# After the storm, Solar comes out: a new service model for children and adolescent mental health

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## Abstract:

Aims: Existing children and adolescent mental health services in the UK 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, organisational 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 prioritise 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 UK. 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 UK.

**Keywords**: community mental health, partnership model, children and young people, integrated-whole system, mental health and crisis intervention

# 1 | INTRODUCTION

There is prominent scientific recognition of the weaknesses of the current Children and adolescent mental health services (CAMHS) in the UK (Care Quality Commision, 2017; The Royal College of Nursing, 2017). Specifically, barriers to access (Brown, Rice, Rickwood, & Parker, 2016; Gulliver, Griffiths, & Christensen, 2010) and complicated pathways to care (Biddle, Donovan, Sharp, & Gunnell, 2007) are some of the main weaknesses of the current CAMHS provision. Furthermore, lack of early intervention and prevention models (Lamb & Murphy, 2013), and lack of crisis care provision have been identified as points requiring urgent transformation (Department of Health, 2015b). 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 UK (Department of Health, 2015a).

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, 2015a; Wolpert et al., 2014). Moreover, the model has been criticised 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, 2015c).

Furthermore, many CYP face difficulties transitioning from CAMHS to Adult Mental Health Services (AMHS). Most Young People (YP) transition to AMHS based on their age, rather than their need (Lamb and Murphy, 2013). Moreover, the transition between CAMHS and AMHS can have potentially detrimental consequences for YP and their mental health (Department of Health, 2015) 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 jeopardise the effectiveness of early intervention (Birchwood & Singh, 2013).

All the above problems indicate that the current traditional CAMHS provision struggles to meet the needs of CYP (House of Commons Health Committee, 2014). Consequentially, 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 UK

Potential solutions for the aforementioned problems to improve CYP mental health provision came through implementations of the Future in Mind (Department of Health, 2015b), Five Year Forward View (NHS, 2014) and the Crisis Concordat (Crisis Care Concordat, 2018) policies. These policies emphasise the importance of transformation and redesign of existing

services in the UK with a focus on early intervention, prevention, improvement of engagement with mental health providers, treatment delivery and recovery-oriented service models. Additionally, the 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). Consequentially, this led to the formation of mental health service provision to cover CYP aged 0-25 (Birchwood et al., 2018a). 14-25 (Maxwell et al., 2019) , 16-25 (Fenton, 2016) and 0-19 models have also been proposed as alternative solutions towards the transformation of the CYP mental health provision.

What is 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 need as well as prepare CYP for better transition outcomes (Alderwick & Dixon, 2019). Yet, the issue of transition at age of 25 may remain. However, in the UK, the effectiveness of the 0-25 model is still unknown and debatable as no published evidence exist of the impact of the 0-25 models on care or on the well documented challenges of the present service structure (Fusar-Poli, 2019).

Furthermore, integrated–whole system models of CYP mental health care are often described as joint ventures between primary, secondary and more specialised mental health care, that 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, that are based on early intervention and prevention of unnecessary admission to acute or inpatient settings (Wilson et al., 2018).

The main aim of this paper is to describe the structure and organisation of 'Solar', a unique and fully integrated community mental health partnership model for CYP aged 0-19 in Solihull, UK. 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 an overview of the service's strengths and limitations.

## 2.1 | Local context

The previous CAMHS service provision in Solihull, UK, utilised a 0-17 service model, facilitated by a collaboration between several providers, organised 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; the lack of early intervention and prevention, and lack of crisis resolution service(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, the Solihull council started the local transformation of CYP mental health services in cooperation with the NHS Birmingham and Solihull Mental Health Fund Trust (BSMHFT) using

'Future in Mind'(Department of Health, 2015a), and the Five-year transformation plan (Centre For Mental Health for NHS, 2016). Justification for this re-transformation was provided for a number of reasons. In 2016 it was estimated that 51,213 CYP aged 0-19 lived in the Solihull borough, and this is predicted to rise by a further 4% by 2021 (Solihull CCG, 2017). 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, Svirydzenka, & Vostanis, 2012), and therefore the existence of an effective service model for YP in the area is essential.

Nevertheless, it is also important to acknowledge that the 0-19 model was conceptualised in the context of the situation in the 2014, before the Future in Mind recommendations have been officially published. The main driver in the Solihull bourough was to move away from a CAMHS service with high thresholds to an emotional wellbeing and mental health service, with improved access, while the main focus point of this transformation was to work in partnership 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 as 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 0-19 model that is part of a community based mental health service as a response to both national policy and local needs. An additional rationale behind choosing a 0-19 model was also 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 the better engagement of CYP with the 0-19 model.

## 3| Structure and Organisation 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 prioritising 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'. Besides the name, YP service involvement played a pivotal role in the service organisation 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 recognised 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 publications, such as "*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 from feedback from CYP and their families. For example, the Solar service is actively engaged in the annual "You in mind" conference that aims to gain feedback from CYP and their families about what needs to be improved with the Solar service. Even today, the involvement of CYP in co-production is an essential part of the model and its evolution.

### 3.2 | Organisation 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 the Children's Charity Barnardo's. 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 the mental health crises while being one of the few crisis teams in the UK that operates within 0-19 age bracket. The crisis team is a new initiative from the 0-19 model and is a component that is currently subject to further evaluation. 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 both CYP and parents. All three partners staff 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 coherent organisation 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, 2015b).

This organisational 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 organisations 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 "Did Not Attend" (DNA) rates for appointments.

### 3.3 | Solar – No Tiers service

Since the Solar service was re-commissioned, 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, 2017). The SPOA has allowed CYP to not only be referred by others, but has also allowed them to self-refer, 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 eliminated 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 appointment, therefore reducing DNA's. One single point enables the assessment provided by the multi-disciplinary team. This also provides an opportunity to involve CYP and their parents in shared decision making about the level of need and suitability of treatments

A positive aspect of this model is its flexibility with signposting CYP who display higher risk or fluctuating needs between different parts of the model (Solihull CCG, 2018).

Furthermore, to achieve short waiting times, Solar utilises the Choice and Partnership model (CAPA), which is 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). CAPA 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). Solar recognises this by using one clinical record and a single care plan stored in a centralised 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 2014-2015 (figure 2).

### 3.4 | Journey through the 'Solar system'

Referral and Screening:
A request to access the service for CYP can be initiated via their GP, education or health

provider, parent/carer, or through self-referral. New referrals into the service are screened daily by a multi-disciplinary team of senior clinicians.

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 for the next 6-8 weeks. Alternatively, CYP are signposted to specialist pathways or redirected for partnership treatment within the 0-19 model or to external organisations.

Assessment:
In cases when needs are more complex, a full assessment is offered. A full assessment is completed within six 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.

Treatment:
Based on the assessment outcomes, a follow-up appointment can be arranged where CYP work with clinicians collaboratively to create a personalised care plan that will be tailored to encompass specific individual needs. This plan reflects all the goals that both the service and CYP agreed to achieve together to achieve full recovery. Treatment can occur in an individual, group or systemic family therapy. Substance misuse issues are dealt within the team using a harm-reduction model[1].

Transitioning:
When CYP are ready to leave the service, the Solar service works with YP to make the discharge process as smooth as possible. Solar liaises with AMHS, while 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 CYP to transition to AMHS based primarily on their individual needs rather than their age.However, we belive that transition as such is still not effective and in need of improvement; this will be addressed in the evaluation.

Outreach:
The recent introduction of the Solaris - Mental Health Support Teams (MHST) develop the 0-19 model's partnerships to encompass local school communities. The Solaris works together

[1] Harm-reduction is all encompassing term for interventions that aim to reduce the problematic effects of behaviours (Logan & Marlatt, 2010).

with schools to develop whole-school approaches aimed to develop resilience, while identifying CYP early who have emerging mental health and emtional wellbeing needs(NHS Solihull Clinical Commissioning Group, 2019) as recommended by the UK government (Department of Health and & Department of Education, 2018). 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 therapies for anxiety or low mood, group therapies such as CBT for CYP and parents, and group parenting support. Similar projects with GP practices are also being trialed.

### 3.5| The Solar community crisis resolution team

Both the Crisis Concordat and Future in Mind highlighted the importance of CYP receiving timely and adequate support when experiencing mental health crisis (Department of Health, 2015a; Department of Health and Concordat signatories & Signatories, 2014a). This also includes the provision of out-of-hours mental health services that provide rapid and comprehensive assessments of CYP in mental health crisis team (Department of Health, 2015b). Although the 0-19 crisis team currently operates seven days a week from 8 am to 8 pm (Solihull Council and CCG, 2017, 2018), a separate out-of-hours service is also offered in cooperation with the neighbouring 0-25 service (Solihull CCG, 2018; Solihull Council, 2017).

Under both the pre-existing daytime crisis service and the out-of-hours coverage, CYP experiencing mental health crisis are triaged within one hour of referral, while an assessment is completed within four hours, as recommended by Crisis Concordat (Department of Health and Concordat signatories & Signatories, 2014b). 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 treatment services, community treatment in the CYP educational settings, 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 stabilised and discharged from the crisis team.

## 4| Discussion

In this article, we have described a newly formed and flexible 0-19, whole integrated model that works in partnership with both statutory and voluntary sectors to provide early intervention, prevention and recovery for CYP aged 0-19. The presented model is just one of many newly created or retransformed service models worldwide that aim to improve service access, CYP outcomes, and improve the transitional experience between CAMHS and AMHS (Malla et al., 2016; P. McGorry, Bates, & Birchwood, 2013). For example, most established models in the world covering age ranges between 12 and 25, such as Jigsaw in Ireland (O'Keeffe, O'Reilly, O'Brien, Buckley, & Illback, 2015) or Australian Headspace (McGorry et al., 2014; McGorry & Mei, 2018). Both models have shown some evidence of accessibility and effectiveness of their community-based services (Hilferty et al., 2015; O'Keeffe 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). This model has a many common features, targeted to meet the needs of CYP up to the age of 19, with the possibility of extending provision up to age 21 with transition to AMHS if needed.

However, in the UK, the service re-provision includes 0-18 for traditional CAMHS services, and the recently transformed 14-25 (Maxwell et al., 2019) and 16-25 models (Fenton, 2016). As Fusar-Poli (2019) noted, these retransformed models still require a demonstration of feasibility and impact (Fusar-Poli, 2019), and we believe thay can best be regarded as 'hypotheses' concerning the ideal structure that can solve the problems of current CAMHS/AMHS model and at the same time improve early access. Thus this status of hypothesis also applies to the Solar 0-19 model.

Furthermore, most transformations of existing 0-18 models of the service provision for CYP is moving towards the direction of 0-25 models, both in the UK and worldwide (Fusar-Poli, 2019) The benefits of 0-25 models are clear as these models may improve access, patients outcomes and satisfaction with care (Fusar-Poli, 2019). However, no evidence supports that 0-25 models are the solution for the aforementioned problems with CYP mental health service provision in the UK. The best example to support this is the service evaluation of Forward Thinking Birmingham (FTB) 0-25 model, which concluded that there are a range of concerns with regards to FTB staff levels, the capacity of the service to meet demand, long waiting times, overwhelming caseloads and poor service infrastructure (Birchwood et al., 2018b). Similarly, Fusar-Poli agrees that there is still a lack of evidence to demonstrate the effectiveness and impact of 0-25 care models (Fusar-Poli, 2019).

Additionally, Fusar-Poli (2019) argued that there are no standards and no single example that can stand out as the best evidence practice model. Similarly, it is crucial to acknowledge that the 0-19 model in comparison to other well established retransformed models, still lacks high-quality pragmatic evidence from randomised control trials (Cleverley, Rowland, Bennett, Jeffs, & Gore, 2018). However, the 0-19 model and its crisis team are currently undergoing a service evaluation that aims to assess the impact of the model on the community, as well as its accessibility, acceptability and stakeholder satisfaction.

Regarding the transition from CAMHS to AMHS, it is evident that the 0-19 model has the same transitional issues as many other well-established models worldwide (Nguyen et al., 2017). These issues stem predominantly from a visible absence of standards and models of care that inform research, service provision designs and its delivery for CYP who transition between two providers (Nguyen et al., 2017). It is interesting to observe that since the TRACK study by Singh et al. (2010) identified these transitional issues, there are still no accepted models that can best address the problems highlighted by this study that can serve as an example of best evidence practice (Fusar-Poli, 2019; Hetrick et al., 2017).

Furthermore, the growing evidence points out that youth-friendly services should focus on early intervention and prevention community models that target both children, adolescent and young people (Fusar-Poli, 2019). A similar perception was shared in a review paper that emphasised early intervention as a fundamental part of healthcare aimed towards detection and treatment before the escalation of CYP adverse mental health (McGorry & Mei, 2018).

Similarly, the 0-19 model shares the same approach towards not just providing early intervention but also offering a youth-friendly mental health service that enables CYP to access PMHS, CAMHS and crisis support under the same roof. This integrative approach prevents further referrals to other services and reduces waiting times for CYP.

Moreover, the partnership between statutory and voluntary sectors has the potential to bring a range of different professions, skills and experiences that can be used to improve CYP pathway of care, treatment and overall satisfaction with the service provision. Besides, these organisations can complement each other by creating more recovery orientated approaches, innovative treatments and support alternatives, and empower CYP to take active control of their mental health (Newbigging, Mohan, Rees, Harlock, & Davis, 2017). This is in line with the Crisis Concordant's (Crisis Care Concordat, 2018) recommendations, which supports joint collaborative partnerships between voluntary and statutory organisations to produce more efficient mental health and crisis pathways that meet the needs of CYP.

However, as with every model in the mental health system, the 0-19 model has its own set of challenges such as high referral rates, long waiting lists, and staff shortages, which add additional pressures to the model. In the case of transitions, the 0-19 model also acknowledges that there are still issues that may act as barriers to sucessful transitions, which may reduce their effectivness. For example, there are different thresholds to access AMHS than for CYP mental health services, which creates potential barriers to access AMHS. The current ongoing evaluation of the 0-19 model will investigate its accessibility, acceptability and efficiency, and how it contributes towards the resolution of problems with CAMHS provision in the UK. In the supplementary document section the service evaluation and research protocol links are provided for futher information about the service evaluation of the 0-19 model.

## 5| SUMMARY AND CONCLUSION

In summary, we have described a new 0-19 service transformation model that is an integrated, whole-system model that works in partnership between statutory and voluntary sectors. This joint partnership between CAMHS, Barnardo's and Autism West Midlands 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 services, home treatments, and a variety of support services to CYP aged 0-19 in a less restrictive and community-based environment. While 0-19 model has its own set of challenges, it nevertheless addresses some of the numerous issues with the current CAMHS provision in the UK

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## 6| Supplementary information:

Link 1 (Service Evaluation Protocol) - http://wrap.warwick.ac.uk/134490/

Vusio, Frane, Birchwood, Max and Thompson, Andrew D. (2018) *Solar (0-19 model) service evaluation protocol - A new mental health 0-19 crisis service model for Children and Young People (CYP), an exploration of its appropriateness, effectiveness and stakeholders' satisfaction.* Coventry: University of Warwick. (Unpublished)

Link 2 (Research Protocol) - http://wrap.warwick.ac.uk/134489/

Vusio, Frane, Birchwood, M. J. and Thompson, Andrew D. (2019) *Research Protocol - 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.* The University of Warwick: University of Warwick. (Unpublished)

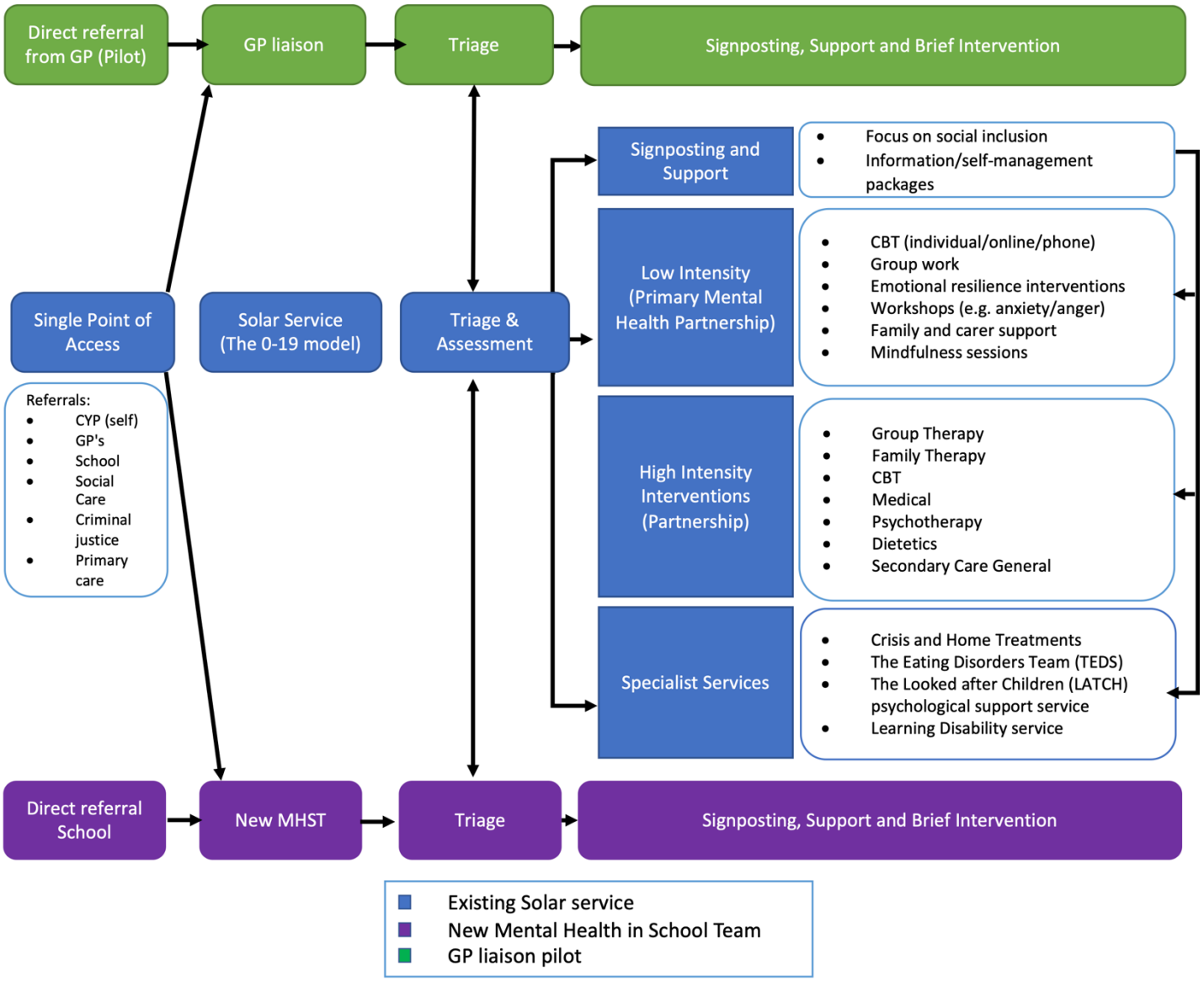


*Figure 1 - Solar (the 0-19 model's) pathways*

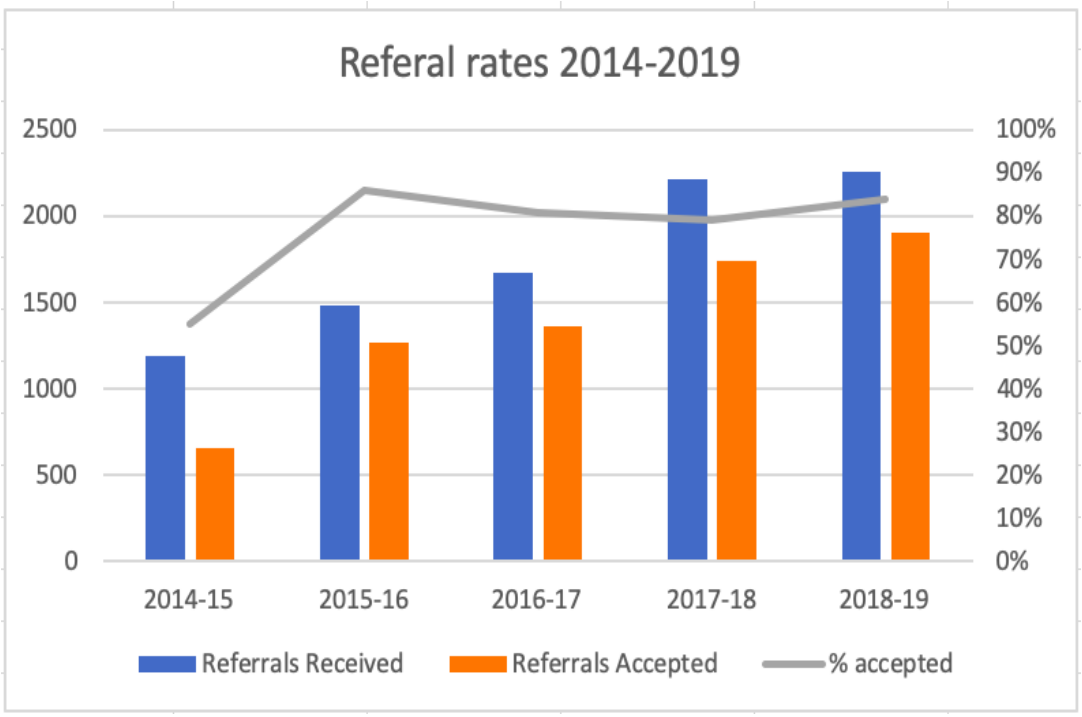


*Figure 2 - Referrals rates of the 0-19 model by academic year (01 September – 31 August) between 2015 and 2019 compared to the previous service (2014-2015)*