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

Frane Vusio[1] | Andrew Thompson[1] | Liam Laughton[2] | Max Birchwood[1]

[1]Warwick Medical School, University of Warwick, Coventry, UK

[2]Solar Service, Bishop Wilson Clinic, Craig Croft, Chelmsley Wood, UK

**Correspondence**
Frane Vusio, Warwick Medical School, University of Warwick, Coventry CV4 7AL, UK.
Email: f.vusio@warwick.ac.uk, frane.vusio@gmail.com

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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

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, Svirydzenka, & 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
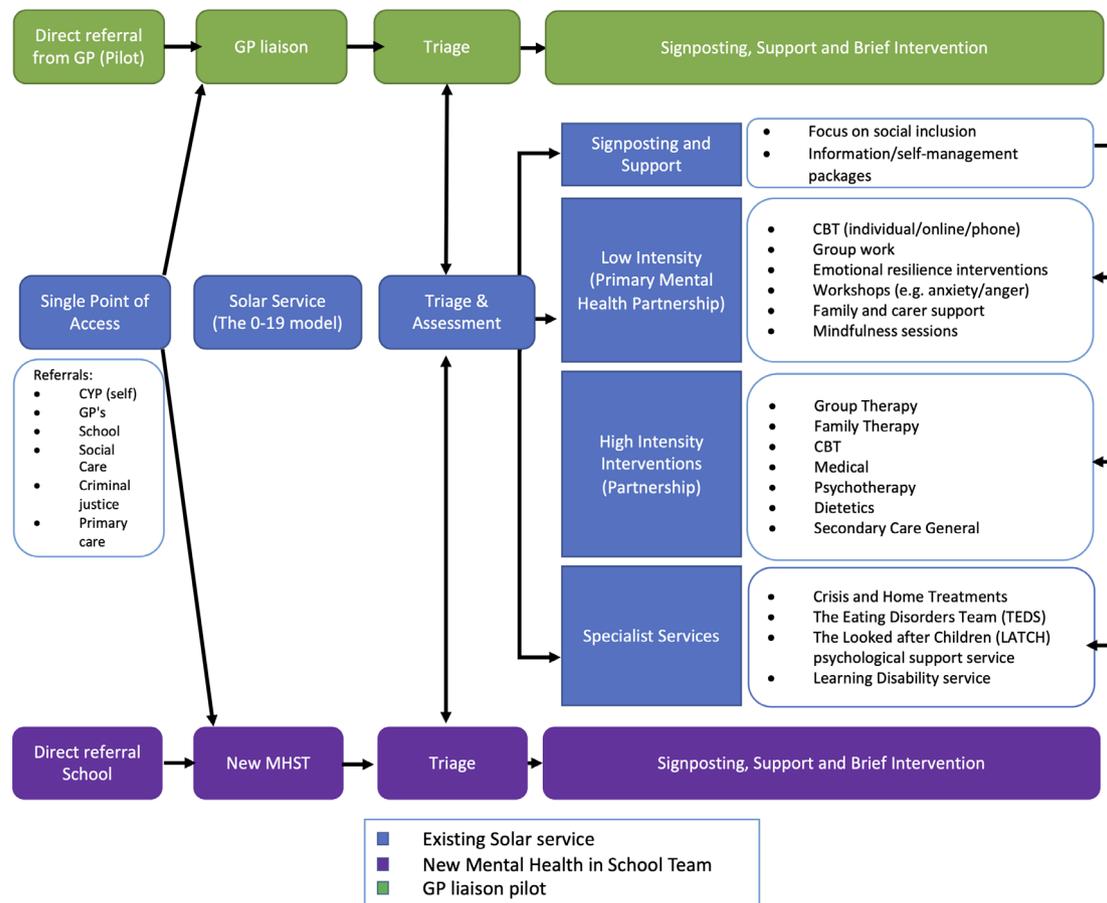
**FIGURE 1** Solar (the 0-19 model's) pathways

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 model[2] (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)



Solar referral rates 2014-2019

Legend: ■ Referrals Received  ■ Referrals Accepted  — % accepted
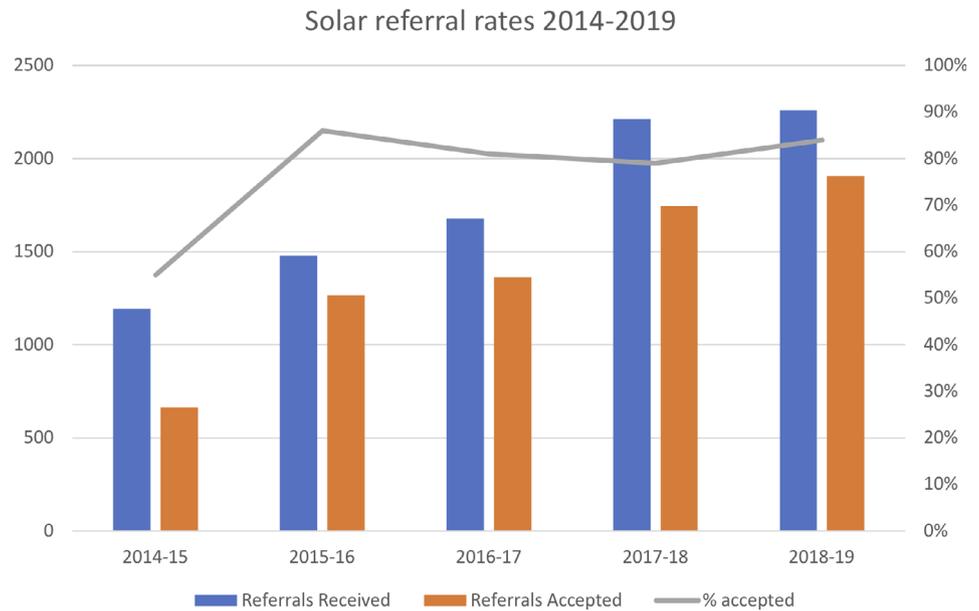
### 3.4.3 | Assessment

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 Solaris[4] 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 the 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'Keeffe, 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'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). 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.

## DATA AVAILABILITY STATEMENT
Data available in article supplementary material.

## ORCID
*Frane Vusio* https://orcid.org/0000-0002-4965-0472

## ENDNOTES
[1] Children's charitable voluntary organization.

[2] 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).

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

[4] Solaris 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.