

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	C11/S/b
Service	Child and Adolescent Low Secure
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Secure adolescent in-patient mental health provision represents a highly specialist resource which should be considered to form part of a range of universal, specialist and highly specialist services for children and young people in England. Such services should include those provided not only by health but also children's social care, education, the youth justice system and other agencies. Within the context of mental health provision for children and young people, secure in-patient care should form part of a clearly defined and coordinated care-pathway which minimises the need for changes of location but ensures that transitions for young people between such settings and other community or residential environments (or vice versa) are adequately supported and provided for. Providers of secure in-patient care should be coordinated nationally to ensure equity of access and provision for young people irrespective of their geographical location or other circumstances.

There are four security levels currently available within in-patient mental health care in England to allow management of different levels of risk presented by young people under 18: medium security, low security, psychiatric intensive care (PICU) and 'open' units (also known as 'Tier 4' units). The first three of these types of setting are known as 'secure in-patient units'.

All secure child and adolescent facilities provide a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of individual young people, other patients, staff and the general public:

- Medium secure settings accommodate young people with mental and neurodevelopmental disorders who present with the highest levels of risk of harm to others including those who have committed grave crimes. In such settings there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium security generally have significant lengths of

stay from months to years.

- Low secure settings accommodate young people with mental and neurodevelopmental disorders at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low secure settings generally require significant lengths of stay from months to years.
- Psychiatric intensive care units (PICU) for young people allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit. Levels of physical, relational and procedural security should be similar to those in low security but there would be fewer facilities (e.g. educational and recreational settings) to support a young person over a sustained period of time as is the case within medium and low secure units

The decision to admit to any secure service will need to be based on a comprehensive risk assessment and detailed consideration as to how identified risks can be managed safely within adolescent secure in-patient settings. The majority of young people admitted to secure services are either in contact with the welfare care system and/or the criminal justice system and may be in the middle of complex civil court matters or charged with or convicted of criminal offences. Adolescent medium and low secure services play a significant key role in assessing an individual's ability to participate in court (civil and/or criminal) proceedings and provide important advice to courts regarding welfare pathways and specific criminal court matters in respect of young people and their families.

This service specification relates specifically to adolescent low secure mental health services for young people up until the age of 18 years with mental disorders including neurodevelopmental disorders and conduct disorders (henceforth referred to in this document as "mental disorders").

1.2 Prevalence

The population of England from the mid-2012 census published by the Office for National Statistics was 53,493,700 and the number of 10-18 year olds was 5,617,300.

NHS England commission a range of secure adolescent beds via the 10 Mental Health Hubs responsible for the direct commissioning of specialised mental health services. The spectrum of secure adolescent beds commissioned includes adolescent psychiatric intensive care (PICU), adolescent low secure services, and medium secure provision. There are currently 100 medium secure in-patient beds (almost all with NHS providers) and approximately 230 other secure beds, the majority of which are low secure and largely with non NHS providers.

1.3 National Policy

Secure mental health in-patient services are currently provided by a range of NHS and independent sector providers.

Since 1 April 2013, in addition to medium secure provision, adolescent low secure and PICU services have been commissioned directly by NHS England as Tier 4 CAMHS specialised services through the 10 Area Teams responsible for the direct commissioning of specialised mental health services. There is no current national clinical network of providers of low secure care for young people (as exists for medium secure provision) and no clearly defined care pathway for linking such provision with the full range of mental health and other provision for

children and young people.

Future in Mind (2015) emphasised the need for ‘improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible’. This includes ‘implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care ‘however, there is a recognition that there will always be some children and young people who require more intensive and specialised inpatient care. ‘The key to commissioning the right type of care, in the right places is to adopt a whole system commissioning perspective.....this should address the role of pre-crisis, crisis and ‘step-down’ services alongside inpatient provision.’. ¹

Another key national is NHS England’s Five Year Forward View for Mental Health², it sets out priorities for children and adolescents’ mental health. An associated implementation plan has been published.³

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

The service is required to monitor clinical outcomes. As a minimum the service will use outcome measures as indicated in QNIC ROM, including:

1. Clinical measures
SDQ (self-report, parent/carer and teacher),
HoNOS-CA,
HoNOS-Sec and CGAS.

These measures will be collected on admission, every six months and at discharge. These outcome measures will be reported on both a national and individual service basis.

2. Education providers will provide the following data:
English and Maths attainment level on entry and discharge using points values
A measure of wider progress and wellbeing in education, in addition to academic progress, to be completed each academic term, such as the Every Child Matters Teacher and Student Assessment. This measure should be agreed and implemented by all units

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

² <https://www.england.nhs.uk/mentalhealth/taskforce/>

³ <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

in the low secure network.

3. Parent / carer and young person feedback

On young people and carer's experience of the service will be routinely sought as described in section 3.2. The means by which this feedback is collected should be agreed and implemented by all units in the low secure network.

Services will be required to submit evidence of achievement of outcome measures as defined in the standard contract. This will include the measures as outlined above plus additional measures that will be reviewed annually.

3. Scope

3.1 Aims and objectives of service

The core objectives for adolescent low secure mental health services are to:

- Assess and treat mental disorder; reduce the risk of harm a young person poses to self and others; support recovery; promote adolescent developmental tasks and aid rehabilitation.
- Operate as a clinical managed network that supports:
 - a coordinated single referral and admission pathway into individual settings and across the network
 - a coordinated response that evidences equity of provision for the population of England.
- Provide multi-disciplinary teams which are experienced in both adolescent forensic and child mental health. These teams should also have highly developed liaison skills with an extensive understanding of statutory frameworks and services available for young people with complex needs outside of in-patient provision.
- Provide a range of specialist treatment programmes delivered either individually or within groups with the aim of safely reintegrating the young person into the community or other secure or specialist provision.
- Provide an exemplary comprehensive service for all eligible referred young people with mental disorders who present a significant risk to others and/or themselves in secure care.
- Provide expert multidisciplinary assessments, diagnosis, management and treatment of mental disorder.
- Provide expert multi professional assessments of the link in the young person between their mental disorder and their high risk behaviours.
- Operate within a robust clinical governance framework that promotes multi-disciplinary working and the care programme approach (CPA) process.
- Provide an individualised, developmentally-appropriate framework of care that provides for the needs of young people and their families.
- Provide care in a psychologically informed environment in which every interaction has the potential for therapeutic value
- Provide high quality information for patients, families and carers in appropriate and accessible formats and media and ensure that all efforts are made to establish good collaborative working relationships with parents/carers and those with parental responsibility for the young person.
- Ensure the development of good relationships with adult mental health and other services for adults to ensure timely and planned transition to such services when a young person reaches the age of 18.

3.2 Service description/care pathway

It is expected that all young people will be treated and managed within a whole care pathway approach where services work collaboratively with each other in order to ensure that admission and transfer within the secure pathways and beyond are achieved seamlessly and efficiently. The pathway through care should, therefore, be identified early in admission but may be subject to change depending on developing needs and circumstances.

Child and adolescent low secure mental health services provide care and treatment to a variety of young people but the predominant need for care and treatment in conditions of low security will be related to the young person's assessed risk of harm to self and/ or others in the context of their mental disorder. The four recognised pathways into adolescent low secure services are:

- Stepping down from the NSFMHSYP (medium secure).
- Direct admission through a criminal court process or from youth justice custodial settings. Such admissions should be subject to an "access assessment" from the medium secure clinical network (NSFMHSfYP).
- Admission from a PICU; from the community or a non-secure adolescent in-patient unit.
- Admissions from special education and welfare settings, including welfare secure units.

Multi-disciplinary working and the Care Programme Approach (CPA) process will underpin service delivery and the service will need to provide the following:

- Admission under the provisions of the Mental Health Act 1983.
- care in line with welfare principles from the Children Act 1989 and the 2015 Code of Practice to the Mental Health Act.
- Young person-centred individualised evidence-based treatment packages, based upon assessment of need and risk.
- Care that involves young people and their families or carers from the beginning of the care pathway.
- Physical and mental health care that meets the needs of young people.
- Admission under the provisions of the Mental Health Act 1983 (as amended).
- Adherence to the Care Programme Approach in accordance with best practice guidance; involving patient, referrers, family, carers and other relevant stakeholders.
- Comprehensive risk assessment and management.
- An extensive range of therapeutic, educational, occupational and recreational opportunities.
- A secure environment where patients can address their problems in safety and with dignity.
- On-going assessment, which meets the needs of patients through their transition to discharge.
- A multidisciplinary approach to the provision of patient care.
- Effective, safe, and timely discharge.
- Specialist professional advice to referrers and other agencies.
- The provision of appropriate educational services in line with OFSTED statutory requirements and demonstrating particular attention to the needs of this group of young people.
- The provision of activity programmes during periods where education is not provided with a minimum of 25 hours of meaningful activities per week.

In addition, the competencies that are particularly needed to meet the needs of young people with a range of complex behaviours are:

- A comprehensive multi-disciplinary team (MDT) with a "core team" of expert psychiatry, psychology (including clinical and forensic competencies), social work, occupational therapy, education and nursing professionals. Services should ensure appropriate access

to other necessary disciplines (such as speech and language therapy, family therapy etc.).

- Units should work to a therapeutic model based on the principles of child development and attachment that acknowledges the importance of relationships and the key role of primary caregivers as agents of change. The model informs the work of the multidisciplinary team and is an underpinning principle of the nursing workforce in maintaining a safe, therapeutic and developmentally appropriate culture within the unit.
- A comprehensive multidisciplinary assessment of a young person and their wider support network will be undertaken. A structured clinical judgement approach to clinical risk assessment and management will be adopted, and reviewed at regular intervals. The assessment will inform an individual formulation including risks and protective factors which will be clearly recorded and shared by the team, the young person and their wider system.
- The therapeutic regime should be able to deliver effectively a variety of psychological interventions at an individual and group level and deliver interventions addressing interpersonal relationships, problem solving, affect regulation, mental health in line with the clinical formulation. The interventions should be flexible and responsive to the needs of the young people. The units will also provide a spectrum of offender-related interventions commensurate with high risk presentations.
- The therapeutic milieu should be comfortable with a psychological understanding of formulations. It should have a capacity to effectively deliver interventions for protracted periods of time and should show a level of resilience capable of dealing effectively with chronic challenging young people with past significant adversity. It should also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients.
- Interventions should draw from the available evidence base, whilst recognising the limits of this evidence for the complex client group. When working outside the evidence base, innovative interventions should be theoretically sound and robustly evaluated and should evidence clinical outcomes and young person and carer satisfaction

Individual services will provide an environment which meets best practice for safety, welfare and security and demonstrates a robust approach to risk assessment and management embedded in the culture of the individual adolescent low secure service and the clinical network.

Individual services as part of the national clinical network will be required to complete regular audits throughout an annual cycle demonstrating the degree to which security within the unit is maintained and reviewed. The clinical network will then report annually to NHS England.

Individual services are expected to review all serious incidents and carry out root cause analysis of serious incidents and near misses so that learning can be disseminated through the national network internal security review meetings.

Robust governance arrangements need to be in place with regard to communication and information governance and all communication should aim to allow the young person access to information about their care in a way that is meaningful for them and enables the provision of feedback about their care.

Information should be given to the young person and their family or carers about the unit they are referred to prior to admission and all information and feedback from service users should contribute towards future service development.

Individual services, in line with national network recommendations, are expected to ensure that robust systems are put in place to gather patient, family and stakeholder organisation feedback. This should be gathered by a variety of means and include feedback mechanisms that are independent from the service. This should include:

- o social groups in wards;
- o therapeutic intervention programmes;
- o discharge questionnaires;
- o patient's self-reports on care and treatment;
- o advocacy support groups;
- o discussion with families and
- o consultation with referrers, commissioners and other stakeholders

The above is not meant to be an exhaustive list of feedback systems but rather the minimum necessary. There should be clear evidence of how the service has acted on feedback to improve patient, family and stakeholder experiences.

Age-appropriate independent advocacy (including independent mental health advocacy) services are to be provided through sub-contractual arrangements. Advocacy services are required to complete regular activity reports on service provision through service review meetings highlighting young people's feedback and any areas requiring action.

Individual services, in line with the national network, should have clear processes that proactively consider safeguarding issues both on an individual patient basis and also that allow for the management of any patient interaction difficulties. This should include evidence of appropriate (Level 3) safeguarding children training for all frontline staff, and dedicated input from a social worker. Each unit should have an identified safeguarding lead within the service who will be a senior point of contact in relation to any safeguarding concerns and who can liaise beyond the unit as necessary with regard to such matters.

Care Pathway

The service on a national basis will provide safe, effective and coordinated clinical care across the different stages of a clearly defined care pathway. The involvement from local/catchment area services in the young person's care and treatment, throughout the admission and transfer/discharge, is essential. This must be maintained through effective communication and involvement in clinical reviews via an identified care coordinator from the young person's home area and an identified social worker in line with s.117 requirements. There should be close communication between the local care coordinator and local commissioners and case managers. Other important local/catchment area services may include: adult mental health, youth offending / probation teams, education, and third sector organisations.

Referral

Young people will normally be expected to be referred to low secure services from the following sources:

- o Adolescent medium secure inpatient services (NSFMHfYP)
- o Inpatient Tier 4 provision ('open' adolescent units and PICUs)
- o Youth Justice System (from courts or transfer from Young Offender Institutions (YOI's), Secure Training Centres (STC's) or Secure Children's Homes (SCH))
- o Secure children's homes where the young person is detained on welfare grounds
- o Other adolescent low secure in-patient services

On occasions young people may be referred from other sources:

- o Community child and adolescent mental health services (including adolescent assertive outreach services, early intervention in psychosis services and community child and adolescent forensic teams)

- Residential care settings (including children's homes and specialist educational placements) via senior child and adolescent mental health professionals;

In general consideration for low secure provision will be undertaken by or in agreement with the team responsible for Tier 4 in-patient and PICU care within the child's home area; other teams such as community adolescent forensic teams may also be involved in this process and in some areas may be used as a consultative reference point for other clinicians and services. This process will be in accordance with established local provider pathway arrangements. All referrals will need to be supported by the specialised commissioning team for the NHS England division from which the young person originates.

Referrals (using NHSE Access Forms 1 and 2) from youth justice settings (courts and custodial units) should be directed to clinicians within the medium secure network (via the medium secure unit closest to the young person's home area who will consider the information available and determine the probable level of security required. Prior to making the referral, the referrer should have informed the NHS England commissioner for the young person's home area and also have discussed the case with a consultant psychiatrist in the medium secure network. Appropriate assessment will then be organised, if necessary in conjunction with the low secure network.

Other referrals should be made to the coordinators of the national low secure clinical network. Referrals should be made via the NHS England CAMHS Inpatient National Referral Forms, Referral will be allocated to a specific unit for assessment. This allocation will be made based on available treatment, geography, and current capacity to admit.

The low secure network cannot cover the country for acute psychiatric emergencies. However, services are often able to provide a rapid response (within days) to help contribute to the assessment and management of imminent risks of harm to others or self as relevant to young people who present with mental health concerns.

Low secure services should facilitate early discussion of potential referrals, and encourage clinicians to make contact to discuss cases prior to referral.

Initial Assessment

Admission to low secure in-patient settings must be carefully considered by both referrer and staff within the low secure service and assessment by both parties, if possible jointly. Admissions are not intended to take place as emergencies although a prompt response (within 5 days) should be provided by the assessing unit when cases are identified as particularly urgent. Repeated assessments for the same young person in relation to a single referral must be avoided and the clinical network must ensure that arrangements are in place to prevent this. If a young person with a significant forensic history (serious interpersonal violence, fire setting and/or significant sexual offences) is placed in a low secure unit, then consideration is needed to ensure that the current patient group will not be put at risk.

Initial assessment will be carried out by members of the multidisciplinary team (to include a senior psychiatrist) from the low secure service. Any decision to admit a young person should include input from a consultant psychiatrist (if they have not been directly involved in the assessment) who will be responsible for the young person's care. Any assessment should include the active involvement of a young person's family or carers. All low secure services are required to give information about available treatments and facilities to the young person, parents, carers and others with parental responsibility prior to admission.

c. Pre-admission

The referrer will be informed by a senior clinician (usually a consultant psychiatrist) as to whether

the young person fulfils criteria for admission within a day of any decision being made. This communication will be undertaken verbally initially and followed by a full written multidisciplinary report. Arrangements for admission will be jointly agreed by the referring agency and the low secure service with particular focus on nursing handover. The admitting low secure service should also inform the young person, parents (and others with parental responsibility), carers, social care, relevant CAMHS clinicians, and commissioners that the young person has been accepted for admission. All should also be kept updated regarding timescales for admission. If the young person does not meet criteria for admission advice on alternative provision and management options will be offered.

d. During admission

There is some degree of overlap between admission criteria for adolescent medium secure, low secure and PICU services. This should be borne in mind by clinical teams following an admission to a low secure setting and at each case review consideration should be specifically given as to whether the young person is appropriately placed. Such consideration should take into account the principle of offering the young person 'the least restrictive option' in terms of their care.

Each adolescent low secure mental health service will operate 24 hours a day, 365 days per year and will provide care that meets the following standards in delivering service:

- Each young person will have their own bedroom.
- Each young person will have a Responsible Clinician.
- The nursing model of care will be based on the 'primary nurse' model, where every patient will have a named nurse who will be responsible for their day to day nursing needs. The patient will also have a Care Coordinator allocated within the low secure service, who will co-ordinate the care for the individual within the Care Programme Approach (CPA) framework.
- The overall model of care will be through a Multi-Disciplinary Team (MDT) approach consisting of psychiatrists, psychologists, occupational therapists, social workers and nurses, in accordance with standards and guidelines outlined by the Quality Network for Inpatient Care (QNIC).
- Each patient will:
 - Be reviewed by the MDT at least weekly.
 - Have a comprehensive up to date MDT care plan and risk assessment developed by the MDT collaboratively with the young person and, if appropriate, their family in accordance with best practice guidance.
 - Have a named practitioner psychologist who will undertake needs based assessment and contribute to a multidisciplinary risk assessment to develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual or group basis
 - Have a named occupational therapist who will undertake a full occupational therapy assessment and will deliver an appropriate programme.
 - Speech and language assessment may be required and where this is not provided 'within house', there should be defined agreements to ensure this can be accessed in a timely fashion during the course of the young person's admission.
 - Have a named social worker within the unit who will liaise with the young person's local Social Care Children's Services to ensure the provision of a full social care service to the patient, family and carers.
 - Have access to the Independent Mental Health Advocates (IMHA) and, where

applicable, Independent Mental Capacity Advocates (IMCA), who will assist by undertaking the direct advocate's role.

- o Receive three culturally appropriate meals per day. The food will be prepared in accordance with NHS National guidelines on nutrition and variety.
- o Have their religious and cultural needs met.
- o Have their rights under the Mental Health Act 1983 explained.
- o Have their physical healthcare needs met through a full range of primary healthcare and dental interventions that include health promotion and physical health screens.

Young people will be provided with a structured day including a minimum of 25 hours per week of structured activity across three domains:

- o Leisure:
Developmentally appropriate and specifically care planned activities provided on and off the ward such as, art, drama, dance, music, gym, sports and group games.
- o Education:
All young people are expected to participate in educational studies to improve their educational attainment. Young people should have education provided in accordance with the National Curriculum.

The provider will liaise with partners to make sure recommendations of Care and Treatment Reviews are undertaken and must ensure that educational needs continue to be met. Where practicable, when a child or young person has a Education Health and Care plan, or Statement of Special Educational Need (where this has not yet been converted) or is receiving SEN support, the provider will ensure that the child or young person continues to access the education and support specified within their plan. This may sometimes require a review or revision of the plan.

- o Therapeutic Interventions:
 - Formal assessment and monitoring of mental state;
 - Assessment of clinical risks and development of management plans;
 - Management of physical health care;
 - Prescribing and monitoring of drugs and their side effects in line with NICE guidance;
 - A broad range of psychological interventions (which may be delivered at an individual, group and systems level). These interventions should be sequenced according to need and readiness, and delivered within a developmentally sensitive framework.
 - Offence specific therapeutic interventions (which may include programmes for sex offending, fire setting, aggression reduction) if indicated by the assessment of risk and need;
 - Occupational therapy;
 - Health promotion (physical and mental health) and relapse prevention;
 - Vocational work activities as appropriate.
 - Other therapeutic interventions that may include family therapy, music therapy and art therapy.
 - Graded programme of section 17 leave (where appropriate).

Care planning and CPA

- Young people should have a comprehensive care plan and risk assessment developed by the MDT collaboratively with the young person and, if appropriate, their family in accordance with best practice guidance.
- All care planning should follow a recovery and outcome process, should be embedded in the Care Programme Approach (CPA) and form the cornerstone of delivery of an effective care pathway through secure care.

Linking with other processes

- Patients should have a designated commissioner in line with responsible commissioner guidelines. Low secure services should support case management from NHS England case managers.
- All patients should have a community Care Coordinator linked to community CAMHS team local to the patient's home area who will remain updated throughout the admission period and is expected to remain involved with the young person's care.
- For restricted patients, adolescent low secure services will need to ensure compliance with the Ministry of Justice requirements.
- For young people who are subject to input from the Youth Justice Services, reviews of orders including remand reviews should be facilitated and may be undertaken jointly with CPA reviews.
- For young people in the care of local authorities, Looked After Children (LAC) Reviews must be facilitated and may be undertaken jointly with CPA reviews.

Considerations in secure care pathway planning

Care pathway planning should always involve balancing the relevant needs of the young person, including:

- The immediate risk posed by the young person to themselves and/ or others
- Ministry of Justice or court-ordered restrictions
- Specialist treatment needs which cannot be met in lower security settings
- The Mental Health Act 1983 (as amended 2007) principle of least restrictiveness
- The young person's vulnerabilities, including potential destabilisation by multiple transitions
- Placement stability and continuity of care the young person's and their family's needs including access to and proximity to home and ease of access to family

In planning future care pathways there should be active consideration of balancing the principles of management in the least restrictive environment and reducing transitions for young people. On occasions, where it can be clearly demonstrated that it is in the best interest of the young person, it may be more appropriate in the context of their longer term future care pathway, for a patient to continue to receive treatment in a low secure service rather than experience transition to a short-term less secure placement.

Discharge

The discharge / transfer of a young person from low secure inpatient care will be dictated by the nature of their mental health difficulties, their risk profile, and their identified needs.

All young people should be supported in taking an active role in their discharge planning.

Recognised discharge routes include discharge / transfer to the following settings:

- Adult secure or non-secure inpatient services, including rehab services

- Adolescent 'Tier 4' non-secure inpatient services
- Community mental health services (community CAMHS or adult CMHT)
- Social care residential settings, including secure welfare placements
- Specialist educational settings
- Family home
- Supported living or other community placement
- Custodial placements (Young Offender Institution, Secure Training Centre, Secure Children's Homes, adult prisons)

Services are required to actively involve the catchment area services from the patient's home area and ensure that they honour their statutory responsibilities (e.g. via section 117 of the Mental Health Act) in supporting discharge. This should include input from:

- Mental health services (CAMHS and/or adult mental health as appropriate)
- Social care services (children's social care and/or adult social care)
- Education and training providers

Post 18 care pathway

In order to ensure good age transition planning, when a young person in an adolescent low secure service is a minimum of six months from their 18th birthday, the Responsible Clinician in the low secure service should liaise with local services, including the Responsible Commissioner, to ensure that the relevant transition processes for mental health and social services are initiated, including access assessment for adult secure provision, if required. In certain cases identification of young people likely to require specialist provision at the age of 18 is possible at an earlier juncture and good practice would require that such needs be signaled earlier.

In some cases young people are required to stay beyond their 18th birthday for completion of adolescent specific treatments. The maximum extended inpatient period will not exceed the young person's 19th birthday and the view of the responsible commissioner in the young person's CCG should be sought six months prior to the young person's 18th birthday to confirm arrangements.

3.3 Population covered

The service outlined in this specification is only relevant to individuals who are the commissioning responsibility of NHS England.

The population covered includes young people liable for detention for mental disorder under the Mental Health Act in need of child and adolescent low secure care. This population includes young people with specific cultural needs and special needs such as deafness, blindness or other physical disabilities and it also includes young people with neurodevelopmental disorders with or without a learning disability.

Child and adolescent low secure mental health services will need competences in the assessment and treatment of young people with such special needs. Many of these will receive appropriate treatment for their primary mental disorders in mainstream low security with only minor adjustments to the care provided. In particular, services should have the skills and training (or to access such skills and training promptly) to meet the communication needs for all young people with and without special needs groups. There may be times when appropriate specialist advice or consultation (for example from the national Deaf CAMHS) should be sought.

When adjustments to child and adolescent low secure facilities are not sufficient to enable adequate communication, equality of outcomes, or participation in the day to day activities or when a specialist treatment is needed then treatment in a specialist service will be required.

This is of particular relevance to young people with a learning disability, who are likely to require admission to a specific learning disability low secure unit to ensure equality of outcomes.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

- The young person is under 18 years of age at the time of referral, and
 - The young person admitted to child and adolescent low secure mental health services will be liable to be detained under Part II or Part III of the Mental Health Act 1983 (as amended), and
 - The young person is not safely managed in an open environment, does not require a medium secure setting, and is assessed as having needs that cannot be managed by shorter term admission to a PICU
- and either
- The young person has been directed to conditions of security under a restriction order by the Ministry of Justice or
 - The young person presents a risk of harm to others or themselves or suffers from a behavioral disturbance that requires inpatient care, specialist risk management procedures and a specialist treatment intervention.

Young people may be accepted with pending criminal charges if there is a significant risk to others or themselves in the context of mental disorder.

Exclusion Criteria

- Young people who present a grave danger to the general public (which may include some high risk young people who may have no offending history, as well as those who have been charged with or convicted of specified violent or sexual offences under Schedule 15 of the Criminal Justice Act 2003) These young people are more suitable for medium secure in-patient settings and assessment in the first instance where this appears likely should be undertaken by the NSFMHSfYP.
- Young people with brief episodes of disturbed or challenging behavior as a consequence of mental disorder). These young people are appropriately cared for in PICU.

3.5 Interdependencies with other services/providers

Child and adolescent low secure mental health services are part of a spectrum of services whose function is to meet the needs of young people with mental disorders in need of specialist care and treatment in a secure environment. Adolescent low secure mental health services also support young people in their recovery and rehabilitation and enable transitions into less restrictive environments as soon as possible.

Key partnerships

At National Level:

- NHS England,
- Appropriate NHS and independent sector providers (including Adult Services).
- Highly Specialised National Secure Forensic Mental Health Service for Young People.

- Local Mental Health Services (including PICUs, non-secure in-patient provision and Community Mental Health Services).
- Organisations representing young people, their parents and families (eg. Young Minds)

At Regional Level:

- Department of Health, Public Health Team, Home Office, Children and Young People leads
- Regional division of NHS England
- Regional Directors of Public Health
- Regional Children and Young People Health and Well-being Boards
- Regional Improvement and Efficiency Partnerships
- Offender Health Regional Strategy Boards (implementing Improving Health, Supporting Justice)
- Regional Children and Young People lead for the Association of Chief Police Officers (ACPO)
- Directors of offender management
- Commissioner and provider representatives for secure establishments
- National Treatment Agency regional managers
- Youth Justice Board heads of region
- Third sector organisations

At Local Level:

- Local Authorities (LAs)
- Local Safeguarding Boards & Public Protection panels
- Children's Services Authorities
- Commissioners (LA and Mental Health)
- Clinical Commissioning Groups
- Directors of Public Health
- Police
- Probation
- Housing
- Youth Offender Team (YOT)
- Third sector organisations
- Local Strategic Partnerships with:
 - Children's Trust Board
 - Local Children's Safeguarding Board
 - YOT Management Board
 - Crime and Disorder Reduction Partnerships
 - Drug Action Teams
 - Local Criminal Justice Board
 - CAMHS Partnership

4. Applicable Service Standards

Best practice guidance in respect of service provision within child and adolescent secure mental health services will be provided through a range of nationally agreed standards, guidance frameworks and legislation as well as mental health literature associated with adolescent mental disorders. Low secure services, like all child and adolescent mental health services are expected to deliver care within best practice guidelines and any newly published mental health strategies

that relate to the treatment of children and adolescents with mental health difficulties. Care standards should be agreed and coordinated by a national low secure network; providers will be expected to adhere closely to such standards.

4.1 Applicable legislation and national standards e.g. NICE

- Care Quality Commission Standards for Hospitals and relevant guidelines regarding restrictive practices.
- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- NICE guidelines for a range of disorders (e.g. psychosis and conduct disorder)
- The National Service Framework for Children and Young People and Maternity services (DoH 2004)
- Every Child Matters in the Health Service (DoH, 2006)
- National Service Framework for Mental Health: Modern standards and service models (DoH, 1999)
- New Horizons for Mental Health (DoH, 2009)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE March 2015)
- Standard for Better Health (DoH 2007)
- Healthy Children Safer Communities (DoH, 2009)
- Human Rights Act 1998
- The Children Act 1989
- Criminal Justice Act 1998
- Criminal Justice Act 2003
- Children Act 2004
- DoH Offender Mental Health Pathway 2005
- Mental Capacity Act 2005
- Code of Practice: See Think Act (Department of Health 2010).
- The Autism Act 2009
- The Evidence Base to Guide Development of Tier 4 CAMHS (Department of Health; Kurtz, Z April 2009)
- Promoting mental health for children held in secure settings: a framework for commissioning services. London: DH, 2007
- Procedure for the Transfer from Custody of Children and Young People to and from Hospital under the Mental Health Act 1983 in England (DoH, June 2011)
- Information Sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, March 2015)

- UN Convention on the Rights of Persons with Disabilities (perhaps an overall statement on Human rights issues).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Quality Network for Inpatient CAMHS (QNIC) standards
- Standards for Adult Medium secure services (CCQI, 2007)
- Standards for Adult Low secure services (CCQI, June 2012)
- National Minimum Standards for Psychiatric Intensive Care Units for Young People (napicu 2015) Healthcare standards for Children and Young People in Secure Settings (Royal College of Paediatrics and Child Health June 2013)
- Developing Services to improve the quality of life for young people with neurodevelopmental disorders, emotional/ neurotic disorders and emerging personality disorder (Royal College of Psychiatrists OP77 June 2011)
- Interventions for children at risk of developing antisocial personality disorder (Report to the Department of Health and Prime Minister's Strategy Unit; Utting et al March 2007).
- Better Mental Health Outcomes for Children and Young People (CHIMAT).

4.3 Applicable local standards

A range of clinical and other standards will be developed and applied by a national clinical network (as is currently the case for young people's medium secure settings). Such a network does not currently exist for low secure settings. Standards might include procedure relating to:

- Admission Criteria and Process
- Terms of Reference and Procedural Guidelines for Referrals.
- Issues of Security.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (further details within Schedule 4 Parts A-C of the contract ('Quality Schedule'))

Clinical standards

Adolescent Low Secure Mental Health Services provide care and treatment by balancing three principles:

- as an **adolescent service** it has to provide developmentally appropriate care attuned to the complex needs this population typically presents with and it needs to facilitate the young person's emotional, cognitive, moral, educational and social development;
- as a **secure service** it has to provide a secure and safe environment that can effectively manage high-risk and often high cost behaviours and at the same time manage high levels of vulnerability;
- as a **mental health service** it has to provide comprehensive multi-faceted evidence-based treatments and evaluate their effectiveness.

Adolescent Low Secure Mental Health Services must meet all three of the above principles to be

effective and it would not be acceptable to provide a secure environment that compromises the delivery of therapy nor would it be acceptable to deliver therapeutic interventions in a manner that compromises the safety of its service users and staff. **Clinical standards will be specified elsewhere within the contracting process but and should be mediated via the national low secure clinical network.**

Clinical standards can be operationalised within three domains:

- indicators by which clinicians and operational managers can demonstrate compliance with the three principles mentioned above:
 - developmentally appropriate care;
 - secure safe environment;
 - multifaceted evidence-based treatments
- a description of the model of psychologically informed care which articulates how the above principles can be sustained;
- a description of standards and functions of the multidisciplinary team (MDT) with particular focus on medical, psychological, nursing, occupational therapy, social work, speech and language therapy and educational professionals' groups.

5.2 Applicable CQUIN goals (See Schedule 4 Part D of the contract)

6. Location of Provider Premises

The Provider's Premises are located at: