SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	170024/S
Service	Tier 4 Child and Adolescent Low Secure Inpatient Service
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

1.1.1 This service specification covers the provision of Low Secure inpatient forensic services for young people.

1.2 Description

1.2.1 Secure inpatient forensic mental health services for young people include services provided by Specialist Secure Forensic Mental Health Service Centres for young people to be delivered within a clearly defined geographical area at Regional/Sub-regional level with service configuration determined locally based on population needs and existing Tier 4 service provision.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

1.3.1 NHS England commissions Tier 4 Child and Adolescent Mental Health Services provided by Specialist Child and Adolescent Mental Health Centres including associated non-admitted care services.

1.3.2 Clinical Commissioning Groups (CCGs) commission services for children and adolescents requiring care in Tiers 1, 2 and 3.

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway

2.1.1 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 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.'

2.1.2 Tier 4 inpatient CAMHS services in England offer care at four levels to support the effective management of differing nature of risk presented by children and young people under 18 years.

2.1.3 Medium secure, low secure and Psychiatric Intensive Care Units (PICU) services provide a range of physical, procedural and relational security measures not required in general adolescent services to ensure effective treatment and care whilst providing for the safety of young people, staff and the public.

- **Medium secure services** accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others including those who have committed grave crimes.
- **Low secure services** accommodate young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people 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.
- **Psychiatric Intensive Care Units (PICU)** manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security.
- **General adolescent services** provide inpatient care without the need for enhanced physical or procedural security measures.

2.1.4 This service specification relates to low secure services.

2.2 Service Requirements and Functions

2.2.1 All young people admitted to low secure services must be subject to the Mental Health Act. The predominant need for care and treatment in low secure must be related to the assessed risk of harm to others and/ or self in the context of the young person's mental disorder.

2.2.2 Young people must be treated and managed within a care pathway approach where services work collaboratively to ensure that admission to and transfers between services are achieved efficiently. The care pathway must be planned early in admission, with changes depending on developing needs and circumstances.

2.2.3 There are four recognised pathways into adolescent low secure care and all referrals must be supported by the NHS England commissioning team from young person's originating area:

- Stepping down from medium secure adolescent services
- Direct admission through a criminal court process or from youth justice custodial settings subject to an access assessment by the National Forensic Mental Health Service for Young People (NFMHSfYP)
- Transfer from Tier 4 general adolescent inpatient services or (PICU or other Tier 4 low secure units
- Admission from specialist education and welfare settings including welfare secure units.

2.2.4 On occasions young people may be referred from community CAMHS including assertive outreach, early intervention in psychosis services or community forensic CAMHS services (FCAMHS).

2.2.5 Multi-disciplinary working and the Care Programme Approach (CPA) process must underpin service delivery; the low secure service must provide:

- Young person-centred individualised multi-disciplinary evidence-based treatment packages, based upon assessment of need, formulation and risk
- Proactive management of aggression and violence
- Physical and mental health care that meets the needs of and involves young people and, if appropriate, their families/carers from the beginning of the care pathway
- Care for people with learning disability and/or autism must be in line with the expectations and principles set out in Transforming Care and proactive support, facilitation and delivery of the Care Education and Treatment Review (CETR) process
- A secure environment where young people can address their

problems in safety and with dignity

- An extensive range of therapeutic, educational and recreational opportunities including activity programmes (minimum of 25 hours per week) during periods when education is not provided or young people beyond school age do not wish to continue in education.
- On-going assessment that supports effective, safe and timely discharge or transfer to other inpatient or community settings
- Provision of care in line with the guiding principles contained in the Children Acts and Code of Practice to the Mental Health Act.
- Specialist professional and clinical advice to referrers and other agencies
- Appropriate educational services from a Department for Education registered provider which is subject to OFSTED inspection.

2.2.6 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), family therapy, social work, occupational therapy, education and nursing professionals
- An ability to provide appropriate speech and language therapy and creative therapies
- 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 and formulation 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
- A therapeutic regime able to effectively deliver a variety of psychological interventions at an individual and group level addressing interpersonal relationships, problem solving, affect regulation and mental health in line with the clinical formulation. The interventions should be flexible and responsive to the needs of the young people
- The ability to provide a spectrum of offender-related interventions commensurate with high risk presentations
- A therapeutic milieu comfortable with a psychological understanding of formulations
- The capacity to effectively deliver interventions for protracted periods of time

- A level of resilience capable of dealing effectively with chronic challenging young people with past significant adversity
- Capability to operate within a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients
- The provision of interventions drawing from the available evidence base, whilst recognising the limits of this evidence for a 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.

2.3 Referrals

2.3.1 Referrals are accepted from the following sources:

- Adolescent medium secure services (NSFMHSfYP)
- Tier 4 general adolescent inpatient services
- Adolescent PICU
- Youth Justice System including courts, Young Offender Institutes (YOI) Secure Training Centres (STC) and Secure Children's Homes where the young person is detained on welfare grounds
- Adolescent low secure services
- Community CAMHS including assertive outreach, early intervention in psychosis services or community FCAMHS.

2.3.2 Consideration for low secure must be made in agreement with the team responsible for Tier 4 general adolescent inpatient and PICU care within the young person's home area. Other teams such as community adolescent forensic teams may also be involved in this and may be used as a consultative reference point for other clinicians and services. This process should be in accordance with established Regional and Sub-regional provider pathway arrangements.

2.3.3 Referrals must be made using the National Referral and Access process (Forms 1 and 2).

2.3.4 Referrals from youth justice settings (courts and custodial units) must be directed to clinicians within the medium secure network (via the medium secure unit closest to the young person's home area) who must determine the level of security required. Prior to making the referral, the referrer must 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 should then be organised, if necessary in conjunction with the Low Secure Network.

2.3.5 Responsibility for the care of the young person remains with the referring agency/service until the point of admission to the low secure inpatient service.

2.3.6 The processing of referrals should not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status.

2.4 Acceptance Criteria

2.4.1 The following must apply:

- The young person is under 18 at the time of referral
- The young person must be detained under Part II or Part III of the Mental Health Act 1983
- The young person is not safely managed in an open environment, does not require a medium secure setting, and is assessed as having needs than 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

- The young person presents a risk of harm to others or themselves or suffers from a behavioural disturbance that requires inpatient care, specialist risk management procedures and a specialist treatment intervention.

2.5 Exclusion Criteria

2.5.1 The following apply

- Young people who present a grave risk 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 behaviour as a consequence of mental disorder. These young people are more appropriately cared for in a PICU.

2.6 Initial Assessment

2.6.1 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.

2.6.2 Admissions are not intended to take place as emergencies and assessments must be completed by the assessing unit within 2 weeks of referral.

2.6.3 Where cases are identified as particularly urgent an assessment must be completed within 5 days of referral to the assessing unit.

2.6.4 Repeated assessments for the same young person in relation to a single referral must be avoided. The Children and Young Person's Mental Health Service Information Passport may be a helpful part of this and can be found at www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/10/cyp-info-passport-yp-example.pdf

2.6.5 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, this must be documented in the risk assessment and action taken to ensure that the current patient group is not put at undue risk.

2.6.6 Initial assessment must be carried out by members of the multidisciplinary team (to include a senior clinician and a nurse) from the low secure service. Any decision to admit a young person must 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.

2.6.7 Any assessment must, where appropriate, 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.

2.7 Pre-admission

2.7.1 The referrer must be informed by a senior clinician (usually a consultant psychiatrist) whether the young person fulfils criteria for admission within a day of any decision being made. This communication will initially be verbal and must be followed by a full written multidisciplinary report.

2.7.2 Arrangements for admission must be jointly agreed by the referring agency and the low secure service, with particular focus on nursing handover.

2.7.3 The admitting low secure service must 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.

2.7.4 If the young person does not meet criteria for admission, the assessing service must verbally inform the referrer as soon as possible and subsequently in writing in an assessment report to the referrer. The feedback must include advice on management of risks and alternative options for meeting the young person's needs.

2.7.5 The referring team must ensure that the staff at low secure service receive all relevant documents and information about the case and include:

(i) The initial assessment and referral (including the referring team's opinion on the reasons for seeking admission to low secure which will be completed by Tier 3 CAMHS Consultant Child and Adolescent Psychiatrist or Child and Adolescent Psychiatry Specialty Trainee ST4-6
(ii) A comprehensive risk assessment.
(iii) Any further relevant information for example from the Youth Offending Team, Police or Social Care if available.
(iv) The individuals who hold parental responsibility should be established prior to admission and clarity obtained as to who is the nearest relative for the purpose of Mental Health Act.

2.8 Admission

2.8.1 There is some degree of overlap between admission criteria for adolescent medium secure, low secure and PICU services. This must be borne in mind by clinical teams and at each case review specific consideration must be given to the principle of care in the least restrictive setting and whether the young person is appropriately placed.

2.8.2 On admission, the service must provide young people with information about the available treatments and facilities, and must ensure that the young people are informed of their rights under section 132 of the Mental Health Act. Written information about rights under the MHA must be sent to the nearest relative unless the patient objects.

2.9 Care and Treatment Programme

2.9.1 Treatment programmes must be delivered across 3 domains in structured days:

(i) **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.
(ii) **Education:** All young people are expected to participate in educational studies to improve their educational attainment. It is expected that when a child or young person has an Education Health and Care Plan (EHCP), 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.

(iii) **Therapeutic Interventions:**

- formal assessment and monitoring of mental state
- assessment of clinical risks and development of clinical multidisciplinary formulation and 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 'when needed medication' (known as Pro Re Nata or PRN medication) and Rapid Tranquilizations, which are reviewed regularly by the clinical team and service Pharmacist
- A broad range of psychological interventions (which may be delivered at an individual, group or systems level) with a view to enhancing social, emotional and behavioural self-monitoring, and self-regulation. These should be in sequenced according to need and readiness and delivered within a developmentally sensitive framework in accordance 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
- Occupational Therapy
- Health Promotion (physical and mental health) and relapse prevention
- Other therapeutic intervention that may include music therapy and art therapy
- Graded programme of s17 leave (where appropriate).

2.10 Home Leave

2.10.1 Home leave is important in helping young people maintain family and community relationships whilst in an inpatient setting and is an important element of the transition to outpatient care.

2.10.2 Home leave for detained patients can only be agreed by the Responsible Clinician under s17 of the MHA.

2.10.3 The plan for home leave must be included in the overall care plan made prior to any leave being taken and should be agreed with the commissioner/Case Manager. The planning process must consider if transition to another element of the adolescent pathway is included as part of the leave plan.

2.10.4 Leave of up to 2 days should be encouraged.

2.10.5 Any additional leave over 2 days per week of greater than 5 days in total on one occasion or over several occasions during an admission, must be agreed with the commissioner/Case Manager.

2.10.6 Each planned home leave must be risk assessed and managed with due regard for the service's duty of care to the patient and the commissioning body's statutory duty of care.

2.11 Care Planning

2.11.1 Young people must 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.

2.11.2 The care plan must reflect the young person's needs in the following domains:

- Mental health
- Developmental needs
- Physical Health
- Risk
- Family support / functioning
- Social functioning
- Spiritual and cultural
- Education, training and meaningful activity
- Where relevant includes a Carer's Assessment
- Where relevant includes accommodation / financial needs
- Where relevant addresses substance/ alcohol misuse
- Where relevant addresses offending behaviour.

2.11.3 All care planning must follow a recovery and outcome process, be embedded in the Care Programme Approach (CPA) and form the cornerstone of delivery of an effective care pathway through secure care.

2.11.4 Low secure services should support case management from NHS England case managers.

2.11.5 The treatment and care plan must be informed by a comprehensive formulation of the young person's needs and difficulties and, where possible, be based upon current NICE guidelines or established evidence-based best practice guidance.

2.11.6 The treatment/care plan must incorporate routine outcomes monitoring such as those set out by QNIC to monitor progress and treatment on a

week to week basis.

2.11.7 All patients should have a community Care Coordinator linked to community CAMHS team local to the patient's home area who should remain updated throughout the admission period and is expected to remain involved with the young person's care.

2.11.8 For restricted patients, low secure services must ensure compliance with the Ministry of Justice requirements.

2.11.9 For young people who are subject to input from the Youth Justice Services, reviews of orders including remand reviews must be facilitated and may be undertaken jointly with CPA reviews.

2.11.10 Where the young person has a learning disability or ASD every effort must be made to hold a (CETR before admission, including a Blue Light CETR if there is not time to convene a full one.

2.11.11 If a CETR was not carried out prior to admission it must be held within 2 weeks of admission. CETRs must be repeated every 3 months during an admission in line with CETR guidance and policy published in March 2017. This guidance can be found using the following link www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

2.11.12 Links must be established proactively with the young person's home local authority at admission and agreement made on the level of social care input required. These links must be maintained until discharge including notifying them of their responsibility at 3 months under section 85 of the Children Acts.

2.11.13 For young people in the care of local authorities, Looked After Children (LAC) Reviews must be facilitated and should be undertaken jointly with CPA reviews where possible.

2.11.14 Care pathway planning must 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 Code of Practice 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 needs including access to and proximity to home and ease of access to family.

2.11.15 In planning future care pathways there must be active consideration of balancing the principles of management in the least restrictive environment and reducing transitions for young people.

2.11.16 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.

2.12 Enhanced Observations

2.12.1 Enhanced observations provide a level of supervision above routine observations. The frequency is determined by the needs of the young person, for example regular 5-minute checks or continuous supervision.

2.12.2 Enhanced Observations will in normal circumstances be considered to be part of the contracted level of general care.

2.12.3 All low secure services must:

- Develop and implement a policy for enhanced observations in the day/in-patient element
- Deliver enhanced observations in line with good clinical practice (for example but not limited to - when a young person exhibits overt physically aggressive behaviour towards others, or is an active risk to themselves).
- Review enhanced observations at least twice daily and reduced to the minimum at the earliest opportunity
- Undertake enhanced observations using staff members who are familiar with the care needs of the young person.

2.13 Seclusion facilities

2.13.1 Low secure services must have appropriate facilities for the management of young people who require periods of care in seclusion/away from the main patient group in order to appropriately manage the level of risk they pose to others

2.13.2 All physical seclusion facilities and patient management practices must comply with Quality Network for Inpatient CAMHS (QNIC), Care Quality Commission and Mental Health Act Code of Practice standards and requirements unless there is a cogent reason for not doing so, this decision and rationale must be clearly documented and reviewed regularly over the period it applies.

2.14 Physical Healthcare

2.14.1 Low secure services must ensure that young people have access to routine and regular physical health needs assessment and treatments for emerging and ongoing physical health issues in a timely and effective manner.

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

2.15 Education

2.15.1 All day/in-patient services must ensure that educational sessions can be provided during the normal academic term. The education provided should be an integral part of the service provision.

2.15.2 The local authority is under a legal duty to make sure that, if a young person of compulsory school age is unable to attend their primary, secondary or special school because of illness, they continue to get a full-time education unless part-time is better for their health needs.

2.15.3 Local authorities are funded to discharge this duty through the dedicated schools grant from the Department for Education. In some cases (e.g. academies) the funding is recouped from local authorities' grant allocations and paid directly by the Education and Skills Funding Agency to the provider. The cost of education provision will not be included in the cost charged to the NHS.

2.15.4 Consequently, the quality and standard of education provided although integrated within the CAMHS provision, is subject to the local authority commissioning arrangements rather than subject to the NHS England's contract with the CAMHS service provider. It is for the relevant local authority to decide what education is delivered, how it is delivered, under a funding agreement or arrangement that depends on the type of education provider.

2.15.5 In all cases the education provided should be in accordance with what is commissioned and funded by the local authority. The type of education provider determines which local authority or authorities are responsible for commissioning and funding the education provision, as follows:

- If a maintained school provides the education, the local authority that maintains the school commissions and funds the education
- If an academy provides the education, the local authority that previously maintained the school, in whose area the academy is located, commissions and funds the education
- If a local authority provides the education directly, or enters into a funding agreement with an independent provider to deliver the education, that local authority commissions and funds the education

- If an independent provider delivers the education commissioned by a local authority on the basis of an agreement in respect of each individual young person, the relevant local authority should be informed of their admission either prior to a planned admission or at the latest within 5 working days after the admission. This will enable the local authority to decide how to commission and fund the young person's education, enter into a funding agreement with the independent provider or make alternative arrangements for the young person's education.

- Independent providers, delivering full time education for five or more pupils of compulsory school age, or one or more such pupils with an education, health and care (EHC) plan or statement of special educational needs, or who are "looked after" by the local authority, must ensure that any provision is registered with the Department for Education as an independent school, and meets the independent school standards.

2.15.6 The standards which the education arranged by the local authority must meet are set out in statutory guidance for local authorities on alternative provision.

2.15.7 In all cases it must be suitable to the young person's age, ability and aptitude and any special educational needs they have, and must include appropriate and challenging teaching in English, maths and science (including IT) on a par with mainstream schools.

2.15.8 The education must be full-time or as close to full-time as in the young person's best interests taking account of their health needs. The full guidance can be found here: https://www.gov.uk/government/publications/alternative-provision and https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school

2.15.9 Where a young person has an EHC plan or statement of special educational needs, the education provider should contact the local authority responsible for drawing up the plan or statement to establish both the provision required whilst the young person is in the Tier 4 CAMHS and any additional funding available.

2.15.10 The education provider must liaise with the virtual school head in the case of all children and young people who are "looked after" by a local authority.

2.15.11 The type of education provider determines how inspections are carried out e.g. by OFSTED, how the results of inspections are reported and how they are followed up to ensure an appropriate

standard of education.

2.15.12 The education provider should establish relationships with relevant schools, colleges and other education providers to support the young person's transition into Tier 4 CAMHS, their education whilst they are a patient and their aftercare and transition back to their usual place of education.

2.15.13 Expectations for Health Providers and Commissioners

I. The health provider and commissioner must jointly liaise with the LA(s) responsible for commissioning education service regarding the needs of the young people in the inpatient service.

II. The provider should expect the education provision to be operated in accordance with the appropriate regulatory framework, which normally includes inspection by OFSTED (see above).

2.16 Discharge/Transitions

2.16.1 All transitions from secure settings must be carefully planned and considered from the point of admission.

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

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

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

- Adult secure or non-secure inpatient services, including rehab services
- Adolescent Tier 4 CAMHS 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).

2.16.5 All transfers of detained patients between inpatient settings must comply with s19 of the MHA.

2.16.6 Services must actively involve the catchment area services from the

patient's home area. If the patient is detained under the MHA the service must ensure that the organisations responsible for aftercare under s117 are involved in discharge planning and decision-making. This includes 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.

2.17 Delayed Discharges

2.17.1 If a patient is delayed from being discharged from the service other than for clinical reasons, the Provider must inform the relevant commissioning body and the referrer as soon as possible to identify how the delay can be overcome. This must involve liaison with other agencies and should also trigger NHS England escalation procedures.

2.18 Family and carer involvement

2.18.1 Family/carer involvement should include, if appropriate:

- rights to visits and phone calls with family/carers
- involvement with family/carers in providing a history
- involvement of family/carers in appropriate treatment and planning for discharge.

2.19 Post-18 care pathway

2.19.1 When a young person is a minimum of six months from their 18th birthday, the Responsible Clinician in the low secure service must liaise with local services and the Responsible Commissioner to ensure the relevant transition processes for mental health and social services are initiated including access assessment for adult secure provision if required.

2.19.2 In some cases identification of young people likely to require specialist provision after age 18 can be made at an early stage; good practice requires that transition planning must start at that point.

2.19.3 In some cases young people are required to stay beyond their 18th birthday for completion of adolescent- specific treatments. The maximum extended inpatient period must not exceed the young person's 19th birthday and the view of the responsible commissioner in the young person's CCG and the Tier 4 commissioner Case Manager must be sought six months prior to the young person's 18th birthday to confirm arrangements.

2.20 Interdependencies

2.20.1 Adolescent low secure services are part of a spectrum of services that meet the needs of young people with mental disorders including neurodevelopmental disorders such as learning disability and autism in need of specialist care and treatment in an intensive setting. These services also support young people in their recovery and enable transitions into less restrictive environments.

2.20.2 Individual low secure services must form part of a regionally and nationally coordinated network to ensure parity of practice and flexibility in terms of availability of in-patient beds.

2.20.3 Interdependent services at national level include:

- Nationally recognised providers of specialist secure adolescent medium and low secure in-patient care for young people with mental or neurodevelopmental disorders, including learning disability or autism
- Youth justice custodial settings (Young Offender Institutions (YOIs), Secure Training Centres (STCs) or secure children's homes)
- Secure welfare settings
- Community FCAMHS providers
- Other providers of highly specialist residential or educational care for young people.

2.20.4 Interdependent services at regional and sub-regional levels include:

- Local providers of secure mental health or neurodisability or other inpatient care for young people or those providing other secure care on youth justice or welfare grounds
- Commissioners of CAMHS (including Learning Disability and neurodevelopmental) services in CCG, Local Authorities and NHS England
- NHS England Case Managers
- Public health in respect of their role to establish local need
- Senior managers in children's social care in different local authorities
- Youth justice (YOT) services and youth and crown courts
- NHS and independent providers of non-secure in-patient care
- Providers of residential care
- Providers of special education
- Police, in particular senior officers responsible for youth justice, but also teams particularly involved with young people (e.g. child abuse investigation units)
- 3rd sector organisations working with young people, particularly those who are hard to engage
- Crown Prosecution Service, in particular decision-makers in relation to youth crime
- Safeguarding leads in all organisations (e.g. named and designated

professionals, local authority and education safeguarding leads)
- All services working with children and young people (e.g. CAMHS, social care, education, substance misuse, youth justice)
- Adult mental health and forensic mental health services (including those for people with neurodevelopmental difficulties, including learning disability and autism.

2.21 Safeguarding

2.21.1 Young people in Tier 4 CAMHS, especially those with a learning disability are often vulnerable, with high levels of dependence, but low levels of trust. This is also particularly true of some Looked After Children (LAC). In addition to the statutory responsibilities of professionals, sensitivity to these young people's potential vulnerabilities is needed.

2.21.2 The service must take all appropriate measures in relation to the safeguarding of young people under their care; in particular ensuring that:

- There is a child protection policy in place that reflects the guidance and recommendations of a 'Competent Authority' and that policy is implemented by all staff
- There is a nominated person within the service who fulfils the role of the competent person for child protection issues;
- There are systems in place to support the Prevent programme and services available aimed at reducing risks of child sexual exploitation.
- There is a robust mechanism in place for the reporting of child protection concerns in accordance with the Children Acts
- All clinical staff complete training in child protection issues to meet their obligations under the Children Acts and to meet the guidance contained in the Royal College of Paediatrics and Child Health publication 'Safeguarding Children and Young People: roles and competencies for healthcare staff Intercollegiate Document' (3rd edition) 2014
- Systems are in place to ensure the statutory guidance in "Working together to safeguard children" (2015) is followed.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

3.1.1 This specification covers children and young people up to age 18 years and who are the direct commissioning responsibility of NHS England.

3.1.2 Specifically adolescent low secure services are commissioned to provide services for young people who meet the following criteria:

- Aged 13 to 18 with mental disorders which cannot safely be contained in Tier 4 general adolescent inpatient care, PICU, community or other residential or custodial settings but does not meet the threshold for medium security
- Require longer-term interventions and specialist risk management procedures and specialist treatment interventions not available in non-secure or PICU settings. This includes young people with needs such as deafness, blindness or other physical disabilities and young people with neurodevelopmental disorders including learning disability and autism.

3.2 Population Needs

3.2.1 In England in 2015 there were over 1450 young people in secure settings at any one time. Over 300 of these were in secure mental health settings; the remaining 1100 were in either welfare secure (approximately100) or youth justice custodial settings (approximately 1000). Young people in all types of secure setting have clearly established significant mental health needs.

3.3 Evidence Base

3.3.1 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.

4 Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

4.1.1 The expected outcomes of the service support the national ambition to reduce lengths of stay, variation in service availability and access and improve the experience of young people, their families and carers using mental health services

4.1.2 The expected outcomes for this service must be delivered in the context of balancing the following three principles

- As an adolescent service provide developmentally appropriate care attuned to the complex needs of young people that facilitates emotional, cognitive, educational and social development
- As a secure service provide a secure and safe environment that can appropriately manage high risk, high cost behaviours whilst effectively managing high levels of vulnerability

- As a mental health service provide comprehensive multi-faceted evidence-based treatments.

4.1.3 The core service aims are to:

- Assess, formulate and treat mental disorders including neurodevelopmental disorders such as learning disability and autism
- Reduce the risk of harm to self and others
- Manage and treat mental and behavioural disturbance which is not manageable in a general adolescent inpatient settings, PICU or other secure settings (such as secure children's homes) for young people
- Provide an individualised developmentally appropriate framework of care that meets needs and includes the young person and family/carers in decision-making
- Embed the principles of safeguarding children in everyday service practice
- Provide a time-limited intervention that supports recovery and will enable a safe transition to an appropriate alternative mental health setting
- Provide all young people using the service with a full multi-disciplinary biopsychosocial assessment and formulation of needs resulting in a care plan developed in collaboration with them and reflective of their wishes and aspirations
- Deliver a range of specialist treatment programmes individually or in groups that enable the return to a non-secure Tier 4 CAMHS setting or effective discharge to a community setting
- Deliver care in line with the principles of Transforming Care including the facilitation and pro-active use of Care Education and Treatment Review (CETR) process
- Achieve delivery of efficient and seamless transfers of young people between acute and intensive care settings
- Use the Care Programme Approach to underpin service delivery
- Proactively manage violence and aggression
- Provision of a range of activity programmes for periods where education is not provided
- Deliver care within a therapeutic regime that places primary importance on behavioural approaches, de-escalation and psychopharmacological treatment of mental illness and agitated behaviour in the context of mental disorder.

4.2 NHS Outcomes Framework Domains

	Domain 1	Preventing people from dying prematurely	x	
	Domain 2	Enhancing quality of life for people with long-term conditions	x	

	Domain 3	Helping people to recover from episodes of ill-health or following injury	x	
	Domain 4	Ensuring people have a positive experience of care	x	
	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x	

4.3 Outcome Indicators

4.3.1 Outcome and activity measures are subject to further development and change. Detailed definitions of indicators setting out how they will be measured, is included in schedule 6.

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
101	% of urgent cases responded to by the assessing unit within five days.	Provider	2, 3, 4, 5	safe, effective responsive caring
102	% of people with learning disabilities and/or autism receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment review within two weeks of admission	Provider	2, 3, 4, 5	safe, effective responsive caring
103	% of patients who have a discharged plan agreed before admission or within 48 hours admission	Provider	2, 3, 4, 5	safe, effective responsive caring
104	% of patients assessed within 7 days of admission using HONOSCA (including patient/family/carer/clinician versions) and GBO to determine their health and social functioning	Provider	2, 3, 4, 5	safe, effective responsive caring
105	Average HONOSCA (see 104 above) improvement score for patients discharged during the quarter.	Provider	1, 2, 3, 4, 5	safe, effective responsive caring
106	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission	Provider	1, 2, 3, 4, 5	safe, effective responsive caring
107	% of young people	Provider	1, 3, 5	safe,

		prescribed antipsychotics who receive appropriate physical monitoring as per NICE guidelines.			effective, caring	
	108	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.	Provider / SSQD	3, 4, 5	safe, effective, well-led	
	109	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services	Provider / SSQD	3, 4, 5	safe, effective, well-led	
	110	Mean length of stay for patients discharged during the quarter	Provider	1, 2, 3, 5	safe, effective, caring	
	111	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Provider	1, 2, 3, 5	safe, effective, caring	
	112	Care hours per patient day	Provider	1, 2, 3, 5	safe, effective, caring	
	Patient Outcomes					
	201	All patients receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive	
	202	All carers receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive	
	202	Patient information is provided at the point of assessment.	Self-declaration	2, 4	effective caring	
	Structure & Process					
	301	There is an MDT in place with membership as per the service specification.	Self-declaration	1, 2, 3, 5	safe, effective responsive caring	
	302	Each patient has a named psychologist and occupational therapist.	Self-declaration	1, 2, 3, 4, 5	safe, effective caring	
	303	There is access to the Independent Mental Health Advocates (IMHA).	Self-declaration	1, 2, 3, 5	safe, effective responsive caring	
	304	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring	

4.3.2 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C.

4.3.3 Applicable CQUIN goals are set out in Schedule 4D.

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

5.1.1 Robust procedures relating to the responsibilities of services and staff under the Mental Health Act, the Children Acts and other relevant legislation must be put in place and regularly reviewed.

5.1.2 The service must deliver services, comply to and work within the requirements of:

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 2003
- Mental Capacity Act 2005
- DoH Offender Mental Health Pathway 2005
- The Autism Act 2009

5.1.3 The service must have regard to the provisions of:

- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent guidance unless there is a cogent reason not to do so
- UN Convention on the rights of the Child.

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 Services must comply with the following requirements:

- Operate 24 hours a day, 365 days per year
- There should be a full CPA review and planning meeting before admission to an LSU which will identify discharge treatment goals and an estimated discharge date and destination (an assessment by the LSU team is not a substitute for this).
- If a pre-admission CPA has not taken place, a full CPA meeting must be held within 2 weeks of admission. This will identify discharge treatment goals, an estimated discharge date and likely destination
- An initial MDT meeting with the family should be held within 1 week of admission to refine the treatment plan
- There must be a full CPA review meeting held 3-6 weeks after admission (for those who haven't had a post admission CPA review) with subsequent CPA review meetings held no less than every 3 months including at the point of service transition/discharge. The CPA can take place after the transition if there would otherwise be a delay in transfer to a less restrictive setting.
- For children and young people with special educational needs including those with an EHCP

    - Where appropriate (when a child or young person has an Education Health and Care Plan (EHCP) 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. When appropriate, providers must complete an EHCP application for a young person who requires additional support
- Discharge arrangements:
    - A responsible CAMHS team, including an allocated Responsible Clinician, must be in place before the start of a discharge process
    - The low secure service must convene at least one Section 117/CPA 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, must be provided at the point of discharge
    - A full discharge summary must be provided within 7 days of the discharge date
- Providers must be registered with QNIC and participate in the peer review process
- Each patient must have their own room and must have a Responsible Clinician allocated by the service for the duration of admission
- The nursing model of care must be based on the 'primary nurse' model, each patient must have a named nurse responsible for their day to day nursing needs
- Each patient must have a Care Coordinator/Case Manager allocated within the low secure service to co-ordinate care within the Care Programme Approach (CPA) framework
- The overall model of care must be delivered 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)
- The MDT must be experienced in the assessment, identification and management of young people with neurodevelopmental disorders including learning disabilities and/or autism
- The service must have expertise in and policies covering the use of psychopharmacology in severe mental illness including the use of rapid tranquilisation and local PRN
- Each patient must be reviewed by the MDT at least weekly and must have a comprehensive up to date MDT care plan and risk assessment developed by the MDT with the young person and, if appropriate, with the young person's family in accordance with best practice guidance. The young person must be kept updated with any changes to their care plan and have the secure HONOSCA

outcomes and improvements scores shared with them regularly.

- Young people with learning disability and/or autism must have their specific needs incorporated in the care plan. This must include practice set out in the Transforming Care national programme particularly the active support, facilitation and delivery of the CETR process
- Each patient must have a named practitioner psychologist who will undertake a needs based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual and/or group basis
- Each patient should have a named occupational therapist who will undertake a comprehensive occupational therapy assessment and will deliver an appropriate occupational therapy programme based on identified needs
- The service must facilitate access to and/or deliver timely and appropriate speech and language assessment and treatment during the course of the patient's admission
- Each patient must have access to a social worker from the low secure service to liaise with the young person's local Social Care Children's Service to ensure the provision of a full range of appropriate social care services to the patient, their family and carers
- Each patient must have access to the Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role
- Each patient must:
    - 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 where practicable
    - Have their rights under the Mental Health Act 1983 explained.
    - Have their physical healthcare needs met through a full range of primary healthcare interventions that include health promotion and physical health screens and appropriate support to access secondary care where required.

5.2.2 Services must comply with the following guidance:

- 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

5.3 Security Requirements

5.3.1 Low secure services must operate within a comprehensive set of physical, procedural and relational security measures, practices and policies that are in line with standards and requirements set by QNIC, CQC and the Mental Health Act Code of Practice.

5.3.2 Operational policies and procedures must comply with Mental Health Act Code of Practice requirements unless there are cogent reasons for not following the guidance in the Code. These reasons must be documented and reviewed regularly.

5.4 Service Environment

5.4.1 The provider must meet the following standards:

- The premises and the facilities generally are young person and family friendly and facilities meet appropriate statutory requirements, are fit for purpose as determined by the relevant statutory regulator (e.g. the Care Quality Commission), conform to any other legislation or relevant guidance
- A clean, safe and hygienic environment is maintained for patients, staff and visitors
- A care environment in which patients' privacy and dignity is respected and confidentiality is maintained
- There is appropriate, safe and secure outdoor space for recreation and therapeutic activities
- A care environment is provided where appropriate measures are taken to reduce the potential for infection and meets the requirements of the Healthcare Associated Infections (HCAI) code of practice
- The service ensures that the nutritional needs of all young people are adequately met and that comments about food and nutrition are incorporated in menu design
- An environment that ensures that no young person, visitor or staff member is allowed to smoke on the premises
- Facilities which include rooms which are suitable for contact between young people and their families/carers, including siblings and are available at weekends and evenings. These should be in proximity to, but separate from the ward.
- Bedroom and bathroom areas should be gender-segregated.
- Provide an area that can be used as a multi faith room

- Where possible the service should provide sleep over facilities for parents or carers nearby to the ward.

5.5 Additional considerations

5.5.1 Young people who are in the process of considering their gender identity and who are dressing and living according to their personal identity should be admitted to beds in male or female areas according to their preferred identity.

5.5.2 There should always be consideration of privacy and dignity for the young person and whether any additional arrangements or supports are needed.

5.5.3 Risk assessment must be completed to support decisions regarding appropriate placement and consider if additional safeguarding is required for the patient or the other young people, this will be a very individual assessment

5.5.4 Gender identity is separate from orientation and does not necessarily present any risks. The key issue is for the young person to feel supported and understood at all points.

5.6 Other Applicable Local Standards

Not applicable

6 Designated Providers (if applicable)

Not applicable

7. Abbreviation and Acronyms Explained

CAMHS: Child and Adolescent Mental Health Services
CCG: Clinical Commissioning Group
CETR: Care Education and Treatment Review
CPA: Care Programme Approach
HONOSCA: Health of the Nation Outcomes Scores for Children and Adolescents
IMHA: Independent Mental Health Advocate
NICE: National Institute for Clinical excellence
MDT: Multi-Disciplinary Team
QNIC: Quality Network Inpatient CAMHS

Appendix 1

Number	Indicator	Detail			Data Source	Alert	O.F Domain 1,2,3,4,5	CQC Key question, Well led, responsive, effective, caring, safe
		Descriptor	Notes	Evidence documents				
	Clinical Outcomes							
101	% of urgent cases responded to by the assessing unit within five days.	% of urgent cases responded to by the assessing unit within five days.		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring
102	% of people with learning disabilities and/or autism receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment review within two weeks of admission	% of people with learning disabilities and/or autism receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment review within two weeks of admission		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring
103	% of patients who have a discharged plan agreed before admission or within 48 hours admission	% of patients who have a discharged plan agreed before admission or within 24 hours admission		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring

104	% of patients assessed within 7 days of admission using HONOSCA (patient/family/carer/clinician versions) and GBO to determine their health and social functioning	% of patients assessed within 7 days of admission using HONOSCA and GBO to determine their health and social functioning		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring
105	Average HONOSCA (see 104 above) improvement score for patients discharged during the quarter.	Average HONOSCA improvement score for patients during the quarter. HONSCA should only be undertaken at a maximum of fortnightly, therefore if a discharge takes place within a fortnight there won't be a discharge HONSCA.		Annual Report	Provider	100%	1, 2, 3, 4, 5	safe, effective responsive caring
106	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission		Annual report	Provider		1, 2, 3, 4, 5	safe, effective responsive caring
107	% of young people prescribed antipsychotics who receive appropriate physical monitoring as per NICE guidelines.	% of young people prescribed antipsychotics who receive appropriate physical		Annual report	Provider		1, 3, 5	safe, effective, caring

		monitoring as per NICE guidelines.						
108	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.		Annual report	Provider / SSQD		3, 4, 5	safe, effective, well-led
109	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services		Annual report	Provider / SSQD		3, 4, 5	safe, effective, well-led
110	Mean length of stay for patients discharged during the quarter	Mean length of stay for patients discharged during the quarter		Annual report	Provider		1, 2, 3, 5	safe, effective, caring
111	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Ratio of substantive staff to agency staff or bank staff during the previous quarter.		Annual report	Provider		1, 2, 3, 5	safe, effective, caring
112	Care hours per patient day	Care hours per patient per day		Annual report	Provider		1, 2, 3, 5	safe, effective, caring
	Patient Experience							
201	All patients receive an experience of service questionnaire.	All patients receive an experience of service questionnaire.		Annual report	Self-declaration		2, 4	effective, caring, responsive
202	All carers receive an experience of service questionnaire.	All carers receive an experience of service		Annual report	Self-declaration		2, 4	effective, caring, responsive

		questionnaire.						
203	Patient information is provided at the point of assessment.	Patient information is provided at the point of assessment and includes details relating to: treatment information about the team information about patient involvement groups and patient self-help groups out of hours contact details/emergency number		Operational Policy	Self-declaration		2, 4	effective caring
	Structure and Process							
301	There is an MDT in place with membership as per the service specification.	The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards. The staff team will include at least: • Consultant level as well as non-consultant		Operational Policy	Self-declaration	N	There is an MDT in place with membership as per the service specification.	The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards. The staff team will include at least: • Consultant level as well as non-consultant grade medical staff • Clinical Psychology • Nursing staff

		grade medical staff • Clinical Psychology • Nursing staff • Occupational therapist • Teaching staff • Social work • Family Therapist • Staff skilled in group work • Creative therapies • Dietetic advice where services provide care for young people with eating disorders • Access to psychotherapy as appropriate • Administrative support • Access to physiotherapy						• Occupational therapist • Teaching staff Social work • Family Therapist Staff skilled in group work • Creative therapies • Dietetic advice where services provide care for young people with eating disorders • Access to psychotherapy as appropriate • Administrative support • Access to physiotherapy

302	Each patient has a named psychologist and occupational therapist.	Patients have • a named practitioner psychologist who must undertake a needs-based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual and/or group basis. • A named occupational therapist who must undertake a comprehensive occupational therapy assessment and deliver an appropriate occupational therapy programme		Operational Policy	Self-declaration		Each patient has a named psychologist and occupational therapist.	Patients have a named practitioner psychologist who must undertake a needs-based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual and/or group basis. A named occupational therapist who must undertake a comprehensive occupational therapy assessment and deliver an appropriate occupational therapy programme based on identified needs. A Care Coordinator/Case Manager allocated within the low secure service to co-ordinate care within the Care Programme Approach (CPA) framework.

		based on identified needs. • A Care Coordinator/Case Manager allocated within the low secure service to co-ordinate care within the Care Programme Approach (CPA) framework.						
303	There is access to the Independent Mental Health Advocates (IMHA).	Each young person has access to Independent Mental Health Advocate (IMHA) and where applicable, Independent Mental Capacity Advocates (IMCA), who will assist by undertaking the direct advocate's role.		Operational Policy	Self-declaration	N	There is access to Independent Mental Health Advocate (IMHA).	Each young person has access to the Independent Mental Health Advocate (IMHA) and where applicable, Independent Mental Capacity Advocates (IMCA), who will assist by undertaking the direct advocate's role.
304	There are agreed clinical protocols/guidelines.	There are clinical guidelines in place as specified by QNIC and detailed within the service		guidelines /protocols	Self-declaration		There are agreed clinical protocols/guidelines.	There are clinical guidelines in place as specified by QNIC and detailed within the service specification.

	specification.