

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	C11/S/d
Service	Tier 4 CAMHS Psychiatric Intensive Care Unit (PICU)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Tier 4 CAMHS Psychiatric Intensive Care Units are part of a system of mental health provision for children and young people which comprises both community provision and inpatient provision.

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.

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 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 behaviour that challenges, self-harm and vulnerability. Young people admitted to low and medium 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 a Tier 4 CAMHS General Adolescent Service including within a High Dependency Area. This behaviour will be associated with a serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability; for example, due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security. Whilst educational and recreational facilities should be available to young people in intensive care and secure settings, these provisions will tend to be set up differently in PICUs, which do not have the same emphasis on providing support over a long period of time. Admissions should not last longer than eight weeks. Any admission likely to last longer than eight weeks should be subject, by the end of the sixth week, to robust clinical review which focuses actively on alternatives to continuing PICU provision including where appropriate transfer to either low or medium security.

The decision to admit to any psychiatric intensive care service will need to be based on a good working risk assessment and detailed consideration as to how identified risks can be managed safely within this setting and resolved in the short term. For an admission to Tier 4 CAMHS PICU to be deemed appropriate the assessment will need to have demonstrated that this risk cannot be managed within a non-secure tier 4 CAMHS service..

This service specification relates specifically to adolescent psychiatric intensive care services for young people up to the age of 18 year with severe mental health problems including neurodevelopmental disorders. PICUs need to be seen as distinct from High Dependency Units (HDUs). As some confusion between the two has arisen, the following essential differences need to be emphasised:

- (i) High Dependency Units are not a separate and discrete prescribed service directly commissioned by NHS England
- (ii) High dependency care is currently a function provided by some Tier 4 CAMHS services to provide care and treatment for those children and young people whose behaviour particularly challenges the service but can be accommodated initially within a non-secure Tier 4 CAMHS in-patient setting
- (iii) High dependency care should be provided by Tier 4 in-patient services within dedicated areas of their provision (known as “High Dependency Units”)

These service specifications do not relate to HDUs.

Adolescent PICUs should complement other Tier 4 CAMHS in-patient provision for young people and should be co-located with other Tier 4 CAMHS inpatient provision. A Tier 4 CAMHS PICU should not be an isolated or stand-alone facility. It is anticipated that a PICU service for young people will serve a wider geographical area than Tier 4 CAMHS general purpose adolescent unit. It is anticipated that adolescent PICUs should accommodate up to a maximum of 12 young people at any one time. Finally, individual PICU services should form part of a regionally and nationally coordinated network which would ensure parity of practice and flexibility in terms of availability of in-patient beds.

Evidence Base

Assessing the incidence and prevalence of severe adolescent mental disorders likely to require Tier 4 CAMHS PICU is challenging. Prevalence is influenced by a variety of factors (social deprivation, family breakdown, learning difficulties, ethnicity etc.) and estimates of prevalence of specific child and adolescent mental health disorders are often broad and relate to the full range of clinical severity whereas only a minority require Tier 4 care. In addition to epidemiological factors service factors such as gaps in service, capacity of community services or quality of “out-of-hours” support will influence use of Tier 4 services (CAMHS Tier 4 Report, 2014).

A number of National Institute for Health and Care Excellence (NICE) guidelines include specific recommendations regarding in- patient care:

- NICE (2004) - Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders CG9
- NICE (2005) - Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder CG31
- NICE (2006) - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care CG38
- NICE (2009) – Borderline Personality Disorder CG78: recognition and management
- NICE (2011)- Psychosis with substance misuse in over 14s: assessment and management CG120
- NICE (2013) – Psychosis and schizophrenia in Children and Young People: recognition and management CG155
- NICE (2015) - Depression in children and young people: identification and management in primary, community and secondary care CG28

There are no randomised controlled trials comparing inpatient care for adolescents (as provided in the UK) with alternative intensive interventions. However, there are a large number of studies using different designs which generally conclude that inpatient care is effective. Summaries of these studies can be found in The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services -COSI-CAPS report (The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study ; Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)Tulloch et al HMSO 2008)

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	

Performance Indicators:

- No of referrals accepted/ declined within 24 hours following referral
- Number of consecutive days without reported incidences of aggression
- Proportion of shifts covered using bank or agency staff
- No of incidents of aggression towards others
- No of incidents of restraint
- No of incidents of damage to property
- Number of incidents of attempted and actual absconding
- Number of incidents of self-harm (PS) requiring medical intervention

Outcomes Indicators:

- Improvement in mental health – HoNOS-CA
- Improvement in functioning - CGAS
- Improvement in behavioural and emotional problems - SDQ.

Outcome Measures will include:

Mental health recovery

- Readmission rates of community and acute patients
- Occupied bed days/length of stay for patients
- Length of time from discharge to readmission
- HoNOS-CA, CGAS and SDQ scores
- Mental Health Quality dashboard
- Patient rated outcome measures (PROMs) and Patient rated experience measures (PREMs)

Reducing the severity and frequency of high risk behaviours

- SUI trends and incidents
- Care plans should identify risk, early relapse indicators and relapse prevention plan.
- Use of restraint and rapid tranquilisation
- Use of seclusion
- Use of special observations

Developing insight

- Advance directives
- Agreed care plan
- Individual engagement with CPA review process
- Use of recovery tool

Recovery from drugs and alcohol problems

- % of patients with dual diagnosis
- % of appropriate care plans addressing substance misuse
- Data on drug and alcohol screening

Making feasible plans

- Service user satisfaction survey responses
- Carer satisfaction survey responses
- Complaints
- Attendance of Responsible Clinician and care co-ordinators at CPA meetings

Staying healthy

- Registration with GP
- Engagement with intervention for physical healthcare
- % of appropriate young people with clozapine blood monitoring
- % of young people prescribed antipsychotics who receive appropriate physical monitoring

Life skills

- % of individuals with a care plan promoting meaningful activities informed by an OT assessment

Relationships

- Identified carers
- Carer assessments undertaken
- Visitor data

3. Scope

3.1 Aims and objectives of service

The core objectives for Tier 4 CAMHS PICU are to:

- Assess and treat mental disorder (including in the context of neurodevelopmental

disorders); reduce the risk of harm a young person poses to self and others; manage acute mental and behavioural disturbance which is not manageable in non-secure Tier 4 CAMHS settings or other settings for young people (this will include secure children's homes where the problem may not be an inability to contain the risk behaviour but an inability to provide appropriate treatment and monitoring).

- Provide a time-limited (days/weeks) intervention which will enable a safe transition to an appropriate alternative mental health setting as soon as this is possible; support recovery and promote adolescent developmental tasks.
- Provide an acute secure inpatient service within a pathway between open and secure adolescent services.
- Form multi-disciplinary teams which are experienced in providing adolescent psychiatric intensive care. 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 returning the young person to a non-secure Tier 4 CAMHS as soon as this is clinically indicated (or occasionally discharge to a community service where this is clinically indicated).

3.2 Service description/care pathway

All young people admitted to psychiatric intensive care units should be subject to the Mental Health Act.

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 acute and intensive care settings 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.

Tier 4 CAMHS PICU services provide care and treatment to a variety of young people but the predominant need for care and treatment in conditions of intensive care 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 three recognised pathways into Tier 4 CAMHS PICU are:

- Stepping up from a Tier 4 CAMHS general purpose adolescent service
- Direct admission from the community, including other institutional/ residential settings for young people (e.g. educational/ residential social care). In this case there should be an assessment first by a senior clinician, preferably a CAMHS Consultant Psychiatrist and if not a Specialist Trainee (ST4-6) in Child and Adolescent Psychiatry (in consultation with a Consultant Child and Adolescent Psychiatrist). In some areas services for 16 and 17 year olds continue to be provided by adult services; in such circumstances adult psychiatrists (and their specialist trainees under supervision) would be responsible for making referrals.
- Admission from a low secure unit

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

- Young person-centred individualised evidence-based treatment packages, based upon assessment of need and risk.

- Proactive (rather than reactive) management of aggression and violence.
- Care that involves young people and, if appropriate, their families 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 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 or transfer to an acute psychiatric setting.
- A multidisciplinary approach to the provision of patient care.
- Provision of care in line with welfare principles from the Children Act 1989 and Code of Practice to the Mental Health Act 2008.
- Effective, safe, and timely discharge or transfer to an acute psychiatric setting.
- Specialist professional advice to referrers and other agencies.
- Appropriate educational services within a DfE registered provider which is subject to OFSTED inspection..
- Activity programmes during periods where education is not provided and for young people who are beyond the age of compulsory schooling and who do not wish to continue in education.

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 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).
- A robust process of assessment that is able to formulate cognitive and behavioural paradigms and yet be flexible enough to allow alternative formulations (psychodynamic, systemic, psychopharmacological etc.);
- Expertise in the use of psychopharmacology in severe mental illness including local PRN and Rapid Tranquilization Policies;
- A therapeutic regime that places primary importance on behavioural approaches, de-escalation and the psychopharmacological treatment of mental illness and agitated behaviour in the context of psychiatric disorder. The therapeutic regime should also be able to deliver effectively a variety of other psychological interventions at an individual and group level and in particular deliver cognitive/behavioural interventions, interventions addressing interpersonal difficulties, family relationships, problem solving and affect regulation.
- Occupational therapy interventions integrated into the care approach.

The suitability of these interventions will of course depend on the likely length of stay. The aim is to discharge young people from PICU when it is safe to do so, which means that lengthier therapeutic interventions will not generally be appropriate, although they should still be available for example as brief interventions

The therapeutic milieu should have the capacity and resilience to effectively deliver interventions in the face of acutely challenging behaviour. It should also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients;

The interventions require robust evaluation and should evidence outcomes using reliable, well-validated clinical outcome measures and satisfaction measures.

The service 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 PICU service. Quality improvement methods such as the NHS Institute for Innovation & Improvement Plan, Do, Study, Act (PDSA) cycles should be used with the objective of reducing violence and use of non-consensual measures such as physical intervention and rapid tranquilisation.

The service will be required to complete regular audits throughout an annual cycle demonstrating the degree to which safety, welfare and security within the unit is maintained and reviewed. The audit annual will report to NHS England.

Equally, the individual services are expected to review all serious incidents (SI) and carry out root cause analysis of serious incidents and Near Misses so that learning can be disseminated through internal security review meetings. (Serious incidents are defined in scheduled 6 of the contract).

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 about the unit they are referred to prior to admission and all information and feedback from service users and their parents or carers should contribute towards future service development.

Services 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 including:

- social groups in wards such as community meetings
- therapeutic intervention programmes;
- discharge questionnaires;
- patients self-reports on care and treatment;
- advocacy support groups;
- discussion with families
- 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.

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.

The delivery of services in adolescent PICUs should also include access to child welfare and educational services. The provision of clinical services should be made by a wide variety of professionals with a background in child and adolescent mental health and experience of working with the serious psychiatric disturbance that would necessitate intensive care.

Care Pathway

The service will provide safe and effective 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, is essential and must be maintained through effective communication and involvement in clinical reviews. Particular attention (above and beyond the requirements of inclusion of the nearest relative for the purposes of the Mental Health Act) should be given by the PICU team to the involvement of parents, when appropriate, from the moment of admission; similar consideration should be given to involving social workers responsible for 'looked after' young people, especially when they have parental responsibility (as is the case with young people on full care orders (S31 Children Act)). Important local/catchment area services include: health and social care professionals, youth offending teams, educational services, NHS England commissioning case managers (both from host Local Area Team for the PICU and from the NHS England team in the young person's home area) and representatives of the home CCG.

a. Referral

Young people will normally be expected to be referred to psychiatric intensive care services from the following sources:

- Directly from the community, including specialist residential settings, (assessment must be by Tier 3 CAMHS Consultant or ST4-6 when this is not practical and waiting for a consultant assessment would result in a significant delay). The referral may come, for example, from an adolescent outreach service, an early intervention in psychosis service, a community adolescent forensic service or an adult mental health service where such services provide care for 16 and 17 years olds.
- From Secure Children's Homes. In this cases, the referral should be made by a CAMHS Consultant or ST4-6 and only for children on welfare legislation under the Children Act 1989 who may be liable for detention under The Mental Health Act 1983.
- In patient Tier 4 provision (open adolescent units)
- Low secure units
- Via youth justice diversion schemes (assessment must be by Tier 3 CAMHS Consultant or forensic adolescent consultant psychiatrist).
- Residential care settings (including children's homes and specialist educational placements) via Tier 3 CAMHS Consultant.

In general, consideration for PICU care will be undertaken by the PICU team in consultation with the referring team currently for the young person's mental health care. The response from the PICU team regarding their ability to accept the referral of a young person should be within 24 hours (as required for decisions regarding admission in tier 4 in-patient units). 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 Area Team covering the region from which the young person originates. Out of hours, over weekends and on bank

holidays there is an understanding by commissioners that providers and referrers will act in the best interests of the young person and will discuss the agreed outcomes with the commissioning team at the earliest opportunity during the next working day.

b. Initial Assessment and admission

Admissions will frequently take place as emergencies but suitability of psychiatric intensive care will need to be considered by both referrer and staff within the unit. The decision to admit a young person should be made on the basis of clinical need and whether there is an available bed; such a decision should be communicated to the referrer within 24 hours of referral. Occasionally the clinical lead in discussion with the multi-disciplinary team at a unit may decide that a young person who has been referred is not appropriate due to the particular mix of young people in a ward at one time; for example, due to vulnerability or an already overly stimulated ward.

Following admission, the initial assessment will be carried out by members of the multidisciplinary team (to include a consultant psychiatrist) from the intensive care unit. Following the assessment, the service will give an opinion as to whether the young person requires an ongoing PICU admission. If the young person does not require ongoing intensive psychiatric care, advice on alternative provision will be given, and a full assessment report will be provided in those cases when a young person's care is transferred to another hospital site, and an alternative option provided, where appropriate.

c. Pre-admission

The PICU staff should have received all relevant documents including the initial assessment (including view on why PICU admission is recommended) by Tier 3 CAMHS consultant or ST4-6 in CAMHS as well as a comprehensive risk assessment. Any further relevant information for example from the Youth Offending Team, Police or Social Care would be useful to have before admission if available.

d. Admission

- Admission to adolescent psychiatric intensive care services should be facilitated in a timely way consistent with the urgency of referral, and it is recognised that admissions will frequently be urgent.
- On admission psychiatric intensive care services are required to give young people information about available treatments and facilities and to ensure that they are informed of their rights under the Mental Health Act.
- An admission CPA review meeting should be convened within five working days to plan care pathway in PICU and discharge.
- Before or very early in the admission to an adolescent PICU, an named community care coordinator and community consultant psychiatrist in Tier 3 CAMHS must be in place.

e. Treatment programmes

Each adolescent psychiatric intensive care 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 and Responsible Clinician allocated within the service, who will co-ordinate the care for the young person 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, nurses and teachers, in accordance with standards and guidelines outlined by the Quality Network for In-patient Care (QNIC).
- Each patient will:
 - Be reviewed by the MDT at least weekly.
 - Have an up to date MDT care plan that has been consulted and communicated with the patient.
 - Have a named practitioner psychologist who will undertake a 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 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.
 - 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 access to a social worker.
 - Have access to the Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role.
 - Receive three culturally appropriate meals per day. The food will be prepared in accordance with NHS National guidelines on nutrition and variety.
 - Have their religious and cultural needs met.
 - Have their rights under the Mental Health Act 1983 (as amended) explained.
 - Have their physical healthcare needs met through a full range of primary healthcare interventions that include health promotion and physical health screens.

Treatment programmes are provided in structured days across three domains:

- Leisure: activities provided on and off the ward such as, art, drama, dance, music, gym, sports and group games.
- Education: All young people are encouraged to participate in educational studies to improve their educational attainment. 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 appropriate (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.

○ 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;
- Clear Guidelines and policies on the use of PRN and Rapid Tranquilizations, which are reviewed regularly by the clinical team and service Pharmacist.
- a broad range of psychological interventions (both group and individual) to enhance social, emotional and behavioural self-monitoring and self-regulation. These should be in line with best available evidence and/or NICE guidelines and may include:
 - Cognitive Behaviour Therapy,
 - Dialectical Behavioural Therapy
 - Family therapy
 - Health promotion (physical and mental health and relapse prevention other therapeutic interventions that may include music therapy and art therapy.

f. Care planning, CPA and discharge

Care planning and CPA

- An initial CPA review meeting should be convened within five working days.
- Further CPA review meetings should take place at a frequency of every three weeks.
- CPA review meeting attendance should be encouraged by use of communication technology such as teleconferencing and videoconferencing. Given the short timescales of PICU care pathways, the involvement and responsibility of multiagency colleagues outside the unit is crucial and must be ensured.
- 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 intensive care.

Considerations in intensive care pathway planning Care pathway planning should always involve balancing the relevant needs in an individual young person, including:

- the immediate risk posed by the young person to themselves and/ or others
- specialist treatment needs which cannot be met in lower intensity settings

- the Mental Health Act 1983 (as amended) 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 needs

Discharge to Tier 4 CAMHS general adolescent units in-patient units, other residential care, and community settings

The discharge of a young person from intensive in-patient care will be dictated by the nature of their presentation and needs but the aim should be to keep length of stay as short as possible without discharging too early, in line with the principle of least restrictiveness. Admissions should not last longer than eight weeks. Any admission likely to last longer than eight weeks should be subject, by the end of the sixth week, to robust clinical review which focuses actively on alternatives to continuing PICU provision including where appropriate transfer to either low or medium security. Any risk of delayed discharges should also be clearly communicated to responsible commissioners who should become actively involved in facilitation of discharge. NHS England Mental Health Case Managers will work for commissioners to monitor lengths of stay. Residential care is listed under discharge destinations and covers secure children's homes.

A number of different mental health problems may lead young people to require intensive psychiatric care, including psychosis, bipolar disorder, self-harm, neurodevelopmental disorders and learning disabilities. Typically a young person in PICU will be transferred first to an open adolescent ward although occasionally to either residential care, a low secure setting or directly to the community with either Tier 3 or specialist CAMHS care.

Family involvement

Family involvement should include, if appropriate,:

- rights to visits and phone calls with family;
- involvement with family in providing a history;
- involvement with family in appropriate treatment and planning for discharge

Post 18 care pathway

It is essential to be aware of young people's age and date of birth prior to admission. There also must be a transition policy in each Mental Health Trust to transfer young people when they reach 18th birthday. It is the responsibility of the Local Tier 3 CAMHS to have organised this six months prior to the young person's 18th birthday. A young person who turns 18 during an admission to an adolescent PICU and who still requires intensive psychiatric care should be transferred to an adult PICU. The adolescent PICU staff should organise the transfer together with the Tier 3 CAMHS service. If the young person does not need further PICU admission but needs an adult acute bed this would also be organised by adolescent PICU staff with the support of young person's care co-ordinator in the community. The above should be pursued through the CPA process.

In some cases young people may stay in an adolescent PICU for a short time beyond their 18th birthday if a brief period of illness is anticipated and it is considered that it would be unnecessarily disruptive to organise a transfer to adult services. The view of the responsible commissioner in the young person's CCG should be sought prior to the young person's 18th birthday to confirm arrangements.

Discharge

All young people are to be supported to take an active role in their discharge planning and would normally be discharged into the following settings:

- Tier 4 CAMHS inpatient care or Day Service
- Open residential settings, including family home and residential care.
- Secure forensic mental health services for young people.
- Secure non-NHS provision

Providers are required to actively involve the catchment area services from where young people come from and enable them to honour their statutory responsibilities in supporting young people's discharge

3.3 Population covered

A respect for diversity and cultural sensitivity is expected in all intensive care services. The service outlined in this specification is only relevant to individuals who are the commissioning responsibility of NHS England. Those young people eligible for admission to a PICU will be subject to acute mental health disturbance which cannot be contained within an open tier 4 adolescent in-patient or elsewhere in community settings and is thought to require a shorter-term intervention than that available in low secure settings. They will equally be subject to part 2 of the Mental Health Act (1983, as amended 2007). This includes young people with 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.

Young People with Neurodevelopmental disorders

PICU services will need competences in the assessment and treatment of people with neurodevelopmental disorders. Many people with mild NDD, coincidental to other mental disorders, will receive appropriate treatment for their primary mental disorders in mainstream adolescent services, with appropriate adjustments to the care provided. All adolescent psychiatric intensive care units will therefore need to provide:

- Screening for neurodevelopmental disorders;
- A clear pathway for formal diagnosis of neurodevelopmental disorders, delivered in partnership with specialist neurodevelopmental disorder services;
- Access to independent advocacy and external support networks with experience in the management of young people with neurodevelopmental disorders.

When adjustments to adolescent psychiatric intensive care are not sufficient to enable equality of outcomes, participation in the day to day activities or when a specialist treatment is needed for the NDD itself, then treatment in a specialist NDD service will be needed.

Adolescent psychiatric intensive care services for people with NDDs will need appropriate staffing numbers and skill mix to meet the whole-person needs of people with NDDs. The staff should have sufficient skills to manage the treatment and communication needs of those young people. In practice this will include:

- An environment designed to meet the needs of people with NDD, including adapted signage, decoration, lighting, and access to sensory areas.
- Access to adapted information, taking account of the sensory and communication needs of individuals.
- Access to a specialist clinical team, including access to psychiatrists and psychologists with skills and competence in working with people with NDD, specialist speech and language therapists, dysphagia specialists, sensory integration trained therapists, and an appropriate mixture of registered learning disability and mental health nurses.

- An adapted care pathway, including specialist access assessment, routine sensory integration, communication, intellectual and adaptive function assessments, and routine diagnostic assessment for autism spectrum conditions.
- Adapted outcome measures, including the use of person-centred planning, and health action plans, that are personalised to allow maximum participation of the individual in their own care pathway.
- Access to adapted treatment programmes, including group and individual psychological therapies and programmes designed to address problem behaviours, and aid rehabilitation. Access to teaching professionals providing specialist education within the service.
- Access to skilled independent advocacy services with expertise in working with young people with NDD.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

All three of the following must apply:

- The young person is under 18 years of age at the time of referral.
- The young person admitted to child and adolescent psychiatric intensive care services will be subject to an order within Part II of the Mental Health Act (1983, as amended 2007). A PICU setting will not be appropriate for young people subject to hospital admission under part 3 of the Mental Health Act (this includes admissions for assessment under sections 35 and 36).
- The young person cannot be appropriately and safely managed in an open in-patient or community environment. This means that the young person will either present a risk of harm to others or themselves and suffers from an acute behavioural disturbance as a result of a mental disorder that requires intensive and acute in-patient care, specialist risk management procedures and a specialist treatment intervention. (Young people may be accepted with pending criminal charges if subject to part 2 of the Mental Health Act)

Exclusion Criteria

- Young people who are presenting with longer term behavioural disturbance, either forensic or non-forensic, who may require care in a low secure or residential setting.
- 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 NSFMHfYP and the gate keeping assessment in the first instance should be undertaken by the NSFMHSfYP.
- Fire Setting not in the context of an acute mental illness.

3.5 Interdependencies with other services/providers

Adolescent PICU services are part of a spectrum of services whose function is to meet the needs of young people with mental disorders (including neurodevelopmental disorders) in need of specialist care and treatment in an intensive setting. They also support young people in their recovery and enable transitions into less restrictive environments as soon as possible.

Key partnerships

At National Level:

- NHS England.
- Highly specialised National Secure Forensic Mental Health Service for Young People.

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
- National Treatment Agency regional managers
- Third sector organisations

At Local Level:

- Appropriate NHS and independent sector providers (including Adult Services).
- Local Mental Health Services (including Community Mental Health Services).
- 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

Adolescent PICUs are expected to deliver care within Best Practice guidelines and any newly published mental health strategies that relate to the assessment and treatment of children and adolescents with mental health difficulties.

Referrals

- Routine/ non-urgent referrals should be responded to within 24 hours.

Admission process

- Admission to adolescent PICU services should take place within 24 hours of an appropriate referral with necessary documentation being received.

Care planning

- An initial internal multidisciplinary care planning meeting should be convened within 48 hours of admission, during which the treatment plan will be refined.
- Young people should have MDT reviews at least once weekly
- An initial CPA meeting with representation from commissioning, the community CAMHS and other relevant agencies (if involved) should be held within the first 5 working days of admission.

This review will discuss the treatment plan and care pathway including:

- Agreement to discharge treatment goals.
- Agreement to discharge destination and discharge care package.
- Determination of whether admission to an acute adolescent ward or the NSFMHSfYP would be more appropriate.
- Estimation of the date a young person can make the transition from PICU to an open setting.
- After the initial meeting, CPA meetings should be held at least every three weeks including at the point of transition to an acute service. The CPA can take place after the transition if there would otherwise be a delay in transfer to a less restrictive setting.
- Care pathway management in adolescent PICU services should be audited against CAMHS optimizing pathway CQUIN standards.

Discharge

- A responsible CAMHS team, including an allocated Responsible Clinician, should be in place before the start of a discharge process.
- The PICU service should convene at least one Section 117 pre-discharge meeting before the start of the discharge process.
- A brief discharge note, including details of diagnosis, medications, allergies and sensitivities, physical health, risk, and recommended discharge care plan, should be provided at the point of discharge
- A full discharge summary should be provided within 7 days of the discharge date.

Physical Healthcare

Adolescent PICU services will ensure that all young people have access to routine/regular physical health needs assessment, in accordance with the CAMHS CQUIN audit standards, and that treatment for on-going and emerging physical health needs are provided in a timely and effective manner.

Routine physical healthcare should be provided by junior medical staff under supervision and there should be access when necessary to paediatric and more specialist medical provision as necessary.

4.1 Applicable national standards e.g. NICE

Treatment in adolescent PICUs should be in line where possible with national standards, for example the NICE guidelines on the treatment of bipolar disorder and psychosis. There are currently no QNIC standards for intensive psychiatric care. However, there are National Minimum Standards for Psychiatric Intensive Care Units for Young People 2015 published by napicu.

Security standards; full specification can be found within existing low secure guidance for commissioners. Security standards should include as a minimum the following:

- Evidence that physical, relational and procedural security is developed and managed in developmentally appropriate manner taking into account child and family welfare issues.
- There is a clearly delineated external secure perimeter.
- Access to the clinical area for staff patients and visitors is through an airlock.
- There is a protocol in place to manage all keys.
- Evidence that staff team has current knowledge and understanding of the physical, relational and procedural security supporting the PICU.
- There is an induction programme with annual updates for relational security that includes material on boundaries, therapy, patient dynamics, child care needs, physical environment, visitors and effective communication.
- There is an updated index of procedural security policies and procedures sensitive to the needs of children and adolescents offering safety to patients, visitors and staff.
- There is evidence of planning in the environment and consideration of the impact on the therapeutic environment and safety of ward size and layout, patient numbers, expected activity levels of the young population and gender.
- There is a multidisciplinary approach to the identification, assessment and management of risk.
- There are clear policies and procedures governing the use of de-escalation techniques and the management of challenging behaviour including the appropriate use of control and restraint and of seclusion.

The providers will provide agreed CQUIN Targets for monitoring data on an agreed annual cycle with NHS England. When any elements of these deviate from the agreed plan, the service provider will provide an explanation accompanying the submission of the report on CQUIN.

Adolescent PICU services should deliver evidenced-based clinical intervention by the judicious use of the adult intensive care, child and adult mental health literatures against a background of nationally agreed standards, NICE guidance, frameworks and legislation.

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

Best practice guidance in respect of service provision within adolescent PICU services is provided through a range of nationally agreed standards, guidance frameworks and legislation as well as mental health literature associated with adolescent mental disorder (including neurodevelopmental disorders) and adult psychiatric intensive care.

All child and adolescent secure 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.

- 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)

- Quality Network for In-patient CAMHS (QNIC) standards
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE March 2013)
- Forensic Child and Adolescent Mental Health Services Quality Indicators
- National Minimum Standards for Psychiatric Intensive Care Units for Young People (napicu 2015)
- Standard for Better Health (DoH 2007)
- Healthy Children Safer Communities (DoH, 2009)
- Human Rights Act 1998
- The Children Act 1989
- Children Act 2004
- Mental Health Act 1983 as amended in 2007
- NICE guidelines for a range of disorders (e.g. psychosis and conduct disorder)
- Mental Capacity Act 2005
- Code of Practice: See Think Act (Department of Health 2010).
- Royal College of Psychiatrists CCQI standards. 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)
- Better Mental Health Outcomes for Children and Young People (CHIMAT).
- The Evidence Base to Guide Development of Tier 4 CAMHS (Department of Health; Kurtz, Z April 2009)
- The Autism Act 2009
- 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)

5. Applicable quality requirements and CQUIN goals

Applicable quality requirements

Clinical standards

Tier 4 CAMHS PICU 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 **PICU 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** is has to provide comprehensive multi-faceted evidence-based treatments and evaluate their effectiveness.

PICU Services must meet all three of the above principles to be effective and it would not be acceptable to provide an intensive 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 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.

- **Applicable CQUIN goals**

The reference numbers for quality requirements and the CQUIN goals which apply to the service should be listed here. This allows clarity about the requirements relating to specific services.

Please note any contractual levers relating to quality, KPIs, CQUINs will need to be included in the relevant schedules of the contracts.

6. Location of Provider Premises

The Provider's Premises are located at:

Tier 4 CAMHS PICU should not be standalone units and should be co-located with other Tier 4 CAMHS services This is to avoid psychiatric intensive care being provided in isolation, which may reduce the range of services that young people have access to, and lead to increased disruption when young people transition to or from a general adolescent service.

Generally, a site location shared by other mental health inpatient services is preferable.

7. Individual Service User Placement

Insert details including price where appropriate of any individual service user placement e.g. mental health. This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.