in qualitative research for categorising, evaluating and reporting emerging themes from participant responses. The thematic analysis provides rich and detailed descriptions of participant perceptions and experiences (Braun & Clarke, 2006; Nowell, Norris, White, & Moules, 2017). As such, thematic analysis can be considered as a foundation stone for all other qualitative analyses (Nowell et al., 2017). While some authors consider this method as a process (Boyatzis, 1998), others view it as *“a unique method in its own right”* (Braun & Clarke, 2006; King, 2004; Nowell et al., 2017).

Nevertheless, according to Nowell et al. (2017), this method can be broadly utilised across a range of epistemologies and can be a successful tool to answer any research question. For this research project, the application of thematic analysis was guided by the research questions to understand and explore CYP experiences with the 0-19 model and their satisfaction with the model and its service provision. Through thematic analysis, we were able to explore participant responses to identify emerging commonalities and underlying patterns that described participant opinions on the impact that the 0-19 model has on the local community, and their personal experiences with the care received. The rationale behind employing thematic analysis in this study was primarily due to its epistemological flexibility, practicality, and its compatibility with other theoretical positions available (Braun & Clarke, 2006).

Besides, the flexibility of thematic analysis made it a useful approach for interviews (Joffe, Yardley, & Marks, 2004). In light of these reasons, the research team agreed that this tool was an appropriate, flexible and well-utilised method in mixed methods research. Finally, to analyse the obtained data, we utilised a step-by-step guide for performing thematic analysis from Braun and Clarke (2006) (table 42).

Table 41 - An overview of the thematic analysis. Adapted from Braun and Clarke (2006)

Step	Action	Description
1	Familiarisation with the dataset	Reading and re-reading all transcripts and field notes with initial note-taking of emerging patterns and ideas
2	Generation of initial codes	Production of initial codes across transcripts by using NVivo and assigning data to each identified code
3	Identification of initial themes	All initially identified codes to be organised into provisional themes
4	Revision of codes and themes	The codes to be re-read, and all codes that share similarity to be grouped, while other codes to be re-named or re-assigned to other codes. The remaining codes to be checked against initial themes – through the use of mind map (thematic map)
5	Generation of final themes	Generation of overarching themes and their sets of subthemes to form the overall narrative of the analysis
6	Narrative reporting	The corresponding extracts or quotations from the participants' transcripts to support narrative explanations of themes, as evidence for the particular theme

6.5.6.1 Applying thematic analysis in the research project

In the first stage, the researcher started to familiarise himself with the transcription content and field notes obtained from the LSP sessions. All transcripts and field notes were read, preliminary ideas and patterns noted and re-read as recommended by Braun and Clarke (2006). In the second stage, all transcripts were run through the NVivo software, where the transcripts' content was coded. In the third stage, all produced codes were combined according to their similarity with the provisional ten themes. Once provision themes were compiled, the codes were re-examined in the fourth stage and compared with the initial ten themes. In order to identify overarching themes, all codes and their fitness to themes were checked by creating a mind-map to represent the thematic map visually. The mind map was helpful in the fifth stage to re-arrange codes into more appropriate subthemes, while some of the complex initial themes were reorganised into a more coherent structure (i.e. a set of subthemes). The product of the thematic analysis was the creation of five overarching themes that were comprised of 16 subthemes.

This data-driven approach towards analysis followed an inductive or “bottom-up” approach, as described by Braun and Clarke (2006). All identified themes were strongly related to the data obtained from participants and, as such, were not linked to the other research themes found by other studies that utilised the LSP methodology. During the analysis stage, the researcher tried to approach the analysis objectively, without any presumptions. However, the researcher had pre-existing knowledge and previous experiences of conducted interviews on similar topics. Nevertheless, it is important to highlight:

“...that researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum” (Braun and Clarke, 2006)

Therefore, the developed themes, subthemes and codes were not developed to complement or fit into any pre-existing coding framework.

6.5.7. Research Governance, Ethics and Participants wellbeing

All interviews did not commence until after full ethics approval had been received from the BSREC-REGO-2018-2294 (Appendix-3). Also, the evaluation approval and letter of access were obtained from the BSMHFT research and innovation department (Appendix 4&4a). More information about participant welfare, ethics approvals and research governance can be found in chapter 3, section 3.3.4.

6.6 Findings - Themes from CYP perception of the 0-19 model

In total, 14 different Lego models were produced. All CYP models were similar and pointed out to the similar experiences between participants, five main themes were then identified through the thematic analysis of the transcripts (Table 43). These findings will be discussed and supported by participants' quotes. Lastly, all themes will be discussed in relation to CYP, parental and staff perceptions obtained from the interviews in chapter 5.

6.6.1 Themes and subthemes of the study

Table 42 - Themes and subthemes obtained through the use of thematic analysis

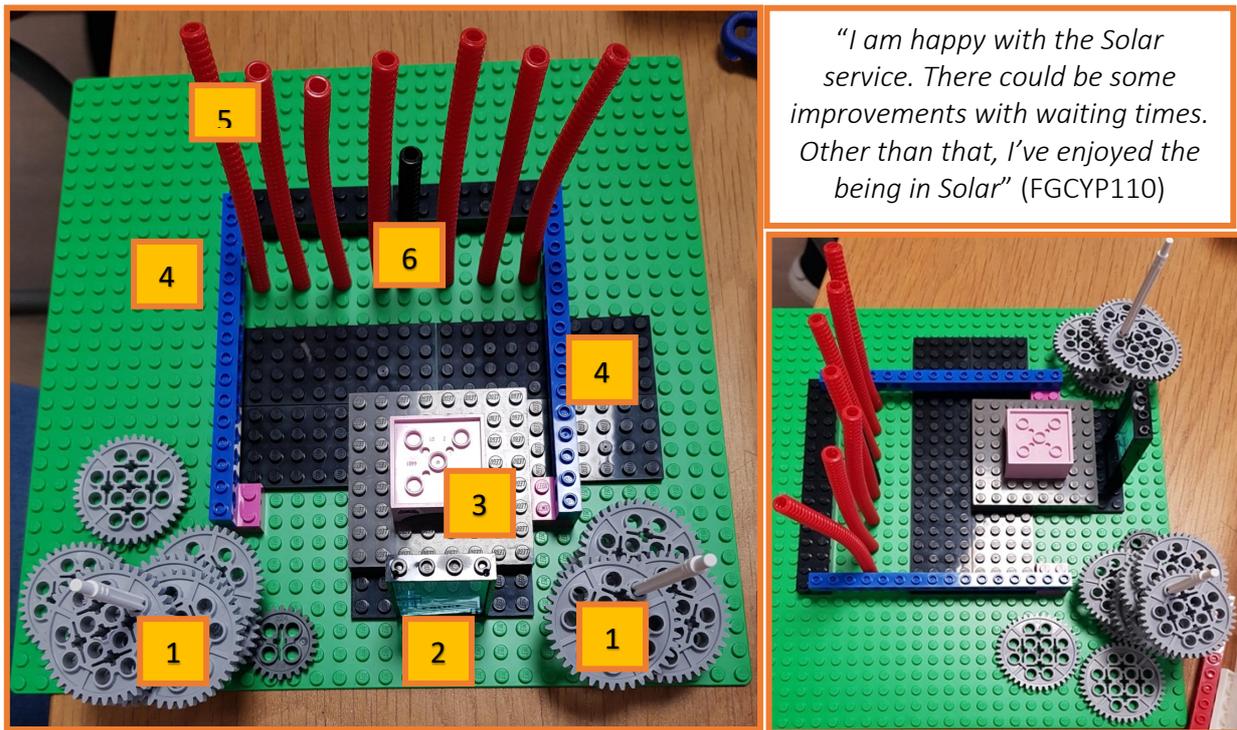
Theme 1 – Accessibility	Waiting times to access the service
	Inconvenient locations
	Need for more flexibility
Theme 2 – Doors into the unknown	Initial emotional reactions of access to service and groups
	Gradual opening-up
	Moving between being sad, okay and happy
Theme 3 – Let it out	Need to speak and be listened to
Theme 4 – Overcoming obstacles	Ladders to climb over
	Grey barriers
Theme 5 – Less is sometimes better	Satisfaction with the service provision
	Smaller group therapy
Theme 6 - Satisfaction with the 0-19 model	

6.6.2 CYP perception of the SOLAR service through LSP models (LSP models overview)

In this section, a sample of eight out of 14 models are presented, while the remaining six photos of models are displayed at the end of this section. The inclusion of sample models was made in discussion between the student and supervisors to avoid any repetition. Some models were removed as they covered similar themes. When comparing two models that covered similar themes, we included those for which we felt that such themes were more clearly

represented in the model. Each presented participant’s model is analysed and accompanied by a visual numerical marker placed above particular segments of the model to provide an understanding of given metaphorical meaning and interpretation of CYP models. Additionally, each model is accompanied by a participant's explanation of their model in the form of a direct quotation.

FGCYP110’s model 1



“I am happy with the Solar service. There could be some improvements with waiting times. Other than that, I’ve enjoyed the being in Solar” (FGCYP110)

Fig 35. FGCYP100 Representation of the Solar service , issues of waiting times and participants reflection on their first experience of access to the 0-19 model

Interpretation:

(1) Cogs represents waiting times to access the service; (2) Police doors represent the scary experience of accessing the 0-19 model for the first time; (3) Pink platform represents changes for young people for the better; (4) Blue bricks represents a need for safety; (5) Red tubes represent CYP participants involved in the group session and (6) Black tube represents the therapist

Participant’s direct quote: *“These cogs here represent a long time to access the service for an initial assessment. They also represent quite a long time to receive the necessary support, so you might wait a long time actually to come onto groups. I’ve done these doors, it’s like a policeman, as it can be quite scary when you come to Solar for the first time. There is this little pink platform with a butterfly which represents a change for young people for better. These blue bits represent safe boundaries so that we are safe altogether. These seven tubes represent the number of young people in the group, while the black tube is a therapist.” (FGCYP110)*

FGCYP116's model 1



"My anxiety box is still little bit full. I still need to go little bit further, but I am happy with the service" (FGCYP116)



Fig 36. FGCYP116 Representation of the first-time experiences of accessing Solar challenges that participant needed to overcome, service as a safe environment and discharge experience

Interpretation: (1) The box represents a place where participant deposits all their fears and anxieties; (2) The dragon represents the fear of coming to Solar for the first time; (3) The white cube with the cross represents the entrance to Solar and the help available; (4) The grey barrier represents challenges that the participant still needs to overcome in order to feel better; (5) The blue bricks represent the safe environment within the Solar service building; (6) The white cube represents discharge from the Solar service; and (7) Red tubes represent celebration at the point of discharge from the Solar service

Participant's direct quote:

"This is the spot (box) where I need to throw away all of my anxieties and fears, and Solar helps me with that. This is some monster that is chasing me. Monster or dragon represents a first time when I came here, and I was a bit scared and nervous. White cube with a cross represents the entrance to Solar. This (grey barrier) presents challenges that I need to go over in order to come to the finish line (white lower cube) and be discharged from the service. Red tubes represent celebration at the point when I leave Solar" (FGCYP116)

FGCYP111's model 1

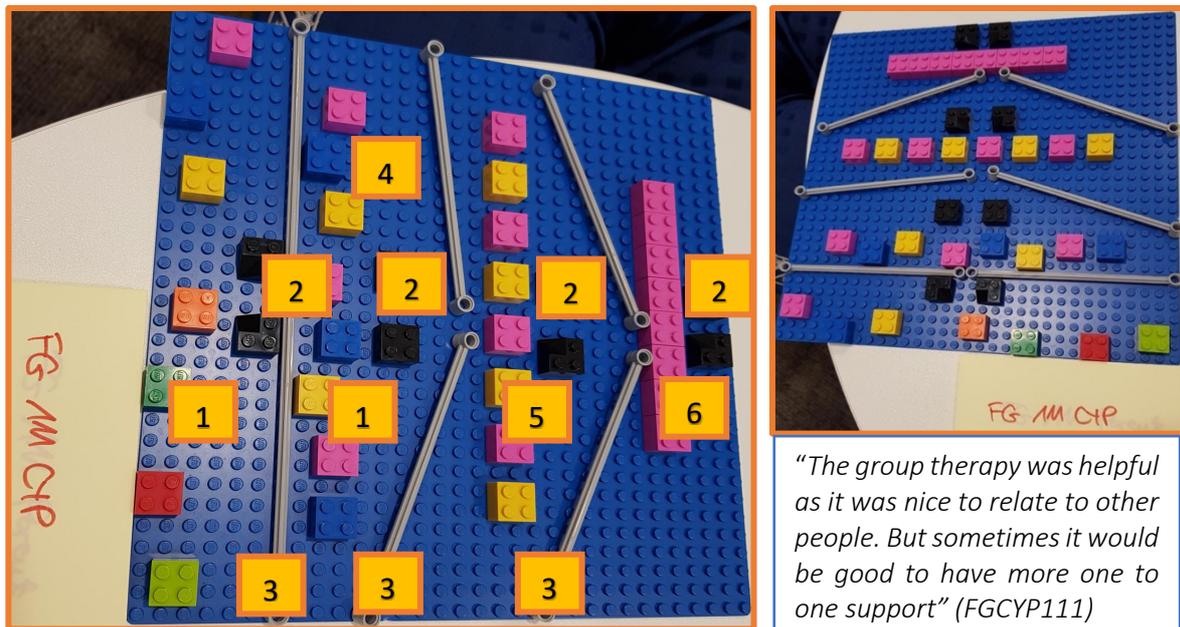


Fig 37. FGCYP111 Representation of participant's experiences within the Solar service therapy environment, importance of therapeutic alliance, gradual mental health improvement, and the service as a safe environment

Interpretation:

Cubical bricks of different colours represent different CYP who suffer from different mental health issues. Participant explained that at this initial stage CYP don't know each other and are reluctant to engage with therapists, which is portrayed with gaps between different coloured bricks; (2) Black cubical bricks represent therapists and facilitators engaged in CYP treatment; (3) Grey boundaries represent different stages of treatment and how much CYP are open to the treatment process; (4) At this stage, CYP have become more familiar with the service, and each other. CYP have also managed to build a rapport with their therapist; (5) The following stage depicted improvement in CYP mental health and improved engagement with each other; (6) The blue bricks represent the safe environment within the Solar service building; and (7) In the last stage, all CYP feel on the same page, they can relate to each other and they feel improvement with their mental health.

Participant's direct quote:

"This is the first week. Black cubes are instructors. Different colours are different people who are in the group. Different colours mean everyone has a different background and different problems and they are quite distanced, far away, because everyone is a bit shy. Reserved and they don't want to open much. (Grey barriers) This shows that everyone is closed. (The second stage) This is a week three and there are only three colours because everyone is a little closer. People start to know each other. They are still a bit awkward, but still, everyone is similar. The grey barrier starts to be more open as people become more open. (The third stage) Week six, people are becoming more similar. The final week, everyone is feeling better and relate to each other more. The group therapy was helpful as it was nice to relate to other people. But sometimes it would be good to have more one to one support, but it's also good to speak to other people and relate to them. "(FGCYP111)

FGCYP114's model 1

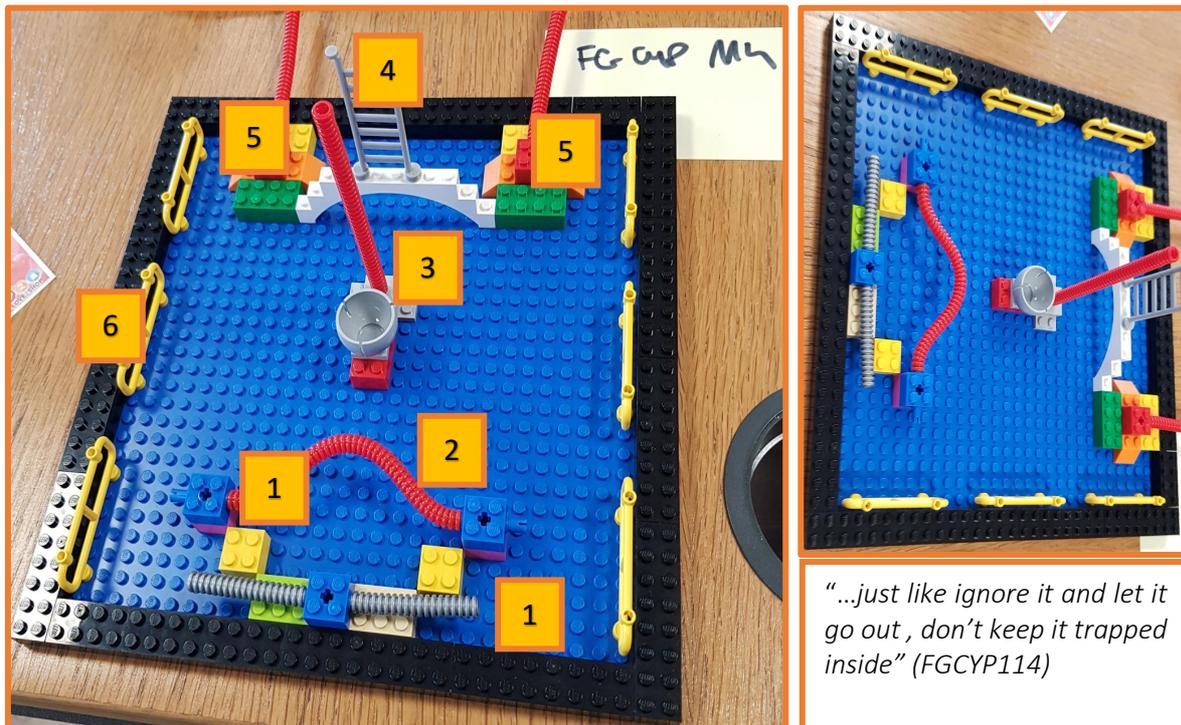


Fig 38. FGCYP114 Representation of participant's experience within the Solar service its safe environment and positive treatment outcomes.

Interpretation:

(1) The model represents both a smiley and sad face. The sad face represents a need for help and being listened to ("let it out, don't keep it inside"); (2) Once CYP needs are met by mental health professionals their sad face can turn to smiley face.; (3) The grey bowl in the centre represents the participant's emotions (anger or sadness), which are all mixed together; (4) The ladder represent overcoming mental health problems ("climb over your problems"); (5) The red tubes at the top of the model represent a release of all the participant's negative emotions ("ignore and let it out, don't keep it inside"); (6) The yellow barriers prevent external factors to harm or influence the participant (such as other people or anger) and helped the participant to block them out; and (7) Black bricks represent the Solar service in which participant feels safe (blue area represents safety)

Participant's direct quote:

" This model is supposed to be a smiley face, mixed with a sad face. Cause if you are sad, you need help with things and speak to mental health workers. For example, people that work here at Solar and they might help. Sad face turns to OK face and maybe happy face... That's like (Bowl) all the emotions at one place. Being angry and sad is all mixed in the one bowl... Ladders mean overcoming things you don't want to do, a way to overcome your problem... The red tubes mean if people annoy you, just like ignore it and let it go out, don't keep it trapped inside... The yellow barriers mean blocking out all people that try to annoy you" (FGCYP114)

FGCYP110's model 2



“There is a need for another clinic. Yes, definitely. Cuz for me it takes 45 minutes to get here (to Bishop Wilson). It shouldn't take this long to access help” (FGCYP110)

Fig 39. FGCYP110 Representation of participant's opinion how the future Solar should look like identification of barriers to access and need for more services like Solar

Interpretation:

(1) Blue bricks represent sense of safety within the 0-19 model; (2) The red door represents the entrance to the Solar service; (3) The white bricks has been perceived as the overall journey through the 0-19 model; (4) Red arches represent all the support that CYP receive throughout their journey through the model; (5) Parents feeling stuck (not knowing what to do); (6) Pink brick is a change, improvement in CYP mental health and new beginnings; (7) Bishop Wilson clinic; (8) Freshfields clinic; (9) A need for more centrally based clinic in the Solihull; and (10) Discharge from the 0-19 model and continuation of the journey.

Participant's direct quote:

“The red door is the entrance to the Solar service and kind of journey (white bricks). You come onto it, and (red arches) this shows that there is a support available. Eventually, you leave the service happy. (Yellow barriers) This represents parents, as sometimes when children are first referred they feel stuck and not know what to do. The Solar service opens up those barriers and helps them (parents and children) to feel more supported. (Pink brick) This represents happiness and new beginnings. (The grey triangles) are three buildings or clinics. One is Bishop Wilson and one is Freshfields. The third building needs to be open, for Solar to become more accessible”. (FGCYP110)

FGCYP116's model 2

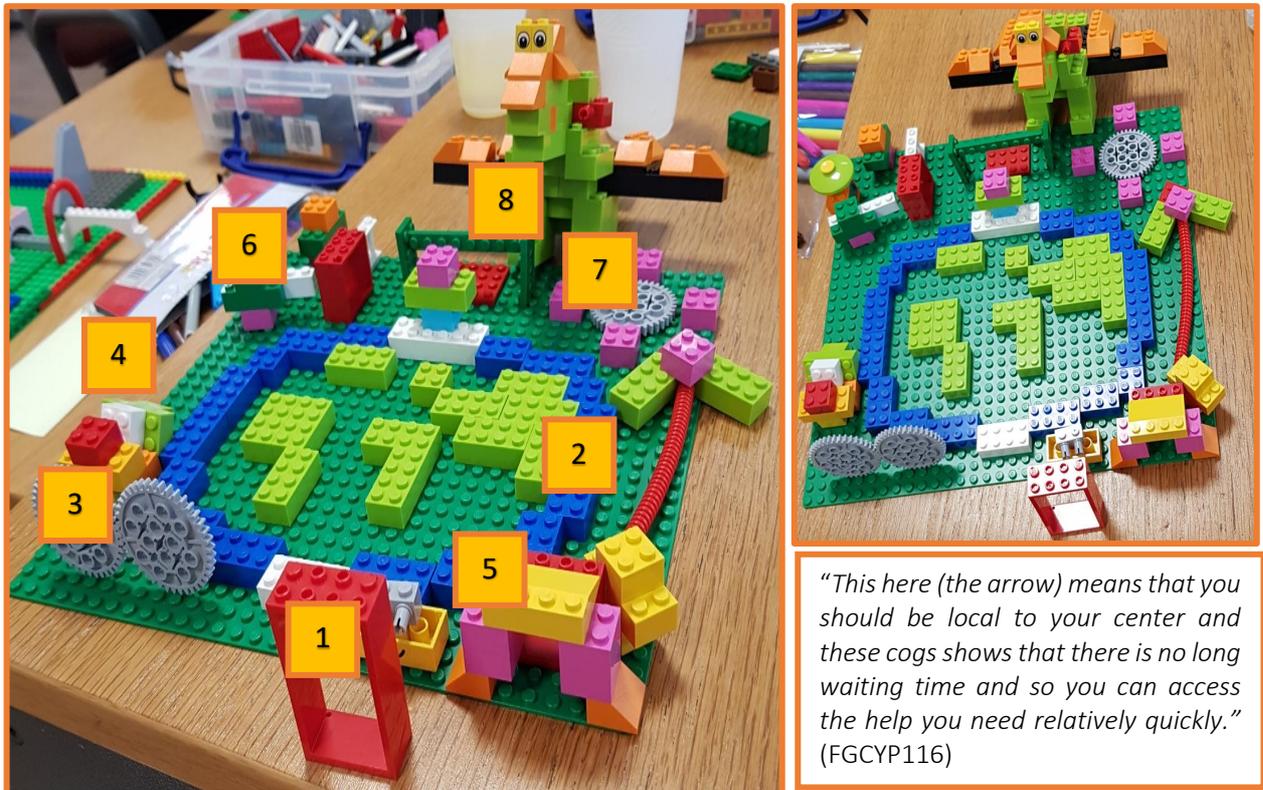


Fig 40. FGCYP116 Participant's perception of the future Solar and need for more local services that are closer to CYP homes and less waiting times

Interpretation:

(1) Door represents a need for openness of the 0-19 model so that everyone feels welcomed; (2) The arrow represent a need for the service to be more local and accessible; (3) Cogs represent reduced waiting times to access the 0-19 model; (4) Green cross represents CYP relying on the 0-19 model's staff to receive appropriate help; (5) Parents also need to be supported and guided; (6) Box represents all the negative emotions that you need to put it away; (7) Groups should be comprised from four people – not too big nor too small; and (8) Dragon represents a need for fight through your obstacles to archive recovery .

Participant's direct quote:

"This (green cross) here means that you can rely and depend on the people (Solar staff), and parents can also be supported and guided to show what they need to do to help their children. This here (box) shows a place where you need to put all your worries away and you should always try to feel happy and overcome your challenges... (pink bricks with a cog in the middle) The groups should be like made out from four people. Not necessarily too big, because then you don't have so much attention on you, but also not too small. Otherwise, you will feel pressured. The blue boundaries represent local community mental health service that should be locally available..." (FGCYP116)

FGCYP111's model 2



"It's just an awkward time for treatments. They should work longer during the week and over weekends (FGCYP110)

Fig 41. FGCYP111 model. The model represents a need for more appropriate and flexible service working times

Interpretation:

- (1) Clock – represents long waiting times and awkward times for the session. Service should work longer and be available during weekends; and
- (2) Icicle – it's always cold in the service

Participant's direct quote:

"That's just supposed to be a clock. As service has long waiting times and awkward timings for treatments. We have to rush from school and sometimes miss the class to receive help here. An icicle represents that it's always cold here (temperature-wise). Pretty cold." (FGCYP111)

FGCYP112's model 2

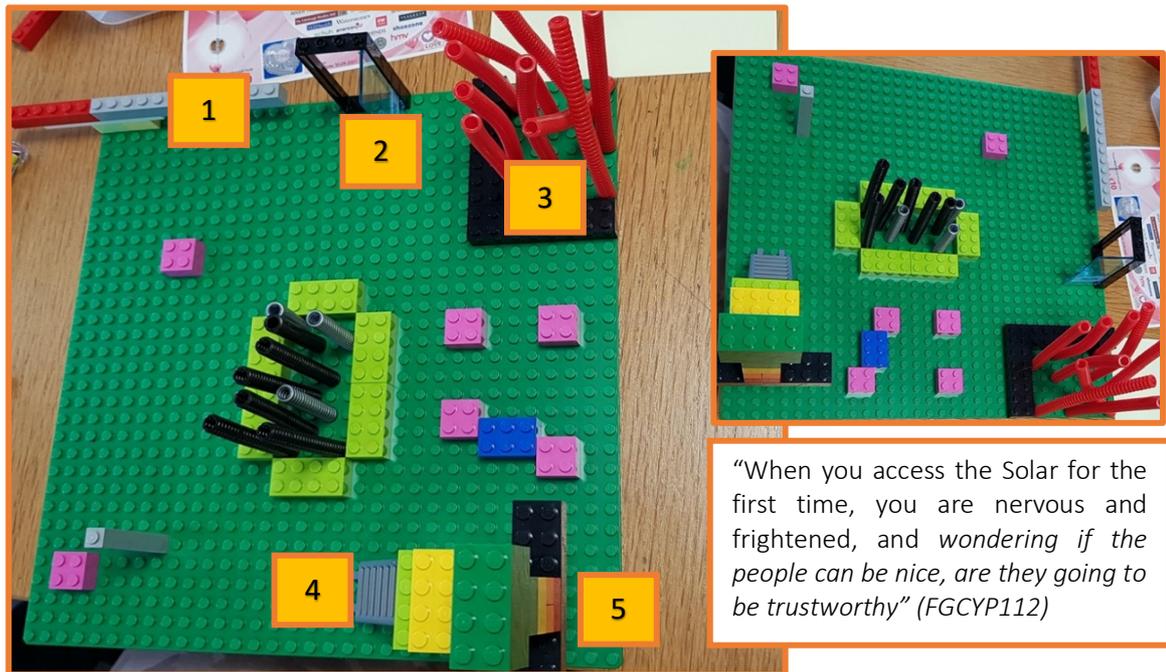


Fig 42. FGCYP111s representation of their experiences with the Solar service and need for closer service to CYP place of residence

Interpretation:

(1) The 0-19 model being closer to the participants place of residence; (2) The service should be more open up for CYP to speak about their emotions; (3) All negative emotions are cornered up and replaced with more positive emotions; (4) Ladder to overcome problem and reaching goals; and (5) Seesaw between positive and negative emotions

Participant's direct quote:

"The first is obviously destinations and need for closer services. that service should be more open to being more safe environments for people to open up and to speak up about their emotions, not bottle them up. The red tubes represent a corner where all negative emotions are being placed, to corner all negative emotions and put positive emotions before negative ones. No matter how hard the goal is to reach just climbing up the ladder, and you will always get there. Obviously, with the sessions in between, the emotional seesaw, there are less negative and more positive emotions" (FGCYP112)

Other models

Similarly, to the previously mentioned models, the six remaining models depicted similar stories that mostly revolved around the need for less waiting, faster access, closer mental health services to their homes, fewer YP in the group sessions and increased satisfaction with the Solar service provision. The helpfulness of the Solar treatment was also evident in these models.

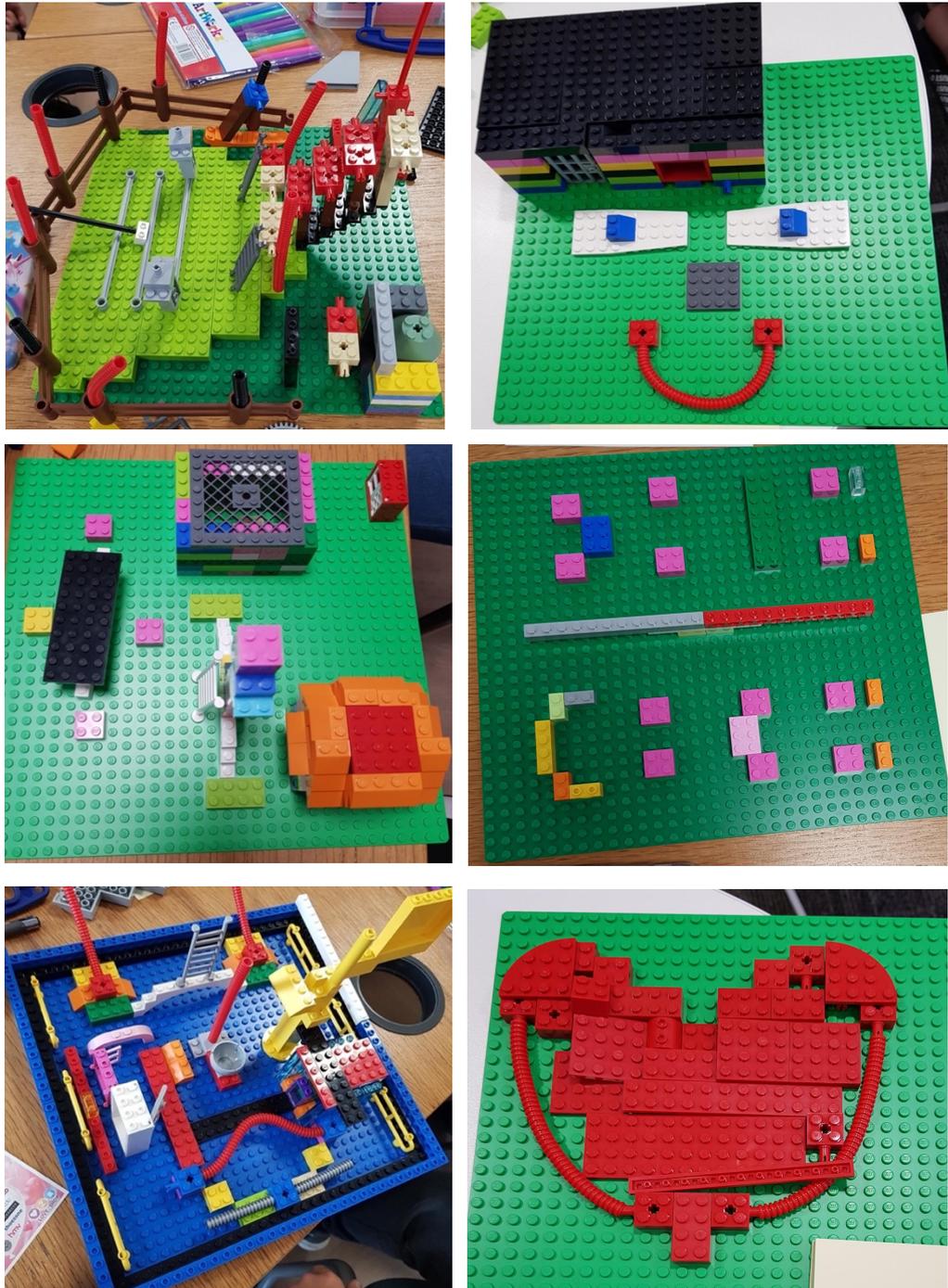


Fig 43. Examples of other constructed models by YP participants

6.6.4 Theme 1 - Accessibility

The first overarching theme identified was 'accessibility', which comprised of three subthemes: (1) long waiting times for access; (2) need for local services and (3) flexibility with scheduled appointments and working times.

The waiting times emerged as the most prominent subtheme and was referenced in most of the CYP's Lego models and responses. The participants used a wide range of metaphors to depict a need for waiting, such as cogs, hills, or clocks. For example, participant FGCYP116 felt that future development of the service should provide quick access to help for CYP and eliminate the need for waiting. A similar metaphorical approach with regards to waiting times was used by participant FGCYP113, who compared them to a hill that needs to be conquered to get appropriate help. This participant considered waiting times as an obstacle to recovery. The participant clearly described the impact that waiting times have on CYP as a barrier to accessing the service. Additionally, they also make it clear that they feel as though there is a disparity between the waiting times of different service users, with some being "*farther away*" from receiving help. Moreover, the celebration in the participant's quote also refers to a chance for getting treatment and improving their mental health. The perception that the service is more accessible for some people in comparison to others was also supported by participant FGCYP114.

The second-most reoccurring subtheme with the accessibility of the service was the location of the service. Most participants in their models had some metaphorical reference that represented a need for closer service locations. For example, FGCYP116 expressed a desire for the service to be more local. Similarly, participant FGCYP112 depicted their desire for the service to be within proximity of the homes of CYP as "*Solar could help more children if the clinics are closer to where they live*". Likewise, participant FGCYP114 reported a need for Solar to grow and be more present within the Solihull area. The participant also acknowledged that for some CYP who live further away, it could be hard for them to get to the clinic. Participant FGCYP114 also added that there is a need for people to have access to more local sites, closer to their homes which would help them to overcome mental health difficulties.

Similarly, participant FGCYP110 agreed with all other participants that there is a need for additional Solar services in the heart of Solihull, which could be much closer to everyone. In their model, the participant positioned the other clinic (represented by a triangular brick) in between Bishop Wilson and Freshfields clinics. In the third subtheme participant, FGCYP111 used a metaphor for a clock to explain a need for more flexibility of service to reduce waiting times for treatment, have longer working hours and weekend service provision. Additionally, participant FGCYP114 also felt that the service “*should stay open for longer*”.

Table 43 - Participants quotes in support of the theme Accessibility

Participants	Quotes in the support of theme
CYP	<p><i>“These cogs here represent a long time to access the service for an initial assessment. They also represent quite a long time to receive the necessary support, so you might wait a long time actually to come onto groups”.</i> (FGCYP110)</p> <p><i>“These cogs show that there is no long waiting time and so you can get access to the help you need relatively quickly”</i> (FGCYP116).</p> <p><i>“That is like a hill, and at the bottom are people that are depressed. These people do not get any help. All these obstacles are like time barriers towards the top of the hill. Some people are closer and some farther away. Once you reach the top of the hill, there is a celebration as you will get help”</i> (FGCY113).</p> <p><i>“Access is quick for some people. It’s like longer for others.”</i> (FGCYP114)</p> <p><i>“This here (the arrow) means that you should be local to your centre. Services as such should be more locally available”.</i> (FGCYP116)</p> <p><i>“So, definitely want more Solar services around Solihull whole area, and this (Yellow column) represents the need for more growth. So, it will grow. People will find it easier to get to Solar. It’s longer for some people to get to the clinic. For some people, it is like five- or ten-minutes’ drive, while for others, it’s half an hour to an hour drive, and for those people it’s quite hard to get in the service”</i> (FGCYP114)</p> <p><i>“People should find their way to the more local sites, more places where they end like help alike locally”.</i> (FGCYP114)</p> <p><i>“The service in future should be closer to where everyone is and close to my home”.</i> (FGCYP115)</p>

From all these quotes, long waiting times to access to appropriate help in the Solar 0-19 model and inconvenient service locations may be seen as barriers for access. Also, CYP expressed a

desire for the service to offer more flexible hours, rather than the limited 9-5 service provision to suit individual CYP needs. However, CYP also discussed the impact that initial barriers to access had on them. This impact will be further explored in the next sections.

6.6.5 Theme 2 - Doors into the unknown

The second overarching theme identified was 'doors into the unknown', which comprised of three subthemes: (1) initial emotional reactions of access; (2) gradual opening-up and (3) moving between being sad, okay, and happy. Most CYP participants depicted doors in their Lego models that represented the entrance to the 0-19 model. For many participants, they also acted as a metaphor for the beginning of their journey. For instance, FGCYP110 described "*the entrance to Solar*" in their model and referred to their experience with Solar as "*kind of like a journey*" where they felt appropriately supported.

Equally, participant FGCYP116 associated doors and entrances to the Solar service with a sense of stepping into a welcoming environment that "*feels friendly and open*". However, these experiences were not equal for all CYP participants. For some CYP, the beginning of the journey was characterised with emotional reactions such as feeling shy, awkward, being nervous and frightened.

For example, participant FGCYP115 reflected that they felt "*nervous at the start. I didn't had any confidence at all*". A similar experience of initial access was shared by the FGCYP112 who felt "*nervous and frightened*" during their first group sessions, while wondering whether the other CYP will be "*nice*" or "*trustworthy*". Similarly, participant FGCYP110 described their first encounter with the service as being scary.

Participant FGCYP111 felt "*a bit shy and still a bit awkward*" in their second therapy session. However, most CYP participants explained that there is a gradual process of opening-up towards the service itself and the rest of the people in group therapy. Similarly, participant FGCYP112 agreed that some amount of time is needed to build up a rapport, which consequently made the participant more comfortable.

As participants became more familiar with the Solar staff and their peers, they started to notice the benefits of the service provision and the first signs of improvement with their mental health. Some participants described this process as moving from being sad to being okay, and consequently happier.

Often the end of the journey in participants’ models was described as another door that leads participants out of the service towards a brand new beginning and new journeys that await them. For example, participant FGCYP116 felt that when CYP are ready to leave Solar, they should feel “on top of the world”.

Table 44 - Participants quotes in support of the theme ‘Doors into the unknown’

Participants	Quotes in the support of theme
CYP	<p><i>“I’ve done these doors, it’s like a policeman, as it can be quite scary when you come to Solar for the first time.” (FGCYP100)</i></p> <p><i>“Then there are only three colours because everyone’s excited too. And they’re a bit closer. People started to know each other a bit more, but still a bit awkward. So, there’s still the divide, but people are starting to be more open”. (FGCYP111)</i></p> <p><i>“Gradually, as the sessions went on, and you get to know people more. And you get in a lot happier and more comfortable”. (FGCYP112)</i></p> <p><i>“For example, people work with Solar, and it might help them, and sad face turns to okay face, and maybe, in the end, happy face too.” (FGCYP114)</i></p> <p><i>“what everyone wants when they come here (Solar), everyone wants to leave the building with the smile. Sometimes even when I come in, I don’t feel happy, but by the end of the session with a therapist, I have a smile on my face.” (FGCYP117)</i></p> <p><i>“ ...people want to walk out from Solar with a smile. Everyone wants to leave with a smile.” (FGCYP111)</i></p> <p><i>“Change and flower represent happiness and new beginnings..and then eventually you leave the service with being happy”. (FGCYP110)</i></p>

All participants depicted their experiences with the 0-19 model as a journey into the unknown, while describing a range of emotional reactions associated with their initial access to the 0-19 model such as being nervous, frightened, and sad. These emotions were predominantly related to not knowing what to expect or not having experiences of 0-19 model environments. However, once participants were familiar with the service and their provision, gradually all

participants reported feeling more comfortable and happier. Nevertheless, all participants agreed that the ultimate goal for everyone is to leave the service with a smile on the face in comparison to when they were sad when they initially accessed the service. A smile on participants' faces can be seen as resolutions of their mental health problems.

6.6.6 Theme 3 - Let it out

The third identified theme was 'Let it out' which encompassed the need to speak and be listened to. All participants discussed the importance of being able to express their negative feelings and emotions to the service staff. For example, participant FGCYP114 stated the importance of externalising and vocalising their inner worries and problems to their therapist by "*letting them (problems) out*" while highlighting that these worries and problems should not be kept "*trapped inside*". Similarly, participant FGCYP112 agreed that it is crucial to speak with staff and "*show off*" their emotions and not "*bottle them up*". Several participants had a metaphorical representation of this need built into their models. For example, participant FGCYP116 used a red box as a metaphor for a place where they "*throw away all (their) anxieties and fears*". Nevertheless, this participant did acknowledge that their "*anxiety box is still a little bit full*", and that the participant "*still need to go a little bit further*" to achieve a full recovery. Equally, participant FGCYP114 used a bowl rather than a box as a similar metaphor. Nevertheless, the participant did emphasise the need to talk about their emotions with the Solar staff.

Table 45 - Participants quotes in support of the theme 'Let it out'

Participants	Quotes in the support of theme
CYP	<i>"(The bowl is) like all the emotions at one place. Being angry and sad is all mixed in the one bowl." (FGCYP114)</i>

From these participants' responses, it is evident their need to externalise and acknowledge their worries and problems. All participants described the 0-19 model and its service provision as being helpful to change their negative behaviour patterns into more positive ones.

Nevertheless, the recovery from mental health problems can be a long journey that is paved with numerous obstacles.

6.6.7 Theme 4 – Overcoming obstacles

The fourth overarching theme identified was ‘overcoming obstacles’, which comprised of two subthemes: (1) ladders to climb over; and (2) overcoming obstacles.

Many participants used ladders as metaphorical representations for overcoming their mental health difficulties and their recovery process. This metaphor was associated mostly with the service staff members who helped CYP on their journey towards recovery. For example, participant FGCYP113 used ladders to explain how the 0-19 model’s service provision enabled them to overcome their difficulties.

Ladders, in this particular case, were referred to existing help and processes placed in the 0-19 model to support CYP towards recovery. Some participants used a metaphor for ladders to describe their progress of recovery by overcoming their difficulties. For example, for participants FGCYP112 and FGCYP114 ladders represented their goals or ways to overcome their difficulties. Similarly, participant FGCYP110 used red arches in their model as the metaphor to show that in Solar service *“there is support available.”*

Lastly, participant FGCYP116 used a different metaphor to describe jumping over barriers. Instead of ladders, the participant used a dragon which represented the participant’s determination to overcome their mental health difficulties.

In the second subtheme, participant's FGCYP116 challenge in the first model was depicted as a thin grey line. A similar approach of using a grey barrier was used by participant FGCYP111 to explain how much CYP are closed of each other within the first few sessions of the group therapy.

Table 46 - Participants quotes in support of the theme 'Overcoming obstacles'

Participants	Quotes in the support of theme
CYP	<p><i>"There are ladders to help you on the way and go up"</i>(FGCYP113)</p> <p><i>" ...and no matter how hard the goal is to reach, you just keep climbing the ladder, and you will always get there."</i> (FGCYP112)</p> <p><i>"Ladders mean overcoming things you don't want to do, a way to overcome your problem..."</i> (FGCYP114)</p> <p><i>"The dragon shows that although you have lots of obstacles to overcome, you still have to fight at the end to reach recovery."</i> (FGCYP116)</p> <p><i>"...challenges that I need to go over to come to the finish line (white lower cube) and be discharged from the service."</i> (FGCYP116)</p> <p><i>"This (grey barrier) shows that everyone is closed."</i> (FGCYP111)</p>

Even though all CYP managed to overcome the initial obstacle of receiving timely access to the service, many participants also described the internal barriers and challenges that they needed to overcome to deal with their difficulties before being ready to leave the service. Receiving appropriate support was perceived by all participants as a necessary and crucial step towards overcoming these obstacles.

6.6.8 Theme 5 – Less is sometimes better

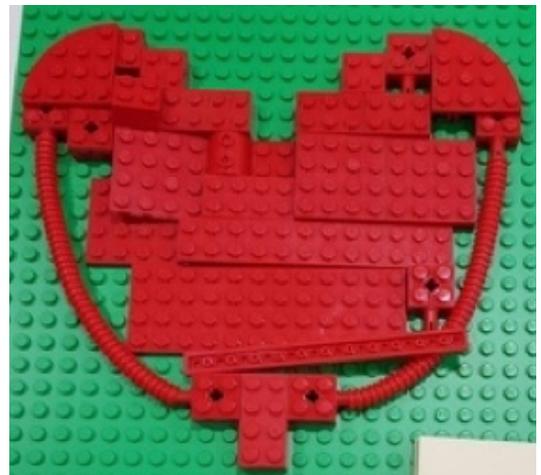
The last overarching theme identified was 'less is sometimes better', which comprised of three subthemes: (1) satisfaction with the service provision; (2) smaller group therapy, and (3) satisfaction with the 0-19 model

All participants in LSP sessions reported satisfaction with all Solar's help provided. Most models had a direct representation of some aspect of the service provision or at least a reference. For example, the participant's FGCYP110, FGCYP 111 and FGCYP115 models depicted their positive treatment experiences. Equally, participant FGCYP112 also acknowledged that the Solar service provision did help to turn their negative thoughts and emotions to more positive ones.

In the second subtheme, a need for smaller groups was highlighted by many participants. For example, participant FGCYP116's model depicted four people in a group with the rationale that the group should not be too big as the therapist cannot devote their time to help each individual. However, the same participant also highlighted that if groups were too small, CYP might feel more pressure due to being put under the spotlight. Equally, FGCYP115 initially built a representation of seven CYP around a table with a therapist in their first model, as a reference to the treatment they experienced. However, in their second model, they reduced the number of participants from seven to only three. FGCYP111 highlighted a similar need for smaller groups and more one to one support. Additionally, the participant felt that it was helpful *"to relate to other people"* who are affected by similar mental health difficulties. Although the participant found group therapy helpful, they also acknowledged that *"it would be good to have more one-to-one support and more advice on how to deal with (problems) when you're struggling"*.

6.6.9 Theme 6 – Satisfaction with the 0-19 model

The last theme related to the overall participant's satisfaction with the 0-19 model. When asked to summarise their overall happiness with the model, all participants expressed a high degree of satisfaction with the whole treatment experience and the 0-19 model. For example, participant FGCYP117 provided a positive reflection of their overall experience with the 0-19 model by constructing a heart in their Lego model:



"I am not sure how to improve the service, but I want to say big thank you, as everyone tried to do their best. I want to say thanks to everyone in the Solar service from the bottom of my heart."
(FGCYP117)

Table 47 - Participants quotes in support of the theme 'Less is sometimes better'

Participants	Quotes in the support of theme
CYP	<p><i>"These seven tubes represent the number of young people in the group, while the black tube is a therapist. I've enjoyed the group session."</i> (FGCYP110)</p> <p><i>"So, they helped me, and I am kind of well now."</i> (FGCYP115)</p> <p><i>"The group therapy was helpful"</i> (FGCYP111)</p> <p><i>"This group helped with my emotional seesaw to turn in from more negative to more positive. Now it's less negative than it was at the beginning of the group"</i> (FGCYP112)</p> <p><i>"The groups should be like made out of four people. Not necessarily too big, because then you don't have much attention on you, but also not too small. Otherwise, you will feel pressured. Also, I wouldn't like to talk about my private thoughts with other people (CYP) in the group."</i> (FGCYP116)</p> <p><i>"Ideally, there should be three people in the group. I would preferer a smaller group".</i> (FGCYP115)</p>

6.7 Discussion

The main aim of this study was to understand the perception of seven CYP participants regarding their views on the accessibility and acceptability of the Solar service. The use of the LSP approach helped to identify five main themes by utilising thematic analysis from CYP LSP transcripts: (1) accessibility; (2) doors into the unknown; (3) let it out; (4) ladders to overcoming obstacles; (5) less is sometimes better, and (6) Satisfaction with the 0-19 model.

The long waiting times to access the 0-19 model and its service provision was the most common subtheme across all the LSP models. However, the desire for the shorter waiting times is not surprising, as most research evidence highlights that long waiting times for admission and treatment are the most reported barriers to access (Anderson, Howarth, Vainre, Jones, & Humphrey, 2017; Bringewatt & Gershoff, 2010; Reardon et al., 2017a; Salloum, Johnco, Lewin, McBride, & Storch, 2016). For example, the average waiting time nationally to begin the treatment in CAMHS services is within two months (56 days), which is double than government-recommended four week period (Whitney & Hutchinson, 2020b). Average waiting times for treatment across CAMHS mental health providers in the UK vary from 1 day to 182 days, with significant differences across local CAMHS providers, which additionally contributes towards many CYP facing long waiting times (Whitney & Hutchinson, 2020a).

Besides waiting times, a second-most prominent theme in the CYP LSP models depicted the need for closer mental health community services to CYP places of residence. A range of existing evidence suggests that the lack of accessibility of the mental health community service can pose a significant barrier towards access. For example, a systematic review found that lack of accessibility was a prominent theme that impacts young people and their ability to find appropriate help (Gulliver, Griffiths, & Christensen, 2010). Also, some studies have found that most YP expressed a need for mental health services that are locally available, with a clear preference for a more convenient and easily accessible location closer to their place of residence (Fusar-Poli, 2019b; Plaistow et al., 2014).

Equally, one review found that parents and carers found the inconvenience of service locations as a barrier to access (Reardon et al., 2017a). A similar parental perception that the location of

mental health service can be a barrier to access mental health services is visible in two other studies that reported that 10% of parents were unable to physically attend their children's mental health treatment (DeRigne, 2010; Mendez, 2010). Also, another study found that 30%-65% of parents terminated their children's mental health treatment early due to barriers to access such as location or waiting times (Manfred-Gilham, Sales, & Koeske, 2002). Therefore, the findings from this study are in line with previous research evidence.

Besides waiting times for access and treatment, and service locations, some CYP also suggested a need for more flexibility with appointment times, as most appointments were scheduled during times when CYP are in educational settings or were unable to attend due to parental work commitments. Previous studies have also revealed dissatisfaction of CYP with appointments scheduled at an inconvenient time (Persson, Hagquist, & Michelson, 2017b), while conflicts between treatment and education were highlighted problematic in another study that reported similar findings (Day, Carey, & Surgenor, 2006).

Furthermore, a previous study has suggested that CYP may be at higher risk of failing to attend treatment sessions if external pressures interfere with the therapeutic process (De Haan et al., 2013). The pressures from external sources on CYP can also affect their treatment outcomes negatively (Ryan & Deci, 2008) and impact CYP satisfaction with their treatment and the overall service (Garland, Aarons, Saltzman, & Kruse, 2000). Similar concerns from local community stakeholders with regards to missing out from the regular school classes are also discussed in chapter 10.

Furthermore, most CYP participants in the LSP sessions expressed a range of both positive and negative emotional reactions associated with being accepted to the 0-19 model and its service provision. A systematic review found that CYP often reported complex initial emotional reactions associated with access to mental health services such as worry, anxiety and frustration as a result of barriers to access and uncertainty which stemmed from a lack of information and appropriate engagement with a service provider (Vusio et al., 2019). Another study also concluded that anticipatory anxiety is often associated with a lack of knowledge about what to expect from mental health service environments when these are attended for the first time (Bone, O'Reilly, Karim, & Vostanis, 2015).

Equally, another review found that CYP often experienced a high level of anxiety and nervousness associated with attending their regular appointments in mental health services (Gulliver et al., 2010). Nevertheless, the findings here demonstrated that initial negative emotional reactions often dissipate once CYP gradually open up towards other group therapy participants. These findings are also in agreement with a study by Persson et al. (2017), which stated that CYP often engage in a gradual process of knowing each other, which helps to encourage their individual and group identities, foster a sense of belonging and feelings of being comfortable within the group setting.

Furthermore, the findings from the LSP sessions also highlighted that CYP need to express and voice their problems and mental health difficulties. This particular need to give voice to CYP and their mental health difficulties has been widely recognised in similar research (Hart & O'Reilly, 2018; Montreuil, Butler, Stachura, & Pugnaire Gros, 2015). Likewise, a study by Person et al. (2017) also emphasised the fact that CYP do value service environments where their healthcare practitioners are actively engaged in listening, validating and taking the concerns raised by CYP about their emotional and mental health seriously. Moreover, active listening and taking CYP seriously also contributes towards better support for CYP during their treatment.

Most CYP in these LSP sessions did acknowledge the importance of an appropriate and good support network that is available in the 0-19 model through metaphorical use of ladders and arches in their LSP models. Likewise, the depiction of good support provided through the journey can be considered as positive feedback for the 0-19 model and its service provision. These findings are well supported by growing research evidence that the LSP methodology may be useful as both a reflection and feedback tool (Thomson, Johnston, & Reid, 2018).

For most participants in this study, ladders or dragons acted as metaphorical representations for the recovery process. According to another study, these metaphorical representations can be seen as the process of personal change in one's attitudes, goals and emotions, which consequently lead CYP towards becoming more hopeful despite their initial mental health difficulties (Lavik, Veseth, Frøysa, Binder, & Moltu, 2018). Most participants in this study

described their forward-looking processes of creating new beginnings and opportunities in their everyday lives through their models. These were often depicted in the LSP models as *'reaching the top'*, celebrations, feeling good or new journeys resulting from successful discharge from the 0-19 model. These findings correspond with findings from the study (Lavik et al., 2018) that similarly explored the improvement of ways of coping of adolescents with their mental health and their recovery processes.

Furthermore, regarding the obtained participant feedback of the Solar therapeutic delivery, it is visible that most participants desired a smaller treatment group. However, most research evidence suggests that having between six and nine CYP participants in the group is an effective way of treatment delivery (Reid & Kolvin, 1993). Similarly, several reviews and a meta-analysis also confirmed that similar positive outcomes are achieved when treatment is delivered in groups in comparison to one to one treatment delivery (Burlingame et al., 2016). However, the effectiveness of both individual and group therapy remains debatable (Burlingame et al., 2016). For example, while some studies have suggested that individual therapy approaches are more effective than group settings (Craigie & Nathan, 2009), others report the opposite (Belloch et al., 2011). However, some studies reported equal effectiveness of both individual and group therapies (Burlingame et al., 2016). Nevertheless, it is essential to acknowledge that both individual and group therapy have their advantages and disadvantages (Paul, 2016). However, group therapy as such should not replace the need for one to one treatment for those individuals who would most benefit from individual therapy.

6.8 Reflection on the utilisation of the LSP methodology

To the researcher's best knowledge, the LSP methodology has never been applied previously in mental health settings or as a way of exploring CYP perceptions of the accessibility, and acceptability with the community mental health service models, interventions, and treatments. However, the LSP method in this study successfully captured both the 0-19 model's strengths and weaknesses.

Besides the identified themes, it is essential to reflect on the experience of conducting the LSP methodology in this research. From this study, it was found that the LSP methodology may be

easy to apply in most of the CYP mental health community services. The LSP methodology appeared to be inclusive, empowering, democratic and fun as is evident in other studies that explored this methodology in healthcare settings (Dixon, 2016; Swann, 2011; Wouters & van Hoof, 2017). The main observed advantage of the LSP approach was the establishment of a dynamic group environment that gave CYP an equal opportunity to reflect, analyse, present their opinions and experiences, which led to a better understanding of CYP realities and their experiences as demonstrated in other participatory research (Dixon, 2016; Veale, 2005). The main benefit of the LSP methodology is its ability to connect with CYP and speak a language that CYP tend to understand – through play. A large pool of psychological evidence and theory, such as Piaget’s theory of play, describe the importance of play for children and its ability to empower children to convey their views on the world that surrounds them (Canning, 2007; Piaget, 1957, 2013). Besides, the use of the LSP methodology has demonstrated its potential to provide richer narratives in comparison to standard interviews or focus group led research. This enrichment of experiences may be seen as a consequence of self-reflection, which may contribute towards a better narrative description compared to more traditional approaches.

6.9 Strengths and Limitations

The main strength of this study was adherence to rigorous methodological standards that previous studies reported of . Both LSP sessions were audio-recorded, photographs of all produced models captured, and field notes were extensively used and later analysed. Additional strengths of the approach are its ability to capture enriched experiences of participants and gain more insight into participants lived experiences.

On the other hand, the main limitation of this study lies in the number of participants that were recruited. While other studies employed a large number of participants, this study recruited a small sample of participants. Therefore, the main findings as such can not be generalised and applied to a broader population within the service. This study used only a narrow sample within one treatment setting, instead of recruiting more broader population sample across the service to achieve a more representative sample. Nevertheless, the findings can be indicative and encouraging for other researchers to replicate this methodology and apply it to other mental health settings. An additional limitation of this study was lack of the group constructed

models that some of the other studies employed (Dixon, 2016; Wouters & van Hoof, 2017). It is also important to caution that the length of the intensity of the sessions may be viewed as a limitation, as similarly reported by Wouters & van Hoof (2017). The use of the LSP method in this study allowed participants to engage in the discussion process and reflect on their whole experiences with Solar and its provision. However, the researcher did not use any other traditional approaches (i.e. focus group) in addition to these LSP sessions. Therefore, it is difficult to establish whether they would obtain similar participants responses if they just used focus groups instead of the LSP approach. Consequently, the researcher cannot judge whether the LSP method resulted in better and richer narratives and experiences in comparison to more traditional focus group approaches. Lastly, one of the most significant limitations of the LSP method may be viewed in its very costly price to equip participants with a substantial amount of Lego bricks. Indeed, the utilisation of the LSP method is more costly in comparison to other traditional qualitative methods (Wouters & van Hoof, 2017).

6.9.1 Recommendations for future research

This study used an adapted version of the LSP methodology. One should be aware that CYP participants have a varied attention span and concentration, and future LSP sessions should account for allowing CYP regular breaks in between building. It is also essential to address a need for a sensitive approach with CYP who deem themselves as not being creative as these CYP may struggle to engage with the LSP process. Therefore, as suggested by Dixon (2017), it is vital to provide these CYP participants with encouragement and support throughout the LSP session. The use of the LSP methodology may be a viable tool that can be applied in mental health settings. However, further research is required to demonstrate this viability. The LSP method can be used successfully in combination with more conventional research methods. However, more research evidence is needed to establish the research value of the LSP method in both CYP and adult mental health.

6.10 Conclusion

In this study, seven CYP participants reflected on their experiences of the Solar model through the use of the LSP approach. Most CYP felt that the Solar service should improve its access by reducing waiting times and offer more flexibility with working times that would meet individual CYP needs. All CYP reported that the Solar model should have a better local presence and be closer to service users' places of residence. Also, CYP participants discussed a range of positive and negative emotional reactions associated with being in the Solar model and treated in the service settings. Equally, CYP also highlighted the importance of being able to convey their emotions and feelings to health workers and being listened to and taken seriously. CYP also reflected on the need for overcoming obstacles and the available support in the 0-19 Solar model that facilitates their change and recovery. All participants expressed satisfaction with the service provision delivered by the service. However, some CYP stated a need for smaller groups and more one to one support. Lastly, CYP generally expressed overall satisfaction with the Solar model. This study is the first attempt of utilising the LSP method in a mental health community setting. The application of the LSP method captured richer experiences of participants and gained more insight into participants lived experiences.

LEGO® SERIOUS PLAY® bricks and configurations are trademarks of the LEGO Group, which did not sponsor, authorise or endorse this research study. This project was conducted as a part of a PhD project at the University of Warwick Medical School. The PhD researcher undertook appropriate LSP training prior administration of the LSP sessions; however, they are not an officially licenced LSP facilitator.

Infobox 9. LSP Disclosure

Chapter 7: Gatekeeping towards crisis – the role of duty workers within the community crisis team

7.1 Chapter outline

In the previous chapter, the use of the Lego® Serious Play® approach was explored to understand CYP perceptions as to how accessible and acceptable the Solar service is. This chapter focuses on the findings of a study using a mixed-methods approach to explore the role of duty workers in the 0-19 model and whether they prevent or reduce admissions to the crisis team without jeopardy (risk). Initially, a summary of the Solar service duty/triage section is presented, followed by the aims and objectives of the evaluation. An overview of the main methodology used for data collection and analysis will be then presented, followed by a presentation of the main findings. The chapter concludes with a discussion of the main findings in relation to other known literature and the strengths and limitations of the study. This chapter aims to describe and understand the role of the duty telephone line component within the Solar service. All research activities in this chapter are well aligned with the activity section of the logic model developed for this PhD project, as previously introduced in chapter 3.

7.2 The role of duty workers in the community crisis team

The telephone duty/triage workers of the Solar model are a support line that provides information, signposting and referrals to a range of stakeholders (GPs, parents, schools or CYP) on the 0-19 population mental health and wellbeing. For example, parents can phone the line and seek further information on their children's mental health and seek to be directed to external community support organisations or where there is an identified risk to be referred and triaged for support within the Solar service. Similarly, GPs or educational settings can seek information from duty workers about Solar's acceptance criteria or receive help with referral procedures. According to one study (Tobin, Yeo, & Chen, 2000), there are three important functions of duty workers that help to improve the flow through a mental health service and prevent bottlenecks that may create barriers to access:

1) Prioritisation of referrals on their urgency; 2) (Re)Direction of resources for the rapid management of incoming emergencies; and 3) Reduction of inappropriate use (or misuse) of service by reducing the unnecessary use of resources.

- Information seeking
- Support seeking (e.g. how to manage a child’s behaviour)
- Help with the referral process (e.g. how to fill out the referral form)
- Request for liaison between statutory agencies (e.g. Social Services, inpatient settings) and Solar
- Advice requesting for the management of mental health and wellbeing
- Requests as to what other forms of help exist in the local community (e.g. Kahoot)
- Identification of the risk and prevention of the escalation of mental health
- Provision of further information to the duty (for other parts of the Solar system)

Infobox 10. Inclusion criteria for the telephone duty/triage

The duty components of mental health service are, therefore considered to be frontline workers and gatekeepers for service admission (Figure 44). The Solar service employs duty workers five days a week (9am-6pm) to act as gatekeepers and prevent unnecessary admissions to other components of the system (including their crisis service component that works closely with duty workers) that would otherwise be compromised (overwhelmed) by a number of referrals.

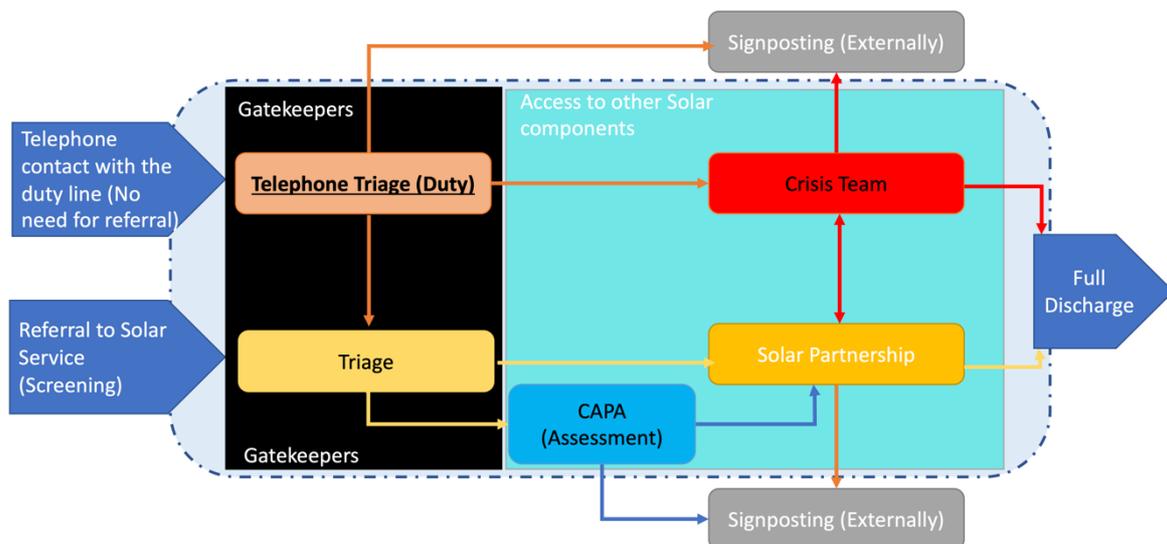


Fig 44. The importance of duty workers as gatekeepers in preventing flooding of the overall system

Duty workers in the service model operate a duty telephone line designed to provide telephone triage, risk assessments and signposting for all non-urgent (i.e. non-crisis) referrals to other parts of the service or external agencies. Moreover, duty/triage workers quickly divert CYP that meet the crisis criteria (e.g. suicidal ideation) to other parts of the system according to identified risks and needs. According to the Solar service records, since the duty line has been introduced, the crisis service has been less overwhelmed by non-urgent referrals, which also has improved the accessibility and flow throughout the crisis service and the overall model. Besides, the role of duty/triage workers seeks to reduce referral pressures on the service and its crisis component and to support these components with further information gathering for the risk assessment purposes. However, in the Solar service, only one nurse is employed in the official (part-time) capacity as a duty/triage nurse, while the rest of other staff from other components in her absence, cover the duty line. Therefore, the main focus of this study was on a single duty nurse employed in an official capacity of the duty/triage nurse.

7.3 Study aims

The most relevant research literature reports on the importance and effectiveness of the duty/triage role in urgent and emergency settings, such as A&E and hospitals (Kevin, 2002). However, there is an evident gap in our understanding of how much CYP community-based mental health service models in the UK utilise the role of the duty/triage, how effective this role is, and whether it helps to facilitate improved access to crisis services (Kevin, 2002). Therefore, the main purposes of this study were to (1) investigate the accessibility, acceptability, and effectiveness of this component of the Solar service for a crisis, and (2) to understand staff members views and experiences with the duty segment and possible future improvements.

7.4 Methodology

In social field research, the mixed-method approach is an alternative to well established qualitative or quantitative approaches (Denscombe, 2008), where either is considered insufficient on its own (Johnson et al., 2007; Tashakkori & Creswell, 2007). Therefore, to fill the

research gap and to further understand the importance of the duty role in the CYP mental health service, this study used a range of qualitative and quantitative retrospective data to evaluate the duty/triage component of the 0-19 model. A full rationale for the use of the mixed-method approach has already been outlined in chapter 3.

7.4.1 Content analysis of duty triage data

As Solar has only one part-time duty nurse employed two days a week for triage, the rest of the regular staff in their absence, cover the duty line and work the rest of the week. This study, therefore, focused only on the key member of the team (duty nurse) who operates the telephone triage on a dedicated basis around whom the service functions. By focusing on this particular staff member, this study aimed to gain an overall view of how the duty line operates. All other professionals involved in the duty/triage role have not been included in this study.

Attempts were made to understand how the entire duty-triage component operates. The student proposed to the service a need for systematically tracking and logging the overall activities of all involved duty workers (i.e. time, duration, presentation and action) on a spreadsheet. However, the service refused this proposal with a rationale that this may increase the workload of the duty workers. As a result, we were unable to fully understand the overall activities of the duty/triage component during the rest of the week by other staff employed in Solar and whether there were any differences in the work undertaken or data recorded by the duty worker and other staff.

It is also important to note that there have been no official statistical records of the duty triage component, and therefore, due to the lack of routinely collected duty/triage data, analysis of the duty nurse diaries and notes were reviewed and recorded retrospectively using the RIO patient database.

7.4.1.1. RIO data

All contacts over six months between May and December 2019 by telephone, email and in-person with the duty worker were recorded, collected, and analysed. Each established contact was recorded in a standardised electronic format in the RIO database, including date, time, patient details, referrer, point of contact, status and treatment. These captured data were transferred to an Excel database for further analysis. All missing data were captured (recorded) from duty diaries and notes as qualitative information, and later either thematically analysed or converted to quantitative codes.

7.4.1.2 Duty nurse diary and notes

Most of the data in the RIO database regarding the activities of the duty worker were basic (patient details, referrer, patient's status, point of contact), and a large amount of data was missing (e.g., nature of the enquiry, presentations/symptoms, and outcomes). This critical information was extracted from the duty nurse diary and notes were made for each patient record. These records were narratively 'rich' and thoroughly written by the duty nurse. The researcher also coded information (Table 49) from these records into separate excel database and thematically organised reasons for contacting the duty worker. The detailed inspection of the duty nurse diary (notes) provided much richer data, such as whether the patient was admitted to the crisis team or other parts of the service, the outcomes of the duty contact with parents or professionals, treatment of CYP and their status, and symptomatology/presentation for each patient.

Table 48 - Example of coding created by the researcher for a reason for established contact with the duty worker

Code	Reason for established contact with the duty worker
111	Crisis related activities
110	Crisis related risk assessments, safety and wellbeing checks
108	Crisis support and advice provided by the duty worker (by telephone)
103	Information gathering and requests for updates
102	MDT contact with other clinicians
100	Contacts with parents and professionals (updates, enquires, non-crisis advice or suggestions)

It is important to note that the researcher was unable to identify any criteria (or references to any official guidelines) used by the duty key worker used for assessment, or evidence of the use of any formally documented risk assessments. There was no evidence of formal noting the outcomes of the assessment (or results of risk assessments) in the electronic patients' records. However, it was observed that the crisis team updated its risk assessments according to the notes of the duty nurse.

There was limited information on the problem and associated risk presented to the telephone duty worker. However, it was evident from the duty workers notes that the duty nurse appropriately (risk) assessed the available (often limited) information (i.e. information shared by the caller at the time of contact with the duty nurse). For example, in the case when a parent reported active suicidal ideation of their child, the duty nurses quickly referred the child to the crisis team. In contrast, in cases where the parent-reported a low mood of their child, the duty worker signposted parent to the Kooth¹ and external agencies in Solihull that provide support for CYP low-intensity problems. The duty nurse did thoroughly document (narratively) their decision-making and consulted the crisis team, where the risk to CYP was not clear, to decide whether the further involvement of the crisis team is needed for further assessment. From the RIO data, the clinicians' diary and notes, it was evident that the duty worker was engaged in support of both crisis and non-crisis service users, and therefore the **researcher divided recorded data into crisis and non-crisis related data (Figure 45)**.

¹ Kooth is an online counselling service

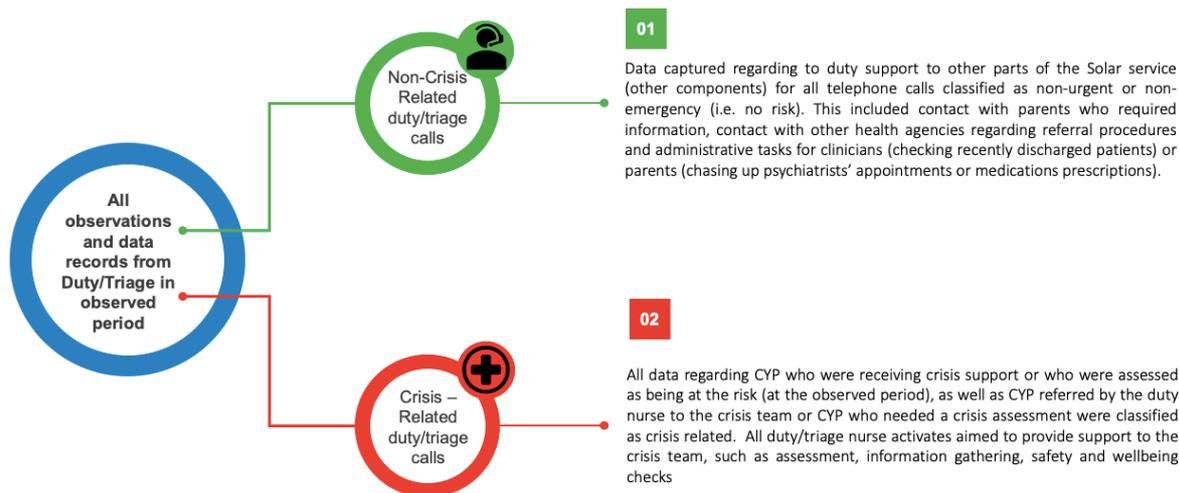


Fig 45. The split of the duty/triage data to non-crisis and crisis related

7.4.1.3 Crisis-related data

All data regarding CYP that received crisis support (at the observed period), as well as CYP referred by the duty nurse to the crisis team or CYP that needed a crisis assessment, were classified as crisis related. This also included any activities performed by the duty nurse for the crisis team, such as data gathering, risk assessments, contact with parents, GPs and inpatients units or safety and wellbeing checks. The duty nurse provided feedback on all obtained information from the case to the crisis team, and the team conducted formal risk assessments, which were recorded in the electronic patient records system (RIO).

7.4.1.4 Non-crisis related data

Since the duty nurse supported other parts of the Solar service, all non-urgent or non-emergency data were classified as non-crisis related. This included contact with parents who required information, contact with other health agencies regarding referral procedures and administrative tasks for clinicians (checking recently discharged patients) or parents (chasing up psychiatric appointments or medications prescriptions).

7.4.2 Analysis

7.4.2.1 Qualitative analysis

All narrative data in the duty diary/notes were thematically analysed and assigned with a specific code that was later descriptively analysed. In contrast, all staff transcripts from semi-structured interviews were analysed following a thematic analysis approach, as outlined in chapter 6.

7.4.2.2 Quantitative analysis

Descriptive statistical analysis was utilised for all quantitative data. Thematic data obtained from the duty diaries and notes were transformed into quantitative codes, which were later analysed descriptively. Each code was counted for the number of events by using the IF functions in the MS Excel. All quantitative data were analysed using MS Excel.

7.5 What is the accessibility, acceptability, and effectiveness of the duty/triage component of Solar crisis service?

All the collected duty/triage data were divided by the researcher into non-crisis (non-emergency contacts), and crisis-related (urgent and emergency contacts) according to the duty nurses' notes. The duty/triage nurse noted their decision-making process regarding their perception of whether the callers presented issues that were at risk (crisis-related) or no immediate risk (non-crisis). The summary of these findings will be further discussed in the following sections. The total number of 223 contacts with the duty/triage nurse between May and December 2019 was analysed (Table 50).

Table 49 - Total number of calls made to the duty/triage nurse between May and December 2019 and their classification

TOTAL DUTY CALLS FROM MAY-DECEMBER 2019	N	%
NON-CRISIS RELATED	167	74.8%
CRISIS RELATED	56	25.1%
TOTAL	223	100%

The non-crisis related data will be presented first, followed by the presentation of crisis-related data. Table 50 summarises the total number of non-crisis related contacts with duty/triage service, the demographics, the source of contact and the reason for contact.

7.5.1 Non-crisis related demographics

Of the 167 telephone contacts that were made to the duty/triage, 85 were for male service users, while 82 were for female service users. Also, the descriptive statistic showed an equal split between contacts made to duty for male and female service users (Figure 46). The average age for male patients was 12.98, while for females, it was 13.93. The overall average age was 13.46 years. The minimum age for both males and females were seven years, while the maximum age for females was 18 years, and for males 20 years.

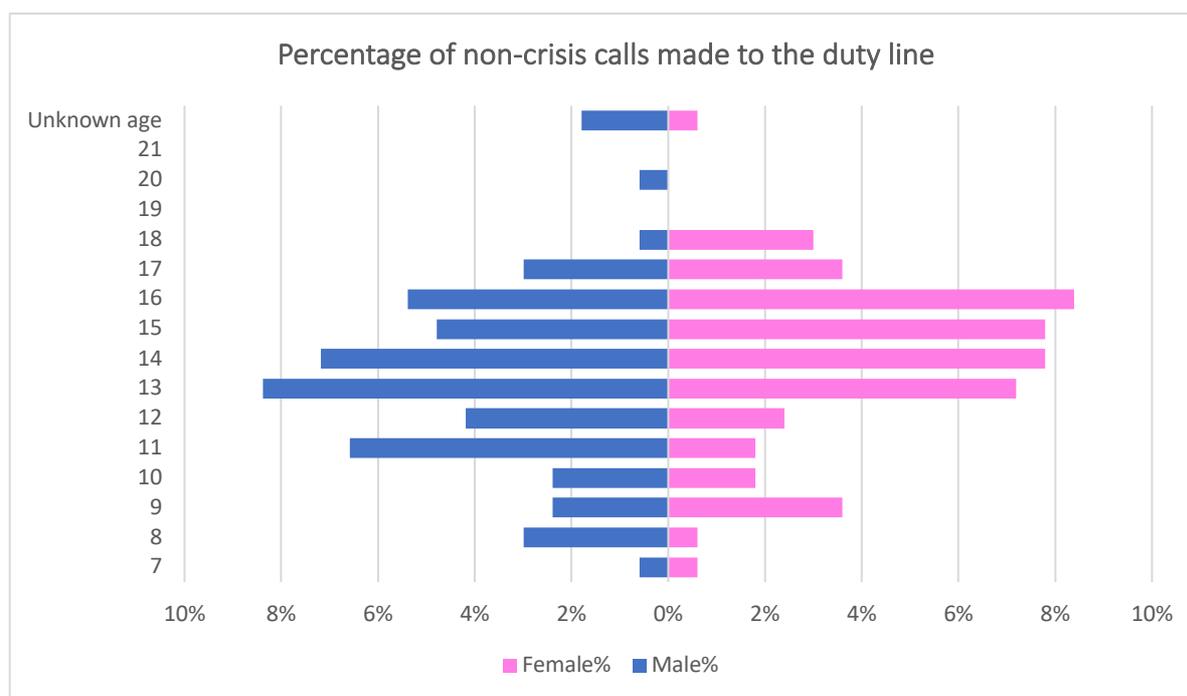


Fig 46. Percentage of non-crisis calls made to the duty line.

Table 50 - Descriptive statistics for gender

Gender	N	Avg.age	Age range	%
Unknown	1	-	-	0.6%
F	82	13.93	Min=7-Max=18	49.1%
M	85	12.98	Min=7-Max=20	50.9%
TOTAL	167	13.46		100%

7.5.1.1 Presentation to duty/triage

The most CYP presentations to the duty/triage were due to anxiety (19.6%), followed by ASD (15%) and bullying (11.4%). Self-harm (6.9%), suicide ideation (5.6%) and low mood (4.6%) were also prevalent in the calls (Figure 47).

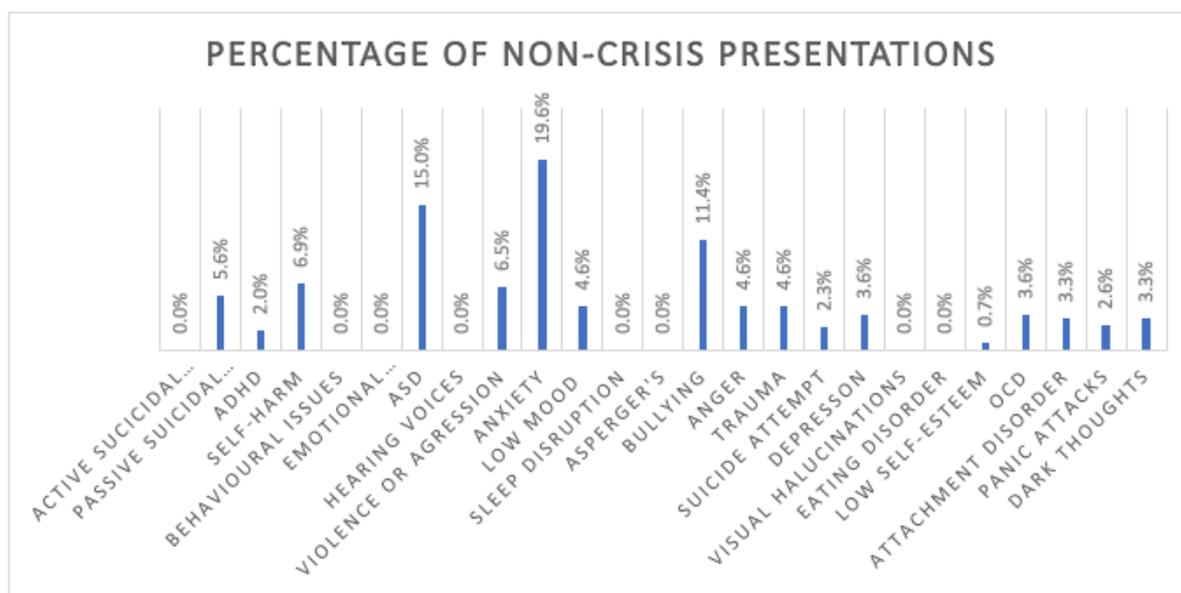


Fig 47. Most common non-crisis related presentations to the duty/triage telephone line.

7.5.2 Sources of referral and patient's status in the Solar service

For all non-crisis related duty calls received or made by the duty nurse in the period between 1st May and 31st December 2019, over half of the service users referred to the Solar service were initially referred by their GP's (53.8%). Hospital referrals were the second most common source of referral (9.5%). However, in the case of other referral sources, only 15 (8.9%) self-referrals and 14 (8.3%) A&E referrals were identified as a primary source of referrals (Table 52). More than 83.8% of contacts with the duty line were made by/for active service users who still received (or were due to receive) treatment from the 0-19 model. Most of the parents were looking for an update on waiting times or needed more support and advice to help their children until they started treatment.

11.9% of calls to duty/triage were made for patients who had been fully discharged from the 0-19 model. These calls mostly came from parents seeking support and advice from the service to manage their child's mental health and possible relapses. Service users were unknown to the service (1.2%) only for a small number of calls. Mostly these calls were made to seek help with the referral process or to seek more information about the mental health support available in the 0-19 model or its local community.

7.5.3 The duty/triage outcomes

The most frequent outcome of the duty/triage process was the need for telephone support; in total, 65.8% of calls made by parents and other external professionals were associated to the need for advice, information or signposting, and telephone support. 16.6% of calls were made by the duty nurse to parents and other third parties for information gathering, while 6.5% of duty calls were made for the safety and wellbeing of referred CYP. As regards the sources of contact with the duty crisis nurse, 50.9% of contacts with duty/triage were made by other professionals and agencies. In comparison, parents made 33.5% of calls to the duty/triage. Education providers (5.9%), as well as service users (4.1%) and GPs (2.9%), made fewer duty line calls, primarily seeking advice and support.

7.5.4 CYP status within the Solar service

Most duty/triage calls concerned service users who had been waiting for treatment (21.4%) or were in Solar Primary care (13.1%) because parents need more support, advice or information about what to do until their children start treatment. Most of the calls for Solar psychiatric services were associated with a need for an update on the next treatment session, a medication review or an update by the parent or other agencies with respect to the treatment status of service users. Some contacts (5.95%) were established with the duty nurse to make an official referral to the Solar service. In the observed period, the duty nurse independently made eight assessments. A full breakdown of CYP status is listed in figure 48.

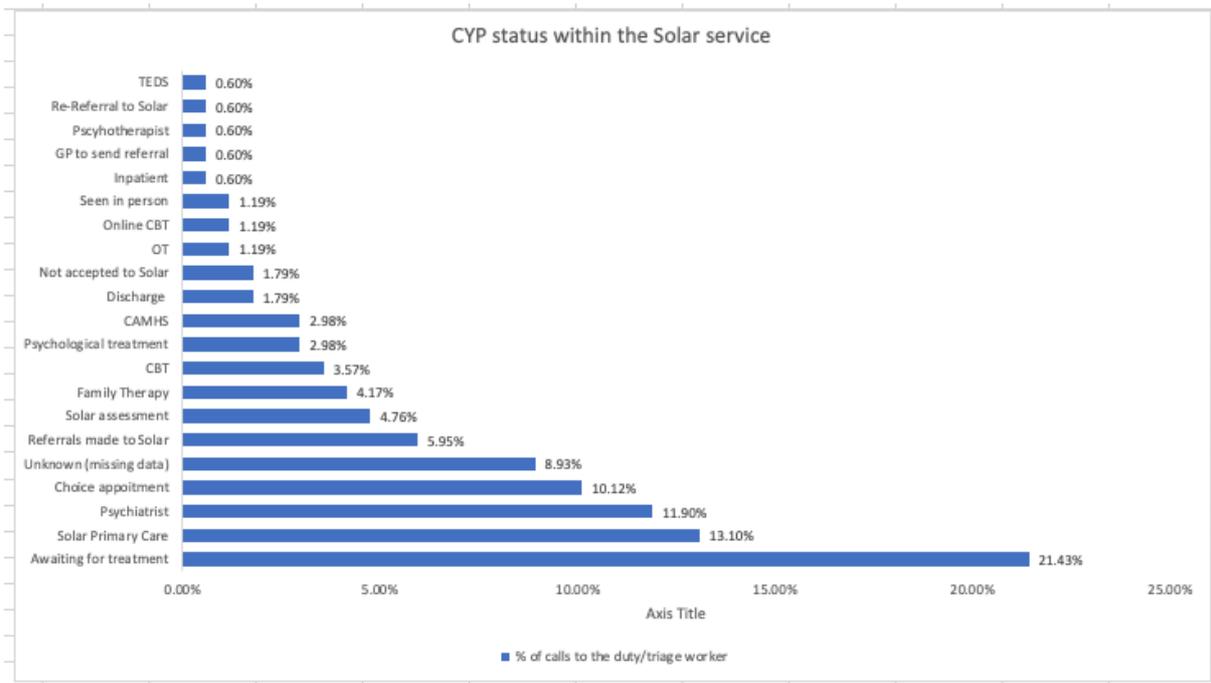


Fig 48. The status of CYP within the Solar service within the observation period

Table 51 - Total number of contacts with the 0-19 model's duty/triage worker by reason and point of non-crisis contacts over the six-months observation period

	n	%
<u>Non-crisis related- the reason for duty contact</u>		
Phone support, advice, signposting	110	65.8%
Safety and wellbeing check	11	6.5%
Information gathering	28	16.7%
MDT	4	2.4%
Administration	9	5.3%
Risk Assessment, or safety and wellbeing check	5	2.9%
TOTAL	167	100.0%
<u>Non-Crisis related – the source of contact</u>		
GP	5	2.9%
Parents (self-referral)	56	33.5%
A&E	0	0.0%
Hospital	2	1.2%
School	10	5.9%
Service user	7	4.1%
Not yet referred	0	0.0%
Other professionals and agencies	85	50.9%
Internal	2	1.2%
TOTAL	167	100.0%
<u>Initial referral made by</u>		
A&E	14	8.3%
GP	90	53.8%
Hospital	16	9.5%
Local Authority	8	4.7%
Unknown	7	4.1%
Other agencies	4	2.4%
Paediatrics	7	4.1%
School	6	3.5%
Self-referral	15	8.9%
TOTAL	167	100%
<u>Current status in Solar</u>		
Active (Supported by some components in Solar)	140	83.8%
Discharged	20	11.9%
Not referred yet	5	2.9%
Unknown	2	1.2%
TOTAL	167	100%

7.5.5 Crisis-related service users' data

All 56 (25.1%) of duty/triage calls made/received by the duty nurse during the period between May and December 2019 were related to CYP's crisis experiences. Out of these 56 calls, 18% were referred to the crisis team (and triaged by the crisis). Similarly, 18% of duty calls came from distressed parents who were looking for advice, signposting and referrals to the crisis team. An inpatient/hospital telephone handover to the Solar service through the duty nurse happened in 16% of calls. At the same time, inpatient units also provided regular weekly updates to the duty nurse regarding service users who were admitted into inpatient settings but were still under the crisis team care (12.5%). The duty nurse also made telephone contacts (10.7%) with parents of CYP in crisis to update them about the progress with the crisis treatment and outcomes. 2% of calls were made by the duty nurse to parents and other third-party subjects with the purpose of information gathering, while 9% of duty calls were made for risk assessment of referred CYP. The duty worker made 27% of calls to external sources (i.e. calling parents, social workers or other agencies), followed by calls from hospitals (25%), inpatient wards (18%) and parents (14.2%). Smaller numbers of calls received by the duty worker came from internal sources (5%), education settings (5%), A&E departments (3.5%) and social workers (2%).

7.5.5.1 Demographics

Most telephone contacts were made with the duty/triage for female patients (n=36), followed by males (n=20). The average age for male patients was 13.90, while for females, it was 15.85. The average weighted age between male and females was 15.14. The minimum age for males was 8, whereas females were 12 years of age, while the maximum age for females was 17, and 18 for males (Figure 49).

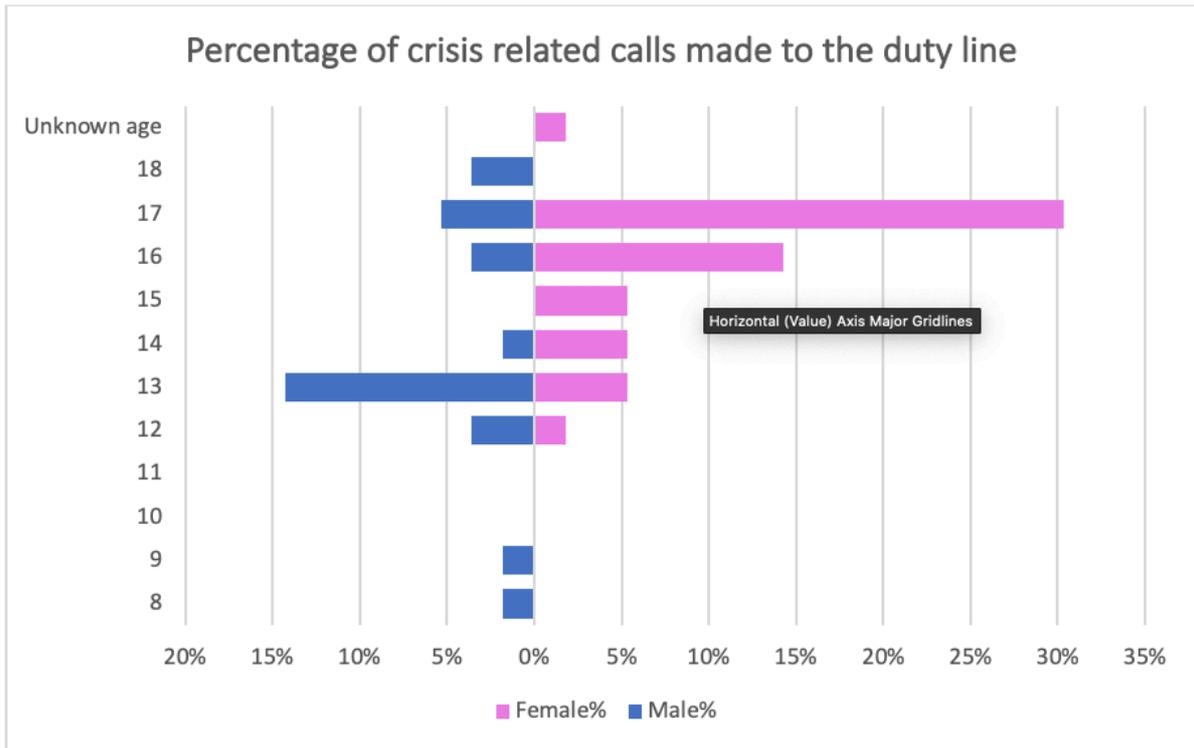


Fig 49. Percentage of crisis-related calls made to the duty line according to gender.

Table 52 - Descriptive statistics for crisis-related service users

Gender	N	Avg. Age	Age range	%
Unknown	1			
F	36	15.85	Min=12-Max=17	64.2%
M	20	13.90	Min=8-Max=18	35.7%
Total	56	15.14	Min=8-Max=17	

7.5.5.2 Crisis related presentations

Most of the crisis presentations to the duty/triage were due to suicide ideation, followed by self-harm and ADHD. Behavioural issues, emotional dysregulation and ASD were also prevalent in the calls. The full representation of the main mental health presentations and the reasons for contact with the duty/triage can be seen in figure 50 and table 54.

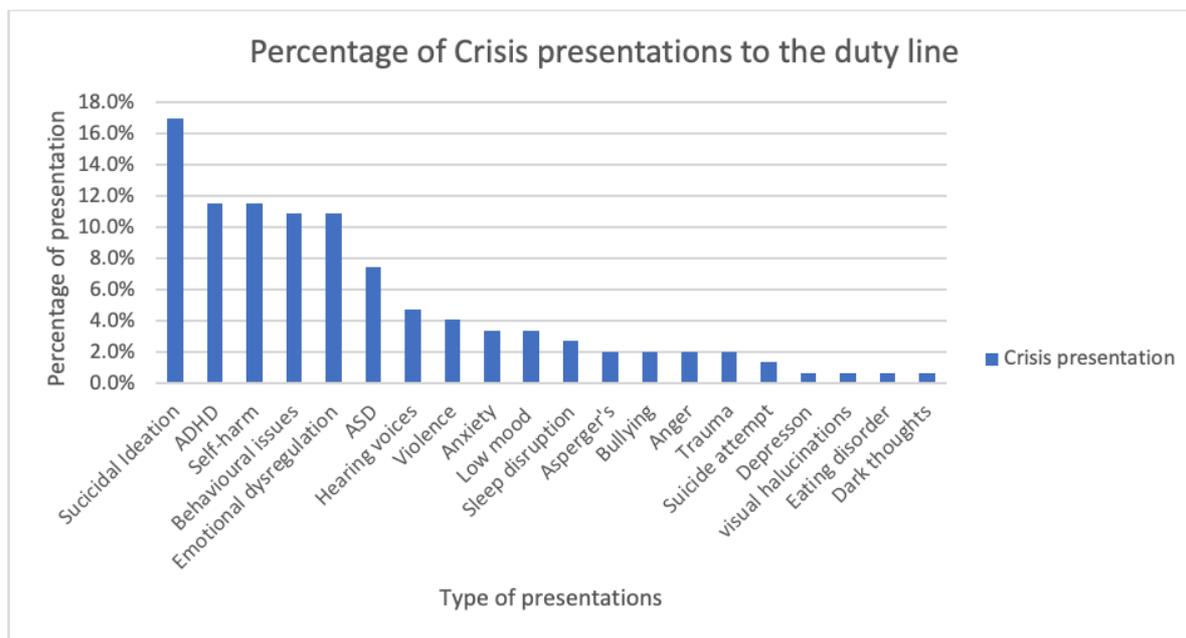


Fig 50. Percentage of crisis presentations to the duty line (according to symptoms)

Table 53 - Total number of crisis related contacts with the duty/triage worker by reason and point of crisis contacts for the observed period

	n	%
<u>Crisis related – a reason for contact</u>	<u>56</u>	<u>100%</u>
Referral to crisis	10	17.8%
Parental support	10	17.8%
Update to parents	6	10.7%
Risk Assessment	5	8.9%
Information Gathering	1	1.7%
Inpatient update	7	12.5%
MDT	3	5.3%
Others update	5	8.9%
Inpatient/hospital handover	9	16.0%
<u>The current point of contact to Duty</u>		
A&E	2	3.5%
Duty call to an external source	15	26.7%
Internal	3	5.3%
Parent	8	14.2%
School	3	5.3%
Hospital	14	25.0%
Social worker	1	1.7%
Inpatient ward	10	17.8%
Total	49	100.0%
<u>Initial referral to crisis</u>		
A&E	15	26.7%
GP	7	12.5%
Hospital	3	5.3%
Internal	4	7.1%
Local authority	17	30.3%
Unknown	3	5.3%
Other agencies	1	1.7%
Paediatrics	4	7.1%
School	2	3.5%
TOTAL	56	100%
<u>STATUS IN SOLAR</u>		
Active (Supported by the crisis team)	44	78.5%
Discharged (Discharged from the crisis team)	9	16.0%
Unknown	3	5.3%
TOTAL	56	100%

7.5.5.3 Crisis-related duty calls

As can be seen in table 55, the largest percentage of contacts with the duty/triage line was for service users who were previously in crisis care (50%). Most of these calls (14.29%) were made by parents who required advice and support from the duty nurse on how to manage their child's mental health. In contrast, a small number of CYP experienced crisis relapse and

subsequently were readmitted back to the crisis treatment (12.5%). Most common crisis presentation evident from the duty/triage nurse's diary and records were deliberate self-harm (36%), suicide ideation (18%), and being at-risk mental state (14.29%) and threats to harm others (14.2%). A small number of CYP were admitted due to family and situational crises (7.1%). The average duration of the crisis care for CYP was 19.14 days. On the other hand, seven CYPs were readmitted (on more than one occasion) to the crisis team, mostly due to suicide ideation (n=4), deliberate self-harm (n=2) and threats to self-harm (n=1). The average duration of the crisis care for these CYP was 27.14 days (Table 55).

Table 54 - Crisis related service users' status and history of crisis relapses

Crisis Status	n	%
Currently in Crisis care*	16	28.57%
Previously in Crisis care	28	50.00%
Re-admitted (Relapse)	7	12.50%
Rejected by crisis	2	3.57%
N/A	3	5.36%
TOTAL	56	100%
*same patient (weekly inpatient update)		
<u>Previously in crisis care</u>		
At-risk mental state	4	14.29%
Deliberate self-harm	10	35.71%
Family and situational crisis	2	7.14%
Suicide ideation	5	17.86%
Threats to harm others	4	14.29%
TOTAL	28	100%
ADoC= 19.14 Min=1 Max=70		
<u>Re-Admitted (Experiences of multiple relapses)</u>		
Deliberate self-harm	2	28.57%
Suicidal ideation	4	57.14%
Threats to harm self	1	14.29%
TOTAL	7	100%
ADoC=27.14 Min=4 Max=129		

7.5.3 Comparison of the presentations of those who were assessed as in crisis and those contacting for other reasons

As can be seen from figure 51, the top three crisis-related presentations to the duty triage were due active suicidal ideation, self-harm and ADHD, as well as behavioural and emotional dysregulation related issues. These presentations can be considered severe, and CYP can be classified as being at risk. In contrast, those contacting the duty/triage telephone line for other reasons reported CYP presentations such as Anxiety, ASD and bullying. From figure 51, those being classified as being in crisis had different presentations compared to the contact for other reasons. For example, most CYP classified as being actively suicidal were immediately referred to the crisis team. On the other hand, all CYP with passive suicide ideation were either signposted to other parts of the Solar service or referred to other forms of external support. However, the duty/triage nurse decision-making process for triaging some service users is unclear, such as in cases of self-harm.

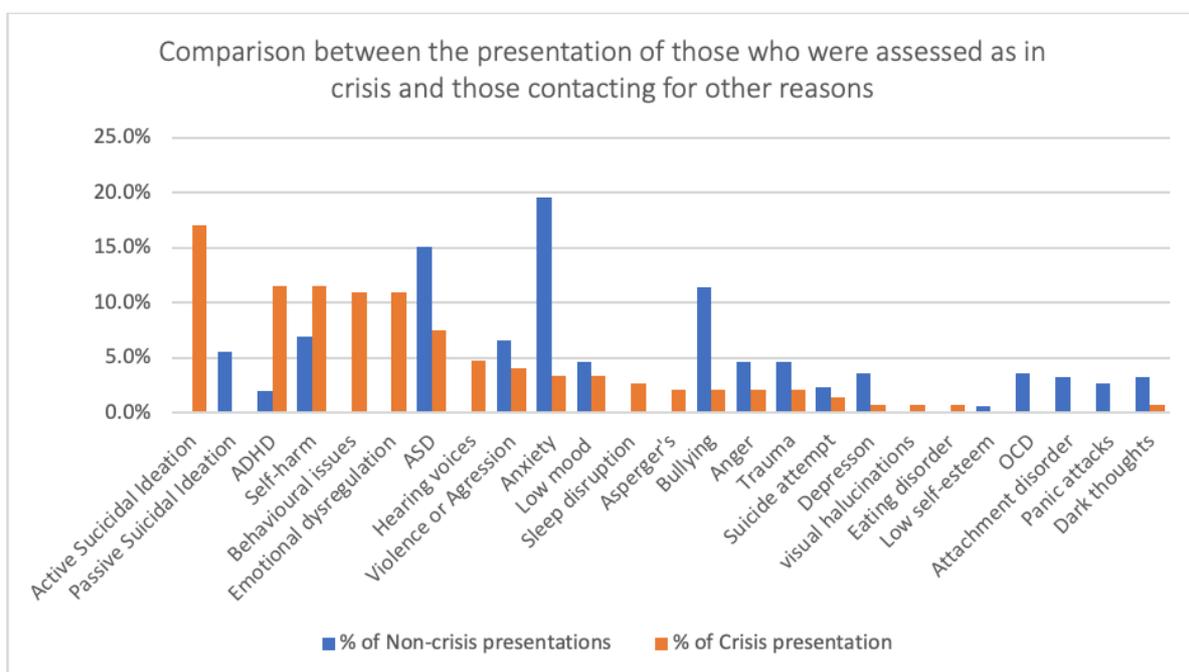


Fig 51. Comparison between the presentation of those who are assessed as in crisis and those contacting for other reasons

7.6 What are the staff members views and experiences with the duty segment and possible future improvements?

All qualitative data for duty/triage segment was taken from interviews previously conducted with 18 staff members in chapter five. All interview transcripts were analysed using thematic analysis, which resulted in two themes and five subthemes (Table 56).

Table 55 - The main themes and subthemes of the thematic analysis

Theme	Subthemes
1. Impact of duty workers on accessibility	• Duty role?
	• Help with improving accessibility
	• Impact of duty/triage on parents
2. Barriers towards the duty/triage access	• A gap in duty coverage
	• A lack of duty staff

7.6.1 Theme one – Impact of duty workers (Pre-Crisis) on accessibility

This first identified theme highlighted the importance of duty/triage on the accessibility to both crisis and the rest of the Solar service. This theme consisted of three subthemes: (1) duty role; (2) help with improving accessibility; and (3) impact of duty/triage on parents.

In the first subtheme, the duty work was characterised by most interviewed staff members as a gatekeeper to access to the crisis intervention and resolution team. For example, participant SSSI101 stated that all calls received by the Solar service are *“triaged by the duty nurse so that they can be signposted”*. Similarly, participant SSSI104 reported that one of the key duty tasks is the pre-crisis screening of telephone calls through *“a duty worker every day”*.

It is therefore clear that the role of duty worker supports not only the crisis team but also the Solar service as a whole. Most participants considered the triage/duty to be helpful for the triage of telephone calls according to their urgency while directing patients to internal support or external signposting. Consequently, having the triage and duty team as a separate team helped to improve the accessibility of both Solar and its crisis segment.

The second subtheme looked more closely at how duty/triage helps to improve the overall accessibility of the Solar and its crisis component. For example, participant SSSI102 explained their perception of the duty role within the Solar service as a “filter” through which all received calls must go through to “see how CYP meet crisis criteria”. Participant SSSI102 concluded that “duty rota truly does support the crisis team” within the Solar model. The same opinion was shared by the participant SSSI110 who stated that duty plays an essential role for access to the crisis team, as patients “don’t come to Crisis unless they come through the duty worker”. Similarly, participant SSSI105 stated that having a duty line helps “towards better accessibility to the crisis team”. Also, participant SSSI107 added that the “crisis team was overwhelmed by non-crisis cases” before the duty was implemented as a role in the Solar service.

The presence of the duty may therefore play a key role in the “filtering” of calls to determine which call is of higher urgency. As a result, the duty separates all non-urgent cases that help the crisis team to be able to focus solely on urgent and emergency cases that fit crisis criteria and prevent the crisis team from being overwhelmed by their workload. However, the last subtheme showed that the role of duty/triage plays a crucial role in the containment of not only CYP crises but more importantly, their parents’ crises. For example, participant SSSI105 stated that having a duty worker “really helps to contain parents and their anxieties”.

Table 56 - Participants quotes in support of theme one

Participants	Quotes in the support of theme
Staff	<p>“You know, so you got a crisis, and then you got your duty separate so that they can take the information they're given and pass it to whichever team needs to be.” (SSI 104)</p> <p>“But we as service have to cipher out fairly, what we can practically do, and what we can’t with the limited amount of staff.” (SSSI107)</p>

7.6.2 Theme two – Barriers hampering the duty/triage access

The second overarching theme identified barriers linked to the duty/triage access and consisted of two subthemes: (1) a gap in duty coverage; and (2) a lack of duty staff

Most of the interviewed staff reported that there is a clear gap in the duty/triage coverage with a part-time employed nurse.

Participant FGR6 reported that there is a need *“to offer more of a telephone crisis support line for young people and parents”* which full-time staff duty role could cover, as at the moment this is *“a gap that needs to be looked at”*. Equally, participant FGSM4 stated that more duty/triage engagement *“might squash some of the pressures on the crisis and the rest of the service”*.

Likewise, other interviewees such as SSSI101 had a similar perception that *“at the moment, duty workers represent a gap with the crisis, as well with the other parts of the service”*. Likewise, participant SSSI104 felt that there are some gaps *“of duty worker to cover crisis calls between 8 am and 9 am, and the lack of duty worker during the weekends”*. Similarly, participant FGR1 also reported that there is a *“lack of full-time duty role”*.

As can be seen from the responses of the participants, the duty position is staffed by one part-time nurse, while the rest of the week the duty line is staffed by other staff employed within the model. However, this lack of full duty coverage was perceived by the staff as a gap that could have an impact on regular service provision and is mainly due to the lack of staff employed in the model as evident from the second subtheme.

In order to bridge this gap, the majority of interviewed participants agreed that more staff should be employed to fulfil the role of duty. For example, participant SSSI107 agreed that there should be *“someone to fill those other days for duty role specifically”*. In contrast, other participants such as SSSI109 added that service should *“create a job-share for duty workers”*. Lastly, participant SSSI110 warned that having too many people working on the duty line who are not duty workers or nurses, could have a negative impact on the care of service users.

However, it is vital to conclude that the identified gaps and lack of duty workers in the Solar model may have a negative impact on the overall service provision. Consequently, the gap with

the lack of specific duty workers to cover triage and telephone crisis support needs to be closed by providing more staff to cover the gatekeeping duty.

The benefits of the duty/triage are evident for Solar. For example, participants SSSI107 and SSSI110 indicated a clear advantage of having a duty worker employed in the model, such as gatekeeping and improvement of accessibility. Indeed, Duty/triage work should be nurtured and be more used within the Solar model.

Table 57 - Participants quotes in support of theme one

Participants	Quotes in the support of theme
Staff	<p><i>“Obviously we have [name], we do have lovely lady that covers duty, but it’s only two days a week. And then it’s shared between the team but that’s not crisis duty support” (FGSM6)</i></p> <p><i>“The duty work should be seven days a week, and quality of the duty service provision should be the same. And what they’re giving out should be the same. So yeah, actually, just thinking about it, I think there’s a bit of cutting corners there at the moment” (SSSI110)</i></p> <p><i>“Early intervention, as this proves that what duty/triage is doing actually helps the service, the gatekeeping, because that in itself is a service” (SSSI107)</i></p> <p><i>“I think duty/triage definitely meets the need; I think the key word was the ‘gatekeeper’. I think that needs to be nurtured.” (SSSI110)</i></p>

7.7 Discussion

This study aimed to investigate the accessibility, acceptability and effectiveness of the duty/triage telephone line component of the Solar service, by using the exemplar of the duty nurse that is employed in the official capacity. The additional aim of this study was to understand staff members views and experiences with the duty segment and possible future improvements to this component. The main findings will be discussed further in the next sections in relation to other available literature.

7.7.1 What is accessibility, acceptability and effectiveness of the duty/triage telephone line component?

Retrospective analysis of duty/triage RIO data entry of one part-time nurse employed in an official duty capacity within the 0-19 model showed extensive documentation of the presented problems (symptoms). However, rationale for the decision-making of what constitutes a crisis is limited and mostly dependent on the personal perception and experiences of the duty worker. This study did not identify any internal guidelines that inform workers about what constitutes mental health crisis and what criteria CYP need to meet to receive crisis intervention. The findings of this study showed similarity with another study regarding the limited rationale for decision-making in duty/triage workers (Grigg, Herrman, & Harvey, 2002). However, this does not imply that the decision-making of the duty worker was inappropriate or that all telephone contacts should be assessed. Instead, it illustrates an internal pathway that represents a filter which mediates the accessibility of the mental health service and manages limited resources (Grigg et al., 2002).

On the other hand, while most referrals to duty/triage in the Grigg et al. (2002) study were self-referrals; in this study, most non-crisis referrals to the 0-19 model were made by GPs, which suggests that GPs are actively involved in the referral processes to the 0-19 model. In contrast, in this study, most of the calls to the duty/triage nurse came from either local authorities or A&E departments.

However, the findings of this study showed that the duty/triage within the 0-19 model plays a crucial role in the allocation of limited resources while preventing the rest of the service from being overwhelmed by cases that may have access to help from other available community resources. These findings are in line with the findings of another study (Tobin et al., 2000). For example, data have shown that a large number of telephone calls have been diverted from the crisis team to relieve the pressures from the crisis and prevent this team from being flooded with non-crisis cases referrals. The duty/triage role in the 0-19 model is, therefore, part of the internal pathway that filters out and facilitates access to the 0-19 model. The filtering and mediating role of duty/triage in this study also shared similarity with the duty/triage component reported in the study by Grigg et al. (2002). From this, it can be concluded that the duty/triage component of the 0-19 model meets Tobin et al., (2000) three criteria as initially outlined in section 7.2.

A consistent approach to filtering access to mental health services is a crucial part of reducing the variance in clinical decision-making (Tobin et al., 2000). However, inconsistency with the employment of other staff members and a lack of full-time duty/triage role within the 0-19 model may reduce the consistency and increase variance in clinical decision-making. Lack of written guidelines and the duty/triage procedures may also contribute to a lack of consistency in the performance of other staff members involved in the duty/triage coverage.

However, in addition to the lack of internal guidelines, there is an evident lack of routinely collected data to thoroughly evaluate the effectiveness of the 0-19 model's duty/triage. Moreover, although the duty worker reported in their diaries the anecdotal satisfaction of service users with the duty calls (support), the lack of more reliable and valid satisfaction outcome is evident. Absence of these measures prevented this study from fully understanding the extent to which the duty/triage component of the 0-19 model is acceptable to its service users.

Although the duty/triage component performed a wide variety of the duties and related to the different parts of the 0-19 model, the most common outcome for non-crisis related calls was mostly associated with the provision of support, advice and signposting of parents to other external services. These findings show similarity with the Grigg et al. (2002) study, which also

found that duty/triage outcomes were mostly related to the provision of support and information to both existing and new patients. These findings therefore may indicate that the duty/triage nurse was successful in diverting non-urgent cases away from the crisis team or the rest of the service.

Finally, due to a lack of routine outcome measures and data collected, this study has not been able to understand whether the presence of duty/triage workers can successfully divert service users from the crisis service or whether duty/triage only delays access to the crisis team. From the data collected, most of the parental contacts with the duty/triage nurse were made due to a need for more information on how to manage their children mental health. Some of these cases, if not adequately treated, may escalate to the full crisis. Besides, quantitative data in table 55 also showed that some service users had progressed towards a full crisis while in Solar. Similarly, the number of relapses of crisis cases may also indicate that the crisis team is not offering to CYP long enough service provision, which may also affect the duty workers and their ability to contain parents and their worries. However, despite limited data and the lack of the outcome measures in this study, some degree of the duty/triage effectiveness is still evident. The observed duty nurse did triage all CYP deemed at risk as crisis cases in cooperation with the rest of the crisis team while diverting non-crisis cases away from the crisis team and the overall service.

7.7.2 What are the staff members views and experiences with the duty segment and possible future improvements

All staff interviewed emphasised the importance of duty workers who act as gatekeepers not only in terms of hospital prevention but also in terms of admission to the crisis service. Duty workers are therefore a key component of crisis resolution teams (CRT) efforts to direct CYPs who are in the crisis to the crisis support and interventions, while at the same time signposting to other areas those who are perceived as not in the crisis. In essence, duty workers are performing much-needed triage functions as a part of the CRTs.

Staff also agreed that the crisis triage function is closely linked with the mental health telephone triage, which plays a vital role in the initial assessment of crisis cases, signposting

and crisis management. These findings are consistent with findings from other studies that reported the importance of telephone triage for assessing, advising and managing urgent and emergency mental health (Kevin, 2002; Sands, 2004). Similarly, one study concluded that the existence of duty workers providing telephone triage is crucial to community mental health services and crisis helplines (Wetta-Hall, Berg-Copas, & Dismuke, 2005). The role of duty workers has also been useful in de-escalating crises and quickly redirecting patients to appropriate crisis interventions and preventing possible hospitalisations (Sands, Elsom, Marangu, Keppich-Arnold, & Henderson, 2013). The importance of the duty workers to contain parents and their anxieties was evident in the findings from this study. Similarly, one study found that duty workers had been quite effective in reducing parental and family anxieties as a result of their relative mental health crises (Sands et al., 2013). Also, the study by Sands et al. (2013) concluded that it is the crucial task of duty workers to maintain telephone contact with family and sufferers and to help them to manage the crisis, which is also evident from the findings of this study.

7.8 Strengths and weaknesses

The main strength of this study is its focus on the retransformed service provision and its duty/triage component for CYP 0-19 years of age. Qualitative findings provided useful experiential findings and understanding of potential gaps that duty/triage components may face. However, the findings of this study demonstrated the importance of the duty/triage components of mental health services and their impact on the gatekeeping towards admission.

On the other hand, the main weakness of this study is the lack of routinely collected data, which could provide more information on the effectiveness of duty/triage services. An additional weakness of this study may be its focus on only one duty worker, while not taking into account the work of other professionals that cover the duty line in the absence of a duty nurse. Despite attempts being made to understand how the entire duty/triage component operates, the service was hesitant to allow a structured approach towards tracking the overall duty components weekly activities. Therefore, we were unable to fully understand the overall activities of the duty/triage component during the rest of the week by other staff employed in

Solar and whether there were any differences in the work undertaken or data recorded by the duty worker and other staff. However, from the qualitative data, it is evident that there is variability in how the rest of the duty/triage workers operate. The staff interviewees confirmed that there is a degree of variability in the work of the duty workers, and they expressed the need for a more unified approach to the duty/triage work.

However, it is essential to highlight that the results of this study may not be generalised to other mental health service models for CYP. However, these findings can still be informative to other service models both in the UK and worldwide, regarding how much is a crucial task of the duty/triage component on the accessibility of the mental health services, as well as the need to have consistent and quality triage decision-making processes.

7.9 Further research

Future research should investigate the rationale and processes behind duty/triage decision making and try to understand what governs them. It is also crucial to investigate the effectiveness of duty/triage workers through the inspection of routinely collected data and outcome measures that the current study has not been able to do.

7.10 Chapter summary

The duty/triage line has a significant number of calls per day to a wide range of service users, healthcare professionals and other parties. Most of these contacts do not warrant the acceptance of CYP in the 0-19 model, as they are diverted by the duty/triage component to other external agencies and resources. This study has shown that the duty/triage line is accessible to a number of stakeholders. However, the effectiveness of this component is not entirely clear. While the duty/triage line is capable of diverting CYP from the crisis service, the question remains as to whether it is actually diverting or only delaying access to the crisis team. However, the duty component plays a crucial role in the allocation of limited resources while preventing the rest of the service from being overwhelmed by cases that may have access to help from other available community resources. This study found limited and anecdotal evidence of service users' satisfaction and acceptability of the duty/triage component. Nevertheless, staff perceived the duty line as a gatekeeper and a key component for improved accessibility. Staff also associated the duty component with a reduction of referral pressures on the crisis service and other parts of the model.

Chapter 8: Investigation of the 0-19 model's crisis pathway

8.1 Chapter outline

In the previous chapter, the 0-19 model's telephone triage component was investigated using a mixed-methods approach that examined the effectiveness of the triage and aimed at understanding the perceptions of staff members regarding this component of the Solar service. This chapter investigates the accessibility and effectiveness of the 0-19 model's crisis service and the effectiveness of the crisis pathway to map CYP journeys through the crisis service from the point of referral to their discharge from the service. The first part of the chapter will introduce the main aims and research questions. The methodology used in this study will then be discussed before the main findings are presented. Finally, the findings will be discussed in the context of the wider literature, along with the strengths and weaknesses of this study and conclusions. This study and its activities are well aligned with the overall logic model and its activity section presented in Chapter 3.

8.2 Study aims

There is currently a gap in our understanding of what constitutes an effective mental health crisis pathway for CYP experiencing a mental health crisis. Despite some attempts to define effective crisis pathways (National Institute for Health and Care Excellence, 2016), no official reports have yet been made to describe an effective CYP mental health crisis pathway, as explained previously in chapter 1. Moreover, one systematic review highlighted that evidence of the effectiveness of crisis pathways is limited due to the lack of methodologically-led crisis care evaluations in the UK (Paton et al., 2016b).

Therefore, the main aim of this chapter is to ascertain the accessibility and the effectiveness of the crisis service and its pathways, and to answer the following research questions:

- How effective is the 0-19 crisis pathway for admission of CYP into the crisis service?
 - What are the pathways to crisis care and patients flows?
- Is the crisis service transforming recovery and resilience such that further use of the crisis services is reduced?
- Is 0-19 crisis model effective in reducing A&E and acute admissions or out of area placements?

8.3 Methodology

8.3.1 Study design

This quantitative study was designed as a prospective cohort approach that investigated CYP journeys through the 0-19 model's crisis service from their point of referral to their crisis discharge point. All consecutive referrals over eight months were captured and further examined.

8.3.2 Sample

During the eight-month tracking period (01st May to 31st December 2019), prospective and consecutive anonymised data from 180 CYP admission records to the crisis team were included. Of these, there were 150 unique individuals, while the other 30 records were for CYP readmitted to the crisis service during the study period. All CYPs were flagged, assigned unique study codes and consecutively tracked from the point of referral to the crisis team until discharge. CYP that were under crisis care at the end of the study period, were tracked until the earliest of 29th February 2020 or their date of discharge. One patient was still under the care of the crisis team at this point as an inpatient and so did not have a discharge date recorded. All tracked CYP were referred to and accepted by the 0-19 crisis service (the main inclusion criteria). All those not accepted into the crisis pathway were excluded from further investigation. All CYP readmitted to the crisis team post-discharge kept their original code assigned at their first admission. The sample description and demographical data will be discussed in section 8.5.1.

8.3.3 Outcome measures

The 0-19 crisis team did not employ any officially standardised clinical outcome measures (such as HoNOSCA, SDQ or ESQ). The ethics permission did not allow the introduction of any other standardised outcome measure to be used for this evaluation. This study focused, therefore, on the posed research questions.

8.3.4 Data collection

BSMHFT's central data analysis team provided the researcher with a weekly anonymised excel spreadsheet regarding the journeys that CYP took through the crisis service, using a template developed and agreed with the team and based on the data entered into the electronic patient record system used by the Trust (RIO). The initial data collection was planned to last a full year (January 2019 – January 2020). However, the first database was delivered on 6th May 2019, while the last was delivered on 3rd January 2020. There was a delay in receiving the data due to staff workload, and this reduced the observation period from one year to eight months. Service data included (but were not limited to) pseudo service users IDs, diagnosis, demographic data, source of referrals, presentations, location of initial assessment, dates of initial contact, the decision regarding treatment, the end date of discharge, DNA rates, handover to the next part of the pathway and reattendance (relapse). For each update, the researcher contemporaneously transferred the data to a spreadsheet designed to clean and rearrange data for further analysis. The researcher performed the final analysis of the overall data once the data analyst team delivered the last dataset.

8.3.5 Missing data

The data provided contained a large number of missing data. For example, the main diagnoses and the outcomes of assessments were reported sporadically. Times between admission to A&E contained over 42% of missing data. Similarly, the starting times of the crisis triage suffered from more than 70% of missing data, making it impossible to calculate the time scales between referral and the crisis triage. The other data also had a large amount of empty or

incomplete information. The data regarding time and duration of hospital admission were not included in the data set analysed in this study.

Table 58 - Example of missing data and fully accessible data

DATA	STATUS
PSEUDO ID	Data fully available
TAKEN ON THE CRISIS TEAM	Data fully available
DATE OF BIRTH	Data fully available
GENDER	Data fully available
PRIMARY DIAGNOSIS	90% Missing data
REATTENDER	Data fully available
KNOWN TO SOLAR	Data fully available
SOURCE OF REFERRAL	Data fully available
REASON FOR REFERRAL	10% Missing data
PRESENTATION TO A&E	42% Missing data
MEDICAL INTERVENTION REQUIRED	30% Missing data
PAEDIATRIC WARD ADMISSION	30% Missing data
ADULT WARD ADMISSION	30% Missing data
START OF CRISIS REFERRAL	Data fully available
START OF CRISIS TRIAGE	70% Missing data
MEDIUM OF REFERRAL	76% Missing data
START OF ASSESSMENT	20% Missing data
END OF ASSESSMENT	20% Missing data
LOCATION OF ASSESSMENT	20% Missing data
OUTCOME OF ASSESSMENT	22% Missing data
HANDOVER TO THE NEXT POINT OF CARE	Data fully available
TEAM HANDED TO	Data fully available
TREATMENT AND ATTENDANCE DATA	Data fully available
OUTCOME MEASURES	100% Missing Data
SATISFACTION MEASURES	100% Missing Data

8.4 Statistical assessment (analysis)

Due to the lack of outcome measures, the effectiveness of the 0-19 crisis pathway and overall service provision assumed a latent effect that could not be measured directly but was inferred from other observational variables such as the duration of crisis care, and readmission rates. Prospective tracking was used to map patient flows through the crisis service and their duration of stay.

8.4.1 Pathway analysis

All patient flows through the crisis service were tracked manually and counted at the entry point (each referral source), their progression (journey) through the crisis service and their exit (end) points. CYP referral movements were mapped with directional arrows to map the healthcare pathways of the service in the same manner as reported in two other studies (Gater et al., 1991; Gater et al., 2005). The data were also analysed and displayed using a Sankey diagram of patients flows to verify the accuracy of the created pathway. During the analysis process, the researcher used Microsoft Excel in combination with the R software to create Sankey diagrams (Bock, 2018).

8.4.2 Descriptive statistics

Descriptive statistics were conducted on all routinely collected and available data, such as demographic data (age or gender), previously known to Solar, reattender, source of referral, the reason for referral, taken on the crisis team and length of stay in the crisis service. The researcher used Microsoft Excel in combination with SPSS statistical package version 26 to analyse all gathered data.

8.4.3 Duration of Crisis Care (DoC)

The duration of crisis care is defined as the number of days that service users spend in the community mental health crisis service. It is calculated from the point of a patient's acceptance to a mental health crisis service until their discharge.

The average duration of crisis care (ADoC) is defined as the average number of days spent in mental health crisis services across all service users. ADoC is produced by dividing the total number of days service users spent in the service during a year by the number of admissions or discharges.

8.4.4 Readmission rate analysis

A relapse or remission may be defined as “deterioration in a patient’s condition after a partial recovery”(Department of Health, 2002). In other words, a patient returns from improved mental health to an acute state of a mental health crisis and subsequent reacceptance back to acute care. Since there are degrees of relapse, the perception of relapse may vary for each individual (i.e. what relapse is for one person may not necessarily be for another). However, the term “relapse” is widely used in a variety of contexts. For many mental health crisis-affected patients, relapse experiences are often associated with “going back to square one”, “failing” or “moving backwards”(Rickwood, 2006). Instead of relapse, these patients often refer to their mental health as feeling “well” or “unwell” (Rickwood, 2006). Moreover, instead of using the word “relapse”, most patients prefer to describe their mental health crisis as a “crisis episode” (Department of Health, 2002).

Similarly, continuous relapse experiences are often referred to as the “revolving door” syndrome (readmission) in patients discharged from mental health services (CDC, 2020). Revolving door syndrome can be defined as the tendency of service users to experience initial and short improvement in their post-discharge mental health, followed by a continuous return of acute mental health (i.e. relapse) and subsequent need for reacceptances back to acute treatments (Garrido & Saraiva, 2012). Therefore, for this study, the term “relapse” was used as a relative term reflecting the return of CYP acute crisis symptoms from post-crisis discharge, regarding their severity, duration, and interference with personal functioning, thus requiring CYP’s reacceptance (or readmission) back to the crisis service. Despite the term reacceptance has been widely used in the community-based settings, for this study, the term readmission was used to refer to reacceptance.

In order to investigate readmission rates (i.e. relapse of crisis symptoms and rereferral to the crisis team), this study sought to investigate patient survival (readmission) over 210-days for all post-discharge patients. Therefore, all patients discharged between 1st May 2019 and 3rd January 2020 (inclusive) (n=176) were included in our analysis of relapse rates from the data collected through prospective tracking.

8.4.5 Survival analysis

The readmission rates of all service users (post-discharge) were investigated using Kaplan-Meier survival analysis. The Kaplan-Meier survival estimate is the simplest way to investigate the survival of patients over time and such plays a significant role in generating evidence-based information on survival time (Goel, Khanna, & Kishore, 2010). In clinical trials, epidemiology and most community settings (e.g. hospital treatments) Kaplan-Meier survival estimates are used to assess the effect of specific treatment by measuring the number of patients who have been saved (or survived) after being exposed to the intervention or treatment over a particular period (Goel et al., 2010).

The goal of this analysis method was therefore to estimate the survival of the population over time by generating a survival curve from the sample data. This method of statistical analysis and its treatment of survival times allows proper allowances for those observations that are censored (i.e. left the study or dropped) while making the most of the available data from these patients up to the time they left the study (Goel et al., 2010). The analysis was performed on the overall sample (n=179, the exclusion applied to n=3) to estimate the cumulative rate of relapse, with data censorship being taken into account for the different duration of the study participant follow-up (i.e. patient survival was censored at the end of the study period). Data were censored if the participants were discharged and had no relapse during the follow-up period. Survival analysis was coupled with Cox's hazard regression model, often used in epidemiology, and medical research to investigate the association between the patient survival time and one or more predictor variables (LaMorte, 2016). Cox Proportional Hazard Regression is often considered as an extension of the survival analysis to assess the risk factors (or exposure) associated with the survival rates (LaMorte, 2016). In Cox's Hazard Regression Model, the measure of effect is the hazard rate that represents the probability of an event (i.e. risk of failure) (LaMorte, 2016).

8.4.6 Ethics

Ethical approval was obtained from:

- The University of Warwick Biomedical Science Research Ethics Committee (BSREC) REGO-2018-2294. (Appendix-3)
- Birmingham and Solihull Mental Health Foundation Trust approved the evaluation protocol and issued the letter of access for the researcher to perform the audit (Appendix 4&4a)

All data were collected without the consent of the participants in accordance with the GDPR, which stipulates that there is no need for consent from participants for already collected and anonymised data (National Office of Clinical Audit, 2019); this was approved by the BSREC and the Trust.

8.5 Results

8.5.1 Description of the sample

During the eight-month evaluation of crisis service user journeys (Table 60), 180 CYPs passed through the crisis service. 63.88% of service users were female, while 36.11% were male. Participants' age ranged from 9 to 18 years of age, while the mean age of participants was 14.84. The majority of CYP crisis service users identified as white British (69.94%), while 18.03% of CYP did not state their ethnicity. Figure 52 shows the breakdown of CYP ethnicity.

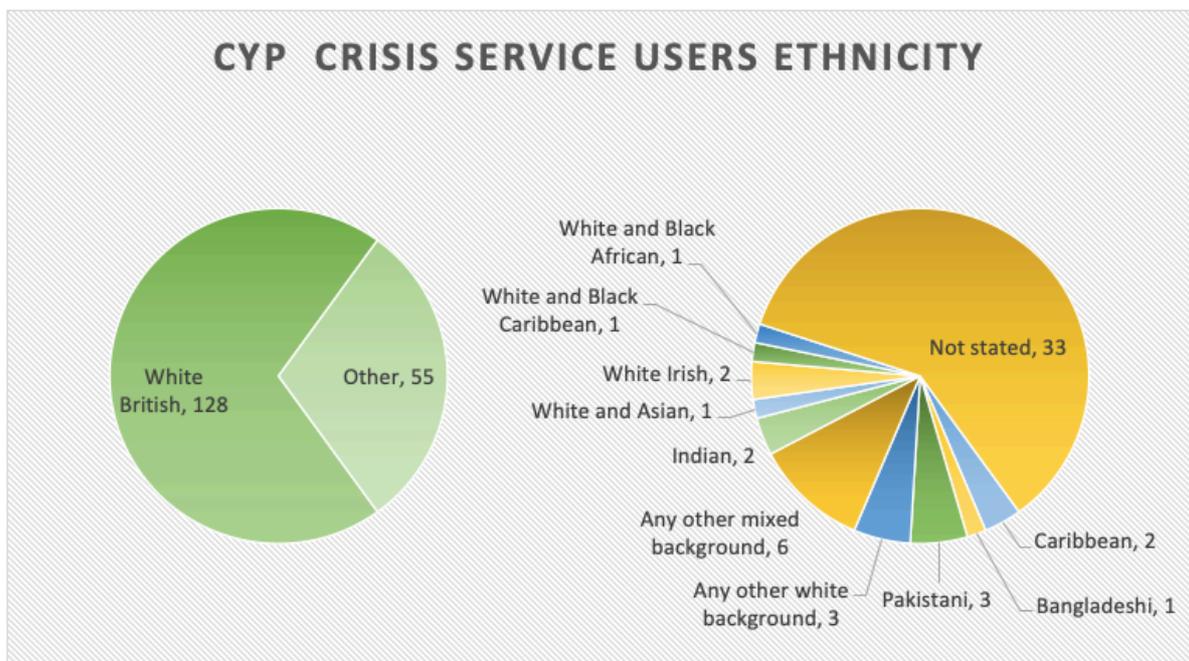


Fig 52. CYP (crisis service users) ethnicity

8.5.1.1. Previous service usage and relapse

Over half of the crisis service users (56.6%) tracked over the eight-month evaluation period were already known to the 0-19 service and had not been officially discharged from the 0-19 model or its crisis component (Table 60). Meanwhile, 21.2% were previously known to the 0-19 model but had been fully discharged from the service. On the other hand, 22.2% of CYP had not previously been service users of the 0-19 model or its crisis component.

The majority of CYP service users were classified as being non-reattenders (71.6%), i.e. new cases, while 21.6% of CYP experienced crisis relapse in the last 12 months. Conversely, 6.6% of CYP experienced relapse more than 12 months ago.

8.5.1.2 Sources of referrals

The most common source of referrals to the crisis team was from other teams internal to the Solar service (31.11%), while 22.22% and 19.44% of referrals came from A&E and hospital-based-paediatric wards, respectively.

8.5.1.3 Main presentations of CYP crisis symptoms

The most common symptom of CYP referred to the crisis team was suicidal ideation (36.11%), followed by intentional self-harm (24.44%) or threats to self-harm (10.56%). The remaining were referred due to being considered at risk (5%), affected by familial or situational crises (3.89%), having made threats to harm others (1.11%), and as a result of non-intentional self-harm (1.11%). More than 90% of CYP diagnosis data were missing.

8.5.1.4 Acceptance rates of CYP to crisis service

Out of the 180 CYPs referred to the crisis service, 142 (78.8%) were accepted by the crisis team, while 38 (21.1%) were rejected. The main reasons for CYP not being accepted were unsuitability for crisis treatment, transferal to another team within the Solar service, service user rejection of crisis service provision, or failure of the service user to attend their appointment (DNA).

Table 59 - Demographic profile of service users (n=179) and crisis service utilisation

	N	%
Age range (mean)	9-18 (14.84)	
GENDER		
Females	115	63.88%
Males	65	36.11%
PREVIOUSLY KNOWN TO SOLAR		
Yes, open	102	56.66%
Yes, closed	38	21.11%
No	40	22.22%
RE-ATTENDING		
Yes, more than 12 months ago	12	6.66%
Yes, within the last 12 months	39	21.66%
No	129	71.66%
TAKEN ON THE CRISIS SERVICE		
Yes	142	78.88%
No	38	21.11%
SOURCE OF REFERRAL		
A&E	40	22.22%
CAMHS Community Service (external to trust)	3	1.67%
CAMHS Inpatient Service (external to trust)	1	0.56%
GP	14	7.78%
Hospital-based Paediatrics	35	19.44%
Internal	56	31.11%
Other Service, Agency or Non-Clinical Source	20	11.11%
School / Other Education	10	5.56%
Police	1	0.56%
REASON FOR REFERRAL		
Suicidal ideation	65	36.11%
Threats to harm self	19	10.56%
Threats to harm others	2	1.11%
Deliberate self-harm	44	24.44%
At-risk mental state	9	5.00%
Family and situational crisis	7	3.89%
Nonintentional self-harm	2	1.11%
Accidental intoxication drug & alcohol	1	0.56%
LENGTH OF STAY		
Range		0-129 days
Mean		16.25 days
Median		13.00 days

8.5.1.5 Duration of Crisis Care (DoC)

Duration of crisis care at Solar crisis service ranged from being discharged on the same day (0 days) up to 129 days, with a mean stay of 16.25 (median 13.00) days. For patients who were already under the care of the crisis team at the start of the study period, their duration of care was calculated by retrospectively investigating their prior acceptance data. Patients under crisis care at the end of the study period were tracked until their point of discharge, as explained in section 8.3.2, to calculate their duration of care. Analysis of the average duration

of crisis care for the period from 1st of May 2019 to 31st of December 2019 (Figure 53) showed that the highest duration of crisis care was in September 2019 (24 days), while the lowest duration of care was in August 2019 (11.50 days)

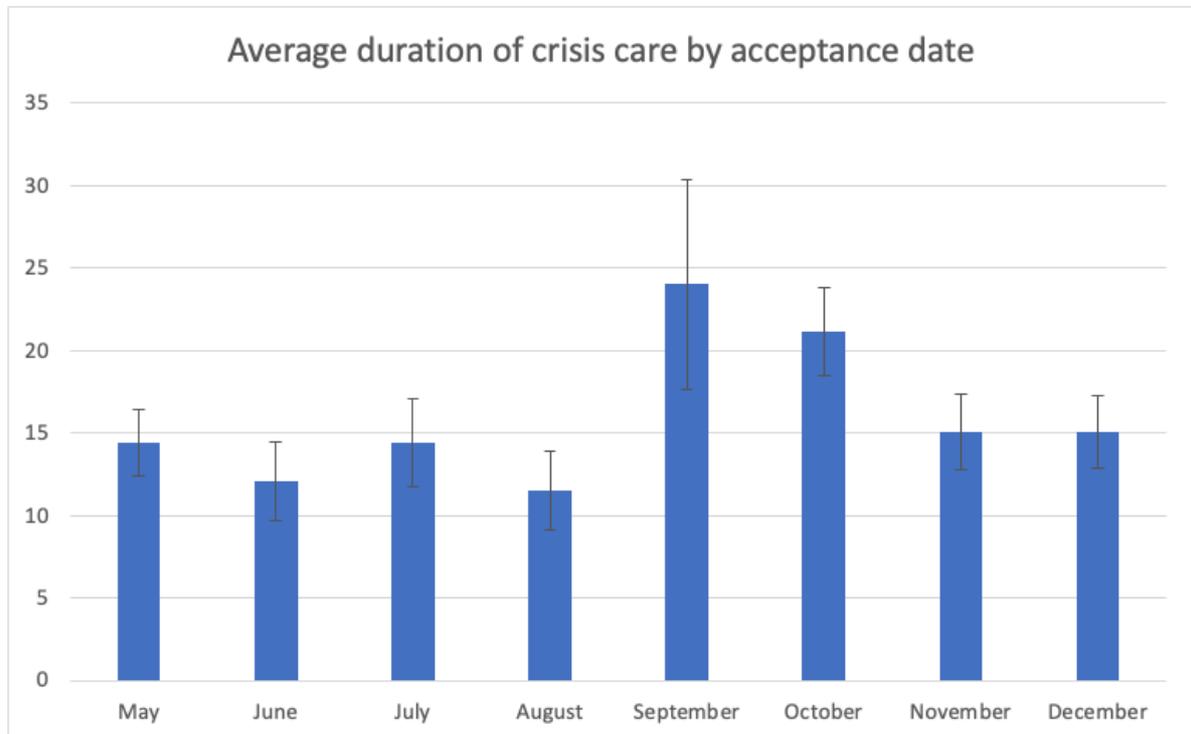


Fig 53. Average duration of crisis care for CYP (for periods between 1st May 2019 to 31st December 2019).

8.5.2 Time to be seen and assessed by the crisis team

Due to a large amount of missing data, it was difficult to assess the mean times between the presentation and the start of the crisis referral. For example, the available data showed that the mean time for the crisis team to see a patient following A&E admission (n=61) was 9 hours and 40 minutes after the referral point. CYP referred following admission to A&E received a full crisis assessment between 15 minutes and 21 hours after their initial referral to the crisis team had been made.

For hospital ward admissions, the mean time from the point of referral to assessment was 18 hours and 22 minutes (n=119). In most cases, the duration of the assessment ranged between 30 minutes and 4 hours and 15 minutes, with a mean time of 1 hour and 27 minutes (n=138).

The data from the point of presentation to the start of the crisis referral for other sources (e.g. GPs) were not available. Of referrals received from other sources that were accepted by the crisis team, nine service users were subsequently admitted to the hospital. Of these nine patients, the time that elapsed from the point of acceptance by the crisis team to their presentation at a hospital lasted from 32 minutes, up to a maximum of 22 hours 46 minutes from the referral point, with a mean time of 10 hours and 43 minutes. As can be seen from table 61, most of these crisis team assessments were conducted at the Bishop Wilson clinic (27.2%), followed by inpatient ward assessments (15.5%) and patients' homes (13.3%).

Table 60 - Locations of crisis assessments

Location of Assessment	Number	%
Bishop Wilson	49	27.22%
Carer home	1	0.56%
Education setting (College)	2	1.11%
Education setting (School)	8	4.44%
Freshfield clinic	7	3.89%
Hospital Heartlands	7	3.89%
Hospital other	1	0.56%
Hospital Solihull	1	0.56%
Hospital Inpatient Heartlands	28	15.56%
Hospital Inpatient Solihull	1	0.56%
Patient Home	24	13.33%
Relative Home	2	1.11%
Telephone call	2	1.11%
Missing data	47	26.11%
Total	180	

A small number of CYPs from this sample were admitted to paediatric wards (n=36), while a small number of CYPs were admitted to adult medical wards (n=6). A large number of patients who were admitted to hospital or A&E did not require any additional medical intervention (n=22).

8.5.2 How effective is the 0-19 crisis pathway for admission of CYP into the crisis service?

Pathway analysis provides valuable information about how patient referrals move through a particular mental health system, and what particular route these referrals follow (Gater et al., 1991; Gater et al., 2005). Besides, the pathway diagram can also reveal the potential bottlenecks and may help focus on potential sources of delay for referrals or care seeking

(Gater et al., 1991). Therefore, to understand the effectiveness of the crisis pathway, it was first necessary to use diagrams and colour coding to construct a representation of the 0-19 model's crisis pathway (Figure 55) based on available data obtained from prospectively following CYPs referrals flow through the crisis care. The overall constructed pathway, as seen in figure 55, showed the presence of four different subtypes of pathways to crisis care that is present within the 0-19 model. Patients in the orange section are under the care of the crisis team, while patients in the blue, green and purple areas are under the care of eating disorders, Solar primary care and Solar general (CAMHS) teams, respectively. It is important to note that the pathway diagram only includes patients who have been under the care of the crisis team during the observation period (1st of May until 31st of December 2019), and will therefore not include service users who have not been under crisis care. As can be seen from figure 55, the largest interactions and service users' referral flows are happening between crisis (orange) and Solar General-CAMHS (purple) sections, which represent the largest portion of the pathway. Besides, the largest bottleneck identified in this referral pathway is associated with Solar General (i.e. CAMHS) teams where most referrals from other parts of the system end up. The most service users discharged from the crisis team experienced long waiting times for the treatment in Solar CAMHS, hence why Solar General is displayed with the largest arrow (i.e. bottleneck).

Key points of the pathway diagram (Figure 55):

- 67.9% of CYP accepted referrals to the crisis team came from external sources, while 32.0% of accepted referrals were made internally (Solar Primary mental health care team, Solar General - CAMHS team and Solar Eating disorders team).
- Of the accepted referrals made by external agencies, 44.2% came from urgent and emergency departments such as hospital-based paediatrics units (21.7%) and A&E departments (22.4%), while 7.69% came from other health care providers such as GP surgeries (5.1%) and external CAMHS community services (2.5%). Lastly, 16.0% of referrals came from non-clinical sources, such as education providers (3.8%) and other services/agencies (12.1%)
- For patients who were solely seen by the crisis team, coming directly from external agencies, 47.3% were directly and fully discharged from the 0-19 service, while 17.8% went on to receive joint care from the crisis team and other teams within the service (6.2% with Solar Primary Care; 11.5% with General), and 34.7% were transferred fully to other teams (23.1% for Solar Primary Care; 11.5% for General).
- As can be seen from figure 54, GP referrals to the crisis team had the highest rejection rate (46.6%), followed by school referrals (33.3%).
- The lowest rejection rate was for external CAMHS community services (0%), followed by Hospital-based paediatrics (5.5%).

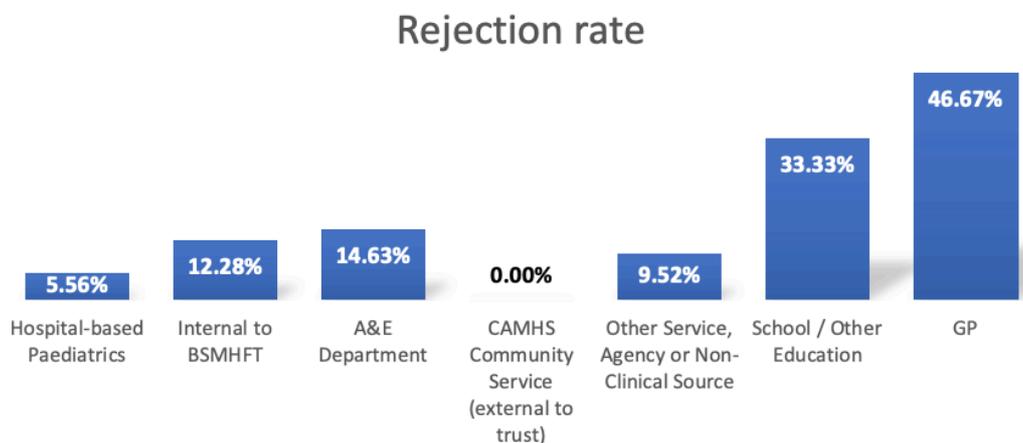
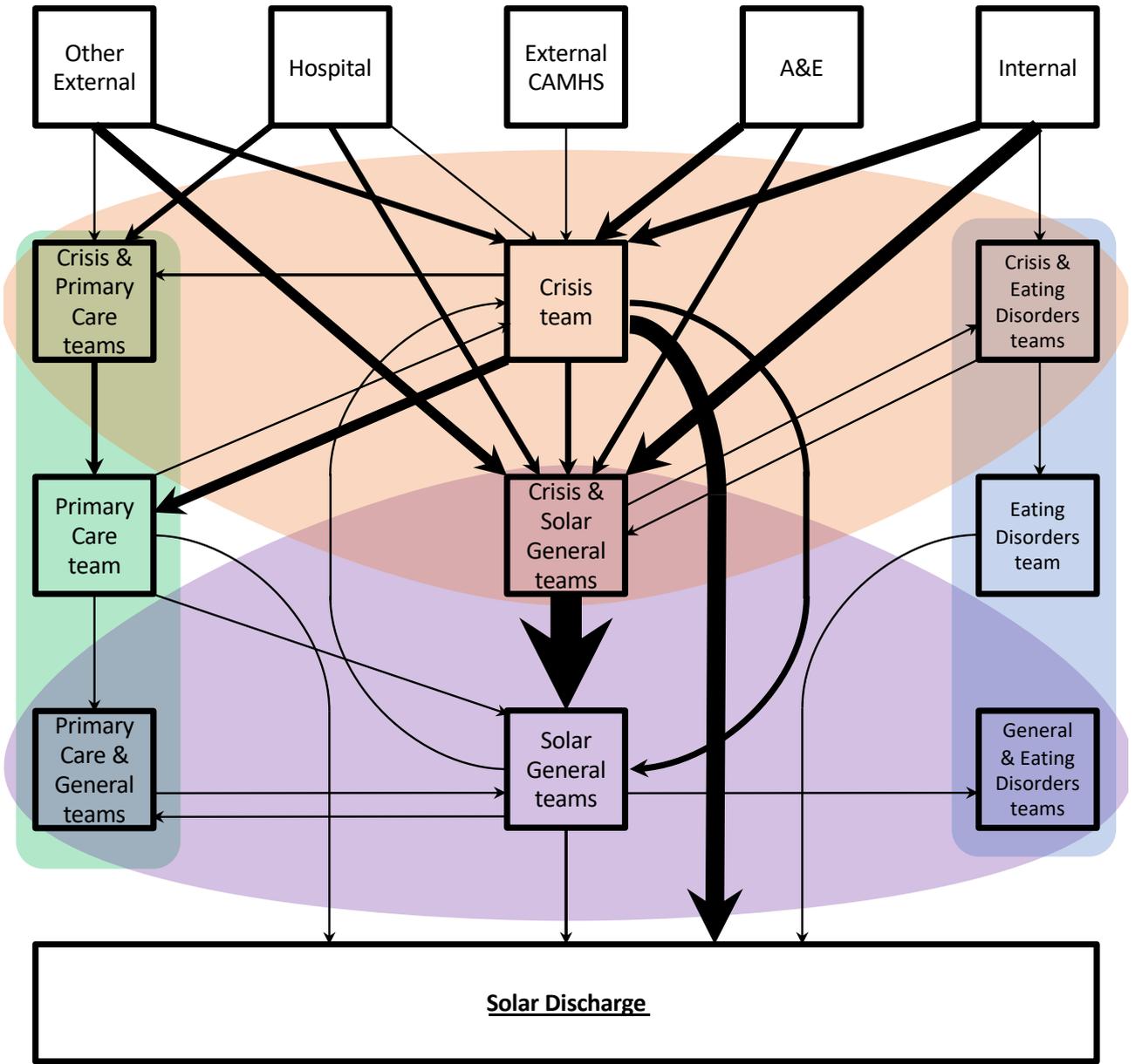


Fig 54. Rejection rates for CYP referrals to the crisis service according to the sources of referral



Number of CYP in Pathways



Fig 55. Referral pathways to and out of the crisis service (Orange - crisis only)

8.5.2.1 What are the pathways to crisis care and patients flows?

All patient crises care pathways in figure 55 were divided into four subtypes (Table 62 and 63):

Table 61 - Examples of four identified crisis subtypes of crisis pathway

NAME OF PATHWAY	EXAMPLE
Direct	Referral – Crisis – Discharge
Gradual	Referral – Crisis – Solar Primary care – Discharge
Long	Referral – Crisis – Crisis and Solar General – Solar General - Discharge
Inpatient	Referral – Crisis – Inpatient (Crisis)

Table 62 - Description of all subtypes of crisis care pathways in figure 55

Pathway	Description of sub-pathway
Direct	Direct is the simplest pathway where CYPs are referred to the crisis team, seen by (and only by) the crisis team for short intervention after which they are fully discharged from the crisis team, and the overall service. For example, an initial referral was made by an educational provider to the crisis team. CYP are accepted by the crisis team and provided with the crisis intervention and treatment, after which CYP are fully discharged from the crisis team and the overall Solar service. This pathway is the most effective one, as CYP receive the help they need, and as soon as they are recovered, they move entirely out of the model. Prospective data showed that 47.37% of CYP followed this crisis pathway.
Gradual	This pathway is more complex, where the crisis team is engaged in joint and short-term treatment with another Solar service component. Once CYPs are fully stabilised, they are discharged from the crisis team (but not from the service) and handed to the other component for short treatment, until that component is ready to discharge CYP from the overall service. For example, the initial referral was made by GP to the crisis team. CYP are accepted by the crisis team and stabilised. However, the crisis team identified additional CYP mental health needs that needed to be met (e.g. anxiety or low-mood) and CYP was handed (discharged) to Solar Primary care team to deliver low-intensity or group treatment, after which CYP was fully discharged from the overall Solar service. The pathway is short in its duration, and the flow of CYP within the pathway is uninterrupted. Prospective data showed that 17.89% of CYP followed this pathway.
Long	The pathway is mostly evident in CYP cases with more complex mental health needs. The referral starts with the crisis team that stabilises CYP so that other parts of the system can help with interventions (the need for parallel psychiatric assessments, medications or being seen by clinical psychologists). Crisis intervention continues to deliver treatment in parallel with other CAMHS treatment until CYPs are gradually handed over to CAMHS. For example, an inpatient unit discharged a patient to the crisis team that has very complex

	<p>mental health needs. The crisis team initially takes over and conducts risk assessments. However, as a patient requires additional multidisciplinary care (e.g. psychiatrist or clinical psychologist), the crisis team delivers care in cooperation with other mental health professionals to ensure that a patient is stable enough to be handed gradually to the CAMHS team for long-term support. Once a patient is transferred to the CAMHS team, a patient remains in the model, and it is not discharged from the Solar team.</p> <p>Despite the rapid flow of CYP from the crisis team to other parts of the system, this pathway is the longest and one of the most prevalent in prospective tracked data of the crisis CYP movements through Solar crisis service. Patients are being discharged from the crisis service but not from the model and referred to other parts of the system for further treatment. However, once CYP are referred to the other parts of the system, due to long waiting times for treatment or because CYP may experience a relapse with their mental health crisis, which will put them back under the care of the crisis intervention teams. This crisis pathway is not short, and the flow of CYP is interrupted within the pathway due to waiting times for the CAMHS treatment. However, it is evident from this pathway that the most apparent bottleneck in the crisis pathway is Solar General (CAMHS), as most of the CYPs are stuck in the CAMHS segment of the Solar model, while only a small portion of CYP moves to other services (Solar Primary care or Eating disorders or back to the crisis team) or progressing to full discharge from the Solar service. Prospective data showed that and 34.74% of CYP followed this crisis pathway.</p>
<p>Inpatient</p>	<p>Inpatient crisis pathway is not present (drawn) in this diagram (as it is external to the Solar model), as very few service users are kept in an inpatient setting for extended periods. However, the crisis team still have an obligation to check these service users weekly and to report on their progress. For example, a patient sanctioned in secure inpatient unit due to being at risk for their safety or safety of others still receives weekly check-ups by the crisis team, until the point when the crisis team can fully take over their treatment.</p>

8.5.4 CYP (Patient) flow through the crisis service

In order to fully understand crisis service users' journeys through the Solar model, it is important to visualise their flows (Kaushal et al., 2017) from the point of referral to the crisis service, their acceptance and their discharge or handover to another component of the Solar model. The Sankey diagram is therefore a useful tool to quickly identified major flow elements in complex interconnected systems (Basole et al., 2015). As the crisis component is part of the larger interconnected system within the Solar model, this study used the Sankey diagram to fully understand the patients flow between these interconnected elements of the Solar model.

Figure 56 is a Sankey diagram of the crisis service users flow for the period between 1st of May and 31st of December 2019. All CYP referred to the crisis service makeup 100% of referrals (n=183). The reason why there is difference between the total number of CYP in the pathway (n=180) and the Sankey diagram (n=183) is due to one CYP crisis case that had four referrals made to the crisis team on the same day. In the pathway, these referrals were merged into a single referral under “external”. However, in the Sankey diagram, they were separated and fully displayed to understand where these referrals came from. Out of all referrals, most came from within the Solar service (31.14%), followed by A&E (22.40%) and hospital-based referrals (19.67%). The smallest number of referrals was from external CAMHS services (2.1%) and education providers (4.91%). Once the crisis team assessed referrals, 85.24% of CYP were accepted by the crisis team for further crisis support and treatment. Only 14.75% of CYP did not meet criteria for being accepted by the crisis team or were considered unsuitable for the crisis treatment and were therefore redirected from the crisis service to other parts of the Solar model or were fully discharged from the service.

For all CYP successfully accepted by the crisis team, 35.2% of CYP were fully discharged from the Solar service after they had completed their treatment with the crisis team. On the other hand, 60.2% of CYP received joint care between the crisis team and other parts of the 0-19 model or were transferred to other parts of the model once they had completed their crisis treatment. For all CYP that were transferred after their discharge from the crisis team to other parts of the 0-19 model, 76.6% of CYP ended up in the Solar General team for further treatment. On the other hand, 23.4% of CYP were transferred from the crisis team to the Solar Primary Care team for further support post-crisis discharge. Crisis patient flow data support the previous referral pathway diagram, showing that ‘direct’ crisis pathway is effective and that CYP are moving quickly through the crisis pathway, depending on complexities of their mental health needs. Similarly, as seen in the previous diagram, the crisis pathway is less effective when it is complex and long, such as in cases when there are more CYP with complex needs. Also, it is evident from figures 55 and 56 that Solar General (CAMHS) is a bottleneck as a significant proportion of CYP who were discharged from the crisis service were either receiving or waiting for further treatment from the Solar General (CAMHS) team at the end of the study period.

However, the crisis team rejected a small number (n=27) of CYP. Out of these 27 cases, the Crisis team assessed 10 CYP as “not in a crisis” and subsequently signposted them to other parts of the model (2CYP to Solar Primary Care team, 7 to CAMHS team and 1 to Eating disorder team). Also, it is evident that a small number of CYP were suitable for crisis intervention (n=7), yet these service users refused help from the crisis team due to unknown reasons. Besides, very small numbers of CYP were discharged from the crisis team due to DNA (n=3) for crisis assessment. In contrast, seven CYP were discharged from the model entirely due to “not meeting acceptance criteria” for both crisis service and/or the Solar service.

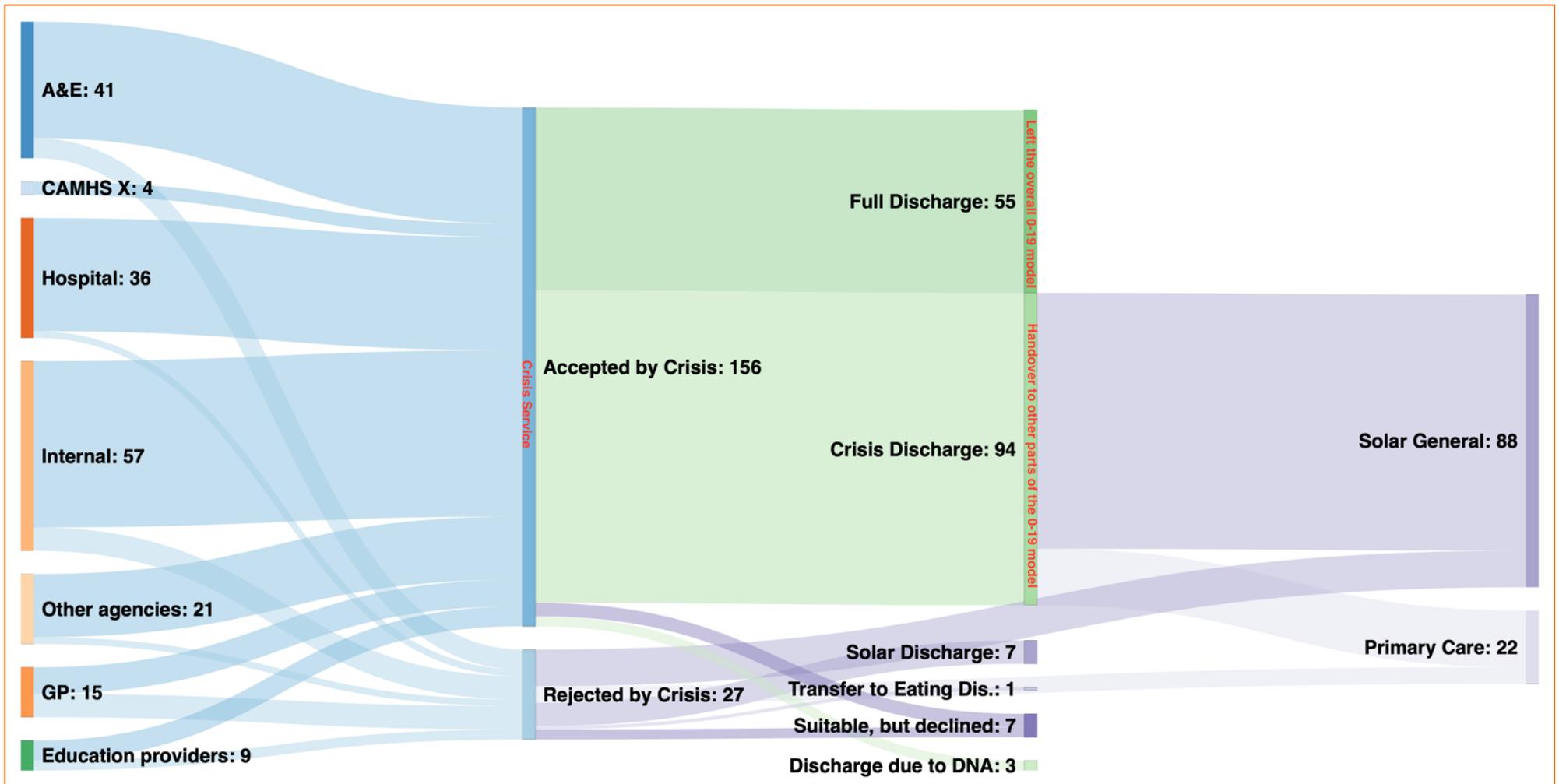


Fig 56. Sankey diagram of the crisis service patients flows

8.5.5 Is the crisis service transforming recovery and resilience such that further use of the crisis services is reduced?

8.5.5.1 Readmission to crisis

Initially, this study investigated the overall sample readmission rates (month 1 to month 7) on a total of 179 observation. It is important to note that for longer observational periods (0-210), patients sample sizes were much smaller. Therefore, these results (Figure 57) should be interpreted with caution. From the visual inspection of crude readmission data in figure 57 (and table 64), it can be seen that 30.3% of the sample (not taking into account gender differences) were re-admitted (i.e. reaccepted) back to the crisis service within the first six months

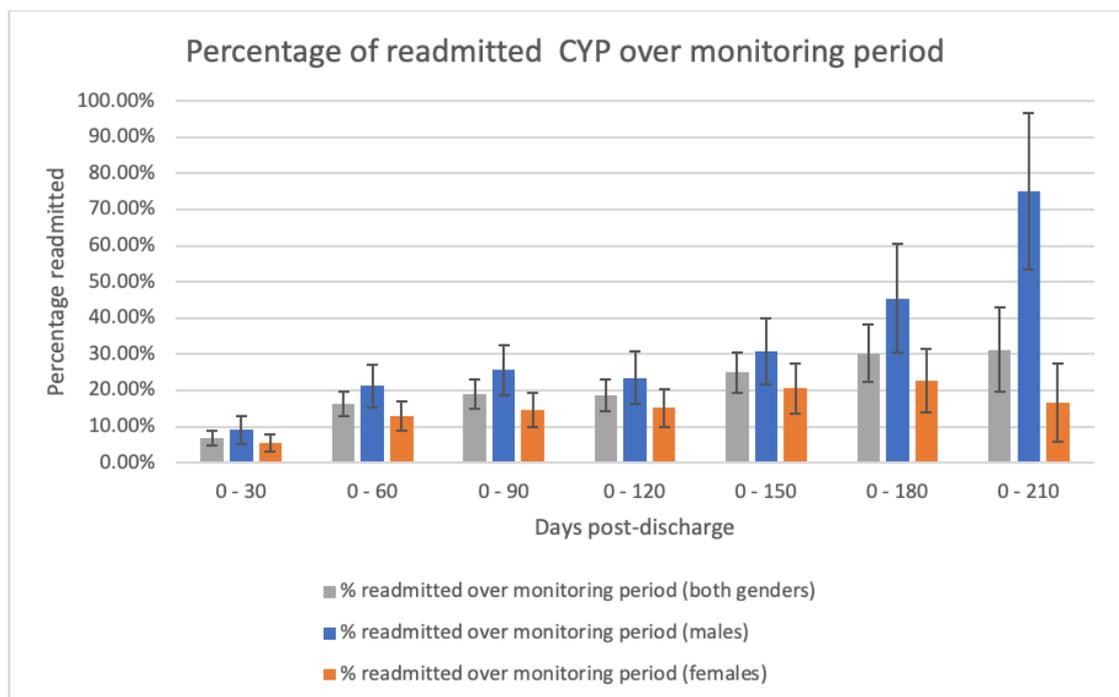


Fig 57. Percentages of readmitted CYP over the monitoring period.

Table 63 - Percentage of readmitted CYP service users over the observed study period

Gender	Discharge period	Number of CYP discharged	Post-discharge follow-up period (days)	Percentage readmitted during follow up period	Standard error of the percentage readmitted
All	01/05/19 - 30/11/19	146	0 - 30	6.8%	2.1%
	01/05/19 - 31/10/19	117	0 - 60	16.2%	3.4%
	01/05/19 - 30/09/19	94	0 - 90	19.1%	4.1%
	01/05/19 - 31/08/19	80	0 - 120	18.8%	4.4%
	01/05/19 - 31/07/19	60	0 - 150	25.0%	5.6%
	01/05/19 - 30/06/19	33	0 - 180	30.3%	8.0%
	01/05/19 - 31/05/19	16	0 - 210	31.3%	11.6%
Male	01/05/19 - 30/11/19	55	0 - 30	9.1%	3.9%
	01/05/19 - 31/10/19	47	0 - 60	21.3%	6.0%
	01/05/19 - 30/09/19	39	0 - 90	25.6%	7.0%
	01/05/19 - 31/08/19	34	0 - 120	23.5%	7.3%
	01/05/19 - 31/07/19	26	0 - 150	30.8%	9.1%
	01/05/19 - 30/06/19	11	0 - 180	45.5%	15.0%
	01/05/19 - 31/05/19	4	0 - 210	75.0%	21.7%
Female	01/05/19 - 30/11/19	91	0 - 30	5.5%	2.4%
	01/05/19 - 31/10/19	70	0 - 60	12.9%	4.0%
	01/05/19 - 30/09/19	55	0 - 90	14.5%	4.8%
	01/05/19 - 31/08/19	46	0 - 120	15.2%	5.3%
	01/05/19 - 31/07/19	34	0 - 150	20.6%	6.9%
	01/05/19 - 30/06/19	22	0 - 180	22.7%	8.9%
	01/05/19 - 31/05/19	12	0 - 210	16.7%	10.8%

For the prospective data, it can be seen that the average duration of the crisis care for CYP readmitted back to the crisis was 19.04 days, compared to 16.25 for those without relapse (Table 65). Females had a higher average length of stay (20.27) compared to males (16.6) (Table 65 and figure 58).

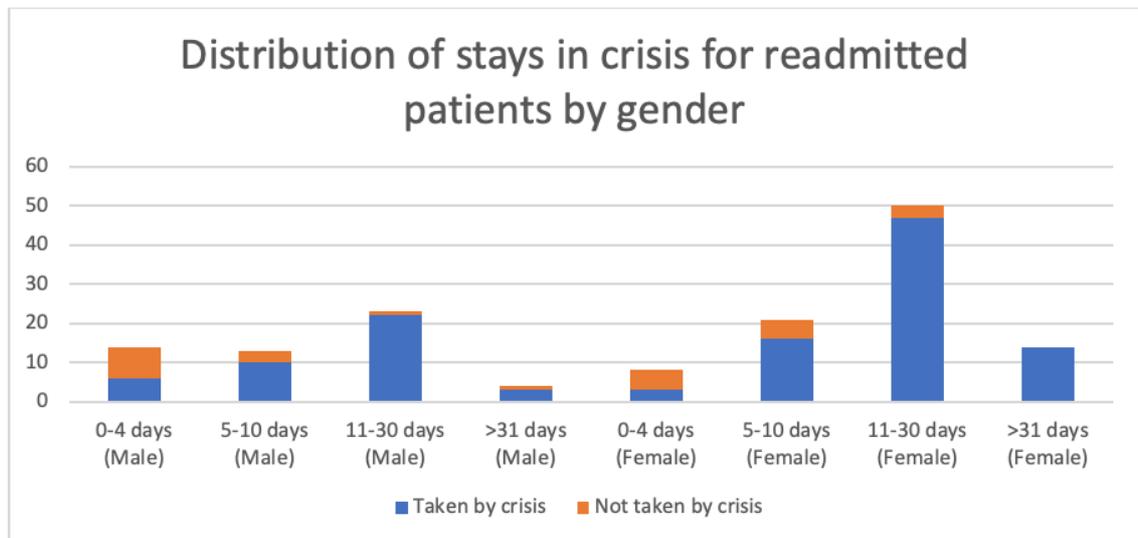


Fig 58. Distribution of stays in crisis care for CYP readmitted back to the crisis treatment

Table 64 - Duration of the crisis care for CYP refused by crisis team and readmitted back to the crisis team

The DoC for accepted by Crisis (Readmitted)	19.04
The DoC for refused by Crisis	6.8
The DoC for Males taken on Crisis (Readmitted)	16.6
The DoC for Males refused by Crisis	5.38
The DoC for Females taken on Crisis (Readmitted)	20.27
The DoC for Females refused by Crisis	8.23

8.5.5.2 Survival analysis of the overall sample

The goal of Kaplan-Meier survival analysis is to estimate the survival of the population over time by generating a survival curve from the sample data. This method of statistical analysis and its treatment of survival times allows proper allowances for those observations that are censored (i.e. left the study or dropped out) while making the most of the available data from these patients up to the time they left the study (Goel et al., 2010). Thus, Kaplan-Meier survival analysis is appropriate to be applied to this study since discharged CYP were monitored for readmission from the point of discharge until the end of the study period. This therefore resulted in different follow-up monitoring periods for each individual, which could be accounted for through data censoring.

Survival analysis of all patients' data (relapse vs non-relapse) obtain during the observation period

A Kaplan-Meier survival analysis was conducted on the overall sample (n=176) observed between the period of 1st of May 2019 and 3rd of January 2020. A small number of service users' records (n=3) were excluded as their discharge date fell after the observed period.

From visual observation, it would appear that that relapse rates may be higher in the 30-60-day period post-discharge, due to the steep negative gradient of the survival function over this period (figure 59). Visual inspection suggests that the total survival rate over the observed period was approximately 75% (i.e. 25% relapsed).

However, the survival analysis did not provide a mean time to relapse, as not enough service users relapsed in the observed period. The median time for relapse was not displayed (computed) as the survival curve did not drop to 0.5 or below.

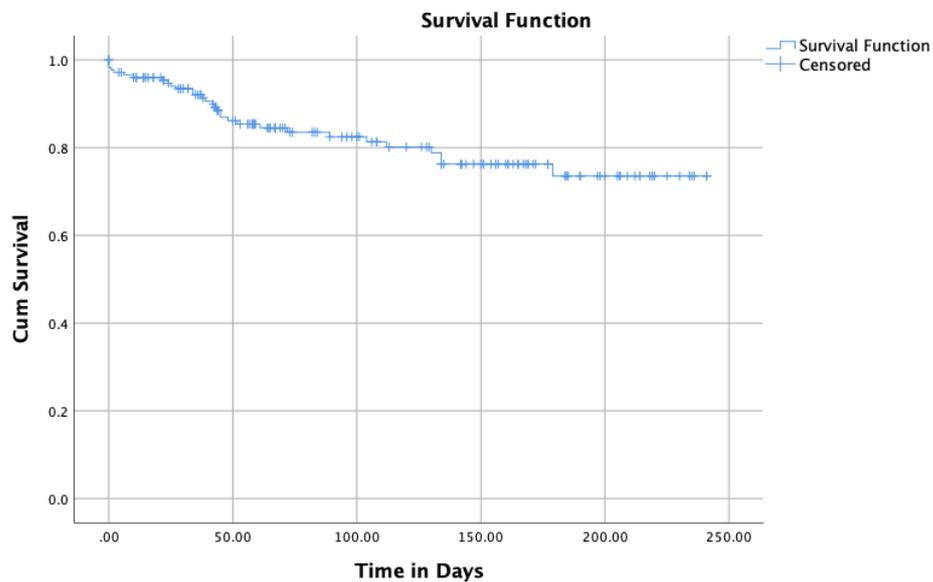


Fig 59. Survival function of crisis discharged service users.

8.5.5.3 Examination of predictors of the crisis readmission using survival analysis

Predictor 1 – Gender

31 participants experienced crisis relapse and were readmitted back to the crisis service (48.3% male and 51.6% female) by the end of the study period.

From visual inspection it appeared that males seem to more likely to relapse (i.e. readmitted) within all observed time periods, compared to females, especially within the first 50 days (Figure 60). However, the survival analysis test did not provide a significant mean value, i.e. there was no significant difference in the likelihood of not being readmitted between genders. For both genders the log-rank test yield a p-value of 0.194 confirming that result was insignificant. The median time for readmission was not displayed (computed) as the survival curve did not drop to 0.5 or below.

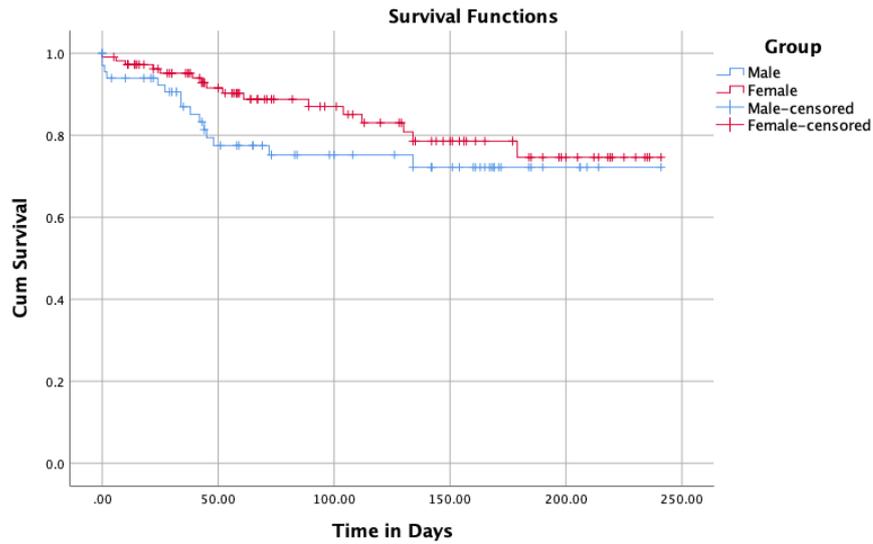


Fig 60. Survival function of crisis discharged service users by gender.

Predictor 2 – Age

From visual inspection of figure 61, it appears that the highest readmission rates were for 16+ group (n=12), followed by 13-year-olds or younger (n=9). The lowest number of readmissions were evident for 14-15-year-olds group (n=10). The survival analysis test did not provide significant mean value, i.e. there was no significant difference between groups. For all three groups, the log-rank test yields a p-value of 0.716, confirming that result was insignificant.

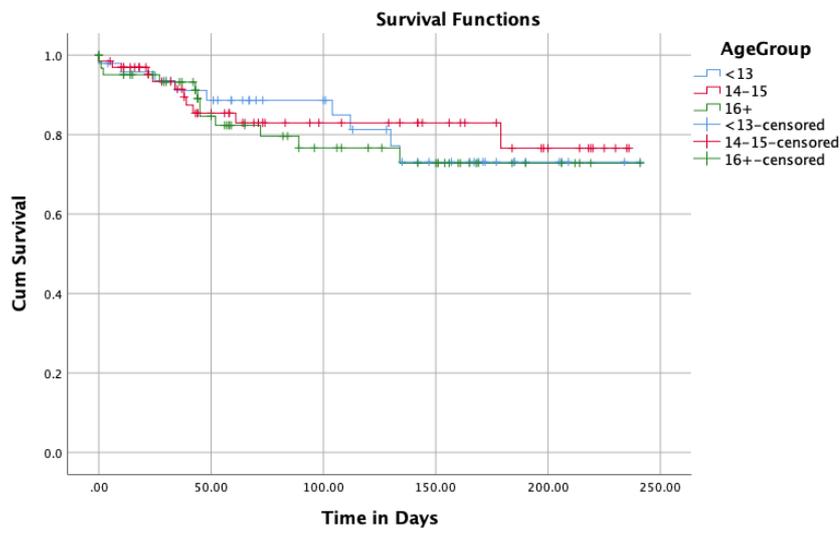


Fig 61. Survival function of crisis discharged service users by age group

Predictor 3 – Source of referral

From visual inspection regarding sources of referral (Figure 62), the largest readmission rates were evident for internal referrals 35.2% (n=9), followed by hospital paediatric referrals 19.3% (n=6) and other agencies 19.3% (n=6). The lowest number of CYP readmissions were evident for referrals made by A&E 12.9% (n=4), while education providers, external CAMHS providers and inpatient units had each only one patient relapsed (3.2%) and readmitted back to the crisis service.

The output of survival analysis of readmission rates according to different sources of referral (predictor) showed that out of 176 CYP, 31 CYP were relapsed and readmitted in the observed period. No formal statistic was computed, as all cases were censored. Overall comparison (Log Rank test) showed non-significant result [$\chi^2(1) = 0.478$, $p < 0.489$].

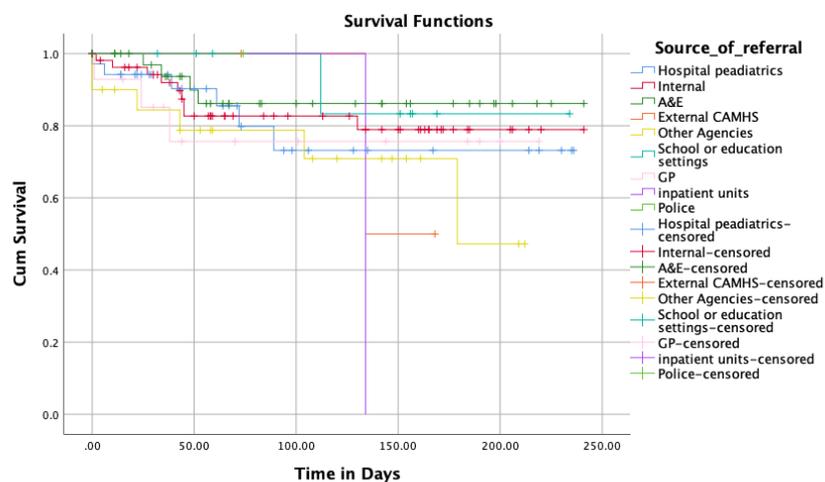


Fig 62. Survival function of crisis discharged service users by the source of referral.

Predictor 4 – Previous attendance to the Solar service

The output of survival analysis of readmission rates according to whether CYP previously attended the Solar service showed that out of 176 CYP, 128 CYP were not previously reattended the Solar service. Out of these 128 observed cases, 77.4% of CYP experienced readmission (n=24). However, 36 CYP in the observed period were

previously known to Solar and were readmitted back into the service within the last 12 months. Out of these 36 observations, 16.1% of CYP experienced readmission (n=5). Lastly, a small number (n=12) of CYP were classified as reattenders who were previously accepted to the Solar more than 12 months ago. Of these 12 CYP, only 6.4% experienced relapse (n=2) and subsequent readmission.

Visual inspection of figure 63 suggests that within the first 60 days, the largest group of CYP who were non-reattenders are more likely to relapse and be readmitted back to the crisis service. However, the survival analysis test did not provide significant mean value, i.e. there was no significant difference between groups. For all three groups, the log-rank test yields a p-value of 0.597, confirming that result was insignificant. The median time for relapse was not displayed (computed) as the survival curve did not drop to 0.5 or below.

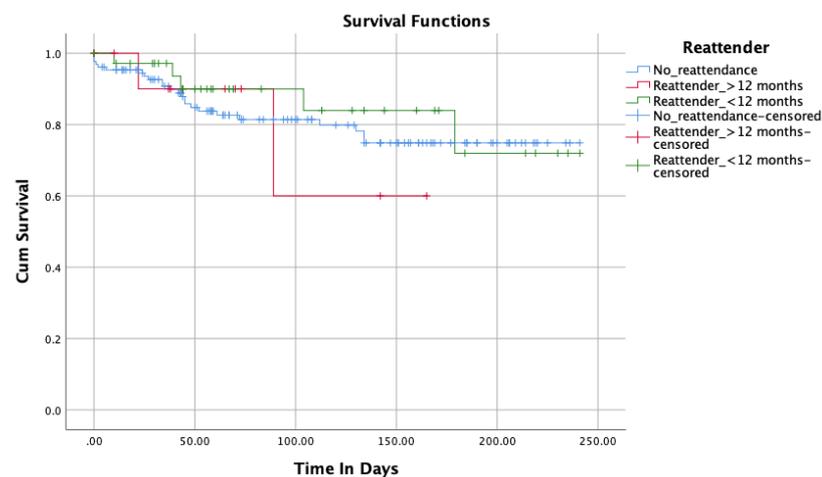


Fig 63. Survival function of crisis discharged service users by their reattendance.

Predictor 5 – Previously known to the Solar service

The output of survival analysis of readmission rates according to whether CYP are known to the Solar service showed that out of 176 CYP, 40 CYP were unknown to the Solar service (i.e. first-time admissions). Out of these 40 observed cases, 22.5% of CYP experienced readmission (n=7). However, 99 CYP in the observed period were known to Solar and still had open access for re-acceptance back into the service. Out of these

99 observations, 67.7.1% of CYP experienced relapse (n=21). Lastly, a small number (n=37) of CYP were classified as known to Solar but fully discharged from the service. Of these 37 CYP, only 9.6% experienced relapse (n=3) and subsequent readmission.

Visual inspection of figure 64 suggested that within the first 50 days, the largest group of CYP who were classified as known to Solar and still open for re-acceptance are more likely to be readmitted back to the crisis service.

The survival analysis test did not provide significant mean value, i.e. there was no significant difference between groups. For all three groups, the log-rank test yields a p-value of 0.368, confirming that result was insignificant. The median time for readmission was not displayed (computed) as the survival curve did not drop to 0.5 or below.

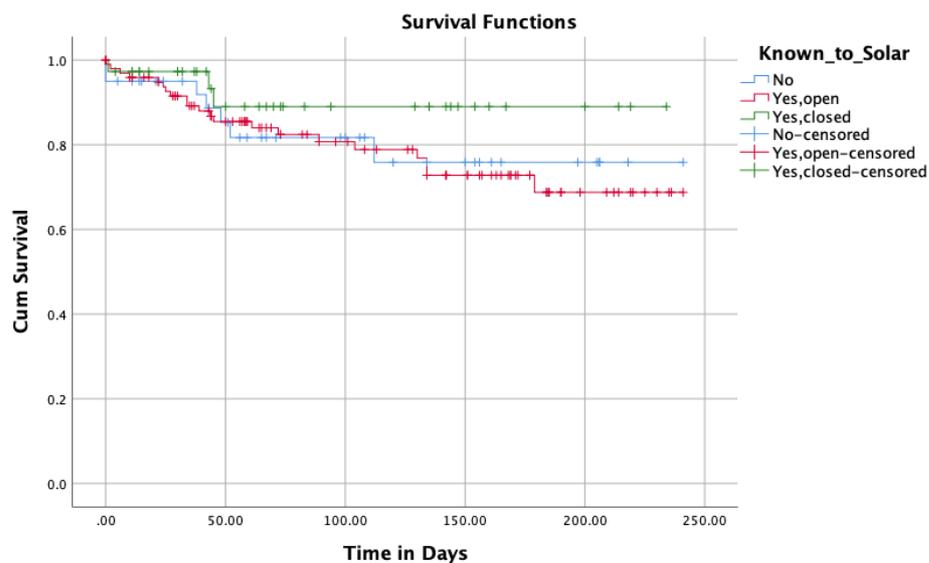


Fig 64. Survival function of crisis discharged service users by the CYP known status.

Predictor 6 – Reason for referral

Visual inspection of figure 65 suggested that that the total survival rate for deliberate self-harm is approximately 59% (41% relapse). Also, the survival rate for the family or situation crisis is approximately 37% (63% of relapse).

Case processing summary table showed that most readmissions occurred for deliberate self-harm, followed by suicide ideation (n=9) and family or situational crisis (n=3). No formal statistic was computed as all cases were censored. Overall comparison (Log Rank test) showed borderline non-significant result [$\chi^2(8) = 14.8688$, $p < 0.0062$]. In the following section, the predictors were further examined together by using the survival analysis and Cox Hazard function to examine if there was a signal regarding which factors contributed to CYP crisis readmission back to the crisis service.

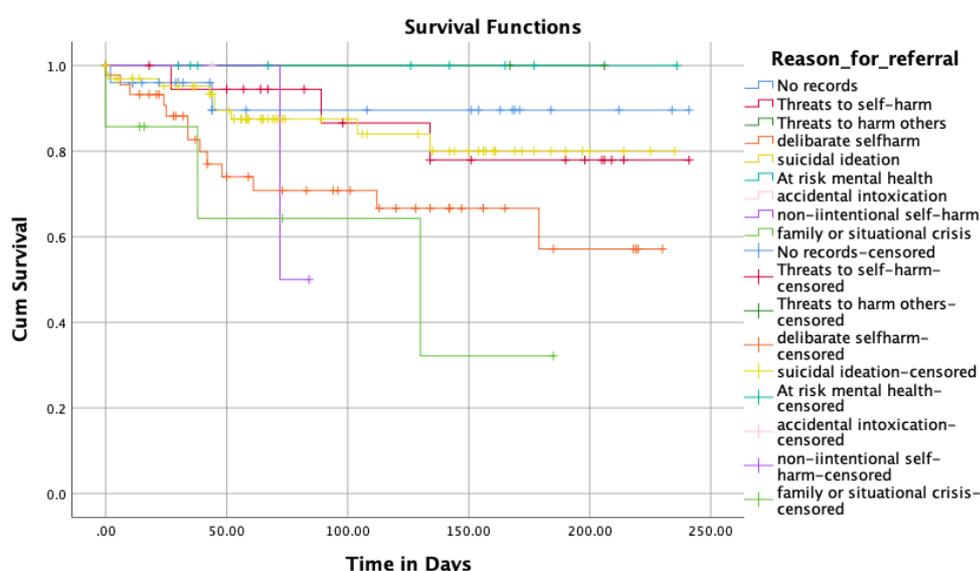


Fig 65. Survival function of crisis discharged service users by the CYP reason for referral.

8.5.5.4 Investigation of predictors of readmission using Cox Hazard function

The Cox Hazard function is a regression model for survival data. The main rationale behind the use of the Cox Hazard function was to simultaneously evaluate the effect of several factors (predictors) on readmission. In other words, the Cox Hazard function allowed this study to examine how specified predictors influence the risk of readmission. In the literature, the Cox hazard function model is preferred over the logistic model, as the Cox hazard model does account for survival time and censored information, while the logistic model does not (Singh & Mukhopadhyay, 2011).

Since Cox Hazard function allows only numerical (continuous) data, all categorical (nominal) variables were retransformed into binary variables for each category within each nominal variable. For example, Reattender variable that contained three nominal categories was retransformed into binary form (reattender [1] vs non-reattender [0]). However, only one predictor (Age group) has not been retransformed, as age group predictor is ordinal data that is supported by the Cox Hazard analysis.

Predictors of readmission (Variables: Age, Gender, Sources of referral and Reason for referral, and Known to Solar)

The likelihood ratio test of the fit of the full model relative to a null model showed borderline non-statistical significance between the number of CYPs status (no relapse vs relapse) and predictor variables (Age, Gender, Sources of referral, Reason for referral and Known to Solar). The result of this test (Table 66) suggests that this model is borderline significant [$\chi^2(19) = 30.092, p < 0.051$] improvement in fit relative to the null. In other words, there is a borderline significant difference between different predictors of readmission.

Table 65 - Test of fitness of the model

Omnibus Tests of Model Coefficients ^a									
-2 Log Likelihood	Overall (score)			Change From Previous Step			Change From Previous Block		
	Chi-square	df	Sig.	Chi-square	df	Sig.	Chi-square	df	Sig.
263.005	27.426	19	.095	30.092	19	.051	30.092	19	.051

a. Beginning Block Number 1. Method = Enter

Variables in the Equation

The regression coefficients predict the hazard for a terminal event as a function of the covariates in the model. A positive coefficient indicates a positive relationship between the covariate and the hazard for the terminal event (i.e. readmission). The higher values on the covariate are associated with less survival time (until the terminal event). A negative coefficient indicates a negative relationship between the covariate and the hazard (i.e. relapse and readmission) for the terminal event. Higher values on the covariate are associated with longer survival time (i.e. non-relapse).

From visual inspection of figure 66, it can be seen that male service users have a higher risk of readmission back to the crisis service within the first 140 days since discharge, compared to female service users according to gender, age, source of referral and reason for referral predictors or relapse.

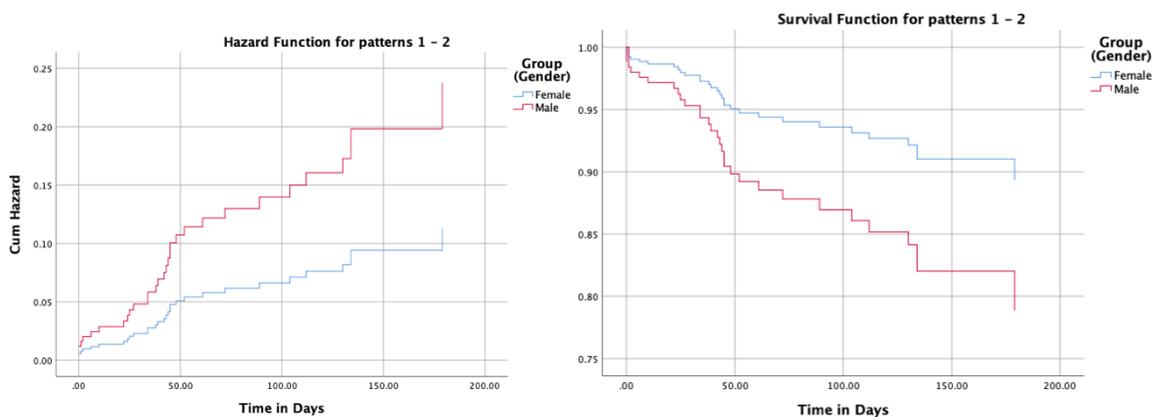


Fig 66. Cox Hazard Rate visual inspection of crisis readmission according to predictors.

However, in table 67, the group variable was coded as 0=males and 1=females. The non-significant negative coefficient ($b=-.773$) indicate that the higher risk of readmission back to the crisis service have males, compared to female service users. However, as this test produced borderline non-significant result ($SE=.398$, $p=.051$), it can be concluded that there is **no difference in the readmission rates between** male and female service users (i.e. non-relapse is greater). However, as the value is close to 5% level of significance, it is feasible to speculate that the hazard rate for crisis

readmission might be greater in males, as opposed to the females' service users, similar as seen from visual inspection from figure 66.

From table 67, it can also be seen that both reasons for referral due to deliberate self-harm and family or situational crisis are greater than one. The Hazard ratio for readmission was 4.89 times higher for service users who had originally been referred due to deliberate self-harm than those referred for other reasons. On the other hand, the Hazard ratio for readmission was 11.59 times higher for individuals who had initially been referred to due to family or situational crisis.

Furthermore, the covariate "Reason for referral deliberate self-harm" was coded as 0= no-deliberate self-harm and 1= deliberate self-harm. The significant positive coefficient ($b= 1.575$, $SE=0.800$, $p=.049$) indicates that the hazard rate for crisis readmission is greater for deliberate self-harm (i.e. readmission rate is greater). Likewise, in case of the covariate "Reason for referral family or situational crisis", the binary code was coded so that 0=no family or situational crisis, while one represented (1= family or situational crisis) presence of family or situational crisis. The significant positive coefficient ($b= 2.451$, $SE=0.947$, $p=.012$) indicates that the hazard rate for the risk of readmission is greater for family or situational crisis compared to no presence of family or situational crisis. This result is logical, as CYP who are affected by family or situational crisis do not have control over their environment and despite crisis intervention delivered, due to re-exposure to the original environment that precipitated crisis event these CYP may easily experience relapse and readmitted to the crisis service. For example, if a CYP experienced a mental health crisis due to family abuse, the crisis team can help CYP to stabilize their crisis. However, the return of a CYP to their home environment without removing the cause of crisis (e.g. family abuse) may precipitate them to re-experience a mental health crisis soon after discharge. Therefore, all CYP who are classified as being in crisis due to family or situational crisis should receive longer and continuous crisis support, period checks post-discharge and family therapy.

Furthermore, the Exp(B) column is the hazard ratio and reflects the multiplicative change in the hazard for the terminal event per unit increases on a predictor. A hazard ratio of 1 indicates that predictor does not affect the risk of readmission. Hazard ratios above 1 indicate that predictor increases the risk of readmission, while below one indicates that predictor decreases the risk of readmission.

Table 66 - Cox Hazard Rate of predictors for readmission to the crisis service.

	Variables in the Equation						95.0% CI for Exp(B)	
	B	SE	Wald	df	Sig.	Exp(B)	Lower	Upper
Gender	-.773	.398	3.767	1	.052	.462	.212	1.008
Age1	.065	.103	.396	1	.529	1.067	.872	1.305
Reason_for_referral_suicide_vs_non_suicide	.992	.795	1.559	1	.212	2.697	.568	12.797
Reason_for_referral_self_harm	.056	1.015	.003	1	.956	1.057	.145	7.725
Reason_for_referral_harm_to_others	-3.492	12.878	.074	1	.786	.030	.000	2.790E+9
Reason_for_referral_deliberate_self_harm	1.575	.800	3.872	1	.049	4.829	1.006	23.173
Reason_for_referral_at_risk_mental_state	-3.654	6.739	.294	1	.588	.026	.000	14104.585
Reason_for_referral_Accidental_intox	-3.655	14.616	.063	1	.803	.026	.000	7.146E+10
Reason_for_referral_non_intentional_selfharm	1.590	1.273	1.560	1	.212	4.905	.404	59.495
Reason_for_referral_family_or_situational_crisis	2.451	.974	6.332	1	.012	11.595	1.719	78.203
Source_of_referral_GP	-.191	24.989	.000	1	.994	.826	.000	1.540E+21
Source_of_referral_Hospital_based	-24.233	122.457	.039	1	.843	.000	.000	5.143E+93
Source_of_referral_Internal_to_Solar	4.338	24.491	.031	1	.859	76.533	.000	5.379E+22
Source_of_referral_AandE	3.997	24.492	.027	1	.870	54.411	.000	3.829E+22
Source_of_referral_CAM_HS_community_EX	4.162	24.510	.029	1	.865	64.197	.000	4.683E+22
Source_of_referral_Other_Agencies	4.620	24.494	.036	1	.850	101.477	.000	7.166E+22
Source_of_referral_Education_settings	3.871	24.507	.025	1	.874	47.988	.000	3.478E+22
Source_of_referral_CAM_HS_inpatient	6.585	24.521	.072	1	.788	724.137	.000	5.394E+23
Source_of_referral_Police			.	0 ^a	.			
Known_to_Solar	.096	.463	.043	1	.835	1.101	.445	2.726

a. Degree of freedom reduced because of constant or linearly dependent covariates

8.5.6 Is 0-19 crisis model effective in reducing A&E and acute admission?

Due to the lack of quantitative data from A&E and hospitals regarding their crisis admission rates, we were unable to answer this research question fully. However, it can be inferred from the previous number of referrals from these urgent and emergency settings that A&E (n=41) and hospitals (n=36,) referrals from these settings are among the highest number of referrals to the crisis service, after referrals from within the Solar service to Solar crisis team. Therefore, it can be concluded that the 0-19 crisis service is, to a degree, effective in reducing the number of admissions to urgent and emergency settings, by diverting CYPs to community-based treatments and reducing their length of hospital stays. However, these referral numbers also show that the 0-19 crisis service is not effective at preventing these urgent and emergency admissions in the first place and preventing CYP from entering urgent and emergency settings to seek help.

8.6 Discussion

The overall aim of this study was to prospectively investigate the extent to which the 0-19 crisis service was accessible and effective. Specifically, this study examined: (1) the effectiveness of the crisis pathways and patients flows from the referral point of the crisis service to the exit point from the crisis service and beyond, (2) the effect and impact of crisis service on the reduction of A&E and acute admission, and (3) the success of the transformation of recovery and resilience (i.e. the prevention of relapse). However, due to large data gaps, and a lack of the administration of outcome measures, it is difficult to draw a definite conclusion as to how effective the 0-19 crisis service is, but the present findings do provide some indicative findings. They rely on prospective cohort data and do not provide comparative data, e.g. from a trial. In this regard, it is important to point out that there is very little (if any) published quantitative research evidence regarding CYP crisis resolution and home treatment in the UK and around the world. This evident lack (i.e. paucity) of comparative published work has also been reported in another study (Titheradge & Galea, 2019), which

prevents and restricts discussion of these findings with broader literature. Responses to the outlined research questions are provided below.

8.6.1 How effective is the 0-19 crisis pathway to admission for CYP?

Given the data obtained through the pathway analysis, it can be understood that the most effective simple pathway to the crisis is the direct one. In this direct pathway, the service users are only in contact with the crisis service, and once they have been stabilised, they often leave the overall Solar service. For this particular pathway, the crisis service is quite effective as it allows the rapid progression of CYP through the crisis service without any delays. Prospective data clearly showed that a large percentage of CYP (47.3%) followed this pathway.

In contrast, the 'long' pathway was the most problematic one for the crisis service, as once the crisis team discharged CYP, those service users were forced to wait for another part of the Solar system to take them for the further treatment, which may lead to a crisis relapse and a return back to the crisis care. Prospective data showed that 34.7% of CYP entering the crisis service followed this pathway in the Solar service. Similar data were obtained from the Sankey diagram of patient flows, which also supported the direct and straightforward crisis pathway as the most effective. If CYP who followed the direct crisis pathway were to have lower readmission rates, then this could infer that the direct crisis pathway may be more effective. However, this was not investigated as part of this study.

In contrast, the Sankey diagram also showed that longer pathways tend to lead to more delays and waiting, which consequently may lead to increased risk of relapse and readmission back to the crisis service. However, it must be emphasised that this study did not conduct a randomised controlled trial to fully understand pathway effectiveness, and there may be selection effect/biases in comparing these groups or other confounding factors (e.g. effect of comorbidity) that were unaccounted for. However, a future RCT may provide evidence to support this study's findings.

Despite the initial assumption that the largest number of referrals to the crisis service will come from hospitals and A&Es, the pathway analyses have clearly shown that the largest numbers of referrals are not coming externally. Rather, the crisis service seems to accept a large number of internal referrals (from within the Solar service), which also raises the question of how effective the team can be to deal with both large numbers of internal and external referrals at the same time.

Furthermore, both the referral pathway and the Sankey patient flow diagram show a large number of the hospital (n=36) and A&Es (n=41) referrals to the crisis team; out of these referrals, small percentages of CYP were classified as “not-being in crisis” for hospital referrals (5.56%). On the other hand, the largest rejection number was evident for A&Es (14.63%) and Internal (12.28%). Therefore, the question remains why do GP (46.67%) and Education (33.33%) referrals experience a large number of rejections of CYP in crisis? The possible reason for this may be in the referral form, as set out in the responses of local community professional stakeholders in chapter 10. From this information, it can be seen that access to the crisis pathway for CYP is not equal. As is evident from the pathway and Sankey diagram, CYP are more likely to be accepted to the crisis service if they come from urgent and emergency or statutory settings as they are perceived to be more at risk, while those from community-based sources (e.g. GP practices or Schools) are less likely to be perceived as being at risk.

Moreover, it is interesting to compare the duration of stay of CYP in the crisis service with other crisis services within the UK. For example, the mean length of stay of CYP in the 0-19 crisis service was 16.25 days (median of 13 days). The duration of crisis care findings of this study are well aligned with findings of another adult Crisis resolution and home treatment study, which reported shorter than average intervention with a median care episode of 13 days (Titheradge & Galea, 2019). In contrast, the 2017 survey data showed that the adult crisis care episode lasted 21 days (Lloyd-Evans et al., 2018). These deviations from average crisis care administration may allow a crisis service to meet a higher CYP demand for the crisis provision that would otherwise have not been met if a service offered a longer episode of care with the current numbers of available staff (Titheradge & Galea, 2019). However, the

shorter and more intensive crisis intervention approaches have some benefits, such as reduced number of crisis staff involved in CYP care, reduced dissatisfaction of service users and their families with the continuity of provided care, and provision of more targeted intervention that may enable a service to meet more increased demands for the crisis interventions (Titheradge & Galea, 2019).

However, while other crisis services employ a significant number (on average between 20-25) of staff (Lloyd-Evans et al., 2018), the 0-19 crisis team is a small nurse-led team (approximately 10). The small size of the crisis team may explain the rationale for providing more intense CYP crisis interventions. However, the small size of the crisis team can also act as a limitation due to lack of 24/7 crisis care and lack of multidisciplinary expertise within the crisis team (e.g. psychiatrist or psychologist), what can also affect the effectiveness of the crisis service. Thus, a balanced multidisciplinary team has well-established benefits and advantages, as it can offer a wide range of interventions and a more holistic approach, while smaller teams often provide a narrower repertoire of interventions, which may also affect the quality and effectiveness of the care crisis pathway (Lloyd-Evans et al., 2018; Titheradge & Galea, 2019). In addition, the lack of direct telephone lines to the crisis team may also compromise the accessibility of the crisis team by, as demonstrated by the participants' responses in chapter 9, which may also prevent early intervention and prevention of the possible need for hospitalisation or A&E involvement.

8.6.2 Is 0-19 crisis model effective in reducing A&E and acute admission?

What can be seen from the pathway analysis is that second and third most common referrals come from hospital and A&E. However, A&E and Hospital admission data were not collected during this study. Although this was original research questions, this study was unable to source data for hospital or A&E admissions. Therefore, it is difficult to fully understand how effective the crisis team is in reducing these admission rates.

However, it is crucial to point out that the current 0-19 crisis service does not operate 24/7. Lack of 24/7 crisis support may force CYP to seek help from A&Es, as it is well established that most of the crisis presentation to A&Es are made in peak hours between 11 pm and 7 am (NHS Confederation, 2016). However, available research evidence suggests a mean reduction of 10% in hospital admissions in areas where CRTs are implemented and operational, with a possible increase up to 20% in cases if CRTs operate 24/7 (Jacobs & Barrenho, 2011). Lastly, the obvious nine cases of CYP that ended up in A&E despite being referred to the crisis service may also indicate that the crisis service does not entirely prevent A&E admissions.

8.6.3 Is the crisis service transforming recovery and resilience such that further use of the crisis services is reduced?

From CYP follow-up data over the seven months, and their post-discharge and readmission rates, it is evident that up to 30% of CYPs experienced a mental health crisis relapse and subsequent readmission back to the crisis care within the first six months (180 days). However, a third of all CYP treated in the crisis team may experience relapse within the first 12 months from the point of discharge. Most literature shows that more than half of patients admitted to acute mental health care in the UK experienced relapse within the first year since their discharge (Mayor, 2018). Similar conclusions were drawn from another study that retrospectively examined 17,666 adult patient's data record with crisis resolution services over six years (2008-2014) to determine the rate of readmission back to crisis treatment (Werbelloff et al., 2017). Their results showed that 51.3% and 53.9% adult cases relapsed and were readmitted back into crisis services within one year in two regions of London (Tracy, 2017; Werbeloff et al., 2017). However, the findings of this study are difficult to compare directly with the Werbeloff et al., (2017) study.

First and foremost, the sample of this study was comprised of CYP rather than adults. Secondly, the prospective observation of CYP cases in this study only covered a period of seven months compared to one year of retrospective examination used in Werbeloff et al., (2017) study. Thirdly, our sample size was small (n=179) compared

to the adult study (n=17,666). Lastly, this study was conducted in Solihull, while the aforementioned study was in London. However, from figure 57, it can be seen that relapse rates for the 0-19 crisis service stabilise around 30% for readmissions within 180 and 210 days. Therefore, if relapse rates were to remain stable for readmissions up to one-year post-discharge, then this would suggest that the 0-19 crisis service compares favourably to the adult study by Werbeloff et al., (2017). However, it should be emphasised that this would be an extrapolative conclusion. Nevertheless, it is a promising indication that the 0-19 crisis service may be performing well (i.e. effective) in reducing readmission rates in comparison to other service models, especially considering the small size of the nurse-led crisis team (approximately 10).

Moreover, another study that investigated the impact of a peers-support post-discharge programme found that the intervention group experienced readmission (relapse) within the first 112 days post-discharge, compared to control group where relapse occurred within the first 86 days since discharge (Johnson et al., 2018). Similarly, another study found that the majority of psychiatric relapses occurred within the first 90 days from the point of discharge (Blader, 2004a). However, the findings of this study showed that most CYP experienced readmission within the first 180 days.

Regarding the predictors of relapse back into crisis care for CYP, there is limited literature on possible predictors of CYP mental health crisis. However, the findings from this study have shown that one of the most obvious predictors of mental health crisis readmission is a family or situational crisis. Similarly, one study found that family factors and circumstances play a crucial factor in the children's relapse and the need for subsequent readmission into urgent and emergency settings (Blader, 2004a). Besides, dysfunctional family environments and parental factors such as parental stress or attitude and parental practices, may affect the child's post-discharge recovery process and contribute to the subsequent need for seeking help from urgent and emergency settings (Blader, 2004a). It is therefore understandable why a possible predictor of a crisis relapse may be associated with a familial or situational crisis and why this factor poses a significant risk of a crisis relapse and a subsequent need for

reacceptance to a crisis service. Family interventions may, therefore, play a crucial role in preventing crisis relapse and subsequent readmissions.

Furthermore, the crisis services can use the knowledge of predictors of crisis relapse to their advantage. For example, findings from the Blader (2004a) study show that the assessment information at the acceptance stage of referral may provide a useful readmission risk index for CYP. Crisis services can use these reasons for help-seeking as an indicator of the risk for relapse, which in turn can help during the crisis treatment and contribute to the development of more effective post-discharge crisis care plans to reduce the risk of crisis readmission. Also, crisis services should be mindful of potential predictors of crisis readmission and ensure that discharged CYPs are periodically being checked for their progress with their recovery.

However, despite crisis intervention, it is evident that some CYP are readmitted to the crisis service, which often requires relapsed CYP to spend longer periods in subsequent crisis treatment compared to their initial time spent in crisis treatment. These results may indicate that either the crisis team discharges CYP too early before they have fully recovered, the crisis support is not provided long enough, or that there is no available post-discharge crisis support. The guidance for commissioners is clear that short length of stays cannot be an indicator of good quality care provision. On the other hand, they may reflect an inappropriate admission (Joint Commissioning Panel for Mental Health, 2013). In contrast, the long length of stays may indicate service inefficiency (Joint Commissioning Panel for Mental Health, 2013).

8.6.4 Strengths and Limitation

The main strength of this study is that it is the first attempt to evaluate CYP crisis pathways. The researcher has not identified any other studies that specifically investigated the effectiveness of crisis pathways.

However, due to time constraints and the short duration of this PhD, there were some limitations to this study. First and foremost, missing data and a lack of recording of

routine data prevented this study from fully understanding the effectiveness of the model's crisis service.

Second, the lack of standardised outcome measures administered by the crisis team prevented us from understanding the CYP baseline difficulties at the start of treatment, as well as their outcomes at the point of discharge. As a result, this study was unable to evaluate any direct degree of CYP recovery. Similarly, given that the crisis service does not use standardised outcome measures for service user satisfaction, this study was unable to gain any statistical insight into how satisfied CYP were with the care they received. Qualitative interviews with CYP were therefore undertaken to fill this gap.

Third, the eight-month follow-up period of CYP proved to be insufficient to generate more meaningful statistical data, particularly on relapse and readmission rates. Ideally, the prospective study should last for a full year, while relapse monitoring should be extended to an additional four to six months post-discharge to see how many CYP relapsed after one year of observation. However, despite the initial prospective study having been planned to last for a year, the delay in data anonymisation affected the study. It reduced the initial observation period down to eight months.

Finally, it is also important to acknowledge that due to well-recognised variation in the implementation of CRHT models in the UK, the findings of this study are therefore likely to be subject to its local context. There is, therefore, an inevitable need for further studies and larger and longer-term trials with robust designs to investigate and report on the effectiveness of other CYP CRHT service within the UK and worldwide.

8.6.5 Chapter summary

This chapter prospectively investigated the extent to which the 0-19 crisis service was accessible and effective. This study found it difficult to draw a solid conclusion as to how effective the 0-19 crisis service is. The pathway analysis findings and the Sankey diagram of patient flows have shown that the direct crisis pathway is the most effective, while other pathway variations can be compromised by waiting times within the 0-19 model. In addition, these analyses pointed out to a large number of internal referrals to the crisis service that is disproportionate compared to the number of external referrals. In addition, higher relapse rates may indicate that CYP are not receiving longer needed crisis support to gain full recovery, resulting in relapse and readmission back to the crisis service and longer time spent on subsequent crisis treatment. Inspection of readmission rates found a promising indication that the 0-19 crisis service may be effective in reducing readmission rates in comparison to other service models, especially considering the small size of the nurse-led crisis team.

Chapter 9: Staff, CYP and parental perceptions on the accessibility, acceptability and satisfaction with the 0-19 model's crisis component

9.1 Chapter outline

The previous chapter aimed to understand how much the 0-19 crisis service is accessible and effective. In this chapter, a template data analysis approach was used on a range of previously collected qualitative data from the 0-19 model staff, crisis service users, and their parents to explore their perception of the Solar's crisis component. Initially, the main aims and objectives of this research are discussed, followed by a summary of the principal methodology and a presentation of the main findings. Once the main findings have been introduced, the discussion section will compare these findings with other available research evidence in the literature. The main aim of this chapter is to understand the perceptions of stakeholders as to how much accessible and acceptable the 0-19 model's crisis service is. Lastly, it is essential to highlight that this study used previously collected qualitative data from chapter 5 and therefore a detailed description of the study methodology, recruitment methods, summary of all participants and data analysis procedure has already been outlined in chapter 5. All activities in this chapter are aligned with the logic model activity section of chapter 3.

9.2 Study aims

As the 0-19 model's crisis service is unique in the UK, it is crucial to explore the main stakeholders' perceptions regarding their experiences of accessibility, effectiveness and acceptability of the crisis component. Aside from understanding these perceptions, this study aims to fill the gaps in the existing literature, as crisis services for CYP were recently introduced in the UK, and there is lack of available evidence regarding qualitative research that explores staff, service users and their family

perceptions and attitudes with CYP mental health crisis services in the UK. The main objectives of this study were to gain an understanding of stakeholder's perceptions and experiences with:

- the 0-19 model's crisis component
- barriers related to accessibility, effectiveness and acceptability of the crisis service
- satisfaction with experienced crisis support and interventions
- what the 0-19 model can improve with its crisis component

9.3 Methodology

Traditionally, qualitative research is utilised by many research studies to gain insight and understanding of patient and staff experiences and perspectives of local healthcare provision and the degree to which this provision meets patients' needs. Researchers often choose to utilise qualitative research methods due to its flexibility and ability to empower interviewed participants to speak about their lived experiences openly and in their own words. Also, the utilisation of semi-structured interviews often helps to facilitate participants reflection and understanding of their world and provide researchers with a new perspective on participant views. Therefore, the choice of qualitative research that utilised semi-structured interviews for this study is well-supported way to achieve the aforementioned aims of this study. The full description of the methodology used in this chapter is identical to the one previously reported in chapter 5. In this chapter, the previously collected qualitative data from a range of interviewed stakeholders were used and analysed using a template analysis approach to construct the final template.

9.3.1 Participants

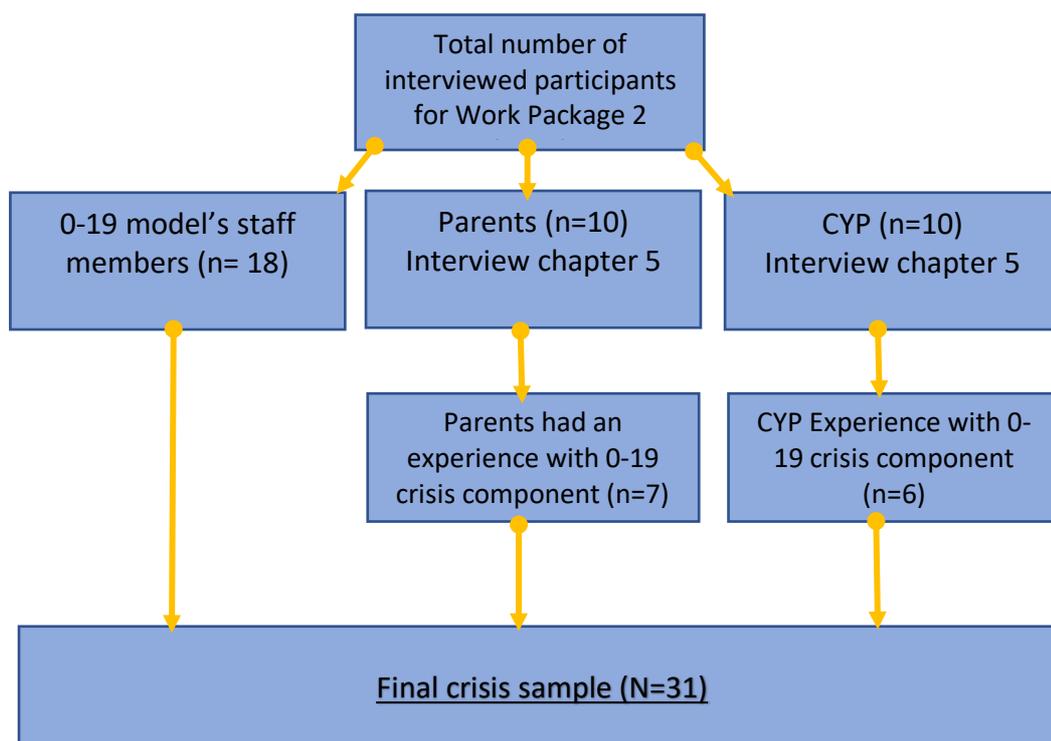


Fig 67. Participants recruitment process

Most interviewed CYP (Figure 67) were referred to the crisis team via the hospital, followed by A&E referral. Only one CYP was referred to the crisis team via their GP. Most reasons for CYP referral was due to the self-harm or overdose episodes. The crisis team saw most CYP within 24 hours of the point of referral. Two CYP were seen the same day as referral was made to the crisis team. Participants reported the duration of the crisis treatment varied between one week and two months.

Table 67 - CYP participants reasons for help-seeking from the crisis service

ID	Age	Gender	Source of referral	Reason for referral
CYP100	16	Male	Hospital-based referral	Suicide attempt, Overdose, self-harm
CYP101	16	Male	GP	Suicidal thoughts
CYP103	15	Female	Hospital-based referral	Overdose
CYP104	14	Female	A&E	Self-harm
CYP107	18	Female	Hospital-based referral	Self-harm, Overdose, suicidal thoughts
CYP108	15	Female	A&E	Suicide thoughts, Overdose

9.4. Data Analysis

The template analysis was chosen as the main qualitative analysis method for this PhD project. This qualitative approach was developed by King (2004) and is based on the thematic analysis of transcripts. The full description of the data analysis and justification for the template analysis is available in chapter 5, **section 5.3.4**.

9.4.1 The final template for the crisis component

The final template was used as a basis for the interpretation of all qualitative data and was a valuable tool that aided analysis. The researcher structured the presentation of the main findings around the main themes that grouped a-priori with emergent themes to produce a chronological flow through the findings section.

All these themes, as well as their subthemes, are hierarchically listed in **box 11**. The researcher coupled these themes with extracts from participants responses that were captured in transcripts to provide any evidence in support of the theme.

Table 68 - Participants quotation codes

Quotation codes:	Interpretation
SSSI	Staff interview responses
SFGR	Staff focus group responses
CYP	CYP interview responses
PC	Parents and carers responses

1. **Integral theme CYP and parental satisfaction with the crisis service [E]**
2. **The pivotal role of the crisis service [E]**
 - 2.1 Crisis component as an essential part of the 0-19 model and local community [E]
 - 2.2 Responsiveness' to presented crises [A]
 - 2.2.1 Liaising with other parts of the model [E]
 - 2.2.2 Signposting [E]
 - 2.2.3 A short-term intervention [E]
 - 2.2.4 Prevention of hospitalisation [A]
3. **CYP and parental needs from the crisis service [E]**
 - 3.1 Understanding what a mental health crisis is? [A]
 - 3.2 Needs of CYP and their parents while in crisis [E]
 - 3.2.1 Need for the quick fix [E]
 - 3.2.2 Heard, understood and taken seriously [E]
 - 3.2.3 Containment [E]
 - 3.2.4 Safety while in crisis [E]
 - 3.2.5 Strategies [E]
 - 3.3 The crisis service meeting these needs [E]
 - 2.2.1 Stakeholders perception of crisis meeting needs [E]
 - 2.2.2 Outreach work as a limitation [E]
4. **Accessibility [A]**
 - 4.1 Barriers to access [A]
 - 4.1.1 Lack of capacity [E]
 - 4.1.2 Staff numbers [E]
 - 4.1.3 Resources [E]
5. **Identified gaps present in the crisis provision [E]**
 - 4.1 The main perceived gaps [E]
 - 5.1.1 Transitional issues post-discharge [E]
 - 5.1.2 Lack of drop-in crisis service [E]

[A] A-priori theme
[E] Emergent theme

9.5.1 Integral theme: CYP and parental satisfaction with the crisis service

The researcher asked all interviewed CYP and parents about their satisfaction with the crisis service and its provision. Out of all interviewed participants who had the experience of being treated by the crisis team or had direct contact with the crisis team, only one parent expressed dissatisfaction with the crisis service. All other interviewed participants had positive experiences and were satisfied with the crisis service and its provision. For example, acceptability and satisfaction with the crisis service is evident from PC116 response:

"I think we're very lucky in Solihull to have that particular(crisis) service, and I know a lot of other areas don't have that service. So as a parent, if I were to summarise the benefit, it makes you feel that you're not dealing with the problem (crisis) alone, you've got a lot of support around you, and that makes life a lot more reassuring and easier for a parent. Both of those are extraordinarily minor points, and I wouldn't like to undermine what in essence is an amazing (crisis) service." (PC116)

9.5.2 Pivotal role of crisis service

All stakeholders agreed that the 0-19 model's crisis component is an essential part of the model, which is very responsive to presenting needs of CYP in a mental health crisis. Most of the stakeholders perceived the crisis team in a very positive light, highlighting the importance of this service to not just the overall 0-19 model but also for the local community.

9.5.2.1 Crisis component as an essential part of the 0-19 model and its local community

Staff

All participants described the crisis team as an essential part of the Solar system, that is needed and helps not just CYP and their families, but also provides much-needed support to other parts of the 0-19 model. Most staff stated appreciation for the presence of the crisis team within the Solar model, as this was seen as reassuring not just to other employees from the service, but also to their service users that they will receive necessary help and support. A similar opinion was shared by participant SSSI110 who stated that the crisis service "*needs to be*" as the crisis team is "*paramount*" to Solar's regular operations. Therefore, it is evident that the role of the crisis team is vital for the Solar and its daily operations.

Parents

Similar opinions were reported by all parents whose children were treated by the crisis service. These parents reported that the existence of the crisis team in the Solihull is paramount, not just for the overall 0-19 model, but also for the entire local community. For example, participant PC115 felt that existence and accessibility of the crisis service are reassuring for parents as they can seek help from the crisis service in the difficult situations and that they will not go through these experiences alone.

CYP

Similarly, responses from CYP participants also backed up perceptions reported by staff and parents regarding the importance of the crisis team. All CYP felt the crisis team was helpful, especially for being there to support them during their crisis journey. Also, both parents and CYP praised the crisis team for their friendly attitude and professionalism. For example, CYP100 reported that the crisis team was helpful for their recovery while comparing their experiences in a crisis team similar to

attending GP appointments. Most importantly, CYP100 was happy that the crisis team existed in their local community. From all CYP participants responses, it can be seen that there is a sense of appreciation for the existence of the crisis team. The Solar crisis team was perceived as helpful in the situation where both CYP and their parents were affected by CYP mental health crisis. For example, participant CYP101 expressed the appreciation for the crisis team being there for them in their "worst hour". Therefore, it is clear from all participants views that the presence of the crisis team in the Solar model and their local community is essential.

Table 69 - Participants quotes in support subtheme one

Participants	Quote in support
Staff	<i>"(The) crisis service is a part of Solar, which is very pertinent. It is quite necessary to have that part of the service. It is nice to know that there is the Crisis component of the service so that CYP can be supported. It is a good thing" (SSSI102)</i>
Parents	<p><i>"It is an amazing (crisis) service, and my fear would be if you lose a crisis service like that, it is catastrophic once you have got it. Moreover, I think it would have a catastrophic effect on the health of Solihull if Solar were to be, you know, the funding was to be diminished, or the crisis team were unable to undertake the function. Because once you have got something that good, you need to hang onto it very dearly really. I think it is going to have an amazing outcome effect on young people." (PC116)</i></p> <p><i>"The main help that Crisis service gives you as a parent is simply knowing that they are there and accessible. So that if something bad is happening, you don't feel you have to deal with it on your own" (PC115)</i></p> <p><i>"I think there is a need for a crisis team because I think... for people whose children have escalated further, to be able to have that contact is vital. And I think the young people themselves, to be able to phone and say, "I'm having a really tough day, you know, I'm thinking of doing something horrible." To have that person who will listen and advise I think is really important. (PC111)"</i></p>
CYP	<i>It was really helpful, and it felt like a GP appointment in a sense. You go there for a problem, and they get to the root of it of fixing it. So, it, it was helpful in the sense you felt like you were getting quality time and getting the help you need. Just say that it's a really good service and I'm glad it's there" (CYP100)</i>

9.5.2.2 Responsiveness to presented crises

CYP

From all interviewed participant's responses, it was apparent that the crisis team had been perceived as very responsive to CYP mental health needs by accepting CYP as soon as they experienced a crisis.

Parents

Similarly, the crisis team's responsiveness was highlighted by most parents in interviews. However, parental experiences also highlighted quite a variability of crisis responsiveness that ranged from being seen the same day as referral was made up to been seen the next day. For example, some parents reported that the crisis team was rapid and responsive to their child's need and quite prompt with their initial assessment. In contrast, participants PC117 and PC119 reported their experience of long waiting close to 24 hours to be seen by the crisis team.

Out of all participant responses, only one parent reported dissatisfaction with the crisis responsiveness. According to participant PC117, the crisis team showed a slow reaction with their child's developing crisis. The participant felt that the crisis team should be available to support CYP at the point of the crisis, not when the crisis has already subsided. Additionally, the participant also reported their concerns with a need for repeating their story and answering the questions that the parent already had answered previously. The reaction from the crisis team had been unhelpful and unsatisfactory.

Furthermore, all parents reported the need for prompt action by the crisis team as something which is very much appreciated in situations when their children are experiencing a mental health crisis.

Moreover, parent PC114 reported that signposting to other parts of the service is something that makes the crisis team so supportive, as they provide parents with alternatives and pathways to pursue in situations where parents do not know what other help is available for their children.

[Staff](#)

Solar staff described the crisis team in favourable terms, as it helps not only CYP and their families but also the rest of the service to successfully manage risks associated with CYP reaching crisis point. This triage management also may explain the rationale behind the need for waiting to be assessed by the crisis, as previously stated by parents.

Most participants highlighted this particular area of managing risk as the most important one. For example, participant SFGR5 stated that the crisis team is good with "*managing crisis and risk*". Participant SSSI105 felt that crisis role is vital for the initial "*triage*" of crisis cases, and if the situation deems crisis intervention, the crisis team will "*go out and assess*". From participant 105's response, it is evident that the crisis team engages in prioritising support for cases that are indeed in crisis. However, even though crisis provision is a response to more complex and severe CYP needs, crisis provision has been often referred by staff as short-term support that aims to stabilise CYP and prepare them for treatment in the other parts of the 0-19 model.

Additionally, the short-term nature of crisis provision also aims to prevent and divert CYP from unnecessary hospital admissions. As such, the crisis team has been characterised by participant SSSI106 as a "*gatekeeper*" to "*prevent a hospital admission*".

Similar to some parents' reports, participant SSSI103 and SSSI107 also stated that the crisis team engages in liaising and signposting CYP to the appropriate level of support within the 0-19 model.

Table 70 - Participants quotes in support subtheme two

Participants	Quotes in the support of theme
CYP	<p>"I was happy with how quickly I got to see the Crisis team. It was if I remember correctly, I think it was like the next day". (CYP100)</p>
Parents	<p>"After (child's) Overdose and of course admission to the hospital, the crisis team was involved immediately, so you know, I'm very happy with the way it works. ... It's quite prompt." (PC116)</p> <p>"On the day that we went to the hospital, they got us the appointment on the day, in the afternoon" (PC115)</p> <p>"We had to wait, we really did, and then it's the next day that Crisis team came. That took, we had to wait a whole day for them to come." (PC117)</p> <p>"I think it was the following day, so it was within 24 hours. It was very close to 24 hours when we saw them." (PC119)</p> <p>"We had somebody when I phoned up, and it was just a random person at the end of the phone. She was like, <Oh, the Crisis Team says that they'll give you a call> and I felt like they didn't really care. It was like, <Oh, yeah, we'll give you a call-back,> as if it wasn't a big deal." (PC117)</p> <p>"I suppose signposting, so when you're a new service user, they can signpost you to other parts of the service. You feel that you've got somewhere that you think will help and support you. So, they, I think they are quite supportive now. ...They, they give you avenues, so other ways to access information and help. It's somewhere for parents to come because other, there's nowhere else. Other places, the NHS is overrun with, too busy or they haven't got the resources or the doctors" (PC114)</p>
Staff	<p>"So, I think it would be maybe signposting them to other services or kind of liaising on behalf of that parent, maybe with school... maybe Crisis de-escalation, if it's within families, liaising with safeguarding, I think that would be some of their primary function." (SSSI107)</p>

9.5.3 CYP and parental needs from Crisis service

In the second theme, all participants gave their perception regarding what CYP and their parents expect from the crisis service. All participants discussed a range of different CYP/parental needs in the following sections such as how much Solar crisis service met those identified needs, what are the main reasons for not meeting service user's needs, and differences in perceptions between staff, and parental views how much crisis service meets those identified needs.

9.5.3.1 Understanding what is a mental health crisis

Staff

Most staff members reported interesting discrepancies between professional and CYP/parental perceptions of what a mental health crisis is. Most participants felt that there is a difference in opinion as to what constitutes a mental health crisis. Service users and their families may perceive any mental health issue as a crisis event. However, clinicians are more guided with a particular set of symptoms and CYP presentations that help them to assess whether CYP are in the crisis or not. For example, participant SSSI105 reported the need for clarity with criteria on what is mental health and what is an emotional difficulty. According to participant SSSI105, even the Solar service does not have clear criteria what constitutes a mental health crisis.

Similarly, participant SSSI110 reported that both members of the public and Solar's staff members should be educated regarding what is a mental health crisis. Therefore, it is evident that the crisis team should raise more awareness in the local community regarding what a crisis is and what is an emotional difficulty.

Table 71 - Participants quotes in support of subtheme two

Participants	Quotes in the support of theme
Staff	<p>"I think you've highlighted something I was thinking about what is Crisis, all the parents, all the service users' idea of Crisis, but it may be challenging to analyse" (SFGR2)</p> <p>"I'd say there needs to be clarity on what mental health or emotional difficulty is. (SSI105)"</p> <p>"Right, it is crucial to understand what crisis is. So, if you've got a child that's about to jump off a bridge, it's a crisis. If you've got a child that has genuinely attempted to strangle themselves with a belt on the back of a door, it's a crisis. So, it's about educating the public, as in what's a crisis, and what isn't a crisis. It's still a crisis, but it's the degree. It's about trying to look at what the criteria for Crisis and what that is. And I think within the service, also, that sometimes has to keep being reinforced. You say, <What is a crisis, and what isn't a crisis?> So for me, that is paramount. (SSSI110)"</p>

9.5.3.2 Needs of CYP and their parents while in crisis

Staff

This particular discrepancy in the perception of mental health crisis could also be the reason why CYP and parents have wrong expectations regarding crisis treatment and the timeframe needed for recovery. All staff participants reported that parents often have unrealistic expectations regarding how quickly the crisis team can fix the mental health problems that their children are experiencing. For example, participant SSSI101 felt that parents and service users often have wrong expectations "to fix everything very quickly ", which according to participant SSSI101, its "not always a reality". Participant SSSI 103 reported a similar opinion that parents have a "need for a quick fix". Besides a quick fix, the most prominent need that was evident in all stakeholders' responses was a need to be heard, understood, and taken seriously. For example, participant SSSI101 stated that both parents and children want from mental health professionals "to be seen, and to be listened to". Moreover, staff participants also suggested that parents and their children need quick and timely access to the crisis provision. For example, participant SSSI110 stated that service users want a help "in a timely fashion" and that is "the core of everything".

Staff participants depicted the main rationale for why parents and their children need prompt access to crisis service as desperation for help-seeking, which correlates with the severity of their children's crisis. In contrast, participant SSSI106 perceived parental desperation more as a need to relieve parental anxieties and worries, as well as reassure them that their children are receiving the best possible care.

Similarly, most of the staff participants felt that all parents want containment of their children's crisis and the situation to be normalised. For example, participant SSSI103 stated that parents' have a "*need for normalisation*" of their children's crisis and "*containment of their crisis needs*". Relatedly, participant SSSI109 felt that all families want to "*go back how they were before*" and once their crisis is "*resolved*" to be able to "*feel happy*". In contrast, participant SSSI107 reported that containment of the mental health crisis should first start within family environments.

[Parents](#)

Most parents reported that they never heard for the term '*mental health crisis*' before their child experienced one. For example, participant PC111 explained the extent of panic of not knowing what to do with their child who displayed suicide ideation.

Therefore, there is an evident need to educate more parents and CYP regarding what a mental health crisis is, and how to deal with them. Raising service users and members of general public awareness of what mental health crisis is may lead towards understanding how to deal with someone who is experiencing a mental health crisis and realistic expectations how long, and what is needed to achieve full recovery. From all parental responses, the most crucial factor for their children's crisis support was someone being there to listen to them and to take their concerns seriously. In addition, some parents also reported that once their children are in the crisis, they must receive support as soon as possible.

From parental interviews, it was clear that parents also need to be reassured that the help their children will receive will be appropriate and safe. For example, most parents

agreed that they felt relief once the crisis took over the treatment of their children. Participant PC118 reported a sense of feeling "*secure and relieved*" once the crisis team accepted their child. Additionally, participant PC119 described how they "*constantly worried*" due to not knowing what is happening to their child and how they can help their child through this period of their lives. Relatedly, participant PC120 stated that as a parent "*you are constantly worrying*".

CYP

Equally, all CYP participants stated a similar need to be heard and taken seriously by the crisis staff. During the interviews, all CYP participants acknowledged that this need had been met by the crisis team. Likewise, CYP103 agreed that crisis staff members met their needs, while CYP characterised crisis staff as "*very chatty*" and "*good listeners*". Also, CYP104 added that for them, the most crucial factor of having crisis support was that they were "*very helpful*" by being there "*to listen*".

What is visible from all stakeholders' responses is that all service users have a strong need to be listened to and taken seriously. However, it is also evident that CYP and parents may have the wrong expectation that the crisis service will provide a quick resolution for their mental health difficulties.

Table 72 - Participants quotes in support of subtheme three

Participants	Quotes in the support of theme
Staff	<p>"CYP/Parents wants help, desperate to get one. More in crisis, more desperate CYP/Parents are to seek help." (SSSI103)</p> <p>"They want somebody. I think families are at breaking point when they're phoning Crisis Team. So, they want to know whomever they're dealing with has got the knowledge and can understand the parent and put the parents' mind at ease as well as the child's, cause the parents are probably at their top end of the anxiety as well with worry about what the child is going through". (SSSI106)</p> <p>"So, if the family are contained, then they can contain and support the child that's in crisis" (SSI107)</p>
Parents	<p>"I phoned the crisis line for advice when my daughter did pick up scissors and, you know, I did say to them, you know, <What, what do I do?> and they gave me information over the phone, and then they passed the details on to my daughter's care worker. But I needed to speak to somebody, I needed to know how do you deal with it when your eight years old has picked up a pair of scissors and is threatening ...? You know, it's like, <Well, what on earth can I do?>. As a parent, you're not equipped to deal with something like that, so actually to be able to phone them up and say, <What do I do? How do I handle it?> And be given that advice is really important." (PC111)</p> <p>"I felt, you know, that we were going to get some help, and I felt that someone was actually taking what I was saying very seriously" (PC119).</p> <p>"I did feel previous to going to Solar nobody believed her. I just felt that you know, I think they were looking at her to say, <Oh, maybe she's thinking it all in the head.> But I could see what my daughter was going through because you know your child and I knew she was going through a rough time. ...but when she got to Solar, I just, she's, I felt that nobody wanted to acknowledge what she was going through if that makes a bit of sense? Oh, the Crisis it felt like, that somebody listened to that and I felt a deep sigh of relief just to feel that somebody wanted to listen, and we were getting somewhere." (PC115)</p> <p>"And obviously as a parent, you're like really freaking out, and you need help like then, not an hour or two later." (PC117)</p> <p>"As soon as really, we had Crisis involved I just felt a huge weight lift off me, a huge weight. I felt that everything that I'm because I've been trying to deal with everything on my own. Thus, when a doctor was involved, I just felt, <I'm totally out of control> but with Crisis I felt I could take a step back and let them do their job. Likewise, I felt entirely secure in the knowledge that these were people who dealt with children like S all the time. Secure, yeah, felt very secure." (PC118)</p>
CYP	<p>"Yeah, they always took me seriously. She (Crisis staff member) listened to me really well" (CYP100)</p>

9.5.3.3 The Crisis service meeting these needs

Staff

Most of the staff members agreed that the current crisis team does meet the local CYP mental health needs. It was also evident from the participants' responses that the crisis team also plays a vital role as a gatekeeper towards prevention and reduction of the hospital admissions, as well as treating CYP in less restrictive environments. Similarly, participant SSSI101 stated that crisis service is doing "*what (is) intended to do*".

Furthermore, the involvement of the crisis team contributed to the improvement of the overall Solar service and its attempts to meet the local needs. All staff participants felt that since the introduction of the crisis team into the Solar model, the overall service started to run much better, and met more local CYP needs.

However, all staff participants reported that more preventative work needs to be done by the crisis team to reduce or prevent CYP reaching the crisis point. In order to engage more in preventative work, all participants felt that the crisis team should be much bigger and offer more extended crisis support. For example, participant SSSI110 stated that the crisis team could be "*bigger*" and "*looked after more*". The similar perception was shared by participant SSSI103 who supported the notion for the crisis team to be "*bigger and going for longer*" and comprised of more staff members as that would offer more extended periods of support "*given time and staffing.*" A key towards more preventative work lies in the outreach work with its local community.

However, it is evident that due to the size of the crisis team and lack of resources needed for such engagement, the crisis outreach work is limited with its capacity to deliver more preventative work in its local community. Therefore, more staff members should be employed in preventative work with local stakeholders. Preventative work may potentially reduce the need for both crisis and hospital admissions.

Parents

Likewise, when parents were asked whether the crisis service meets their children's needs, most parents agreed that crisis team indeed met not just their children's needs but also their needs and their overall family needs as well. Almost all parents did characterise the crisis team as supportive and helpful in meeting their needs. Similar to staff reports, most of the parents also reported that CYP would benefit more if they were supported longer by the crisis team until other parts of the system would take over their children's care and further treatment. For example, PC120 expressed the desire for "*a longer support*" from the crisis team until children "*start the next phase of treatment.*"

CYP

The perception that the crisis service successfully managed to cover mental health needs was also evident in CYP responses. Some CYP reported, the crisis team did manage to give them what was needed and directed them towards recovery. However, most CYP felt that the crisis service helped them to change their perception regarding the situation that initially caused the crisis in the first place. Similarly, some CYP also confirmed the need for longer support from the crisis team for a more extended period. For example, participant CYP108 stated that they might potentially benefit from staying longer in the crisis team for "*a few more sessions*".

Table 73 - Participants quotes in support of subtheme four

Participants	Quotes in the support of theme
<p>Staff</p>	<p>"So, I think Crisis is definitely needed. I think Crisis is a service that meets the need. I think from what I've observed with the team, and I think they do meet the needs. I think the keyword was the 'gatekeeper'. I think that needs to be nurtured". (SSSI110)</p> <p>"Yes, definitely, I feel like the service is running a lot better with Crisis, cause if it was a time where there were lots of kids going in through Crisis and we didn't know what to do and we had to kind of manage it and maintain it, but I feel like the Crisis Team has helped up a lot. I think it's quite secure as well, and it's quite reassuring for parents and young people to know that if you're in mental health service, the Crisis Team are there." (SSSI105)</p> <p>"Need for more preventative work in the schools that would actually reduce the need of getting into the crisis team. This resource is missing." (SSSI101)</p>
<p>Parents</p>	<p>"I think everything that we needed to do and what was covered with us, was covered to be quite honest". (PC115)</p> <p>"I can't fault what they've done for me and A, well, and the whole family because they have helped my son trying to deal with A's emotions as well. So really, I can't fault what they've done for all of the family and how quickly they responded to our needs as well." (PC120)</p> <p>"I did feel previous to going to Solar nobody believed her. I just felt that you know, I think they were looking at her to say, <Oh, maybe she's thinking it all in the head.> But I could see what my daughter was going through because you know your child and I knew she was going through a rough time. ...but when she got to Solar, I just, she's, I felt that nobody wanted to acknowledge what she was going through if that makes a bit of sense? Oh, the Crisis it felt like, that somebody listened to that and I felt a deep sigh of relief just to feel that somebody wanted to listen, and we were getting somewhere." (PC115)</p> <p>"And obviously as a parent, you're like really freaking out, and you need help like then, not an hour or two later." (PC117)</p> <p>"As soon as really, we had Crisis involved I just felt a huge weight lift off me, a huge weight. I felt that everything that I'm because I've been trying to deal with everything on my own. Thus, when a doctor was involved, I just felt, <I'm totally out of control> but with Crisis I felt I could take a step back and let them do their job. Likewise, I felt entirely secure in the knowledge that these were people who dealt with children like S all the time. Secure, yeah, felt very secure." (PC118)</p>
<p>CYP</p>	<p>"They did everything, everything they've said. They gave me strategies, and they talked to me, and make me think differently about the situation". (CYP104)</p>

9.5.4 Accessibility

[Staff](#)

Regarding the accessibility of the crisis service for CYP, all interviewed participants agreed that the crisis service is accessible. For example, participant SSSI106 stated that there is a range of different referral routes through which CYP can gain access to the crisis service.

Similarly, participant SSSI105 added that the existence of the crisis service eliminated a need for waiting for assessments of urgent and emergency cases. Instead, the crisis team can quickly see and assess CYP on the spot. Additionally, the participant also highlighted the benefit of the accessibility of the crisis service for CYP who are reluctant to engage with standard CAMHS or any other alternative help-seeking behaviours. However, participant SSSI107 highlighted the existence of very high threshold criteria that CYP need to meet to be accepted by the crisis service. According to participant SSSI107, the crisis team should lower this specific threshold for accessing crisis help.

[Parents](#)

Most parents shared similar perceptions regarding the crisis service's accessibility. However, parental experiences with help-seeking and access to Solar crisis team varied significantly. For example, three parents described their experiences of accessing crisis provision via telephone as very easy.

On the other hand, some parent's children were seen by the crisis team in hospitals or A&E departments after their children overdosed or self-harmed. Three parents expressed happiness that both hospital staff has treated their child for their physical injuries as well as crisis team for their mental health issues. For example, participant PC116 expressed "*satisfaction*" with the accessibility of the crisis team via the hospital admission route.

Similar satisfaction with ease of accessibility of the crisis team was highlighted by three parents that reported their first contact with crisis service in their homes or education settings. For example, parent PC120 stated that the crisis team did provide "*home visits*" and that they also supported their child "*at school.*"

CYP

Equally, CYP participants had quite varied and different experiences with the accessibility of the crisis service. However, all CYP did confirm that initial access to the crisis team was easy. Also, CYP participants recalled how responsive the crisis team was with seeing them for an initial assessment.

While the crisis team assessed some CYP in urgent and emergency settings, other CYP had their first contact with the crisis team in their homes. Most CYP who accessed the crisis team in such settings stated their preference for the home visits, and for the delivery of home treatment over being seen and treated in more clinical settings. Moreover, the crisis team intervention at service users' homes were perceived as more personal and helpful.

Therefore, an evident benefit of the crisis team lies primarily in their responsiveness and flexibility to adapt crisis provision according to the particular and individual needs of each CYP.

Table 74 - Participants quotes in support of theme

Participants	Quotes in the support of theme
Staff	<p>"I think its brilliant access. I think it's great that parents can self-refer CYP, doctors, schools, I think it's really good we do a quick turnaround. The majority of the time, we are responsive so that that child would have been seen within the four hours. I think it's great" (SSSI106)</p> <p>"For example, if there is somebody who is not open to the service, but he's going through Crisis, instead of having to wait to be assessed, he can go straight to the Crisis Team. And I think that improves access to mental health service, especially for young people who are maybe scared or have an idea about mental health services, it's kind of changes it because it's there whenever you need it" (SSSI105)</p> <p>"I think if somebody was expressing suicidal ideation and we felt (inaudible) it almost feels like they have had to have self-harmed before they get that support. So, I think they (crisis) are responding to very urgent crises, but I think maybe the threshold would, should, could be lowered" (SSSI107)</p>
Parents	<p>"Well, I think to get into the crisis service is extremely easy because it just takes a phone call from a parent or a young person to at least have contact with them, so they can triage and see whether further help is needed." (PC115)</p> <p>"After an overdose, of course, and admission, the crisis team will be involved immediately, so you know, I'm very happy with the way it works" (PC116)</p>
CYP	<p>"I think it was quite easy to access crisis service. (Liked) Pretty much everything. They were very helpful." (CYP104)</p> <p>"They went out of their way for me, so someone from Crisis came to my house every day after I'd come home from the hospital. And they were really helpful going through things with me, talking to me. Obviously, at that point, I didn't want to leave the house, so it was very nice to have someone who could come to me. Yeah, it makes you feel like somebody cares I as well think, it's very personal." (CYP103)</p>

9.5.4.1 Barriers to access

Staff

Several participants highlighted a few barriers that are still affecting the accessibility of the crisis service. For example, participant SSSI106 explained how the lack of staff impacts the overall service provision of the crisis team. Besides, this participant also

indicated that there is not enough time with the current staff levels to cover all areas of the crisis service.

Similarly, participant SSSI106 reported how the crisis team is "*short-staffed*". Similar responses were captured from several other participants. Participant FGSR6 expressed concerns that crisis staff are "*overwhelmed*" with their caseloads, as well as their lack of capacity to offer home or intensive treatments, mainly due to "*a resource issue*". Equally, participant SSSI103 also stated that due to the lack of staff in the crisis, CYP and their families may not receive urgent response, as expected from the crisis team. Relatedly, participant SSSI103 warned that a "*lack of staff and resources*" could cause potential barriers toward accessing the crisis service. Similarly, participant SSSI105 also felt that the lack of staff might pose a barrier towards access to crisis service.

Furthermore, other staff members touched on the crisis staff capacity to deal with more demand for their services. The crisis team capacity is one of the barriers that is indicated by stakeholders as the main barrier of the crisis service. For example, participant SSSI101 felt that staff could offer longer crisis provision if crisis staff members are capable of doing so. Nevertheless, the demand for the crisis team sometimes can prevent them from doing home or school visits. Therefore, participant SSSI101 suggested separation of the crisis team on two segments, one that will deal with crisis cases and one that will deliver home or school treatments.

Most staff participants highlighted the main reasons for this lack of service capacity and staff members in the crisis team. The first reason that was mentioned by most of the participants lies with the lack of resources, mostly financial ones. For example, participant SFGR5 felt that the main reasons for this lack of capacity are due to "*resource issues*" which created the crisis service that operates without "*enough staff*" while being "*overwhelmed*".

Parents

However, one interviewed parent also highlighted the similar perception that crisis staff members were understaffed and overworked. Parent PC116 expressed concerns regarding crisis staff members and their workload, which may potentially impact their professional judgment and have a discernible impact on the care that they provide. Equally, PC112 agreed that there is an evident lack of staff in the crisis service, which creates an access barrier to the crisis team before mental health escalates even further. Participants perceived this lack of staff and their consistency as a direct consequence of a lack of funding.

Table 75 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Staff	<p><i>I think we're two staff members down, and then in the next couple of weeks, we've got two members of staff off and another member of staff on annual leave. So, we're working on one early, one late. And if any of them are off sick, I mean thank goodness we haven't got a record of people going off sick. If they were to go off sick, we would be without a paddle. It's just staff shortages. If we were a full team, then you could allocate one person to spend all day on the phones. Just time. I think the problem we have is we physically haven't got time. Literally, those phones ring all day. And if duty worker is not in, we're then picking up all the duty calls. And then at, a call can take two hours to sort out or signpost. And it's just time. (SSSI106)</i></p> <p><i>"Had couple of parents who's CYP were turned away from A&E and were told to wait for Crisis team at home. There is a need for an immediate initial response when in crisis". (SSSI103)</i></p> <p><i>"I think the only thing that I would as a potential barrier is obviously the staffing issue, cause if there's not enough staff, they have to, kind of, prioritise who should be visited." (SSSI105)</i></p> <p><i>"Crisis team can't always do home visits or school visits, for all their appointments to fit everybody. So that's also a barrier. Cause we could, you know, hold people for longer, there is the staff capability so say if there were a defined two separate teams" (SSSI101)</i></p>
Parents	<p><i>"...it's not my business to say, but I just have suspicions that they are, an observation they are working more than they perhaps are contracted to do, observationally. Which is wonderful but it's not good for your own health if you're doing that. The other thing I would add is a lot of the crisis team go above and beyond their duty, by phoning a young person at the weekend, even when they're not working, to make sure they're okay. And I suppose this comes back to crisis staff welfare really, they're very committed and work like that, but sometimes they need their own life. And you know, they need to</i></p>

stay well themselves, so they work really hard and, they are committed, but that can be detrimental to their own family life sometimes." (PC116)

"When there's a crisis it's difficult to get hold of somebody sometimes. It's only when it gets to the point of hospitalisation that you usually have an intervention; they (crisis team) come around. And consistency with staff, really important that is, but that is not their fault I suppose, you know, I realise we are living in a world where the budgets are pretty limited." (PC112)

9.5.5 Gaps within crisis service and its provision

In this theme, participants identified several gaps within the crisis service and its provision. Mostly these gaps relate to transitioning gaps between crisis and the 0-19 model once CYP are ready to leave crisis service, lack of psychiatrists in the crisis team and a lack of a drop-in crisis service. These gaps will be explored further in subsequent sections.

9.5.5.1 The main perceived gaps

Staff

Several staff participants reported that once CYP are discharged from the crisis service there is significant waiting for the continuation of treatment within the rest of the Solar service. Often high waiting times are for 1:1 therapy modes of delivery, while the lowest waiting times are for workshops. However, even for group therapies, there are long waiting times that could impact CYP mental health and contribute towards relapse with their mental health. Also, participants emphasised that during that waiting period CYP are left unsupported, stuck in between two parts of the 0-19 model.

Moreover, several participants have offered a possible solution for this gap. The idea of having drop-in crisis services would allow both recently discharged CYP or new patients to seek short time help and support from this drop-in service. The crisis team could offer the drop-in service at schools and colleges, which would contribute

towards both outreach and preventative work. Having a few of these hubs within the Solihull area would help to deliver brief interventions and talking sessions, which would also contribute towards the improvement of engagement of CYP with crisis service.

On the other hand, participant SSSI103 added that more preventative work is needed in cooperation with schools to reduce the need for the crisis service in the first place. Lastly, some staff members reported that the presence of medics in the crisis team would mostly benefit the crisis team. For example, participant SSSI106 believed that at the moment "*the real weakness*" of the crisis team is "*a lack of medics*" in the crisis service.

Parents

Three interviewed parents reported that CYP are left unsupported after being discharged from crisis care while waiting for other parts of the 0-19 model to pick them up. For example, parent PC120 expressed that this particular gap of care continuity could cause a relapse and decline of their child's mental health. Therefore, it is evident that this gap needs to be closed to prevent possible relapse or the decline of CYP mental health. Aside from the lack of resources, some parents were surprised by the absence of medics in the crisis team. Most parents perceived the absence of psychiatrists (similar to the staff responses) as a gap in the crisis service.

Table 76 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Staff</p>	<p>"There is a gap in crisis provision, and once CYP are due to be discharged from the crisis, no one is picking them up, what is resulting that CYP don't have support for few months. Just the wait from discharge from Crisis to intervention from Primary Care or another tier, such as Core CAMHS. Just that gap cause while they are waiting. Who is holding them? I think nobody, they (CYP) are left unsupported." (SSSI105)</p> <p>"Crisis team should offer DROP IN SERVICE, so say, I don't know, on Monday 9 till 12 at whatever school, you know. There will be mental health nurse that would have offered that session and try to do some work, preventative workaround that really. I think that is a massive resource, but yeah, it is generally missing." (SSSI101)</p> <p>"But if you could work around that, or maybe have, like, a drop-in hub or something neutral that is not going to frighten kids or maybe perhaps reduce their anxiety, I think. Yeah, like a drop-in centre that's able to kind of provide brief interventions. Something like the Portal at the Children's Hospital where you do not have to wait six months, you can just come in, have that." (SSSI105)</p> <p>"Need for more preventative work in the schools that would reduce the need of getting into the crisis team. This resource is missing." (SSSI105)</p>
<p>Parents</p>	<p>"Not having the extra support while waiting for the next part of the Solar after the crisis, that is all, for me. I just think it would have been nice if she could have remained under the Crisis Team until the workshop starts because we've had a period now where we haven't quite got the support." (PC120)</p> <p>"I think they should have a psychiatrist, not just nurses because nobody explained to us that the medication, they put her on caused all this. I know that takes a hell of a lot of money, but it's something that I think every crisis service should have." (PC117)</p>

9.6 Discussion

This study aimed to investigate key stakeholders (CYP, parents and staff) perceptions of accessibility, effectiveness, and acceptability of the 0-19 crisis service. The main findings were structured around the main themes identified through the use of the template analysis. The final template included five main themes for the Solar crisis model: (1) CYP and parental satisfaction with the crisis service, (2) the pivotal role of the crisis service, (3) CYP and parental needs from the crisis service, (4) accessibility, and (5) identified gaps present in the crisis provision. This discussion section aims to further discuss these five themes in relation to the research questions and available evidence from the literature in the upcoming sections.

9.6.1 What is stakeholders' (staff, service users and parents) satisfaction with the crisis service?

The key stakeholders in this study reported high levels of satisfaction with the crisis service and its service provision. There is lack of research evidence that explores CYP perception and experiences with similar Crisis Resolution Teams (CRT) and Crisis Resolution and Home Treatment Teams (CRHTT) to make any direct comparison with the current study. The majority of available evidence supporting service users and family satisfaction with CRT comes from the adult population. For example, a systematic review found evidence showing that service users were more satisfied with CRHTT than with inpatient care (Winness, Borg, & Kim, 2010). Similarly, several other studies reported greater satisfaction with CRT that serves the adult population, with little or no evidence that takes into account carer or parental experiences of CRT (Barker, Taylor, Kader, Stewart, & Le Fevre, 2011; Johnson, Nolan, Hoult, et al., 2005; Johnson, Nolan, Pilling, et al., 2005; Shepperd et al., 2009; Winness et al., 2010).

All aforementioned evidence suggests that CRHTT and CRT may increase the satisfaction of service users and decrease the burden on carers when the implementation of these services is appropriate. In contrast, several other studies

reported an increase in the level of carer burden and their complex decision-making as to whether the individual affected by the crisis should be treated in a home versus hospital environment (Fulford & Farhall, 2001). According to the study (Fulford and Farhall, 2001), this complex decision-making process depends heavily on the carer's coping and resilience mechanism.

On the other hand, another systematic review has found some evidence of increased satisfaction of CYP and parents with alternative models of urgent and emergency care compared to inpatient settings or care as usual (Vusio et al., 2019). Another review also reported an increased CYP satisfaction in intensive community services (ICS) and home-based multisystem therapy (MST) studies with CYP population (Kwok et al., 2016). There is, however, an apparent scarcity of available evidence as to how satisfied CYP and their parents are with the crisis services and their provision.

9.6.2 What is the effectiveness of the crisis service?

This emergent theme explored the importance of the crisis service within the 0-19 model's context as well as the overall local community. In this theme, both staff and service users agreed that the existence of the crisis service is paramount. In addition to the key role of the crisis service, the findings of this study pointed to key critical activities of the crisis team, such as the responsiveness, risk management, gatekeeping, and signposting.

Some evidence to support this theme stems from studies with adult populations. This research evidence considers CRHTT and CRT services to be more viable alternatives to more costly and unpopular inpatient treatments, often capable of reducing the duration of hospital stays (Kingdon, 2011; McCrone et al., 2009). Besides, CRHTT and CRT may also improve the quality of care provided, which contributes to the reduction of hospital admissions, out-of-area placements, and provides support for carers/parents during times of crisis (Kingdon, 2011). However, it is essential to recognise that these services exist within complex community settings that rely heavily on the effective functioning of other parts of the mental health system, such

as CAMHS, primary care and inpatient settings, in order to ensure adequate provision of crisis care (Middleton, 2008; Onyett et al., 2008). Evidence from the 2007 report supports the notion that CRT/CRHTT have a positive impact on both acute and community mental health services in local community settings (Bourn, 2007). In a study by Morat et al. (2017), the authors argued that CRT/CRTT services must forge and foster good relationships and communication with other local services in order to work effectively (Morant et al., 2017).

In the case of the 0-19 model's crisis component, it is evident that the crisis team liaises well with other services. Besides, the 0-19 crisis team has forged excellent relationships with acute wards, and internal and external community mental health services, which can be seen from the reactions of staff members and service users. Local community professional stakeholders shared the same perception regarding the local impact of the 0-19 crisis service presented in chapter 10.

Similarly, there is also a clear need for cooperation between crises services and parents, mainly due to the increased carer and parental dependence on CRTs (Albert & Simpson, 2015). Involvement of CYP social network is crucial to their recovery and crisis resolution, and without this support, most patients would experience hospital admission (Bowers et al., 2005). However, some research evidence suggested that parents and carers often experience an interplay between their desire to protect their children whilst being rejected by mental health services (i.e. "double deprivation²"). As a result, experiences of double deprivation can lead carers towards isolation, rejection and feeling of abandonment by crisis professionals (Albert & Simpson, 2015).

Regarding the responsiveness of the crisis team, most interviewed stakeholders agreed that the crisis team was responsive. On the other hand, as can be seen from the example of PC117, the participant was frustrated by the slow crisis team response to their child's developing crisis. Other research evidence indicates that this parent is

² Double deprivation can be defined as a complex interplay between carers need to protect loved ones and rejection by mental health professionals (Albert & Simpson, 2015)

not the only one with this experience. Albert & Simpson (2015) reported similar experiences of slow response to the crisis, which also affected parental trust and confidence in the crisis services. Also, similar evidence of frustration among carers is evident in situations where carers feel that they have been unsupported, disrespected, misunderstood, or not taken seriously and dismissed by CRTs (Albert & Simpson, 2015). Other studies reported similar parental experiences of a range of adverse emotional reactions (frustration, anger and exhaustion) when seeking urgent and emergency help for their relatives (Van de Bovenkamp & Trappenburg, 2011; Weimand, Hedelin, Sällström, & Hall-Lord, 2010). Additionally, high levels of carer/parental stress are also evident as a contributing factor towards their relatives' experiences of mental health relapse (Cormac & Tihanyi, 2006).

Furthermore, most participants reported that the responsiveness of Solar's crisis service varies significantly. In most cases, the crisis team intervened within 24 hours from the point of referral. Other studies also supported a need for crisis responsiveness. For example, most researchers define responsive CRT teams as services that provide crisis provision at the right time (NHS East of England Clinical Networks, 2017). In theory, this means that crisis staff are available 24/7 throughout the week. However, the crisis provision in the 0-19 model runs from 8 am - 8 pm, seven days a week. A similar need for CRTs responsiveness is highlighted by NHS England, which emphasised a need for assessing patients in crisis within a one-hour window from the point of emergency department referral. At the same time, crisis teams are expected to deliver treatment within a four-hour window period (National Institute for Health and Care Excellence, 2016). Participants who had experienced a crisis intervention as a result of a referral made by an A&E department made it clear that the crisis team had intervened relatively quickly.

Similarly, the Crisis Concordat stipulates that CRTs should provide an assessment of all crisis cases within a four-hour window period in a community (Department of Health and Concordat signatories & Signatories, 2014). Despite this ambitious assessment window, the question is whether the four-hour assessment period is realistic? The majority of professional local community stakeholders agreed that it is

difficult to achieve (chapter 10). However, all interviewees identified the 0-19 crisis team as responsive and prompt with their interventions.

Crisis responsiveness is closely tied to appropriate risk management, especially taking into account that risk management is the most extensive and intensive crisis intervention beyond the point of assessment (Onyett et al., 2008). Appropriate risk management is particularly important, a mental health crisis³ can be defined as a combination of mental health symptoms, social problems and associated risk (Johnson, Bindman, & Thornicroft, 2008). Adequate risk management was carried out by the 0-19 crisis service, as was evident from the participants' responses. A proper crisis risk assessment is needed from the early stages of a crisis to avoid any possible escalation of the CYP mental health, reduce their risk for emotional or physical harm, and improve their ability to cope with the triggers of the crisis (Caplan & Caplan, 2000; Caplan, Mason, & Kaplan, 2000).

The importance of early risk assessment is crucial, especially as some studies report that the risk of harm or neglect to patients in their immediate surroundings is often found to be the main feature of crisis episodes (Lyons, Hopley, Burton, & Horrocks, 2009). Additionally, one study (Albert & Simpson, 2015) reported that parents mostly withhold information from CRTs, which often has an impact on risk assessments and is often the consequence of the parental/carers sense of loyalty. The need for appropriate risk assessment is also supported by a systematic review which found out that the most common reason for hospital admission of patients under the CRTs care was due to the risk to themselves (Carpenter, Falkenburg, White, & Tracy, 2013). It is therefore important to stress that risk management is a key activity of crisis teams that has the potential to prevent or reduce unnecessary hospitalisation of crisis-affected patients.

Furthermore, the gatekeeping has been perceived by the 0-19 staff and some parents as a crucial activity that prevents unnecessary hospitalisation of CYP. Besides hospital

³ Definition of mental health crisis is provided in chapter 1, section 1.3.6 (page 32)

prevention, the gatekeeping also plays a vital role in facilitating early hospital discharge (Begum & Riordan, 2016). From the available evidence, it can be seen that most CRTs offer short-term intensive crisis care to those individuals considered to be at the risk of admission to prevent their hospitalisations (Department of Health, 2001). However, not every CRT has good gatekeeping practice. According to one systematic review, only well established and effective CRT teams are capable of decreasing or preventing the number of hospital admissions significantly (Carpenter et al., 2013).

Nevertheless, the available literature shows that CRTs are not capable of preventing all hospital admissions due to their patchy fulfilment of gatekeeping role (Onyett et al., 2008). Similar findings were evident in the current study, where some parents expressed the need to be hospitalised to get access to the crisis team. At the same time, one study found that some health care professionals had the opinion that YP had to generate crises to get access to appropriate crisis intervention (Richards & Vostanis, 2004). The inability of CYP to access regular mental health service or crisis provision may result in CYP ending up their lives (Richards & Vostanis, 2004).

However, it is also evident from available research evidence that the role of CRT's as gatekeepers is still not adequately investigated (Carpenter et al., 2013). Another study shared a similar opinion that there is limited available evidence regarding gatekeepers responsibilities within the CRHTT roles (Begum & Riordan, 2016). As previously mentioned, the partnership between CRT, gatekeepers and families are necessary towards achieving patient's recovery from a crisis. Several other studies supported this partnership between family and CRT, stating that this partnership is the best example of the effective CRT/CRHTT and best evidence practice (Begum & Riordan, 2016; Karlsson, Borg, Eklund, & Kim, 2011; Ness, Karlsson, Borg, Biong, & Hesook, 2012). Therefore, the gatekeeping role remains the crucial factor for delivery of less restrictive treatments in the community settings (Sjølie, Karlsson, & Kim, 2010).

Beside gatekeeping, the CRT plays an integral part in the signposting not just CYP but also their parents/carers to more appropriate levels of care. Both staff members and parents in this study agreed that signposting is needed, and it is an essential factor

that makes 0-19 crisis service supportive. A range of research evidence well supported a need for signposting carers and parents. For example, the study by Olasoy et al., (2017) highlighted a need for parents/carers to be appropriately signposted and more involved in care when their relatives are in the crisis. Similarly, another review found evidence that supports the need for signposting the overall family of individuals affected by the crisis (Vusio et al., 2019). Qualitative evidence from this systematic review showed that most parents reported adverse effects of their child's crisis on the overall family functioning (Vusio et al., 2019). Parallel evidence to support a need for signposting individuals is evident in the study which found that the small number of crisis service users shared positive experiences of being signposted by the CRT provider to additional services (Morant et al., 2017). Similar positive experiences of CYP aged 16-25 years with signposting to other services were evident in the UK study (Brimblecombe et al., 2017). However, the study by Morant et al. (2017) also found that most CRT providers are hesitant towards signposting families to available support and parents have perceived this lack of signposting as a barrier (Morant et al., 2017). CRTs should therefore consider implementing family therapy when working with CYP in crisis, as these interventions can contribute towards higher levels of parental satisfaction and reduce the burden on carers (Campbell, 2004).

9.6.4 How accessible is the crisis service?

The findings of this study showed that all stakeholders reported satisfaction with accessibility and flexibility of crisis, and preference for home treatment over a hospital or clinical environments. Throughout this chapter, it was evident that the 0-19 model crisis component is accessible to a broader range of CYP experiencing a mental health crisis. Most of the interviewed participants acknowledged that the crisis team is responsive. However, mostly this accessibility can be seen as a reaction to crises, rather than action towards preventing crisis. Similar crisis service that is a part of the "One-stop-shop" model reported an increase in the demand for crisis service since its implementation (Sfar-Gandoura et al., 2017). Its service users perceived the crisis service as more accessible than the other parts of the model, mostly due to its responsiveness, flexibility and meeting CYP needs (Sfar-Gandoura et al., 2017).

The parallel service “York” which operates as the 0-18 model (chapter 4) also expressed a need for CYP to access the crisis service provision closest to the place of their residence (Wright et al., 2016). In the findings of this study, it is evident that the crisis team does offer local accessibility via phone, in clinics, community, home and education settings visits, similarly as reported in another study (Wright et al., 2016). As visible, the 0-19 crisis model does resemble the York model with its accessible crisis service provision. Differences between the two models are also evident. For example, 0-19 crisis service operates 8 am-8 pm, seven days a week, while York model offers 24/7 crisis provision, which may improve the overall accessibility of the York model. Recently, the 0-19 crisis service started to cooperate with Forward-Thinking Birmingham (FTB) to offer coverage for CYP who experience a crisis during non-operating hours of the 0-19 crisis service. These CYP are covered in those instances by the FTB crisis team and later handed to the Solar crisis team.

Similarly, a published review also found that most adults crisis patients identified that good crisis services are the ones that provide easy access and rapid response when a crisis occurs (Winness et al., 2010). Several studies in this review showed that patients preferred 24/7 crisis availability, home treatments and easy access to the crisis team via telephone and flexibility of referral routes (Winness et al., 2010). In comparison, although Solar crisis service does not offer full 24/7 provision, still the service offers direct crisis telephone support and flexibility with referrals routes within the 0-19 model. Moreover, the review by Winnes et al. (2010) also highlighted that comprehensive and accessible crisis support helped crisis patients to recover quicker. Additionally, once CRT de-escalated a crisis, all patients reported appreciation for accessible support of CRHTs that helped patients with further referrals to appropriate mental health support (Winness et al., 2010). These findings are in line with findings from the current study, as evident from the responses from interviewed stakeholders.

In addition, the review by Winnes et al. (2010) concluded that the most positive aspects of CRHTs lie in their accessibility and availability to crisis service users. Nevertheless, the review also cautions that lack of accessibility of the crisis support or

presence of barriers that prevents immediate crisis access resolution or can leave service users frustrated and distressed (Winness et al., 2010). In the case of Solar crisis service, it is visible that the service delivers flexible crisis provision in a wide range of non-threatening environments to maintain its accessibility. This flexibility of Solar's crisis service is well in line with the findings from Gallanger and Schlösser (2015). Regarding CYP and parental preferences for home treatment rather than being treated in hospitals or clinics, it is visible that service users did value the 0-19 crisis service flexibility to deliver crisis intervention in their homes and educational settings. Similar CYP preference is well established in the literature (McGorry et al., 2013; Morant et al., 2017; Onyett et al., 2008). For example, one review reported a preference of CYP to be treated in the community rather than in a hospital or clinical settings, with a clear preference for outreach services (Plaistow et al., 2014). Equally, another study found the same CYP preference for community and outreach treatment in comparison to hospital-based treatment (Rani, Prosser, Worrall-Davies, Kiernan, & Hewson, 2009). Another study reported that there is evidence that CRT can provide an effective and good quality home-treatment in the community (Morant et al., 2017). However, Morant et al. (2017) emphasised the lack of evidence of carers/parental experiences with CRT interventions in service users' homes.

9.7 Strengths and weaknesses

The main strength of this study lies in its attempt to fill the gap in the lack of experiential data from a range of stakeholders who have experience of working in or accessing crisis service provision. This study obtained perceptions and attitudes from a wide range of stakeholders such as staff members employed by the 0-19 model and its crisis component, its service users, and their family members. A further strength of this study is that since the implementation of Future in Mind and Crisis Concordat, no other studies have been conducted that have focused their research on crisis service provision for CYP. To our best knowledge, this is the only study that explores experiences of CYP, their parents and a range of healthcare workers with crisis service provision within a CYP mental health system. Lastly, a range of barriers, gaps, strengths and weaknesses of this crisis component can inform other CYP mental

health services and providers, while the findings of this study may also be of use to other researchers and policymakers.

On the other hand, the main limitation of this exploratory study is predominantly in the small sample sizes of recruited CYP and their parents, out of which only one parent expressed dissatisfaction with the crisis service. Despite all efforts having been made to reduce the impact of selection bias, it is difficult to conclude with certainty whether the full range of experiences of the service have been captured. Although the inclusion and exclusion criteria were created to guide the recruitment, it is possible that the criteria also posed a risk for selection bias. For example, CYP were excluded from this study if they were at the risk or at the beginning of their crisis treatment. Therefore, it is possible those CYP may have expressed different views of the crisis service. Besides, all participants were recruited in a small geographical area that does not necessarily represent the full picture of the UK. Although this study can be informative to other models, the findings of this study cannot be generalised to the entire population. However, the results of this study may encourage other researchers and services to devote their activities towards understanding CYP and their parental crisis experiences, which are currently incredibly scarce and under-investigated.

9.8 Chapter summary

The vast majority of interviewed stakeholders expressed satisfaction with the 0-19 crisis component and its service provision. All participants perceived the activities of the crisis team and their presence in the Solihull as essential to the local community and the 0-19 model. In terms of the crisis service's effectiveness, gatekeeping, risk management, liaison and signposting were the main crisis activities and elements considered to be crucial to the stakeholders. All interviewees identified a range of needs such as differences between the perception of parents and healthcare professionals as to what a mental health crisis is, the need to be listened to and taken seriously, timely access to appropriate crisis support and the need for containment. Most interviewed stakeholders agreed that the 0-19 crisis service met CYP and parental needs. However, most participants highlighted limitations of the crisis service, such as the limited number of crisis staff members, the limited duration of the crisis interventions and limited capacity. In terms of accessibility, the 0-19 crisis service was perceived by interviewees as accessible and responsive to CYP needs. However, both staff and parents highlighted significant barriers to the accessibility of the crisis service. These identified barriers were mostly linked to a lack of resources. Apart from barriers, participants also identified several gaps within the current crisis service such as a need for continuity of care once CYP are discharged from the crisis service.

Chapter 10: Impact of the 0-19 model and its crisis component on the local community

10.1 Chapter summary

In the previous chapter, the stakeholder perspective and experiences of Solar crisis service were investigated to understand how accessible and acceptable the crisis service is. In this chapter, semi-structured interviews were conducted with eight local stakeholders in Solihull, UK. These interviews were analysed using a template analysis approach to explore stakeholders' perceptions of the accessibility and acceptability of the Solar service and its crisis component. The main aims of this study are initially described, followed by a description of the methodology and a presentation of the main findings. These findings will then be discussed and subsequently compared with existing evidence from the literature. The final parts of the chapter present the strengths and weaknesses of the study. In this chapter, all the research activities are well aligned with the overall logic model and its corresponding activity section presented in chapter 3.

10.2 Study aims

The main aim of this study was to determine the perception of local community stakeholders regarding the accessibility and acceptability of the Solar service. Aside from this aim, box 12 sets out three additional overarching aims to be addressed in this study.

Develop knowledge and understanding	Develop knowledge and understanding of perceptions and attitudes of stakeholders regarding the provision of local mental health services in their community
Networks and linkages	Understand the extent to which professionals are linked to local mental health services and the barriers to linkages and networks
Identification of a range of barriers	Develop an understanding of what particular barriers local community stakeholders have experienced regarding access to mental health services and CYP engagement in treatment

Infobox 12. Overarching aims of this study

Since Solar is a unique and novel service model in the UK, it is crucial to explore the professional insights, experiences and perceptions of Solar’s strengths and weaknesses. Obtaining these can contribute to a better understanding of their experiences of accessibility, acceptability, and satisfaction with the Solar service. Ultimately, gaining a better awareness of local stakeholder’s experiences may also help to identify specific gaps in the model or its service provision, and potential improvements that can be made. Thus, this may contribute to better service provision that is more acceptable to the local community and truly meets CYP mental health needs. However, there is currently a gap in our understanding of local community professional experiences with newly created or retransformed mental health community service models for CYP in the UK. To the researcher’s best knowledge, there are no studies that conveyed experiences of local professional community stakeholders with retransformed models in the UK. Some previously conducted studies found some limited evidence regarding the community stakeholders experiences of the traditional 0-18 CAMHS model (Bromley et al., 2013; Thornicroft, Tansella, & Law, 2008). In contrast, other global models such as Australian Headspace successfully investigated experiences and perceptions of local professional community stakeholders to establish what impact Headspace has on its local community and improve their service provision, and understand what barriers to access still exist (Headspace-National Youth Mental Health Foundation, 2020).

In order to fill this gap, a research question was formulated: a) how accessible and acceptable is the 0-19 model and its crisis component for local community stakeholders. A qualitative research design based on the semi-structured interviews was chosen as a way of obtaining insights, experiences, and perceptions from community stakeholders. Bearing in mind that interviews are one of the most effective methods in qualitative research of gaining insight into participants experiences and attitudes, that choice of qualitative approach in this study was well justified (DeJonckheere & Vaughn, 2019).

10.3 Methodology

In this study, a semi-structured interview was used with eight local community stakeholders to develop knowledge and understanding of stakeholders' perceptions and attitudes regarding the provision of local mental health services in their community.

10.3.1 Participant's selection for the study

Sampling and eligibility criteria

The sampling procedure in this chapter followed the same sampling and recruitment procedure based on the purposive sampling, as outlined in previous chapters 5 and 9. The following eligibility criteria were used for inclusion of local community mental health professionals in the qualitative research study for work package 3:

Table 77 - Recruitment criteria for Local Community Professional Stakeholders

Local Community Mental Health Professionals recruitment criteria:
<ul style="list-style-type: none">• The stakeholder should be experienced in working with CAMHS services, crisis teams or have a referral experience of CYP to Solar crisis services• Knowledge about the existence of Solar and its crisis service• Age 18-67 years• Have the capacity to provide informed consent to participate• Ability to read and write in English• Ability to converse in the English language

10.3.2 Participants' recruitment

The researcher tried to include a wide range of professionals in this sample (e.g., educational psychologists, hospital doctors and nurses). Local community professionals were recruited using a purposive sampling strategy from various educational and urgent and emergency settings outside of the Solar and its crisis service. The main rationale for the use of purposive sampling in this PhD project has already been discussed in chapter 5.

All Solihull education settings with high referral rates to Solar or its crisis service were initially contacted by email. The email explained the purpose of the study and provided the stakeholders with an "invitation letter for the research project" (**APPENDIX-Vol2-1**). In contrast, for the recruitment of professionals from GP surgeries and urgent and emergency settings, the researcher identified from the RIO crisis notes hospitals and A&E departments that mostly referred CYP to the crisis team. A list of most common referral sources from hospitals and A&E settings was compiled, and email invitation was sent to the heads of these settings. Only three people from the educational setting agreed to participate in the first round of interviews.

In contrast, all professionals from urgent and emergency settings contacted the researcher back to confirm their willingness to participate. All of these stakeholders

were then provided with electronic versions of the participant information sheet (**APPENDIX-Vol2-2**) and consent form (**APPENDIX-Vol2-3**). However, out of 20 electronic invitation letters sent to various GP surgeries in the Solihull, which had a high rate of referral to Solar or its crisis service, the researcher did not receive any response.

The researcher agreed to contact the participants who had agreed to the initial interview within 48 hours to see whether the participants were still willing to participate in the research. Other participants in this study were recruited through direct contact with the researcher. The researcher established contact with several educational providers in the Solihull via a telephone call to present the research and to understand whether these professionals would be willing to participate in the interview. For participants who expressed interest, the researcher provided them with an electronic version of the PIS form and the consent form and informed stakeholders that a follow-up telephone call would be made 48 hours later to understand the stakeholder's decision on participation.

After 48 hours, the researcher contacted stakeholders to understand their decision on participation. Most of the professionals who showed an initial interest in participation in this research confirmed their participation. A small number of participants from educational settings refused to participate, while none of the GP surgeries contacted by the researcher agreed to participate in this research. All stakeholders who were willing to be interviewed, agreed on an appropriate day/time that suited their work schedule. Participants were offered the possibility that the interview could take place in their workplace or by telephone. Only one participant expressed a desire for a remote interview, while the other participants agreed to a face-to-face interview.

10.3.2.1 Interview schedule

The researcher developed an interview schedule for this specific study (**APPENDIX-Vol2-4**) based on the findings from the previous two studies that were presented in chapters 5 and 9. The first part of the interview schedule was intended to generate initial professional participants working experiences with Solar and its crisis service. The rest of the interview schedule used a funnelling approach that raised more general questions about the impact of Solar and its crisis service on its local community and the satisfaction of its stakeholders.

10.3.3 Data collection

All interviews with local community stakeholders were booked in advance and conducted face-to-face in various professional settings within the Solihull area. Only one interview was conducted via telephone with one professional. The researcher recorded all the interviews with the Olympus DS-7000 Digital Encrypted Voice Recorder. All participants agreed to be recorded, both on the consent form and verbally. Besides audio recordings, the researcher also informed participants that during interviews, research notes would be taken. The researcher stopped recording the interview once when the participants answered all the questions in the interview schedule. The duration of all interviews ranged from 23 minutes to 60 minutes, with an average duration of 40:23 minutes.

10.3.3.1 Participants' consent

All participants gave their written and verbal consent to participate and to be recorded. The researcher applied the exact consent procedure as previously outlined in chapters 5 and 9.

10.3.4 Participants' demographics data and nature of service contact

All interviewees were recruited from a range of education and urgent and emergency settings in the Solihull. All participants had completed at least an undergraduate degree, while two participants had a post-graduate certificate, and two participants had a post-graduate diploma and a medical degree. All the interviewed participants interviewed were female. The average age of the participants was 37.62 (Range 28 to 52).

Table 78 - Participant's ethnicity

Ethnic group	Interviews
White British	6
White Asian British	1
Asian	1

Regarding the referral experience to the Solar service or its crisis component, only one participant did not have any experience of referral to Solar, while one participant did not have any referral experience to Solar crisis service.

Table 79 - Participants referral experiences to the Solar service and its crisis component

	Yes	No
Referral experience to Solar	7	1
Referral experience to Crisis	7	1

10.3.5 Data preparation for analysis

Once all the interviews were completed, all forms signed and filled out by the participants were stored at the University of Warwick, Medical school secure filing cabinet. The researcher sent all audio recordings for transcription to the external transcription service Appen. Verbatim transcripts of all audio recordings from interviews were completed. The researcher reviewed all transcripts for accuracy and assigned a unique pseudo identifier to each transcript, which corresponded to the

participant's consent form. The transcription data analysis was based on the process described by King (2004) and the principles of the template analysis (King, 2004a, 2004b) as outlined in chapter 5.

10.3.6 Ethical approval

The University of Warwick sponsored this research study. Full ethical approval was obtained from the HRA NHS Edgbaston Research Ethics Committee (**Appendix 5&6**) before the official start of recruitment. A full description of ethics and research governance and participants wellbeing can be accessed in chapter 3.

10.4 The main findings

10.4.1 The final template

This final template was used as a basis for interpreting all interviews and their findings and was an effective tool that aided analysis. The template analysis was applied to the eight interview transcripts and the researcher's field notes to understand the impact of Solar and its crisis service on the local community. Interpretation of findings (results section 5.5) was structured around the main themes grouping A-priori with emergent themes to generate chronological flow throughout the findings section.

1. Integral theme - Satisfaction with the Solar service [A]
2. Local community context [E]
 - a. Education settings context [E]
 - b. Urgent and emergency settings context [E]
3. Accessibility [A]
 - a. Referral experiences [A]
 - b. Responsiveness' [A]
 - c. Barriers to accessibility [A]
 - i. Solar service locations [E]
 - ii. Need for the drop-in hubs [E]
 - iii. Assessment timeframes [E]
 - iv. Lack of staff [E]
 - v. Continuity of care [E]
4. Community needs from the Solar and its crisis service [A]
 - a. Need for the Solar service and meeting local community needs? [A]
 - b. Communication [E] (Findings presented in Appendix 24)
 - c. Need for more support in the local community [E]
5. Impact of the 0-19 model and its crisis service on the local community [A]
 - a. The main perceived impact of Solar [E]
 - 5.1.1 Invisibility of the model [E]
 - b. Partnership [A]
 - c. Impact of FTB on the Solihull community [E]

10.4.2 The main findings

10.4.2.1 Satisfaction with the Solar service and its crisis component

All stakeholders who had contact with the Solar service expressed a predominant satisfaction with the crisis team; however, only some participants have expressed their satisfaction with the rest of the Solar service. For example, LCSH100 noted that they are *“more satisfied with the crisis service than with Solar”* mainly because of *“better crisis team responsiveness compared to the responsiveness of other parts of the service”*. However, the participant also added the overall satisfaction *“with the Solar service in comparison to the FTB service”*. Moreover, LCSH101, in addition to expressing their satisfaction with the crisis team, also stated their high satisfaction with the Solar service mainly due to *“Solar’s ongoing support”*. On the other hand, LCSH102 expressed their indifference between being satisfied and dissatisfied:

“To be honest, with parts of Solar I am very satisfied, but with other parts not so much. For example, the lack of linkage between our education setting and the Solar service is something that I would say that I am not happy at all, while I am very much happy with how the Solar crisis team works” (LCSH102)

LCSH102 added that *“the linkage is crucial between (Education provider) us and FTB, and I am satisfied with how that works”*. Similar indifference stance was reported by LCSH103 who argued that for them *“it is not important whether I am satisfied or dissatisfied with Solar, it is important that Solar works for my students and that they are satisfied with the service.”*

However, all hospital staff expressed praise and satisfaction with the Solar crisis service. Still, since they are not involved with the rest of the Solar model, they did not comment on their satisfaction with the overall Solar service. For example, LCSH104 compared their satisfaction between *“two services that we do use, and Solar crisis is heads above the other service that we receive”*. Similarly, LCSH106 stated their satisfaction with the Solar crisis team, as *“their contribution was invaluable to the*

hospital staff". Equally, LCSH105 shared their satisfaction with the crisis team, mainly due to *"a better rapport with the Solar crisis team on the unit, than we have with the FTB."* Therefore, it is evident that all stakeholders were very satisfied with the crisis team, while only some with the overall Solar service.

10.4.2.2 Local community contexts

Solihull is geographically located next to Birmingham, UK's second-largest city. Both Solihull and Birmingham have many points of contact, and people from both areas commute, work or study within and between these two areas. Similarly, the Solar service covers CYP mental health and emotional wellbeing in the Solihull area, while FTB covers the wider Birmingham area. However, both teams occasionally operate outside their catchment boundaries. In this theme, participants explained how the two areas are closely interlinked and how these services affect education and clinical settings.

Education setting context

The majority of education providers in Solihull look after not only local CYP mental health needs, but also the needs of students that live in the Birmingham area. The majority of students in all three larger Solihull colleges comes from Birmingham areas.

In contrast, secondary schools in the Solihull area reported fewer students from the Birmingham area, and more referrals made to the local Solar service. For example, participant LCSH100 stated that *"most of our dealings are with the Solar service"*. Likewise, participant LCSH107 reported that *"our predominant number of students are from Solihull, but we are small in comparison to some other schools."*

Therefore, it is evident that larger educational providers, such as colleges, tend to have a large proportion of their Birmingham-based students compared to many local secondary schools. It is also evident from the participants' responses that some

colleges have more interactions with FTB than with the Solar service, mainly due to the significant representation of Birmingham students.

Table 80 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Local community professionals	<i>“Because of where we are positioned a lot of our students live in Birmingham and some live in Solihull, so we obviously refer to both the services (Solar and FTB).” (LCSH101)</i>
	<i>“I think a very important point to understand is although our college is based in Solihull, 60%-64% of our students come from the Birmingham area. So, the nature of the students that come to our college are from Birmingham areas and postcodes, and Birmingham GP’s, which is why we’ve made a link with FTB.” (LCSH102)</i>
	<i>“I’ve probably referred more people to FTB than to Solar, because our student’s cohort demographics are currently, I think, about just over 60% from the Birmingham area.” (LCSH103)</i>

Urgent and emergency care context

Similar to educational providers, hospital units are geographically positioned so that they receive patients from Solihull and Birmingham areas. However, all hospital workers described their work context in a different light between two services. The majority of hospital staff described differences between patients from the Solihull area, in comparison to patients from Birmingham areas. According to two participants, Solihull has been perceived as more prosperous compared to Birmingham.

Additionally, participant LCSH106 added that despite a small cohort of their patients from the Solihull area, these patients tend to have *“a lot better care for mental health”* than those in the Birmingham areas. However, the problem of overrepresentation of patients in the Birmingham area, as opposed to Solihull, is evident even in-hospital providers. For example, participant LCSH106 stated that *“a majority of our children that comes to the hospital are still from the Birmingham”*. Although there are

similarities between educational and hospital setting in Solihull and Birmingham, there are nevertheless noticeable differences between the two.

Table 81 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Local community professionals	<i>“The FTB area is a very different with demographics. Cause for lot of patients, English is a second language. These areas are very deprived, and their expectations are obviously a lot lower of what they expect. Solihull on the other hand is very different with demographics, predominantly middle-class families and parental perceptions and their expectations are a lot higher, and they want everything now” (LCSH104)</i>
Local community professionals – urgent and emergency settings	<i>“(In Birmingham) there are very deprived areas, and patients’ expectations are a lot lower of what to expect. So, I say to some of them <Oh, you can go home now>, but they go <Really? I like it here, because you get your food and everything else provided> and they don’t want to go home” (LCSH105)</i>

10.4.2.3 Accessibility of the Solar’s crisis service

In this theme, all participants considered the accessibility of the Solar service as a crucial factor. However, the participants also mentioned additional factors that are closely linked to accessibility such as referral experiences, responsiveness, and barriers to accessibility, which will be further explored as subthemes of accessibility.

Referral experiences

Most of the interviewees agreed that referral experience to the Solar crisis service was easy and straightforward. However, the experience of referral varied between the different participants and their professions. For example, most participants in educational settings needed contact with the Solar crisis team when students started to show signs of a crisis.

Likewise, the participant LCSH102 reflected on their referral experiences to the Solar crisis team, and the participant’s impressions were that the referral process was *“straightforward, yes, as we do it all the time”*. However, participant LCSH101 shared

their experience of referring to the Solar crisis service as *“always straightforward”*. Nevertheless, referrals to Solar have also been described as *“not difficult just long and not that straightforward”* (LCSH101).

Similarly, all other education professionals expressed satisfaction with the referral process to Solar’s crisis service. However, their satisfaction was significantly lower for referrals to another team within the Solar. Moreover, different educational providers had different referral practices. While some participants made direct referrals to the Solar service, others only encouraged parents or YP to self-refer to Solar or to seek a referral from their GP’s. For example, participant LCSH100 stated that they tend to refer their students to the Solar service if they need to do so. However, the participant also felt that it was essential for the service to receive two referrals, as it would be much faster if both GP and education provider referred CYP to Solar in comparison with the referral only from the education provider. In contrast, instead of directly referring YP to the Solar, the participant LCSH101 encouraged their students to refer themselves to the service.

Furthermore, the main rationale why some educational providers may encourage students to self-referrals to the service may also be due to the interviewee’s perception that long referral form for the Solar service may also affect the accessibility of the service.

During interviews, most hospital staff reported that they only work with the Solar crisis team. All interviewees from hospital settings perceived the crisis team as accessible and responsive. However, all these participants stated that they do not have any further contact with other parts of the Solar system to share their experiences of referring to Solar. However, some hospital staff reported that some CYP had been sent to A&E by their GP’s, instead GP’s making a direct referral to the Solar service.

However, according to hospital staff experiences, it is not just GPs who are cutting corners and trying to pass patients on to hospital care. Some educational settings also misuse A&E and hospitals so that students can have faster access to Solar. For

example, participant LCSH106 explained that there is often “a real lack of understanding from schools of what the hospital is here for”. Similarly, participant LCSH105 added that children are often being tossed between “schools to GPs, and GPs to A&E”.

Table 82 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals - Education</p>	<p>“If CYP don’t feel very well or they’re not coping is by saying they’re going to commit suicide and or do some harm. And so, I will have to sort of get in touch with the Crisis Team for that. Usually it’s, phoning them up, getting advice and then if they need to then I’ll refer, so it’s only been a couple times. I’ll always get advice as to which path to take because sometimes it might not be appropriate. So, if in doubt, I will liaise with Solar as a course of action so, so that’s the positive, the referral kind of side of things.” (LCSH100)</p> <p>“If it’s going to be a referral, I will make the referral but also advise parents to take the child to the GP and get them to refer as well, as sometimes like that can be quicker to get faster access to treatment. I think when schools refer it’s not enough information... Cause it’s a very long waiting list and so I just feel that sometimes going via the GP can also be quicker.” (LCSH100)</p> <p>“So, we’ll give them the information about the Solar website and encourage them, if at all possible, to liaise themselves and make their own referrals.” (LCSH101)</p> <p>“So, we’ve done a lot of work with Solar Crisis with the young people that come into our care for self-harm, suicidal intention, aggression, behavioural problems. When we refer, it’s quite a straightforward service” (LCSH104)</p> <p>“... three hours approximately I spent on one student, to refer them externally. And I see about, on average 25 students a week. That’s a huge amount of my time. So, with FTB, their referral form isn’t very long, and I can put in there <Please see initial assessment> what with Solar long referral form I cannot” (LCSH105)</p> <p>“I think it’s quite a long form, somewhat convoluted form if I can remember, but they weren’t difficult, although time consuming., it’s like six to seven, eight pages, so definitely long form to fill” (LCSH101)</p>
<p>Local Community Professionals – Urgent and Emergency settings</p>	<p>“With Solar we don’t tend to have a significant referral delay. Usually we will make a referral to them in the morning, and we will see somebody by the end of the day or middle of the day, unless the child is on treatment. In higher episodes of admissions, exam time predominately, Solar referrals can be slower, and the assessments can take a little bit longer, but that’s purely for the fact that the increase of number of patients, which we all understand that.” (LCSH106)</p> <p>“So, GPs send them (CYP) to A&E because sometimes it’s easier for them to pass patients forward than to make a proper referral themselves. But GPs need education in what’s the right way to refer in. “(LSH104)</p>

Responsiveness

Regarding the responsiveness of the Solar service and its crisis component, education providers had different experiences. All education providers reported that the crisis team is more responsive than the Solar service as a whole. For example, participant LCSH100 stated their understanding that Solar is under pressure due to large numbers of incoming referrals. Still, the participant also added that *“trying to get a referral and get an appointment with Solar can be quite difficult.”*. Therefore, LCSH100 stated a preference for the crisis team due to their rapid response compared to the Solar service, mainly due to *“how quickly the crisis team sees students”*.

On the other hand, all hospital sites commended the responsiveness of the Solar crisis team. The participant LCSH106 also reported that the Solar’s crisis team is responsive to their patients’ needs, and that the team sees patients as quickly as possible for crisis assessment. However, LCSH106 raised an interesting point about the timing of crisis referrals, assessment and crisis treatment that should be carried out within the four-hour window as stipulated by Crisis Concordat. All hospital workers found this four-hour window for crisis assessment and treatment planning to be unrealistic. LCSH104 (and LCSH106) added that the Trust does not blindly follow four-hour window period as *“we don’t think it’s right for young people.”* Therefore, the four-hour period for assessment and treatment of CYP in crisis is more perceived as an advisory rather than a mandatory requirement. In contrast, participant LCSH105 felt that the crisis team do not have enough staff to cover both community and hospital referrals within the four-hour window. However, all hospital and educational staff shared a similar perception that the Solar’s crisis team is responsive to the initial assessment of CYP in a mental health crisis.

Table 83 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals - Education</p>	<p><i>"I think generally when the referral goes through, I think it's two to three weeks before they (Solar), kind of, get some kind of response in terms of treatment. " (LCSH102)</i></p> <p><i>"If it's going to be a referral, I will make the referral but also advise parents to take the child to the GP and get them to refer as well, as sometimes like that can be quicker to get faster access to treatment. I think when schools refer it's not enough information... Cause it's a very long waiting list and so I just feel that sometimes going via the GP can also be quicker." (LCSH100)</i></p> <p><i>"So, we'll give them the information about the Solar website and encourage them, if at all possible, to liaise themselves and make their own referrals." (LCSH101)</i></p> <p><i>"So, we've done a lot of work with Solar Crisis with the young people that come into our care for self-harm, suicidal intention, aggression, behavioural problems. When we refer, it's quite a straightforward service" (LCSH104)</i></p> <p><i>"... three hours approximately I spent on one student, to refer them externally. And I see about, on average 25 students a week. That's a huge amount of my time. So, with FTB, their referral form isn't very long, and I can put in there <Please see initial assessment> what with Solar long referral form I cannot" (LCSH105)</i></p> <p><i>"I think it's quite a long form, somewhat convoluted form if I can remember, but they weren't difficult, although time consuming., it's like six to seven, eight pages, so definitely long form to fill" (LCSH101)</i></p>
<p>Local Community Professionals – Urgent and Emergency settings</p>	<p><i>"(Crisis)They normally come within a day. Occasionally it has been within in four hours period, but, yes, they normally come that day. Once a child is medically fit, obviously if they're on treatment for a specific overdose then they can't come. They don't normally come until they're deemed as medically fit. So (Crisis team), I do feel that they do prioritise the hospital and they do come as soon as they can. Four hours sounds ambitious and sounds, like I wouldn't think that we'd get all the kids seen in four hours, if I'm honest, from the initial point of referral. It sounds great to me, but I can't see that we get that." (LCSH106)</i></p> <p><i>"(Crisis team) They don't get seen always within four hours. But that usually it's fine. They will be seen the same day, which is okay. Within four hours would be wonderful, but we live in a realist world. So, seeing them the same day is fine. From the Solar crisis perspective, they come the same day, so I don't personally have any problems with that. Within this Trust, we don't do that. So, when they (CYP) come in, they're seen by, um, a doctor in A&E, just to make a medical assessment, as such, that they're okay, and then they come up to Paediatrics. So, the clock then stops. So, there's no pressure to get them seen by Crisis." (LCSH104)</i></p> <p><i>"We seem to get a referral, I know that obviously it's not within the four hours normally, which would be lovely, and obviously sometimes we have periods where we have a high influx of CAMHS patients and then that's difficult for them to all be seen in a day." (LCSH105)</i></p>

Barriers to Accessibility

All participants from educational and hospital settings reported a range of barriers that affect the accessibility of the Solar and its crisis component. The following barriers to access will be further explained: The Solar service locations and lack of drop-in hubs; continuity of care; timeframes; and lack of staff.

Solar service locations and lack of drop-in hubs

All participants from the education settings agreed that the current locations of the Solar service are not particularly suitable for CYP in the Solihull area. For example, participant LCSH101 reported that some CYP have struggled to get to the Solar services in cases where *“parents are not driving, or parents are not willing to take a young person to appointments”*. The participant added that the location could be a reason why some CYP are discharged as *“did not attend treatment because of not being able to reach the service”*. Situations in which parents are not proactive in helping their child often results with their children appointment *“doesn’t get followed up, and then they miss the appointments, and then they get obviously discharged from the service.”* Therefore, the participant often drives their students to one of the Solar locations so that they do not miss their treatments due to the inaccessibility of the service locations.

Likewise, participant LCSH107 also reported that if students want to attend to the Freshfields clinic for their appointment *“in terms of public transport, I don’t think (CYP)they’d know how to get there. There is just no direct bus or transport link from Chelmsley Wood”*. Other educational interviewees reported a need to drive their students to Solar for the CYP appointments.

Equally, participant LCSH103 reported that *“Solar service is inaccessible to students”*. In contrast, the participant thought that the main reasons for this inaccessibility were because *“these those two locations are the two extremes of Solihull, aren’t they?”*.

However, LSCH103 suggested that the Solar service would be more accessible with *“a more central Solihull location or at least a drop-in centre”*.

The need for a drop-in centre was a prominent theme among all the participants, who viewed these centres as a possible way to improve the accessibility of the Solar service. The participant LCSH100, for example, believed that *“Solar would benefit from more hubs across Solihull that would cater to all parts of the borough”*. LCSH103 similarly felt that Solar would benefit if *“they had a drop-in place similar to the Pause in Digbeth, but in the centre of Solihull”*.

Participant LCSH101 added that most YP need a small conversation with someone to *“get something off their chest”* without having to wait a long time or make an appointment, with a place *“where you can turn up at any time”*. The participants believed that this would make YP *“feel kind of better and then it probably wouldn’t even require much more intervention”*. Likewise, participant LCSH106 felt that *“it would be fantastic if the Crisis Team had like a drop-in clinic more centrally.”*

Additionally, participant LCSH102 also reported that *“the drop-ins are the way to go, maybe a hub in the town centre?”* The rationale for why these drop-in hubs are needed has been further explained by LCSH102 due to a shift in the YP’s perceptions that *“healthcare services have to go to patients, instead of patients to healthcare providers”*. Therefore, the participant concluded that to save the CYP *“we need to make mental health services as much as accessible. So definitely hubs everywhere”*.

Table 84 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals - Education</p>	<p><i>“So, at the moment I'm taking them to those appointments over there at Freshfields clinic and back to school “(LCSH107)</i></p> <p><i>“Sometimes when our students go to these groups treatments they don't come back to school, as transport is an issue for them, and the majority of our students are transported into school. And if transport is an issue for parents, they can't get them to the Solar. “(LCSH100)</i></p> <p><i>“I do like the drop-in centre because it's, you know, you can just advise young people to go there and have a look without any commitment. And I think that's, that would be the useful thing about having a front facing drop-in centre in Solihull.” (LCSH103)</i></p> <p><i>“So, I think more hubs would definitely be a good thing. More hubs, more appointments, more convenient for people depending on where they are in terms of locality. And another gap would be, is that I know Forward Thinking offer Pause and I think that's really great that you can have somewhere where you can just turn up, you can just be seen on the day, you know, it's just a complete drop-in. If Solar could offer something like that, I think that would be amazing 'cause I think that would cover so many bases” (LCSH101)</i></p>

Assessment timeframes

The timeframe between being referred to the Solar and being seen by someone in the Solar has been identified as a barrier to access by some participants, mostly those from educational settings. As participants LCSH100 explained, there is an evident gap between “once you've made the referral before somebody's possibly can see somebody”. The participant was under the impression that CYP should be seen “by somebody initially I think pretty soon within a week I think, if not sooner”. Also, LCSH100 added that some of their students' referrals are not even assessed two months after the referral was sent to Solar, and “that's a huge amount of time of waiting for a young person who is experiencing suicidal thoughts, as by the time they are assessed they could have acted on”.

Lack of staff and continuity of care

All interviewees thought that both the Solar and its crisis component are understaffed, which also impacts their capacity, consistency and continuity of care. For example, LCSH100 reported that CYP who do not have consistency and continuity in their care would often *“have to repeat the story”*. The participant compared this to a situation where *“the GP hasn’t read your notes, and you’ve seen a different GP to the previous time, and you need to say your story all over again”*. A similar need for the consistency with care was evident in LCSH102 response, who perceived that care consistency is absent from the Solar service due to *“the high staff and clinicians’ turnover”*. The participant emphasised the importance of the therapeutic alliance *“to make that initial connection with the therapist.”*

However, changes in staff and a high staff turnover often affect not only therapeutic alliance and continuity of CYP care but also parental satisfaction with the overall service. For example, LCSH100 explained that the impact of high staff turnover affect not only CYP but their parents as well, as they are forced to repeat their children’s stories. Similarly, hospital staff also stated that the crisis team is understaffed. For example, participant LCSH104 acknowledged that *“there are staff shortages within their crisis team”*. Equally, LCSH104 agreed that *“more staff in the crisis team would be good”*, as more crisis staff could contribute to *“more training and extra hospital support”*. Likewise, LCSH105 agreed that *“there’s not enough crisis staff in the Solar service to see patients at the hospital quickly”*, mainly as existing staff members are *“already looking after a lot of children that are in the community”*.

The consensus among all interviewees was that the crisis team seems to be overstretched, but still capable of providing invaluable crisis interventions to CYP in their communities.

Table 85 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals - Education</p>	<p><i>“(Solar staff) They don’t come here anymore to do anything, and I think that’s more to do with them not having the capacity. I know they were in Crisis because of lack of staff and not having enough psychiatrists.” (LCSH100)</i></p> <p><i>“The parents don’t like it either. I’ve had a while ago parents who complained that psychiatrists were often changing, they didn’t know who they were seeing. And the difficulty is then to building that relationship with the families, and especially for young people. They get used to one and then it changes, and they feel they have to go through the whole story again and that’s something that they don’t like.” (LCSH100)</i></p> <p><i>‘Cause there was a time when (Staff) they were changing so frequently that the parents were getting very fed up. Just, well I’m having to repeat everything every time I see somebody. And they don’t like to. Some don’t mind, some like to talk about their life history. But a lot of the parents they don’t want.” (LCSH100)</i></p>

10.4.2.4 Community needs from Solar and its crisis service

All stakeholders saw the Solar service as a community service, which provides crucial service provision for CYP mental health needs in its community. Furthermore, in this theme participants shared their perception on whether the Solar service meets CYP mental health needs, and desire for more available community support in the Solihull.

Need for the Solar service and meeting local community needs

All participants reported that there is an evident need in the Solihull borough for the Solar and its crisis service. For example, LCSH102 believed that the Solar service is *“absolutely needed, 100% needed”*. Other participants from education settings shared similar opinion.

Participants’ responses show that Solar and its crisis service are very much needed in their local community. It is also evident that the service meets most of CYP mental health needs. However, as LCSH104 pointed out *“these needs are mostly met during the day”* while the apparent gap is with the number of employed crisis staff and

service provision during the Solar non-working hours and weekend provision, compared to 24/7 service provision of the FTB.

Table 86 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Local community professionals - Education	<p><i>'Yes, definitely that service is needed. I think quite often the Crisis team is the first point of entry, because, you know, when a young person's kind of experiencing mental health issues for so long, or, you know, something's happened, whether they're in that crisis, sometimes that's the time when they actually do reach out for support, 'cause sometimes if (CYP) they don't reach crisis, (CYP)they don't ask for support.'</i> (LCSH101)</p> <p><i>'We have a lot of students that present with crisis situations, as you can imagine, college and universities are a highly pressured environment. We quite often have the ambulance and the mental health car out here, we have the police here as well. Often the crisis calls are made by the safeguarding officers, and all over really, we have to make quite a number of crisis calls. So Solar is not just needed, it does meet CYP needs.'</i> (LCSH102)</p>

Participants	Quotes in the support of theme
Local community professionals – Urgent and Emergency settings	<p><i>'Without a shadow of a doubt, both Solar and crisis are needed. And sometimes the pressures from (CYP)their family or themselves can cause a lot of the issues, so it is paramount to have good community mental health service. However, I think that Solar crisis does meet needs during the day, yes. I also think in an evening and a weekend, probably not. And again, that's due to the funding for the number of nurses that you can get to provide a service'</i> (LCSH104)</p>

Need for more support in the local community

Although all interviewees welcomed the presence of the Solar service in the Solihull, some participants felt that there was insufficient local community support for CYP who are affected by mental health. For example, the majority of hospital staff pointed out that the main reasons why YP end up in urgent and emergency care settings is mainly due to limited community support. From the perspective of hospital staff, it can be seen how much local community mental health support for CYP and their families is essential. The role of early intervention and prevention needs to be more prioritised in communities so that these services can educate service users and their families, but also spot the signs of mental health issues in their early stages and prevent further escalation of mental health issues.

Table 87 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals – Urgent and Emergency settings</p>	<p><i>“I think, from what (CYP/parents) they say, from the reports you get off the families, they don’t receive as much support as they would like in the community. And that’s why (Parents) they bring (CYP) them into hospital, and why child again, you know, becomes anxious or has some self-harming thoughts and then results them coming into hospital; takes an overdose or self-harming.” (LCSH105)</i></p> <p><i>I think parents get frustrated that they don’t have as much support in the home, and when they pitch back up with their children they’ll say, “You know we haven’t been given what we necessarily need. They’re not seen frequently enough.” And you can only sympathise for that, because there’s only so many people that can support them, and children’s needs are very different. But as a parent they’re just worried for their own child, aren’t they? They don’t necessarily see the bigger picture of the whole service and the whole needs of the community. They just see their own child. So, I think a little bit more communication with them, education with them. But I think long-term education with parents anyway, to be honest.” (LCSH106)</i></p>

10.4.2.5 Impact of the 0-19 model and its crisis service on the local community

In the last theme, all interviewees reflected on the degree of impact that Solar made since its implementation in its local community. Besides the impact, participants also shared their perception of the Solar partnership model and contrasted the Solar model with its neighbouring service provider – FTB.

The main perceived impact of Solar

Most of the participants’ responses were split between Solar making impact versus not making enough impact on its local community. For example, LCSH100 said *“I would certainly hope so that Solar makes an impact in the Solihull”*. The participant added that for some of their students *“the service does make a significant impact in their lives”*, but for others *“they don’t want to engage, and you can’t force them to engage”*. LCSH100 concluded that *“you are always going to get those that don’t want to engage and there’s nothing you can do about that”*.

LCSH101 and 103 also stated similar perceptions that Solar is making an impact in the lives of CYP in the local community. For example, LCSH101 reported that *“the service does make an impact”*, while LCSH103 stated, *“previously no, but now Solar does make an impact, but still not to the extent as FTB does”*.

Likewise, LCSH105 stated the similar opinion that *“every attempt of improving young’s people mental health is good”* while the participant added that *“crisis service is making an impact, but I cannot tell for other parts of Solar”*. Equally, participant LCSH106 agreed that *“(Crisis) Solar made an impact in the Solihull”*, but participants also added that they tend to treat in their hospital only *“a small cohort of patients that come under Solihull”*. Despite small numbers, LCSH106 stated that *“CYP still have a lot better care from Solar for mental health.”*

In contrast, a more critical perception of the impact of the Solar service in the Solihull was stated by LCSH102, who argued that *“as long as Solar is invisible in its local community, there is no impact”*. The participant added that *“Solar is invisible on the campus”* what according to LCSH102 is a clear indicator that *“Solar did not make enough of an impact on its community”*. However, if Solar has a more significant impact in the Solihull, LCSH102 suggested that *“there needs to be a huge presence of Solar here at the college, but also the local community, so Solar needs to link more with local communities”*. Lastly, LCSH102 added that *“Solar is not linked with its local community and (Solar) they call themselves a community local service”*.

Although Solar is widely perceived as a service that impacts the local community, it is also evident that a lack of Solar’s linkage with educational providers may also reduce its overall impact and the degree of visibility of the model in the community. By contrast, most colleges have established good ties with FTB. Besides, FTB has a good presence in social media, many promotional materials and education leaflets. Therefore, it is clear that the Solar service needs to consider similar steps and engage more closely with educational providers and increase its visibility in the community in order to have an even more significant impact on the local community.

Partnership

Most of the interviewees had a positive view of the Solar partnership. However, some participants were sceptical about the partnership, mainly due to the involvement of Autism West Midlands (AWM). For example, LCSH100 was under the impression that Solar partnership “*probably is not working*”, mainly due to “*limited involvement of AWM*” with Solar. However, LCSH100 was more optimistic regarding the partnership between NHS and Barnardo’s. The similar negative perception of AWM came from LCSH101 who stated that their stance is “*we don’t want to have anything to do with Autism West Midlands*”. On the other hand, LCSH101 added: “*the rest of the Solar partners are closer to us, and they offer more reliable service provision for our students*”. More optimistic and positive perceptions of the Solar partnership came from LCSH102, who perceived the partnership as “*good and needed*”. The participant also commended Solar for “*bridging the three partners together*”. The participant concluded, “*I think it’s a great partnership*”. Lastly, participant LCSH103 stated that they were “*not aware that the partnership even existing within the Solar service*”. Despite some negative perception of AWM, most participants still had a positive opinion of the Solar partnership between NHS, Barnardo’s and AWM. Negative attitudes regarding AWM were primarily related to their limited engagement with the Solar service and lack of more support for ASD students and their families. The overall partnership was welcomed and perceived as needed.

Table 88 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Local community professionals - Education	<p>“I mean, Autism West Midlands support is very limited, I know they’re supposed to be working with Solar, but I’ve not had anything from them for a while. Because my understanding is that Autism West Midlands are meant to help the families, but their services are very limited. And would be nice to have them here so that maybe we could set up something with parents so that they know that they’re here and are available, as we have so many students with Autism, and most parents feel abandon by the lack of autism support in this area .”(LCSH100)</p> <p>“The rest of the Solar partners - I think they do work well together. I think the Tier 2, Tier 3 work well together ‘cause I know that when they’re at Tier 3 sometimes and that work is done, they move down to Tier 2 or vice versa. So that’s not too bad.” (LCSH100)</p>

Solar versus FTB

When participants were asked about their preferences for working between Solar and FTB mental health service, experiences of participants from educational and hospital settings varied significantly. In the case of educational settings, preference was stated for the service that the education provider has well-established linkages or most positive referral experiences.

For example, participant LCSH103 stated that they mostly deal with Birmingham students in their educational setting, and FTB is a logical choice of mental health service that address their student's mental health needs. The participant explained that they are *"more familiar with FTB than with the Solar service"*. Similarly, the preference for FTB service was also evident in another participant's response, largely due to better visibility, support and responsiveness of the FTB team. Furthermore, LCSH101 reported that despite the size of the FTB, the accessibility of the model is still limited. The FTB's service provision is fragmented between different external providers under the umbrella of FTB. Equally, LCSH103 reported the perception of FTB and its barriers to access by stating that *"the length of waiting time for a referral is a barrier to access"*. However, the participant also added that *"the length of waiting time, that is the problem"* for both FTB and Solar.

In contrast, hospital staff provided different perceptions of their preferences between two services. All hospital staff have explained that both services have their positive and negative sides. However, most hospital staff reported more preference for Solar crisis team. For example, participant LCSH104 reported that out of the two services that they use in the hospital *"Solar is heads above the other service that we receive"*. However, the participant stated that in some cases, even Solar service has drawbacks and limited-service provision, especially with night coverage, while FTB *"tends to pick up the patients during the night, rather than Solar"*. Still, LCSH105 stated that hospital staff are mostly struggling with one segment of the Solar service *"the medic side of Solar that we struggle with, compared to FTB"*. Participant LCSH107 also reported that *"getting medic reviews is a difficulty, with both FBT and Solar."*

Table 89- Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p>Local community professionals - Education</p>	<p><i>“Most of my dealing is with Solar and so I’m going to say that I prefer Solar. I know when I phone up Solar, they will share the information and I will share with them as well as much as I can with GDPR. So, we’re able to help support that child better. Whereas with Forward Thinking it’s not been the case and the information sharing from Forward Thinking has been less forthcoming than Solar.” (LCSH100)</i></p> <p><i>“I am very impressed with FTB and their responsiveness. The FTB supports us, although we are based in Solihull, FTB sent to college their big posters, and leaflets. So, it would be great to have the same from Solar” (LCSH102)</i></p> <p><i>“When you're referring to Forward Thinking, the set response is, <Okay, you can have six sessions with Open Door counselling service> and that's just a set response you get for realistically any referral that you put in (FTB)they, kind of, commission it out so you've got, like, Health Exchange, Open Door, Living Well Consortium, and generally the set response is, no matter, kind of, what the level is, <Off you go to one of those>. And then you have your six weeks and at the end of that, you obviously get discharged, and then there's, like, a three-month cooling off period. So even at the end of that, if that young person's still in distress they can't go back into the service for another three months. So, it's, kind of, like, a barrier then. I found that quite challenging with Forward Thinking, and their waiting lists are really long for actually getting a key worker. I don't think I've ever had a referral go straight to being picked up for one-to-one, you know, kind of, under Forward Thinking. It's always passed out to external services who are, kind of, commissioned by Forward Thinking” (LCSH101)</i></p>
<p>Local Community Professionals – Urgent and Emergency settings</p>	<p><i>“I think we’ve probably got a better rapport, to be honest, with Solar on the unit than we have with the FTB Team. Simply, preference for Solar as we’ve got a better sort of working arrangement with them, and their staff are really friendly”. (LCSH105)</i></p> <p><i>“Where (FTB) their advantage is they’ve got a team around them. So, they’ve got a medical team as well. So, we can get a little bit, they can get a little bit more medical support faster if they think that the child needs that, whereas Solar probably a little bit slower. However, Solar is a lot more personal, better communication, much faster at responding for assessment” (LCSH106)</i></p> <p><i>“I definitely think that the Solar crisis team are very responsive in the capacity that they’ve got. As I said, I know they can't go out to everything, I know that they can't pick up everything because if they did, as I said, it would be ineffective. Whereas with Forward Thinking it's not that simple sometimes, because once that's been passed off to one of the external agencies we've got to, kind of, phone up, try and find that number, then contact the person, it's actually quite complicated to actually find a person to speak to on the Birmingham side.” (LCSH107)</i></p>

10.5 Discussion

This study aimed to investigate local community stakeholders' perceptions regarding the impact that the Solar model has on its community, its accessibility and acceptability. The main findings from this chapter are structured around the main themes identified through the template analysis. The final template included five main themes: (1) Satisfaction with the Solar service and its crisis component, (2) Local community context, (3) Accessibility, (4) Community needs from the Solar and its crisis service, and (5) Impact of the 0-19 model's crisis service on the local community, which will be further discussed.

All stakeholders in this study expressed satisfaction with the Solar crisis team, while only some expressed satisfaction with the overall Solar service. Similar findings were also evident in the previous chapters 5 and 9. According to a findings of the 2017 report, 64% of education providers indicated a low of satisfaction with traditional CAMHS services, mainly due to non-accessibility of services, their limited support available and issues with the timeframe for support (Marshall, Wishart, Dunatchik, & Smith, 2017). Similar findings were evident in another study that found that CAMHS waiting times, lack of flexibility and service availability were seen as barriers to access, and were also one of the main reasons for educational settings dissatisfaction with mental health providers (Allison, Roeger, & Abbot, 2008). Although some participants were satisfied with Solar, the education providers in this study agreed that Solar still has issues linked to accessibility and timeframe for assessment and treatment compared to the crisis service that was perceived as more accessible and responsive.

Stakeholders also reflected on their experiences of referring to the Solar and its crisis service. All stakeholders agreed that the Solar crisis service referral experiences were positive and straightforward. However, the experiences associated with the Solar model were quite divided due to the referral form that was perceived as convoluted and lengthy. In the literature, there is a similar perception of multiple administrative and bureaucratic barriers to accessing CAMHS services. For example, one report stated that some professional health care workers, such as GP's, found referral forms

and admission to CAMHS to be complicated and 'bureaucratic' (Healthwatch Leeds, 2015). The same report also added that 7% of healthcare professionals found referrals to CAMHS as "*fairly lengthy process*", while the referral form was perceived as "*too detailed and not practical for GPs to use*" (Healthwatch Leeds, 2015). Similarly, in other qualitative studies, parents reported a range of administrative and bureaucratic barriers to mental health service acceptance (Reardon et al., 2017b). Equally, YP also reported the presence of bureaucratic referral procedures that acted as barriers to acceptance (Wilson, 2001). The existence of bureaucratic or administrative barriers may contribute and precipitate misuse of A&E's and hospitals to gain a faster acceptance into the mental health services.

The majority of hospital interviewees in this study emphasised how hospitals and A&Es can be misused by GPs and schools to pass children forward and avoid the need for waiting for access or deal with lengthy referral forms. A recent review found that often patients seeking help from hospitals and A&E is mainly due to a need for speed, compliance with advice from other healthcare professionals or frustration due to not being able to get a GP appointment (O'Cathain, Connell, Long, & Coster, 2020). This review concluded that some GPs and other services are actively advising patients to seek help from urgent and emergency care systems (O'Cathain et al., 2020). Indeed, the 2017 report stated that there had been an increase in urgent and emergency patients visit over last 20-year period in urgent and on the recommendation of either a GP or another healthcare professional (Masoni, O'Keeffe, Jacquesi, Rimmeri, & Ablardi, 2017). This report also found a substantial increase in the number of patients (51.5%) reported to be advised by other healthcare professionals to seek help from urgent and emergency settings. In comparison, 35% of these patients reported being advised by their GP to attend urgent and emergency settings (Masoni et al., 2017). Therefore, the report concluded that GPs and other healthcare professionals need to be provided with training in the assessment and treatment of paediatric patients.

Furthermore, regarding the responsiveness of the Solar and its crisis service, the findings of hospital workers and educational setting agreed that the crisis team was

more responsive compared to the rest of the service. These findings are in line with findings from chapters 5 and 9.

However, in the case of Solar, it is evident that waiting for treatment is necessary what may be perceived as a barrier to access. Similarly, the interviewees also mentioned several other barriers that could affect the accessibility of Solar service such service locations, lack of drop-in hubs, lack of continuity of care, long timeframes for assessment, and lack of staff. Most of these findings have already been mentioned in chapter 5 and 9 by parents, staff and CYP. Additionally, in the previous discussion section of chapter 5 and 9, the researcher also compared the available literature, which highlighted the extent to which lack of accessibility, long waiting times and lack of staff (resources) could have an impact help-seeking behaviour, service engagement and CYP development of therapeutic alliance with staff members. However, the Solar service was perceived by all participants as a community service that meets CYP needs and is very much needed in the local area.

Furthermore, it was evident from the interviewees' responses that there is currently an apparent lack of more local community support for CYP in the Solihull area. These findings are well supported by the recent survey, which found the lack of early support for YP mental health in their local communities across the UK has put additional pressures to GPs (Young Minds, 2019a). The evident lack of youth clubs, drop-in centres, and youth organisations in YP communities works against effective early intervention, which leads to increased pressures on GPs, and urgent and emergency settings. The Future in Mind report made it clear that every area within the UK should have a more visible one-stop-shop service that is easily accessible to CYP to seek help, advice and support in a local community environment (Department of Health, 2015). However, the findings of this study confirm that there is still an apparent lack of more local community support for CYP, which may, therefore, contribute to an increased help-seeking from urgent and emergency settings. If community mental health services can meet the local CYP needs, it might be predicted to prevent (or reduce) a need for urgent and emergency mental health care. A recent editorial concluded that CYP who are treated in the local community should be able to better cope with their

mental health and less likely to seek help from urgent and emergency services (Cotgrove, 2018).

In the last theme, all interviewees reflected on the degree of impact that Solar, and its crisis component have had since their implementation in the local community. Most participants agreed that the service does have a degree of impact on the local community. Still, more needs to be done, especially regarding the links between Solar and educational settings. Most literature points out that individuals affected with mental health illnesses are more prone to be at risk of educational difficulties, decreased productivity, poverty and social problems (Kessler, Foster, Saunders, & Stang, 1995; Merikangas et al., 2009). Also, early onset of mental health disorder often compromises an individual's ability to engage fully in education, as individuals affected by mental health illnesses are less likely to complete higher education than YP of the same age who are not affected by ill mental health (Kessler et al., 1995). Besides education, poverty can also have detrimental consequences for mental health, by creating a vicious cycle through which poverty acts as a precipitator of mental health illness. Consequently, mental health illness contributes to an increase in the risk of poverty and contributes to the continuity of that cycle (Lund et al., 2011).

For these reasons, it is crucial to establish good and effective links between local mental health services and education providers to promote good mental health and wellbeing outcomes and build CYP resilience (Public Health England, 2017). Additionally, the UK government "Green paper" report published in 2017 outlined plans for the expansion of mental health and laid the foundation for Mental Health Support Teams trailblazer work to enable early intervention and prevention of mental health difficulties (NHS England, 2020). Similarly, the Solar service recognised this by establishing in 2019 a link between the service and educational providers called Solaris. Solaris intend to improve the linkage between the service and educational setting (Solihull CCG, 2019). However, the service still needs to address the identified issue of lack of the visibility of the model, as making mental health service provision more visible may contribute to better accessibility and engagement with the model,

and create a more significant impact on the local community (Care Quality Commission, 2017).

Furthermore, the overall participant's perception regarding the Solar partnership was mostly positive. The whole partnership between statutory and voluntary sectors was welcomed and perceived as needed, and as such, was viewed as a positive step forward. However, some participants considered AWM to be the weakest link of this partnership of the Solar service. These findings are similar to the previous findings from chapter 5, which also found AWM as the weakest link in the overall Solar model.

However, integrated work between the statutory and voluntary sectors has well established positive outcomes and good literature backing, as mentioned previously in chapter 5. Furthermore, integrated–whole-system models of CYP mental health care are often described as joint ventures between the statutory, voluntary and more specialised mental health care sectors, which allows CYP with a range of mental health problems to be safely treated closer to home, in a community setting (Gill & Border, 2017). These ‘joint partnership’ models have the potential to create more youth-friendly services based on early intervention and prevention of unnecessary admission to acute or inpatient settings (Wilson et al., 2018). The voluntary sector also plays a key role in supporting families and CYP mental health in the local community settings (The Children’s Society, 2015).

Besides, these organisations can complement each other by creating more recovery-orientated approaches, innovative treatments and support alternatives and empowerment of CYP to take active control of their mental health (Newbigging, Mohan, Rees, Harlock, & Davis, 2017). Additionally, even Crisis Concordat’s (Crisis Care Concordat, 2018) recommendations supported a collaborative partnership between voluntary and statutory organisations to develop a more efficient mental health and crisis pathway to meet the needs of CYP. Indeed, partnership within the Solar service is a positive step forward.

However, the problem of waiting times remains and is identified by all interviewees as problematic, which may, therefore, contribute to a greater need for help-seeking from urgent and emergency settings. All participants agreed that both the 0-19 and 0-25 models expose CYP to long waiting times for access to assessment and treatment. Recent performance statistics of the different NHS England trusts showed a significant increase (58%) in waiting times for access to CAMHS service provision (NHS England, 2019a). Nevertheless, the NHS England has announced a new waiting times target for CYP mental health provisions, such as four-week waiting times for specialist mental health services and a one-hour target for assessment of CYP experiencing mental health crisis in urgent and emergency settings (Young Minds, 2019b). Some participants in this study have already shown a degree of scepticism about narrow assessment times. However, it remains to be seen whether these measures will reduce the waiting times for CYP to access the assessment and needed treatment and improve overall access to local mental health services.

10.6 Strengths and Limitations

The main strength of this study can be seen in its community-based participatory research orientation aimed at developing further knowledge and understanding of the local mental health service provision for CYP by empowering, encouraging and involving participants to share their experiences and attitudes regarding Solar and its crisis component. Community engagement is a vital part for evaluating complex community systems such as the 0-19 model and its crisis component, to understand how the model behaves in its community and the relationship between the model and its local professional community. A further strength of this study is in its first attempts to use the local community stakeholders to understand how the UK's retransformed mental health services operate from local professional stakeholders' perspective. The findings of this study are well supported by the findings from chapters 5 and 9, and these findings are an interesting overview of two different service models operating close to each other and their impact on the local community.

However, this study has limitations mainly seen in the modest sample size and its local community orientation. Additionally, all recruited participants were female, as this study failed to recruit any male professionals. This sample size can be seen as a limitation due to its focus on a relatively small local geographical area and limited recruitment of other occupations in the sample. Therefore, this study findings cannot be generalised to the entire population and other parts of the UK. Besides, the additional limitation of this study is the lack of GP representatives in this sample. In this study, we tried to recruit a small sample of GPs. Of 20 interview invitations sent to various local GP practises and five practices that the student visited personally, not even one GP practice responded positively to this research. Therefore, future research should seek to understand GP's attitudes about barriers to CYP referral to mental health services and the issues raised by interviewees. Lastly, the lack of focus groups with community stakeholders can also be seen as a limitation of this study. Most of the other community engagement research studies used focus groups in their design, while this study only conducted a range of interviews.

10.7 Chapter summary

The main aim of this study was to gain an understanding of professional local community stakeholders' perceptions of the accessibility and acceptability of the Solar service and its crisis component. All interviewees expressed higher levels of satisfaction with Solar's crisis service compared to its overall service. The crisis service was also perceived to be more accessible and responsive to CYP needs than other parts of the service. The interviewees also reported a range of barriers that could affect the accessibility of Solar services such as lengthy referral forms, inaccessible service locations, long timeframes for assessment, and a lack of staff, continuity of care and drop-in hubs. However, despite all the barriers identified, Solar was still perceived as a much-needed service in its local community that met most CYP needs; however, some interviewees felt the service had visibility issues. Furthermore, a lack of out-of-working-hours service was perceived by all participants as a service gap. Interestingly, most participants agreed that the partnership between NHS, Barnardo's and AWM is a positive step forward, although some considered AWM as the partnership's weakest link. Lastly, as some participants had worked with both Solar and FTB models, this allowed for interesting comparisons between the two. While some participants stated a preference for the FTB service, others considered Solar to be more integrated and responsive.

Chapter 11: Young people and parental journeys through a crisis and beyond

11.1 Chapter outline

In the previous chapter, local community professional stakeholder's perception of accessibility, acceptability, and impact of the 0-19 model and its crisis component on the local community was explored. However, this chapter aimed to explore the experiences of YP and their parents regarding the impact of the mental health crisis on individuals, their families, and the overall family functioning. This chapter also describes the overall journey that YP and their families have made between the onset of initial crisis symptoms, initial help-seeking, treatment at the Solar's crisis team and post-crisis recovery. Initially, the main aims and objectives of this research are discussed in this chapter, followed by a summary of the main methodology. The recruitment and data collection procedures are then explained, followed by the presentation of the main findings. These findings are then discussed with respect to other known research. All research activities in this study are aligned with the overall Logic model and its corresponding activity section presented in chapter 3.

11.2 Study aims

The main aim of this study was to understand the impact of the mental health crisis on YP, their families and their overall journey through the crisis treatment in the Solar's crisis service, as well as the assessment of the participants' recovery as of the post-crisis discharge from the crisis team. The design of this study aimed to fill the gaps in the existing evidence literature regarding the lack of understanding of the sources of the mental health crisis and the factors that trigger the YP mental health crisis, the impact of the crisis on the overall family functioning, the journey experiences of YP through the crisis resolution service and their degrees of recovery. In order to fill these gaps following research questions have been created:

1. What are the main sources and triggers of a mental health crisis for CYP?
2. What is the impact of the YP mental health crisis on parents, siblings and overall family functioning?
3. What was YP and their family's journey through the Solar's crisis service, and their perceptions of its accessibility and acceptability?
4. What was the personal perception of recovery and satisfaction with the overall crisis treatment?

11.3 Rationale for qualitative methodology

The primary purpose of this study was to create an in-depth understanding of YP, and their families lived experiences of a mental health crisis, their perceptions regarding accessibility and acceptability of the crisis intervention, and their perceived assessment of recovery from the mental health crisis as a result of discharge from the Solar crisis service. Therefore, to understand these participants' experiences and perceptions, the researcher has chosen a qualitative approach based on semi-structured interviews, mainly because the mental health crisis can be perceived as a sensitive and intimate matter to participants. Because of the sensitivity of this topic, the researcher believed that conducting individual interviews would allow better anonymity for participants and create an environment where participants would feel comfortable discussing this sensitive issue compared to the focus group setting.

Researchers often choose to utilise qualitative research methods because of their flexibility and ability to empower interviewed participants to speak openly and in their own words about their lived experiences. Also, the use of semi-structured interviews often helps to facilitate participants' reflection and understanding of their world and also provides researchers with a new perspective on participants' views. The full justification for the semi-structured interviews has already been outlined in chapter 5. Therefore, the choice of qualitative research using semi-structured interviews is a well-supported way to achieve the aims mentioned above of this study.

11.4. Methodology

In this study, semi-structured interviews were used with several parents and YP to understand their experiences of mental health crises, as well as their experiences of journeys through the Solar’s crisis service and beyond.

11.4.1 Sampling

In this study, the researcher used purposive sampling, which allowed the researcher to sample participants “*based on a specific purpose rather than randomly*” (Tashakkori & Teddlie, 2003). The main rationale for the use of purposive sampling in this study is in its broad application in qualitative research in situations where researchers want to identify and select participants who would offer “information-rich” narratives to the investigated phenomenon and developed research questions (Palinkas et al., 2015).

Aside to purposive sampling, the participant inclusion criteria were created to guide sampling for this study. As the aim of the study was to recruit only YP with experience with of mental health crisis, the inclusion criteria were as follows (Box 14 and 15):

- Currently or previously accepted to Solar crisis service
- Already discharged (within last three months) or ready to be discharged from the crisis service
- Age 10-19
- Experience of being treated by the Solar’s crisis team
- English language proficiency
- Ability to read and write
- Solihull resident
- Willingness to accept being interviewed with its parent/carer
- Acceptance of its parent’s participation in separate interview

Infobox 14. Inclusion criteria for YP

- Acceptance of their child to the Solar’s crisis service or recent discharge from the Solar crisis team
- Their child is ready to be discharged or YP previously was discharged from the crisis team
- Offspring aged 10-19
- Their child had experiences of being treated by the Solar’s crisis team
- Knowledge of English language (both verbal and written)
- Ability to read and write
- Solihull resident
- Willingness to accept being interviewed with its child
- Acceptance of its child’s participation in separate interview

Infobox 15. Inclusion criteria for parents/carers

11.4.2 Participants’ recruitment

The researcher completed the overall recruitment of participants in cooperation with the Solar crisis staff. All YP were considered for participation in this study after their crisis subsided (i.e. individuals who were close to discharge or already discharged). The service staff members initially approached the participants to explore their desire to participate in the research and to disseminate the invitation letter and the study information sheet. If the participant expressed a willingness for participation, the crisis staff provided them with a letter of invitation (**APPENDIX-Vol2-5&11**), PIS (**APPENDIX-Vol2-7&12**), and the expression of interest for participation form (**APPENDIX-Vol2-6**). The staff returned the expression of interest form to the researcher, who then established contact with the parents and the YP and further presented the study to the participants. The researcher contacted only those participants who had given written consent to be contacted. If the participants were willing to take part in the interview, the researcher agreed suitable day, location and time for the interview that would suit the participants’ availability. The researcher sent a confirmation email to all participants with an electronic version of the PIS and consent forms to allow participants to familiarise themselves with the study and consent procedure before the interview.

11.4.3 Interview schedule

For this study, the researcher developed a semi-structured interview based on the findings of the systematic review in chapter 4. The first part of the interview schedule was intended to elicit the participants' initial experience and the underlying reasons for the mental health crisis. In contrast, the rest of the interview schedule used a funnelling approach. Initially, more general questions were asked about the impact of the mental health crisis on the family functioning, experiences of help-seeking, while leading to more specific questions aimed at understanding the participants' satisfaction with the crisis service, and personal assessment of their recovery.

11.4.4 Data collection

The researcher conducted all face-to-face interviews with participants at Bishop Wilson and Freshfields clinic. The researcher coordinated with the participants a suitable day and time corresponding to their visit to one of the clinics. All interviews took place before or shortly after their session in the Solar. Only on one occasion, the researcher interviewed the parent and YP at their place of residence due to the mobility issues of the participant. Two interviews were conducted with both parent and YP present, while two further parents and YPs were interviewed separately. The researcher recorded all interviews with an Olympus DS-7000 Digital Encrypted Voice Recorder. All participants agreed both on the consent form and verbally that they consented to be recorded. Beside audio recordings, the researcher also informed the participants that research notes would be taken during interviews. The researcher stopped recording once when participants answered all the questions from the interview schedule form. The duration of all interviews ranged from 55:57 minutes to 87:15 minutes, with an average interview duration of 68:10 minutes.

Participant's Consent

The researcher sent the electronic version of the consent form and the PIS to the participants before the interview. Before the interview started, the researcher provided all participants with two versions of the PIS, the consent form (**APPENDIX-Vol2-9,10&13**) and a copy of the brief demographic questionnaire (**APPENDIX-Vol2-13a**). The demographic questionnaire aimed to capture the necessary demographic data. All participants were given ten minutes to read the consent form and to include their initials in each part of the consent form. The researcher remained available to answer all participants questions. Once the participants completed all forms, the forms were returned to the researcher who checked that all participants filled out the forms correctly. Participants kept a copy of PIS and the consent form for their records. The researcher started to record the interview once the participants indicated that they were ready to begin.

Participants demographics

This study included four parents, and their children (n=4) who experienced a mental health crisis and were treated by the Solar crisis team. All interviewees were White British. Parents were equally represented between male and females, while YP participants were all females. Parental participants had an average age of 46.75 (Min age 41, while Max age 55), YP participants had an average age of 16.25 (Min age 15, while Max 18).

Table 90 - YP reasons for the crisis referral and reoccurrences of the crisis relapse

The primary reason for crisis referral	Experience of crisis relapse
Active suicide ideation, overdose	Regular
Anxiety, body dysmorphia, overdose	Not at the moment
Self-Harm and suicidal thoughts	Regular
Overdose and Depression	Regular

Most parents stated in the demographic sheet stated that active suicide ideation, overdose and self-harm were the main reason for crisis referral. Most of the YP had

experienced more than one crisis relapse. Only one YP indicated an improvement in their mental health and only one YP said they had never been treated in the Solar service before they had a mental health crisis.

Data preparation for analysis

The researcher followed identical procedure with data preparation as outlined previously in chapters 5,9 and 10. Transcription data analysis was based on the process described by King (2004) and the principles of the template analysis (King, 2004a, 2004b) as outlined in chapter 5. The NVivo software 2019 was used for the initial coding stage.

Ethical approval

This research study was sponsored by the University of Warwick. Full ethical approval was obtained from the HRA NHS Edgbaston Research Ethics Committee (**Appendix 5&6**) before the official start of recruitment, as described in chapter 3.

11.5 The main findings

1. Roots of crises [E]

1.1 Interplay between range of different factors [E]

1.2 Crisis breaking point [E]

1.3 Triggers [E]

1.4 Failure of early intervention services [E]

2. Impact of mental health crisis on family functioning [A]

2.1 Impact of crisis on parents [E]

2.1.1 Impact on the self [E]

2.1.2 Social and cultural differences [E]

2.1.3 Strains between partners [E]

2.2 Impact of crisis on siblings [E]

2.3 The impact of crisis on family functioning [E]

[A] A-priori theme
[E] Emergent theme

3. Journey through the Solar crisis service [A]

3.1 Accessibility [A]

3.1.1 Barriers to access [A]

3.2 Treatment [A]

3.2.1 Lack of communication [E]

3.3 Discharge [A]

3.3.1 "Cliff edge" [E]

3.4 Satisfaction [A]

4. Degree of recovery from the crisis [A]

4.1 YP personal perception of recovery [A]

4.2 Parental perception of their child's recovery [E]

4.3 Relapse [E]

11.5.1 Roots of crises

In this theme, parents and YP discussed the potential causes that escalated minor mental health problems into a full-blown crisis. All participants described various factors that worked together to influence and precipitate crisis experiences. All participants reflected on the specific triggers that precipitated the mental health crisis and its reoccurrence, as well as the initial help-seeking attempts that led nowhere.

Interplay between range of different factors

Both CYP and their parents reported that the mental health crisis did appear gradually, largely due to the interplay of different factors that contributed to the crisis breaking point. For example, parent RPC103 explained that “*combination of different things*” contributed to a “*gradual decline*” in their child’s mental health while “*depression*” was perceived as a starting point that further precipitated their child’s mental health crisis. Similarly, RPC101 stated that the contributing factors towards their child’s crisis was “*the whole aspect of history*” that their child had experienced. Similar experiences were shared by RPC100 and RPC101 who believed that in the case of their children, all mental health problems started with “*bullying*” that caused a domino-effect on their children’s mental health.

It is evident from all parental reflections that the mental health crisis did not occur suddenly. Instead, it was a gradual progression due to a range of different social and environmental factors that slowly contributed to YP reaching the breaking point. All parents reported that their children experienced the first onset of mental health issues between the ages of 10 and 11, with the first obvious ‘mini-crises’ occurring between the ages of 11 and 12. Likewise, YP also shared similar accounts of what contributed to their mental health breaking point. For example, RCYP102 agreed that “*build-up of like other things*” contributed to their experience of the mental health crisis. At the same time the participant identified the onset of the first mental health symptoms from “*about age 11*”. Likewise, RCYP101 agreed that their “*self-harming*” started in year six, when “*parents noticed*” self-inflicted injuries. However, RCYP101

stated that their mental health further declined when they entered “secondary school in year 7”. Similarly, participants RCYP100 and RCYP103 reported identical accounts of early onset of their mental health problems and bullying as the main starting point for their mental health decline.

Table 91 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p style="text-align: center;">Parents</p>	<p>“I think there was a combination of different things. There was some bullying. Difficulties with a boyfriend, hiding things from parents, stress of education, very high expectations of herself, and I think it was a gradual thing.” (RP103)</p> <p>“It all started when she was in year six. She started getting bullied at school. And then she was self-harming. She had time off because of her school injury. After she recovered, she went back to school for a week or two and she realised that she didn’t have any friends and I think that affected her greatly. And then she contracted [disease] and things just started slipping and sliding after that. The self-harming started getting worse. She started smoking, drinking and solvent abusing.” (RPC101)</p> <p>“It all started with bullying. She started off with some minor self-harm and then attempted suicide, and she has attempted suicide twice now, that we know of. So, it’s all sort of continued on from that point” (RPC100)</p>

Reaching Crisis breaking point

Reaching a crisis breaking point had detrimental effects on both YP and their parents. While some parents were coping with witnessing the breaking point of their children, other parents said they were going through their breaking point and overwhelming panic. For example, RPC103 reported going through the overall experience of “bouncing” and “hyperventilating” when their child attempted suicide. A similar experience was reported by RPC101 who recalled the first time they had witnessed their child’s experiencing mental health crisis as “she sounded possessed, saying that she wants to die” describing this experience as being “horrendous”. As a result of witnessing their child’s breaking point, the parent reported being “deeply affected” by this experience. The parent explained that their first instinctive reaction was “to get her to a hospital”.

Similarly, participant RPC102 reported that their first thought that passed through the head of the parent while witnessing their child's crisis was *"This is not good"*. However, RPC102 added that although this experience was a *"shock"* that made the parent *"bewildered"*, at the same time the participant was not surprised, as they had witnessed a few *"mini-crises"* of their child in the past. However, both RPC102 and RCYP102 stated that mom found a lot *"more difficult"* to understand what is going on with their child, and that her initial reaction was *"You're doing this to spite me"*. In contrast, RPC100 stated that despite their daughter's first suicide attempt came out of the blue, they were already *"familiar"* with a mental health crisis as they had *"previous exposure to mental health crisis"* with their eldest child. Nevertheless, RPC100 still reported being *"concerned and anxious"* at those moments of witnessing their child's mental health crisis.

All parents' responses showed that witnessing their child's mental health crisis was a traumatic experience for parents. Each parent described different physical or emotional reactions to witnessing the child's crisis. Despite these reactions being individual, they can be interpreted as a period of great stress and anxiety experienced by all parents.

Triggers

All participants believed that the mental health crisis was triggered by particular events that made the YP lose control over their lives. For example, RCYP102 recalled how their crisis was triggered by the realisation that they had *"no control over anything"* of what they had done. In contrast, an experience of depression and social anxiety was reported by RCYP101. Likewise, participant RCYP100 reported that *"depression"* and *"social anxiety"* were the tip of the iceberg, as *"PTSD"* was the main trigger for their breaking points. However, RCYP100 added that their mental health crisis sometimes can be triggered with *"reason"* while, on the other hand, their crisis can sometimes be triggered with *"no apparent reason"* what participant found to be *"very stressful"*.

What is evident from these CYP responses is that a combination of different factors, such as past traumatic experiences and exposure to a number of internal or external pressures from the environment were attributed as triggers for the mental health crisis. Most interviewed YP had the experience of being bullied what might have contributed to becoming more socially anxious and also affected YP's self-perception of their bodies. Constant exposure to social media content in the most cases had precipitated worsening of their mental health and has contributed to the development of a range of mental health issues, such as anxiety, depressive disorder or body dysmorphic disorder.

All parents also acknowledged that their children's mental health crisis was triggered by a wide range of factors. For example, RPC101 reported that *"bullying at school"* was seen as a massive trigger that also contributed to their child's *"low-self-perception"* and *"constant comparison"* with other peers, including their siblings. RPC101 also reported that the role of *"bullying"* had a massive impact on their child's mental health and ultimately led the child to develop *"eating disorder"*. However, the parent stated uncertainty whether *"that's just social media or it's just a teenage thing"*.

Similar uncertainty about what was the main trigger for their child crisis was reported by parent RPC103 who said that they *"never really got to the bottom of it, what the trigger is"*. However, parent RPC103 believed that *"bullying"* played a major part amongst other *"different things"* that had happened in their child's life. Parent RPC100 felt that, in case of their child mental health *"bullying triggered everything"*. However, RPC100 explained that despite an initial traumatic event occurred a long time ago their child is now *"bullies herself"* due to developed *"PTSD"* as a result of traumatic experiences from being bullied.

Similarly, parent RPC102 stated that the *"bullying"* triggered the mini crises of their child, which led to the development of body dysmorphic disorder, social anxiety, and depression. Consequently, these disorders created a *"vicious circle"* and eventually resulted in their child's *"breaking point"*. Parent RPC102 added that *"there are many*

triggers for the crisis, and social media is just one of them". It can be seen from all the interviewees' response that triggers for mental health crisis are unique to each individual and their lived experiences. All interviewees agreed that the mental health crisis was a combination of their children's previous experiences and recent environmental pressures that just precipitated unresolved traumatic experiences to spiral out of control.

Furthermore, the parent RPC100 explained that a mental health crisis can be compared to a *"pot with water on a stove"* that is manageable until the boiling point is reached. However, once *"water starts boiling and spilling over the pot"* that's when mental health *"spirals out of control"*. It is also evident from RCYP101 that some YP were trying to reach out to their friends only to be disappointed by their lack of understanding and support, which may also affect their help-seeking behaviour and further precipitate their mental health problems into a mental health crisis.

Table 92 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Parents	<i>"She's constantly reliving everything that's happened time and time again, and she just can't get passed that." (RPC100)</i>
YP	<p><i>"It was triggered by how I looked and how I felt. I just felt like ashamed. I felt like I couldn't see people, I couldn't do anything. On social media, no one had been nasty to me, but it was kind of like you look at other people and you look at things aren't unreal and then you are like ...depressed and anxious. That all led to social anxiety, depression, self-harm and to my crisis point when I wanted to die" (RCYP102)</i></p> <p><i>"I got bullied a lot and that hurt so much. Absence from school due to sickness, that just made my depression ten time worse because I felt more alone. But I think a lot of things triggered me. And home life hasn't always been the best. One of the main triggers was my low body confidence and perception of my peers that showing your emotions is a massive weakness. In this generation, (peers) they do see it as attention seeking. Some friends may support you but other will just call you an attention seeker, and that will make things much worse. And now, the recent crisis was due to the pressure of school and the pressure of social media as your whole life is being watched 24/7. It's all those pressures that sometimes cause you to just crash." (RCYP101)</i></p> <p><i>"My PTSD (result of bullying) is getting quite bad recently, because I relive everything anyway certain things could trigger it off even if I don't realise. Physically nothing's happened, but obviously mentally, there's always things happening." (RCYP100)</i></p>

Failure of first responding services (GPs and School counsellors)

Some of the YP in this sample reported experiences of not being understood, taken seriously or even listened to by their immediate social environment. These experiences contributed to help-seeking avoidance. In contrast, some parents admitted that they noticed changes in their children's behaviour what ultimately resulted in help-seeking from early intervention services such as GP's and school counsellors. However, both parents and children were shocked by the failure of these services to take them seriously. For example, RCYP102 explained that they had previously been seeking help *"and contacted people and this stuff, and we just did not get any help"*. RCYP102 added that their initial experience with GP" was *"unhelpful"*.

"My initial experience with GP, I was crying, and he just was like <Oh, just go on these online services for like bullying> and I was like <Okay, you don't want to help me>." (RCYP102)

However, the biggest shock to this YP was the fact that their GP *"seemed really awkward"* and *"uncomfortable"* with YP seeking help for mental health. Parent RPC102 agreed with their daughter's description of the initial GP, but the parent related this to the fact that *"GP was quite...well, he was quite young"*. Similarly, parents and their child sought help from the school counsellor that was described as *"a waste of space"* and *"hopeless"*, largely as they explained to RPC102 *"they don't do anything unless you're threatening to kill yourself"*. In order to help their child, the parents changed their GP and described the big difference as the second GP *"was right on it, and she was phoning everyone and doing all sorts"*. However, according to RPC102 *"little bit too late, as [name] had a breaking point"*. Similar experience was shared by RPC103, who stated that the GP was the first point in their help-seeking but *"prescribed medication didn't have any impact"*. However, the parent was more disappointed with the fact that before their daughter crisis occurred, they were on *"the waiting list for IAPT"* and even after the crisis happened, their daughter is *"still on the waiting list for IAPT, and we've still not heard anything from (IAPT) them"*. RPC103 added: *"(Solar) Crisis team was the only service that intervened"*. Parent RPC103 expressed anger with the fact that their child's crisis was preventable only *"if*

IAPT saw her sooner". However, RPC100 stated that their child tends to experience mental health issues during the night so *"we have to take her to A&E"*, while RPC101 agreed that A&E or hospital was their instinctive place to seek help, as school counsellors were also perceived as *"unhelpful"*.

What is evident from all the participants' responses is the apparent failure of the 'first-line' responders (GPs and counsellors) services, which play a potentially critical role in preventing the escalation of the mental health. However, these services, which are supposed to be gatekeepers to hospital or A&E admission are failing to signpost CYP to the relevant community mental health service before their mental health further escalates to a chronic condition. Therefore, it is evident that not intervening effectively or early enough has in the eyes of CYP and parents, contributed to the escalation of YP mental health and the progression to the mental health crisis.

11.5.2 Impact of the mental health crisis on family functioning

Experience of mental health crisis not only affected YP but also did negatively resonated on the overall functioning of the family, affecting each member of the family separately. The best way to describe how much of YPs mental health crisis has affected the whole family unit is to use an example given by participant RPC100, who said that their daughter's crisis is *"the pebble in the water, and the ripples that her crisis makes is affecting everybody"* in their family (Figure 68). Therefore, this section will further explore the impact of the YP mental health crisis on the overall family and their functioning.

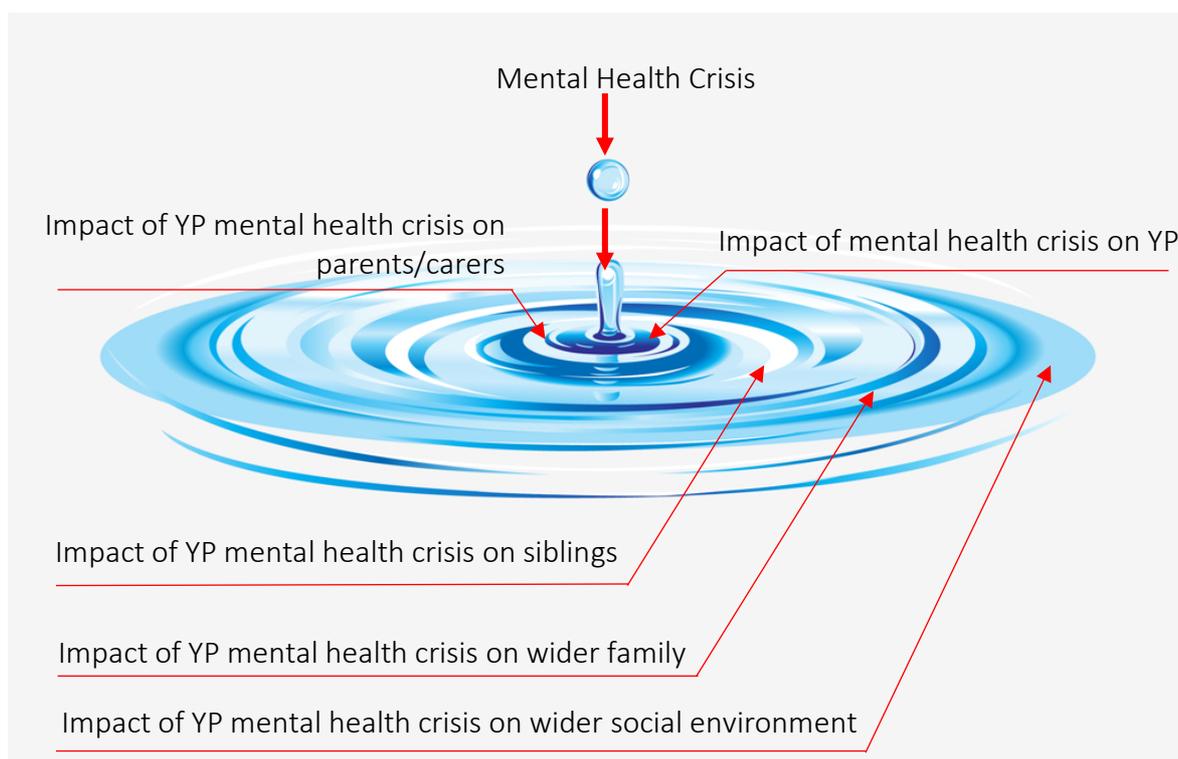


Fig 68. Rippling effect of YP mental health crisis on their social environment

11.5.2.1 Impact of the crisis on parents

Beside YP who were most impacted by mental health crisis experiences, all parents reported that child's experience of mental health crisis also had a significant impact on them. For example, parent RPC103 reported that they felt "failing" their child for "not spotting early enough signs of mental health issues". RPC103 added that they felt like a "failure as a parent". Similarly, RPC101 reported on the impact of their child's crisis on them to the point that they felt "ashamed" and "useless" as a parent. RPC101 added:

"Useless! I felt like I wasn't doing my job as mum. I felt I've really failed. You know, because, you know, you think of crisis, you know, it's life or death, isn't it? That's what crisis is. It's horrible" (RPC101)

However, fathers described a higher degree of resilience to their child's crisis. For example, parent PC102 described the impact that child's crisis had on them as being "bewildering, sad and scary" experience. Similar reactions were also expressed by other father PC100 who said that they were "already resilient" to go through this

experience again. In contrast, not all fathers coped well with their child's mental health crisis. RPC102 explained that their husband expressed "*difficulty to cope*" with their child's mental health crisis "*and I think he' really struggled*".

However, social and cultural factors had also played a significant role in the extent to which parents had been affected by their child's mental health crisis and their degree of resilience. For example, RPC101 reported that they were brought up in a home that considered mental health professionals to be "*a waste of time and money*". RPC101 also reported that their "*upbringing wasn't that good*" either. As a result of their child's crisis, a parent shared that they needed "*a support*" and "*medication*" because of their "*developed mental health issues*" that stemmed from their child's crises.

Three out of the five participants reported a difference in perceptions of mental health between them and their partners. This was perceived by these participants as a contributing factor for their lack of resilience that led to them being more impacted by their child's crisis. For example, RPC103 acknowledged that their husband is from the Caribbean background who experienced their child situation as "*you just get on with it*" as in that age "*there's no such things as mental health*". While the child's father was under the impression that "*go to the gym and you will be fine*", in contrast, RPC103 was brought up in a different environment where going to the gym only works "*if you're mildly impacted*" so that "*you can lift yourself up*". However, both parents soon realised that their child had passed that stage with their mental health. RPC103 was of an opinion that these differences in the social or cultural perceptions of mental health and the fact that their child was in crisis have contributed to the conflicts and tensions between parents, which has also affected their relationship as well. According to RPC103, because of these differences "*a lot of disagreements at home*" occurred between partners, which led to "*a bit of friction at home*" and strains between partners. These frictions and strains due to different perceptions of how to deal with their child's crisis were reported in most parental responses.

For example, RPC102 explained their belief that their child's mental health crisis "*was disruptive*" not only to the entire family but also to their marriage, as the participant's

wife found it *“difficult to understand and process what is going on”*, which resulted with *“strains between (father)me and (mother)her”*. The parent explained that they managed to process the situation more because of their greater involvement in the daughter’s crisis intervention treatment, which also contributed to a better understanding of the situation. However, RPC102 reported that their child’s experience of crisis has also affected their wife’s mental health *“to a breaking point”*. A similar account of the tensions caused by the child’s mental health crisis between partners was also reported by RPC101. According to RPC101 their child’s mental health crisis caused *“strains”* between them and their partner, which led to a *“split up for a while, because we couldn’t cope”*. However, RPC100 believed that despite the *“tremendous effect”* that the crisis had on the family, he and his wife still *“made all decisions together”* as they were able to *“cope with their daughter mental health crises”*.

Therefore, it is evident that mental health crisis affects YP’s mental health but also can have a significant impact on parents and their partners. Mostly strains and tensions between parents occur because one or both partners are unable to cope with a child’s mental health crisis. The presence of mental health crises in the household and these strains and frictions also affected other family members, such as siblings.

11.5.2.2 Impact of crisis on siblings

The child’s mental health crisis appeared to have a ripple effect on every family member as reported earlier by RPC101, and these ripple effects have also affected their other children. According to RPC101, as a result of their middle child’s mental health crisis, their older daughter *“moved out at the age of 16”* from their family home. The parent felt that *“(older daughter) she wanted to be in an environment that wasn’t volatile”*. Consequently, the younger participant’s son started to be affected more since the older sister moved out of the family home and *“(son) he’s got to a point where he’s had enough of everything”*. Similar effects of a mental health crisis on siblings were also reported by participant RPC100, who believed that their older daughter was also affected by her sister’s crisis and caused her to *“worry constantly”*.

A similar account of the impact of the child’s crisis on older siblings also was reported by parent RPC103 who stated that due to the situation with his sister, their older child was also affected, what took a toll on their son’s education. Similarly, RPC102 was of belief that their older child had been “*affected up to a point*” by the mental health crisis of their younger sister.

What is visible from all parental experiences is that all family members, including siblings, are deeply affected by a mental health crisis. However, there were also individual differences in how the siblings are coping with the presence of a mental health crisis in their household. While some had fewer coping mechanisms, others showed more resilience to cope with their relative mental health crisis.

Table 93 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p style="text-align: center;">Parents</p>	<p><i>“(Older daughter) she feels that the first sister’s suicide attempt was her fault. So, it’s affected her mentally, thinking that it was her fault for not trying to stop her (to commit suicide). So, it’s affected her, and she always thinks that everything is her fault now” (RPC100)</i></p> <p><i>“(Son) He has just floated through it. But he’s a pretty chilled sort of person” (RPC102)</i></p>

11.5.2.3 The impact of crisis on family functioning

Exposure to the relative’s mental health crisis and the onset of strains and frictions between the child-parent-parent relationships, also contributed to a change in the overall family functioning and their dynamics. Most of the parents in this sample reported that their child’s breaking point changed everything. For example, parent RPC100 stated that they “*can’t operate as a normal family in any way, shape or form*”. Parent further explained that since their child’s breaking point “*many restrictions are placed on us*” as family. Since the crisis occurred most RPC100 reported that all family members are constantly engaged in “*checking on her*” and trying to “*keep her included*” and make sure “*that she’s ok*” even during the night. The parent added that most family members “*don’t sleep properly*”. However, this parent explained that

“being on the permanent suicide watch” had an impact on each family member, as since the crisis occurred *“this watch became constant”*. RPC100 concluded *“We’ve literally changed our lives to suit her”*.

Similar experience of constant pressures on the family unit as the consequence of their relative’s mental health crisis was also reported by RPC101, who stated that *“there’s five of us in the family, and we can’t just keep revolving around [name] all the time”*. However, the parent added that whenever her daughter mental health crisis hit *“pebbles in the water, all the ripples affect us all”*. The parent also reported that they needed to change the whole family functioning due to their child’s mental health crisis as *“she kicks off on us all and we can’t go anywhere because of her panic attacks”*. However, the parent was more optimistic that if they get her child *“out of the water, all the ripples will go in and everything will be fine”*. Parent concluded that then *“we’ll be tight-knit again”*.

Likewise, parent RPC102 also reported that the mental health crisis caused strains between their daughter and mother, what also spilled on the other family members. However, according to parent RP102, this family realised that *“obviously mental health comes above anything else”*. What is evident from the experiences of these participants is that the mental health crisis affects the entire family and strains each family member. In addition, each family dealt with the crisis in its unique way. While some families reported some minor effects on their family functioning, others reported that the mental health crisis profoundly changed their family interactions and cohesion, and ultimately contributed to widening gaps between family members.

Table 94 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Parents	<i>“It’s just constant. There is no day off, there is no hour off. There is no minute off because there is that risk of not knowing when the next time, she’s going to try something. We, as family, are permanently on suicide watch with her. It’s non-stop” (RPC100)</i>
YP	<i>“I think mom found it more difficult, quite frankly, not to blame her, but her initial reaction was <You are doing this to annoy me>” (RCYP102)</i>

11.5.3 Journey through the Solar crisis service

In this section, both parents and their children reflected on the overall experiences of their journeys through the Solar crisis service from the point of referral to the point of discharge. Additionally, both YP and their parents reported their overall satisfaction with the Solar crisis service.

11.5.3.1 Accessibility

All interviewees reported that the crisis team is accessible and responsive to the needs of service users. For example, RPC103 recalled that *“(crisis) they were the only service that intervened”*. According to RPC103, the crisis team *“came as a help and they were the right team for her at the time”*.

The participant explained that their child ended up in crisis due to overdose, and that an ambulance was also involved. From A&E, the crisis team took over treatment once their child was safe to be discharged from the urgent and emergency setting. The similar route of referral occurred in the case of RCYP101, who also reported being admitted to a hospital due to self-harm as the main referral route to the crisis team.

The parent RPC101 reported their opinion that the crisis team was *“accessible and responsive”* as they *“seem to want to help”* their daughter. A similar pattern of hospital referral to the crisis team was evident from the experiences of RPC100 and RCYP100. Both the parent and YPs reported that the crisis team was responsive and would intervene *“next day”* as YP mental health crisis tends to occur *“during the night-time”*. For these participants, therefore, A&E was the only option to seek help in those hours.

Likewise, both participants RPC102 and RCYP102 reported that their referral experience to the Solar crisis was *“very quick”* and *“worked well”* for them. However, their referral experience differed from that of most of the other interviewed

participants. RCYP102 was directly referred by her GP due to self-harm to the crisis team and *“next day around 2 o’clock”* the crisis team intervened. According to parent RPC102, the crisis team *“swung everything into action so quickly”*, what in parent opinion was *“reassuring”*. Both the parent and their child stated that access to the crisis team was *“quick and needed”* in the case of a mental health crisis.

Both parents and YP reported the crisis team is responsive and accessible to the mental health needs of YP. The need for rapid intervention and response from the Solar crisis team was welcomed by all interviewees, as the mental health crisis was often characterised in participants opinions as a matter of life and death. Without the existence of mental health crisis teams such as the Solar crisis, most YP interviewees would be forced to spend longer periods in hospitals, while for parents visits to A&E’s would be the only source of help that would provide to their children an urgent and emergency response.

However, most parents believed that there is still a specific barrier to accessibility. According to the parent’s perceptions, the lack of a direct telephone line to the crisis team was perceived as a major barrier to accessibility. Likewise, parent RPC100 reported that they had received a yellow slip with crisis direct contact number that was *“wrong and didn’t work”*. RPC100 added *“and this is meant to be a crisis number”*.

Similarly, RPC100 and RCYP100 felt that contacting the crisis team over the phone *“wasn’t completely straightforward experience”*. Additionally, RPC100 reported that better accessibility to the crisis team can be achieved if the crisis team starts to use more social media, such as *“WhatsApp groups”*. RCYP100 added that it would be excellent as sometimes *“you don’t feel like talking to someone in person”*.

Other parents and their children also reported that the lack of a direct telephone line to the crisis team is seen as a barrier that might prevent accessibility, especially in situations where the mental health crisis has developed, or it is ongoing.

Table 95 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Parents	<p data-bbox="571 331 1390 461"><i>“When Crisis came to hospital it made me realise that I had more support than I ever thought. It made me realise that they actually do care, and they took time out of their day to come and see me. It made me realise that it was worth carrying on.” (RCYP101)</i></p> <p data-bbox="571 495 1390 589"><i>“The positive thing is that (crisis) they were there. They stepped in at the time of crisis. For every other service it’s a massive, long waiting list, isn’t it?” (RPC103)</i></p> <p data-bbox="571 622 1390 716"><i>“Normally our experience is mainly out-of-hours, so we don’t phone the Crisis team. We just go straight to A&E and they contact the Crisis team because obviously [name] can’t be released until the Crisis team agree it” (RPC100)</i></p> <p data-bbox="571 750 1390 815"><i>“..you have to wait 20 minutes on the phone to get through the switchboard, I mean that’s not good.” (RPC103)</i></p>

11.5.3.2 Treatment

Most YP perceived crisis treatment as flexible to their needs, as the crisis team provided their intervention and treatment in a variety of environments that suited YP and their needs. RCYP101 added that the duration of these visits varied a lot, depending on *“how you are in that moment”*. Similarly, RCYP103 described their crisis treatment as more like *“coping, thinking and reflecting”*. The participant added that they were equipped with *“distraction techniques and things like that”* that they *“adapted”* to suit their needs. According to RCYP103, the crisis team would ring them for a telephone check-up after each session. In addition, RCYP103 also reported that *“lots of handouts”* had been provided. Likewise, RCYP102 stated that they were provided *“with many different options”* with their treatment and most importantly *“a choice to choose”*. RCYP102 also added that they had received a *“mixture”* of different treatment settings, such as home visits and clinic treatments when they were seen by the crisis team. In contrast, RCYP100 expressed dissatisfaction with their crisis treatment by reporting that *“delivered crisis treatment works for some people, for me it doesn’t”*.

However, all interviewees reported similar views that there was a clear lack of communication between the members within crisis team, which made the treatment experience more difficult, largely due to the need to reexplain their personal stories, and that the crisis staff did not read each other’s notes. For example, RCYP103 reported that the only thing that the crisis team needs to improve is “*probably just communication between them*” as the crisis staff members “*didn’t really communicate with each other*”. RCYP103 added that sometimes they had “*to re-explain things and that’s not nice to talk about*”. Likewise, RPC103 also reported that they were not sure that “*(crisis)they read each other’s notes*”.

A similar opinion was also shared by RPC101 who thought that “*possibly communication is something that (crisis)they need to improve more*”. Likewise, RPC100 also stated that there is a degree of miscommunication between the crisis staff as their child has been seen by a number crisis staff members who “*knew nothing about her*” and you need to “*keep going back through the whole history time and time again*”. RPC100 added that “*the communication is a key, so everyone’s aware of what’s going on*”. However, RPC100 also reported that “*the communication is poor*” not only for the crisis team but for the entire Solar service. RPC100 concluded that the service must keep in mind that “*consistency, communication and trust*” are essential.

Table 96 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Parents	<p><i>“So, sometimes we’d have a meeting with one and then we’d have a conversation with a different worker, a couple of days later perhaps, and it was as if they hadn’t read the information. You know I appreciate time pressures, all of that, but somebody who has been through it, and re-living it, it’s not helpful.” (RPC103)</i></p>
YP	<p><i>“(Crisis Team) came out to me about four times. One home visit and I think three times whilst I’ve been at school” (RCYP101)</i></p> <p><i>“When you start talking, they would listen. And then when you have a break, they will give you solutions on how to fix that certain thing, or how to control everything that’s going on. They gave me loads of strategies.” (RCYP101)</i></p> <p><i>“Draw on yourself with red pen. Hold an ice cube. Elastic bands. I have done all of them. They don’t work for me. It doesn’t always work for everyone, and</i></p>

	<i>if they can see that it's not working for someone, then maybe they need to try a different approach. My current clinician he doesn't tell me what I need to do. Instead, he tells me what's going on to help me realise what I can do"</i> (RCYP100)
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11.5.3.3 Discharge

All interviewees experienced the process of discharge as sudden. Most CYP participants and their parents felt that discharge from the crisis was premature. For example, RPC101 stated that the crisis team discharged her child *"just a little bit too quickly"*. RPC101 added that in their opinion, the crisis decision to discharge their child was premature *"especially with the lack of communication that we had"*. Equally, RPC102 reported that the discharge process made them *"a little bit worried"* that discharge was made prematurely.

On the other hand, RCYP102 expressed the *"sadness to be discharged"*, as they *"liked all the people from Crisis"* as well as the desire and preference for *"longer support from the crisis team"*. Similar concerns also experienced participant RPC103 whose first thoughts associated with their child's discharge was *"we're going to be back at square one"*. However, RPC103 acknowledged that the crisis team has kept their child *"longer than they normally would"*. The participant added that the crisis team had been looking to discharge her child several times *"but it wasn't the right time, so they didn't"* largely due to their plea. Participant RPC103 also raised interesting point that sometimes it felt like the crisis team *"was too crisis focused"*.

However, most of the interviewees described their discharge process as being as the *"cliff-edge"*. Besides, CYP and their parents reported that there is a month of waiting for the next phase of treatment and that there is no other support available in between. As a result, participant RCYP102 reported a fear that *"you can kind slip out of good habits"* due to lack of support what may consequently lead to a future crisis. Although the crisis team left them open to phone them any time, RPC102 thought that *"phone support it's not quite the same as face-to-face stuff"*. Similarly, RPC101 felt

that the crisis team should follow up with them after discharge with them to see their child's progress.

Likewise, RCYP100 also felt that the crisis team should gradually discharge YP from the crisis service and not simply "cut the cord". RCYP100 added that it is crucial to have someone who can "come around and visit" and see "how everything's going" especially after the crisis discharge. Equally, RPC100 stated a similar opinion that the crisis team should "periodically check upon young people" they discharge, as this can "reduce the amount of anxiety and issues that are raising up to the crisis level". Lastly, RPC102 stated that there is a need for a crisis team that "works with (YP) them for a bit longer", as the parent explained further "so that there's some stability, and then discharge. But in Solar, there isn't. There's just crisis discharge."

It is evident from interviewees' stories that crisis discharge process should be made gradually, once YP are confident that they are ready to be discharged or transferred to another Solar team for further treatment. Besides, leaving YP without support after a crisis episode may push YP to experience a relapse and need for further crisis intervention. Indeed, early discharge from the crisis team may lead to reacceptance to the crisis team and subsequent need for prolonged crisis treatment.

Table 97 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
<p style="text-align: center;">Parents</p>	<p><i>"I've said to them <Can you keep (crisis treatment) it a bit longer?> And I felt they did listen to that. But I think if I hadn't said as a parent <I don't think we're ready yet> she would have been discharged prematurely and that would have been big issue really" (RPC103)</i></p> <p><i>"I think it is difficult for them because they're obviously short staffed, they only work with people when they're in crisis. So, I feel, if you're not in crisis, then you can be discharged, but I think it's about how do you define crisis. If you've only, you know, if you were really low last week and thinking about suicide, but this week you're okay, does that mean you're not in crisis?" (RPC103)</i></p> <p><i>"It just kind of felt a little bit like being left all at sea. You know just kind of <Off you go then, bye>. You're out in a lifeboat and you're just bobbing around waiting to be picked up" (RPC102)</i></p> <p><i>"Perhaps a text message, or a phone call every week from the crisis team, you know, just to see how are things?" (RPC101)</i></p>

11.5.3.4 Satisfaction

Although most interviewees stated dissatisfaction with the crisis discharge, in terms of overall satisfaction, most participants reported that they were satisfied with the overall crisis team and their interventions/treatment. Mostly, YP stated preference for the flexibility of the crisis team to deliver intervention at YP homes, schools and community. For example, RCYP100 stated that they also prefer home treatment, mainly because *“when I am in a crisis situation, I don’t want to go anywhere, I don’t want to do anything.”* Similarly, RCYP103 reported that it was good how crisis team *“come to you”*, as *“it made it easier when you’re feeling low”*. In addition, RCYP103 admitted that they never felt *“uncomfortable or judged”* with the crisis team, as *“it’s easier to tell like a stranger that like you are feeling suicidal because they’re not emotionally attached”*.

Similarly, RCYP101 felt that the crisis team *“let you get everything off your chest”*, while the most satisfaction with the crisis team the participant stated for the fact that they *“listen and they don’t seem bored, and they actually engage with you”*. RCYP101 concluded that *“it’s hard to find people like that, who just listen”*. Besides, for RCYP102 being treated by the crisis team was *“definitely like positive”* and felt like a *“turning point”*.

RCYP added that thanks to the crisis team they can *“start to sort things out”*. On the other hand, RCYP100 openly stated their dislike towards the crisis team due to previous bad experiences with some crisis staff members. RCYP100 explained that they *“did not feel comfortable at all”* being seen by crisis team, as they felt *“being judged”* which according to participant *“it’s not the best situation just after taking an overdose”*. RCYP added, *“you can put any label on me, but don’t judge me”*.

Similar degrees of satisfaction to those of YP were also evident in most parental responses. For example, RPC103 stated their *“positive experience”* with the crisis team *“right from the beginning”*. The participant felt *“being on the right track and reassured that things were now going in the right direction”*. Likewise, parent RPC102 stated that

their experience was also *“really positive”*. RPC102 added that they were mostly satisfied with *“how quick the crisis team response was”* as well as being *“impressed”* by one of the crisis team staff members. The participant concluded that the staff member *“struck up an immediate rapport”* with their daughter, which was a crucial factor for recovery, since *“the trust is there right from the beginning”*. Similarly, RPC101 felt that *“(crisis team) they seem to want to help”* their daughter. RPC101 added that they are mostly satisfied with the crisis team because *“they’ve made it known that they’re there for her, whenever she needs them”*.

However, RPC100 was the only parent to share his dissatisfaction with the crisis service. The main reason for the parental dissatisfaction was their hospital experience when the crisis team came to do the initial assessment when both parent and child had an impression that the crisis team staff *“didn’t want to be there, didn’t really care and didn’t want to know”* about what their daughter is going through, while adding *“It was just bad. We just wanted them to leave”*. Parent compared their satisfaction with the Solar crisis service with the Likert type scale, stating that they would score the crisis service *“between three and four”* largely due to their *“very cold and clinical, very in and out, thank you very much, my job’s done, handing you on to somebody else now”* approach.

Indeed, most service users reported having a good experience with the crisis team that led to their increased satisfaction with the crisis intervention, while other service users felt that crisis team approach was more trying to fit a person into *“one size fits all”* approach that does not always work for every YP. Parent RPC100 reported that the crisis team had evolved since 2018 when most of their negative experiences had occurred. Therefore, it is evident that the Solar crisis team has a heavy task not only to maintain high levels of satisfaction of its service users, but also to increase it further.

Table 98 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
CYP	<p><i>“It just comes back to the same thing that we’re real people. We’re suffering real things, and sometimes we do just want to be listened to and not talked at, because it can get quite patronising. And some of the crisis staff were just talking over me and directing what I need to do, instead of just listening”</i> RCYP100</p>

11.5.4 Degree of recovery from the crisis

In the last theme, the personal assessment of the post-discharge YP recovery from the crisis team will be discussed both from the YP and parental perspectives.

11.5.4.1 YP personal perception of recovery

All YP participants said that crisis treatment helped with their immediate mental health crisis. However, all YPs also stated that their mental health fluctuated significantly. For example, RCYP102 stated that they *“had a bad past three days”* where they felt more *“insecure and wanted to hide and not do anything”*. However, the participant reported that this time *“it wasn’t as bad as it was before, as it was more manageable”*.

Likewise, RCYP101 explained their degree of recovery by stating that, thanks to the Solar and its crisis team they *“haven’t done solvent abuse in two and half-years”*. However, the participant acknowledged that some progress had been made as they *“haven’t self-harmed last month and a half”*. The last participant RCYP100 also provided insight into their recovery process post-crisis discharge. RCYP100 explained that the crisis team *“does help, but obviously if it was a completed fix, then I wouldn’t be here where I am now”*. The participant added that *“sometimes for things like that it takes a long time to recover”*.

After discharge from the crisis team, all interviewed YP continued working with a range of other mental health professionals. Two participants continued to attend CBT therapy, while the other two were seen by both clinical psychologist and psychiatrists. The crisis team provided the necessary intervention to help CYP manage their own mental health and prevent future crises. However, despite being lifesaving, crisis intervention cannot resolve all of the underlying YP mental health problems.

Table 99 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
CYP	<p><i>“Well, yes I’m definitely in a better position than before. I don’t need (Crisis team) them as much now, but in the beginning I was. But I think it helped me to be more open with people about it as well.” (RCYP103)</i></p> <p><i>“Suicidal thoughts are there, but I don’t feel like acting upon them. It’s fluctuating. That’s the only problem with mental health, you can’t say that it’s going amazingly, because it can go so good one day and then...” (RCYP101)</i></p>

11.5.5.2 Parental perception of their child’s recovery

Since the last episode of a mental health crisis, all parents have also provided their personal assessment of their child’s recovery. For example, parent RPC102 reported that since crisis intervention, their daughter *“comes out of (mental health problems) it a lot quicker and easier than she would have done before and that’s good”*. However, the parent was a bit cautious to say whether their daughter had fully recovered since discharge. RPC102 concluded that *“it’s too soon to say whether the crisis team helped us”*. In contrast, RPC101 stated that their daughter’s mental health *“is up and down”* depending on *“what mood she wakes up in”*. However, the parent also said that their daughter still *“kicks off with her volatile episodes”* which still indicates that *“she needs more help”*. Similarly, RPC100 claimed that their daughter *“has a relapse probably every single week”*. Parent RPC103 felt that the crisis team was good with *“helping her to understand that is an illness”*, as their daughter prior crisis experience felt like a *“freak”*. However, the crisis team *“helped her to sort of like re-label it”* which RPC103 found very helpful.

Table 100 - Participants quotes in support of the subtheme

Participants	Quotes in the support of theme
Parents	<p><i>"I shouldn't say that, I don't want to tempt fate, but she's in a really good place at the moment. But actually now, you know she sat the exams. So, in seven months she went from attempting suicide to sitting A-levels. I think that's amazing."</i> (RPC103)</p>

11.6 Discussion

This chapter aimed to gain insight into the impact of the mental health crisis on YP, parents and their families, and their overall journey through the Solar crisis service. In addition, this study aimed to understand the personal recovery of YP as a result of discharge from the crisis team. The main findings of this chapter are structured around the main themes identified by the template analysis. The final template included four main themes: (1) Roots of crises; (2) Impact of mental health crisis on the family functioning; (3) Journey through the Solar crisis service; and (4) Degree of recovery from the crisis, which will be further discussed to answer proposed research questions.

11.6.1 What are the main sources and triggers of a mental health crisis for CYP?

In most YP cases, a mental health crisis is rarely triggered by a mental health problem alone, but the presence of bullying, the impact of past or present traumatic experiences or current family circumstances may also precipitate YP's mental health deterioration and lead to a mental health crisis (NHS East of England Clinical Networks, 2017). Moreover, most YP have very significant crossovers and interplays between different internal or external factors that inevitably affect YP, as can be seen from the findings of this study. Therefore, it is evident that the root causes of YP mental health crises are the result of traumatic or adverse life experiences, mental health difficulties and environmental impacts on the YP self-perceptions.

However, each individual's pathway for the developing mental or behavioural disorders and (or) mental health crises vary significantly. Similarly, each person may also experience a range of triggers such as genetic, environmental, adverse childhood experiences (traumas) and stressors that in combination between each other may increase the likelihood of an individual who already has an underlying root cause factor to develop mental health problems (Tonkin & Silcock, 2017) or experience of a mental health crisis. This interplay of a range of different factors, triggers and pathways for the development of mental health illness or crisis is also evident in the findings of this study, which showed that complex interactions between a range of previous adverse YP experiences, environmental, external and internal factors determined the degree of presence or lack of resilience and contributed to an escalation of their mental health. Another study also found that the impact of one risk factor on the mental health of YP may be minimal, but several risk factors and their accumulative effects may significantly affect the mental health of YP (Bekkhuis, 2012). Therefore, the sum of these factors may lead to CYP breaking points as explained by participants in findings from this study.

Furthermore, all YP reported experiences of being bullied as a contributing factor for the crisis intervention. A large amount of research evidence shows that bullying is the most common type of adverse CYP experience that is likely to have a negative and long-lasting impact on the personal and social life of YP that may well last into adulthood (Allison, Roeger, & Reinfeld-Kirkman, 2009; Copeland, Wolke, Angold, & Costello, 2013; Wolke, Copeland, Angold, & Costello, 2013; Wolke & Lereya, 2015). Other studies associated experiences of bullying with increased suicide risk and other mental health problems (Hinduja & Patchin, 2010; Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Kowalski & Limber, 2013).

Moreover, this study also showed that some YP expressed the existence of internalising problems, the feeling of loneliness and the impact of psychosocial and emotional wellbeing as the consequence of being bullied, similar to findings of other studies (Sinclair et al., 2012; Woods, Done, & Kalsi, 2009). Other studies also highlighted that educational pressures affects YP and their resilience, and that girls

may be more affected than boys (Gunnell, Kidger, & Elvidge, 2018; Patalay & Fitzsimons, 2016). Similarly, findings from this study also showed that YP listed A-levels and school performance as one their mental health triggers.

Likewise, the impact of social media on YP mental health also may contribute to a range of mental health problems (Children's Commissioner., 2018; Woods & Scott, 2016). Another study also found an association between anxiety and social media use in YP, which often led to worsening of YP anxiety and psychological distress (Sampasa-Kanyinga & Lewis, 2015). However, many YP engage in "compare and despair" behaviours that create low self-consciousness, low self-esteem and need for perfectionism due to the unrealistic expectations and nature of social media, thus paving the way for anxiety disorders (Cramer, 2018). Similarly, the use of social media was also linked to YP depression, psychological distress and suicide ideation (Lin et al., 2016).

More research evidence shows that social media in particularly affects young girls and their body image compared to non-social media users (Tiggemann & Slater, 2014). Another study showed that young girls desire to change their physical appearances when exposed to social media (Fardouly, Diedrichs, Vartanian, & Halliwell, 2015). Similar accounts were also evident in YP responses in this study sample, which led some of them to develop a body dysmorphic disorder. Indeed, the roots and triggers of mental health crisis are complex and sometimes difficult to link with a particular single problem or event. Instead, a mental health crisis represents an accumulation of adverse mental health and emotional problems that over time further declines the YP mental health until the breaking point.

However, the findings of this study show that most of YP's pre-crisis mental health problems were manageable and preventable if only early intervention and prevention services had intervened earlier. Therefore, it is evident that not responding early enough has contributed to YP mental health escalation and mental health crisis progression.

11.6.2 What is the impact of the YP mental health crisis on parents, siblings and overall family functioning?

In this study, the main findings showed that YP mental health crisis has a significant impact on the overall family functioning, as well as detrimental effects on intra-family relationships of each family member. These findings of this study corroborate and build on previously published literature and illustrate the profound impact and degree of disruption of the mental health crisis on the overall family and its functioning (Ferrey et al., 2016; C. McLaughlin, McGowan, O'Neill, & Kernohan, 2014).

Also, a number of different emotional reactions such as shock, shame, guilt and helplessness experienced by parents as a result of witnessing their child's breaking point were significant findings in this study. Equal findings were evident in one study, which also reported similar emotional reactions that parents described when their children attempted suicide or self-harm (McLaughlin et al., 2014). Likewise, another study also reported initial parental feelings of distress, disbelief, fear and anxiety due to their child's self-harm (Ferrey et al., 2016) similar to the findings of this study.

Indeed, most parents in this study reported that a child's mental health crisis experience was traumatic for parents, and often led parents to feel helpless and doubtful about their parental abilities. Similar accounts of parental helplessness and concerns about their parental ability were also evident in a study that also reported similar traumatic experiences of parents with their child's self-harm (Raphael, Clarke, & Kumar, 2006). Both the child's mental health crisis and suicide behaviours have often adversely affected the psychological and physical wellbeing of parents and other family members, and significantly increased the carers burden (McLaughlin et al., 2014). In this study, all parents reported significant impacts of their child's mental health crisis on the overall family functioning, as well as the toll that crisis had on the family relationships. Similar findings were also evident in the McLaughlin et al. (2014) study, which described how much the relatives' suicide ideation changed both the parental and family dynamics and their function. Likewise, McLaughlin et al. (2014) study also reported negative effects of relative suicide behaviour on parents and other

family members' physical and emotional health. Similarly, the findings of this study showed that most parents reported sleep deprivation, high levels of anxiety, depression and mental health deterioration, as a result of a relative's mental health crisis. Sleep deprivation and depression were also common among parents of children who had self-harmed, which eventually led parents to feel tired-out (Ferrey et al., 2016). Consequently, some parents in this study reported the need for professional help and medication for their mental health to cope with their child's mental health crisis. Parents of children who have self-harmed have also reported that due to high-stress levels, anxiety and depression, some were prescribed with antidepressants, while others also received professional help (Ferrey et al., 2016).

However, in this study, besides the impact on the mental and physical health of parents, the impact of mental health crisis also resulted in a strain between partners and relationships within the family. Similarly, in other studies, the impact of YP self-harm also affected the relationship between family members, which also led to marriage difficulties and the deterioration of parental relationships with their parents due to generational or cultural gaps in understanding of mental health (Ferrey et al., 2016; McLaughlin et al., 2014).

However, being exposed to a relative's mental health crisis, parental power struggles, anxiety exposure and a volatile family environment affected mostly siblings of YP who have experienced a mental health crisis. While the sibling's reaction in this study varied significantly, most siblings displayed worry and willingness to help, but their mental health was also impacted by a relative's mental health crisis. Similarly, the study by Ferrey et al. (2016) found that the siblings had a range of reactions to their relative's self-harm, ranging from anger, worry, frustrations and anxiety. Indeed, YP mental health crisis can be considered as a pebble in the water, and the ripples it causes affects everyone in their immediate surroundings.

11.6.3 What was YP and their family's journey through the Solar's crisis service, and their perceptions of its accessibility and acceptability?

Although most of the interviewees agreed that the Solar crisis team was accessible and responsive, participants noted that the lack of a direct telephone line could be seen as a barrier to accessibility. Similar findings were also evident in a report that found that contacting crisis teams over the phone, especially outside regular working hours can be challenging (Glasper, 2015). However, CRT must be contactable, as any delay in reaching CRTs can lead to further escalations of mental health crises and increase YP distress and harm. Additionally, a report also highlighted that direct crisis telephone numbers provided to service users should be correct and operational, as services must ensure the quality of their operation of telephone helplines (Glasper, 2015). This is consistent with some of the interviewees' reports in this study that they struggled to reach the crisis team over the phone, or they received an incorrect crisis number. Therefore, the direct crisis line must be accessible to those YPs who have experienced a crisis and operated with a sensitive approach to meet the mental health needs of YP (Glasper, 2015).

In contrast, treatment wise, most participants in this study were satisfied with the crisis intervention. However, most interviewees complained about lack of staff continuity and lack of communication between staff members, forcing YP to re-tell the same story again. The issue of lack of communication and staff continuity is recognised as a national issue for CRHT teams (Titheradge & Galea, 2019). Similar lack of staff continuity and ineffective intra-service communication was reported in the study by Morant et al. (2017). However, another study noted that continuity of care has significant implications for patient safety and the potential for incidents is increased by repeated handovers or lack of communication of clinical information among CRHTs staff (Titheradge & Galea, 2019). Equally, the staff continuity has massive significance for creating and maintaining a therapeutic alliance with service users or their family support system, while the lack of continuity of staff can have a significant impact on this alliance and contribute to relapse and crisis readmission (Morant et al., 2017; Titheradge & Galea, 2019). In addition, Morant et al. (2017) and

Titheradge & Galea (2019) also reported that service users were forced to repeat their personal stories as a result of frequent staff changes, what was perceived as unhelpful due to constant reliving mental health breakdown and impact on the recovery process. Moreover, Future in Mind is clear that service users should only tell their personal stories once (Department of Health, 2015). However, CRHT should ensure that good communication is the best practise for risk management, as findings from other studies showed that communication issues are consistently identified as contributing factors to service users suicide and potential causes for CRHT service user's safety incidences (Appleby et al., 2016; Lloyd-Evans et al., 2016).

Regarding the discharge from the Solar's crisis team, the findings of this study showed that both YP and their parents perceived crisis discharge as premature, while YP expressed a desire for longer crisis team treatment. The interviewees' responses also pointed to the existence of "cliff-edge" discharge where YP are left without any support from Solar until the next phase of treatment in the Solar service, which triggered participants fears of a potential mental health crisis relapse. These interviewees fears are well-founded, as one study showed that patients recently discharged from crisis services often experience a relapse of their mental health crisis and consequently are readmitted back to acute care and crisis treatment (Johnson et al., 2018). Likewise, another report also highlighted that 16% of all UK suicides between 2005 and 2015 were performed by service users under the care of CRHT teams at higher rates than in inpatient settings (Appleby et al., 2016).

Similarly, one report also stated that crisis resolution team could engage in the premature discharge of their patients who are only provided with a crisis support number on their discharge point, which ultimately led to a significant increase in the future crisis and resulted in several deaths of former crisis patients (Glasper, 2015). Likewise, other studies also found that crisis service users expressed a desire for more extended crisis treatment (Gallagher & Schlösser, 2015), while other crisis patients expressed a need for a safe and well-organised CRHT exit plan that would allow continuity of care without a "cliff-edge" discharge (Winniss et al., 2010).

However, a possible explanation as to why service users experienced premature discharge in this study may be due to a lack of service resources. One editorial supported these findings by stating that there are groups of people that tend to bounce around the system primarily due to a lack of both human and financial resources (Wise, 2017). In contrast, one study added that shorter and more intensive crisis interventions and treatment might require smaller core team to deliver more focused interventions and resources, enabling the crisis team to meet greater demands (Titheradge & Galea, 2019). However, the premature discharge may still have a significant impact on YP's mental health recovery and may indeed indicate that the Solar crisis team is understaffed, as previously seen in chapters 9 and 10.

11.6.4 What was the personal perception of recovery and satisfaction with the overall crisis treatment?

Although most interviewees reported a significant positive outcome from crisis interventions, most parents were cautious about how much their children have recovered from the crisis post-discharge. Similar to the findings of this study, most participants in another study reported faster recovery when treatment was delivered to the home of the service user (Morant et al., 2017). Equally, in this sample, interviewees stated that crisis staff reassured and provided their children with a sense of hope that also aided the recovery process and was similar to Morant et al. (2017) findings. Similarly, one study highlighted that the overall YP family must be part of the YP recovery process beside CRHTs (Clarke & Winsor, 2010). Therefore, YP parents must be included in the overall discharge and recovery process, which was not the case for some participants in this study. Johnson et al. (2018) study clearly showed that post-crisis discharge relapse of a patient's mental health is common, while possible factors that CRHT's can implement to prevent patients' relapse are the use of self-management and peer-led intervention to prevent possible mental health crises relapses.

11.7 Strengths and limitations of the study

Strength of this study may be seen in understanding of the accumulative external and internal effects of a mental health crisis contributing to a YP mental health crisis. The interviewees also reflected on Solar's crisis service provision. Similar accounts of other CYP mental health crisis services within the UK are scarce and limited. Indeed, the findings of this study covered existing gaps in understanding YP and their family experiences from the point of experiencing the onset of first symptoms, referral to the crisis team, treatment, and discharge from the Solar crisis team, as well as personal assessments of post-crisis discharge recovery.

On the other hand, the main weaknesses of this study are the small sample size of a predominantly white British sample of YP and their families. Due to the size of recruited sample, it is possible that true parental and YPs perceptions were not fully captured with this study. During the recruitment stage, the researcher attempted to recruit participants from other ethnicities. However, most of the former crisis service patients that came from other ethnicities refused to participate. It was also evident from the YP demographics that predominant YP sample consisted of young females. The additional weakness of this study therefore was the lack of recruiting young males to understand their mental health crisis experiences. Compared to other research studies (Clarke & Winsor, 2010), this study was able to recruit equal representation between male (N=2) and female (N=2) parents, while YP (N=4) were all young females. This small sample size makes it difficult to generalise findings to the UK's general population. Moreover, since two interviews were jointly conducted with parents and YP, it is important to note that due to the parental presence, YP may not have disclosed everything or reflected their actual views. Likewise, parents may not have disclosed the true impact of their children's crisis, especially in front of their children who have recently experienced a mental health crisis. The researcher offered both parents and YP a choice whether to engage in interviews together or independently. Two parents and two YP chose to take part in a joint interview, while four other participants decided to take part in separate interviews.

In addition, other research literature reported parental tendencies to find causes and meaning to their children's mental health difficulties in order to gain understanding of their children's mental health (McLaughlin et al., 2014; Ferrey et al., 2016). Consequently, the root causes discussed in this study such as social media and bullying, although plausible, would benefit from further investigation in future studies. This research study may therefore provide some insight into the mental health crisis journeys experiences of YP and their parents and may serve as a basis for the future youth mental health crisis research.

11.7.1 Future research direction

The findings of this study clearly showed that the mental health crisis had an adverse impact on the sibling's mental health. Future research should therefore investigate the impact of a relative mental health crisis on siblings. In addition, there is a clear need to investigate the impact of mental health crises on YPs and their families, as this study failed to recruit BME participants. Future research should seek to understand the mental health crisis experiences of YP and their families from other ethnic backgrounds. Finally, the future research should also try to explore further the impact of social media and bullying on CYP experiences of mental health crises.

11.8 Chapter summary

This study examined YP and parents' perceptions of the root causes of the mental health crisis and its impact on YP, the mental health of their parents, the impact on their siblings, and recovery of YPs post-discharge. The findings of this study also explained the overall interviewees' experiences of Solar crisis service from the point of referral to the point of discharge from the crisis team. The main findings demonstrated the interplay of different accumulative external and internal factors that contributed to the YP mental health crisis. It was also evident that the YP mental health crisis may have a ripple effect on the overall family, which may also contribute to strains between family members. The mental health crisis had a significant impact on the mental health of YP, but also had a detrimental effect on the mental health of family, carers and siblings. Although most of the interviewees reported helpfulness of the Solar crisis team and satisfaction with the crisis interventions, participants also highlighted several barriers to access, such as lack of direct telephone line and difficulties in contacting the crisis team when required. At the same time, participants reported several barriers present in the Solar crisis team, such as intra-service communication issues, lack of consistency with the staff that had an impact on the therapeutic alliance that forced YP to retell their stories. Furthermore, all interviewed stakeholders reported the existence of a "cliff-edge" discharge where YPs were left without no support before the next phase of treatment in Solar. According to the interviewee's accounts, the crisis team intervention may have a positive effect on YP lives.

Chapter 12: Thesis summary

12.1 Chapter overview

The final chapter provides an overall summary of this PhD project and integrates all findings from the project's three work packages to highlight how this project has addressed the identified research questions and gaps in the literature. This should enhance our understanding of how much the 0-19 model and its crisis service have contributed towards reform of CYP mental health services in the UK, and whether the 0-19 model has been able to remove some of the identified weakness of the CAMHS system presented in chapter 1. The first part of this chapter summarises and synthesises the main findings from the previous chapters and relate them to the posed research questions. The chapter then reflects on the project's methodological strengths and weaknesses. This is then followed by a personal reflection on the quality of the conducted research, and whether any potential researcher's biases may have impacted the data analysis and its interpretation. Finally, recommendations for policymakers and commissioners informed by the project's findings are made before the summary of the status of the reform of CYP mental health services in the UK. This is then followed by a summary of the unique contributions made by this project. This chapter is aligned with the logic model's outcomes and impact section presented in chapter 3.

12.2 Summary of the main findings

The overall aim of this project was to gain an understanding of the degree to which the 0-19 model and its crisis component are accessible, acceptable and effective. Besides, this project also aimed to understand the impact of the Solar model and its crisis service have on their local community, service users and their families. A mixed-method design was used to meet these aims and to fill all identified research gaps (uncertainties) from chapter 1. A summary of all the research findings of this project is presented in tables 102 and 105.

12.2.1 How accessible, acceptable and effective is the 0-19 model?

Accessibility

Chapter 1 established that the current CYP mental health services in the UK are affected by a number of different barriers to access, such as long waiting times, inaccessibility of service provision, fragmented service provision, complicated pathways of care, reliance on the rigid tiers system, gaps between different services, delays to initial treatment, and low CYP engagement with mental health providers.

From the findings of this PhD project, it can be seen that the 0-19 model was successful in removing some of these barriers, but not all of them. For example, chapter 2 showed that the 0-19 model had successfully moved away from the tiers system and eliminated the previously fragmented service provision by using the partnership approach between statutory and voluntary sectors. Furthermore, the qualitative findings from chapters 5 and 10 showed that the majority of the participants (CYP, Parents, Staff and Local Community stakeholders) interviewed welcomed the partnership and perceived it as a way forward. The experiential data from CYP, parents and staff confirmed that the 0-19 model improved its accessibility, especially when the model was compared to the previous 0-17 model. The staff, parents and CYP also felt that the 0-19 model was working to reduce the waiting times and improve its accessibility. For example, most of the interviewed parents and YP reported preference and satisfaction with the self-referral route, which helped to improve the accessibility of the 0-19 model. Besides, the introduction of the duty/triage line, as seen in chapter 7, may also contribute to better accessibility of the model by filtering through the referrals and diverting resources where they are most needed.

However, these stakeholders also raised a range of accessibility issues that are still evident in the 0-19 model. For example, most professionals (nurses, doctors and teachers), parents and CYP interviewees reported a long waiting times for appropriate treatment and delays in the initial treatment. Similarly, the need to wait for treatment

was also confirmed by interviewed staff members. Moreover, this issue of long waiting times (between six months and a year) was especially evident in cases where CYP were waiting to be seen by a psychiatric component. Furthermore, in chapter 5 both parents and CYP also reported a need to become assertive on their part to gain faster access to the 0-19 model, which could be a clear indication that the 0-19 model is still struggling with accessibility.

Similarly, chapters 5 and 6 also shared experiences of CYP who reported that the service locations were not accessible and had inconvenient working hours, which also contributed to the notion that the 0-19 model still had evident accessibility issues. Moreover, Local community professional stakeholders felt that inaccessible locations of the 0-19 model clinics could be perceived as barriers to access. These stakeholders also pointed out in chapter 10 that a lengthy referral form could also be considered as a barrier to accessibility.

Furthermore, most interviewees reported the existence of additional barriers to the accessibility of the 0-19 model, such as lack of resources (in particular staff). The lack of staff was evident in the responses from staff, service users, parents and local professionals. Qualitative findings showed that the 0-19 model and its crisis component are often inconsistent due to frequent staff changes and limited staff numbers that could negatively affect future help-seeking behaviours and contribute to the disengagement from the model. Indeed, the lack of staff can have a negative impact on waiting times, on accessibility and the provision of treatment and can be seen as a barrier to access. Lastly, local community professionals highlighted in chapter 10 that the 0-19 model is still relatively unknown to its key population. Therefore, it can be concluded that CYP are not well informed about the service and its provision. This also indicates that the 0-19 model needs to engage more in outreach and community work with YP in Solihull.

- ❑ Existence of policies and procedures to enable free and affordable mental health service provision to all CYP
- ❑ Services have convenient working hours and locations
- ❑ Key population (CYP) are well informed about a range of help available in their community and how to get access to them
- ❑ Local community members understand the benefits of mental health service provision for CYP and support their provision
- ❑ Outreach workers, local community members and YP are involved in reaching out to other YP in their community

Infobox 17. Accessibility of youth-friendly services according to WHO framework. Adapted from Fusar-Poli (2019)

From box 17, it can be seen that the 0-19 model met three out of five criteria to be considered an accessible youth-friendly health service. For example, the 0-19 model demonstrated the existence of a free mental health service provision for CYP and some evidence of outreach engagement with its local community. The work of the 0-19 model was also supported by local professional stakeholders in chapter 7, while staff, service users and parents referred to the model as the community-life line. The key stakeholders, therefore, have a good understanding of the benefits of the 0-19 model for their local community, and they also support the further development of the model. However, it is also evident that the 0-19 model still has accessibility issues, mainly with long waiting times and treatment delays, inconvenient working times and service locations, and lack of human resources.

Acceptability

Chapter 1 identified a range of research gaps (uncertainties) regarding the extent to which newly transformed CYP mental health service models are acceptable in the UK. In comparison, based on available evidence and examples of other global models of CYP mental health, such as Headspace and Jigsaw, literature provided some evidence in support to the acceptability of these two retransformed models. However, there is lack of research into how much these new UK models are acceptable to service users and local communities.

However, the findings of this PhD project shed some light and provided some of the evidence to support the acceptability of retransformed models for CYP mental health care. For example, the findings in chapter 5 presented the reports of CYP, parents and

staff regarding their opinions that the 0-19 model is acceptable and very much needed in their local community. Most interviewees felt that the 0-19 model was a life-line in their community and a way forward. Similarly, CYP in chapter 6 felt that the 0-19 model was acceptable and helpful to them. Besides, all interviewees in this project felt that the 0-19 model and its crisis component were very much needed in Solihull. Similar opinions were also reported by the local professional stakeholders (chapter 10), who also felt that the 0-19 model was essential to their local community. However, these interviewees clearly stated a preference for the crisis service, compared to the rest of the 0-19 model. Indeed, all interviewees in this project reported that the 0-19 model was acceptable while reporting clear preferences for community-based treatments closer to home. Lastly, most parents and CYP in the qualitative chapters reported that the 0-19 model is considered as a youth-friendly and attractive treatment environment.

However, all interviewees (CYP, parents, staff and local professionals) identified a range of issues that needed to be addressed in the 0-19 model. First and foremost, parents and CYP reported in chapter 5 that some staff members in the 0-19 model, in particular psychiatrists, had not listened to them or took them seriously. Similarly, CYP also reported in chapter 5 that some psychiatrists were dismissive and attempted to impose their opinions and influence the decision-making of service user. Moreover, CYP participants in chapter 6 emphasised the need to be listened to and taken seriously. Likewise, local professional stakeholders also reported a need to be listened to and taken seriously as crucial for the satisfaction of service users. These stakeholders have reported that often staff changes can have a negative impact on the satisfaction of service user and can contribute to the disengagement from future help-seeking.

Secondly, according to some mostly anecdotal reports, the 0-19 duty/triage telephone line appeared to be acceptable to its service users. However, the acceptability of the duty/triage line was not properly investigated due to a lack of satisfaction outcome measures. Nevertheless, the staff of the 0-19 model reported that the duty/triage telephone line was a crucial part of the model and was helpful to its service users.

Thirdly, it can be seen from all qualitative findings that service users, parents, staff and local community stakeholders were least satisfied with the 0-19 model's psychiatric component and Autism West Midlands.

Lastly, despite increased service user and parental satisfaction with the 0-19 environment, it is hard not to miss the reports of YP that the model is more children orientated than YP suitable. Similarly, the Freshfields clinic has been characterised by its staff as inadequate for the purpose, while parents perceived the clinic to be overly clinical. However, the irony is that most YP stated more preference for the Freshfields clinic compared to Bishop Wilson.

- ❑ Existence of policies and procedures that protect services user's confidentiality
- ❑ Mental health service staff provide necessary treatment information and support their service users to make free and informed choices according to their individual mental health needs
- ❑ Mental health service staff act in the best interest of their service users and are able to provide adequate time to their service users
- ❑ Mental health service staff provide non-judgmental and considerate care
- ❑ Mental health services should ensure that care is provided in a short waiting time and provide fast access to needed help (i.e. swift referral)
- ❑ Mental health service providers should ensure safety, privacy and confidentiality in stigma-free environment
- ❑ Mental health services should provide an appealing and clean and youth-friendly environment to its service users
- ❑ Mental health services providers should actively involve YP in service operations, the assessment and service provision

Infobox 18. Acceptability of youth-friendly services according to WHO framework. Adapted from Fusar-Poli (2019)

From box 18, it can be seen that the 0-19 model meets four out of eight criteria to be considered as acceptable youth-friendly service. For example, the 0-19 model provided confidential service provision to its users and protects their confidentiality under UK and EU standards. Moreover, from the experiences and perceptions of CYP, parents, staff and local professionals, it can be seen that staff provides non-judgmental and considerate care in youth-friendly and stigma-free environment. Similarly, it can be seen from the staff interviewees' reports that the service is actively

engaged in the engagement of CYP in the service operations, assessment and service provision.

In contrast, although most of the staff provide care in accordance with point two (box 15), the service users and parental reports clearly stated that psychiatrists in the model do not allow free and informed choices. Similarly, regarding point three in box 15, some reports by CYP, staff, parents and local professionals suggest that staff are overwhelmed and compromised by accepting more service users than they can dealing with effectively. This may indicate that the staff does not have enough time to devote to their service users. Lastly, it is evident from the previous section that the 0-19 model is struggling with waiting times for assessment and treatment delays. Therefore, not meeting the fourth point.

It can be concluded from all these points that the 0-19 model meets only partially the WHO criteria. However, the reports from CYP, staff, parents and local professionals made it clear that the 0-19 model is acceptable to them.

Effectiveness

Chapter 1 showed that the effectiveness of the newly transformed CYP mental health service models in the UK is uncertain. As this project gathered only qualitative data, the effectiveness of the Solar model cannot be entirely ascertained; nevertheless, some indications of its effectiveness can be drawn. For example, staff interviewees reported extensive use of signposting service users to external services, waiting time pressures and a large number of CYP referrals, which together compromised the capacity of the model. Similarly, both service users and parents reported a wide range of perceived weaknesses of the model, including long waiting times, a lack of continuity of care, dismissive and pressurising psychiatrists, and limited support and presence of AWM within the 0-19 model. Local community professionals also pointed out that the 0-19 model is still relatively unknown in the local community. On the same note, the investigation of the effectiveness of the duty/triage telephone line also

resulted in limited evidence to fully understand the effectiveness of this component of the 0-19 model.

- ❑ Mental Health service providers have required competencies
- ❑ Mental Health service provision is guided by national guidelines and sound protocols
- ❑ Mental health services have all necessary supplies, equipment and basic service to deliver mental health service provision

Infobox 19. Effectiveness of youth-friendly services according to WHO framework. Adapted from Fusar-Poli (2019)

It can be seen from box 19, that the 0-19 model partially meets some of these criteria. For example, all staff in the 0-19 model had needed competencies. However, it is also evident from staff reports in chapter 5 that some of their competencies have been challenged by large numbers of CYP cases, in particular ASD cases that they do not feel competent to deal with. Similarly, the role of Autism West Midland is also peripheral when, in fact, should be more central and supportive to other partners within the 0-19 model. Indeed, the 0-19 model works under all national and local policies. However, there is an apparent lack of written protocols duty/triage protocols (Chapter 7) within the service that can ensure consistent provision of mental health services. As previously mentioned, this project did not conduct a full evaluation of the overall 0-19 model. It is therefore difficult to infer how effective the 0-19 model truly is.

12.2.2 How accessible, acceptable, and effective is the 0-19 model's crisis service?

Accessibility

Chapter 1 identified a gap in our understanding of the extent to which CYP crisis services in the UK are accessible. Furthermore, the findings of the systematic review (chapter 4) highlighted the accessibility of identified alternatives to urgent and emergency settings. Equally, CYP, parents, staff and local community stakeholders perceived the 0-19 model's crisis service as accessible. Indeed, local community stakeholders reported that the 0-19 crisis service is more accessible than the rest of

the Solar service. Similarly, most parents and CYP reported in chapter 9 that the crisis service is very much responsive and tends to be flexible enough to meet the needs of its service users in a variety of community-settings for initial assessment, treatment and support. For example, most CYP stated that the crisis team had provided home treatments, conducted school visits, and met with service users at locations that are more convenient for them.

Similarly, in chapter 11, parents reported that the crisis service was the only service that intervened on time and prevented further CYP physical and mental health harm. Furthermore, staff members reported (Chapter 9) that the commission of the crisis team also contributed to the improvement of the accessibility of the overall 0-19 model. Both the crisis team and the duty/triage telephone line were perceived by its staff members and local professionals as the gatekeeper to hospital admissions and facilitators of early hospital discharge.

However, a lack of staff (and multidisciplinary roles within the team) and a direct crisis telephone line may hinder access to the crisis service. Most of the parents in chapters 9 and 11 reported a need for waiting for access to the crisis telephone support and a lack of direct crisis telephone lines. Similarly, some parents in chapter 9 also reported that the crisis service had intervened when the crisis had already subsided. All interviewees (staff, parents, CYP and local professionals) agreed that the crisis team was too small and overstretched and that this could also affect the accessibility of the crisis team and the crisis line. However, it was evident from the reports of parents, staff and local professionals that the crisis service lacks support for out-of-working hours crisis (especially during weekends and nights). Most of these stakeholders perceived this as the main crisis service gap. Nevertheless, all the findings in this project indicate that the crisis team is accessible to its service users, their parents, staff and local professionals.

Acceptability

The findings of this project indicate that the crisis component of the 0-19 model is acceptable in its provision as reported by CYP and their parents. Similar reports also came from the staff of the 0-19 model who felt that the crisis service is acceptable. Likewise, local professional community stakeholders felt that the crisis service was more acceptable in terms of its service provision than the rest of the model.

Despite the high levels of satisfaction of stakeholders with the crisis service, all stakeholders (CYP, parents, staff and local professionals) identified a range of barriers that could have an impact on acceptability. For example, CYP and parents reported (Chapter 9) issues with continuity of care and often changes of the crisis staff members that could have an impact on rapport and CYP engagement with the crisis service. Similarly, all stakeholders have reported that the crisis team seems understaffed and under-resourced. Local professionals also highlighted that the team is relatively small for the great demand for their services.

Moreover, some parents reported that their perception of whether their child was in a crisis differed to that of the crisis team. Similarly, parents and CYP also reported that the crisis service should be more engaged in listening and taking the users of their service seriously, as the stories of these interviewees show that CYP and parents are forced to repeat their stories on more than one occasion. These findings were consistent with the findings of the systematic review (Vusio et al.,2019). Besides, staff members reported the need for more timely access to the crisis service and the need for containment of both CYP mental health crisis and parental anxieties.

Despite these identified weaknesses, all stakeholders have expressed satisfaction with the crisis team and appreciation for their work. Some parents and local professionals felt that there was a great need for a crisis service in Solihull and that this team should be more nurtured.

Effectiveness

The systematic review (Chapter 4) identified a range of interventions (e.g. the Family-Based Crisis Intervention and Resilient Therapy) and technological solutions (e.g. Myplan) applied to community-based, urgent and emergency settings. Most of these interventions and technological solutions have been perceived as effective. For example, these interventions and technological solutions have been associated with improved treatment outcomes, decreased family burden, and an overall improvement in the functioning and satisfaction of service users. Telepsychiatry has also been seen as feasible and well tolerable for the CYP population (Vusio et al., 2019). However, some studies have reported limited evidence of the effectiveness of telepsychiatry or computer-based treatment applications, despite their promising potentials (Vusio et. al.,2019).

In line with the findings of the systematic review, the findings of this evaluation have shown that the crisis service appears to be effective with its direct crisis pathway and prevention of future readmissions. However, the lack of outcome measures, the time-limited prospective follow-up of CYP and the lack of post-discharge follow-up prevented this study from fully understanding the effectiveness of the 0-19 crisis service. The pathway findings, however, have shown that the direct crisis pathway is effective. Likewise, the effectiveness of the crisis team may also be hindered by the disproportionately high number of internal referrals compared to external referrals and CYP crisis referrals discharged to other parts of the 0-19 model. This may therefore have an impact on the accessibility of crisis service and its effectiveness, especially given the small size of the nurse-led team. Furthermore, although chapter 8 found that the waiting times to be seen by the crisis team do not correspond to the guidelines of recent UK policies, the most urgent and emergency hospital staff suggested that these recommendations were unrealistic and that they should be more flexible, depending on the individual CYP needs.

Furthermore, it can be seen from the parents, and CYP reports in chapters 9 and 11 most of the interviewees reported “cliff-edge” discharge experiences from the crisis

service. This may be a good indicator that CYP were discharged before they were ready to leave crisis service and potentially experience a crisis relapse. Similarly, some CYP and their parents (Chapters 9 and 12) reported that due to premature discharge, some CYP were readmitted back to the crisis service. Accordingly, chapter 8 findings have shown that higher relapse rates may indicate that CYP are not receiving more extended crisis support to gain full recovery. Consequently, an early discharge may lead to a relapse and readmission back to the crisis service and the need to spend a longer time on subsequent crisis treatment.

Likewise, chapter 8 also reported the existence of two predictors of crisis readmission, a situational or family crisis and deliberate self-harm. It is therefore clear that the crisis service should devote longer service provision for CYP accepted to the service and provide additional support, such as family therapy or periodical check-up.

However, it can be seen from chapter 8 that the rate of CYP readmission are relatively low, compared to adult CRHTT readmission numbers. Chapter 8 estimates that approximately 30% of CYP may experience relapse within the first 6-12 months from the point of discharge. In contrast, some evidence from adult crisis studies shows that readmission rates of adults who have experienced a mental health crisis is around 50% within the first 12-month post-discharge period. Taking into account that the readmission rate can be a good indicator of service effectiveness, it can be inferred from the Solar crisis readmission rates that the crisis team may be effective in reducing readmission rates back to the crisis service.

Table 101 - Joint display table for the synthesis of findings of the PhD project

Chapter	Study type	Area	Findings	Models Strengths	Model's Weaknesses
4	Systematic Review	Accessibility	<ul style="list-style-type: none"> ▪ Alternative models to inpatient, urgent and emergency settings 	<ul style="list-style-type: none"> ○ Found to be a suitable alternative to inpatient settings ○ Most models are organised according to recommendations from recent UK policies. ○ The main innovations of these models are their accessible, multi-disciplinary triage approaches, their partnerships with both statutory and voluntary sectors and their fully integrated services which enable smooth navigation through the care pathways for CYP 	<ul style="list-style-type: none"> • Parents reported a range of complex emotional reactions associated with accessibility and engagement with crisis care and some barriers (stigma, fear of opening up and lack of communication) to accessibility that also may contribute to disengagement of CYP with mental health service providers • Need for development of assertiveness to gain faster help • Battling through the system experiences
		Acceptability	<ul style="list-style-type: none"> ▪ CYP and Parental increased satisfaction with alternative models ▪ CYP and Parents reported a range of needs that these alternative models need to meet 	<ul style="list-style-type: none"> ○ Increased satisfaction with alternative models compared to care as usual ○ Preference for treatment in the community-based setting ○ A clear preference for more flexible models that are adaptable to individual CYP needs 	<ul style="list-style-type: none"> • The negative impact of the alternative models on the overall family functioning • Patients reported not being listened to and taken seriously or being respected to
		Effectiveness	<ul style="list-style-type: none"> ▪ Interventions for urgent and emergency settings applied to community-based settings perceived as effective ▪ A range of tele, web and mobile solutions for mental health applied to urgent and emergency settings were identified. 	<ul style="list-style-type: none"> ○ Improved treatment outcomes ○ Some interventions resulted in decreases in family burden and increased satisfaction of service users. ○ These interventions also decreased parental stress, improved empowerment of family members, contributed to better communication with staff and resulted with overall improved functioning of service users ○ Benefits of such solutions are reduction of stress in carers, empowerment of family members and improved communication between service users and clinicians and increase of overall functioning of service users 	<ul style="list-style-type: none"> • Lack of RCT clinical evidence and more robust methodologies • Some studies reported limited evidence of the effectiveness and efficiency of telepsychiatry or computer-based treatment applications, despite their promising potentials.

				<ul style="list-style-type: none"> ○ There is evidence that telepsychiatry is feasible, acceptable and well tolerable for the CYP population 	
5	Qualitative	Accessibility	<ul style="list-style-type: none"> ▪ All interviewees satisfied with the self-referral pathway in the 0-19 model ▪ Need for development of assertiveness (CYP and parents) 	<ul style="list-style-type: none"> ○ A clear preference for the community-based treatment close to home ○ Service users reported that the referral process was straight forward. ○ Once CYP successfully gain access to the treatment, things tend to improve ○ Some service users accounts showed that the Solar service improved accessibility gradually to the model 	<ul style="list-style-type: none"> • Interviewees reported that CYP are being exposed to a degree of waiting and lack of accessibility (e.g. long waiting times for psychiatrists) • Range of barriers to access identified: service locations, lack of staff and resources.
		Acceptability	<ul style="list-style-type: none"> ○ All stakeholders felt that Solar is a way forward ○ Interviewees welcomed the partnership between statutory and voluntary sectors ○ Solar has been perceived as acceptable 	<ul style="list-style-type: none"> ○ All interviewees felt that the Solar service is a community lifeline to service users and their families. ○ Service users also felt positive about the youth-friendly ethos of the service and its design of clinics that were perceived as modern and suitable for CYP 	<ul style="list-style-type: none"> • The main perceived weakness of the Solar service was psychiatric component, while the least-joined part of Solar was perceived as AWM
		Effectiveness	<ul style="list-style-type: none"> ○ Service users expressed mixed experiences with treatment outcomes 	<ul style="list-style-type: none"> ○ Some parents and CYP reported some degree of improvement thanks to the help provided by the Solar service 	<ul style="list-style-type: none"> • Few parents compared their children's treatment outcomes and their treatment experiences to a rollercoaster ride
6	Qualitative	Accessibility	<ul style="list-style-type: none"> • CYP reported a range of barriers to access • The Solar's service locations perceived as inaccessible. • A need for more flexibility with working times/appointments 	<ul style="list-style-type: none"> ○ Responsiveness ○ Support and advice ○ Signposting 	<ul style="list-style-type: none"> • Waiting times for treatment, • Preference for more locally based hubs and mental health services
		Acceptability	<ul style="list-style-type: none"> ▪ Range of positive and negative emotions described in relation to acceptance and treatment ▪ Participants described the helpfulness of Solar and its staff 	<ul style="list-style-type: none"> ○ Once CYP became familiar with the Service they started noticing benefits of the Solar's help and more hope for their recovery 	<ul style="list-style-type: none"> • Initial reactions associated with scariness, worry, fear. • Participants emphasised the need to be listened to and taken seriously
7	Mixed-Methods	Accessibility	<ul style="list-style-type: none"> ▪ Telephone triage accessible to a number of stakeholders ▪ Crucial in the allocation of the resources within the 0-19 model ▪ The role of gatekeeper 	<ul style="list-style-type: none"> ○ Prevention of flooding the Solar service with non-crisis patients or patients that could receive help from other community services (i.e. Filtering access to 0-19 model) ○ Preventing the crisis service to become overwhelmed with non-crisis referrals 	<ul style="list-style-type: none"> • Non-duty coverage of duty line • No permanent role of duty • Consistency • Unknow (and unclear) whether the duty is successful in diverting CYP or just delaying

				<ul style="list-style-type: none"> ○ The key component for improving accessibility 	<p>their acceptance to the crisis team</p>
		Acceptability	<ul style="list-style-type: none"> ▪ Service users and their parents perceived the duty/triage line as acceptable ▪ Staff found the duty/triage component to be vital (i.e. gatekeeper) 	<ul style="list-style-type: none"> ○ Duty/Triage component as valuable and should be more nurtured ○ Telephone triage line acceptable 	<ul style="list-style-type: none"> • Barriers identified: lack of staff, resources and coverage through a week
		Effectiveness	<ul style="list-style-type: none"> ▪ No standardised outcome measures, lack of triage assessment screening tools and their records in the RIO database, lack of routinely collected data 	<ul style="list-style-type: none"> ○ The Duty/Triage nurse maintained through written documentation of conversations with callers 	<ul style="list-style-type: none"> • Effectiveness of duty/triage is not clear.
8	Quantitative	Accessibility	<ul style="list-style-type: none"> ▪ Crisis responsiveness ▪ Easy access options ▪ The flexibility of the crisis team 	<ul style="list-style-type: none"> ○ A cohesive team that supports each other ○ Mobility ○ Provision of community-based crisis interventions 	<ul style="list-style-type: none"> • Small nurse-led team • Lack of additional number of crisis staff • Not meeting recommendations from recent UK policies • Lack of direct telephone crisis line • Unclear criteria for acceptance to the crisis care • Lack of routine outcome measures
		Effectiveness	<ul style="list-style-type: none"> ▪ The pathway analysis findings and the Sankey diagram of patient flows have shown that the direct crisis pathway is the most effective ▪ Thirds of all crisis discharged service users may experience relapse within the first 6 months up to 12 months from the discharge point ▪ Two predictors of the crisis relapse identified (and one possible) 	<ul style="list-style-type: none"> ○ A large percentage of CYP who follow direct crisis pathway successfully exited the model ○ CYP Readmission rates showed that the largest number of readmissions occur within the first 60 days ○ Family or situational crisis and deliberate self-harm were statistically significant predictors of the crisis relapse (readmission). The third predictor (Gender) was borderline significant (p=0.051). However, male gender seems to be more probably to experience relapse and subsequent readmission back to the crisis service. 	<ul style="list-style-type: none"> • Other pathway variations can be compromised by waiting times and bottlenecks within the 0-19 model. Also, these analyses pointed out to a large number of internal referrals to the crisis service that is disproportionate compared to the number of external referrals • Question of whether the crisis team discharges CYP prematurely and whether they receive long enough support.

					<ul style="list-style-type: none"> • Small sample sizes and small prospective study period without follow-up - difficult to properly assess the effectiveness of the crisis team
9	Qualitative	Accessibility	<ul style="list-style-type: none"> ▪ Perceived by interviewees as accessible and responsive 	<ul style="list-style-type: none"> ○ The presence of the crisis service also contributed to improvement in the accessibility of the overall 0-19 model ○ Gatekeeper to hospital admission ○ Facilitator of early hospital discharge 	<ul style="list-style-type: none"> • Presence of particular accessibility barriers such as lack of resources, a lack of staff and a lack of adequate funding for the crisis team • Number of gaps identified such as lack of continuity of care and cliff-edge discharge
		Acceptability	<ul style="list-style-type: none"> ▪ All participants expressed satisfaction with the crisis service ▪ Participants felt that the crisis service truly meets the CYP needs 	<ul style="list-style-type: none"> ○ The activities of the crisis team and their presence in the Solihull perceived as essential to the local community and the 0-19 model ○ Parents and CYP have identified the need for the crisis service responsiveness as the most crucial element of the crisis service 	<ul style="list-style-type: none"> • A range of needs highlighted that crisis service still need to improve differences between the perception of parents and healthcare professionals as to what a mental health crisis is, the need to be listened to and taken seriously, timely access to appropriate crisis support and the need for containment
10	Qualitative	Accessibility	<ul style="list-style-type: none"> ▪ Crisis perceived by professionals in the local community as more accessible and responsive compared to other parts of the Solar service 	<ul style="list-style-type: none"> ○ The crisis team is doing what is commissioned to do ○ Rapid response to CYP in a mental health crisis 	<ul style="list-style-type: none"> • Lengthy referral form for Solar perceived as a barrier to access • Range of other barriers such as service locations, lack of drop-in hubs, lack of continuity of care, long timeframes for assessment, lack of staff and staff continuity.
		Acceptability	<ul style="list-style-type: none"> ▪ Professionals expressed more satisfaction with the crisis service, compared to the rest of Solar 	<ul style="list-style-type: none"> ○ The crisis team was perceived as helpful and professional 	<ul style="list-style-type: none"> • Participants highlighted that the crisis team is underfunded and stretched. • Not enough staff
		Effectiveness	<ul style="list-style-type: none"> ▪ Interviewees still perceived Solar as the service that meets most of CYP needs and the much-needed service in its local community. 	<ul style="list-style-type: none"> ○ Stakeholders' perception that communication with Solar has improved and is currently satisfactory, some participants felt that communication should be further improved 	<ul style="list-style-type: none"> • Lack of out-of-working service coverage (especially during weekends and nights) was perceived as the service gap.

			<ul style="list-style-type: none"> ▪ Regarding the service's impact on its local community, most participants thought that Solar had some impact. 	<ul style="list-style-type: none"> ○ Most participants agreed that the partnership between NHS, Barnardo's and AWM is a positive step forward. 	<ul style="list-style-type: none"> • Solar still relatively invisible to CYP in Solihull • Participants considered AWM as the partnership's weakest link, mainly due to its limited service provision and engagement with the rest of the Solar service
12	Qualitative	Accessibility	<ul style="list-style-type: none"> ▪ Barriers to access to the crisis service 	<ul style="list-style-type: none"> ○ Fast access in cases of life-threatening crises ○ The flexibility of the crisis team to do initial assessment and treatment in a range of community-settings 	<ul style="list-style-type: none"> • Barriers: lack of direct telephone line and difficulties in contacting the crisis team when required, intra-service communication issues, lack of consistency with the staff that had an impacted on the therapeutic alliance that forced YPs to retell their mental health crisis stories.
		Not classified	<ul style="list-style-type: none"> ▪ The interplay of different accumulative external and internal factors that contributed to the YP mental health crisis ▪ Presence of the Rippling effect of CYP mental health crisis on the entire family (including siblings) and their functioning ▪ Interviewees stated that crisis team intervention might have a positive effect on YP's lives 	<ul style="list-style-type: none"> ○ The findings of this study also explained the overall interviewees' experiences of the Solar mental health crisis service from the point of referral to the point of discharge from the crisis team ○ Most of the interviewees reported helpfulness of the Solar crisis team and satisfaction with the crisis interventions 	<ul style="list-style-type: none"> • Increased family burden and strains between family members due to CYP crisis • Presence of cliff-edge crisis discharge, CYP and parents felt that discharge was made prematurely.

12.3 Strengths and limitations of this PhD project

12.3.1 Strengths of the PhD project: core findings regarding the effectiveness, accessibility and acceptability of the 0-19 model

Although several systematic reviews have examined alternatives for CYP inpatient settings and generated evidence-based conclusions on their usability and clinical use, none of these reviews have explored CYP and their parents' experiences regarding these alternative models. The systematic review in chapter 4 included new models, technological solutions and interventions that can be used in urgent and emergency settings (Vusio et al., 2019). However, the key elements of the systematic review were the experiences and satisfaction of CYP and parents/carers with these alternative models. Besides, the findings of the systematic review also informed us of what CYP, and parents/carers thought the best crisis care model should be. The systematic review was a crucial element of this PhD project, which also helped to identify significant gaps in the existing literature and also helped to shape the other work packages to address these identified issues.

Secondly, as research evidence on CYP's retransformed mental health crisis models and crisis resolution and home treatment services is scarce, this PhD project provided a comprehensive examination of the 0-19 model and its crisis component. By using a mixed-methods approach, this project was able to describe and evaluate the effectiveness of the CYP crisis pathway that has not been previously done in the UK. Similarly, by using qualitative research, this PhD project also gained an understanding of how much the retransformed 0-19 model addressed some of the main weaknesses of the CAMHS system in the UK. It can be concluded from the findings that some barriers to accessibility, transition issues and lack of appropriate resources (both human and financial) remain the main weaknesses of the retransformed models that need to be fully addressed.

Thirdly, understanding the local impact of the 0-19 model and its crisis component reinforces the idea that the waiting times for access and treatment are still a significant issue for the retransformed models. However, the findings of chapter 10 indicate that the 0-19 model and

its crisis service have had some impact. Local professionals considered the model to be very much needed in the local community. Furthermore, this study is one of the first attempts to understand how much these retransformed models have an impact on their local communities and what local professional stakeholders perceive as barriers and issues.

Fourthly, this PhD project was the first attempt to use the Lego® Serious Play® approach in mental health and wellbeing research. The LSP methodology provided valuable insight into how much CYP perceived the 0-19 model to be accessible and acceptable to its service users. The LSP approach demonstrated its applicability to mental health research by outlining the satisfaction of CYP and their perceptions of barriers to accessibility and how the 0-19 model can be improved.

Lastly, the use of the mixed-methods approach, coupled with the template and thematic analysis helped triangulate the findings across all three work packages (Torrance, 2012). Evident experiences from CYP and their parents, for example, have been confirmed in the systematic review as well as in all qualitative research studies. Similarly, barriers to accessibility have also been similar across different research studies. The use of mixed-methods approach, therefore, strengthened the credibility of all work package findings.

12.3.2 Limitations of the PhD project: what remains unclear or unknown

Despite all aforementioned strengths, this PhD project also had several limitations. First and foremost, the impact of Covid-19 limited our understanding of how much CYP recovered post-crisis discharge, as well as an understanding of how many CYP would experience relapse six months after the outcome measure ReQuest would be administered. As a result of the outbreak, this part of the project was impacted by the nationwide lockdown and consequently remained incomplete. Second, the prospective follow up of CYP through the crisis service during the eight months was insufficient to draw a significant conclusion on the effectiveness of the crisis care. Ideally, the prospective study should have been conducted for a full year (as initially planned), followed by an additional 4-6 months of post-discharge CYP follow-up to understand how many of them had relapsed and subsequently been readmitted back into the crisis care.

Third, the lack of routinely collected data and crisis outcome measures also prevented us from fully understanding the actual effectiveness of the crisis service. Outcome measures are important tools that inform not only CYP care but are also crucial to understanding how effective the crisis service is. Similarly, the lack of routinely collected data for the telephone duty/triage also prevented us from fully understanding the effectiveness of the triage/duty component.

Fourth, small recruitment samples for qualitative parts may also be seen as a limitation of this PhD. For example, only seven participants were recruited for the LSP group. However, several recruitment attempts were made to increase these numbers without much success. The service working times and limited flexibility with appointments also contributed to a lack of interest in LSP sessions. Similarly, this project also attempted to recruit local community GPs and representatives from Autism West Midlands. Despite several recruitment attempts, there was an apparent lack of interest on the part of these stakeholders to participate in this project.

Fifth, despite the fact that the 0-19 model offers promising improvements with YP transition issues, this PhD project did not investigate the transitional experiences of YP within the Solar model. The main rationale why more focus was not placed on transitions was due to the small number of YP that engage in the transition step to AMHS within the 0-19 model. As can be seen from table 102, between 1st April 2019 and 31st December 2019 very few YP progressed beyond age of 19 within Solar during this period. In addition, the vast majority of YP left the 0-19 model at the age of 18, while a very small percentage of YP left the service at the age of 19. However, the service and the Clinical Commissioning Group acknowledged that transitions are still not effective and are in need of further improvement (Solihull CCG, 2018). Therefore, the effectiveness of transitions between the 0-19 model and AMHS remains unknown.

Table 102 – Percentage of YP discharged from the 0-19 model between April and December 2019

Age at discharge	Total YP discharged	% of YP discharged
18	88	74%
19	26	22%
20	2	2%
21	1	1%
24	1	1%
Total	118	100%

Lastly, the limited time of this PhD prevented us from undertaking a full and formal evaluation of the overall 0-19 model. As this PhD lasted three years, it was impossible to evaluate both the 0-19 model, its crisis and duty/triage component. Therefore, since this PhD was primarily commissioned to understand the crisis service, the predominant focus of this project was on that component. In cooperation with the Solar service, it was agreed that certain qualitative aspect would be conducted to understand the accessibility and acceptability of the model.

12.4 Reflection

For each chapter, the strengths and weaknesses of each study were determined separately. However, several other considerations require further clarification of the qualitative and mixed-method research design, which are not fully addressed in previous chapters. These considerations of methodological adequacy of the used research methods to answer the questions posed will be discussed in the following sections.

12. 4.1 Reflection on the qualitative approach using template analysis

The initial step in this PhD project was to conduct a systematic review, so that the researcher would be familiar with a range of issues, strengths and weaknesses of newly retransformed models and alternatives to inpatient settings. The application of the Grounded Theory, which was initially planned as the main approach to data analysis, was therefore abandoned. Reflecting on the reasons why the researcher had moved away from the Grounded theory was

pragmatic, as the risk of bias would increase due to the researcher's prior exposure to the parental and CYP experiences from the systematic review of qualitative data. Glaser and Strauss are clear that during data collection and their analysis, the qualitative researcher should have "no preconceived ideas" (Allan, 2003). However, the researcher was exposed to preconceived ideas (e.g. what is working and what is not) that generated research questions, and interviewing participants without an appropriate agenda and well defined semi-structured interviews would create unfocused research that would not be ethical or have an appropriate effect.

Instead, the researcher used the template analysis defined as "*a form of thematic analysis which emphasises the use of hierarchical coding but balances a relatively high degree of structure in the process of analysing textual data with the flexibility to adapt it to the needs of particular study*" (Brooks et al., 2015). It is also crucial to highlight that the template analysis is not strictly bound to any well-established epistemologies, and instead, the flexibility of the template analysis allowed for its adaptation to the particular needs of the research project. As a result, the researcher used a well-established "realist position" for this PhD research project to uncover the underlying causes of specific actions and phenomena as they are (Brooks et al., 2015). The researcher developed a set of well-defined and robust interview questions (supported by literature findings and systematic review and research questions) before interviews that represented a-priori themes. These a-priori themes ensured that the research is focused on key areas that were relevant to the study were addressed in interviews, while allowing interviewees to expand and include other relevant pieces of information that they felt it was needed to be disclosed. All themes that came from the direct response of the participants were classified as emergent themes (i.e. emerging from the participants' responses in transcripts).

In cooperation with the supervisors, the researcher developed and discussed several templates with them to minimise any bias in analysis or interpretation of findings. The final template is, therefore, an agreement between the researcher and the two supervisors involved in this PhD project. The researcher followed well-established research questions during the design of a-priori themes, recruitment (i.e. matching population to the research questions using purposive sampling), data analysis and its interpretation.

However, it is crucial to report that a degree of “admission bias” may be present in this project, as all service users and parents have been recruited from the two services in the Solihull area. Consequently, the findings of this project cannot be applied to the general population, as indicated in the limitations of all qualitative chapters. However, the researcher avoided selection bias by applying well-established inclusion criteria, and all stakeholders had an equal likelihood of being included in this project. Both training, previous knowledge and experience in qualitative research have guided the researcher to minimise or eliminate the risk of bias. The bias in research can warp findings and results, and ultimately lead to wrong conclusions.

Given that this area of research is in clinical practice, the risk of minimising the bias was crucial to this project, as misinterpreted results may have a tremendous impact on clinical practice. As a result, the researcher engaged in reflective practice during data collection, analysis and interpretation to reduce and minimise the effect of bias (especially analysis bias) on this research project. For this purpose, the researcher used a research diary (during the design, recruitment, data collection and analysis phases) which captured the researcher’s thoughts and feelings about the research and analysis process and its reflexivity to understand how the researchers’ assumptions about the research phenomenon could influence the analysis. Transparency wise, in order to report the findings of the template analysis, the researcher used the natural and exact language of participants in the quotations to accurately report the participants’ perceptions without any grammatical or slang corrections. This allowed participants to be represented accurately in the research and to convey their opinions exactly as they were interviewed. A full audit trail is available and will be handed over to the WMS upon successful completion of this PhD project for safekeeping.

12.4.2 Reflection on the use of the thematic approach

A reader may have noticed; the researcher used thematic analysis in two chapters 6 and 7. The main rationale for this was pragmatic. The researcher did not develop any a-priori themes for the LSP chapter (6). Instead, the researcher believed that all findings should be derived from the transcripts. Participants guided the LSP session, and the researcher asked only two questions that were guidance (or themes) for participants to build their models. The researcher did not use any prompts beside “*can you explain to me what this represents*”. The group

discussion between the participants was not interfered by the researcher, who took the role of facilitator by allowing CYP to discuss and reflect on their own and other CYP models.

As template analysis is a type of thematic analysis, it shares a flexible approach to the development of a particular (hierarchical structure). The researcher therefore believed that thematically analysing data would produce a similar structure but on a much smaller scale. Similarly, for the secondary analysis of the qualitative staff interviews, the researcher did not have any a-priori themes to specifically understand the acceptability, accessibility and effectiveness of the duty/triage component. Since all findings were drawn from the transcripts, the application of the template analysis would not be appropriate. Instead, the researcher used thematic analysis to create themes and subthemes, similar to the LSP study approach. All other qualitative studies have been conducted following the template analysis. Again, in these cases, all findings, final themes and subthemes were agreed upon by the researcher and supervisors to reduce and minimise the impact of the analysis bias. The reflexive approach has also been applied to these two studies, as described in the previous section.

12.4.3 - Reflection on the quality of mixed-methods design

The choice of the mixed-method design was pragmatic and influenced mainly by the lack of standardised outcome measures to measure the satisfaction of service users. It was, therefore, crucial to obtain experiential data (as well as quantitative) that would indicate the degree of satisfaction of the stakeholders with the model and help to answer the research questions raised. The findings across all individual studies were consolidated in this chapter. The use of the joint table 101 and 104 (in this chapter) provided a clear understanding of where the findings were generated, while the logic model (in chapter 3) provided the overall condensed findings from all chapters. Indeed, the use of the logic model was a useful way to show and follow all the research activities in this PhD project. Besides, the logic model represents the logical steps of research activities, their outcomes and findings of this the PhD research project.

Table 103 - Strengths and Weakness of the qualitative study components of the PhD project in relation to guiding principles

Guiding principle	Strength	Weaknesses
Transparency	<ul style="list-style-type: none"> ❑ Systematic and transparent data collection and use of the template analysis which facilitates systematic interpretation of data from transcripts ❑ Use of NVivo and review meetings with supervisors uploaded to Tabula ❑ Through the use of participants quotations that represent their exact words (without changing any grammar or any corrections) ❑ Pictures of LSP models supported CYP perceptions ❑ The double-checking procedure that transcriber (Appen) done their job correctly ❑ Supervisors included in the form of interpretation templates and the constructions of final templates ❑ Existence of audit trail 	<ul style="list-style-type: none"> - The researcher chronologically adapted themes to give interpretation chronological flow - The quotes and images were chosen by the researcher to represent a particular theme(s) - The researcher did not use the participatory approach or member-checking procedure to make sure that participant approve the use of images
Reflexivity	<ul style="list-style-type: none"> ❑ As a non-native English speaker, the participant may misinterpret the researcher's posed questions ❑ Attempts to create more participatory research environment by allowing the participants to talk as much as possible ❑ Introduction of participatory research that facilitated shared experiences and minimised the researcher's effect on participants ❑ Use of research diaries throughout the project to understand the impact of the project on the researcher and the researcher belief on the project ❑ Reducing the power balance between the researcher and participants 	<ul style="list-style-type: none"> - Position of an adult researcher working with CYP population - Cultural differences between the researcher and participants - The researcher was impacted with the local dialect which may contribute toward misinterpreting information (verification was sought in cases when this was a case)
Transferability	<ul style="list-style-type: none"> ❑ The predominant focus of the researcher was on CYP and their parents ❑ Pursue the research that will benefit the local population and practice ❑ The attempt of recruitment of participants from a broad diversity backgrounds and professions ❑ Recruitment from the wide West Midlands area 	<ul style="list-style-type: none"> - CYP population predominantly White British - Lack of diversity (attempted recruitment but unsuccessful) - Participants limited to only two services
Integrity	<ul style="list-style-type: none"> ❑ The qualitative approach allowed the successful completion of the project aims and research questions 	<ul style="list-style-type: none"> - Small samples of CYP and parents' samples - Lack of diversity within the CYP and Parent sample - Small numbers of male parents and CYP participants
Risk of Bias	<ul style="list-style-type: none"> ❑ Avoidance of sampling bias by adhering to inclusion criteria ❑ Minimisation of analysis bias through double-checking with two other supervisors and using the principle of agreement 	<ul style="list-style-type: none"> - Admission risk of bias possible (However, this was explained for each qualitative chapter in the study limitations)

12.5 The current status of the CYP mental health service reforms

In the UK, most of the CAMHS models still provide services to CYP up to the age of 18 (Vusio et al.,2020). However, based on examples of global models such as Australian Headspace (McGorry et al., 2014; McGorry & Mei, 2018) and Irish Jigsaw (O’Keeffe, O’Reilly, O’Brien, Buckley, & Illback, 2015) there are evident attempts in the UK to move gradually towards the implementation of similar models that will serve mental health needs of CYP population aged 0-25. The 0-25 model offers particular benefits, such as improved accessibility, continuity of care, and better outcomes for patients, and is primarily designed to meet the age incidence of CYP mental health problems (Vusio et al.,2020; Fusar-Poli, 2019). Moreover, well-established models such as Headspace and Jigsaw have successfully demonstrated their appropriateness, acceptability and accessibility (Fusar-Poli, 2019). It is, therefore, understandable why UK policy-makers seem to favour the retransformation of existing mental health service model to the 0-25 model (Vusio et al.,2020; NHS England, 2019).

- ❑ Convenient and accessible service location
- ❑ Youth friendly services
- ❑ Services run by young people for young people
- ❑ Provision of timely access to needed help and appointments
- ❑ High standards of privacy and confidentiality
- ❑ Presence of multiple service provision under the same roof
- ❑ Delivery of appropriate treatments and interventions

Infobox 20. Benefits of the 0-25 models. Adapted from Fusar-Poli (2019)

However, despite the clear benefits of these retransformed models (Jigsaw and Headspace), some of the well-established weakness in CYP mental health identified in chapter 1 are still evident, such as transition issue between CAMHS and AMHS services. For example, 12-25 models such as Headspace, also showed transitional limitations at the extremities of the age ranges (Vusio et al.,2020; McGorry, Bates, & Birchwood, 2013). Similarly, despite its better continuity of care compared to the care as usual, the 0-25 model may still suffer from transition issues and consequently may create a new transition gap at the age of 26. Likewise, one study also reported that newly retransformed 14-25 and 16-25 CYP models might also introduce new transitional gaps “*through which YP may fall at extremities of the age ranges covered by these models*” (Vusio et al.,2020; Maxwell et al., 2019). Besides, another study also pointed out that despite all research efforts, there is still no single example of the best evidence-based model for CYP mental health (Fusar-Poli, 2019).

- ❑ Lack of evidence to support what constitutes the best evidence-based practice CYP mental health service models
- ❑ Lack of standards
- ❑ Lack of the effectiveness of retransformed models and their mental health outcomes is models
- ❑ Lack of randomised controlled trials
- ❑ Lack of cost-effectiveness of these models
- ❑ Lack of evidence for CYP aged 0-12

Infobox 21. The main challenges of the 0-25 model. Adapted from Fusar-Poli (2019)

Similarly, Fusar-Poli (2019) stated that the effectiveness of these CYP retransformed models remains modest and still insufficiently investigated with more rigorous methodological approaches. Although it is clear that the current CAMHS structure fails to meet CYP mental health needs, it is well established what needs to be improved and changed (e.g. Better access, improved engagement with providers and more early intervention/prevention frameworks). However, there are various models for CYP mental health in the world (e.g. 0-25, 12-25, 14-26), with no clarity as to which model should be recommended and presented as the most effective. Similarly, the funding and operation of these models remain highly variable (Rickwood et al., 2019). There is therefore an evident need for more “*feasibility and acceptability studies, trials and “real-world” evaluations*” (Vusio et al., 2020). Lastly, the advancement of youth mental health reforms around the world is evident, and more knowledge sharing is needed regarding what works (Rickwood et al., 2019).

12.5.1 The current status of CYP mental health service reforms in the UK

The recent introduction of a range of UK policies and guidelines has precipitated the development of a range of retransformed models such as 0-25 (Birchwood et al., 2018), 14-25 (Maxwell et al., 2019) and 16-25 (Fenton, 2016) and 0-19 (Vusio et al., 2020). However, similar to some of the models mentioned in the previous section, the effectiveness of these models is still relatively unknown (Vusio et al., 2020). For example, although the 0-25 model is favoured by the policy-makers in the UK, the effectiveness of these models (within the UK context) is still unknown, as there is no published evidence to support the accessibility, acceptability and effectiveness of these models (Vusio et al., 2020; Fusar-Poli, 2019). However, the evaluation of the 0-25 model found that although the model was well received by stakeholders (CYP, parents, commissioners, and local professionals), the model still demonstrated a lack of

effectiveness and accessibility (Birchwood et al., 2018). Besides this single service evaluation, no other published evidence is available to inform the impact of the 0-25 model of care (Fusar-Poli, 2019).

Similarly, this project findings showed that the 0-19 model is a bold attempt to improve CYP mental health services. However, similar to the 0-25 FTB model, the 0-19 model also displays issues with waiting times and accessibility but also shares similarity with FTB in terms of acceptability. However, this PhD project was not able to look at the effectiveness of the 0-19 model using a more robust methodology. Instead, the project provided a basic understanding of accessibility and acceptability of the 0-19 model through the use of qualitative approaches. Therefore, there is an evident need for more robust study designs to understand the effectiveness of the 0-19 model fully.

However, the recent study demonstrated the robust evidence of the impact of the CAMHS transformation attempts (based on the recent national policies) in England (Rocks et al., 2020). The findings of the study showed that transformation could indeed facilitate improved accessibility, effective use of resources and better treatment outcomes (Rocks et al., 2020). However, the authors cautioned that attempts to improve one part of the system might subsequently have negative effects on other parts of the system (Rocks et al., 2020).

Lastly, similar to the global CYP models, there is an evident need in the UK to conduct more robust investigations of how effective and accessible new retransformed models for CYP are. Based on the findings of this project, it can be concluded that despite some improvements of the service provision for CYP, some issues are still evident and persistent such as waiting times, accessibility and transition issues.

The new retransformed models for CYP mental health aim to improve accessibility by using the more permeable front door. Still, they suffer from the consequent increase in demand for their services and subsequent lack of capacity. Notably, most of these retransformed models in the UK are retransformed within the existing resources, which may not be sufficient to make them fully effective and accessible.

12.6 Implication of this PhD project

As can be seen from the findings of the project in tables 102 and 105, the crisis service was generally considered to be accessible, acceptable and to a degree effective. On the other hand, the overall 0-19 model was perceived to be accessible to some degree. However, both the 0-19 model and its crisis component have several barriers and gaps that need to be addressed appropriately to make their provisions more accessible and effective. It is clear from the findings that the model and its crisis and duty/triage components are underfunded and understaffed.

Similarly, the involvement of Autism West Midlands with the rest of the model should be reviewed, as it is evident that a large number of service users are affected by learning disabilities and need more formal and appropriate support, which is currently lacking. The model as such should also address the service locations, as the current locations of the Solar services are inaccessible for some CYP in the Solihull. There is therefore a great need for consideration of more community-based drop-in hubs or additional services. Besides, the Solar service should be involved in the community-based promotion to raise awareness of its existence among the critical population. The introduction of the Solaris sub-service may help to increase awareness among stakeholders of the overall model, similar to the GP trailblazer project (chapter 2).

As this project has not been able to investigate the degree of recovery, it is therefore, crucial for future studies to investigate 1) the degree of CYP recovery post-discharge to understand the effectiveness of crisis resolution and home treatment and 2) whether recovery from a mental health crisis leads to improved CYP resilience. This PhD project has demonstrated the potential use of the LSP method for both research and clinical practice. For example, the LSP method showed excellent potential for further use in mental health research with the CYP population. It is also important to explore its applicability to the adult population in mental health research settings.

Moreover, more studies are needed to understand how feasible this approach is. However, the findings of this project have shown that the LSP approach improves the participation and

involvement of participants with mental health and wellbeing research. However, more investigations are needed to confirm the findings of this project. Besides, the LSP study also showed the potential for this approach to be used as a complement to other well-established recovery measures. However, a much more rigorous methodological approach is needed to verify these findings.

Lastly, chapter 11 showed that effects of CYP mental health crisis on their immediate social environment (i.e. ripple effect). The findings of the study showed the negative impact of the CYP's mental health crisis on siblings and the overall functioning of the family. There is therefore a need for more research (both qualitative and quantitative) to understand these impacts and whether crisis intervention should be offered to encompass not only affected individuals but the family as a whole.

The findings of this project suggest a need for:

- A clear definition of what constitutes a mental health crisis and what presentations (symptoms) CYP need to have to be classified as being in the mental health crisis. The qualitative and systematic review findings clearly indicate the need to develop defined set criteria for a mental health crisis that will reduce variance in professional decision-making. This may help triage and duty workers to better screen through telephone calls and referrals forms and may also serve as a reference guide for A&E and Hospital staff. Besides, this may reduce the differences in perceptions between parents and crisis staff as to what a mental health crisis is, as demonstrated by qualitative and systematic review findings.
- Defining what particular treatment is appropriate for CYP in a mental health crisis. It is important to emphasise that most CYP mental health crisis models were developed from adult crisis models. Therefore, there is a need to develop policies and guidelines based on the best evidence-based practice that will inform which crisis treatments are suitable for CYP population and how they should be delivered. The qualitative and quantitative findings of this project identified variability in decision-making regarding the crisis treatment. The absence of these clear guidance may increase the variability of crisis care and increase the potential for unsafe crisis care practice.
- Development of criteria for the duration of crisis care is crucial as this may provide a reference guide to what is the minimum amount of crisis care needed to be provided. Quantitative findings of this project showed a quite variability of duration of crisis care. For example, the average duration of care is 13 days for CYP. In contrast, if CYP are being readmitted, the average duration of care is up to 19 days. However, one adult study reported that the average duration of crisis care for adult patients is 21 days (Lloyd-Evans et al.,2018). Therefore, it is evident a clear variability of duration of crisis care provision and a need for more guidance regarding what is an optimal duration of CYP crisis care.
- A clear definition of what is the effective crisis pathway for CYP mental health crisis services. This project identified four subtypes of the crisis pathway. Other services may, however, have significant variations in their crisis pathways. It is, therefore, crucial to develop policies that will inform what constitutes an effective crisis pathway.
- Policies and guidance for the administration of appropriate and evidence-based outcome measures that can be used in mental health crisis settings for assessment, diagnosis, outcomes and evaluation of treatment and its effectiveness. The findings of this project showed that the evaluated crisis service did not use any outcome measures. The lack of appropriate psychometric evaluation tools can contribute to the variability of care and can lead to the wrong decision-making process, as to whether someone is in the crisis or not.
- More research to improve our understanding of what constitutes the best evidence-based crisis practice model. Despite some obvious efforts to describe the best examples of the crisis care models (NHS East of England Clinical Networks, 2017), there is still a clear gap in our understanding what constitutes the best evidence-based model for CYP crisis care provision. More policies, research and guidance, are needed to provide an example of the best evidence-based crisis care practice for CYP.
- Eliminate the “cliff-edge” crisis discharge and to provide CYP with more continuity of care until the next treatment opinion is available. It was evident from the findings of this project that all stakeholders reported the existence of cliff-edge discharge. Removal of cliff-edge discharge may, therefore, help to reduce the potential of crisis relapse and further deterioration of CYP mental health.

12.7 Chapter conclusions and contributions of this PhD project

This PhD project has made a number of new and unique contributions to the existing scientific literature.

First and foremost, although some previous research efforts have been made to understand alternative models to inpatient, urgent and emergency settings (Kwok et al., 2016; Paton et al., 2016b; Shepperd et al., 2009), the systematic review undertaken in this project was the first attempt to synthesise CYP and parental experiences to the accessibility and acceptability of these alternatives. This review also included a range of newly identified models, interventions and technological solutions for urgent and emergency alternatives models.

Second, this project is the first attempt to examine the experiences of CYP, staff and parents with a 0-19 model. Interviewees identified a range of barriers to accessibility, gaps in service provision and a range of strengths and weaknesses in the overall 0-19 model that were similar to the findings of a systematic review. Despite its weaknesses, the overall 0-19 model was perceived as crucial to the local community, while the partnership between statutory and voluntary sectors was welcomed. However, many interviewees raised concerns with the model's psychiatric component and AWM's involvement in the partnership.

The LSP study also made similar findings to the other qualitative aspects of the project and the systematic review. The LSP study was the first attempt to apply this methodology to research in mental health. As such, this study and its findings represent a truly novel and unique research contribution.

A further contribution of this project was the audit investigation of the accessibility, acceptability and effectiveness of the model's duty/triage telephone line. The retrospective audit of service users' clinical records showed this component is an important gatekeeper and performs a crucial triage and signposting function.

Table 104 - Summary of the main findings

(Chapter)Research questions	Method	Summary of the main findings
<p>Chapter 4</p> <ol style="list-style-type: none"> 1. What are the experiences and satisfaction of CYP and their parents, with mental health crisis services or alternatives to inpatient settings? 2. What are the identified interventions that can be applied to CYP in urgent and emergency environments? 3. What are the newly developed alternative models to inpatient or emergency department admissions for CYP experiencing mental health crisis? 	<p>Systematic Review</p>	<ul style="list-style-type: none"> • Alternative models to inpatient, urgent and emergency settings • Interventions for urgent and emergency settings applied to community-based settings • Tele, web and mobile solutions for mental health applied to urgent and emergency settings • CYP and parental increased satisfaction with alternative models compared to care provided by inpatients settings or care as usual • CYP and parents expressed a range of need that these alternatives need to meet and what appropriate crisis service should look like • A range of barriers to access identified (need for assertiveness, waiting times, battling through experiences) • Preference of stakeholders for treatment in the community-settings
<p>Chapter 5:</p> <ol style="list-style-type: none"> 1. What are the stakeholder's experiences with the overall Solar service? 2. How accessible Solar is to CYP, and what are perceived barriers related to accessibility and acceptability of the 0-19 model? 3. What is stakeholder's satisfaction with the overall 0-19 model's service provision? 	<p>Qualitative</p>	<ul style="list-style-type: none"> • All stakeholders perceived the Solar model as a way forward • The partnership between statutory and voluntary sector welcomed • The Solar model was perceived to be acceptable • The self-referral pathway perceived as helpful by all stakeholders • Service users and parents reported a preference for the treatment near home and in the community settings • Interviewees reported some of the accessibility issues, while parents and CYP reported a need for assertiveness and battling through experiences • Service users and parents reported mixed-experiences with their treatment outcomes
<p>Chapter 6:</p> <ol style="list-style-type: none"> 1. What is the stakeholders' perception of the 0-19 model's accessibility and acceptability? 2. What is the overall satisfaction of the 	<p>Qualitative</p>	<ul style="list-style-type: none"> • Participants described helpfulness of the Solar service staff • CYP reported a range of barriers to access and preference for quicker access • Locations of the Solar service were perceived as inaccessible • A need for more flexibility regarding opening times and more appropriate times for sessions were reported by most of the participants • A range of negative emotional reactions were reported associated with access to the Solar service • CYP participants stated a need for more one-to-one sessions and smaller group sessions

<p>stakeholders with the 0-19 model and its service provision?</p>		
<p>Chapter 7: 1. What is the accessibility, acceptability and effectiveness of this component of the Solar service for a crisis? 2. What are staff members views and experiences with the duty segment and possible future improvement?.</p>	<p>Mixed- Methods</p>	<ul style="list-style-type: none"> • Telephone triage accessible to a range of service users and stakeholders • Triage as a crucial role in the allocation of resources • Telephone triage perceived by staff and stakeholders as acceptable • Lack of evident standard outcome measures, triage assessment screening tools and lack of routinely collected data to establish the effectiveness
<p>Chapter 8: 1. How effective is the 0-19 crisis pathway for admission of CYP into the crisis service? What are the pathways to crisis care and patients flows? 2. Is the crisis service transforming recovery and resilience such that further use of the crisis services is reduced? 3. Is 0-19 crisis model effective in reducing A&E and acute admissions or out of area placements?</p>	<p>Quantitative</p>	<ul style="list-style-type: none"> • Patient flows demonstrated effectiveness of the direct crisis pathway • Third of service users may experience relapse between first 6- and 12-months post-discharge • Variation of waiting times and time to be seen by the crisis team • Two significant predictors of readmission (relapse) family or situational crisis and deliberate self-harm • Gender may be considered as an additional predictor (especially males) for being readmitted (borderline significant)
<p>Chapter 9: 1. What are stakeholders' perceptions regarding their experiences of accessibility, effectiveness and acceptability of the crisis component?</p>	<p>Qualitative</p>	<ul style="list-style-type: none"> • Participants expressed satisfaction with the crisis service • Stakeholders agreed that the crisis service meets the CYP needs • The crisis service perceived as accessible and responsive (some barriers and gaps identified)

<p>Chapter 10:</p> <ol style="list-style-type: none"> 1. How accessible and acceptable is the 0-19 model and its crisis component for local community stakeholders. 	<p>Qualitative</p>	<ul style="list-style-type: none"> • Local Community stakeholders perceived the crisis service more accessible and responsive compared to the rest of the 0-19 model • A range of barriers to accessibility identified • The Solar models have been perceived as the community life-line • The Solar service meets most of CYP mental health and wellbeing needs • Regarding the impact of the Solar service, most stakeholders reported that Solar has a degree of impact on its local community • Stakeholders felt that the model is still relatively unknown to CYP in community
<p>Chapter 11:</p> <ol style="list-style-type: none"> 1. What are the main sources and triggers of a mental health crisis for CYP? 2. What is the impact of the YP mental health crisis on parents, siblings and overall family functioning? 3. What was YP and their family's journey through the Solar's crisis service, and their perceptions of its accessibility and acceptability? 4. What was the personal perception of recovery and satisfaction with the overall crisis treatment? 	<p>Qualitative</p>	<ul style="list-style-type: none"> • The interplay of different accumulative external and internal factors as a contributor to CYP mental crisis • Rippling effect of CYP mental health crisis on their immediate social environment • The significant impact of CYP mental health crisis on siblings, parents and family functioning • Interviewees perceived the help and interventions from the crisis team as helpful with a positive effect on CYP lives • Interviewees identified a range of barriers and weakness of the crisis service

The prospective study of CYP movements through the 0-19 crisis service helped to investigate the effectiveness of the crisis pathway. The findings showed the direct crisis pathway is the most effective, while the three other pathway subtypes were less so. This study found the rate of readmission to the crisis service within 180 days was 30%. If the rate of readmission within one year was not to increase significantly more than this, this would indicate that the model's crisis team is effective and performs well (compared to adult models). Lastly, the Cox Hazard analysis identified two significant predictors of crisis readmission: family and situational crisis, and deliberate self-harm. These findings represent a novel and unique contribution to existing literature, as this was the first attempt to explore and describe the effectiveness of a CYP crisis service in the UK.

Due to a lack of satisfaction outcome measures, this project conducted a qualitative study to explore stakeholders (CYP, parents and staff) perceptions of the 0-19 crisis service. The crisis team was considered to be acceptable and accessible. However, stakeholders identified several barriers that may hinder the accessibility of the crisis team, such as lack of resources, a lack of staff and a lack of adequate funding for the crisis team. CYP and parents also identified a number of gaps in the crisis provision, such as a lack of continuity of care and 'cliff-edge' discharges. These findings made a unique and novel contribution to the research knowledge, as no other published study has investigated the effectiveness of crisis service provision for CYP.

A qualitative research study was then conducted with local community professional stakeholders to investigate the impact of the model on the local community. Some barriers to access were identified, such as the length of referral forms, inaccessible locations, and a lack of drop-in hubs, staff, consistency of care and continuity of staff. However, most interviewees reported that the crisis service was more accessible and acceptable, compared to the rest of the model, and that the model as a whole was vital to the local community. Nevertheless, this component of the project highlighted that retransformed models that operate according to recent UK national and local policies still display similar weaknesses as traditional CAMHS 0-18 models.

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Appendices

- The appendices section contains the crucial documents such as published studies, all ethics approvals and documentation used in the Work Package 2.
- The supplement section will cover separately all documentation used for the Work Package 3.



After the storm, Solar comes out: A new service model for children and adolescent mental health

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Abstract

Aim: Existing children and adolescent mental health services in the United Kingdom have many gaps, such as reduced access to community-based services, and a lack of early intervention, prevention, and 24/7 crisis care. These gaps prevent timely access to appropriate levels of care, decrease children and young people's engagement with providers, and lead to increased pressures on urgent and emergency care. In this paper, we outline a newly created 0-19 model and its crisis service, which have been transformed into a fully integrated, "joint partnership" service, in line with the recommendations from the recent UK policies that aim to meet the aforementioned challenges.

Method: The "Solar" service is described as a case study of a 0-19 service model. We cover the national and local contexts of the service, in addition to its rationale, aims, organizational structure, strengths and limitations.

Results: The presented model is a fully integrated and innovative example of a service model that operates without tiers, and helps to create an inclusive, compassionate, stigma-free and youth-friendly environment. Additionally, the model aims to prioritize recovery, early intervention, prevention and the development of resilience.

Conclusion: The 0-19 model is a result of the recent transformation of children and youth mental health services in the United Kingdom. The ongoing evaluation of the 0-19 model and its crisis component will investigate the model's effectiveness, accessibility and acceptability, as well as understanding the potential of the model to contribute towards solving numerous gaps in the existing mental health service provision within the United Kingdom.

KEYWORDS

children and young people, community mental health, integrated-whole system, mental health and crisis intervention, partnership model

1 | INTRODUCTION

There is prominent recognition of the weaknesses of the current children and adolescent mental health services (CAMHS) provision in the

United Kingdom (Care Quality Commission, 2017). Specifically, barriers to access (Brown, Rice, Rickwood, & Parker, 2016) and complicated pathways to care (Biddle, Donovan, Sharp, & Gunnell, 2007) are some of the main weaknesses identified. Furthermore, the lack of

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early intervention and prevention models (Lamb & Murphy, 2013), and crisis care provision have also been identified as points requiring urgent transformation (Department of Health, 2015).

Since its inception in 1995, the four-tier model was the main system for the delivery of mental health service provision for Children and Young People (CYP) in the United Kingdom (Department of Health, 2015). The model comprises of four levels of care, with community and outpatient services covering tiers one to three, which respectively encompass universal mental health services, specialist CAMHS and community-based services, and targeted mental health interventions. Meanwhile, the fourth tier covers services that support more complex CYP needs, such as inpatient settings. However, the four-tier model has gained criticism due to the requirement of CYP to fit into a particular tier, instead of the model fitting an individual CYP's specific and changing needs (Department of Health, 2015; Wolpert et al., 2014). Moreover, the model has been criticized for creating fragmented care and service divisions, and for potentially having created unintentional gaps between different tiers, which CYP can fall through (Department of Health, 2015).

Furthermore, many CYP face difficulties transitioning from CAMHS to Adult Mental Health Services (AMHS). Most transitions are based on age, rather than need (Lamb & Murphy, 2013). Moreover, the transition between CAMHS and AMHS can have potentially detrimental consequences for young people (YP) and their mental health if the transition is poorly planned and executed (Singh et al., 2010). Therefore, it is essential to address and close the service gaps, since breaking the cycle of continuity of care can jeopardize the effectiveness of early intervention (Birchwood & Singh, 2013).

All the above problems indicate that the current CAMHS provision struggles to meet the needs of CYP (House of Commons Health Committee, 2014). Consequently, the current service provision may lead to help avoidance behaviours (Singh & Tuomainen, 2015) and increase the need for crisis intervention (Hawke et al., 2019). Therefore, it is evident that the current system of mental health provision for CYP requires transformation, both in national and local contexts.

2 | TRANSFORMATION OF CYP MENTAL HEALTH SYSTEM WITHIN THE UNITED KINGDOM

Potential solutions for the aforementioned problems to improve CYP mental health provision were proposed in the Future in Mind (Department of Health, 2015), Five Year Forward View (NHS, 2014) and Crisis Concordat (Crisis Care Concordat, 2018) policies. These policies emphasize the importance of transformation and redesign of existing services in the United Kingdom with a focus on early intervention, prevention, improvement of engagement with mental health providers, treatment delivery and recovery-oriented service models. Additionally, these policies recommended the creation of integrated-whole system and partnership working models between voluntary and statutory mental health service providers that are comprehensive, sustainable, and community-based (McGorry, 2007; Mental Health Taskforce, 2016). Consequently,

this led to the formation of mental health service provision to cover CYP aged 0 to 25 (Birchwood et al., 2018), 14 to 25 (Maxwell et al., 2019), and 16 to 25 (Fenton, 2016), which have been proposed as alternative solutions towards the transformation of CYP mental health provision.

What are common to all these models are their attempts to prevent CYP from falling through the gaps between CAMHS and AMHS, as well as enabling CYP to be adequately prepared for transitioning between providers. However, as noted by Maxwell et al. (2019), even though the 14-25 and 16-25 models remove transitional boundaries at 18 years of age, these models still may produce new gaps through which CYP could fall at the extremities of the age ranges covered by these models. Therefore, a flexible model such as 0-25 may provide more continuity with the care that is needed, as well as preparing CYP for better transition outcomes (Alderwick & Dixon, 2019). Yet, the issue of transition at the age of 25 may remain. However, in the United Kingdom, the effectiveness of the 0-25 model is still unknown, as no published evidence exists of the impact of 0-25 models on CYP care (Fusar-Poli, 2019).

The main aim of this paper is to describe the structure and organization of "Solar", a unique and fully integrated community mental health partnership model for CYP aged 0 to 19 in Solihull, United Kingdom. Throughout this article, we aim to detail the reasons for the implementation of the current model with regards to the local context, service structure and its strengths and limitations.

2.1 | Local context

The previous CAMHS service provision in Solihull, United Kingdom, utilized a 0-17 service model, facilitated by a collaboration between several providers, organized within a four-tier system (Solihull CCG, 2015). However, a review of CAMHS undertaken in 2014 highlighted issues with service provision such as multiple barriers to access; lack of early intervention, prevention, and crisis resolution services (Solihull CCG, 2015). Moreover, feedback obtained from CYP and their families also highlighted the inaccessibility and inefficiency of the previous service as being a significant concern (Solihull CCG, 2015).

In 2015, Solihull council started the local transformation of CYP mental health services in cooperation with the Birmingham and Solihull Mental Health Fund Trust (BSMHFT) using "Future in Mind" (Department of Health, 2015), and the Five-year transformation plan (Mental Health Taskforce, 2016). The justification for this re-transformation was provided for a number of reasons. In 2016 it was estimated that 51 213 CYP aged 0 to 19 lived in the Solihull borough, and this is predicted to rise by a further 4% by 2021 (Solihull CCG, 2017a). Furthermore, there is a significant inequality gap present in Solihull, with an estimated 1 in 6 children living in relative poverty (Solihull CCG, 2015). Socioeconomic factors such as inequality and growing up in deprived and disadvantaged backgrounds can have discernible effects on CYP mental health (Dogra, Singh, Sviryzdenka, & Vostanis, 2012).

Nevertheless, it is also important to acknowledge that the 0-19 model was conceptualized in the context of the situation in the 2014,

before the Future in Mind recommendations had been published. The main driver in Solihull was to move away from a CAMHS service with high thresholds to an emotional, wellbeing and mental health service, with improved access, and partnership work with a wide range of stakeholders. The five-year plan (NHS, 2014), suggested the creation of a transformation plan for CYP mental health and wellbeing, covering a range of available services, from promotion and prevention to intervention and support, with transitions between services being a crucial element (Solihull CCG, 2015).

The result of the transformation was the creation of an integrated-whole system that provided more joined-up care by coordinating services and provision around the needs of CYP, and a partnership forming a community-based 0-19 model as a response to both national policy and local needs. An additional rationale behind choosing a 0-19 model was to bridge the transitional gap between CAMHS and AMHS and to allow CYP more choice and flexibility with their transition to AMHS, based on their actual need, rather than age. One of the advantages of 0-19 model is its flexibility to continue to support CYP up to the age of 21 if CYP are not fully ready to do transition at 19. Furthermore, the positioning of the 0-19 model as youth-friendly service ensures mental health service provision that is attractive to CYP, which can result in improved engagement of CYP with the 0-19 model.

3 | STRUCTURE AND ORGANIZATION OF THE 0-19 MODEL

The main aims of the newly commissioned 0-19 model are to create an all-inclusive system, with a compassionate and stigma-free environment that is centred around the mental health and emotional needs of CYP while prioritizing and promoting recovery, prevention, the development of resilience, and the creation of the partnerships between parents and the service (NHS England, 2014).

3.1 | Co-production between the 0-19 model and young people

The 0-19 model has engaged with YP from the local area in collaborative work and joint decision making from its inception to make its service provision more attractive to CYP. One of the first results produced from this collaboration was the name of the service model, "Solar". Service users' involvement also played a pivotal role in the service organization and design. The co-production with YP helped create the service's logo and motto: "*Solar - Brightening young futures*". The need for friendly and attractive environments to CYP was recognized and addressed through collaboration with CYP, which helped create service environments that are more attractive and less clinical to service users.

Additionally, the service has produced a publication "*Your journey through Solar*" (Solar, 2016), in collaboration with CYP to provide information to future service users from a CYP perspective. Lastly, the

model's service provision priorities are shaped by feedback from CYP and their families. For example, Solar is actively engaged in the annual "You in mind" conference that aims to gain feedback from stakeholders about what needs to be improved with the service.

3.2 | Organization structure

The Solar service can be best described as an emotional and wellbeing mental health service with a multi-disciplinary approach towards assessment and treatment of CYP who are affected by a range of presentations of mental health difficulties. The model is fully oriented towards providing early intervention in emerging mental health for CYP in the least restrictive and community-based environment. To facilitate both assessment and treatment, the model is comprised of a CAMHS service facilitated by BSMHFT and a primary mental health service (PMHS) run by Barnardo's.¹ An overarching segment of the 0-19 model that works with both CAMHS and PMHS is the crisis-home treatment team that aims to reduce hospital admission through community management of mental health crises. Finally, Autism West Midlands is the last partner that delivers more specific support to the 0-19 model, such as learning disability support and education for service users. Staff from all three partners operate jointly under the Solar service name, working alongside each other. Additional support services within the model also include parental and infant mental health; eating disorders; "looked after children" and the learning disability service.

The single governance arrangement across the service ensures consistency and a coherent organization structure with no gaps between different services of the model into which CYP could fall. Additionally, as CYP only have to tell their story once, they can move quickly between different services within the model, according to their need as recommended by the Future in Mind guidance (Department of Health, 2015).

This organizational structure makes the Solar service an innovative model, primarily due to its partnership with both voluntary and statutory sectors, which has jointly created a broad range of skills and knowledge for improving the service provision and CYP experiences (Figure 1). As such, the partnership ensures that the service does not expose CYP to long waiting times for re-referrals to external organizations unless it is necessary. This particular integration is an essential part of the Solar service, which aims to create a system that is both effective, safe and guarantees responsiveness to CYP mental health needs and the delivery of an appropriate level of care. This consequently has reduced treatment delays and non-attendance rates for appointments.

3.3 | Solar: No tiers service

Since the Solar service was recommissioned, the provision of mental health moved gradually from a tiered system, merging PMHS with CAMHS into a single point of access (SPOA) that significantly reduced transition points (Solihull CCG, 2017a). The SPOA has allowed CYP to

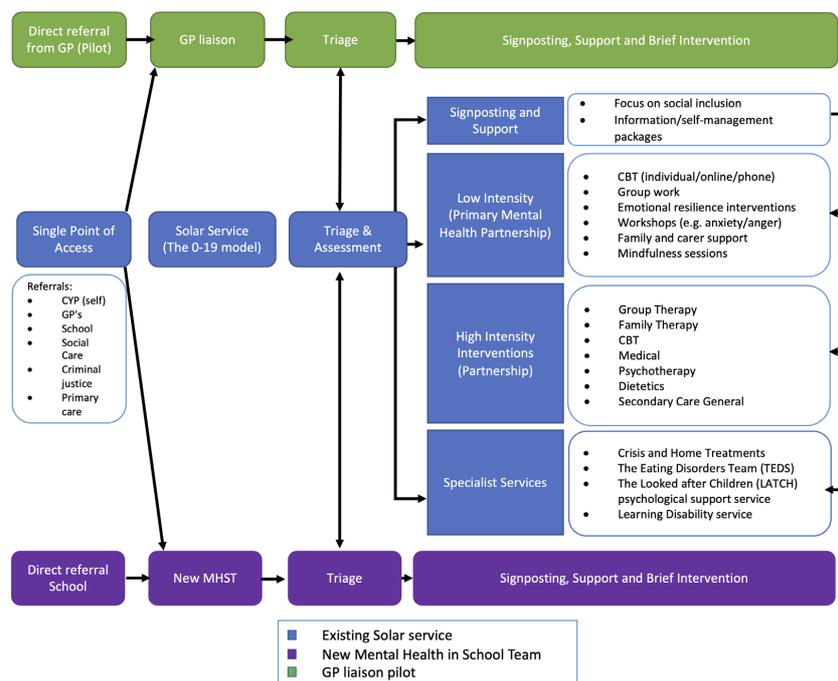


FIGURE 1 Solar (the 0-19 model's) pathways

self-refer to the model, while enabling the service to provide a more coherent and coordinated approach. The SPOA allows CYP and their families to give a detailed picture of the presenting problem, the duration of the problem, or what they are expecting from the service. Furthermore, the SPOA allows direct access for CYP, which has reduced the need for GP referrals and has improved the flow of access. As CYP and their families have consented to the service and understand the service, they are more likely to attend their assessment, therefore reducing non-attendance. The SPOA enables a single assessment by the multi-disciplinary team, and an opportunity to involve CYP and their parents in shared decision-making about the level of need and suitability of treatments.

Furthermore, to achieve short waiting times, Solar utilizes the choice and partnership model² (CAPA), a clinical system that brings together the active involvement of CYP and their families, and creates a new approach to clinical skills and job planning (York & Kingsbury, 2013). Solar recognizes this by using one clinical record and a single care plan stored in a centralized system. This allows the fluid movement of CYP through interventions, enabling CYP to be simultaneously under the care of multiple practitioners at Solar.

Maintaining optimum patient flow throughout the model is particularly important since there has been an increasing demand for the Solar service since it was recommissioned in 2015. Moreover, there is little evidence that referral acceptance rates have been compromised

due to this increased demand, with yearly acceptance rates for the Solar service being consistently above 80%, compared to an acceptance rate of 55% for the previous service in 2014 to 2015 (Figure 2).

3.4 | Journey through the “Solar system”

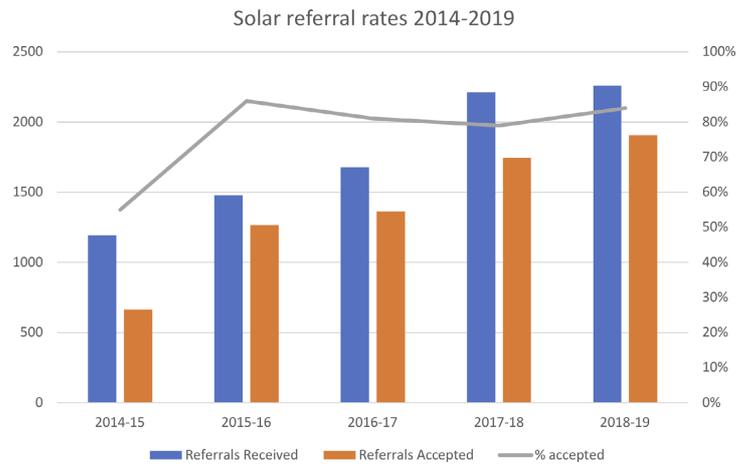
3.4.1 | Referral and screening

A request to access the service for CYP can be initiated via a range of education or health providers, parent/carer, or through self-referral. New referrals into the service are screened daily by a multi-disciplinary team of senior clinicians.

3.4.2 | Triage

Following the screening, the 0-19 model undertakes a triage assessment with the goal of information gathering, risk assessing, making contact with CYP and referrers. If CYP are presented in crisis to the triage, they are signposted to the crisis team to take over the individual case. Alternatively, CYP are signposted to specialist pathways or redirected for partnership treatment within the 0-19 model or to external organizations.

FIGURE 2 Referrals rates of the 0-19 model by academic year (01 September-31 August) between 2015 and 2019 compared to the previous service (2014-2015)



3.4.3 | Assessment

In cases when needs are more complex, a full assessment is offered. A full assessment is completed within 6 weeks following an accepted referral when there are more complex needs or presence of symptoms that are of concern and require urgent risk assessment and management plans followed by more detailed assessment and formulation.

3.4.4 | Treatment

Based on the assessment outcomes, a follow-up appointment can be arranged where CYP work with clinicians collaboratively to create a personalized care plan that will be tailored to encompass specific individual needs. This plan reflects all the goals that both the service and CYP agreed together to achieve full recovery. Treatment can occur in individual, group or family therapy settings. Substance misuse issues are dealt within the team using a harm-reduction model.³

3.4.5 | Transitioning

When YP are ready to leave the service, Solar works with YP to make the discharge process as smooth as possible by liaising with AMHS and continuing to provide support to YP until they are fully ready to transition at a pace that suits their needs. The transition process starts with a pre-transition questionnaire to ascertain the readiness of YP for transition and provide baseline information for the receiving service (Solihull CCG, 2018). A transitional booklet is provided to YP, which explains the overall transition process. Following their transition, a second questionnaire is administered to confirm whether AMHS fits an individual YP's needs. In cases where AMHS is not the right fit for an individual or if a YP is not adequately prepared for the

transition, the YP will continue to receive support from the service until they reach their 21st birthday. During this time, they will gradually be prepared for a second attempt of transitioning if required. The 0-19 model's flexibility, therefore, allows for YP to transition to AMHS based primarily on their individual needs rather than age. However, we believe that transition as such is still not effective and in need of improvement.

3.4.6 | Outreach

The recent introduction of Solaris⁴ developed the 0-19 model's partnerships to encompass local school communities. Solaris works together with schools to develop a whole-school approach aimed to develop resilience, while early identifying CYP who have emerging mental health and emotional wellbeing needs (Solihull CCG, 2019). Early identification of these needs will help towards early intervention and prevention, and ensure CYP get appropriate support at the right time. A range of brief goal-focused interventions are offered for CYP and their families, such as individual low intensity and group therapies. Similar projects with GP practices are also being trialled.

3.5 | The Solar community crisis resolution team

The 0-19 crisis team currently operates 7 days a week from 8 AM to 8 PM. A separate out-of-hours service is also offered in cooperation with the neighbouring 0-25 service (Solihull CCG, 2018; Solihull CCG, 2017b). Under both the pre-existing daytime crisis service and the out-of-hours coverage, CYP experiencing mental health crisis are triaged within 1 hour of referral, while an assessment is completed within 4 hours, as recommended by Crisis Care Concordat (2018). Additionally, CYP who are admitted to inpatient settings in the region

are also assigned with clinical support and care from the Solar crisis service. Furthermore, the crisis line is an additional first port of call, where CYP or their parents can get advice and support from the crisis team. Lastly, the 0-19 crisis resolution service also provides home and community treatment, crisis support over the phone or support in Solar clinics. Thus the crisis team aim to provide maximum flexibility for CYP and their families. The benefit of having a crisis team closely tied to other parts of the model allows CYP to be prepared for ongoing support from other mental health professionals within the model, once they are stabilized and discharged from the crisis team.

4 | DISCUSSION

We provided a case study of a retransformed and flexible 0-19, a whole integrated model that works in partnership with statutory and voluntary sectors to deliver the early intervention, prevention and recovery for CYP aged 0-19. The commission of this model was a response to major identified weaknesses of the whole CAMHS system in the United Kingdom. The lack of early intervention, prevention, and "cliff-edge" transitions between CAMHS and AMHS are just some of weaknesses of traditional CAMHS that compromise CYP safety (House of Commons Health Committee, 2014). Also, the incidence of youth mental health problems rises steeply just at the point of the traditional CAMHS/AMHS split, while for AMHS, the level of attendance and treatment delivery for 18- to 24-year-olds was lowest of all age groups in the previous adult service in Birmingham (McGorry, Bates, & Birchwood, 2013).

This 0-19 model is one of many service transformations that attempt to improve service access, CYP outcomes, and transitional experience between CAMHS and AMHS (Malla et al., 2016; McGorry et al., 2013). For example, many retransformed models in the world cover age ranges between 12 and 25, such as "Jigsaw" in Ireland (O'Keefe, O'Reilly, O'Brien, Buckley, & Illback, 2015) and "Headspace" in Australia (McGorry, Goldstone, Parker, Rickwood, & Hickie, 2014; McGorry & Mei, 2018). Both models showed evidence of accessibility and effectiveness of their community-based services (Hilferty et al., 2015; O'Keefe et al., 2015). Headspace, for example, has service provision that is both integrated and multidisciplinary, while being centred around the needs of CYP and their families (McGorry et al., 2014). Likewise, the 0-19 model utilized by Solar shares some similar features, with provision for CYP up to the age of 19, with the possibility of it being extended up to age 21 if needed; however, this may be seen as a limited in comparison with other models that offer provision for CYP up to the age of 25. Nevertheless, the flexibility of the model utilized by Solar offers service users a guarantee that they will not face a "cliff-edge" transition at the age of 18.

Currently, service provision in the United Kingdom predominantly consists of traditional CAMHS (0-18), in addition to recently transformed 0-25, 14-25 and 16-25 models. As Fusar-Poli (2019) noted, these retransformed models still require a demonstration of feasibility and impact. We therefore believe they, in addition to Solar's 0-19 model, can best be regarded as "hypotheses" of potentially effective

structures that can solve the problems of the current CAMHS/AMHS model, while at the same time improving early access and treatment.

In the United Kingdom, many of CAMHS services that are undergoing transformation are moving gradually towards the direction of 0-25 models as they appear to be worldwide (Fusar-Poli, 2019). The benefits of 0-25 models are that they are congruent with the data on age incidence of mental health problems in CYP and the hope is that these models may improve access, patients outcomes and satisfaction with care (Fusar-Poli, 2019). Indeed, an evaluation study of Headspace showed YP preferences for the 12-25 model in comparison to traditional CAMHS. Similarly, an evaluation of the first 0-25 model in the United Kingdom showed that it was well-received by CYP, their families and local healthcare professionals and commissioners (Birchwood et al., 2018). However, this evaluation also highlighted that the model was compromised by huge CYP demand for services that exceeded capacity, lacked additional financial resources, and had issues with the mobilization of the service, having to move services from previous providers (Birchwood et al., 2018).

At the time of writing, there is still no universally accepted model that can best address the now widely understood problems of the traditional CAMHS/AMHS structure (Fusar-Poli, 2019; Hetrick et al., 2017). Indeed, as with many other models worldwide (Nguyen et al., 2017), transitional issues still exist in Solar's 0-19 model, despite its flexible and individual-based approach. Comparatively, 12-25 models have transitional weaknesses at the extremities of the age ranges (McGorry et al., 2013). Moreover, even the 0-25 model may not be fully immune to transitional issues, yet it may provide better continuity with care in comparison to traditional transition points (Alderwick & Dixon, 2019).

It is important to stress that we are at a critical point in CYP service transformation. While we are clear about the failings of the current structure, the goals of a service transformation (improved access, delivery of evidenced-based care with high engagement rates all within an early intervention framework), we do not have evidence to clearly support the various alternative service structures proposed (status quo; 12-25; 0-18; 0-25). What is needed are feasibility and acceptability studies, trials, "real-world" evaluations (and to remember that the status quo has none of these). There are strong parallels with the formative phase in the development of the early intervention in psychosis teams: it was clear that the status quo was failing and good evidence concerning the key features requiring reform (access, engagement, delivery of evidenced-based care, sustained intervention during the critical period) which informed a hypothesis about a service structure, which then went on to be the subject of trials and later NICE approval.

The proposed 0-19 model is the subject of an ongoing feasibility evaluation which aims to investigate the potential impact of the model, its accessibility and acceptability, and whether this model has the potential to improve transition, among other factors. In the supplementary document section, research protocol links are provided for further information about the service evaluation of the presented model. In the United Kingdom, the 0-25 model seems to be favoured from a policy perspective (NHS England, 2019), and we look forward to a period of careful and rational scientific analysis.

5 | SUMMARY AND CONCLUSION

In summary, we have described a new 0-19 model that is an integrated, whole-system model that works in partnership between statutory and voluntary sectors. This joint partnership offers a unique and different approach to mental health service provision for CYP, their families and the local community. With a range of different services residing under one roof, this 0-19 model provides traditional CAMHS-PMHS, crisis resolution and home treatments, and a variety of support services to CYP aged 0-19 in a less restrictive and community-based environment. While the 0-19 model has its own set of challenges, it nevertheless addresses some of the numerous issues with the current CAMHS provision in the United Kingdom.

ACKNOWLEDGEMENTS

The authors would like to thank the Solar service, and all its staff members (from both Bishop Wilson and Freshfields clinics) for their cooperation and help provided. The authors would like to express additional gratitude to Julie Hackett, Solihull Clinical Care Commissioner, for her assistance. In addition, we would like to express gratitude to all the reviewers for their suggestions that improved the overall article. This article has been conducted as a part of a PhD project by F. Vusio at the University of Warwick, funded by the Birmingham and Solihull Mental Health Foundation Trust and Warwick Medical School. M. Birchwood was partially funded by the Applied Research Centre (ARC). This research is supported by the National Institute for Health Research (NIHR) Applied Research Centre (ARC) West Midlands. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

DATA AVAILABILITY STATEMENT

Data available in article supplementary material.

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ENDNOTES

¹Children's charitable voluntary organization.

²CAPA is a transformation model of engagement and clinical assessment that uses a collaborative approach between clinicians and service users to enhance both user satisfaction and effectiveness of the service, and improve flow throughout the system (York & Kingsbury, 2013).

³Harm-reduction is an all-encompassing term for interventions that aim to reduce the problematic effects of behaviours (Logan & Marlatt, 2010).

⁴Solaris is the current Solar's core support for the schools that will be further enhanced by the Mental Health Support Teams trailblazer to provide "a whole school approach" as recommended by the UK government (Department of Health & Department of Education, 2018).

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

How to cite this article: Vusio F, Thompson A, Laughton L, Birchwood M. After the storm, Solar comes out: A new service model for children and adolescent mental health. *Early Intervention in Psychiatry*. 2020;1–8. <https://doi.org/10.1111/eip.13009>

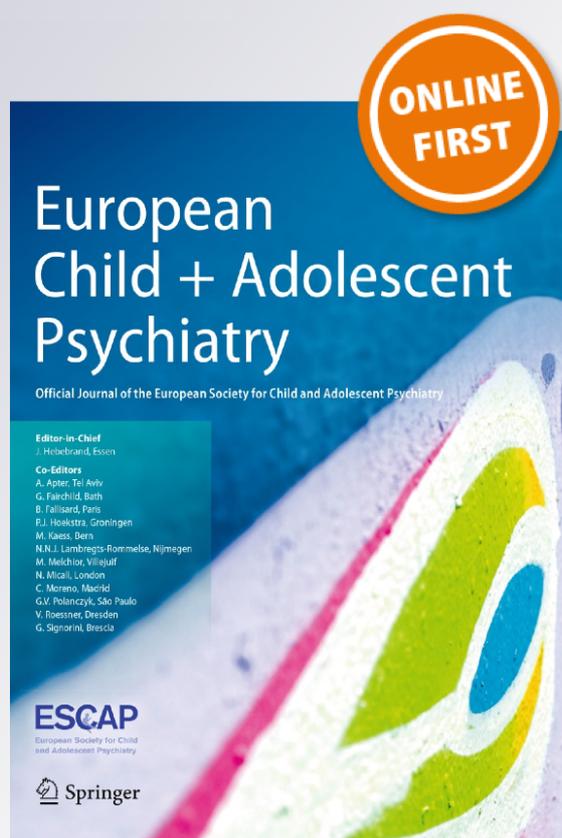
Experiences and satisfaction of children, young people and their parents with alternative mental health models to inpatient settings: a systematic review

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European Child & Adolescent Psychiatry

ISSN 1018-8827

Eur Child Adolesc Psychiatry
DOI 10.1007/s00787-019-01420-7



 Springer



Experiences and satisfaction of children, young people and their parents with alternative mental health models to inpatient settings: a systematic review

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Received: 10 July 2019 / Accepted: 3 October 2019
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Abstract

Community-based mental health services for children and young people (CYP) can offer alternatives to inpatient settings and treat CYP in less restrictive environments. However, there has been limited implementation of such alternative models, and their efficacy is still inconclusive. Notably, little is known of the experiences of CYP and their parents with these alternative models and their level of satisfaction with the care provided. Therefore, the main aim of this review was to understand those experiences of the accessibility of alternative models to inpatient care, as well as overall CYP/parental satisfaction. A searching strategy of peer-reviewed articles was conducted from January 1990 to December 2018, with updated searches conducted in June 2019. The initial search resulted in 495 articles, of which 19 were included in this review. A narrative synthesis grouped the studies according to emerging themes: alternative models, tele-psychiatry and interventions applied to crisis, and experiences and satisfaction with crisis provision. The identified articles highlighted increased satisfaction in CYP with alternative models in comparison with care as usual. However, the parental experiential data identified high levels of parental burden and a range of complex emotional reactions associated with engagement with crisis services. Furthermore, we identified a number of interventions, telepsychiatric and mobile solutions that may be effective when applied to urgent and emergency care for CYP experiencing a mental health crisis. Lastly, both parental and CYP experiences highlighted a number of perceived barriers associated with help-seeking from crisis services.

Keywords Children and young people · Alternatives to inpatient settings · Mental health crisis · Experiences and satisfaction · Crisis intervention · Parental experiences

Introduction

The latest 2017 survey of mental health prevalence for children and young people (CYP) in England showed that approximately 12.5% of 5–19 year olds were affected by adverse mental health issues [1]. In addition, despite the high prevalence of mental health disorders among CYP in the UK, help-seeking rates among CYP are in decline [2, 3]. Furthermore, there are evident treatment gaps, with up

to 55% of adolescents aged 12–15 not receiving access to Children and Adolescent Mental Health Services (CAMHS) [4]. The treatment gap is similar for 16–20 year olds, whilst it may be as high as 64% for 21–25 year olds [4]. Moreover, a survey showed that 35% of young people (YP) requiring mental health services did not have any contact with them [5]; primarily due to insufficient resources within CAMHS services and a reluctance amongst some CYP to engage with CAMHS services [5].

Consequently, the high prevalence rates of mental health disorders amongst CYP aged 0–25 are applying significant pressures to inpatient settings and emergency departments struggling to cope with these increasing numbers [6, 7]. As result of this high demand for mental health provision, the quality of mental health services in emergency departments and inpatient settings is declining [2]. Moreover, a lack of beds in inpatient settings [7, 8] is resulting in increasing numbers of CYP being sent to adult inpatient services that

Electronic supplementary material The online version of this article (<https://doi.org/10.1007/s00787-019-01420-7>) contains supplementary material, which is available to authorized users.

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Published online: 21 October 2019

Springer

are inappropriate for their needs [9]. Additionally, many CYP are also admitted to inpatient settings that are miles away from their places of residence, which can negatively impact their mental health outcomes and recovery [8]. All these factors may contribute towards a decline in CYP help-seeking behaviours and an increase in the number of CYP experiencing mental health crisis [10, 11].

To decrease the pressures on emergency departments and inpatient settings, there is a growing area of research that proposes the utilisation of alternative models for CYP in crisis that are capable to intervene early and prevent the escalation of mental health issues through less restrictive and community-based approaches [12–15]. These particular alternatives to inpatient settings could help develop more cost-effective services that could act as gatekeepers towards the admittance of CYP to inpatient settings [14, 16].

In 2008, a systematic review conducted by Shepard et al. [13] identified eight worldwide commonly used alternative models to inpatient care for CYP with complex mental health needs. These particular models were classified as multisystemic therapy, day hospitals, intensive specialist outpatient service (including crisis intervention and rapid outreach), home treatments, family preservation/wraparound services, case management, temporary residential care and therapeutic foster care provision [13, 17]. Despite a lack of high-quality evidence, Shepard's review concluded that these models may be suitable alternatives to inpatient settings [13, 17].

Similar alternative models are well employed across the UK, such as intensive home treatments, early intervention services for psychosis, assertive outreach; intensive day services and outpatient treatment, day hospitals, therapeutic foster care and crisis intervention services [17]. Nevertheless, a review conducted in 2012 indicated that these alternative models vary widely in structure, with inconclusive methodological evidence rated as low or very low for their clinical effectiveness [15]. A similar conclusion came from another review, stating that “there is little systematic evidence of efficacy” of intensive community services (ICS) as an alternative to inpatient settings [12]. However, ICS may be considered a possible alternative approach with very limited evidence, which according to Kwok et al. [12] is focused predominantly on data generated from YP with moderate-to-severe levels of mental health needs.

From this literature review, it was visible that positive steps have been made towards the improvement of alternatives to inpatient settings and that there is an increasing focus on community-based services. However, the effectiveness of these alternatives still remains unclear. Nevertheless, there is some evidence that such alternatives and community-based models could be suitable substitutes to inpatient settings. However, to our best knowledge, no systematic review has explicitly examined the experiences and satisfaction of CYP

and their parents during the time they were accessing urgent and emergency mental health services. Additionally, we are still not sure whether there are any newly developed models or interventions, since these reviews were published, that have more unique approaches towards prevention of hospitalisation or inpatient admission.

Therefore, this systematic review aims to focus on the following questions: (1) what are the experiences and satisfaction of CYP and their parents, with mental health crisis services or alternatives to inpatient settings? (2) What are the identified interventions that can be applied to CYP in urgent and emergency environments? (3) Besides well-established and known models, are there any newly developed alternative models to inpatient or emergency department admissions for CYP experiencing mental health crisis?

Methods

This systematic review was both conducted and reported following the PRISMA guidelines [18]. The systematic review protocol for this review was submitted and approved by PROSPERO (ID: CRD42019110875).

Search strategy

The present searching strategy was expanded upon from previously conducted systematic reviews [12, 13, 15]. We developed our search strategy based on terms relating to ‘alternatives to inpatient settings’, ‘urgent and emergency mental health provision’, ‘children and young people’, and ‘patient satisfaction’. The searching strategy (Table 1) was conducted on Embase, Medline and Psychinfo, Scopus; Web of Science; CINAHL and ASSIA databases.

The last rerun of the searching strategy was completed in June 2019 and resulted in no additional papers. Besides the searching strategy, we also conducted forward and backward manual searches applied to the studies that met the inclusion criteria. The backward searches helped us identify and examine references cited in the articles, while forward searching allowed us to identify any recent publications made by authors of studies that met inclusion criteria after publication of their article.

Eligibility criteria

During the process of assessing the suitability of screened articles, the following inclusion criteria were applied: studies published between January 1st 1990 and December 20th 2018 predominantly on CYP who had experiences of acute mental health or mental health crisis. Additional

Table 1 Example of searching strategy applied to Ovid Medline

	Search strategy
a)	((Child OR adolescen\$ OR youth\$ OR teenage\$ OR 'young people')
AND	
b)	(mental health crisis OR mental health crises OR (mental health emergency OR mental health emergencies) OR (psychiatric adj (crisis OR crises OR emergenc* OR acute OR intensive)) OR (mental\$ adj disorder\$) OR (mental\$ adj ill\$) OR psychopathology)
AND	
c)	(ambulatory care OR residential treatment OR home care service\$ OR psychiatric hospital* OR community mental health service* OR inpatient* OR community service* OR wraparound OR psychotherapy OR early intervention OR crisis intervention OR foster home care OR continuity of patient care OR (alternative adj(inpatient or in-patient)) OR assertive community treatment* OR mobile mental health crisis OR (multi-systemic or multisystemic) OR virtual mental health OR respite centre OR outpatient treatment OR child\$ mental health service\$ OR mental health treatment* OR mental health hospital admission OR mental health treatment outcome*)
AND	
d)	(user experience OR subjective experience OR patient satisfaction OR patient perspective))

criteria included parents or carers of CYP who experienced acute mental health; models and interventions that could be applied to both mental health crisis and alternatives to inpatient settings or could improve inpatient admission and reduce the length of stay.

Studies were included where at least 50% of the sample comprised of CYP aged 0–25. Studies were excluded if they involved patients older than 25 or reported on staff perceptions. Systematic reviews, book chapters, dissertations, grey literature, and articles on young offenders and learning disabilities, or those that were published in other languages than English were also excluded.

Study selection

All articles taken from the seven electronic databases were transferred into the software 'Rayyan' [19], which was used for their analysis. Once all duplicates were removed, titles and abstracts were screened independently by two researchers (FV and LC). Any study that met the inclusion criteria was screened by full text, again independently by two researchers (FV and LC). Any disagreement between the researchers was handled by involving a third party (AT). The decision of the third party was considered final.

Quality assessment and risk of bias

The quality of the included articles was assessed by the Mixed Methods Appraisal Tool [20]. The MMAT is a critical appraisal tool that is suitable for both qualitative, quantitative and mixed-method studies [20]. According to Hong et al. [20], the MMAT "permits to appraise the methodological quality of five categories to studies: qualitative research, randomised

controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies". Due to the lack of research evidence in this particular area, and as recommended by Hong et al. [20], we did not exclude studies with low methodological quality from this systematic review.

Appraised studies were classified into three categories according to their quality: low, medium and high. Studies were rated high if all five MMAT criteria were met. In the event that a study met four or three criteria, the study was classified as medium, i.e. meeting some criteria. Lastly, in the event that a study met one or two criteria, the study was classified as low quality, i.e. meeting minimum criteria. If any study did not meet the MMAT minimum screening criteria [20], the study was still included and reported, but without the MMAT screening result. We found two papers that did not pass MMAT minimum screening criteria [21, 22].

Data extraction

Initially developed and piloted on a smaller sample of studies, the data extraction form was later adopted and used on the 19 identified articles. Our results are divided into four main themes, with the following data extraction information: authors, publishing year, country of origin, model or intervention name, study design, age and sample size, key findings, outcomes and satisfaction data. Two reviewers independently carried out data extraction (FV and LC).

Data synthesis

We adopted a three-stage narrative synthesis approach as described by Popay et al. [23] in which the first stage starts with the development of the preliminary synthesis of findings of included studies. In the second stage, it

is recommended to explore relationships both within and between studies, while the third stage requires an assessment of the robustness of the synthesis. As the studies covered by this systematic review had significant differences with their methodological approaches, a meta-analysis was not feasible. Nevertheless, the qualitative studies were analysed by re-occurring themes and subthemes.

Results

Study selection

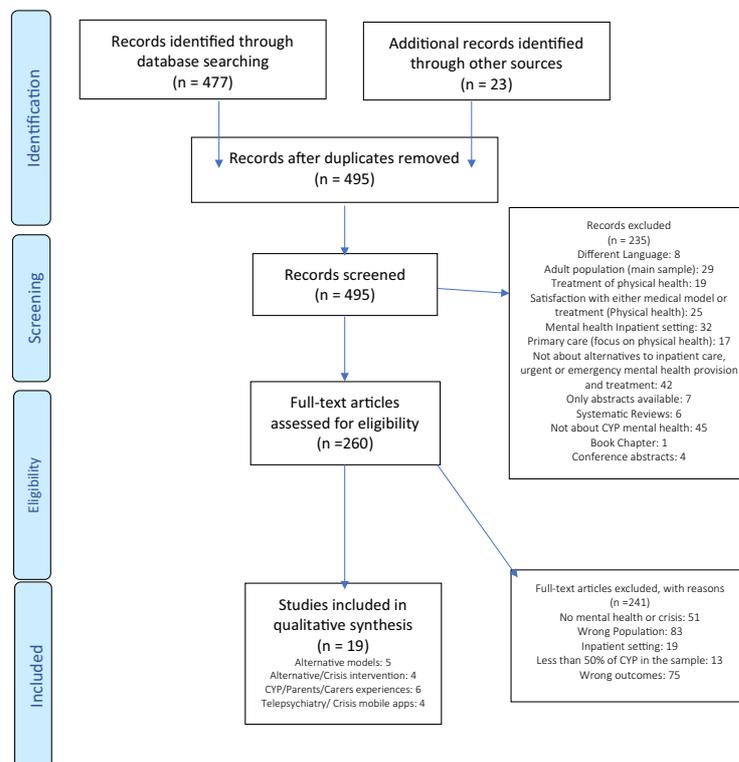
Our search strategy identified a total of 477 articles, from which an additional 23 articles were identified using both forward and backward manual searches of reference lists. Following the removal of duplicates, 260 articles were selected for full-text examination, while 235 articles were excluded. Common reasons for the exclusion of these articles were due to non-CYP study populations, a focus on inpatient settings, and a lack of relevance to CYP mental

health, amongst others (Fig. 1). Of the 260 articles that were fully screened, 19 studies were independently chosen for inclusion by both reviewers. There were no disagreements. The full selection process is presented in the PRISMA flowchart [24] (Fig. 1).

Study characteristics

The 19 studies included in this review came from 5 different countries; 8 studies came from the UK [21, 22, 25–30], 5 from the US [31–35], 3 from Australia [36–38], 2 from Canada [39, 40] and 1 from Denmark [41]. Eight studies utilised a qualitative methodology [25, 28, 29, 34, 36–38, 40] and two studies were based on a qualitative case-study approach [22, 33]. In contrast, three studies followed a quantitative descriptive approach [30, 35, 39], while one study had a mixed-methods design [26]. Two studies followed an RCT design [27, 31] and two studies were non-randomised with their methodological approach [21, 32]. Lastly, one study was identified as an RCT protocol [41]. Only three studies [25, 36, 37] included experiential data obtained from

Fig. 1 Prisma flowchart selection process



parents and relatives, while all others involved only CYP between 0 and 25. The sample size of CYP in the included papers ranged from 5 to 1397. Detailed information of the included studies are available in “Appendix”.

Synthesis of results

The final sample comprised of 19 articles included in this review and provides outcome evidence in the following four domains: alternative models [21, 26, 27, 29, 30]; interventions applied to Crisis [22, 31–33]; telepsychiatry and mobile applications applied to mental health crisis [35, 38, 39, 41]; and experience and satisfaction with mental health crisis provision [25, 28, 34, 36, 37, 40].

Alternative models

We identified five alternative models based in the UK:

- *The York model* is a multidisciplinary, fully integrated community-based model that works in partnership with both statutory and voluntary sectors to provide multi-agency provision for CYP within the UK [26]. The main advantages of this model lie predominantly in its accessibility, responsiveness, single point of entry, 24/7 urgent and emergency provision for CYP, and fully integrated service which enables smooth navigation through care pathways for CYP [26]. These features of the model reduce the need for re-referrals, as all the services are closely integrated, which consequently prevents CYP to fall through the gaps between the services [26].
- A similar multi-agency approach was taken by *the UK One Stop Shop model*, a nurse-led drop-in clinic for CYP who are affected by ADHD [30]. Even though similar ‘one stop shop’ models are known and widespread, this particular model is quite innovative, as it allows a reduction in waiting time for CYP who are experiencing a crisis, with swift access to appropriate crisis help, flexibility with care, and has improved efficiency and CYP satisfaction [30].
- *The ‘New Beginnings’ crisis recovery model* [21] was created as a recovery model for inpatient settings, with a flexible and recovery-orientated approach. The model is based on the idea that continuous exposure to a persistent problem contributes towards crisis [21]. To resolve CYP crisis, the model utilised interventions to stabilise adolescents by managing their disorganisation, applied systemic functional analysis of presented problems and identified the systemic functional analysis of change required [21]. However, the model is no longer operational due to the reorganisation of the local NHS Trust [21]. The crisis recovery model shows potential to be

adapted in community-based settings to manage crisis and reduce the need for in-patient settings [21].

- Additionally, *the Supported Discharge Service* (SDS) is a mixed model between intensive and assertive community treatment that shows a promising reduction in the need for hospitalisation or emergency admission, and self-harm rates and improved school reintegration in comparison to care as usual [27]. The use of such community models may help in reducing a need for hospital or A&E admissions. This particular model may be used as an alternative to the inpatient setting with a degree of caution if applied to other treatment models [27].
- The last model identified in this systematic review represents a complementary and non-clinical model that may act as an alternative to both in-patient setting and crisis services [29]. *The UK Club House model* of mental health recovery is a community mental health service model that supports YP with complex mental health needs to reintegrate them back into society [29, 42]. Pardi and Willis [29] found that in some cases, the use of clubhouses can be a suitable alternative to acute and emergency settings. Even though the model is utilised in non-clinical settings, the clubhouse model signposts individuals to appropriate mental health services where appropriate. Moreover, the flexible and fluid approach of the model aids early intervention and prevention of CYP in crisis. In addition, this particular model could bridge the gap in transition of CYP between CAMHS and AMHS services [29]. However, there is a clear need to investigate the fidelity of the clubhouse model further [42].

CYP satisfaction with alternative models

In terms of satisfaction, the One Stop Shop model [30] highlighted increased service user satisfaction and positive service experiences, as well as accessibility and flexibility in comparison to the previous service provision. Similar favourable CYP satisfaction with service provision is visible in the case of the Recovery model [21], while in the case of the SDS, the CYP satisfaction did not differ in comparison to treatment as usual [27]. The CYP satisfaction data were not reported for the York model [26], while in the case of the Clubhouse model, the YP expressed more positive experiences in comparison to experiences with other mental health services they received [29].

Interventions applied to a mental health crisis

Three interventions applied to urgent and emergency care from the USA [31–33] and one from the UK [22] were identified.

The Family-Based Crisis Intervention (FBCI) [33] was initially developed for Emergency Departments (ED) to prevent unnecessary hospital admission, and provide patients and their families' stabilisation intervention followed by signposting and treatment in the community-based setting, thereby avoiding hospital admission [33].

Similarly, the SAFETY program [31] is the brief CBT family intervention, devised for ED's for treating suicide attempt in YP. The phase 1 of the study reported support for the safety, feasibility, and benefits of the SAFETY intervention, with statistically significant improvements on measures of hopelessness, suicidal behaviour, depression, and youth social adjustment in the intervention group [31]. However, further evaluation of the intervention efficacy and effectiveness is needed.

In contrast, resilient therapy (RT) [22] presents an outcome-focused approach toward developing and improving the resilience of CYP and their families. The RT is designed to improve children's functioning, and it is also a reflexive tool that can be applied in many different contexts [22]. The main advantage of the RT lies in an adapted language, which is easily understood by CYP, i.e. the use of magic, potions, spells and remedies.

Lastly, the clinical measure of emotional distress dispositions is assessing youth crisis events in both residential and community settings using the Child and Adolescent Needs and Strengths (CANS) intervention-oriented instrument [32]. The finding from this study indicated emotional distress disposition could be clinically measured, and can be a valuable tool for assessing and early detecting CYP behavioural disruption in both residential and community setting [32].

CYP/parental satisfaction with identified interventions

Limited satisfaction and improvement in outcomes are reported only in two studies [31, 33]. The SAFETY intervention highlighted that both CYP and their parents reported high satisfaction rates associated with their treatment [31]. Conversely, the FBCI stated that patient and parents reported an improvement in individual and family functioning, and gratitude for being treated by the FBCI [33].

Tele Mental Health (TMH)—telepsychiatry and mobile application solution applied to urgent and emergency care

Four studies looked into TMH applications that are being applied to urgent and emergency care. A Canadian study [39] indicated that telepsychiatry is both reliable and cost-effective method for assessment and follow up in the geographically remote areas. Similarly, an American study [35] indicated that the use of telepsychiatry shows clinical and operational efficiency in ED's by demonstrating that TMH

improved access to speciality healthcare services, and increased system capacity, while promoting the delivery of appropriate care in remote and rural areas [35].

In contrast, there is potential in the RCT study protocol [41], which aims to investigate a self-management application for CYP who are experiencing a mental health crisis (suicide ideation). Similar technological endeavour has been noted in the Australian study [38], which created in the cooperation with YP foundations for the first eMental Health clinic.

Satisfaction with TMH

The US and Canadian study reported high satisfaction with the use of telepsychiatry [35, 39]. Telepsychiatry is perceived as CYP friendly with a high degree of CYP/Parental acceptability and improved service experience [39]. Similar high outcomes with regards to parental and staff satisfaction with acceptability, effectiveness and efficiency of TMH were reported in the US study [35].

Parental and CYP experiences of accessing mental health crisis services

Three studies [25, 36, 37] were focused predominantly on the parents, carers and relatives of individuals who underwent mental health crisis, while two studies [28, 34] were focusing solely on the CYP experiences of undergoing crisis care. The last study was exploring the experiences of both CYP and parents [40]. The analysis resulted in 68 analytical themes, from which we derived five related domains: barriers, emotions and emotional reactions, experiences, needs and what appropriate crisis service should be. The predominant overarching themes between parental and carers and CYP experiences were identified and summarised in "Appendix" (Table 4).

Summary of qualitative findings

Barriers Eight barriers were perceived and experienced by parents, while two barriers were experienced by CYP that prevented successful engagement with mental health crisis services and positive mental health outcomes. For CYP, a combination between stigma and fear of opening up is identified as a barrier that can prevent engagement or even create disengagement from further contact with the service [34] (Tables 2, 3).

In contrast, a larger number of barriers are evident for parents, carers or relatives of CYP who are being treated by mental health crisis services. For example, a lack of communication from the mental health crisis service providers is a theme that was evident throughout all three studies and is also one of the main reasons for parental dissatisfaction

Table 2 What appropriate crisis service should be according to views from parents and CYP

Theme	Parents CYP
Appropriate crisis service should be:	<p>Community-based with a strong relationship between the hospital and the community to provide services</p> <p>In an ideal world, there would not be any such thing as different mental health agencies, it would just be one cohesive thing, and maybe there would be different locations</p> <p>A need for greater flexibility emerged as a key finding along with the concept of immediate real-time services as a necessary shift from the traditional medical mode</p> <p>Authentic youth/caregiver engagement and delivery of services through a flexible, real-time system of care that emphasises prevention and recovery-oriented community-based services</p> <p>Solution: Adaptive recovery-oriented and real-time system of care that integrates hospital and community sectors</p>

Table 3 Thematic analysis (domains and themes)

Theme	Parents/carers/relatives	Children and young people
Barriers	<p>Lack of communication from providers</p> <p>Inadequate support from crisis services</p> <p>Fear of confidentiality breaches</p> <p>Lack of involvement with care planning</p> <p>Concerns over the inconsistency of crisis services establishing whether their children are in crisis or not</p> <p>Perception not being listened to</p> <p>Concerns that their parental experiences and observations are not taken into account</p> <p>Reluctance to become involved with help-seeking</p>	<p>Fear of opening up with crisis services</p> <p>Stigma about seeking help from crisis services</p>
Emotions and emotional reactions	<p>Powerlessness</p> <p>Exclusion</p> <p>Frustration</p> <p>Great anxiety</p> <p>Worry</p> <p>Sense of isolation</p> <p>Suffering</p> <p>Complex feelings of guilt and loyalty</p> <p>Feeling abandoned</p>	<p>Powerlessness</p> <p>Exclusion</p> <p>Frustration</p> <p>Anxiety</p> <p>Worry</p> <p>Fear of opening up</p> <p>The feeling of not knowing</p>
Experiences	<p>Lack of understanding</p> <p>The sense of being lost</p> <p>Not being listened or understood</p> <p>Felt often tossed between the crisis assessment services</p> <p>Lack of choice</p> <p>Traumatic and Terrifying experiences</p> <p>The sense of battling through the overall experience</p> <p>Experience of rejection</p> <p>Being told that a child hasn't relapsed</p> <p>Frequent changes of staff members</p> <p>'Double deprivation' by not receiving appropriate support</p> <p>Being told child not in crisis</p>	<p>Lack of understanding</p> <p>The sense of being lost</p> <p>Not being listened or understood</p> <p>Felt often tossed between the crisis assessment services</p> <p>Lack of choice</p> <p>Struggle to get appropriate help or any help from crisis</p> <p>Disengagement</p> <p>Being Judged</p> <p>Being honest perceived as damning</p> <p>Difficult experiences</p> <p>Lack of therapeutic alliance with crisis staff,</p> <p>Short appointments seen as negative experiences</p> <p>Frequent changes in the staff members</p> <p>Telling their problem more than once (story)</p> <p>In crisis and out of control</p>
Needs	<p>Need to be respected and listened by crisis providers</p> <p>Need to be more assertive</p> <p>Need to battle through the crisis services</p> <p>Need to be signposted to appropriate parental help or support network</p> <p>Need for development of a coping mechanism for dealing with both CYP crisis and mental health crisis services</p>	<p>Need to be respected and listened by crisis providers</p> <p>A need to be treated as a human being</p> <p>A need for safe expression of feelings</p> <p>Need for crisis providers to show that they care</p>

[36, 37]. This ties in with other subthemes such as a lack of involvement with care planning; a perception of not being listened to and not taking into account parental experiences and observations. Parents and carers in two studies reported that they felt they received inadequate support from the mental health crisis provider [25, 36].

Emotions and emotional reactions Findings from this particular domain revealed the complex, and often identical emotional reactions that are reported both by parents and CYP. For example, the sense of frustration, powerlessness, worry, anxiety are often results of the barriers to access and uncertainty which results from the lack of information and appropriate engagement with service provider [34]. Furthermore, parents reported experiences of high burden as a consequence of dealing with a CYP who are undergoing a mental health crisis and crisis service itself at the same time. High level of carers burden was often associated with a sense of isolation, suffering, and feelings of being abandoned by the crisis provider while travelling through the crisis care system [40].

Experiences Both positive and negative experiences with crisis provision were a theme expressed in all six articles. Moreover, a lack of understanding or choice, coupled with the sense of being lost in the system, a consequence of being thrown between different crisis assessment services and not being listened or understood are themes that commonly expressed by both parents and CYP. Furthermore, often staff changes are reported both in CYP and parental experiences, which consequently created an impact on the therapeutic alliance, as well as a need to tell their story on multiple occasions [40].

Additionally, parents and carers often characterised their experiences as terrifying or traumatic [25], while being rejected by the crisis services on several occasions due to staff perceptions that their child is not in crisis or not experiencing relapse [25, 37]. The best way to summarise the parental experiences would be to describe their journey through the crisis services as ‘battling through the system’ [37]. Similar experiences were shared by CYP, who characterised their experiences as difficult, ‘in crisis and out of control’, struggle to get any help from the crisis services, and being judged by the staff members [28, 40]. Besides, short appointments were often seen as a negative experience while being honest was perceived as damning [34, 40]. All these factors led some CYP to experience disengagement from the crisis service [34, 40].

Needs The range of different needs were identified for both CYP and parents such as a need to be listened to and respected by the care provider [34, 37, 40]. Furthermore, parents expressed a set of different needs that parent must

have to survive the journey through crisis service. Need for development of a coping mechanism for dealing with both CYP crisis and mental health crisis services, as well as need to become more assertive is reported [37].

Additionally, parents did express that their child’s crisis has a negative impact not just on the parents, but also on the whole family [36]. Therefore, there is a need to be signposted by the crisis service to appropriate parental or family support network [36]. In the case of the CYP, they expressed the need for safe expression of their feelings, being taken seriously, treated as human beings and being showed that crisis staff do care for them [28, 34, 40].

CYP and parental perception of what appropriate crisis service should be Both parents and CYP expressed a positive experience of being treated in the community setting [34, 36]. CYP and Parental opinions were that mental health services should be all encompassed under one roof, with excellent links between hospital and community, with different hubs across the community, using a flexible (non-traditional medical model) approach that emphasises early prevention and recovery [40].

Discussion

In total, 19 studies were identified in this review. We divided these into four domains: alternative models, interventions applied to mental health crisis, telepsychiatry and mobile applications for urgent and emergency mental health help, and CYP and parental satisfaction and experiences of accessing urgent and emergency mental health services. A surprisingly small number of studies ($n=5$) focused on new alternatives to inpatient settings or urgent and emergency care models. Additionally, studies that explore the accessibility, acceptability and satisfaction of the CYP and their families with alternatives models are scarce. However, the utilisation of mobile and internet technologies to improve access to mental health services for CYP is increasing, as evidenced by more studies in recent years. Lastly, some of the interventions identified have the potential to be utilised in mental health crisis treatment and may help to reduce hospital admissions and pressure on A&E departments.

We found evidence that synthesised models may be suitable alternatives to inpatients settings. Specifically, we identified two community-based models [26, 30] that offered promising alternatives to hospital-based settings for treating CYP. These are organised in line with the recommendations from the Future in Mind [43] and Five Year Forward view for mental health [44] policies, which state that service providers should be responsive, community-based, and provide improved access with a single point of entry in addition to 24/7 urgent and emergency provision for CYP in crisis. The

main innovations of these two models lie predominantly in their accessible, multi-disciplinary triage approaches, their partnerships with both statutory and voluntary sectors and their fully integrated services which enable smooth navigation through the care pathways for CYP [26]. Additionally, the recovery model and support discharge service are also synthesised models that offer a unique approach whereby CYP are treated in community-based settings on the basis of an individual's needs.

The need for such community-based models is supported with parental and CYP experiential findings that were synthesised as part of this review, which highlighted CYP preferences of being treated in community-based services rather than in hospital or clinical-based settings [40]. These particular findings are in line with previously conducted systematic reviews that emphasise the need for providing mental health treatment in the least restrictive environment [12, 13, 15]. Additionally, intensive community models of service provision promise an alternative to inpatient care for CYP who are affected with mental health issues [12, 13, 15].

Surprisingly, Club house models, despite being non-clinical, perform better in reducing CYP hospitalisation than some clinical models. This is in line with the findings another recently published review, which highlights the potential of the Club house models to decrease re-admission of YP to hospital settings [42]. However, with the evidence currently available, Club house models may be considered more as a complementary model rather than alternatives to both in-patient and crisis services. However, Club house models may have the potential to reduce the reliance of CYP on crisis services and improve the experiences of YP transitioning from CAMHS to AMHS [29]. Nevertheless, further research is required to evaluate the fidelity of the Clubhouse models with appropriate methodological approaches. This is also supported by another recently published review [42].

In the case of four identified models, there is an evident degree of satisfaction of CYP with newly developed services as well as better treatment outcomes. This also corresponds with the findings from Kwok et al. review [12], which clearly stated that more positive CYP experiences could contribute towards higher engagement with providers and better outcomes for both CYP and their parents. Similarly, in the case of the Club house model, the YP indicated high satisfaction with the model, primarily due to not being judged and their opinions and contributions being valued [29].

However, the reported satisfaction with the alternative models as mentioned above does not provide a full understanding of their accessibility and acceptability of those models. This corresponds with the findings from Sheppard et al. [13], which reported similar issues in their systematic reviews, such as a lack of qualitative research that investigated the acceptability of alternative models to inpatient settings.

Furthermore, it is clear from the results of this systematic review, that there is a need for further research with regards to what constitutes appropriate interventions and treatment for CYP experiencing a mental health crisis. Parental qualitative experience and satisfaction indicate that their children are often perceived as not in crisis or not suitable for crisis admission by services, despite being in the crisis or experiencing a relapse [25, 36, 37]. Parental reports also highlight concerns over conflicting diagnosis between different clinicians and the inability of some staff to recognise the crisis [25, 36]. Therefore, there is an evident need for a clear definition of what defines mental health crisis and what particular criteria CYP needs to satisfy to be classified as in crisis [37].

Identified and synthesised interventions in this systematic review showed that most interventions could be applied to urgent and emergency mental health care with CYP. For example, both the Family-based crisis intervention and the SAFETY program are short-term in duration of treatment and such can be successfully delivered both in A&E and outpatient community settings and, therefore, reduce the need for hospitalisation and inpatient admission. Furthermore, these two interventions decrease the carer's burden, while showing improvement in functioning and increased satisfaction by both CYP and their families. When the whole family receives support and intervention during a crisis event, there is a visible improvement with levels of satisfaction with service provision, a reduction in both burden and stress in carers, empowerment of family members and improved communication and overall functioning [25, 31, 33, 45].

Separate to the specific interventions, new TMH approaches have been identified. First, the Telepsychiatry models are well established and widely used, especially in the remote and rural areas [46], and may help towards reducing pressure to A&E's and hospital admissions, by providing timely access to mental health provision. However, several previous reviews have highlighted that there is limited evidence of the effectiveness and efficiency of telepsychiatry or computer-based treatment applications, despite their promising potentials [47–49]. Nevertheless, there is evidence that telepsychiatry is feasible, acceptable and well tolerable for the CYP population [49]. However, telepsychiatry treatments according to some authors should not be used as a sole treatment option; instead, it should complement other mental health models [50]. Second, there are an increasing number of new web and mobile applications that have the potential for use in urgent and emergency mental health services, while some may offer alternatives to inpatient settings, such as Myplan and eMental health. Utilising such technology could offer many potential benefits, such as improved access, reduced waiting times and improved quality of mental health provision for CYP. This is in line with a recent meta-analysis, which clearly supported mobile

health interventions for CYP, stating that these interventions seem viable [51].

Finally, the qualitative data provide some understanding of CYP and parental experiences with access and satisfaction with urgent and emergency mental health care which is consistent with findings from a previous systematic review conducted by Shepard et al. [13].

At present, it is clear that some barriers exist that prevent access to mental health crisis provision, and contribute towards disengagement from existing crisis care [52]. From the qualitative data, it is visible that a lack of crisis support coupled with a lack of communication may increase a sense of burden and may result in a lack of confidence in the mental health service providers, which may lead towards disengagement from the service or a reluctance to become involved with any other service [36, 37].

Taking into account the emotional responses from both CYP and their parents, it is clear that some mental health crises can produce unpleasant and traumatic experiences. However, if parents and CYP are taken seriously, fully supported during their mental health crisis treatment journey, and if their experience of mental health crisis treatment is improved, this may contribute towards a reduction of negative experiences or emotional reactions. Often, changes of the staff members can be a cause of concern as this may have a considerable effect on the therapeutic alliance. The importance of the therapeutic alliance is well documented and supported with research evidence, which shows that a good therapeutic alliance is the strong predictor of the positive treatment outcomes [53]. Changes of staff members can contribute towards the need for CYP to repeat their story, and become disengaged from future care. Moreover, Future in Mind recommends that CYP should tell their story only once [43].

Strengths and limitations

The main strength of this review is the synthesis of experiences and satisfaction of CYP and their families, which, according to our knowledge is the first attempt of reporting the accessibility, acceptability and satisfaction with alternative models to inpatient settings, and urgent and emergency care. Furthermore, we applied a search strategy that resulted in consistent numbers of identified articles in several additional searches. Adherence to the PRISM [24] standards allowed us to maintain methodological rigour. Additionally, the authors employed AMSTAR [54, 55] to check the reliability, validity and methodological quality of this systematic review.

During the process of screening articles, the authors noticed numerous articles in Dutch, German, Swedish and Norwegian that we could not assess, since our protocol

criteria required only publications in English to be taken into account, which could be considered a limitation.

Additionally, the qualitative studies included utilised small sample sizes and therefore it may be difficult to extrapolate from their findings for the wider population. Moreover, identified parental experiences and satisfaction related predominantly to females and mothers, with few data from males and fathers.

Implication for future research

This review found a relative lack of both CYP and parental/carer experiential data in the existing literature. This lack of experiential data is particularly evident in the case of males and fathers, which should be investigated further. It is clear that more research is required on the accessibility, acceptability and satisfaction of service users with alternatives to inpatient settings, and urgent and emergency care. There are also grounds for future research into the TMH applications to mental health crisis and this area appears to be promising and developing rapidly. Lastly, further research could be conducted into the fidelity of Club house models to establish whether they could serve as an alternative or complementary model to clinical models of urgent and emergency care. Additionally, future research could also try to investigate whether Club house models could help improve transition experiences of CYP from CAMHS to AMHS services.

Conclusion

In this review, we identified 19 studies that we divided into 4 domains: alternative models; CYP/parental satisfaction and experiences of accessing urgent and emergency mental health services; interventions applied to mental health crisis and telepsychiatry/mobile applications for urgent and emergency mental health. Our findings showed that alternative models to inpatient or acute settings may be feasible alternatives for some CYP. We found that CYP had increased satisfaction with alternative models in comparison with care as usual. This was in agreement with previously conducted systematic reviews. However, parental experiential data identified high levels of parental burden and a range of complex emotional reactions associated with engagement with crisis services. Importantly, both parental and CYP experiences highlighted a number of perceived barriers associated with help-seeking from crisis services. Furthermore, the identified and synthesised interventions in this systematic review showed that most interventions could be applied to urgent and emergency mental health care with CYP. However, it is clear from the results of this systematic review, that there is a need for further research to understand what constitutes

appropriate interventions and treatment for CYP experiencing a mental health crisis. Moreover, there is limited evidence of the effectiveness of TMH interventions, despite them being widely used. However, recent evidence shows that TMH interventions may be viable, feasible, acceptable and well tolerable for CYP populations. Lastly, this review showed that there is a lack of research evidence investigating the accessibility, acceptability, effectiveness and satisfaction of CYP and their parents with alternative models of mental health crisis provision.

Acknowledgements I would like to thank Samantha Johnson for her help with searching strategy, and her suggestions for adaptation of searching strategy for databases. Also, I would like to thank my partner for all the support and help through time when this review was taking place. In addition, I would like to thank both reviews for their contribution with their suggestions and feedback, which helped to improve this systematic review.

Funding This systematic review has been conducted as a part of PhD project at the University of Warwick. No conflict of interest to report. The PhD project has been sponsored by the NHS Solihull Clinical Commissioning Group (CCG)

Compliance with ethical standards

Conflict of interest None.

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Appendix

See Table 4.

Table 4 Searching strategy (Medline-Ovid)

#	Searches
1	(child or adolescen\$ or youth\$ or teenage\$ or "young people").mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
2	mental health crisis.ti.ab.
3	mental health crises.ti.ab.
4	(mental health emergency or mental health emergencies).ti.ab.
5	(psychiatric adj (crisis or crises or emergenc* or acute or intensive)).ti.ab.
6	(mental\$ adj disorder\$).ti.ab.
7	(mental\$ adj ill\$).ti.ab.
8	(psychiatric adj (crisis or crises or emergenc* or acute or intensive)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
9	psychopathology.mp.
10	or/2-9
11	ambulatory care.mp.
12	residential treatment.mp.
13	home care service\$.mp.
14	psychiatric hospital*.mp.
15	community mental health service*.mp.
16	inpatient*.mp.
17	community service*.mp.
18	wraparound.mp.
19	psychotherapy.mp.
20	early intervention.mp.

Table 4 (continued)

#	Searches
21	crisis intervention.mp.
22	foster home care.mp.
23	continuity of patient care.mp.
24	(alternative adj (inpatient or in-patient)).mp.
25	assertive community treatment*.mp.
26	mobile mental health crisis.mp.
27	(multi-systemic or multisystemic).mp. [mp = title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
28	virtual mental health.mp.
29	respite center.mp.
30	respite service.mp.
31	outpatient treatment.mp.
32	child\$ mental health service\$.mp.
33	mental health treatment*.mp.
34	mental health hospital admission.mp.
35	mental health treatment outcome*.mp.
36	or/11–35
37	user experience.mp.
38	subjective experience.mp.
39	patient satisfaction.mp.
40	patient perspective.mp.
41	or/37–40
42	1 and 10 and 36 and 41
43	limit 42 to (english language and humans and yr = "1990–Current")

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Appendix 3: The University of Warwick Ethics approval (BSREC) WP2



PRIVATE
Mr Frane Vusio
WMS
University of Warwick
Coventry
CV4 7AL

21 November 2018

Dear Mr Vusio

Study Title and BSREC Reference: *A new mental health 0-19 crisis service model for Children and Young people (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction* REGO-2018-2294

Thank you for submitting the revisions to the above-named study to the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee for approval.

I am pleased to confirm that approval is granted.

In undertaking your study, you are required to comply with the University of Warwick's *Research Data Management Policy*, details of which may be found on the Research and Impact Services' webpages, under "Codes of Practice & Policies" » "Research Code of Practice" » "Data & Records" » "Research Data Management Policy", at: http://www2.warwick.ac.uk/services/ris/research_integrity/code_of_practice_and_policies/research_code_of_practice/datacollection_retention/research_data_mgt_policy

You are also required to comply with the University of Warwick's *Information Classification and Handling Procedure*, details of which may be found on the University's Governance webpages, under "Governance" » "Information Security" » "Information Classification and Handling Procedure", at:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling>.

Investigators should familiarise themselves with the classifications of information defined therein, and the requirements for the storage and transportation of information within the different classifications:

Information Classifications:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/classifications>

Handling Electronic Information:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/electronic/>

Handling Paper or other media

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/paper/>.

Please also be aware that BSREC grants ethical approval for studies. The seeking and obtaining of all other necessary approvals is the responsibility of the investigator.

These other approvals may include, but are not limited to:



1. Any necessary agreements, approvals, or permissions required in order to comply with the University of Warwick's Financial Regulations and Procedures.
2. Any necessary approval or permission required in order to comply with the University of Warwick's Quality Management System and Standard Operating Procedures for the governance, acquisition, storage, use, and disposal of human samples for research.
3. All relevant University, Faculty, and Divisional/Departmental approvals, if an employee or student of the University of Warwick.
4. Approval from the applicant's academic supervisor and course/module leader (as appropriate), if a student of the University of Warwick.
5. NHS Trust R&D Management Approval, for research studies undertaken in NHS Trusts.
6. NHS Trust Clinical Audit Approval, for clinical audit studies undertaken in NHS Trusts.
7. Approval from Departmental or Divisional Heads, as required under local procedures, within Health and Social Care organisations hosting the study.
8. Local ethical approval for studies undertaken overseas, or in other HE institutions in the UK.
9. Approval from Heads (or delegates thereof) of UK Medical Schools, for studies involving medical students as participants.
10. Permission from Warwick Medical School to access medical students or medical student data for research or evaluation purposes.
11. NHS Trust Caldicott Guardian Approval, for studies where identifiable data is being transferred outside of the direct clinical care team. Individual NHS Trust procedures vary in their implementation of Caldicott guidance, and local guidance must be sought.
12. Any other approval required by the institution hosting the study, or by the applicant's employer.

There is no requirement to supply documentary evidence of any of the above to BSREC, but applicants should hold such evidence in their Study Master File for University of Warwick auditing and monitoring purposes. You may be required to supply evidence of any necessary approvals to other University functions, e.g. The Finance Office, Research & Impact Services (RIS), or your Department/School.

May I take this opportunity to wish you success with your study, and to remind you that any Substantial Amendments to your study require approval from BSREC before they may be implemented.

Yours sincerely

pp.



Dr David Ellard
Chair
Biomedical and Scientific
Research Ethics Sub-Committee

Biomedical and Scientific
Research Ethics Sub-Committee
Research & Impact Services
University of Warwick
Coventry, CV4 8UW.
E: BSREC@Warwick.ac.uk

http://www2.warwick.ac.uk/services/ris/research_integrity/researchethics/committees/biomed



Birmingham and Solihull **NHS**
Mental Health NHS Foundation Trust

**National Centre for Mental Health
Research & Innovation Department**
The Barberry
25 Vincent Drive
Birmingham
B15 2FG
bsmhft.serviceevaluations@nhs.net
Tel: 0121-301 4343

9th October 2018

Frane Visuo
PhD Student- Univeristy of Warwick

Dear Frane,

Re: SOLAR Service evaluation: A new mental health 0-19 crisis service model for Children and Young people (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

Thank you for submitting the above Service Evaluation to the Research and Innovation department for approval. Based on all the information received and further email correspondence, I can confirm that the Research and Innovation department are satisfied with all checks and are able to approve this service evaluation. You may begin your work with immediate effect.

The version of the service evaluation that we are approving is attached to the same email as this letter, as is confirmation that this project is regarded as a service evaluation (HRA tool screenshot) and your Letter of Access. An honorary contract is not required as you have provided with a copy of your research passport.

I will continue to liaise with you regarding necessary requirements around your chosen transcription service provider but this does not prevent you from progressing your service evaluation. Please just ensure that prior to sending any data to the transcription service that you have received confirmation from ourselves that all Information Governance requirements have been met.

Please can you also complete the attached non-payroll ESR form, so we have a record from a HR perspective. Please return it to the email address at the bottom of the form. You will need to have this signed off by Elaine Murray or Stephen Harrison as local collaborators.

I would like to inform you that in the near future all approved Service Evaluation proposals and final reports will be available on our trust intranet pages, with a brief summary and to this end, we would kindly request that you send us a copy of the final report once completed.

Copied in are the Service Manager, Clinical and Associate Directors for information, which is standard practice. I have also copied in the Research Manager who issued your Letter of Access.

Chair: Sue Davis, CBE Chief Executive: John Short
Customer Relations Mon – Fri, 8am – 8pm Tel: 0800 953 0045 Text: 07985 883 509
Email: customerrelations@bsmhft.nhs.uk Website: www.bsmhft.nhs.uk



Improving mental health wellbeing



I wish you luck in your project and look forward to hearing the outcome

Yours sincerely,



Katie Warner
Research Development and Innovation Manager

cc. Clinical Director, Associate Director and Service Manager

Appendix 4a: Birmingham and Solihull Mental Health Foundation Trust Letter of Access WP2



Birmingham and Solihull 
Mental Health NHS Foundation Trust

Research and Innovation
Birmingham and Solihull Mental Health NHS Foundation Trust
National Centre for Mental Health
The Barberry
1st Floor
25 Vincent Drive
Edgbaston
Birmingham
B15 2FG

Tel: 0121 301 4340

[9th October 2018]

Frane Vusio
Warwick Medical School
University of Warwick
Coventry
CV4 7AL

Dear Frane Vusio

Service Evaluation Title: A new mental health 0-19 crisis service model for Children and Young people (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

IRAS Number: n/a

Letter of access for research

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is Birmingham and Solihull Mental Health NHS Foundation Trust.

In accepting this letter, Birmingham and Solihull Mental Health NHS Foundation Trust confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **[09/10/2018]** and ends on **31/08/2020** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from Birmingham and Solihull Mental Health NHS Foundation Trust. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from Birmingham and Solihull Mental Health NHS Foundation Trust of their agreement to conduct the research.

The information supplied about your role in research at Birmingham and Solihull Mental Health NHS Foundation Trust has been reviewed and you do not require an honorary research contract with the Trust. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to Birmingham and Solihull Mental Health NHS Foundation Trust.

You are considered to be a legal visitor to the Trusts premises. You are not entitled to any form of payment or access to other benefits provided by Trust to its employees, and this letter



does not give rise to any other relationship between you and the Trust, in particular that of an employee.

While undertaking research through Birmingham and Solihull Mental Health NHS Foundation Trust you will remain accountable to your substantive employer **University of Warwick** but you are required to follow the reasonable instructions of **Elaine Murray and Stephen Harrison as Local collaborators** in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Birmingham and Solihull Mental Health NHS Foundation Trust policies and procedures, which are available to you upon request, and the UK Policy for Health and Social Care Research.

You are required to co-operate with Birmingham and Solihull Mental Health NHS Foundation Trust in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and Birmingham and Solihull Mental Health NHS Foundation Trust prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on Birmingham and Solihull Mental Health NHS Foundation Trust premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation does not accept responsibility for damage to or loss of personal property.

Birmingham and Solihull Mental Health NHS Foundation Trust may revoke this letter and may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of Birmingham and Solihull Mental Health NHS Foundation Trust or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.



Birmingham and Solihull

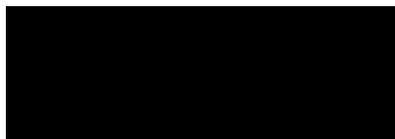


Mental Health NHS Foundation Trust

No Trust will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager at Birmingham and Solihull Mental Health NHS Foundation Trust and the Research and Innovation department in this Trust.

Yours sincerely



Linda Everard
R&I Implementation and Performance Manager

cc: HR.services@warwick.ac.uk

Appendix 5: HRA and Health and Care Research Wales (HCRW) Approval Letter with list of approved documents



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales



Dr Max Birchwood
University of Warwick
Gibbet Hill Campus, Medical School
Coventry
CV4 7AJ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

02 April 2019

Dear Dr Birchwood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	A new mental health 0-19 crisis service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, resilience and prevention of future mental health crises
IRAS project ID:	253272
Protocol number:	SC.06/18-19
REC reference:	19/WM/0018
Sponsor	University of Warwick

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?

You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

IRAS project ID	253272
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It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Jane Prewett

Tel: [REDACTED]

Email: sponsorship@warwick.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **253272**. Please quote this on all correspondence.

IRAS project ID	253272
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Yours sincerely

Maeve Ip Groot Bluemink
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Jane Prewett, The University of Warwick – Sponsor Contact*
Ms Katie Williams, Birmingham and Solihull Mental Health Foundation Trust –
Lead R&D Contact
Mr Frane Vusio. The University of Warwick - Student

IRAS project ID	253272
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List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [17.26 ReQuest Poster Advert]	v3.1	04 February 2019
Copies of advertisement materials for research participants [17.20 Participant Recruitment Poster- Interviews (CYP)]	v3.1	04 February 2019
Copies of advertisement materials for research participants [17.21 Parents and Carers Recruitment poster (General - Interviews)]	v3.1	04 February 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Copy of the University's insurance certificate]	MH/IND	27 July 2018
HRA Schedule of Events	1 (HRA final)	12 March 2019
HRA Statement of Activities	1 (HRA final)	02 April 2019
Interview schedules or topic guides for participants [17. 18 Local community professional members semi structure interview]	v3.1	04 February 2019
Interview schedules or topic guides for participants [Baseline Interview Protocol for Parents and Carers]	V2. P/C BIP	30 October 2018
Interview schedules or topic guides for participants [Baseline Interview Protocol for children, young people]	V2. CYP BIP	30 October 2018
IRAS Application Form [IRAS_Form_25022019]		25 February 2019
Letter from funder [Funding Evidence]	V1	10 August 2017
Letter from sponsor [Awarded Sponsorship Approval Letter (The University of Warwick)]	V1	22 November 2018
Letters of invitation to participant [17.1 Invitation for participation in research project (CYP)]	v3.1	04 February 2019
Letters of invitation to participant [17.2 Invitation for participation in research project (Parents or Carers)]	v3.1	04 February 2019
Letters of invitation to participant [17.3 Invitation for participation in research project (Local Community Professional Stakeholders)]	v3.1	04 February 2019
Non-validated questionnaire [Participant Demographic Sheet (CYP)]	CYP v2.0	30 October 2018
Non-validated questionnaire [Participant Demographic Sheet (Parent/Carer)]	Parent/Carer v2.0	30 October 2018
Non-validated questionnaire [Participant Demographic Sheet (Community stakeholder)]	Stakeholders v2.0	30 October 2018
Non-validated questionnaire [Participant Demographic Sheet (Parent/Carer)]	Parent/Carer v2.0	30 October 2018
Other [IRAS requested changes (additional clarification) - for Ms Ip Groot]	v1	04 February 2019
Other [Response to the request for clarification by the Edgbaston REC]	1	04 February 2019
Other [Context of the study as requested by the Edgbaston REC]	v1	04 February 2019
Other [Response for Ms Maeve Ip Groot Bluemink 13.03.2019]	v1	13 March 2019
Participant consent form [17.13 Consent form for Local Community Professional Members]	v3.1	04 February 2019
Participant consent form [17.10 Consent form for Parent consenting on behalf of their child (age 10-15)]	v3.1	04 February 2019
Participant consent form [17. 11 Consent form (Parents and Carers – Baseline-Telephone post-discharge Interview)]	v3.1	04 February 2019
Participant consent form [Expression of Interest for Research Project - V2 (ex C4C)]	v3.1	04 February 2019
Participant consent form [17.9 Assent form for CYP participants]	v3.2	05 March 2019

IRAS project ID	253272
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Participant consent form [17. 28 Consent form (Parents and Carers –Telephone post-discharge Interview)]	v3.2	05 March 2019
Participant consent form [17.12 CYP and Parent Consent form for Re-Quest]	v3.2	13 March 2019
Participant consent form [17.12a CYP (10-15) Assent Form and Parent Consent form for the Re-Quest]	v3.2	13 March 2019
Participant consent form [17.9 Assent form for CYP participants]	v3.2	13 March 2019
Participant consent form [17. 11a Consent form (CYP over 16 – Baseline- Interview)]	v3.2	13 March 2019
Participant information sheet (PIS) [17.3 Participants Information Sheet (ParentsCarers – Baseline Interview)]	3.2	02 April 2019
Participant information sheet (PIS) [17.4 Participant Information Sheet]	3.2	13 March 2019
Participant information sheet (PIS) [17.5 The Re-Quest Participant Information Sheet (CYP 10-19 years old)]	3.2	13 March 2019
Participant information sheet (PIS) [17.6 The Re-Quest Participant Information Sheet (ParentsCarers)]	3.2	02 April 2019
Participant information sheet (PIS) [17.7 Participants Information Sheet and Consent Form (Local Community Professional Members)]	3.2	02 April 2019
Referee's report or other scientific critique report [Confirmation of upgrade to PhD]	V1	17 June 2018
Research protocol or project proposal [Research Protocol]	v3.2	13 March 2019
Summary CV for Chief Investigator (CI) [CV for Chief Investigator CI]	V1	03 September 2018
Summary CV for student [Students CV]	V1	06 December 2018
Summary CV for student [PhD Student Research Passport]	V3	06 September 2017
Summary CV for supervisor (student research) [CV DR Birchwood - Chief Investigator]	V1	03 September 2018
Summary CV for supervisor (student research) [Dr Thompson GCP certificate]	v1	04 February 2019
Summary CV for supervisor (student research) [Dr Thompson CV]	v1	04 February 2019
Summary, synopsis or diagram (flowchart) of protocol in non technical language [The research summary chart]	v3.1	04 February 2019
Summary, synopsis or diagram (flowchart) of protocol in non technical language [The ReQuest summary chart graph (Participant involvement in the project and timeline)]	v3.1	04 February 2019
Validated questionnaire [Example of how Re-Quest outcome measure looks like (Re-Quest YP)]	V1 Re-Quest YP	30 October 2018
Validated questionnaire [Example of how Re-Quest outcome measure looks like (Re-Quest PYP)]	V1 Re-Quest PYP	30 October 2018

IRAS project ID	253272
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Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	Further documentation will be produced during the study. This will be submitted as an amendment once produced.
2.1	Participant information/consent documents and consent process	Yes	Changes have been made to the PIS and CF by non-substantial amendment after the REC opinion to align them with HRA & HCRW Approval standards.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is intending to use a separate site agreement. The agreement (mNCA 2018) is unmodified.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	Funding has been secured from Birmingham and Solihull Mental Health Foundation Trust There will be no financial provisions to the sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	The Applicant confirmed that audio recordings will be destroyed once transcription is complete. Transcripts will be retained for 10 years after the end of study.

Section	Assessment Criteria	Compliant with Standards	Comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	REC Favourable Opinion was issued by the West Midlands - Edgbaston REC.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

<p><i>This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.</i></p> <p>There is one type of participating NHS organisation; therefore, there is only one site type.</p> <p>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.</p> <p>If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.</p>

Principal Investigator Suitability

<p><i>This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).</i></p>
--

Local Collaborator (LCs) are expected for this type of study. The LCs have been identified in the Statement of Activities.

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations.

Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking:

- **Interviews with patient participants** would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.
- **Interviews/focus groups with staff participants** would be expected to hold Letters of Access if focus groups were held in clinical areas. Letters of Access would not be expected if focus groups were held in non-clinical/administrative buildings.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Some participants may also be identified outside the NHS. HRA & HCRW Approval does not cover activity outside the NHS. Before identifying potential participants outside the NHS the research team must follow the procedures and governance arrangements of responsible organisations.

Appendix 6: The University of Warwick Research Sponsorship Approval



Professor Maximillian Birchwood
Warwick Medical School
University of Warwick
Coventry
CV4 7AL
United Kingdom

22 November 2018

Project Title: A new mental health 0-19 crisis service model for Children and Young people (CYP), and its effectiveness in promoting recovery, resilience and prevention of future mental health crises

Chief Investigator: Professor Maximillian Birchwood

PhD student: Frane Vusio

Our Ref: SC.06/18-19

Dear Professor Birchwood,

I confirm that the University of Warwick will act as research sponsor for the above project, in accordance with the Department of Health's Research Governance Framework for Health and Social Care (2005), and, where appropriate, UK Statutory Instrument Number 1031, that implements the Medicines for Human Use (Clinical Trials) Directive 2004 and subsequent amendments; effective from **22 November 2018**.

I confirm that the University holds Public and Products Liability Insurance, and, where appropriate, Clinical Trial Insurance, which will provide cover for this study.

Any researcher involved in the project is required at all times to comply with the University of Warwick's Research Codes of Practice and Policies, available on the Research and Impact Services website via the following link:

http://www2.warwick.ac.uk/services/ris/research_integrity/code_of_practice_and_policies/

Researchers are also required to comply with all relevant requirements of Standard Operating Procedures (SOPs), which are applicable to all University of Warwick sponsored studies and are available via the following link:

<https://warwick.ac.uk/fac/med/research/ctu/conducting/planning/sop2016>

In particular, please ensure that you are familiar with the relevant safety and reporting requirements applicable to your study, as set out in SOP 17 'Safety Reporting' and SOP 31 'Deviations, Violations, Misconduct and Serious Breaches of GCP and/or Trial Protocol'.

Researchers processing (including collecting, storing, sharing or disposing of) personal data as defined in the General Data Protection Regulation (GDPR), including pseudonymised data, are required to comply with the principles set out in the GDPR. In addition, researchers



are required to complete both the GDPR and Information Security Essentials e-learning courses prior to undertaking the research. Both courses and further GDPR guidance can be accessed via the following link to the Information & Data Compliance Team GDPR webpages: <https://warwick.ac.uk/services/idc/gdpr/other>

Please notify the Research Governance Team via email to sponsorship@warwick.ac.uk of any key changes to your University sponsored study throughout its lifecycle, in particular if your study requires amendment, changes status, closes, is completed or if there are any changes to the proposed or anticipated closure date. Please also copy the above email address into any Annual Progress Reports or End of Study Notifications sent to the Health Research Authority (HRA) or Research Ethics Committee (REC), where appropriate

If you have any queries regarding these responsibilities or research sponsorship more generally, please contact the Research Governance Team via email at: sponsorship@warwick.ac.uk

Kind regards,



Mathew Gane
Secretary, Sponsorship Committee

The University of Warwick
Coventry
CV4 7AL
E: sponsorship@warwick.ac.uk
T: + 44 (0) 2476 575386

Appendix 7: Invitation for participation in service evaluation (Staff) WP2

V1.0 Staff 14/02/2018

Date:

Dear Sir/Madam,

Service Evaluation Title:

**A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction**

I am writing you to invite you to take a part in a service evaluation being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how Solar service now provides support for children and young people's mental health in the 0-19 age group in Solihull. We are keen to learn more about what is working well and not so well, about your experience of meeting with service users and their families; about the information that is made available for people seeking help and support and also how service and its provision can be improved to respond effectively to more increasing demand for children and young mental health and crisis service.

One researcher will be asking Solar staff members about their experience of services and general background questions about you in an interview that would last around 40-50 minutes at Solar service, at the time that suits you.

We are particularly keen to speak to you as someone who has recently supported children, young people experiencing a mental health crisis and their families in Solar and its mental health crisis service.

If you are happy to consider being involved, I will arrange for one of our team to contact you to describe the project in further detail at a time and place convenient for you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Appendix 8: Participants Information Sheet and Consent Form (Staff) WP2

Frane Vusio
The University of Warwick,
Warwick Medical School
Farmhouse
CV4 7AJ, Coventry
01st of August, 2018

Participants Information Sheet
V1.0 Staff 30th of May, 2018

Service Evaluation Title:

A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

I am writing you to invite you to take a part in service evaluation, conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how services provide support for children and young people in a mental health crisis in the 0-19 age group in Solihull UK. We are particularly interested in learning more about what is working well and not so well, about the experience of working in services; about how information is made available and also about anything that you feel might be missing from the way services are provided. We are keen that the information you provide can be used to help improve the mental health services provided for young people and their parents/carers in the region.

Why have I been invited?

You have been invited as an expert by experience of being a member of staff working with children and young peoples who experience mental health crisis, in Solar and its crisis service so that we can represent your views on existing mental health service provision for children and young people in your area and to learn from your experience of working with local services. We are hoping to include up to 12 experts by experience in this service evaluation. Although taking part may not benefit you personally, it may help to improve services in the long-term.

Do I have to take part?

It is up to you to decide if you are happy to take part in the service evaluation. We will describe the service evaluation and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. If you choose to withdraw, any information we have collected from you will be removed, unless the information has already been anonymised and transcribed. Please let the interviewer know if you do not wish to take part or contact (Frane Vusio) whose details are at the end of the form.

What happens if I agree to take part?

If you are happy to take part you will be asked to take part in a focus group interview where you will be asked questions about your experience of the crisis mental health service for children and young people aged 0-19 in your area and a small number of questions about yourself. We will take an audio recording of the interview to allow us to complete it more quickly. We will label the interview recording with a code number and give it to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed-up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. The discussion will involve you with some other staff member experts and a researcher and should last no longer than 40-50 minutes.

Will the service evaluation be kept confidential?

Any questions that you complete and everything you say/report is confidential (will not be shared) unless you tell us something that causes us to think that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Your information will not have your name anywhere on it and a different name will be used so that your name will not be connected to the service evaluation. Only the research team will have access to your information which will be given a code and stored on a secure University of Warwick computer. After everyone's information is collected, it will be explored for common responses and results will be written into a report that will be made available on the Solar website.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local services for children and young people experiencing a mental health crisis. The focus group will involve speaking about your experience of mental health services and there is a possibility that this may cause some distress to you or other participants involved in the focus group. If you are distressed by anything discussed during the interview, please inform the researcher who can put you in direct contact with a senior NHS manager.

What will happen to the results of the service evaluation?

The results of this service evaluation will be collected into a report that will be made available on our website at <https://www.bsmhft.nhs.uk/our-services/solar-youth-services>. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes.

We would like to provide you with your own copy of the report and you are asked to confirm if you would like to receive a (printed or electronic) copy on the consent form.

Who is organising and funding the service evaluation?

The service evaluation is funded by the Birmingham and Solihull Mental Health Foundation Trust and the interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands

Who has reviewed the service evaluation?

This service evaluation has been reviewed and given a favourable opinion by the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee (BSREC) and Birmingham and Solihull Mental Health Foundation Trust Ethics committee. A Research Ethics Committee is a group of independent people who review research/service evaluation to protect the dignity, rights, safety and wellbeing of participants and researchers.

What if I want to make a complaint?

If you are unhappy with any element of this service evaluation or wish to make a complaint, please contact Dr Max Birchwood ([REDACTED])

Yours faithfully,

Frane Vusio

Appendix 9: Consent form (Staff Members) WP2

Participant Identification Number:

CONSENT FORM v1.0 (Staff) 21st of February 2018

Title of Project:

A new mental health 0-19 crisis service model for Children and Young People (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

		Please tick box	
		YES	NO
1	I confirm that I have read the information sheet dated _____ 2018 (v1.0 C/P/F) for the above service evaluation. I have had the opportunity to consider the information, ask questions and have had these fully answered		
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected		
3	I understand that the focus group discussion will be digitally recorded and encrypted as an audio file and typed into a written version		
4	I agree to take part in the above service evaluation		
5	I would like a copy of the service evaluation report sent to me by post/email (If 'yes' please add postal or email address below):		

Postal/Email address: _____

Name of Participant	Date	Signature
Name of Person Taking consent	Date	Signature

Appendix 10: Participant Demographics Sheet (Staff Members) WP2

*A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction*

Demographic Sheet – Staff v1.0 March 26th, 2018

Date: __ / __ / _____

We would appreciate it if you could tell us a little about yourself

Please tick the appropriate box

Your Gender: Male Female

Your Ethnicity:

White British Black Caribbean/
Black British-Caribbean Asian/
Asian British-Pakistani Asian/
Asian British-Indian

Asian/ Asian British Bangladeshi Black African /Black British African Chinese

White Other Black Other Asian Other

Mixed Race

Other (please specify :) _____

Age: _____

Professional Role: _____

Current Speciality: (e.g. General Practitioner / Community Mental Health Team)

Length of time working in mental health services: ____ years ____ months

Length of time working in the Solar service: ____ years ____ months

Educational level: _____

Appendix 11: Focus group with service staff members WP2

Introductions and ‘ground rules’

A team from the University of Warwick has been commissioned to evaluate the new 0-19 mental health service for children and young people. We are very grateful that you have agreed to take part in the evaluation of the new service. The purpose of us talking with you is to hear about your views and experiences of working in the 0-19 service for children and young people in Birmingham.

Before we start, we would just like to run through a few things:

- Taking part in the evaluation is entirely voluntary and you are free to stop at any time. Our conversation with you will last about 1 hour.
- Your views and comments will be used in the final evaluation report but will remain confidential to the evaluation team and anonymous in the way they are written up. If you say something that we would like to quote, we will discuss this with you before including it in the evaluation report.

Your experience of working in the 0-19 service: general impressions

- Which part of the 0-19 service do you work in? (e.g. Solar reception; local mental health community team; inpatient care, crisis team)
- How long have you worked in the service?
- What does your part of the 0-19 service do – where are you based, who do you work with, what treatments/interventions do you offer?
- Were you working in other mental health services for children, young people and families in Solihull or other areas before you came to work for the 0-19 service?

Views about what the 0-19 service offers

Meeting local needs

- What do you think children, young people, parents and carers want from mental health services in Solihull?
- Are there any problems that services particularly need to address? (e.g. engaging with certain groups, addressing high rates of certain mental health problems, improving the transition between CAMHS and adult services)
- Do you think the new service is improving access to mental health services for the local population – how does it do this? (e.g. new ways of working? Online access? Wider age range?)
- If access and/or engagement is still a concern for some groups, what do you think needs to happen to improve this?
-

Communication

- What processes are in place for sharing information/keeping in touch with other services about the treatment and care you offer children, young people and their families?
- What arrangements are there for multi-disciplinary planning meetings or reviews, to support care and treatment planning?
- Have the arrangements now in place in the 0-19 service changed the way different services communicate when compared to past mental health service provision in Birmingham – e.g. is there more information sharing? Is the sharing of information more timely?
- Any suggestions for improvements or adaptations needed?

Partnership working (e.g. with voluntary and community sector partners, schools, FE colleges and social care)

- Can you explain how you link with partner services working with children and young people aged 0-19? What do you offer local schools and colleges? What links do you have with primary care (e.g. health visitors, paediatricians and GPs), social care, housing providers, and youth justice? What governance arrangements underpin this?
- Are you working to any Key Performance Indicators (KPIs) or any activity targets (e.g. numbers of young people to be seen each year)?
- How joined up does services feel? Are the care pathways clear and easy to navigate?
- Do all children and young people seen in the service have their own care plan?
- The new model is based on a partnership with many different providers across the voluntary and community sector, and the independent sector and also with providers (Barnardo's and Autism West Midlands) how do you think this is working?
- Are there areas that still need development? Any other thoughts on how local partnerships are working?

Outcomes monitoring and involvement of children and young people/parents and carers

- How are outcomes monitored? What tools do you use (e.g. CGAS, HoNOSCA, etc.)? How often do you report on these?
- How do you involve children, young people, parents and carers in outcomes monitoring/agreeing goals of treatment? How are they involved in service development more generally (e.g. do you have a service user forum, involve them in staff recruitment, seek feedback from them on a regular basis?)

Staff development and training

- Are you able to access/have you been offered any training since you joined the 0-19 service as part of your continuing professional development and the overall workforce development of the new service?
- If yes, what training have you undertaken?
- If no, what training do you want/feel you need?

The 0-19 Crisis service

- In your opinion, how much helpful is Solar crisis service for children and young people, and their parents?
- What are your views about Solar crisis service, their strengths and weaknesses, and opportunities for their further development?
- How well crisis service is integrated with the rest of the Solar service?

Views about the new service model overall - improvements/strengths and gaps/weaknesses

- Overall, are there any improvements or strengths you see in how the 0-19 service is working – e.g. easier to access, shorter waiting times, more choice of therapies, better join up across the age range, able to work with children, young people and with families?
- Are there any particularly innovative aspects of the service you wish to highlight?
- In your opinion, are there any parts of the new service model that are working less well? Are there any gaps or weaknesses in the provision that need to be addressed? What might enable these barriers you identify?

Wrapping up

Appendix 12: Interview Protocol for 0-19 model service staff WP2

Introductions and 'ground rules'

A team from the University of Warwick has been commissioned to evaluate the new 0-19 and its crisis mental health service for children and young people.

We are very grateful that you have agreed to take part in the evaluation of the new service. The purpose of us talking with you is to hear about your views and experiences of working in the 0-19 model and its crisis service for children and young people in Solihull.

Before we start, we would just like to run through a few things:

- Taking part in the evaluation is entirely voluntary and you are free to stop at any time.
- Our conversation with you will last about 1 hour.
- If you don't understand any of our questions please tell us – and if there is something you don't wish to answer, please just tell us.
- Your views and comments will be used in the final evaluation report but will remain confidential to the evaluation team and anonymous in the way they are written up.
- If you say something that we would like to quote, we will discuss this with you before including it in the evaluation report.
- Before we start, do you have any questions or anything to check? (Collect up consent form at this point).

SECTION 1: Participants roles, professional experience working with mental health crisis and involvement with 0-19 (Solar) model and its crisis service:

a. Can you tell us briefly, a little bit about your professional role and how it relates to the mental health crisis? (Prompts: Where are you based, what interventions/treatments are you competent to deliver?)

b. How long are you involved with the service?

c. Where you employed previously in other mental health services for children and young people prior to your appointment to 0-19 service?

SECTION 2: What does Solar service as 0-19 model of crisis mental health care offers?

Meeting the local children, young people and parents/carers need:

- a. What do you think children, young people and their parents/carers want from 0-19 model and its crisis service?
- b. Can you think of any particular problems that crisis service needs to address (e.g. long waiting times, lack of staff, non-existent 24 support)
- c. Do you think that the current crisis mental health service is capable to meet the needs of children, young people and their parents/carers?
- d. Can you think more about access to crisis service for children and young people? Do you think that Solar's crisis service is improving access to urgent and emergency mental care for children and young people? Can you tell us how service is achieving this? (e.g. innovative approach of doing things, online access or similar).
- e. Do you think that some group of children and young people are having particular problems of accessing or engagement with the crisis service? What is your opinion with regards, what needs to be done in order to improve this?
- f. Can you think of any barriers to access to crisis services?

Communication:

- a. What processes and procedures are placed for information sharing with other services, with regards to treatment and care you offer for children, young people and their parents/carers. (e.g. what is information sharing with A&E, inpatient units, different wards or different NHS trusts).
- b. Are there any multi-disciplinary meetings that allow planning, reviews or support of treatment/care.
- c. Would you say that Solar and its crisis service is achieving good communication with other services or care bodies such as Social Services?
- d. Do you think that any improvements are required with regards to communication and information sharing?
- e. Do you think that Solar/Crisis service is achieving good communication with its service users and their parents/carers?

Partnership working within 0-19 model and its crisis:

- a. How joined up to do Solar feels? Do you think that partnership with Barnardo's, NHS and Autism West Midlands has helped with creating more clear and easy pathways to care for children and young people?

b. Do you think that this partnership is working for children and young people who are experiencing a mental health crisis?

SECTION 3: Outcome monitoring, service users/parent's engagement and CPD

a. In your everyday work, how are outcomes monitored? Can you tell us what outcome measures you use?

Besides the regular outcome measures that you use in everyday practice, is there any that you remember that they are utilised in this 0-19 model and its crisis service?

b. How often do you record/report outcome measures?

c. How do you involve children, young people and their parents/carers in outcome monitoring/agreeing goals of treatment? How are children, young people and their parents involved in service development (do you have a service forum, are they involved in staff recruitment, providing feedback on a regular basis?)

d. Since you joined this 0-19 model and its crisis service, did you have an opportunity for further development and training?

e. If yes, what training did you undertake?

f. What additional training do you still required/ or you want to undertake?

SECTION 4: Final views – improvements\strengths and gaps/weaknesses:

a. Can you tell us any particular strength/weakness of the 0-19 model and its crisis service?

b. Can you tell us of any recent improvements with crisis provision?

c. Do you think that any areas of 0-19 model or its crisis service still needs additional development or improvement?

d. Do you think of any gaps or weaknesses in crisis mental health provision that need to be addressed?

e. Is there any particular innovative practice present within 0-19 model and its crisis service that you think it's worth to mention?

Wrapping up : The meeting will end with a brief summing up/checking back on the key issues or ideas put forward. The facilitators will explain what happens next – e.g. if there is to be follow up focus group when some of the findings will be written up and also how to contact the evaluation team if they have further comments they wish to make.

Appendix 13: Invitation for participation in service evaluation (CYP) WP2

V1.0 SU/CYP 01/05/2018

Date:

Dear Sir/Madam,

Service Evaluation Title:

**A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction**

I am writing you to invite you to take a part in a service evaluation being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how Solar service provide mental health crisis support for children and young people in the 0-19 age group in Solihull, UK. We are keen to learn more about what is working well and not so well, about your experience of meeting with people from services; about the information that is made available for people seeking help and support and also how services can improve how others understand children and young people's mental health issues.

The project involves one of our research team asking children and young people about their experience of services and general background questions about you in an interview/focus group that would last around 40 at Solar service or a location and time that suits you.

We are particularly keen to speak to you as someone who has recently experienced a mental health crisis or been a service user of the Solar and its mental health crisis service.

If you are happy to consider being involved, I will arrange for one of our team to contact you to describe the project in further detail at a time and place convenient for you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Thank you for taking the time to read this.

Yours faithfully

Frane Vusio

Expression of Interest for Research Project

The Solar service in the cooperation with the University of Warwick Medical School is conducting a service evaluation project with children, young people and their parents who are willing to be contacted about their participation in this research. Children, young people and their parents with this form are expressing interest to receive more information about the project. In addition, parents are giving permission to healthcare researcher team to contact them in order to supply participants with more information about the research, Participant Information Sheet and copy of consent form.

Please read the Children and Young People / Parents Information Leaflet prior to completing this form.

Please initial each box if you agree to consent and sign the bottom of the page.

1. I agree to my contact details can be used for the research team, so that they can contact me with regards to providing more information about the research project.

Initial

2. I understand this consent form does **NOT** commit me to take part in any research without further information and consent being obtained from me

Initial

3. I have read and understood all of the information presented in the Invitation for participation in research project leaflet and understand what is being asked from me on this form.

Initial

4. I have been provided with contact details to obtain more information or have any questions answered relating to the Expression of Interest form.

Initial

5. Parents of child/adolescent/ young person ONLY

I agree to my contact details can be used for the research team, so that they can contact me with regards to providing more information about the research project that involves children and young people and their parents.

Initial

6. I understand this consent form does NOT commit my child to take part in any research without further information and consent being obtained from me.

Initial

Please sign the page _____

Date: _____

YOUR DETAILS

□

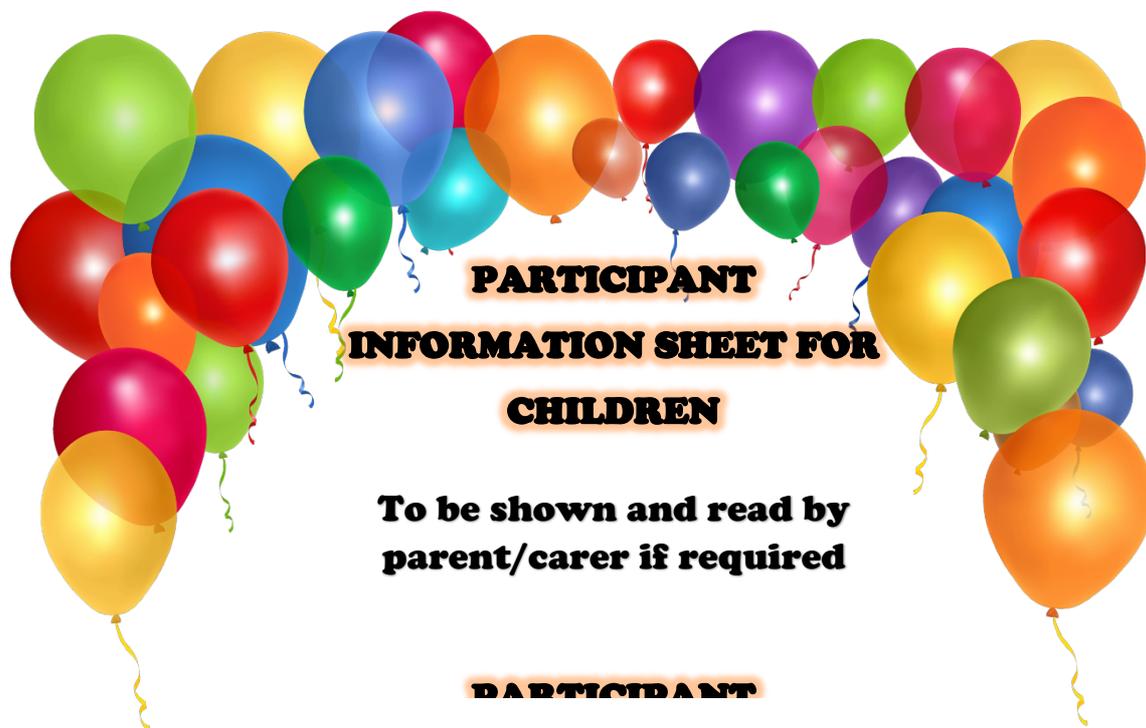
Name:									
Address: <small>(Please include postcode)</small>									
Gender:	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:
Email:									
Telephone:									
Mobile:									
Preferred mode of contact	Email	<input type="checkbox"/>	Mobile	<input type="checkbox"/>	Telephone	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:

If parent is consenting to be contacted on behalf of their child/ adolescent

Name of Child:									
Child Age:									
Gender:	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:
Contact details <small>(if different from above)</small>									

Please sign the page _____

Date: _____



Study title

A new mental health 0-19 crisis service model for Children and Young People (CYP), an exploration of its appropriateness, effectiveness and stakeholders' satisfaction

1. What is service evaluation?

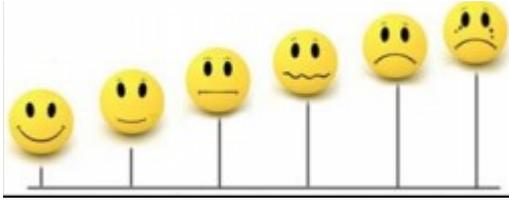
Service evaluation seeks to find out how well Solar **service** is doing what is supposed to do, to help children and young people with their mental health problems.

2. Why is this project being done?

We want to try and find out what children think about Solar service and how they are feeling whilst being treated there. We would like to ask you a few questions that will help us to improve how children are treated in mental health crisis care. You can help us, by telling us how happy you were with Solar and what is your idea how to make Solar service even better.



3. What is a mental health crisis?



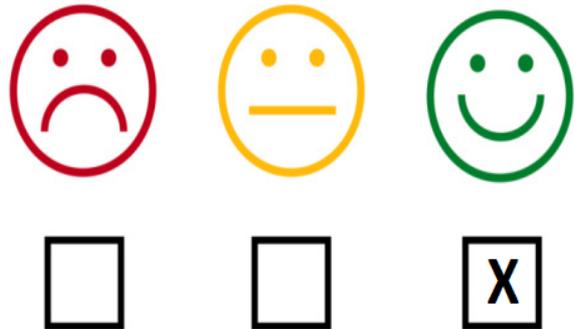
Children and young people can face many pressures and challenges on a daily basis. Sometimes things around you (school, friendships, and family difficulties) or specific events (moving to a new area, the death of someone close) can affect you. You may find that you develop a physical health problem,

or you may develop a mental health problem (you may feel very sad, or anxious or you may feel very angry and upset and not know how to deal with these feelings). Sometimes you might require a little help for these difficulties, this could be from parents/carers, someone at school, or a friend or it may be that you need more specialist help, from mental health service in order to stay with good emotional and mental wellbeing.

4. Why me?

You have been chosen because you previously visited Solar mental health crisis. You can help us find some answers that will help us to make Solar service much better place for children and young people. We are asking 30 children altogether. We will normally speak to you in Solar service. However, on very rare occasions you may have gone home from the service, having told us that you would like to take part in the study. On these occasions, we will call you to make

Your feedback matters



an appointment to come and see you at home to gain written consent and ask you a few questions. The duration of this home visit is only the time it will take to gain written consent and have wee chat with us.

5. Do I have to take part?

No, you do not! It is up to you. We would like you to read this information sheet. If you agree to take part, we would like you to write your name in two forms. We will also ask your mum, dad or carer to write their name on the forms and give one back to us. You can still change your mind later. If you don't want to take part, just say no!





6. What will happen?

Then we would like to simply ask you and your parents some questions. Your care will be unaffected.

- The questions will ask when you started feeling unwell and what your parents then did, or who they consulted with.

You will only be doing something towards the study whilst you are answering the questions, no extra tests will be done.

That means that there will be **no poking, no needles or big machines**. Just words and talks.

Although we are studying how you came to Solar and how Solar was looking after you, we only need permission from you and your parents to do this. Your care will be completely the same as if you refused to let us study you.

In exchange for your time and effort, we will be offering a £10 voucher on completion of the study questionnaires. So that you buy all those goodies that you like. Vouchers will be sent by post, with your name on the letter.

7. What else might happen?

There are no risks to you in entering this study. Sometimes children or parents do not like to talk about their children's illness, but often this can, in fact, be helpful

8. What happens when the service evaluation stops?

We will collect all the information together and we will process every word you told us, to make sure that we can improve Solar service, for all other children that might need help.

9. What if something goes wrong?

Your mum, dad or carer will be able to talk to someone who will be able to tell them what they need to do about it.

10. What if I don't want to do the service evaluation anymore?

Just tell your mum, dad, carer or me at any time. Nobody will be cross with you.



11. What if I wish to complain about the evaluation?

If you want to complain to you or your mum, dad or carer can talk to Dr Max Birchwood.

12. Will anyone else know I'm doing this?

The people in our research team will know you are taking part. No one else will know because we will not use your name or address. You will get a number which will be used instead.

13. What happens to what the researchers find out?

When we collect your information, we will make sure it is stored in a safe place and only the people doing the service evaluation can look at it. We will use the information to improve Solar service, as well as put it in medical magazines and on websites so that health professionals can read it. A short summary will also be on the Solar website. No-one will know you were in the study.



14. Did anyone else check the study is OK to do?

This study has been checked by several people, to make sure it is alright.



15. How can I find out more about this study?

Your mum, dad, carer or another grownup you trust may be able to answer your questions.

Thank you for taking the time to read this – please ask any questions



Appendix 14a: CYP Participant Information Sheet WP2

Frane Vusio
The University of Warwick,
Warwick Medical School
Farmhouse
CV4 7AJ, Coventry
01st of August 2018

Participants Information Sheet
V1.0 SU 21st May 2018

Service Evaluation Title:

**A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction**

I am writing you to invite you to take a part in service evaluation, conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how Solar service provides support for children and young people experiencing a mental health crisis in the 0-19 age group in Solihull UK. We are particularly interested in learning more about what is working well and not so well, about the experience of meeting with people from services; about how information is made available and also about anything that you feel might be missing from the way services are provided. We are keen that the information you provide can be used to help improve the crisis mental health services provided for young people and their careers in the Solihull.

Why have I been invited?

You have been invited as an expert by the experience of being a child or young person who has had treatment from the Solar service so that we can learn about your views on crisis mental health services provided for young people in your area and to learn from your experience of meeting people from the Solar. We are hoping to include up to 10 experts by experience in this service evaluation. Although taking part may not benefit you personally, it may help to improve services in the longer-term.

Do I have to take part?

It is up to you to decide if you are happy to take part in the service evaluation. We will describe the service evaluation and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. **If you choose to withdraw, any information we have collected from you will be removed, unless the data has been already transcribed or disseminated.** Please let the interviewer know if you do not wish to take part or contact interviewer, whose details are at the top of this form.

What happens if I agree to take part?

If you are happy to take part, you will be asked to take part in a focus group interview where you will be asked questions about your experience of the Solar and its crisis mental health service for children and young people aged 0-19 in Solihull. We will take an audio recording of the interview to allow us to complete it more quickly. We will label the interview recording with a code number and give it to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed-up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. The discussion will involve you with some other young people and a researcher and should last no longer than 40-50 minutes.

Will the service evaluation be kept confidential?

Any questions that you complete and everything you say/report is confidential (will not be shared) unless you tell us something that causes us to think that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Your information will not have your name anywhere on it and a different name will be used so that your name will not be connected to the service evaluation. Only the research team will have access to your information which will be given a code and stored on a secure University computer.

After everyone's information is collected, it will be explored for common responses and results will be written into a report that will be made available on our website www.bsmhft.nhs.uk/our-services/solar-youth-services

A printed copy of the report will be sent to you if you have requested this on the consent form.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local service for children and young people's mental health. The focus group will involve speaking about your experience of mental health services and there is a possibility that this may cause you some distress. If you are distressed by anything discussed during the interview, please let the researcher know as they can put you in direct contact with a senior NHS manager.

What will happen to the results of the service evaluation?

The results of this evaluation will be collected into a report that will be made available on the above-mentioned website. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes.

We would like to provide you with your own copy of the report, and you are asked to confirm if you would like to receive a (printed or electronic) copy on the consent form.

Who is organising and funding the service evaluation?

The service evaluation is funded by the Birmingham and Solihull Mental Health Foundation Trust and the interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands

Who has reviewed the service evaluation?

This service evaluation has been reviewed and given a favourable opinion by the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee (BSREC). A Research Ethics Committee is a group of independent people who review research/service evaluation to protect the dignity, rights, safety and wellbeing of participants and researchers. Additionally, the Birmingham and Solihull Mental Health Foundation Trust service evaluation committee approved this service evaluation.

What if I want to make a complaint?

If you are unhappy with any element of this service evaluation or wish to make a complaint, please contact Dr Max Birchwood ([REDACTED])

Yours faithfully,

Frane Vusio

Appendix 15: CYP Consent form WP2

Participant Identification Number:

CONSENT FORM v1.0 SU 21st of May 2018

Title of Project:

A new mental health 0-19 crisis service model for Children and Young People (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

		Please tick box	
		YES	NO
1	I confirm that I have read the information sheet dated _____ 2018 (v1.0 SU) for the above service evaluation. I have had the opportunity to consider the information, ask questions and have had these fully answered		
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected		
3	I understand that the focus group/interview discussion will be digitally recorded and encrypted as an audio file and typed into a written version, that will be anonymised		
4	I agree to take part in the above service evaluation		
5	I would like a copy of the service evaluation report sent to me by post/email (If 'yes' please add postal or email address below):		
6	Parental consent for children and adolescent, aged 5-15 Parent consenting on behalf of their child, please fill out the form v1.0 P/C/F for SU		

Postal/Email address: _____

Name of Participant	Date	Signature
Name of Person Taking consent	Date	Signature

Appendix 15a: Consent form for **Parent** consenting on behalf of their child (age 5-15)

WP2

Participant Identification Number:

CONSENT FORM v1.0 P/C 21st of May 2018

Title of Project:

A new mental health 0-19 crisis service model for Children and Young People (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

		Please tick box	
		YES	NO
1	Parental consent for children and adolescent, aged 5-15 As a parent, I have read participant information sheet dated _____ 2018 (v1.0 P/C/F for SU) for the above service evaluation and have been given the opportunity to ask questions.		
2	I understand that my child's participation is voluntary and that my child is free to withdraw at any time without giving any reason, without my child medical care or legal rights being affected		
3	I understand that the focus group/interview discussion will be digitally recorded and encrypted as an audio file and typed into a written version, that will be anonymised		
4	I give consent for my child to participate in this service evaluation		
5	I would like a copy of the service evaluation report sent to me by post/email (If 'yes' please add postal or email address below):		
6	Name of Child: _____ Age of Child: _____		

Postal/Email address: _____

Name of Participant	Date	Signature
Name of Person Taking consent	Date	Signature

Appendix 16: Interview Protocol for children and young people WP2

Introductions and 'ground rules'

A team from the University of Warwick has been commissioned to evaluate the new 0-19 and its crisis mental health service for children and young people.

We are very grateful that you have agreed to take part in the evaluation of the new service. The purpose of us talking with you is to hear about your views and experiences with the 0-19 model and its mental health crisis service for children and young people in Solihull.

Before we start, we would just like to run through a few things:

- PiS form
- Consent forms
- Confidentiality confirmation
- Duration of an interview between 75-90 minutes

- Timing and decision to seek help:
 - When, how, and by whom decisions were made about getting professional mental crisis help
(Prompts: *How did you decide to go about your health problems? Where did you seek help?*)
 - Did you ever hear before for the Solar or its services, before you were accepted as a patient?
 - What led to the decision to seek help from the Solar crisis? (Prompts: *Did you consider any other alternatives? Did you seek any help prior to being admitted to the Solar Crisis service?*)
 - What were five words that popped into your mind when you found out you had to be admitted to mental health crisis service?
 - What was your initial thoughts and feelings that you can associate with being referred or admitted to Solar Crisis service? How easy was for you to be admitted?

- Waiting time:
 - How long did you have to wait before you received help from the Solar /Crisis service? (Prompt: *How did you feel during the period of waiting to receive treatment?*)

- Engagement with the Solar or Crisis service:
 - What is your initial impression after being admitted to the Solar or Crisis service? (Prompt: *Did you like the Solar Crisis for the first time? How did you feel the first time being there?*)
 - When and where did you engage for the first time with Solar or crisis?

- What is your experience of the initial process (Prompt? *(un)helpful process or experiences*)
- What do you think, is there any suggestion for improving the initial process?

- Acceptability and Pathways of the mental health provision:
 - Do you think that you received appropriate help from the crisis team according to your needs
(Prompts: *What did you think about the recommendations you received? What was similar or different in what you thought about your problem and how the person you referred to assessed it? How Solar staff explained to you, your condition?*)
 - What is your journey through the Solar system (Prompt: *What services did you take whilst being in the Solar*)
 - What is your satisfaction with the help that you received from the crisis team of the Solar service?

- Sense of environment, staff and care provided:
 - Do you think that the Solar and its crisis service are better or worst environment than Hospital or A&E?
 - Tell me about how it felt to be there? (Prompt: *How did you feel with the staff members involved in your care? What is your general experience of staff?*)
 - How were you treated whilst being there? (Prompts: *Did you feel like you were taken seriously? Did the staff involve you in decision making with regards to treatment preferences?*)

- (Post) Discharge experience
 - Can you describe how your discharge experience was?
 - Did you have the need, or did you seek any additional mental health help after being discharged from the crisis service? (Prompt: *What kind of the help/services – if YES*)
 - Do you think that the crisis team meet your mental health needs? (Prompt: *Are there still any unmet mental health needs? Are there any needs you felt weren't met, whilst being treated in the crisis service?*)
 - Can you tell me, do you feel any improvement/decline with your mental health?
 - How this improvement/decline impacts your school, college, and relationships
 - Do you still need like you need help, despite being discharged from the Solar crisis service?
 - Do you think you would benefit from any additional help from some other service, such as peer support or mental health support worker after you have been discharged? (Explain what peer support is or what mental health support worker is)
 - Do you think that Solar crisis team helped you to self-manage your mental health?

- Wrap up – Final impressions:
 - Can you describe to us in detail, how much Solar crisis service was (un)helpful to you and your whole family to overcome the crisis and contributed towards your recovery?

- What is the very good experience that you can remember whilst be admitted to the Solar Crisis service? Can you describe any particular events or happenings that left positive experience on you?
 - What is your worst experience that you can remember whilst be admitted to the Solar Crisis service?
 - Is there anything you feel that Solar crisis service could be done differently?
 - Is there anything you would like to change or improve?
- Ending part:
 - Is there anything you would like to add or maybe ask?

Wrapping up

The meeting will end with a brief summing up/checking back on the key issues or ideas put forward. The facilitators will explain what happens next – e.g. if there is to be follow up focus group when some of the findings will be written up and also how to contact the evaluation team if they have further comments they wish to make.

Appendix 17: Invitation for participation in service evaluation (Parents or Carers) WP2

V1.0 C/P/F 14/02/2018

Date:

Dear Sir/Madam,

Service Evaluation Title:

**A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction**

I am writing you to invite you to take part in a service evaluation being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how Solar service provide mental health crisis support for children and young people in the 0-19 age group in Solihull, UK. We are particularly keen to learn more about what is working well and not so well; about you experiences accessing the crisis service and meeting people from the service; about the information that is made available for people seeking help and support and also how service can improve how others understand children and young people's mental health crisis.

This project involves one of our research team members asking people about their own experiences of the Solar crisis service and some general background questions about you in an interview that would last around 40-50 minutes at the time that is convenient for you.

We would be very keen to speak to you as someone who has recently been the career of a child or young person who was in a mental health crisis or have been seen by Solar mental health service or Solar crisis team.

If you are happy to consider being involved in this service evaluation, I will arrange for one of our team members to contact you to discuss the project in further detail at the time that suits you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Thank you for taking the time to read this

Yours faithfully

Frane Vusio

Appendix 18: Participants Information Sheet and Consent Form (Parents/Carers) WP2

Frane Vusio
The University of Warwick,
Warwick Medical School
Farmhouse
CV4 7AJ, Coventry
01st of August, 2018

Participants Information Sheet
V1.0 C/P/F 21st February 2018

Service Evaluation Title:

*A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction*

I am writing you to invite you to take a part in a service evaluation being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of the service evaluation?

The purpose of this service evaluation is to develop a better understanding of how Solar service provides support for children and young people experiencing a mental health crisis in the 0-19 age group in Solihull, UK. We are particularly interested in learning more about what is working well and not so well, about the experience of working in services; about how information is made available and also about anything that you feel might be missing from the way service is provided. We are keen that the information you provide can be used to help improve the Solar and its crisis mental health service provided for children and young people, and their carers in the Solihull.

Why have I been invited?

You have been invited as an expert by experience of being a carer of a young person who has been a recent user of Solar or its crisis mental health service so that we can represent your views on existing crisis mental health service provision for young people in your area and to learn from your experience of local service. We are hoping to include up to 10 carer experts by experience in this service evaluation. Although taking part may not benefit you personally, it may help to improve services in the longer-term

Do I have to take part?

It is up to you to decide if you are happy to take part in the service evaluation. We will describe the service evaluation and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. **If you choose to withdraw, any information we have collected from you will be removed, unless the data has been already transcribed or disseminated.** Please let the interviewer know if you do not wish to take part. Interviewer details are at the top of this form.

What happens if I agree to take part?

If you are happy to take part you will be asked to take part in a focus group interview where you will be asked questions about your experience of the Solar and its crisis mental health service for children and young people aged 0-19 in your area. We will take an audio recording of the interview that will be later transcribed. We will label the interview recording with a code number and give it to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed-up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. The discussion will involve you with some other carer experts and a researcher and should last no longer than 40-50 minutes.

Will the service evaluation be kept confidential?

Any questions that you complete and everything you say/report is confidential (will not be shared) unless you tell us something that causes us to think that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. Your information will not have your name anywhere on it and a different name will be used so that your name will not be connected to the evaluation. Only the research team will have access to your information which will be given a code and stored on a secure University of Warwick computer. After everyone's information is collected, it will be explored for common responses and results will be written into a report that will be made available on our website www.bsmhft.nhs.uk/our-services/solar-youth-services.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local service for young people's mental health. The focus group will involve speaking about your experience of crisis mental health services and there is a possibility that this may cause you some distress. If you are distressed by anything discussed during the interview, please inform the researcher who can put you in direct contact with a senior NHS manager.

What will happen to the results of the evaluation?

The results of this service evaluation will be collected into a report that will be made available on our website at www.bsmhft.nhs.uk. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes.

We would like to provide you with your own copy of the report, and you are asked to confirm if you would like to receive a (printed or electronic) copy on the consent form.

Who is organising and funding the service evaluation?

The service evaluation is funded by the Birmingham and Solihull Mental Health Foundation Trust and the interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands

Who has reviewed service evaluation?

This evaluation has been reviewed and given a favourable opinion by the University of Warwick's Biomedical and Scientific Research Ethics Sub-Committee (BSREC). A Research Ethics Committee is a group of independent people who review research/service evaluation to protect the dignity, rights, safety and wellbeing of participants and researchers. Additionally, the Birmingham and Solihull Mental Health Foundation Trust service evaluation committee approved this service evaluation.

What if I want to make a complaint?

If you are unhappy with any element of this service evaluation or wish to make a complaint, please contact Dr Max Birchwood ([REDACTED])

Yours faithfully,

Frane Vusio

Appendix 19: Consent form (Parents and Carers) WP2

Participant Identification Number:

CONSENT FORM v1.0 C/P/F 21st of February 2018

Title of Project:

A new mental health 0-19 crisis service model for Children and Young People (CYP), and exploration of its appropriateness, effectiveness and stakeholders' satisfaction

		Please tick box	
		YES	NO
1	I confirm that I have read the information sheet dated _____ 2018 (v1.0 C/P/F) for the above service evaluation. I have had the opportunity to consider the information, ask questions and have had these fully answered		
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected		
3	I understand that the focus group discussion will be digitally recorded and encrypted as an audio file and typed into a written version		
4	I agree to take part in the above service evaluation		
5	I would like a copy of the service evaluation report sent to me by post/email (If 'yes' please add postal or email address below):		

Postal/Email address: _____

Name of Participant	Date	Signature
Name of Person Taking consent	Date	Signature

Appendix 20: Participant Demographic Sheet (Parent/Carer) WP2

*A new mental health 0-19 crisis service model for Children and Young People (CYP),
and exploration of its appropriateness, effectiveness and stakeholders' satisfaction*

Demographic Sheet – Parent/Carer v1.0 March 26th, 2018

Date: __ / __ / _____

We would appreciate it if you could tell us a little about yourself

Please mark the appropriate box

Your Gender: Male Female

Your Ethnicity:

White British Black Caribbean/ Black British-Caribbean

Asian/ Asian British-Pakistani Asian British-Indian

Asian/ Asian British Bangladeshi Black African /Black British African

Chinese White Other

Black Other Asian Other Mixed Race

Other (please specify :) _____

Age: _____

Occupation/Professional Role: _____

Educational level: _____

Marital status: _____

Relationship to Service User (e.g. Mother / Father / Sibling / Carer): _____

Approximate age of the child or young person when first referred to mental health services: _____ years

What year was this? _____

Approximate length of time Service User seen by mental health services: _____ years _____ months

Main mental health service seen by Service User (e.g. Solar Bishop Wilson or Fresh fields):

Any other mental health service used before being admitted to the Solar service?

Any other mental health service used after discharge from the Solar service?

Thank You for your time and participation

Appendix 21: Interview Protocol for Parents and Carers

- Timing and decision to seek help:
 - When, how, by whom decisions were made about getting professional mental crisis help for your child?
 - How mental health crisis impacted your child at home, school, community, and relationships with your family?
 - What led to the decision to seek help for your child from the Solar crisis? (Prompts: *Where did you seek help?*) Did you consider any other alternatives? Did you seek any help for your child prior to being admitted to the Solar Crisis service? (Prompts: *What stopped you from seeking help earlier?*)
 - Did you ever hear before for the Solar or its services?
 - What was your initial thoughts and feelings that you can associate with your child being referred or admitted to Solar Crisis service? (Prompts: *What were five words that popped into your mind when you found out that your child had to be admitted to mental health crisis service?*)

- Waiting time:
 - How long did your child have to wait before receiving help from the Solar /Crisis service?

- Engagement with the Solar Crisis service:
 - What is your initial first impression after your child was admitted to the Solar Crisis service? (Prompt: *Did you think that this is an appropriate place for your child and his/her needs?*)
 - When, where and why did your child engage for the first time with Solar crisis?
 - What is your experience as a parent/carer of the initial process (Prompt: *(un)helpful process or experiences*)
 - What do you think, is there any suggestion for improving the initial process for children and their parents?

- Acceptability and Pathways of the mental health provision:
 - Do you think that your child received appropriate support from the crisis team, while your child was undergoing a mental health crisis? (Prompts: *What did you think about recommendations your received? What was similar or different in what you thought about your child problem and how the person you referred to assessed it? How Solar staff explained to you, your child condition?*)
 - What is your child's journey through the Solar system (Prompt: *What services did you take whilst being in the Solar*)
 - What is your satisfaction with the help that you received for your child from the crisis team of the Solar service?

- Sense of environment, staff and care provided:

- Do you think that the Solar and its crisis service are better or worst environment than Hospital or A&E?
- Tell me about how it felt to be there? (*Prompt: How did you feel with the staff members involved in your child's care? What is your general experience/impression of staff?*)
- How were you treated whilst being there? (*Prompts: How was your child treated? Did you feel like you were taken seriously and that you listened? Did the staff involve you in decision making with regards to treatment preferences?*)
- Did you participate in decision making with regards to treatment preferences for your child?

- (Post) Discharge experience
 - Can you describe how your child's discharge experience was?
 - Did you seek any additional mental health help for your child, after your child has been discharged from the crisis service? (*Prompt: What kind of the help/services – if YES*)
 - Do you think that the crisis team meet your child's mental health needs? (*Prompt: Are there still any unmet mental health needs? Are there any needs you felt weren't met, whilst being treated in the crisis service?*)
 - Do you think that the Solar crisis team managed to help to develop self-management skill for your child to recognise on time signs of a mental health crisis? (*Prompt: In what ways?*)
 - Can you tell me, do you feel any improvement/decline in your child's mental health? Did your child experience any relapse, after being discharged from the Solar crisis service?
 - How this improvement/decline impacts your child's school, college, and relationships
 - Do you think that your child still needs help, despite being discharged from the Solar crisis service?
 - Do you think your child would benefit from any additional help from some other service, such as peer support or mental health support worker? (Explain what peer support is or what mental health support worker is)

- Wrap up – Final impressions:
 - Can you describe to us in detail, how much Solar crisis service help your child and the whole family to overcome the crisis and build resilience?
 - What is your good experience with Solar service whilst your child has been admitted to the Solar Crisis service?
 - What is the bad experience that you can remember whilst your child was admitted to the Solar Crisis service?
 - Is there anything you feel that Solar crisis service could be done differently?
 - Is there anything you would like to change or improve?
 - Do you think that you gained enough knowledge and experience to help you manage your child's future mental health crisis?

- Ending part:
 - Is there anything you would like to add or maybe ask?

Wrapping up

The meeting will end with a brief summing up/checking back on the key issues or ideas put forward. The facilitators will explain what happens next – e.g. if there is to be follow up focus group when some of the findings will be written up and also how to contact the evaluation team if they have further comments they wish to make.

- Thank you for your participation

Appendix 22: Participant Recruitment Poster- Interviews (CYP and Parents) WP2

WE NEED YOUR HELP

with evaluating **SOLAR 0-19 CRISIS SERVICE**
Children and Young people (5-19 yro) are needed:

The purpose of this service evaluation is to develop a better understanding of how Solar and its crisis service now provide support for children and young people's mental health in the 0-19 age group in Solihull.

We are particularly keen to speak to you as someone who has recently experienced mental health crisis and been a user of the Solar and its crisis service. We are keen to learn more about what is working well and not so well, about your experience of meeting with people from services; about the information that is made available for people seeking help and support and also how services can improve how others understand young people's mental health issues.

The project involves researcher asking children and young people about their experience of services and general background questions in an interview that would last around 40-50 minutes at a location that suits you. Everything that you told us will remain "CONFIDENTIAL". This way you can be confident in talking honestly to us about your experiences with the Solar and its crisis service.

Your feedback is essential for Solar and its crisis service to know what's working and what's not. Without your feedback, Solar won't be able to improve its services.

If you are happy to consider being involved, please let us know and we will contact you to describe the project in further detail at a time and place convenient for you. For any further questions, please contact me on below provided email or postal address.

PARENTS AND CARERS STUDY PARTICIPANTS NEEDED

SERVICE EVALUATION OF 0-19 MENTAL HEALTH CRISIS SERVICE (SOLAR)

The purpose of this service evaluation is to develop a better understanding of how Solar and its crisis service now provide support for children and young people's mental health in the 0-19 age group in Solihull.

We are particularly keen to speak to you as a parent or carer of child/young person, who has recently experienced mental health crisis and been a user of the Solar and its crisis service. We are keen to learn more about what is working well and not so well, about your experience of meeting with people from services; about the information that is made available for people seeking help and support and also how services can improve how others understand young people's mental health issues.

Help us to improve the Solar and its crisis service

- by participating in one of our focus groups with other parents and carers
- by participating in one to one interview session
- by expressing your opinion, experience and any suggestions that might help to improve children and young people mental health crisis provision and their experience
- your feedback is essential for Solar and its crisis service to know what's working and what's not. Without your feedback, Solar won't be able to improve its services.

Your opinions are important to us!

All focus groups and interviews will be held in the Solar service. If you wish to participate in any other setting, we will accommodate your wishes. Everything that you told us will remain "CONFIDENTIAL". This way you can be confident in talking openly and honestly to us about your experiences with the Solar and its crisis service.

If you are happy to consider being involved, please let us know and we will contact you to describe the project in further detail at a time and place convenient for you. For any further questions, please contact me on below provided email or postal address.

September 2018
 Frane Vusio
 frane.vusio@nhs.net
 F.Vusio@warwick.ac.uk

Warwick Medical School
 The University of Warwick
 Coventry CV4 7AL
 United Kingdom

Appendix 23: Addition to the crisis discussion part of chapter 9

9.4.6.3 Identified gaps

All interviewed stakeholders identified several gaps in the crisis service provision such as transitioning gap between crisis and the 0-19 model once CYP are ready to leave crisis service, the lack of psychiatrist in the crisis team and the lack of drop-in crisis service. These gaps will be further discussed in line with available research evidence.

The need for continuity of care with other parts of Solar, once discharged from the crisis service, has been evident from all interviews with staff, parents and some CYP. Most stakeholders indicated that there is an apparent waiting time needed to receive follow-up treatment from other parts of the 0-19 model. This waiting time could potentially put CYP at risk of relapse due to their crisis, as any part of the service does not support CYP during this waiting time.

A need for continuity of care once discharged from the crisis service is under-reported and limited evidence exist. Most of the evidence stems from adult studies that support the notion that continuity of care is required not just during the crisis treatment but also post-crisis discharge (Wheeler et al., 2015). Likewise, another study found that service users were dissatisfied with the discontinuity of crisis care and short-term follow-up care, mainly due to staff shortages (Winness et al., 2010). In addition, the lack of psychiatrist in CRT and CRHTT is clearly evident in the research literature dealing mostly with adult CRT services. For example, the Norwegian study found that CRT had a limited number of full-time psychiatrists employed to provide crisis interventions and assessments . Moreover, this study also warned that a lack of psychiatrists within CRTs could have an impact on the multidisciplinary of care.

Similarly, the study by Hasselberg et al. (2011) reported an evident lack of psychiatrists within CRTs. These findings are identical to our findings from the present study in the aspect that the Solar crisis team is nurse-led, with no apparent presence of psychiatrist within the team. Several other studies also highlighted the importance of having psychiatric input and presence within the CRT's. They concluded that presence of psychiatrists in crisis services provides the

"boundary spanner" (Richter, West, Van Dick, & Dawson, 2006) that helped to promote more effective inter-team working (Middleton, Glover, Onyett, & Linde, 2008). More importantly, the study by Middleton et al. (2008) concluded that CRTs with psychiatrists embedded in their services were more effective gatekeepers in the prevention of hospital admission compared to CRT who were just nurse-led.

A similar conclusion was found in the study by Rodes and Giles (2014), which pointed out that psychiatrist's presence in CRHTT is increasing their service capacity to prevent hospitalisation. Additionally, this study also recommended that medical prescribers should be a part of CRT's (Rhodes & Giles, 2014). However, there is some empirical evidence that supports the benefits of inclusion of psychiatrists within the CRTs (Reding & Raphelson, 1995; Wheeler et al., 2015). Several quantitative studies have suggested that the presence of psychiatrists within the crisis team and longer working hours of CRT's may increase CRT' ability to prevent hospital admissions (Wheeler et al., 2015).

Finally, the need for drop-in crisis services has been prominently identified by most CYP and staff members and some parents during the interviews. Similar examples of CYP drop-in services and their benefits are well documented in the broader literature (Austerberry et al., 2008; Wilf-Miron, Sikron, Glasser, & Barell, 2002; World Health Organisation, 2012). In the UK, for example, the Pause is well known drop-in clinic as part of the FTB in Birmingham (Wolpert et al., 2017). Similarly, One-Stop-Shop also offers drop-in contact hours with its crisis team (Sfar-Gandoura et al., 2017). Several studies considered drop-in clinics to be appropriate for providing mental health services provision that improves CYP accessibility; reduces time away from school; decreases DNA rates; improves CYP's involvement with service providers and reduces the need for crisis interventions (Sfar-Gandoura et al., 2017).

Similar to finding of our study, young people in another study expressed same preferences for mental health services and drop-in hubs with accessible and attractive locations, such as those in the community settings that are close and accessible independently (Plaistow et al., 2014a). Therefore, there is an evident need for the 0-19 model and its crisis component to establish more hubs in the local community that would act as early intervention and prevention for both crisis and hospital admissions.

9.6.4.1 Barriers to access to crisis service

Staff members employed by Solar highlighted most barriers to access. Several parents also emphasised a few perceived barriers that in their opinion, could reduce the accessibility to the 0-19 crisis service. The most commonly reported barriers to access identified by all participants were related to under-staffed crisis services, lack of resources and capacity to meet demand.

Regarding the crisis service being understaffed, some studies reported similar situations with other crisis and mental health services for CYP. For example, one study that used the sample of CYP aged 16-19 reported that most statutory mental health services are overburden and understaffed (Richards M. & Vostanis, 2004). However, it is crucial to emphasise that CRHTT and CRT model may be more effective in cases when there is a low turnover of their staff and more flexibility within the team (Rhodes & Giles, 2014). Similarly, CRTs that are understaffed, underfunded and have a high turnover of staff may produce adverse effects on their service users and their treatment outcomes (NHS Nottingham CCG, 2016).

Additionally, one systematic review did emphasise that most of the CAMHS services lack appropriate funding and adequate staffing levels in comparison with AMHS, what contributes towards barriers to access (O'Brien, Harvey, Howse, Reardon, & Creswell, 2016). Likewise, another review reported both professionals and service users perception of services as being understaffed and underfunded (Gondek et al., 2016). Equally, a study by Winnes et al. (2010) also highlighted that crisis service users considered staff shortages as a barrier to access. The study by Morant et al. (2017) also highlighted the negative impacts on the staff continuity of under-resourced and under-funded services. Indeed, one of the most significant challenges facing all new mental health services is the lack of adequate resources and funding (Gallagher & Schlösser, 2015).

However, it is crucial to emphasise that the NHS mandate for 2014/2015 stated that accessibility and quality of urgent and emergency mental health care is a priority. At the same time, every community crisis service should have sufficient resources available for crisis care (Paton et al., 2016c). In the same way, staff capacity depends heavily on the appropriate level of funding. On the other hand, most research studies often reported the inability of

services to meet demand due to lack of funding. For example, one study found that service users reported an increase in demand for mental health services, while a decrease in resources contributed to larger and longer waiting lists (G. J. Reid & Brown, 2008). Therefore, there they may be service limitations in terms of time and resources, and limits to service sustainability due to lack of funding (Hetrick, Bailey, Smith, Malla, Mathias, Singh, O'Reilly, Verma, Benoit, & Fleming, 2017).

Appendix 24: Chapter 10 – Findings of emergent theme for Communication

Due to the University of Warwick's requirement that the thesis should not be longer than 80,000 words, this emergent theme finding from chapter 10 is presented as appendix. The theme "Communication" between the professional local community stakeholders and the Solar service will be first presented, followed by short discussion that aims to relate findings to the broader literature.

Communication

Most of the interviewees from educational settings had positive experiences of communication with Solar and its crisis service. For example, participant LCSH100 stated that they were "*satisfied*" with the communication with the Solar service. The participant also added that "*on the whole, (communication) it's better than it was before*". The participant also added that "*it is very important for our young people that there is communication between school and Solar so that we can help to support young people*". Participant LCSH103 shared a similar view that communication is "*generally quite positive and supportive in terms of interaction with Solar*". Equally, participant LCSH102 reported that "*in terms of the communication we had with Solar, it's always been positive*" experience. However, participant LCSH101 said that in their experience with Solar, communication can be "*patchy*" and "*if you can get through to (Solar) them on the first call, you are doing well*". However, the participant added that "*we have okay communication with them so, that's positive*". Therefore, from participants responses, it is evident that there is good communication between the service and its local education providers. However, from some participants responses, it is also evident that communication has been an issue in the past. The Solar has managed to improve its communication by contributing to better satisfaction of the local professional stakeholders with the service.

Similar positive experiences in communication with Solar were also evident in responses from participants working in hospital settings. For example, LCSH104 expressed satisfaction with communication with the crisis team:

"We always get a response. We've never really had any issues with waiting for Solar to come. They usually come on the same day. So, there's no issues there." (LCSH104)

Equally participant LCSH106 added *"crisis team communicate well and professionally"* while the participant found that excellent communication is *"crucial as the ward is dealing with young people that really need crisis intervention"*. Likewise, LCSH105 shared similar positive experience of excellent communication with the crisis team:

"Yes, we always have a good response. They ring every morning normally as well and ask if there's been any admissions overnight." (LCSH105)

However, two participants stated that communication between the schools and the service could be improved. For example, LCSH103 stated:

"There could always be more, there could always be improved communication. It works fine at the moment. But I suppose there could always be improved communication." (LCSH103)

Equally, participant LCSH100 offered a further explanation of why the communication between the service and its local community needs to improve:

"With anything it's all about communication. Because there'd been so many changes, I don't know who's working where. If I want to make contact with somebody, are they in Bishop Wilson, are they at Freshfields, where are they based? I still don't know who all the psychiatrists are because there's been so many changes. I was told ... we, there was one and then I was told she was leaving and then she's moving to the other centre. So, I don't know. This type of communication needs improving." (LCSH100)

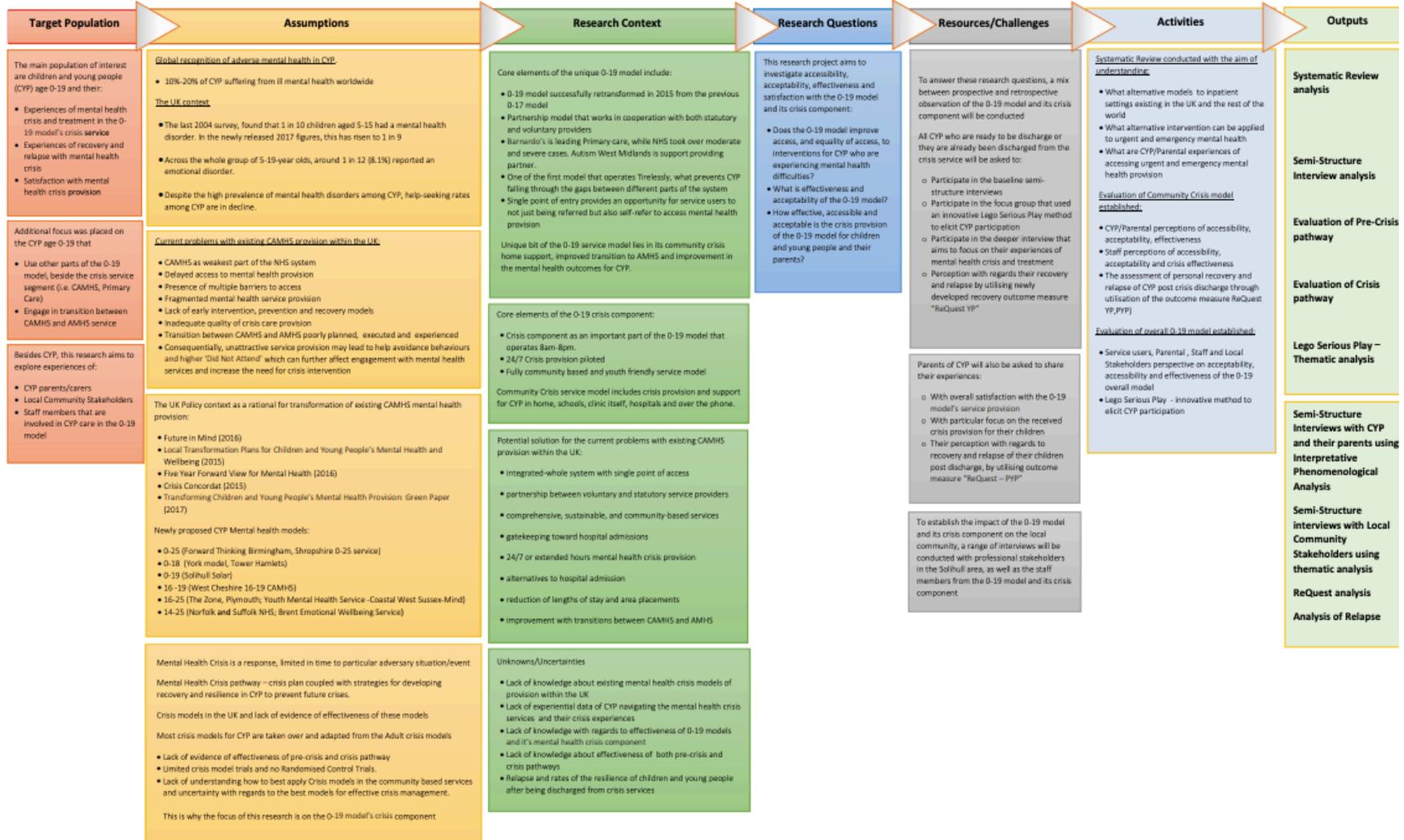
It is evident from all participant's responses that communication between the Solar model and local professionals in its community is reasonably good. Some of the participants thought that this communication could be improved. Nevertheless, effective communication is needed, and as LCSH100 stated: *"it's all about communication"*.

Discussion

Although most of the participants in this study expressed that communication with the Solar model and its crisis component is good, some participants expressed the need for more improved communication. The importance of good communication between mental health services and the local community is well documented in the broader literature, and such is associated with positive treatment outcomes for CYP (Care Quality Commission, 2018).

Equally, communication between mental health services and third sector organisations has contributed to a more effective referral process, reduced waiting times for CYP and improved collaborative practises between services (Care Quality Commission, 2018). However, it is also evident that most services have poor communication with both service users and their referrers while CYP are waiting for assessment or treatment (Care Quality Commission, 2017a). The lack of support, combined with poor service communication, was seen as a barrier to both access and treatment for CYP (Care Quality Commission, 2018). Conversely, maintaining contact with CYP and their referrer during the waiting periods enhanced the stakeholder's overall experiences of the care (Care Quality Commission, 2018). The Future in Mind report is clear that there is a need to improve communication, access and referrals to community mental health services (Department of Health, 2015). Indeed, good communication between mental health services and their service users is not only needed but is of paramount importance.

Appendix 25: Initial version of the logic model



Thesis Supplement for Appendices for Work Package 3 (Vol.2)

Appendices for Work Package 3 are continued in Volume 2 – Supplement to this thesis

REFORM MODELS FOR CHILDREN AND YOUNG PEOPLE MENTAL HEALTH SERVICES IN THE UK: EVALUATION OF THE 0-19 MODEL'S EARLY INTERVENTION APPROACH (Vol.2)

By Frane Vusio

A thesis Supplement

October 2020
University of Warwick
Warwick Medical School, Department of Health Science



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Dear Sir/Madam,

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

I am writing you to invite you to take a part in a research project being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust/Solihull CCG, funded by the Birmingham and Solihull Mental Health Foundation Trust.

What is the purpose of this research project?

The purpose of this research project is to develop a better understanding of how services now provide support for children and young people's mental health in the 0-19 age group in Solihull, UK. We are keen to learn more about what is working well and not so well, about your experience of meeting with people from services; about the information that is made available for people seeking help and support and also how service can improve its provision for children and young people's mental health.

The project involves one of our research team asking you about your experience of services and general background questions about you in an interview/focus group that would last around 40-50 minutes at Solar service or a location and time that suits you. We are particularly keen to speak to you as someone who has experience working with children and young people (0-19 age group) and their mental health and have previous experience of referring children and young people to Solar and its mental health crisis service.

If you are happy to consider being involved, I will arrange for one of our team to contact you to describe the project in further detail at a time and place convenient for you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Thank you for taking the time to read this.

Yours faithfully,

Frane Vusio

Appendix 2: Participants Information Sheet (Local Community Professional Members)

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises

You are invited to take part in a study. Before you decide, you need to understand why the study is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

Part 1 - tells you the purpose of the study and what will happen to you if you take part.

Part 2 - gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the research project?

The purpose of this research project is to develop a better understanding of how the Solar service provides support for children and young people experiencing a mental health crisis in the 0-19 age group in Solihull UK. We are particularly interested to learn more about what is working well and not so well, about your experience of meeting with people from services; about how information is made available and also about anything that you feel might be missing from the way services are provided. We are keen that the information you provide can be used to help improve the crisis mental health services provided for children and young people and their parents/carers in the Solihull.

Why have I been invited?

You have been invited as local community member and professional who is working with children and young peoples who experience mental health difficulties in your area and to learn from your experience of working with local Solar service. We are hoping to include up to 10 professionals from different areas of expertise in this research project. As a small token of appreciation, you will receive vouchers in value £10 if you participate in our interview.

Do I have to take part?

It is up to you to decide if you are happy to take part in the research project. The PhD student – Frane Vusio will describe the research project to you and go through this information sheet with you. If you choose to participate, we will ask you to consent to take part. If you choose a face-to-face interview, you will sign a consent form. If you choose a telephone interview, we will audio-record you giving consent. You will be free to withdraw up to one week after the interview, without giving a reason.

If you choose to withdraw your personal data from the study, you can do that up to seven days from the point of taking part in the study. After seven days, your data will be transcribed and anonymised.

What happens if I agree to take part?

If you decide to take part in a face-to-face interview, Frane Vusio will meet you at Solar service in North Solihull (1 Craig Croft, Birmingham B37 7TR) at a scheduled time at your convenience. The interview

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will take place in a private room. Alternatively, if you prefer to have an interview at your workplace or via telephone, please let us know, and we will try to accommodate this.

Frane Vusio will first introduce himself and the study and will remind you that you can ask any questions. Afterwards, you will be whether you want to proceed with the study. If you say 'yes', we will then ask you to give your consent.

For a face-to-face interview, we will ask you to sign a consent form. For telephone interviews, we will ask you all the questions on the consent form for telephone interviews. Only if you answer all the questions with yes and indicate your name, will you be considered as having given consent for taking part. You giving consent will be audio-recorded.

Participating in the interview will take between 40-50 minutes. During the interview, Frane Vusio will ask you about your views and experiences working with Solar and its mental health crisis. Once the interview is completed, we will send you as a token of appreciation £10 high-street voucher to your home address. In order to protect your identity; we will label the interview audio recording with a code number and give it to a typist who will type out everything you said in the interview. The typist has signed an agreement to keep everything you say in the interview secret.

The digital recording and the typed-up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. After we put down your words on the paper, the audio file will be securely destroyed.

Participants Payments

If you decide to take part in this study, after you participate in our interview, you will receive a token of our appreciation - £10 high street voucher.

Will the research project be kept confidential?

Yes. We will follow the strict ethical, and legal practice and all information about you will be handled confidentially. Further details are included in Part 2.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local service for children and young people's mental health.

The interview will involve speaking about your work experience, and there is a possibility that this may cause you some distress. If you are distressed by anything discussed during the interview, please let the researcher know as they can put you in direct contact with a senior NHS manager.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Detailed information is given in Part 2.

This concludes Part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Who is organising and funding the research project?

The research project is funded by the Solihull CCG and the Birmingham and Solihull Mental Health Foundation Trust, while the University of Warwick is acting as a research sponsor. All interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands.

What will happen if I don't want to carry on being part of the study?

Participation in this study is entirely voluntary. Refusal to participate will not affect you in any way. Even if you have agreed to participate and given consent, you may withdraw from the study until up to seven days after the interview and decline any further contact by study staff after you withdraw. If you wish to withdraw from the study, you should inform Frane Vusio up to one week after the interview. Frane Vusio will send you a confirmation via email that your data will be removed. Your data will be securely deleted, and there will be no further contact.

What if there is a problem?

This study is covered by the University of Warwick's insurance and indemnity cover. If you have a problem, please contact the Chief Investigator of the study:

Dr Max Birchwood
[REDACTED]
[REDACTED]
Warwick Medical School, Gibbet Hill Campus,
Coventry, CV4 7AL

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry
CV4 8UW
Email: researchgovernance@warwick.ac.uk
Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjali Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

What will happen to the data collected about me?

Every participant will be assigned with a unique participant number ensuring your anonymity. Direct quotes and personal information from you, which might be used in publications etc. will be anonymised so that you cannot be identified. Only members of the research team will be able to identify you. This is necessary so that we can identify your data and destroy it in case you should decide to withdraw from the study. All data from the study will be stored for ten years in accordance with the University's Records Retention Schedule.

The University of Warwick is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. All anonymised data from the study will be stored for ten years in accordance with the University's Records Retention Schedule. However, all your identifiable information (Participant consent forms) will be destroyed once the study is completed.

The University of Warwick will keep **unidentifiable** (anonymised) information about you for a maximum of ten years.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting Dr Max Birchwood, the Chief Investigator.

The University of Warwick will use your name, and contact details to contact you about the research study where necessary, and make sure that relevant information about the study is recorded and to oversee the quality of the study. The only people in the University of Warwick who will have access to information that identified you will be the person conducting the research study and anyone who needs to audit the data collection process, should that be necessary. Your data will not be identifiable at the point of analysis and researchers will not be able to find out your name or contact details when analysing data for the study.

Data Sharing

All interview recordings will be a label with a code number and will be given to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed-up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. This audio recording after transcription is done, will be destroyed. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. The University of Warwick has in place policies and procedures to keep your data safe.

What will happen to the results of the study?

Collective and anonymised results will be published in scientific journals. The results of this research project will be collected into a report that will be made available on our website at www.bsmhft.nhs.uk. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes. We would like to provide you with your copy of the report if you request from us, after the 30th of May 2020. Please contact us for your copy of the report on the following email address:

Who has reviewed the research project?

This study has been reviewed and given a favourable opinion by the Edgbaston Research Ethics Committee (Ref. 19/WM/0018) and the Health Research Authority. A Research Ethics Committee is a group of independent people who review research projects to protect the dignity, rights, safety and wellbeing of participants and researchers.

Data Protection Privacy Notice

The data controller for this project will be the University of Warwick. The Information and Data Compliance Team at Warwick will provide oversight of activities involving the processing of personal data, and can be contacted via gdpr@warwick.ac.uk. The Data Protection Officer for the University of Warwick is Anjeli Bajaj. Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data is Article 6(1b) a task in the public interest.

In addition to the legal basis for processing personal data, the University of Warwick must meet a further basis when processing special category data, including: racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data, data concerning health, data concerning a natural person's sex life or sexual orientation. The basis for processing your special category personal data is Article 9(2j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry
CV4 8UW
Email: researchgovernance@warwick.ac.uk
Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjeli Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

Edbaston Research Ethics Committee Ref. 19/WM/0018

Protocol number: SC.06/18-19

IRAS Project ID: 253272

V3.2 | 4th of February, 2019

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

What if I want more information about the study?

If you have any questions about any aspect of the study, or your participation in it, not answered by this participant information leaflet, please contact:

PhD Student - Researcher
Frane Vusio



The University of Warwick,
Warwick Medical School,
Gibbet Hill Campus,
Farmhouse,
Coventry,
CV4 7AL

Thank you for taking the time to read this Participant Information Leaflet

Yours faithfully,
Frane Vusio

Appendix 3: Consent form for Local Community Members

Research project Number: _____

Participant Identification Number: _____

CONSENT FORM v3.1 LCM

4th of February, 2019

<p style="text-align: center;">Research Project Title:</p> <p>A new mental health 0-19 crisis service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises</p>		<p>Please tick off appropriate box if you agree with the box content</p>
1	<p>I confirm that I have read the information sheet dated 04/02/2019(v3.1 LCM) for the above Research project. I have had the opportunity to consider the information, ask questions and have had these fully answered</p>	<input type="checkbox"/>
2	<p>I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected</p>	<input type="checkbox"/>
3	<p>I understand that the focus group/Interview discussion will be digitally recorded as an audio file and typed into a written version</p>	<input type="checkbox"/>
4	<p>I agree to take part in the above Research project</p>	<input type="checkbox"/>
<p>If you would like a copy of the research results, please contact the research team after May 2020 on the following email address: [REDACTED]</p>		
_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person Taking consent	Date	Signature

Appendix 3a: Participant Demographic Sheet (Community stakeholder)

A new mental health 0-19 crisis service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

Demographic Sheet – Stakeholders v2.0 30th of October, 2018

Date: __ / __ / _____

We would appreciate it if you could tell us a little about yourself

Please tick the appropriate box

Your Gender: Male Female Other: _____ Prefer not to answer

Your Ethnicity:

White British Black Caribbean/ Asian/
Asian/
Indian Black British-Caribbean Asian British-Pakistani Asian Brit

Asian/ Asian British Bangladeshi Black African /Black British African
Chinese

White Other Black Other Asian Other

Mixed Race

Other (please specify) _____

Occupation/Professional Role: _____

Age: _____

Educational level: _____

Appendix 4: Local community professional member's Semi-Structure interview

Introductions and 'ground rules'

A team from the University of Warwick has been commissioned to evaluate the new 0-19 and its crisis mental health service for children and young people.

We are very grateful that you have agreed to take part in the research project for the new service. The purpose of us talking with you is to hear about your views and experiences with the 0-19 model and its crisis service for children and young people in Solihull.

Before we start, we would just like to run through a few things:

- Taking part in the research project is entirely voluntary and you are free to stop at any time.
- Our conversation with you will last about 1 hour.
- Please don't disclose anything confidential
- If you don't understand any of our questions please tell us – and if there is something you don't wish to answer, please just tell us.
- Your views and comments will be used in the final research project report but will remain confidential to the research project team and anonymous in the way they are written up.
- If you say something that we would like to quote, we will discuss this with you before including it in the research project report.
- Before we start, do you have any questions or anything to check? (Collect up consent/demographics form at this point).

Introductions:

- Can you tell us briefly, a little bit about your professional role and how it relates to the mental health or mental health crisis? (Prompts: Where are you based, what experience do you have with CAMHS? What experience you have with the Solar service)
- Did you have any previous experience working with children or young people who experienced a mental health crisis?

Baseline levels of awareness and knowledge of the Solar 0-19 model and its crisis service

- Did you know that a new mental health service for 0-19-year-olds started in Solihull in 2015?
- Do you know what it offers/how you can refer children and young people to it/access consultation advice and support?
- Have you received any promotional information materials about the 0-19 service or its crisis service?

If answers to the above questions are 'no', then a brief overview of the new service will be provided and then views sought on this, e.g. does this service sound like it would be helpful to children, young people and their families? Will be easy to access, is it offering the right sorts of help, is open at the right time, in the right place etc.

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Suggestions for what else needs to be offered/developed will be sought, including any views as to why they won't use the service/will use another source of support; also their ideas for publicizing and promoting the 0-19 service across the local population.

If the interview participant do know about the service and/or have referred children, young people, parents and carers to it, then the next section of questions will be asked.

Participant experiences of using the new 0-19 service: general impressions

- Which part of the 0-19 service have you worked with or came in contact with? (e.g. CAMHS, Crisis team, Primary care; inpatient care)
- How did you first access the service – did you refer a child or young person, or a family, yourself?
- What is your opinion about self-referrals to Solar service?
- How easy was **accessing** the 0-19 model or its crisis service? What are your views on the **length of time needed to access** the service– was this OK, about right, too long etc. (Prompt: if you worked with Solihull's mental health services in the past, how does the 0-19 model - service compare in terms of how quickly and easily you can get information, advice and help?)
- Do you think that there are particular **barriers to access** to 0-19 model or its crisis service? If so, what kind of **barriers** you can identify?
- Did you receive any information about what the new 0-19 service was going to offer you? How was this information given and what did you think of it? Any suggestions for improving it? Views on the amount of choice offered.

Questions for participants with experience of using the service and/or local delivery partners

- In your own opinion, what children and young people need while undergoing a mental health crisis?
- What is needed for a multi-agency mental health crisis response for children and young people? What are the key requirements to achieve this?
- What processes and procedures are placed for information sharing with other services, with regards to treatment and care you offer for children, young people and their parents/carers. (e.g. what is information sharing with A&E, inpatient units, different wards or different NHS trusts).
- Are there any multi-disciplinary meetings that allow planning, reviews or support of treatment/care.

- Would you say that Solar and its crisis service is achieving good communication with other services or care bodies such as Social Services.
- Do you think that any improvements are required with regards to communication and information sharing?

Partnership working within 0-19 model and its crisis:

- How joined up to do Solar feels? Do you think that partnership with Barnardo's, NHS and Autism West Midlands has helped with creating more clear and easy pathways to care for children and young people?
- Do you think that this partnership is working for children and young people who are experiencing a mental health crisis?

Improvements, gaps and areas needing development

- Are there any improvements or strengths you see in how the 0-19 service is working – e.g. easier to access, online appointment booking system, shorter waiting times, more choice of therapies, better join up across the age range, able to work with children, young people and with families?
- In your opinion, are there any gaps or weaknesses in the service that need to be addressed? What might enable this development/any barriers you identify?
- What are the strengths of the Solar service? What are the strengths of the crisis service?
- Are there any gaps or unmet children and young people mental health needs that should be considered? If so, what are they?
- How would you like to see Solar service in the next five years? How would you like to see the Solar crisis service within next five years?
- What particular impact do you think Solar and its crisis have on the local community?

Wrapping up

The meeting will end with a brief summing up/checking back on the key issues or ideas put forward. The facilitators will explain what happens next – e.g. if there is to be follow up a focus group when some of the findings will be written up and also how to contact the research project team if they have further comments they wish to make.

Wrapping up

After Interview Activity:

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1. Upon completion of the interview, an audio recording will be downloaded and copies will be saved
2. An email will be sent to staff who participated to once again express gratitude for participation.
3. Notes will be made about the main points that came across.
4. Transcription
5. Data analysis.

Appendix 5: Invitation for participation in a research project (CYP)

V3.1 SU/CYP 04/02/2019

Dear Solar service user

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

I am writing you to invite you to take part in a research project being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust/Solihull CCG, funded by the Birmingham and Solihull Mental Health Foundation Trust/ Solihull CCG.

What is the purpose of this research project?

The purpose of this research project is to develop a better understanding of how Solar service provide mental health crisis support for children and young people in the 0-19 age group in Solihull, UK. We are keen to learn more about what is working well and not so well, about your experience of meeting with people from services; about the information that is made available for people seeking help and support and also how services can improve how others understand children and young people's mental health issues.

The project involves one of our research team asking children and young people about their experience of services and general background questions about you in an interview that would last around 60-90 minutes.

If you decide to take part in a face-to-face interview, Frane Vusio will meet you at Solar service in North Solihull (1 Craig Croft, Birmingham B37 7TR) at a scheduled time at your convenience. The interview will take place in a private room. Alternatively, if you prefer to have an interview at your own home or via telephone, please let us know, and we will try to accommodate this. For your participation, as a small token of appreciation, you will receive vouchers in value £15 if you participate in our interview.

If you are under the age of 16, your parents should attend an interview with you.

We are particularly keen to speak to you as someone who has recently experienced a mental health crisis or been a service user of the Solar and its mental health crisis service.

If you are happy to consider being involved, I will arrange for one of our team to contact you to describe the project in further detail at a time and place convenient for you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Thank you for taking the time to read this.

Yours faithfully

Frane Vusio

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Appendix 6: Expression of Interest form



Expression of Interest for Research Project

The Solar service in the cooperation with the University of Warwick Medical School is conducting a research project with children, young people and their parents who are willing to be contacted about their participation in this research. Children, young people and their parents with this form are expressing interest to receive more information about the project. In addition, parents are giving permission to healthcare researcher team to contact them in order to supply participants with more information about the research, Participant Information Sheet and copy of consent form.

Please read the Children and Young People / Parents Information Leaflet prior to completing this form.

Please initial each box if you agree to consent and sign the bottom of the page.

1. I agree to my contact details can be used for the research team, so that they can contact me with regards to providing more information about the research project.
2. I understand this consent form does **NOT** commit me to take part in any research without further information and consent being obtained from me
3. I have read and understood all of the information presented in the Invitation for participation in research project leaflet and understand what is being asked from me on this form.
4. I have been provided with contact details to obtain more information or have any questions answered relating to the Expression of Interest form.
5. **Parents of child/adolescent/ young person ONLY**
I agree to my contact details can be used for the research team, so that they can contact me with regards to providing more information about the research project that involves children and young people and their parents.
6. I understand this consent form does NOT commit my child to take part in any research without further information and consent being obtained from me.

Initial

Initial

Initial

Initial

Initial

Initial

Please sign the page _____

Date: _____

V3.1 – 4th of February 2019



YOUR DETAILS

Name:									
Address: (Please include postcode)									
Gender:	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:
Email:									
Telephone:									
Mobile:									
Preferred mode of contact	Email	<input type="checkbox"/>	Mobile	<input type="checkbox"/>	Telephone	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:

If parent is consenting to be contacted on behalf of their child/ adolescent

Name of Child:									
Child Age:									
Gender:	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>	Other	<input type="checkbox"/>	Specify:
Contact details (if different from above)									

Please sign the page _____

Date: _____

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Appendix 7: Participant Information Sheet (10-19 years old CYP – Baseline Interview)

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

You are invited to take part in a study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

Part 1 - tells you the purpose of the study and what will happen to you if you take part.

Part 2 - gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the research project?

The purpose of this research project is to develop a better understanding of how the Solar service provides support for children and young people experiencing a mental health crisis in the 0-19 age group in Solihull UK. We are particularly interested in learning more about what is working well and not so well, about your experience of meeting with people from services; about how information is made available and also about anything that you feel might be missing from the way services are provided. We are keen that the information you provide can be used to help improve the crisis mental health services provided for children and young people and their parents/carers in the Solihull.

Why have I been invited?

You have been invited as you previously been service user and received treatment from the Solar service. We are hoping to include up to five children and young people in this research project. Although taking part may not benefit you personally, your experience could potentially improve crisis care for other children or young people in the future. A small token of appreciation, you will receive vouchers in value £15 if you participate in our interview.

Do I have to take part?

It is up to you to decide if you are happy to take part in the research project. The PhD student – Frane Vusio will describe the research project to you and go through this information sheet with you. **If you choose to participate, we will ask you to assent to take part (if you are younger than 16) and consent to take part (if you are 16 years old and older).** If you choose a face-to-face interview, you will sign a assent/consent form. If you prefer a telephone interview, we will audio-record you giving assent/consent. You will be free to withdraw up to one week after the interview, without giving a reason.

If you choose to withdraw your personal data from the study, you can do that up to seven days from the point of taking part in the study. After seven days, your data will be transcribed and anonymised.

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What happens if I agree to take part?

If you select to take part in a face-to-face interview, Frane Vusio will meet you at Solar service in North Solihull (1 Craig Croft, Birmingham B37 7TR) at a scheduled time at your convenience. The interview will take place in a private room. Alternatively, if you prefer to have an interview at your own home, please let us know, and we will try to accommodate this.

If you are under the age of 16, your parents should attend an interview with you.

Frane Vusio will first introduce himself and the study and will remind you that you can ask any questions. Afterwards, you will be whether you want to proceed with the study. If you say 'yes', we will then ask you to give your assent/consent.

For a face-to-face interview, we will ask you to sign a assent/consent form. For telephone interviews, we will ask you all the questions on the assent/consent form for telephone interviews. Only if you answer all the questions with yes and indicate your name, will you be considered as having given assent/consent for taking part. Your given assent/consent will be audio-recorded.

Participating in the interview will take between 40 and 60 minutes. During the interview, Frane Vusio will ask you about your views and experiences of mental health crisis and crisis help that was offered to you by Solar service. Once the interview is completed, we will send you as a token of appreciation £15 high-street voucher to your home address.

To protect your identity, we will label the interview audio recording with a code number and give it to a typist who will type out everything you said in the interview. The typist has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. After we put down your words on the paper, the audio file will be destroyed.

Participants Payments

If you decide to take part in this study, after you participate in our interview, you will receive a token of our appreciation - £15 high street voucher.

Will the research project be kept confidential?

Yes. We will follow the strict ethical, and legal practice and all information about you will be handled confidentially. Further details are included in Part 2.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local service for children and young people's mental health.

The interview will involve speaking about your experience of Solar crisis service, and there is a possibility that this may cause you some distress. If you are distressed by anything discussed during the interview, please let the researcher know as they can put you in direct contact with a senior NHS manager.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Detailed information is given in Part 2.

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This concludes Part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

Who is organising and funding the research project?

The research project is funded by the Solihull CCG and the Birmingham and Solihull Mental Health Foundation Trust, while the University of Warwick is acting as a research sponsor. All interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands.

What will happen if I don't want to carry on being part of the study?

Participation in this study is entirely voluntary. Refusal to participate will not affect you in any way. Even if you have agreed to participate and given assent/consent, you may withdraw from the study until up to seven days after the interview and decline any further contact by study staff after you withdraw. If you wish to withdraw from the study, you should inform Frane Vusio up to one week after the interview. Frane Vusio will send you a confirmation via email that your data will be removed. Your data will be securely deleted, and there will be no further contact.

What if there is a problem?

This study is covered by the University of Warwick's insurance and indemnity cover. If you have a problem, please contact the Chief Investigator of the study:

Dr Max Birchwood
[REDACTED]
[REDACTED]
Warwick Medical School, Gibbet Hill Campus,
Coventry, CV4 7AL

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry

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CV4 8UW

Email: researchgovernance@warwick.ac.uk

Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjeli Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

Will my taking part be kept confidential?

Yes. Every participant will be assigned with a unique participant number ensuring your anonymity. Direct quotes and personal information from you, which might be used in publications etc. will be anonymised so that you cannot be identified. Only members of the research team will be able to identify you. This is necessary so that we can identify your data and destroy it in case you should decide to withdraw from the study. All data from the study will be stored for 10 years in accordance with the University's Records Retention Schedule.

The University of Warwick is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Warwick will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting Prof Max Birchwood, the Chief Investigator.

The Solar service will collect information from your medical record for this research study in accordance with our instructions. The Solar service will keep your NHS number, contact details and patient records confidential and will not pass this information to the University of Warwick.

The Solar service will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from the University of Warwick and regulatory organisations may look at your medical and research records to check the accuracy of the research study. The University of Warwick will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, your patient NHS number or contact details.

The University of Warwick will use your name, and contact details to contact you about the research study where necessary, and make sure that relevant information about the study is recorded and to oversee the quality of the study. The only people in the University of Warwick who will have access to information that identified you will be the person conducting the research study and anyone who needs to audit the data collection process, should that be necessary. Your data will not be identifiable at the

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point of analysis and researchers will not be able to find out your name or contact details when analysing data for the study. The University of Warwick will keep identifiable information about you from this study for 10 years after the study has finished.

The University of Warwick will keep both identifiable and unidentifiable information about you from this study for 10 years after the study has finished/ until August 2030.

Data Sharing

All interview recordings will be a label with a code number and will be given to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. This audio recording after transcription is done, will be destroyed. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. The University of Warwick has in place policies and procedures to keep your data safe.

What will happen to the results of the study?

Collective and anonymised results will be published in scientific journals. The results of this research project will be collected into a report that will be made available on our website at www.bsmhft.nhs.uk. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes. We would like to provide you with your copy of the report if you request from us, after the 30th of May, 2020. Please contact us for your copy of the report on the following email address:

████████████████████

Who has reviewed the research project?

This study has been reviewed and given a favourable opinion by the Edgbaston Research Ethics Committee (Ref. 19/WM/0018) and the Health Research Authority. A Research Ethics Committee is a group of independent people who review research projects to protect the dignity, rights, safety and wellbeing of participants and researchers.

Data Protection Privacy Notice

The data controller for this project will be the University of Warwick. The Information and Data Compliance Team at Warwick will provide oversight of activities involving the processing of personal data, and can be contacted via gdpr@warwick.ac.uk. The Data Protection Officer for the University of Warwick is Anjeli Bajaj. Your data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your data is Article 6(1b) a task in the public interest.

In addition to the legal basis for processing personal data, the University of Warwick must meet a further basis when processing special category data, including: racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data, data concerning health, data concerning a natural person's sex life or sexual orientation. The basis for processing your special category personal data is Article 9(2j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

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Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry
CV4 8UW
Email: researchgovernance@warwick.ac.uk
Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjeli Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

What if I want more information about the study?

If you have any questions about any aspect of the study, or your participation in it, not answered by this participant information leaflet, please contact:

PhD Student - Researcher
Frane Vusio



The University of Warwick,
Warwick Medical School,
Gibbet Hill Campus,
Farmhouse,
Coventry,
CV4 7AL

Thank you for taking the time to read this Participant Information Leaflet

Yours faithfully,
Frane Vusio

Appendix 8: Assent form for CYP participants

Research project Number: _____

Participant Identification Number: _____

ASSENT FORM v3.2 SU

13th of March, 2019

Research Project Title: A new mental health 0-19 service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises		Please tick off the appropriate box if you agree with the box content
1	I confirm that I have read the information sheet dated 04/02/2019 (v3.1 SU) for the above Research project . I have had the opportunity to consider the information, ask questions and have had these fully answered	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected	
3	I understand that the interview will be digitally recorded as an audio file and typed into a written version, that will be anonymised	
4	I agree to take part in the above Research project	
5	Parental consent for children and adolescent, aged 5-15 Parent consenting on behalf of their child, please fill out the form v3.1 P/C/F for SU	
If you would like a copy of the research results, please contact the research team after May 2020 on the following email address: [REDACTED]		

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person Taking consent	Date	Signature

Appendix 9: Consent form (Young People 16 and over – Baseline Interview)

Research project Number: _____

Participant Identification Number: _____

CONSENT FORM v3.1 C/P/F

4th of February, 2019

Research Project Title: A new mental health 0-19 service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises		Please tick off appropriate box if you agree with the box content
1	I confirm that I have read the information sheet dated 04/02/2019 (v3.1 C/P/F) for the above Research project . I have had the opportunity to consider the information, ask questions and have had these fully answered	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected	
3	I understand that the interview discussion will be digitally recorded as an audio file and typed into a written version	
4	I agree to take part in the above Research project	
If you would like a copy of the research results, please contact the research team after May 2020 on the following email address: [REDACTED]		
_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person Taking consent	Date	Signature

Appendix 10: Consent form for Parent consenting on behalf of their child (age 5-15)

Research project Number: _____

Participant Identification Number: _____

CONSENT FORM v3.1 P/C/F for SU 4th of February.2019

Research Project Title:		Please tick off appropriate box if you agree with the box content
A new mental health 0-19 service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises		
1	Parental consent for children and adolescent, aged 5-15 As a parent, I have read participant information sheet dated 04/02/2019 (v3.1 P/C/F for SU) for the above Research project and have been given the opportunity to ask questions.	
2	I understand that my child’s participation is voluntary and that my child is free to withdraw at any time without giving any reason, without my child medical care or legal rights being affected	
3	I understand that the interview discussion will be digitally recorded as an audio file and typed into a written version, that will be anonymised	
4	I give consent for my child to participate in this Research project	
5	Name of Child: _____ Age of Child: _____	
If you would like a copy of the research results, please contact the research team after May 2020 on the following email address: [REDACTED]		
_____ Name of Participant	_____ Date	_____ Signature
_____ Name of Person Taking consent	_____ Date	_____ Signature

Appendix 11: Invitation for participation in the research project (Parents or Carers)

V3.1 C/P/F 04/02/2019

Dear Parent/Carer

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

I am writing you to invite you to take part in a research project being conducted by the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust/Solihull CCG, funded by the Birmingham and Solihull Mental Health Foundation Trust/Solihull CCG.

What is the purpose of this research project?

The purpose of this research project is to develop a better understanding of how Solar service provide mental health crisis support for children and young people in the 0-19 age group in Solihull, UK. We are particularly keen to learn more about what is working well and not so well; about you experiences accessing the crisis service and meeting people from the service; about the information that is made available for people seeking help and support and also how service can improve how others understand children and young people's mental health crisis.

This project involves one of our research team member asking people about their own experiences of the Solar crisis service and some general background questions about you in an interview that would last around 60-90 minutes.

If you decide to take part in a face-to-face interview, Frane Vusio will meet you at Solar service in North Solihull (1 Craig Croft, Birmingham B37 7TR) at a scheduled time at your convenience. The interview will take place in a private room. Alternatively, if you prefer to have an interview at your own home or via telephone, please let us know, and we will try to accommodate this. For your participation, as a small token of appreciation, you will receive vouchers in value £15 if you participate in our interview.

We would be very keen to speak to you as someone who has recently been the parents/career of a child or young person who was in a mental health crisis or have been seen by Solar mental health service or Solar crisis team.

If you are happy to consider being involved in this research project, I will arrange for one of our team members to contact you to discuss the project in further detail at the time that suits you. Please contact me either:

By post: Frane Vusio, The University of Warwick, Warwick Medical School, Farmhouse, CV4 7AJ, Coventry

By email: [REDACTED] or [REDACTED]

Thank you for taking the time to read this
Yours faithfully, Frane Vusio

Edbaston Research Ethics Committee Ref. 19/WM/0018

Protocol number: SC.06/18-19

IRAS Project ID: 253272

V3.2 | 4th of February, 2019

Appendix 12: Participants Information Sheet (Parents/Carers – Baseline Interview)

Research Project Title:

A new mental health 0-19 service model for Children and Young people (CYP), and it's effectiveness in promoting recovery, and resilience by preventing future mental health crises

You are invited to take part in a study. Before you decide, you need to understand why the study is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

Part 1 - tells you the purpose of the study and what will happen to you if you take part.

Part 2 - gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the research project?

The purpose of this research project is to develop a better understanding of how the Solar service provides support for children and young people experiencing a mental health crisis in the 0-19 age group in Solihull UK. We are particularly interested in learning more about what is working well and not so well, about your experience of meeting with people from services; about how information is made available and also about anything that you feel might be missing from the way services are provided. We are keen that the information you provide can be used to help improve the crisis mental health services provided for children and young people and their parents/carers in the Solihull.

Why have I been invited?

You have been invited as your child has previously been a service user and received treatment from the Solar crisis service. We are hoping to include up to five parents or carers in this research project. Although taking part may not benefit you personally, your experience could potentially improve crisis care for other children or young people in the future. As a small token of appreciation, you will receive vouchers in value £15 if you participate in our interview.

Do I have to take part?

It is up to you to decide if you are happy to take part in the research project. The PhD student – Frane Vusio will describe the research project to you and go through this information sheet with you. If you choose to participate, we will ask you to consent to take part. If you choose a face-to-face interview, you will sign a consent form. If you choose a telephone interview, we will audio-record you giving consent. You will be free to withdraw up to one week after the interview, without giving a reason.

If you choose to withdraw your personal data from the study, you can do that up to seven days from the point of taking part in the study. After seven days, your data will be transcribed and anonymised.

What happens if I agree to take part?

If you decide to take part in a face-to-face interview, Frane Vusio will meet you at Solar service in North Solihull (1 Craig Croft, Birmingham B37 7TR) at a scheduled time at your convenience. The interview

Edbaston Research Ethics Committee Ref. 19/WM/0018

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will take place in a private room. Alternatively, if you prefer to have an interview at your own home or via telephone, please let us know, and we will try to accommodate this.

Frane Vusio will first introduce himself and the study and will remind you that you can ask any questions. Afterwards, you will be whether you want to proceed with the study. If you say 'yes', we will then ask you to give your consent.

For a face-to-face interview, we will ask you to sign a consent form. For telephone interviews, we will ask you all the questions on the consent form for telephone interviews. Only if you answer all the questions with yes and indicate your name, will you be considered as having given consent for taking part. You giving consent will be audio-recorded.

Participating in the interview will take between 60-90 minutes. During the interview, Frane Vusio will ask you about your views and experiences of caring for your child during your child's mental health crisis and crisis help that was offered to your child by the Solar service. Once the interview is completed, we will send you as a token of appreciation £15 high-street voucher to your home address.

In order to protect your identity, we will label the interview audio recording with a code number and give it to a typist who will type out everything you said in the interview. The typist has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. After we put down your words on the paper, the audio file will be destroyed.

Participants Payments

If you decide to take part in this study, after you participate in our interview, you will receive a token of our appreciation - £15 high street voucher.

Will the research project be kept confidential?

Yes. We will follow the strict ethical, and legal practice and all information about you will be handled confidentially. Further details are included in Part 2.

What are the risks and benefits of taking part?

Although taking part may not benefit you personally, it may help to improve local service for children and young people's mental health.

The interview will involve speaking about your experience of Solar crisis service, and there is a possibility that this may cause you some distress. If you are distressed by anything discussed during the interview, please let the researcher know as they can put you in direct contact with a senior NHS manager.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Detailed information is given in Part 2.

This concludes Part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Who is organising and funding the research project?

The research project is funded by the Solihull CCG and the Birmingham and Solihull Mental Health Foundation Trust, while the University of Warwick is acting as a research sponsor. All interviews are being carried out by research staff from the University of Warwick in cooperation with the Birmingham and Solihull Mental Health NHS Foundation Trust, Barnardo's and Autism West Midlands.

What will happen if I don't want to carry on being part of the study?

Participation in this study is entirely voluntary. Refusal to participate will not affect you in any way. Even if you have agreed to participate and given consent, you may withdraw from the study until up to seven days after the interview and decline any further contact by study staff after you withdraw. If you wish to withdraw from the study, you should inform Frane Vusio up to one week after the interview. Frane Vusio will send you a confirmation via email that your data will be removed. Your data will be securely deleted, and there will be no further contact.

What if there is a problem?

This study is covered by the University of Warwick's insurance and indemnity cover. If you have a problem, please contact the Chief Investigator of the study:

Dr Max Birchwood
[REDACTED]
[REDACTED]
Warwick Medical School, Gibbet Hill Campus,
Coventry, CV4 7AL

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services

University House

University of Warwick

Coventry

CV4 8UW

Email: researchgovernance@warwick.ac.uk

Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjali Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

What will happen to the data collected about me?

Every participant will be assigned with a unique participant number ensuring your anonymity. Direct quotes and personal information from you, which might be used in publications etc. will be anonymised so that you cannot be identified. Only members of the research team will be able to identify you. This is necessary so that we can identify your data and destroy it in case you should decide to withdraw from the study. All data from the study will be stored for ten years in accordance with the University's Records Retention Schedule.

The University of Warwick is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. All anonymised data from the study will be stored for ten years in accordance with the University's Records Retention Schedule. However, all your identifiable information (Participant consent forms) will be securely destroyed once the study is completed.

The University of Warwick will keep **unidentifiable** (anonymised) information about you for a maximum of ten years.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting Dr Max Birchwood, the Chief Investigator.

The University of Warwick will use your name, and contact details to contact you about the research study where necessary, and make sure that relevant information about the study is recorded and to oversee the quality of the study. The only people in the University of Warwick who will have access to information that identified you will be the person conducting the research study and anyone who needs to audit the data collection process or regulatory bodies, should that be necessary. Your data will not be identifiable at the point of analysis and researchers will not be able to find out your name, or contact details when analysing data for the study.

Data Sharing

All interview recordings will be a label with a code number and will be given to a typist who will type out everything you said in the interview. The typist (Appen) is approved by the University of Warwick and has signed an agreement to keep everything you say in the interview secret. The digital recording and the typed up record (transcript), identified only by the code number, would be kept in a secure place at the University of Warwick. This audio recording after transcription is done, will be destroyed. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. The University of Warwick has in place policies and procedures to keep your data safe.

What will happen to the results of the study?

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Collective and anonymised results will be published in scientific journals. The results of this research project will be collected into a report that will be made available on our website at www.bsmhft.nhs.uk. We will make sure that no-one is identifiable within the report and will not use people's names with any quotes. We would like to provide you with your copy of the report if you request from us, after the 30th of May, 2020. Please contact us for your copy of the report on the following email address:

Who has reviewed the research project?

This study has been reviewed and given a favourable opinion by the Edgbaston Research Ethics Committee (Ref. 19/WM/0018) and the Health Research Authority. A Research Ethics Committee is a group of independent people who review research projects to protect the dignity, rights, safety and wellbeing of participants and researchers.

Data Protection Privacy Notice

The data controller for this project will be the University of Warwick. The Information and Data Compliance Team at Warwick will provide oversight of activities involving the processing of personal data, and can be contacted via gdpr@warwick.ac.uk. The Data Protection Officer for the University of Warwick is Anjeli Bajaj. Your personal data will be processed for the purposes outlined in this notice. The legal basis that would be used to process your personal data is Article 6(1b) a task in the public interest.

In addition to the legal basis for processing personal data, the University of Warwick must meet a further basis when processing special category data, including: racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic data, biometric data, data concerning health, data concerning a natural person's sex life or sexual orientation. The basis for processing your special category personal data is Article 9(2j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry
CV4 8UW
Email: researchgovernance@warwick.ac.uk
Tel: 024 76 522746

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer, Anjeli Bajaj, Information and Data Director who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful, you can complain to the Information Commissioner's Office (ICO).

What if I want more information about the study?

If you have any questions about any aspect of the study, or your participation in it, not answered by this participant information leaflet, please contact:

PhD Student - Researcher
Frane Vusio



The University of Warwick,
Warwick Medical School,
Gibbet Hill Campus,
Farmhouse,
Coventry,
CV4 7AL

Thank you for taking the time to read this Participant Information Leaflet

Yours faithfully,
Frane Vusio

Appendix 13: Consent form (Parents and Carers – Telephone post-discharge Interview)

Research project Number: _____

Participant Identification Number: _____

CONSENT FORM v3.1 C/P/F

4th of February, 2019

Research Project Title: A new mental health 0-19 service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises		Please tick off appropriate box if you agree with the box content
1	I confirm that I have read the information sheet dated 04/02/2019 (v3.1 C/P/F) for the above Research project . I have had the opportunity to consider the information, ask questions and have had these fully answered	
2	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected	
3	I understand that the interview discussion will be digitally recorded as an audio file and typed into a written version	
4	I agree to take part in the above Research project	
If you would like a copy of the research results, please contact the research team after May 2020 on the following email address: [REDACTED]		
_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person Taking consent	Date	Signature

Appendix 13a: Participant Demographic Sheet (Parent/Carer)

A new mental health 0-19 crisis service model for Children and Young people (CYP), and its effectiveness in promoting recovery, and resilience by preventing future mental health crises

Demographic Sheet – Parent/Carer v2.0

30th of October, 2018

Date: __ / __ / _____

We would appreciate it if you could tell us a little about yourself

Please mark the appropriate box

Your Gender: Male Female Other: _____ Prefer not to answer

Your Ethnicity:

White British

Black Caribbean/ Black British-Caribbean

Asian/ Asian British-Pakistani

Asian British-Indian

Asian/ Asian British Bangladeshi

Black African /Black British Africa

Chinese

White Other

Black Other

Asian Other

Mixed Race

Other (please specify :) _____

Age: _____

Occupation/Professional Role:

P.T.O

Educational level: _____

Marital status: _____

Relationship to Service User (e.g. Mother / Father / Sibling / Carer):

Age of your child:

Approximate age of child or young person when first referred to mental health services:

_____ years

What year was this? _____

Approximate length of time Service User seen by mental health services: _____ years

_____ months

Main reason for acceptance of your child to Solar service

Main mental health service seen by Service User (eg Solar Bishop Wilson or Fresh fields):

Any other mental health service used before being admitted to the Solar service?

Any other mental health service used after discharge from the Solar service?

Thank You for your time and participation

Appendix 14: Baseline Interview Protocol for Parents and Carers

V2. P/C BIP

30th of October 2018

• Timing and decision to seek help:

- When, how, by whom decisions were made about getting professional mental crisis help for your child? (Prompts: *How did you feel? What was going on in your mind then? (thoughts/ associations)*)
- How mental health crisis impacted your child at home, school, community, and relationships with your family?
- What do you think is the cause of your child's mental health crisis? (Prompts: *Was the cause of the crisis situational? Did mental health crisis escalate from some minor problem?)*
- Do you think that exposure to social media and school/peer pressure also contributed towards mental health crisis for your child?
- What led to decision to seek help for your child from the Solar crisis? (Prompts: *Where did you seek help? Did you consider any other alternatives? Did you seek any help for your child prior being admitted to the Solar Crisis service? (Prompts: What stopped you from seeking help earlier?)*)
- Did you ever hear before for the Solar or its services?
- What was your initial thoughts and feelings that you can associate with your child being referred or admitted to Solar Crisis service? (Prompts: *What were five words that popped into your mind when you found out that your child had to be admitted to mental health crisis service?)*

• Waiting time:

- How long did your child have to wait before receiving help from the Solar /Crisis service? (Prompt: *How did you feel during the period of waiting for your child to receive treatment?)*

• Engagement with the Solar Crisis service:

- What is your initial first impression after your child was admitted to the Solar Crisis service? (Prompt: *Did you think that this is appropriate place for your child and his/her needs? How did you feel as a parent for the first time being there?)*
- When, where and why did your child engage for the first time with Solar crisis?
- What is your experience as a parent/carer of initial process (Prompt: *(un)helpful process or experiences)*)
- What do you think, is there any suggestion for improving initial process for children and their parents?

• Acceptability and Pathways of the mental health provision:

- Do you think that your child received an appropriate support from the crisis team, while your child was undergoing mental health crisis? (Prompts: *What did you think about recommendations your received? What was similar or different in what you thought about your child problem and how the person you referred to assessed it? How Solar staff explained to you, your child condition?)*

- What is your child's journey through the Solar system (Prompt: *What services did you take whilst being in the Solar*)
- What is your satisfaction with help that you received for your child from the crisis team of the Solar service?

- **Sense of environment, staff and care provided:**

- Do you think that the Solar and its crisis service are better or worst environment than Hospital or A&E?
- Tell me about how it felt to be there? (Prompt: *How did you felt with staff members involved in your child's care? What is your general experience/impression of staff?*)
- How were you treated whilst being there? (Prompts: *How was your child treated? Did you felt like you were taken seriously and that you were listened? Did staff involved you in decision making with regards to treatment preferences?*)
- Did you participated in decision making with regards to treatment preferences for your child?
- Did you feel your role as a parent/carer and your knowledge was recognised and valued by the service?
- If you had any needs, were you able to communicate them and where your needs been met by the service?
- Did you receive any information or education about mental health crisis, mental health issues or problem that is related with your child mental health crisis?
- If you had any cultural or religious needs, were there recognised and/or were they dealt with sensitivity?
- How safe did you feel as parent in the Solar service? (Prompt: *How safe you think your child felt?*)
- What is your opinion on the physical environment of the service? (Prompt: *Is it making you are your child more relaxed? Is it more suitable for children and parents? How did you feel whilst spending your time in the Solar service?*)

- **(Post) Discharge experience**

- Can you describe how your child's discharge experience was?
- Did you seek any additional mental health help for your child, after your child has been discharged from the crisis service? (Prompt: *What kind of the help/services – if YES*)
- Do you think that the crisis team meet your child's mental health needs? (Prompt: *Are there still any unmet mental health needs? Are there any needs you felt weren't met, whilst being treated in the crisis service?*)
- Do you think that the Solar crisis team managed to help to develop self-management skill for your child to recognise on time signs of mental health crisis? (Prompt: *In what ways?*)
- Can you tell me, do you feel any improvement/decline in your child's mental health? Did your child experience any relapse, after being discharged from the Solar crisis service?
- How this improvement/decline impacts your child's school, college, and relationships
- Do you think that your child still needs help, despite being discharge from the Solar crisis service?
- Do you think you child would benefit from any additional help from some other service, such as peer support or mental health support worker? (Explain what peer support is or what mental health support worker is)

- **Wrap up – Final impressions:**

- Can you describe to us in detail, how much Solar crisis service help your child and whole family to overcome the crisis and build resilience?
- What is your good experience with Solar service whilst your child has been admitted to the Solar Crisis service?
- What is your bad experience that you can remember whilst your child was admitted to the Solar Crisis service?
- Is there anything you feel that Solar crisis service could done differently?
- Is there anything you would like to change or improve?
- Do you think that you gain enough of knowledge and experience to help you manage your child's future mental health crisis?

- **Ending part:**

- Is there anything you would like to add or maybe ask?

Wrapping up

The meeting will end with a brief summing up/checking back on the key issues or ideas put forward. The facilitators will explain what happens next – e.g. if there is to be follow up focus group, when some of the findings will be written up and also how to contact the research project team if they have further comments they wish to make.

- Thank you for your participation

After Interview Activity:

6. Upon completion of the interview, audio recording will be downloaded, and copies will be saved
7. Notes will be made about main points that came across.
8. Transcription
9. Data analysis.

Appendix 15: Participant payment form



Participant Voucher Form – Love2shop

For participation in the interview

Please complete this form to confirm that you would like to receive a £15 supermarket voucher for participating in the service evaluation "***A new mental health 0-19 crisis service model for children and young people, and exploration of its appropriateness, effectiveness and stakeholders' satisfaction***" (SC.06/18-19) and that you understand that voucher will be posted to you at a later date by recorded delivery.

Voucher serial number : _____

Participant name: _____

Address: _____

Signature: _____

Date: _____

The information on this form will be stored securely, confidentiality and separately to any data you have contributed to this research study.

WE NEED YOUR HELP

Children and Young people (10-19 years old) are needed

Help us with **SOLAR CRISIS SERVICE** research project and receive a £15 voucher

If you are a child or young person aged 10-19 and have recently experienced a mental health crisis and have been a user of the Solar crisis service we would like to talk to you.

We will ask about your experience of the service and general background questions about you in an interview lasting 60 - 90 minutes at Solar, at your own home or by telephone. Everything that you tell us will remain confidential.

Your feedback is essential for Solar and its crisis service to know what's working and what's not. Without your feedback, Solar won't be able to improve its services.

If you are happy to consider being involved, please let us know and we will contact you to describe the project in further detail at a time and place convenient for you. For any further questions, please contact me on below provided email or postal address.

PosterMyWall.com

Frane Vusio
Doctoral Researcher
University of Warwick

F.Vusio@warwick.ac.uk
Frane.Vusio@nhs.net

The University of Warwick
Warwick Medical School
Farmhouse, F106
Coventry CV4 7AL
United Kingdom

**PARENTS AND CARERS
STUDY PARTICIPANTS
NEEDED**

Research Project on SOLAR MENTAL HEALTH CRISIS SERVICE

The purpose of this research project is to develop a better understanding of how the Solar crisis service provides crisis support for children and young people's mental health in the 10-19 age group in Solihull.

We are particularly keen to speak to you as a parent or carer of a child/young person who has recently experienced a mental health crisis and has been a user of the Solar crisis service.

Help us to improve the Solar crisis service and receive a £15 voucher

- by participating in a one to one interview session (60-90 minutes duration)
- by expressing your opinion, experience and any suggestions that might help to improve children and young people's mental health crisis provision and their experience
- your feedback is essential for the Solar crisis service to know what's working and what's not. Without your feedback, Solar won't be able to improve its crisis provision.

Your experiences and opinions are important to us!

Interviews will be held at the Solar service., or If you wish to participate in your own home or by telephone, we will accommodate your wishes. Everything that you told us will remain confidential.

If you are happy to consider being involved, please let us know and we will contact you to describe the project in further detail at a time and place convenient for you. For any further questions, please contact me on the email or postal address below

Frane Vusio
frane.vusio@nhs.net
F.Vusio@warwick.ac.uk

The University of Warwick
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