Service Specification: Community Forensic Child and Young People Mental Health Service (FCAMHS)

1.0 Service Details	
1.1 Service name	Community Forensic Child and Young People Mental Health Service (FCAMHS)
1.2 Date published	7 May 2024
1.3 Accountable Commissioner	NHS England
2.0 Service Overview	
2.1 Service Description	This service specification describes a community-based Forensic Child and Young People's Mental Health Service (FCAMHS) model. The service will be delivered for a geographical area as defined by local commissioners but will generally cover one or more Integrated Care Systems, as determined by local arrangements. Evidence from service evaluations and national evidence *(***see Appendix 1)** suggests that users of FCAMHS will have multiple, complex needs and are more likely to present with high-risk behaviours, high levels of harm to others, and a high vulnerability toward victimisation. FCAMHS use a team-around-the-professional model to support frontline services through consultation, improving local pathways, strengthening transitions between local services and reducing out of area placements. FCAMHS play a specific role in preventing admission to secure care and supporting transitions back into the community for Medium Secure Units (MSUs). However, the same cohort of children and young people will be supported by a range of other services, including those for which healthcare is commissioned by NHS England (NHSE) Health & Justice (H&J) and other in-patient and specialist mental health services commissioned by NHSE Specialised Commissioning Teams. It is therefore important that FCAMHS are commissioned and delivered to wrap around this system to prevent (re) offending or (re) admission into secure care, support continuity of effective mental health support and ensure children and young people can be effectively supported within their home communities.
2.2 Commissioning Responsibilities	NHS England retains commissioning responsibility for Childrens and Young People's Mental Health Specialised Services, including FCAMHS, when delivered as part of an NHS Lead Provider Collaborative.

3.0 Demographics & Evidence Base

3.1 Population covered

FCAMHS are commissioned for children and young people up to age 18 years, who are the direct commissioning responsibility of NHS England. Specifically, FCAMHS is commissioned to deliver quality mental health consultation, advice, assessment, and limited intervention for high-risk young people with complex needs living within the catchment (or belonging to that catchment but placed elsewhere), who meet the following criteria:

- under 18 years old at the time of referral (no lower age threshold for access to the service although most referrals will be for 10- to 18-year-olds).
- presenting with serious conduct and emotional issues, neuropsychological difficulties, or serious mental health problems and/or neurodevelopmental conditions (including learning disability or autism) with/without learning difficulties, where there are legitimate concerns about the existence of such conditions.
- usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault, and sexual offending.

In exceptional cases the service may support other children and young people who have highly complex needs and are causing major concerns across agencies. This should be agreed on a case by case basis, based on clinical need.

The catchment for each service should be 'regional' in the sense that it covers a population and/or geographical area for a total population of about 2.5 million. Careful consideration should be given to the mix of densely populated/rural areas and levels of deprivation in the area covered.

3.2 Population needs

The links between early adverse childhood experiences (ACEs) and the development of anti-social behaviour are now well-evidenced (Bailey & Chitsabesan, 2019). Children and young people accessing FCAMHS have multiple cross-cutting mental health needs. These are often complicated by co-morbidity with other physical health needs, substance misuse and/or neurodiversity. They have often faced significant trauma and loss – as evidenced by the significant over-representation of children in the care of Local Authorities within the MSU cohort (Centre for Mental Health, 2011b, Singleton et al. 1998).

FCAMHS play a particularly important role where children and young people present a significant risk of harm to others and who are causing significant concern to agencies across their network. Meeting the needs of these children and young people can require additional specialist input into care planning and treatments, and this is the role of FCAMHS. A key aim in developing FCAMHS services was to reduce the risk of future detention within the secure estate, including:

- Young Offender Institutions (YOIs)

- Secure residential children's homes
- Secure training centres
- Secure schools
- Medium Secure Units (MSUs – for those with highly complex mental health needs)

Since the national roll-out, FCAMHS services have evolved in line with regional circumstances and these services now play a vital role in facilitating effective care and treatment for children and young people in a range of settings.

3.3 Evidence Base

A National Evaluation of FCAMHS (Anna Freud National Centre for Children and Families, 2021) demonstrated that community FCAMHS teams made a positive impact for young people, their families and the professionals working with them, contributing to significant improvements in children and young people's health and well-being.

The economic evaluation found that cost savings following the roll-out of FCAMHS appeared to be significant and the programme demonstrated savings to society and the public sector, because of decreased engagement in crime. The review concluded that if 1/100 young people supported by FCAMHS aged 15-17 years avoided a year's detention, this alone could make FCAMHS a cost neutral – if not a cost saving – service.

The national model and best practice are derived from an independent evaluation of the regional community FCAMHS service in the Thames Valley (Public Health Resource Unit, 2006) and subsequent re-evaluation of a second service replicating the service model across Hampshire and the Isle of Wight (Solutions in Public Health, 2011).
For more information on the current Evidence Base, please see Appendix 1.

3.4 Future Demand

In 2021/22 FCAMHS received 2,200 referrals nationally. Since then referral numbers have generally been increasing nationally. NHSE anticipate a 40% increase in the number of young people in secure settings as the covid court backlog is addressed, while the acuity of mental health needs seen in community services is also increasing. Therefore, it is likely that demand for FCAMHS support will increase over time.

To meet these needs FCAMHS services will need to work collaboratively with community partners to design and implement innovative service pathways and work with NHSE to explore future funding options.

4.0 Service Aims and Outcomes

4.1 Service Aims & Ethos

The **primary service aim** is to provide high-quality, consistent mental health support that reduces the risk of offending, or escalation in offending and addresses health inequalities

experienced by children and young people who present with high risk, high harm, high vulnerability needs. The service will achieve this by providing high quality consultation, advice, assessment and limited treatment to children and young people with a mental health condition, who present with a high level of risk and harm to others and have additional vulnerabilities. The FCAMHS model should achieve this aim by reflecting the principles of the Mental Health Act set down below:

- **Maximising independence and promoting the least restrictive option –** Where it is possible to treat a person safely and lawfully without detaining them under the Act, the person should not be detained. Wherever possible a person's independence should be encouraged and supported, with a focus on promoting recovery.
- **Respect and dignity –** Children and young people, family and carers should be treated with respect and dignity and listened to by professionals**.** All young people from an identified geographical catchment should be able to access a quality service regardless of disability, sex, race, gender, or location.
- **Empowerment and involvement –** Children and young people should be involved in decisions about care, support, and treatment. There should be active collaboration with family and carers where possible. Their views should be fully considered when decisions are made and where decisions are taken that are contradictory to views expressed, professionals should explain the reasons for this.
- **Effective treatment –** The intensity of treatment should match the extent of the risk posed by the young person**.** Decisions about care and treatment should be individualised with clear therapeutic aims and should be informed by current national and best practice guidelines. Treatments should promote recovery with an emphasis on behavioural and cognitive approaches targeting proximal causes of offending behaviour (peer groups, promoting family communication, enhancing self-management and problem-solving skills), rather than the distal causes. Principles of safeguarding children and young people should be embedded in the service.
- **Efficiency and equity –** Providers, commissioners, and all partner organisations should ensure that quality of mental health care is given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe, and supportive discharge from detention. Intensity of care and treatment should match the extent of risk posed by the patient.
- **Collaboration with community services –** Close pathways must be maintained with relevant community services to ensure children and young people's care is personalised, they are not repeating their history and transitions are as seamless as possible.

It is also noted that many young people supported by FCAMHS are known to the youth justice system and Children and Young People Secure Estate (CYPSE) – oversight of healthcare for the CYPSE sits with the NHSE Health and Justice (H&J) commissioning team. Close partnership working and collaborative commissioning between these teams is vital to support outcomes for children and young people.

4.2 Service Outcomes

The expected outcomes of the service support the national ambition to:

- Improve mental health and well-being by identifying and addressing the mental health needs of high-risk young people in a range of secure, residential and community settings.

- Reduce numbers of inpatient admissions and lengths of stay.
- Reduce variations in service availability and access and.
- Improve the experience and outcomes of in-patients, families and carers using mental health services.

NHS Outcome Framework

All NHS Services must have due regard for the NHS Outcomes Framework and are required to be able to articulate how their services support delivery of national priorities.

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

The measures below relate to the primary outcomes of FCAMHS and are not inclusive of all service metrics. The service will complete/ upload data for wider quality metrics to the national Specialised Services Quality Dashboard (SSQD).

There is the opportunity to update quality metrics outside of the service specification development process. Updated quality metrics can be commenced at any time within the year but will only be updated once per year.

The minimum quality outcomes are set out in the table below.

NHS Outcomes Framework Domain	Rationale	Name of outcome/ description
3	Demonstrates CYP's improvement/recovery while in the service	Percentage of current in-patients over last 6 months with improved HONOSCA score
3	Demonstrates CYP's improvement/recovery while in the service	Mean change in score for in-patients with improved HONOSCA score in last 6 months
3	Demonstrates CYP's improvement/recovery while in the service	Percentage of current in-patients over last 6 months with improved HONOS-Secures

3	Demonstrates CYP's improvement/recovery while in the service	Mean change in score for in-patients with improved HONOS-Secure score in last 6 months.

The service will complete/ upload data for all listed quality metrics to the national Specialised Services quality Dashboard (SSQD). The full version of the quality metrics and their descriptions including numerators and denominators are at:
https://www.england.nhs.uk/commissioning/spec-services/npccrg/spec-dashboards/

FCAMHS services should use the following measures as appropriate:

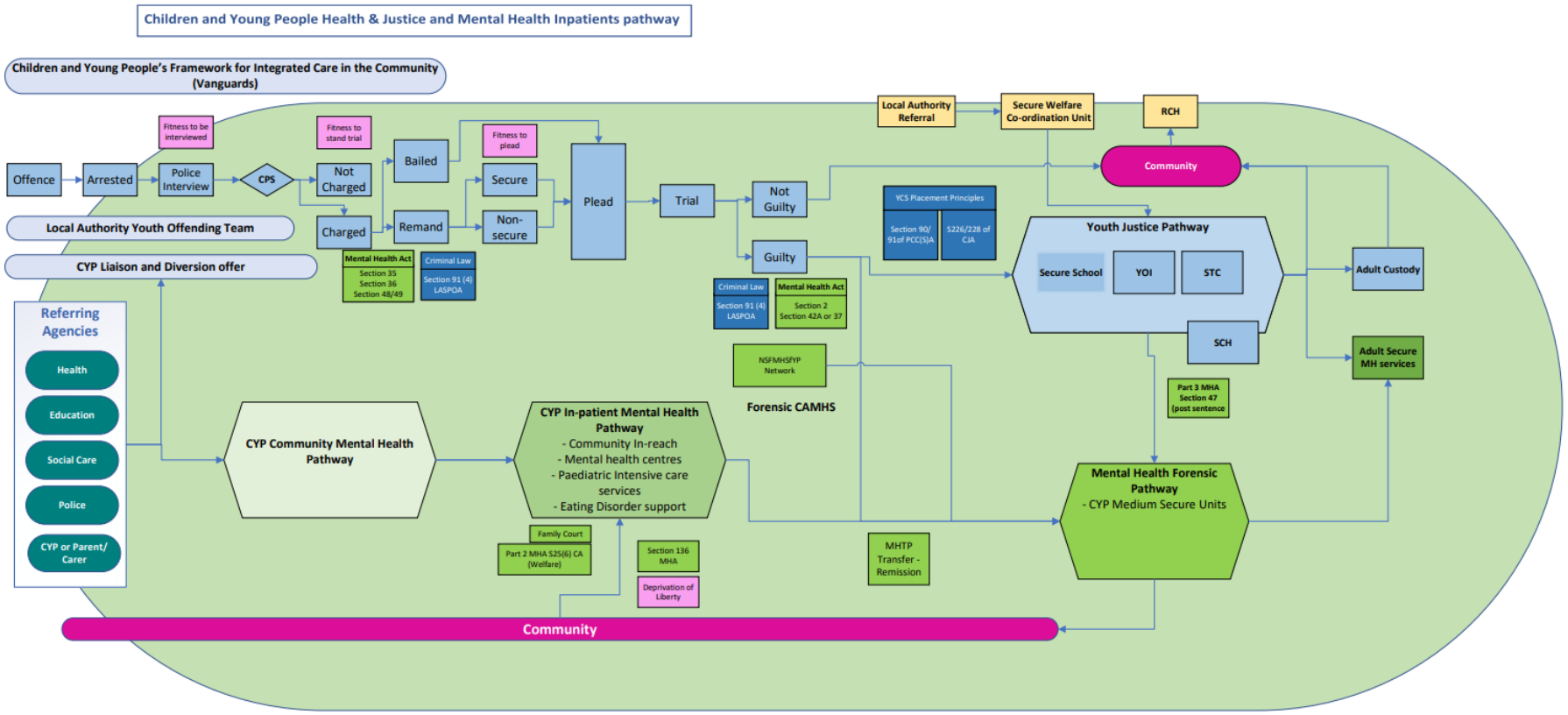
- Health of the Nation Outcome Scales (HoNOSCA) for Children and Adolescents - developed for under 18 year olds in contact with mental health services.
- HoNOS-secure version 2b – the latest version of what was previously known as HoNOS-MDO*. It is specifically designed for use in health and social care settings such as secure psychiatric, prison health care and related forensic services, including those based in the community. Parts of the original HoNOS can be hard to interpret in secure settings, and this scale meets that need. https://www.rcpsych.ac.uk/events/in-house-training/health-of-nation-outcome-scales
- Child Global Assessment Scale (CGAS) – a numeric scale used by mental health clinicians to rate the general functioning of children and young people under the age of 18.

Services should monitor referral rates, including how service users access services and their preferences, to support both the outcome metrics in this service specification and locally devised reporting, based on local needs and priorities.

5.0 Service Description

5.1 Care Pathway Children and Young people Health and Justice and Mental Health In-patients Pathway (NECS, 2023).

FCAMHS teams are part of the wider Children and Young people Health and Justice and Mental Health Pathway (NECS, 2023), which requires close partnership working with services that support children and young people in the community, as well as those transferring in/out of in-patient or secure services (including MSUs and CYPSE).



Service Functions

All FCAMHS teams should deliver the following core service functions:

- Consultation and Advice
- Direct Assessment
- Intervention within the child or young person's professional network

2. Consultation and Advice involves:

- Facilitation of **smooth transitions** for young people between services and agencies and between children's and adult services and into and out of **secure settings**, including providing support, advice and follow-up of cases where young people move out of area, or facilitating return from secure custodial, welfare or mental health placements.
- Developing **strategic links between local provision and regional and national specialist** services, to identify and resolve gaps in service provision – ensuring children and young people receive a **high quality of individualised care** irrespective of geography or system barriers.
- **Coordination of, and liaison with** mental health, educational, social care services and the CYPSE, ensuring that care is provided in line with the welfare principles of the Children Act (1989 and 2004) and Code of Practice 2015 to the Mental Health Act (as amended 2007).
- **Liaison and specialist advice to youth justice partners**, including local youth offending teams, courts, legal system and secure settings. On occasion specialist advice and signposting may be required to support the justice process. This does not replace, or perform the role of, traditional medicolegal processes, but will include maintaining consistent links with professionals supporting children and young people from their area, regardless of the setting in which they are placed.
- Developing **joint working arrangements** with a wide range of interdependent children and young people's services (see **Appendix 5**) to support the management of care.
- **Provision of training** to practitioners from all agencies in relation to areas within the service's specialist remit.
- Develop effective partnerships with agencies (children's social care, education, and the youth justice system) who are **providing care for young people presenting with complex, high-risk behaviours in the overall pathway** for children involved in criminal justice and mental health services (e.g., services for young people with sexually harmful behaviours, mental health in-reach to local secure welfare or custodial settings and involvement in criminal justice liaison and diversion teams).
- **Partner with local services** to ensure the young person has a timely assessment where there are indicators of undiagnosed needs that pertain to high risk, high vulnerability presentation. FCAMHS may be well placed to complete assessments in such instances, as part of their case formulation. FCAMHS teams should have clear policies in place to describe the circumstances in which they may be able to support assessment, where a delay is negatively impacting appropriate care and treatment pathways.
- **Promotion of continuity of care** wherever possible, ensuring a holistic approach to care and supporting the young person to achieve their developmental potential, and to promote healthy family functioning.

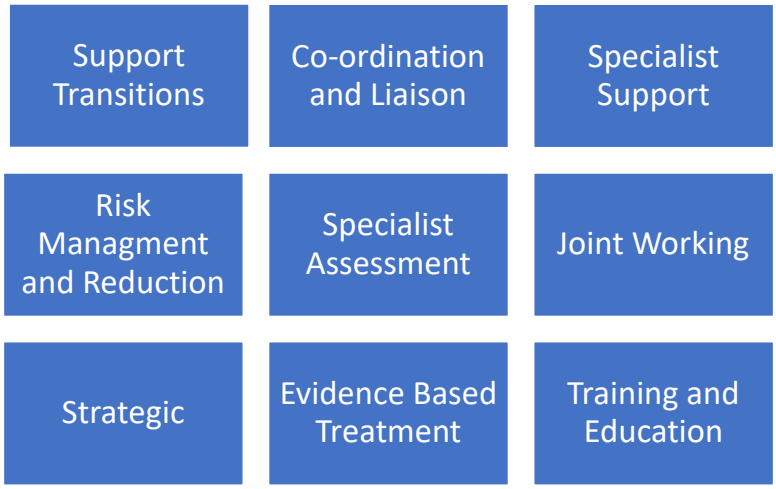
2. Direct Assessment involves:

- Case formulation in partnership with the referring agency and specialist mental health assessment (including forensic assessment) where appropriate. The referring agency remain the case holder of the young person. Direct assessment will be offered only in high-risk cases, where there is a need for specialist opinion to ensure that children and young people presenting high risk of harm to others are managed.

3. Intervention within the child or young person's professional network may involve:

- Clinical supervision to community practitioners, in line with the consultation model.
- Specific training, reflection or guidance to professionals within the child or young person's network to address specific issues identified during the formulation process.
- Psychoeducation around diagnoses.
- Time-limited support to support children and young people to understand their formulation and next steps.

Interventions from FCAMHS are likely to be focussed on preventing admission to in-patient settings where appropriate alternatives exist or where in-patient admission is unlikely to prove successful, as well as preventing escalation of youth justice involvement. This should include close adherence to the 'Transforming Care' agenda and engagement with the CETR process in cases of learning disability, autism, or both.



Service provision should be flexible, using a mix of online, in-person and hybrid delivery methods as appropriate, with risks effectively mitigated.

Where the young person has a learning disability or autism spectrum disorder, every effort must be made to hold a Care, Education and Treatment Review (CETR) before admission, including a Blue Light CETR if there is not time to convene a full one. 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 January 2023. https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/#heading-1
For more information on CETR process, please see **Appendix 3.**
For more information on Clinical Networks, please see **Appendix 2**.

5.2 Referral process and Eligibility Criteria

The team will accept referrals from all agencies that have contact with young people in the youth justice system, or who are exhibiting risky behaviours, who have mental health difficulties and will seek to make itself **accessible to any professional** who wishes to make initial contact regarding a young person giving cause for concern and about whom there are questions regarding his/her mental health.

FCAMHS is not a case holding service, so the responsibility for risk management and care planning remains with the referrer throughout the process, unless otherwise agreed (for example where issues identified during an initial contact identify the need for alternative case holding responsibility).

Discussion and formal consultation with referrers should be undertaken by experienced members of the team. The Service should provide a response to initial contact from a referrer within 5 working days of receipt.

There should be very clear expectation of meaningful engagement and joint working with the specialist outreach team from a child's local CYPMHS team for any child referred by agencies other than CYPMHS. The team does not necessarily expect that a young person at referral will have a previously diagnosed mental health difficulty and a child not known to CYPMHS should not be excluded from accessing support from FCAMHS.

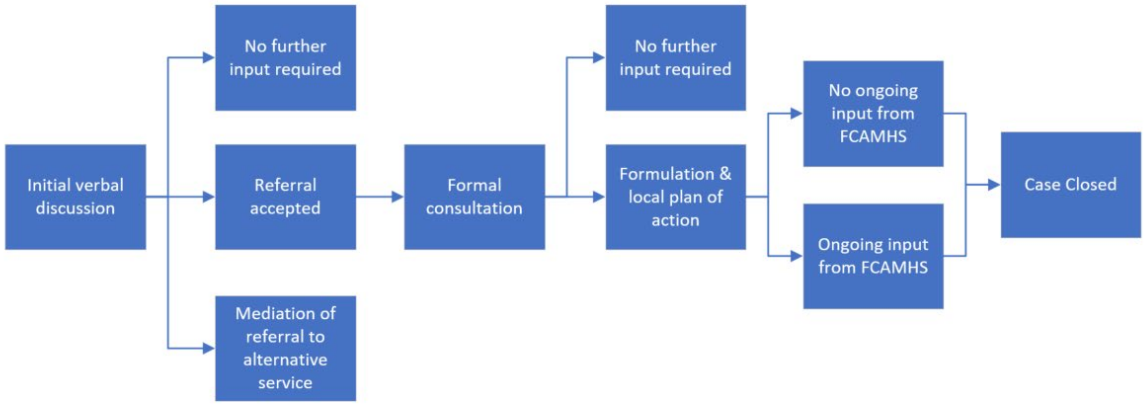
The service will have broad and inclusive criteria for initial contact with the team. Flexibility should apply in some cases to age of young person, depending on need and appropriateness of ongoing input beyond their eighteenth birthday.

The referral process has been put in place to ensure:

- specialist assessments and interventions are only undertaken when necessary.
- local services are supported to continue their work with identified young people and are encouraged to do this in situations where they might not have felt able to do so.
- young people receive input at a level commensurate with their needs and with their potential for risk of harm to others or themselves.

Referral Criteria are deliberately broad, covering all young people up to their 18th birthday about whom there are questions regarding mental health or neurodevelopmental needs including learning disability and autism who present high risk of harm towards others and about whom there is major family or professional concern.

Referral Pathway



If the referrer is not from a local CYPMHS team and the referral is accepted for further input after an initial discussion, the FCAMHS will discuss the referral with the young person's local CYPMHS team. This will facilitate a clear, collaborative approach to the young person's care plan and enable joint assessment and intervention where possible.

Formal consultation and referral accepted by FCAMHS for specialist assessment and treatment still requires the home CYPMHS team and family and carers to remain involved with the young person's case (e.g. by providing a care/case coordinator) and usually to participate in ongoing risk-management in conjunction with the outreach team.

Following the assessment, FCAMHS will remain involved, as appropriate, to support the local CYPMHS team and family and carers to manage the case and provide specific intervention. Written feedback outlining details of assessment and recommendations will be provided to the referrer and relevant others, including family and carers.

In general it is expected that support will be offered from the FCAMHS team covering their originating area. Collaborative working between FCAMHS teams is expected to ensure all children and young people receive equitable access to FCAMHS. All referrals should be managed in line with the guidance which can be accessed at: FCAMHS Out Of Area Guidance Document – National FCAMHS, CAMHS LSU and CAMHS MSU Workspace – FutureNHS Collaboration Platform

5.3 Clinical Interventions

FCAMHS must have a robust understanding of a range of interventions and be able to offer advice and guidance on their implementation to a child or young person's professional network. Knowledge of the following interventions and evidence base may be required:

- Psychotherapy
- Pharmacotherapy
- Behaviour Targeted Interventions (e.g., Cognitive Behavioural Therapy (CBT))
- Vocational Training
- Family Therapy

- Art / Music / Dance Therapy
- Mindfulness-based Interventions
- Dialectical Behaviour Therapy (DBT)
- Multi-Systemic Therapy
- Mentalisation-based Treatments for Adolescents (MBT-A)
- Speech and Language assessments and interventions
- Occupational Therapy assessments and interventions

Care should be delivered in line with the principles of the Care Programme Approach and the Community Mental Health Framework as appropriate.

Interventions should be specially of value for young people with offending or challenging behaviour, and FCAMHS teams are required to be competent to deliver support to a range of settings – including residential or foster care and educational settings.

In all situations, reasonable adjustments should be made for children and young people with learning disability, autism or both, and adapted treatment programmes should be available.

Trauma-Informed Approaches
There is strong evidence that trauma-informed services are vital when supporting this cohort of young people, as well as ensuring the resilience of the workforce. FCAMHS should operate on a continuum of services that recognises and appropriately responds to trauma to prevent escalation of needs and risks. This should include trauma-informed practice as standard and appropriate trauma-informed training for all staff working directly with children and young people. Consideration of Post Traumatic Stress disorder (PTSD) should be captured if they have fled their country due to war. In aligning with the CYPSE, FCAMHS should work within the principles of the Framework for Integrated care (SECURE STAIRS). See **Appendix 4** for more information.

5.4 Additional Vulnerabilities

Providers should be aware of the additional vulnerabilities and health inequalities facing children and young people in their care and be able to evidence how they adapt their processes, policies, and interventions to meet the needs of all children and young people – including supporting cultural differences. This should include making use of best practice and relevant statutory guidance for children and young people who:

- are looked after (CLA) or care leavers.
- have experienced child sexual exploitation (CSE) or child criminal exploitation (CCE).
- have neurodiverse needs including learning disability, autism, ADHD, acquired brain injury (ABI), or Tic disorders (e.g. Tourettes).
- have speech, language and communication needs.
- experience gender dysphoria or gender identity challenges.
- are misusing drugs or alcohol.
- display Harmful Sexualised Behaviour.
- have been excluded from education and/or are at risk of being long-term not in education, employment or training (NEET).

Health and Wellbeing Needs Assessments for the area or setting(s) should be used to understand local prevalence of these needs, as well as any other additional vulnerabilities that might be identified.

Providers should consider at a minimum:

- how their assessment process supports effective identification of additional vulnerabilities.
- what reasonable adjustments are made to screening/assessment or interventions and clinical and non-clinical environments to ensure all children and young people can access and benefit from services equally.
- how identified vulnerabilities are recorded to ensure continuity of care throughout a child or young person's journey, and to reduce re-assessment.
- how information is shared with wider support networks throughout the care pathway – but especially at the point of discharge – to ensure care and support from all agencies is appropriate and co-ordinated in the best interests of the individual child or young person.
- how the staffing model ensures that children and young people are supported by professionals who understand and can meet their individual needs – e.g., through 'champions', Train the Trainer models, Lived Experience inclusion within the workforce, skill mixes within multi-disciplinary teams and/or access to peer support.
- how the workforce is trained and supported to identify and respond to additional vulnerabilities.

Race, Diversity and Culture

Forensic mental health services need to differentiate interventions and approaches to engaging young people from different ethnic groups to ensure equity of access and outcome. Professionals supporting young people need to understand how their ethnicity may have had an impact on their journey into that service, including how:

- The level of previous assessment or type of diagnosis may differ from their peers. For example, have culturally sensitive assessments been considered? Have differences in cultural presentations been considered?
- Their knowledge of mental health services and interventions may differ from their peers and may need to be adapted to their needs.
- Their attitude toward, or trust in professionals, may have been shaped by previous experience.

Providers should ensure children and young people have access to quiet rooms and multi-faith spaces (such as prayer rooms) within hospital settings, as well as chaplaincy services.

Neurodiversity

All services will ensure that accurate submissions of data regarding disabilities are flagged in the Mental Health Dataset to ensure that the full range of neurodevelopmental disorders and physical health needs are captured and both prevalence rates and outcomes for these cohorts can be compared to the wider population. All services will:

- identify and assess a range of disabilities (including Autism, Attention Deficit Hyperactivity Disorder (ADHD), learning disability, speech and language difficulty and acquired brain injury).

- make reasonable adjustments to clinical interventions and physical spaces to ensure all young people can access support equitably.
- ensure their workforce planning supports accessible and appropriate interventions that meet individual needs.
- Develop a skills matrix for staff working within forensic mental health services to ensure appropriate training and development opportunities are available to support children and young people with additional needs. Training will include Oliver McGowen training, Care Quality Commission (CQC) requirements and QNIC standards.
- Raise the profile of the five good communication standards Microsoft Word – RCSLT Good standards v 8 Nov 13

5.5 Discharge and Continuity of Care

Referrers will retain overall clinical responsibility for young people they refer and assume a case coordination role, irrespective of level of FCAMHS involvement. In this way the service local to the young person remains linked with the young person's progress and can ensure local case management. Referring services must identify a case coordinator who will remain in contact with the case throughout the period of involvement from the FCAMHS.

Any discharge from the service, irrespective of level of input required should be undertaken in consultation with the referrer and the child/young person and/or their family and carers.

The service will ensure rigorous care planning from the point of referral to discharge, prioritising meeting immediate mental health needs and effective risk management. This should take into consideration the needs and wishes of the young person and family and carers, and the involvement of other professionals. A copy of the discharge information should be shared with referrers, and where relevant with children and young people, family and carers; general practitioners and, with the permission of the family, to any other involved professionals.

Children and young people open to FCAMHS may move to other services and other geographical locations. Contact with the case will not automatically end if the young person moves out of catchment, into specialist residential, custodial, educational or secure mental health in-patient provision. FCAMHS teams should remain aware of where children and young people from their catchment who present a forensic risk are currently living and are encouraged to proactively seek referrals from in-patient and secure services. This will require active engagement with key settings within the FCAMHS catchment, to develop and maintain relationships that support effective transitions and discharge. FCAMHS are best placed to follow the young person through any out of county placement, ensuring that the young person's needs continue to be met and that transition back to the home area can be facilitated.

Support for 18 year olds.
While referrals will only be accepted up to a young person's 18th birthday, those approaching their 18th birthday on referral are likely to receive a time-limited service from FCAMHS. The focus of such interventions should be on ensuring a robust transition plan to appropriate

services. It is anticipated that FCAMHS involvement will end on a young person's 18th birthday, following appropriate early discharge planning.

6.0 Workforce

To effectively address the underlying causes of offending behaviour and risks inherent within individual experiences and circumstances, FCAMHS teams should be overseen by a highly skilled professional, with extensive experience of working with children and young people in forensic and mental health settings, and in the assessment and treatment of complex, high-risk young people. The multidisciplinary team should draw on expertise such as:

- Psychiatrists
- Psychologist(s) with appropriate forensic and clinical experience.
- Clinical nurse specialist/senior mental health practitioner(s) (at least Band 7).
- Mental Health Nurses
- Learning Disability Nurses
- Occupational Therapists
- Creative Therapists (art/music/drama)
- Family Therapists
- Social Worker
- Speech and Language Therapists
- Dedicated team administration

In particular, the service will have specialist understanding of statutory mental health, welfare, youth justice and educational processes and understanding of the interfaces between them. It must be experienced regarding the needs of young people with neurodevelopmental presentations.

The emphasis should be on a small, highly experienced, and active team whose members are equipped to provide authoritative specialist support to local generic networks. It is recognised that recruitment and retention of suitable experienced specialist roles is a national challenge, and a flexible design and development of regional MDTs is encouraged to meet identified needs.

The function of the specialist team combines support for generic children and young people's services and specialist clinical assessment, formulation, and intervention skills. The role of the consultant psychiatrist is essential given the specialist knowledge of the Mental Health Act required in this work. Psychology support is also crucial given the frequent need for structured psychometric cognitive and other psychological assessments as well as consideration of appropriate interventions. The administrator's role is central and requires a wide range of skills and coordination of a peripatetic team.

Staffing levels per catchment should be determined in line with the team's core functions, catchment population and geographical size and levels of deprivation.

Geographical co-location within existing CYPMHS provision is highly advisable. This reinforces the fact that FCAMHS constitute part of an overall care pathway for children and young people with mental health or neurodevelopmental needs. Such an arrangement also

facilitates access and allows meaningful feedback, while preventing isolation of a specialist service.

Premises should be available to the team to undertake clinical assessments flexibly, in proximity to residential provision while enabling suitability, privacy, and confidentiality. As a result, the team is likely to be peripatetic but should retain a clearly defined team base. It must provide outreach across each region/sub region and ensure that there is consistent and equitable coverage to meet the population needs according to population density, geographical distribution, and levels of deprivation.

Providers should be expected to demonstrate routinely that:

- they champion and improve staff wellbeing, responding pro-actively to the specific needs of their local workforce.
- staff have access to regular clinical supervision, reflective practice and safeguarding supervision as appropriate to their role.
- wherever possible, their workforce is demographically representative of the children and young people being supported by the service.
- training on cultural values and beliefs is accessible to staff, to ensure they can appropriately support young people from all backgrounds.

A review via a training matrix of all staff should take place annually to ensure all staff working with this cohort have the required skills and knowledge to provide the best support.

Providers should consider how to develop female, LGBT+, substance misuse, neurodiversity and BAME pathways within their service – overseen by champions within their workforce – to enhance local pathways and respond to the voice of these young people.

Where community practitioners lack a particular cultural expertise, they should partner relevant culturally specific agencies to support children and young people on discharge from FCAMHS.

7.0 Safeguarding

Safeguarding

Young people accessing FCAMHS, especially those with a learning disability or autism, are often vulnerable, with high levels of dependence but low levels of trust. In addition to the statutory responsibilities of professionals, sensitivity to these young people's potential vulnerabilities is needed.

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

- 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 and establishes good working links with Lead safeguarding Dr and Nurse and safeguarding systems in their organisation.
- 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 Act.
- 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 . All staff must have access to and attend safeguarding supervision.
- Systems are in place to ensure the statutory guidance in "Working together to safeguard children" (2015) is followed.

Cases without Consent

Due to the nature of the cases referred to FCAMHS, there may be instances where information sharing without the consent of the child, young person or family and carers may be appropriate under relevant legal frameworks, e.g. Prevent. Where parental consent is not provided, but FCAMHS involvement is deemed necessary, referrers should be encouraged to use their local safeguarding policies and processes.

8.0 Patient Experience

Services should undertake work to ensure engagement and feedback mechanisms are proactively utilised and response rates are maintained.

Working in partnership with people and communities.

All NHS providers should adhere to the statutory guidance 'Working in Partnership with People and Communities' May 2023. The document sets out how the guidance should be used; the main legal duties; reasons for working with people and communities; and the leadership needed to realise these benefits. It gives 10 principles to follow to build effective partnerships with people and communities – https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/#the-benefits-of-partnership

Involvement of family and carers.

Family and carer involvement should include, where appropriate:

- Involvement with family and carers in providing a patient history.
- Involvement of family and carers in appropriate planning and delivery of treatment.
- Family and carers being supported and made aware of their rights of access and support including through **carers contingency plans** and other resources for unpaid carers, including NHS England » Carer support and involvement in secure mental health services

9.0 Interdependencies with Other Services

FCAMHS must be expert in liaising and establishing good working relationships with a wide variety of agencies, particularly community mental health teams, MSUs and the CYPSE. It is critical that all secure settings, FCAMHS and all community services work closely together to ensure the best outcomes for the young people with whom they have contact – especially in supporting effective transitions between services. FCAMHS teams must be capable of advising, supporting, and challenging a wide range of agencies and institutions. At times their role in high-risk cases will involve the containment of anxiety, while at others it will involve the injection of concern where risks were poorly addressed.

FCAMHS teams should be adept at collaborative working across agencies and institutions operating not only locally but also at regional and national levels. (Appendix 5).

10.0 Standards and Legislation

National Standards

Service delivery must comply with:

- Mental Health Act 1983, as amended 2007.
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 1998
- Criminal Justice Act 2003
- DoH Offender Mental Health Pathway 2005
- Mental Capacity Act 2005
- The Autism Act 2009
- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent legislation.
- NHS Patient and Carer Race Equality Framework
- Any other relevant legislation that may come into force or be deemed relevant during the life of the service.

Service Standards

- Information Sharing – Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, March 2015)
- Healthcare Standards for Children and Young People in Secure Settings Updated April 2023 (RCPHC, 2023)

Guidance and Best Practice

- NICE guidelines for a range of disorders occurring in children and adolescents (e.g. psychosis and conduct disorder)
- Code of Practice: See Think Act (Department of Health 2010)
- Department of Health/Youth Justice Board Information Sharing Guidance
- Supporting people with a Learning Disability and/or Autism who Display Behaviour that Challenges, including those with a Mental Health Condition: Service Model for Commissioners of Health and Social Care Services ('Transforming Care')

- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE 2018)
- Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers (DFE July 2018)
- Future in Mind (NHSE 2015)
- Health and Justice Children Programme national partnership agreement 2023-25 (NHSE 2023)
- Standards for children in the youth justice system (YJB, 2019)
- Criminal exploitation of children and vulnerable adults: county lines (Feb 2020, Home office)
- Child sexual exploitation - Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (Feb 2017, DofE)
- Prevent duty guidance: Guidance for specified authorities in England and Wales (HM Gov, Sept 2023)

Security Standards

- Promoting mental health for children held in secure settings: a framework for commissioning services. London: DH, 2007
- Procedure for the Transfer from Custody of Children and Young People to and from Hospital under the Mental Health Act 1983 in England (DoH, June 2011)
- Healthcare standards for children and young people in secure settings (2013) Intercollegiate Document (Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners, Royal College of Nursing; Royal College of Psychiatrists, Royal College of Forensic and Legal Medicine and Faculty of Public Health)

Appendices

1. **Desktop Literature Review**
2. **Additional Service Functions**
3. **CETR Process**
4. **SECURE STAIRS**
5. **Interdependent Services**

Abbreviations and Acronyms

ABI: Acquired Brain Injury
ACES: Adverse Childhood Experiences
ADHD: Attention Deficit /Hyperactivity Disorder
CBT: Cognitive Behavioural Therapy
CCE: Child Criminal Exploitation
CETR: Care Education and Treatment Review
CGAS: Children's Global Assessment Scale
CLA: Children Looked After
CQC: Care Quality Commission
CYP: Children and Young People
CYPMHS: Children and Young People's Mental Health Service (Community CAMHS)
CYPSE: Children and Young People Secure Estate
DBT: Dialectical Behaviour Therapy

FCAMHS: Forensic Children and Young People Mental Health Service
H&J: Health and Justice Services
MBT-A: Mentalisation-based treatments for Adolescents
MDT: Multidisciplinary team
MHA: Mental Health Act
MSU: Medium Secure Unit
NECS: Care System Support Organisation
NEET: Not in Education, Employment and Training
NHSE: NHS England
NICE: National Institute for Health and Care Excellence
QNIC: Quality Network for Inpatient standards
PTSD: Post Traumatic Stress Disorder
RCPHC: Royal College of Paediatrics and Child Health
SSQD: Specialised Services Quality Dashboard
STC: Secure Training Centre
YOI: Young Offender Institution

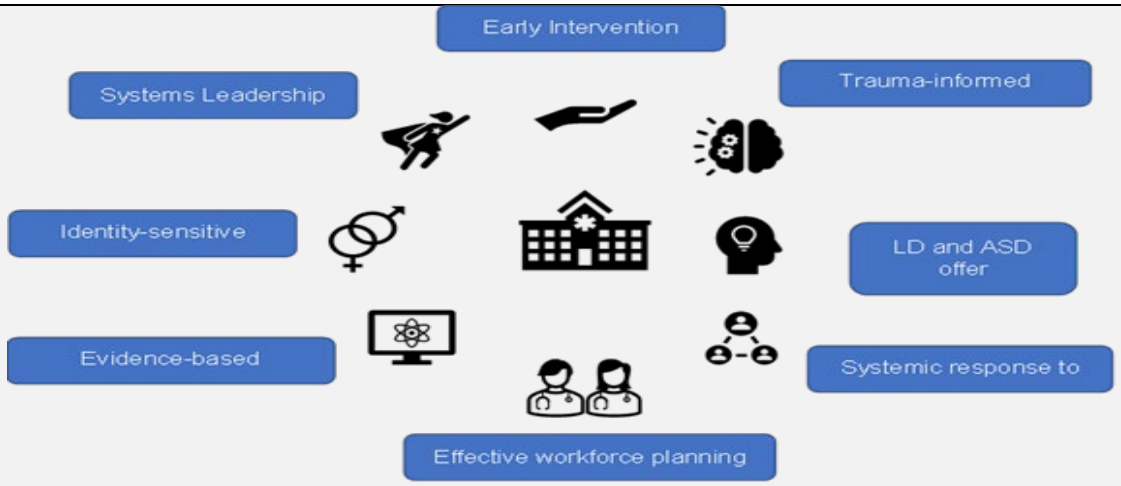
Child or young person: references to 'a child' or to 'person' with mental health needs, rather than to patients or service users, is made to focus on the person as an individual.

Family and carers: references to 'family and carers' is to mean the family members, partners, friends, neighbours or other members of a person's social network, who provide support to a person with mental health needs. This includes those acting as a person's attorney or as a deputy appointed by the Court of Protection, as set out in the MCA Code of Practice. For children and young people, the term family and carers should always include those with parental responsibility. For most children and young people this will be their parent or guardian. Where the child is looked after by the local authority, the local authority should be contacted to clarify who holds parental responsibility and for their involvement in discussions about the care of the child or young person. Foster carers and residential staff will not hold parental responsibility, but they should be involved in discussions about the child or young person's care, unless there are exceptional reasons not to do so.

Appendix 1 – Desktop Literature Review

A desktop literature review of Forensic Services (including Medium Secure Units and FCAMHS) was commissioned by NHSE Specialised Commissioning Team (2023) to consider how the National Service Specifications for these services should evolve to better meet the needs of children and young people in the future.

The Review supported an ambitious move toward community-based treatment for this cohort of children and young people. However, it recognised that change will not be immediate, nor will the development of alternative care negate the statutory requirement for secure care of young people sentenced by the Youth Courts. In the meantime, the Review has identified 8 themes for action within existing service provision, outlined below.



Since the national roll out of FCAMHS, local areas have developed innovative approaches to integrating FCAMHS services into local provision and this approach should be continued to deliver the priorities set out above.

Appendix 2 – Additional Service Functions

Clinical Networks

The FCAMHS National Clinical Network was established to share good practice, drive improvements in quality and support consistent alignment to a national model.

Clinical Lead

The lead of the clinical network will be a statutory member of the Childrens and Young Peoples Mental Health Transform Clinical Reference Group.

Membership

All Providers of children's and young people's Medium Secure Service are required to be active members of the network. Children and young people and third sector organisations will be core stakeholders within the networks.

Hosting

The network referrals meeting will be hosted by a named organisation within the network geography and rotated yearly between providers.

Accountability and responsibility

The Clinical network covers a national footprint to reflect patient flows, provider scale and catchments, and cuts across commissioner boundaries (LPC and regional). The networks will be accountable to the CYPMH Strategic Oversight Group (NHSE), attendance is required from the National Clinical lead or delegated member or the clinical network.

Clinical Network Aims:

- A single national coordinated referral and admission pathway into individual service settings and across the network.

- A coordinated national response that evidences equity of provision across services in England.
- Reducing unwarranted variation and health inequalities.
- Improving access to timely assessment and interventions.
- Support and consultation to child/young person's networks to support them in the least restrictive setting.
- Workforce development through peer support/ learning/reflective spaces.
- Alignment with FCAMHS, Secure services in both welfare and criminal justice settings.

Network sub-groups will need to have evenly balanced partner representation from stakeholder organisations and include wider professional representation including nursing and allied health professions.

Appendix 3 - Care, Education and Treatment Reviews (CETR)

Building the Right Support (2015) and the NHS Long Term Plan (2019) set out what people with autism and people with a learning disability should expect when they need healthcare and support in the community. This includes specific intervention and support for their mental health needs and at times of crisis or difficulty for them and their family.

Dynamic Support Registers (DSRs) and C(E)TRs are central to the NHS Long Term Plan commitments by 2024 to:

- reduce the number of children and adults with a learning disability and autism in mental health inpatient services.
- avoid inappropriate admissions to mental health inpatient settings.
- develop responsive, person-centred services in the community.

Early identification of people at risk of admission to a mental health hospital and their access to person-centred planning and support are essential for the prevention of avoidable admissions. If someone with a learning disability or an autistic person does need to be admitted, this should be for the shortest time possible and during their stay they should receive high standards of mental health and physical healthcare.

DSRs are the mechanism for local systems to:

- use risk stratification to identify people at risk of admission to a mental health hospital.
- work together to review the needs of each person registered on the DSR.
- mobilise the right support (e.g. a CETR, referral to a keyworker service for children and young people, extra support at home) to help prevent the person being admitted to a mental health hospital.

The DSR enables systems to identify adults, children and young people with increasing and/or complex health and care needs, who may require extra support, care and treatment in the community to prevent admission to a mental health hospital. Additionally, they play a role in ensuring that people's needs are included in commissioning plans, financial plans, service delivery and development.

All autistic children, young people, or adults and those with a learning disability are required to have a community C(E)TR if they have been admitted to or are at risk of admission to a mental health hospital. If they do not have a community C(E)TR, they must have a post-admission C(E)TR within the required timescales – 28 days for adults and 14 days for children and young people.

Appendix 4 – Secure Stairs

The framework aims to promote consistent, trauma-informed, formulation driven, evidence-based care, delivered within a whole systems approach by well trained and supported staff. Additionally, the evaluation (Anna Freud, 2022) identified that "children and young people reported in interviews that being involved in formulations was empowering" because:

- They had their voice heard by professionals.
- They talked about who they were, their needs, and what was important to them.
- It built confidence in talking to other people about their story.

S	**Staff** with the skill sets appropriate to the interventions that are needed.
E	**Emotionally** resilient staff who are able to remain child-centred in the face of challenging behaviour.
C	**Cared for staff:** through supervision and support.
U	**Understanding** across the secure setting of child development, attachment, trauma and other relevant key theories.
R	**Reflective system:** staff who are able to consider the impact of trauma at all levels.
E	**'Every interaction matters':** a whole system approach.

Appendix 5 Interdependent Services

At National Level:

• Nationally recognised providers of specialist secure adolescent medium 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

• Other FCAMHS providers

• Other providers of highly specialist residential or educational care for young people

At Regional and Local Levels:

• Local services providing secure mental health or neurodisability or other inpatient care (including in-reach) for young people or those providing other secure care on youth justice or welfare grounds

• Commissioners of CAMHS (including Learning Disability and neurodevelopmental) services
- Criminal Justice Liaison and Diversion Services
- Complex neurodevelopmental services
- Educational support and/or early intervention services developed locally
- Specialist services for children in the care of the Local Authority
- Framework for Integrated Care Vanguard Services (and those that develop from such services during the life of the contract)
- Public Health

• Senior managers in children's social care in different local authorities
• Youth justice (YOT) services, police, and youth and crown courts
• NHS and independent providers of non-secure in-patient care
• Providers of residential care
• Providers of special education
- Local Authority Social Care Teams
- Schools

• 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)