Service Specification: Specialist Children's and Young People's Mental Health Medium Secure In-patient service (MSUs)

1.0 Service Details	
1.1 Service name	Specialist Children's and Young People's Mental Health Medium Secure In-patient service (MSUs)
1.2 Service Specification Number	170025/S
1.3 Date published	7 May 2024
1.4 Accountable Commissioner	NHS England
2.0 Service Scope	
2.1 Service Description	This service specification covers the provision of specialist Children and Young People's Mental Health Medium Secure Services (MSUs) for children and young people with forensic mental health presentations, who are detained under The Mental Health Act 1983. MSUs are delivered on a national footprint and children and young people are admitted via a central referral network. MSUs provide care and treatment within a highly prescribed set of physical, relational, and procedural security measures, to a variety of young people. The secure system for young people in England is complex and there is no 'high secure' environment for children and young people. This means the most complex and vulnerable children and young people will be supported within MSUs. The predominant need for care and treatment will relate to the young person's assessed risk of harm to self and/or others because of their mental health need. The relevant legal framework under which young people can be deprived of their liberty in England is The Mental Health Act (MHA; 1983, as amended 2007). Some children and young people will be referred into MSUs from the community. Others will already be detained under: • The Mental Health Act (within other in-patient settings). • Section 25 of the Children Act (1989) placing them in a secure children's home. • the Youth Justice System (YJS) on remand or serving a sentence in a Secure Children's Home (SCH), Secure Training Centre (STC) or Youth Offending Institutions (YOI).
2.2 Commissioning Responsibilities	The budget and commissioning responsibility remain with NHS England (NHSE)for children and young people's MSUs. The services will remain as prescribed specialised services subject to consistent national service

	specifications and evidence-based clinical policies, with universal access for children and young people around the country. Services should be developed and delivered in close partnership with the children and young people's secure estate (CYPSE), including SCHs, STCs and YOIs (as well as developing Secure Schools). These services remain the commissioning responsibility of NHSE Health and Justice, but many of the same children and young people will be supported across both pathways.

3.0. Demographics & Evidence Base

3.1 Population covered

MSUs are commissioned for children and young people up to age 18 years, who meet the following criteria:

- The child/young person is under 18 years old at the point of referral, liable to be detained under Part II or Part III of the Mental Health Act and presents significant risk to others with one or more of the following:
    - Direct serious violence liable to result in injury to others.
    - Sexually aggressive behaviour
    - Destructive and potentially life-threatening use of fire and there is clear evidence prior to referral that serious consideration of a less restrictive environment has been considered.

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 in-patient services 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).

However, children and young people accessing MSUs will generally be distinguishable by their more complex risk profile, due to the significant risk of harm they can present to others.

As a result, admissions to MSUs have historically come via the youth justice route (from the CYPSE or court). However, in the last 5 years roughly 55% of referrals came via alternative routes, including from other in-patient services or direct from their home communities.

3.3 Evidence Base

A desktop literature review was commissioned by NHS England (NHSE) Specialised Commissioning Team to consider how the National Service Specifications for MSUs, and Forensic Child and Adolescent Mental Health Services (FCAMHS) can evolve to better meet the needs of children and young people. The findings of the Review are based on analysis of best practice and available national evidence, alongside extensive engagement with

stakeholders through online surveys, virtual workshops, and site visits – as well as interviews with children and young people.

For more information on this Review, **see Appendix 1**.

Interventions should draw from the available evidence base, while recognising the limits of this evidence for the complex client group. When working outside the evidence base, innovative interventions should be theoretically sound and robustly evaluated and should evidence clinical outcomes and young person and carer satisfaction.

3.4 Future Demand

NHSE anticipate a 40% increase in the number of young people in secure settings as the covid court backlog is addressed, which is likely to lead to an increased demand for MSU admissions from secure services. As the acuity of mental health needs seen in community services it is likely that demand from other areas will also increase. However, the trajectory of service development across the NHS is focused on reducing in-patient admissions and prioritising investment in community outreach services. Therefore, national MSU capacity is expected to remain static, as no expansion is planned.

4.0 Service Aims and Outcomes

4.1 Service Aims

The **primary service aim** is to help children and young people with a mental health need presenting with a significant risk of harm to others to live safely within their communities, by providing high quality assessment and treatment.

MSUs 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 do so safely and lawfully, children and young people should be treated without detention.
- **Respect and dignity.** Children, young people, families, and carers should be treated with respect and dignity and listened to by professionals**.** All young people should be provided with a quality service regardless of disability, sex, race, gender, or location. Recognising and responding appropriately to inequalities and/or health inequalities faced by children and young people referred to the service is paramount.
- **Empowerment and involvement.** Participation and collaborative work with children, young people and parent/carers should always be prioritised, unless there is a clinical or legal reason not to do so.
- **Effective treatment.** Decisions about care and treatment should be individualised, with clear therapeutic aims be informed by current national guidelines and best practice. Units should work to a therapeutic model based on the principles of child development and attachment, which acknowledges the importance of relationships and the key role of primary caregivers as agents of change. Principles of safeguarding children and young people should be embedded in the service.
- **Efficiency and equity.** Providers should ensure that quality of mental health care is given equal priority to physical health and social care services and that pathways for access, transition and discharge to and from MSUs provide continuity of care. Intensity of care and treatment should match the extent of risk posed by the child or young person.

- **Collaboration with community services.** Providers should develop close pathways with relevant community services – especially Forensic Child and Adolescent Mental Health Services (FCAMHS) and services within the CYPSE - to ensure integrated working and smoother transitions for children and young people. Services should provide consultation expertise to services and professionals where appropriate, to support appropriate referrals into the MSU network.

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 in-patient admissions and lengths of stay.
- Reduce variations in service availability and access.
- Improve the experience and outcomes of children, young people, 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 MSU services 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). The full version of the quality metrics and their descriptions including numerators and denominators can be accessed at https://www.england.nhs.uk/commissioning/spec-services/npccrg/spec-dashboards/

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

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

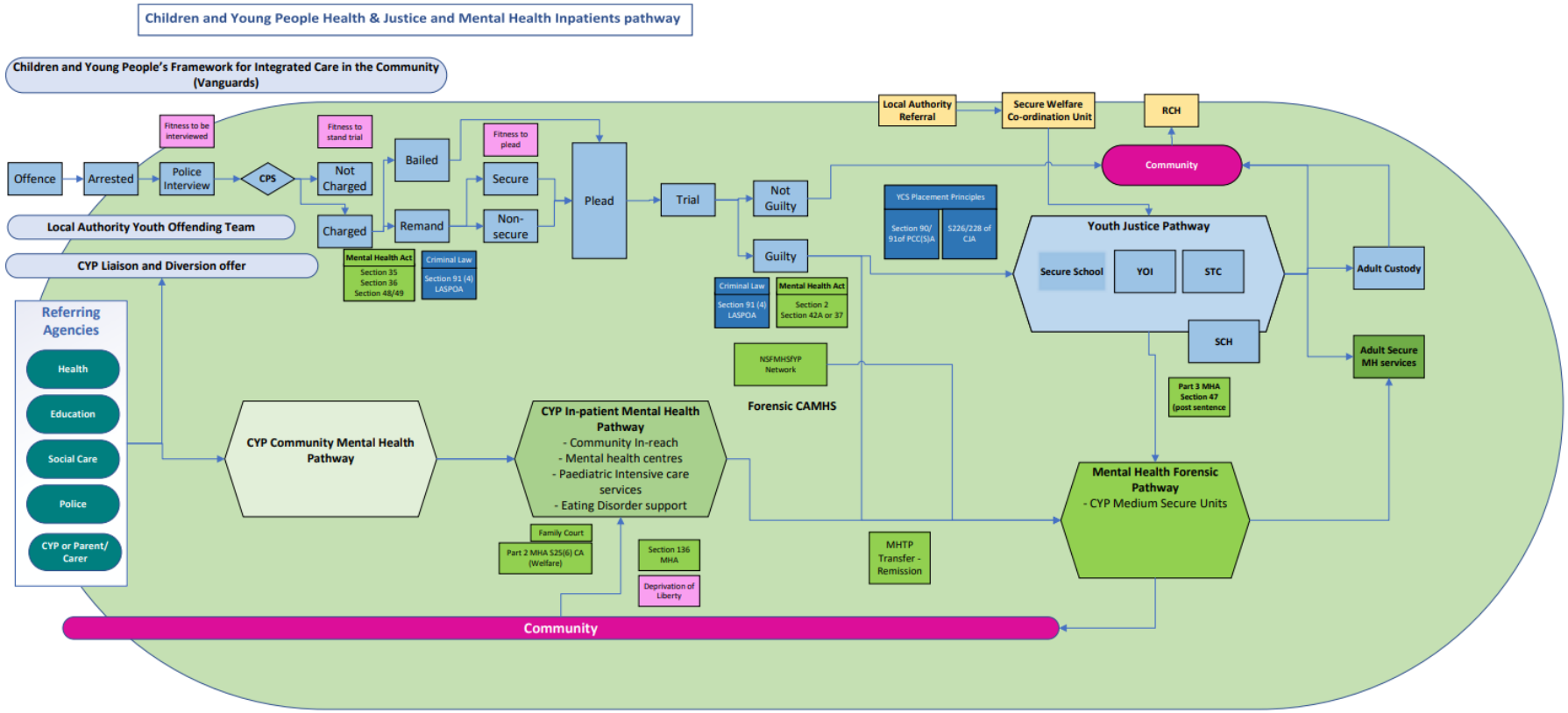
Within MSUs at least one of the following measures should be used as appropriate:

- 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. (www.rcpsych.ac.uk/ health of nation outcome scales)
- Child Global Assessment Scale (CGAS) - a numeric scale used by mental health clinicians to rate the general functioning of youths under the age of 18.

5.0 Service Description

5.1 Care Pathway

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



Service Functions and Requirements

This section sets out the core service requirements that all MSUs must deliver and the overarching functions to be provided.

Services must comply with the **following requirements**:

- Providers must be **registered with Quality Network for In-patient Care (QNIC)** and participate in the peer review process. Services must be delivered in line with QNIC standards for in-patient care and providers should have achieved accreditation within 3 years.
- MSUs must **operate 24 hours a day, 365 days per year**.
- An **initial planning meeting** with the multidisciplinary team (MDT), including the family, should be held within 1 week of admission - unless delayed by mutual agreement to facilitate an individual child or young person's needs.
- A **full multiagency MDT** review should be held before admission to an MSU. Where this has not been possible it must be held within the 2 weeks following admission and establish an early estimation of discharge date and discharge pathway - unless delayed by mutual agreement to facilitate an individual child or young person's needs.
- Subsequent **multiagency reviews must be held at least monthly**.
- Each child or young person must be reviewed by the MDT regularly (minimum weekly) and must have a comprehensive up to date MDT care plan and risk assessment developed by the MDT with the young person and, wherever possible, with their family/ carer in accordance with best practice guidance. The young person must be kept updated with any changes to their care plan and have the agreed outcome measures and improvement scores shared with them regularly.
- The overall model of care must be delivered through a Multidisciplinary Team (MDT) approach consisting of psychiatrists, psychologists, occupational therapists, social workers, nurses and teachers, in accordance with standards and guidelines outlined by the QNIC.
- The nursing model of care must be based on the 'primary nurse' model, each child or young person must have a named nurse responsible for their day-to-day nursing needs.
- Each child or young person must have their **own room** and must have a **Responsible Clinician** allocated by the service for the duration of admission.
- **Each child or young person must also have**:
    - a **Care Coordinator/Case Manager** allocated within the MSU to co-ordinate care within the Framework for Community Mental Health.
    - 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.
    - 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 timely access to suitably experienced **speech and language** assessment and treatment during their admission.
- Each child or young person must have access to a suitably experienced, qualified social worker 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 child or young person, their family and carers.

- **Each child or young person must also**:
  - **receive three culturally appropriate meals per day** 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.
- Service delivery should align with the principles of the Secure Stairs model. **See Appendix 3** for more information on Secure Stairs.
- The service must be delivered in line with the National Prison Transfer and Remission Guidance.

MSUs must provide:

- **A comprehensive multi-disciplinary team** (MDT) with a core team of expert psychiatry, psychology (including clinical and forensic competencies), social work, family therapy, occupational therapy, family, education and nursing professionals. The MDT must be experienced in the assessment, identification and management of young people with neurodevelopmental needs. Services should ensure appropriate access to other necessary disciplines (such as speech and language therapy, art/dance/music/drama therapy).
- **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 secure environment** where young people can address their problems in safety and with dignity and reduce the risk of harm to self and others to a level that can be managed safely in the community.
- **Relational security** provided through effective, experienced workforce planning.
- **Procedural security** provided through robust, consistent policies, training and support for staff. For example, the service must have expertise in, and policies covering, the use of psychopharmacology in severe mental disorders, including the use of rapid tranquilisation 'as needed' (PRN).
- Care within **a therapeutic regime** that proactively manages risk (e.g. violence and aggression; substance misuse) and assesses for psychopharmacological treatment for mental health conditions.
- A **range of time-limited specialist treatment programmes** individually or in groups that enable effective transition or safe discharge to an alternative setting.

Reasonable adjustments to screening, assessment, clinical interventions, communication approaches and physical spaces to ensure all young people can access support equitably, including but not limited to children and young people with learning disability and/or autism. Young people with learning disability and/or autism must have their specific needs incorporated in the care plan. Care must be provided in line with the principles of the Core Capabilities Framework for people with autism and people with a learning disability. This must include practice set out in the Transforming Care national programme particularly the active support, facilitation and delivery of the Care, Education and Treatment Review (CETR) process - **See**

Appendix 2 for more information. Services should adhere to sensory principles in the overall environment. Regular audit environments against the principles in 'It's not Rocket Science' Its-not-rocket-science-V6.pdf (ndti.org.uk)

- **An extensive range of meaningful recreational opportunities** alongside the statutory education that is provided (minimum of 25 hours per week).
- Well planned and delivered **step-down services and outreach offers**.
- **Liaison and referral into a wide range of health, criminal justice and social services** who are involved in the children and young people pathway, to ensure joined up working during assessment, planning, treatment and transition between services.
- **Efficient and seamless transfer** of young people between services.
- **Appropriate training and development** opportunities for staff in relation to supporting CYP with additional needs. This will include (but is not limited to) Oliver McGowen training, Care Quality Commission (CQC) requirements and QNIC standards.

The therapeutic milieu should be comfortable with a psychological understanding of formulations. It should have a capacity to effectively deliver interventions for protracted periods of time and should show a level of resilience capable of dealing effectively with chronic challenging young people with past significant adversity. It should also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and children and young people.

MSUs are also set apart from other in-patient services in the level of engagement required with the Youth Justice/Criminal Justice Systems and therefore, MSUs must be equipped to support particularly vulnerable children and young people to navigate this system effectively. This will require expert knowledge and experience, including assessing Fitness for Interview, Fitness to Plead and Fitness for Trial. MSU services may also be required to give specialist opinions to court on Disposals.

See Appendix 2 for additional information on Service Functions.

5.2 Referral process and Eligibility Criteria

There are three typical pathways into an MSU:

- Direct admission through a criminal court process; youth justice custodial settings; police custody settings.
- Admissions from non-criminal justice and welfare settings including welfare Secure Services and specialist educational settings.
- Admission following referral/admission to child and young person in-patient centres.

Inclusion Criteria

The child or young person is aged under 18 years at the point of referral;
and
meet the criteria for detention under Part II or Part III of the Mental Health Act;
and
presents significant risk to self and others with one or more of the following:

- Direct serious violence liable to result in injury to others
- Sexually aggressive behaviour
- Destructive and potentially life-threatening use of fire

and

there is clear evidence prior to referral that serious consideration of less secure provision has been made and/or tested and discounted as the young person's needs/risk exceed the threshold for and ability of those services to manage.

NHSE is committed to ensuring that no young person is admitted to a mental health in-patient unit unless they need treatment for mental disorder.

Enquiries

The MSU network may respond to initial enquiries from professionals (including from community partners and the CYPSE) and share relevant details with the national network referrals meeting.

Referrals

The clinical referrals network will consider all referrals from youth justice settings (courts and custodial units). In general, young people from these settings are likely to require a medium security environment, but on rare occasions admission to a lower level of restriction may be more appropriate.

Referrals can be made to any unit in the referrals network using the NHS England National Access and Referrals process referral forms (Form 1). Children and young people's mental health case managers (CYPMHCMs) should be the first point of contact when considering referral when transfer to hospital is indicated. NHSE Form 1's must be completed appropriately and should facilitate hearing the voice of the young person and their story (e.g., health care passport methodology). The referring senior clinician makes the initial judgement on whether the referral is an Urgent/Routine on the Form 1.

Where a child or young person is referred to an MSU their local CYPMH service should be notified. For those young people not yet detained under the Mental Health Act, an early-stage opinion from an appropriate Section 12 Doctor is required.

All referrals are discussed on a weekly basis by the members of the MSU clinical network. However, depending on the nature of the referral (Urgent/Routine) individual cases may need to be discussed with members of the network outside this meeting. Such discussions should include the Chair of the network or the Clinical Lead. The processing of referrals should not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status. Responsibility for the care of the young person remains with the referring agency/service until the point of admission to the MSU.

Referrals will be sent directly to the unit closest to the current location of the child or young person and to the chair of the relevant referrals meeting.

Referral Categories

1) **Urgent** - reviewed and responded to by a senior clinician within 48hrs, assessment within 1 working week. Verbal feedback to the young person, parent/carer, referrer and case manager within 48 hours of assessment and written feedback (including outcome and recommendations) within 7 days. This should include children and young people who:

- Are acutely mentally unwell.
- Are currently experiencing significant risk to physical health (for example not eating/drinking).

- Are currently in an unsustainable environment, such as police custody, or a place of safety.

2) **Routine** – reviewed and responded to within 1 week and assessment offered within 2 weeks. Verbal feedback to the young person, parent/carer, referrer, and case manager within 10 working days, with written feedback within 28 days of assessment (including outcome and recommendations).

The decision as to whether a referral is urgent or routine is a clinical one, which should be taken by the referral network following discussion with the referring clinician.

Young people approaching their 18th birthday

MSU admissions may occur up to an individual's 18th birthday. However, the decision to admit a young person approaching their 18th birthday should be based on individual factors. It may be appropriate for some young people to be admitted to an adult MSU prior to their 18th birthday based on their needs and circumstances, to avoid multiple transitions. Joint access assessments of these young people by adolescent and adult secure services should be undertaken wherever practical.

Input must also be sought from adult secure mental health services at the time of any mental health sentencing recommendations to courts for young people aged 17 years and older"
camhs-adult-secure-transition-practice-guidance.pdf (england.nhs.uk)

Referral Outcomes

5.3 Assessment

Pre-admission

The referring team must ensure that the staff at the MSU receive all relevant documents and information about the case including:

(i) The initial assessment and referral (including the referring team's opinion on the reasons for seeking admission to Secure services) will be completed by Children and Young Person Mental Health Services CYPMHS Consultant Child and Young person Psychiatrist or Child and Young Person Psychiatry Specialty Trainee ST4-6 and Registered Mental Health nurse.

(iii) Any further relevant information for example from the Youth Offending Team, Police, Social Care if available.

(iv) Pre-admission CETR documentation with recommendations for care and treatment of CYP with a learning disability or autism.

(v) if transferring from secure setting, a warrant is provided and clear timescales established.

(vi) 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.

It is essential that prior to any admission to an in-patient environment the young person and their family are given information about what to expect, having explored possible alternatives. Families must be involved in each step of the young person's journey including admission. (**unless there are safeguarding concerns) and wherever possible treated as equal partners in designing and implementing care plans for children and young people.

The MSU must agree arrangements for admission with the young person's current placement. This must include written confirmation of admission timescales/date.

Admission assessments (deciding on admission)
Clinical teams at each case review must consider the principle of care in the least restrictive setting and whether the child or young person is appropriately placed due to being a significant risk of serious harm to others.

On admission the service must provide young person with information about the available treatments and facilities and 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 child or young person objects.

Repeated assessments for the same young person in relation to the same referral must be avoided.

All assessments should include practical recommendations to current treating team / referrer on how to provide effective support, whether or not admission to MSU is planned. Where admission is not planned, consideration should be given to a referral to the child or young person's home Forensic Children and Young person's Mental Health Service (FCAMHS) team.

Initial assessment (post-admission)
Assessors must have the clinical skills/experience and authority to make decisions and recommendations – for example an Approved Clinician. The service must ensure that respective assessments are conducted by the most clinically appropriate individual or team members. Those undertaking assessments should be able to attend clinical referrals meetings as needed and participate in any dispute resolution processes.

The service must conduct access assessments within a structured framework, which includes personalised safety planning and:

- uses recognised risk assessment tools when considering risk to others
- must fully involve professionals involved with the young person
- must fully involve parents and carers.

Comprehensive reports need to be written that summarise the reason for referral, sources of information, background information, risk summary, initial formulation and opinion and recommendations.

Information about the available treatment and facilities must be shared with the young person, family/carers and others with parental responsibility prior to admission. Information and meetings must be provided and set up in a way that family/ carers can participate fully.

See Appendix 4 for information on Dispute Resolution.

5.4 Care Treatment Programme

Clinical Interventions

The therapeutic regime should be able to effectively deliver a range of 1 to 1 or group mental health interventions, in line with the clinical formulation. The **trauma-informed interventions** should be flexible and responsive to the needs of the young people and **adapted for neurodevelopmental needs**.

All therapeutic activities and engagement should be meaningful, available, and appropriate to the individual and **may include**:

- Psychotherapy
- Pharmacotherapy
- Behaviour Targeted Interventions (e.g. Cognitive Behavioural Therapy (CBT))
- Vocational Training
- Speech and Language Therapy
- Family therapy
- Sensory interventions
- Speech and language interventions
- Mindfulness-based interventions
- Dialectical Behaviour Therapy (DBT)
- Mentalisation-based treatments for young people (MBT-A)
- EMDR
- Addressing interpersonal relationships
- Problem solving
- Emotional regulation
- Occupational Therapy
- Health Promotion (physical and mental health) and relapse prevention.
- Art / Music / Dance Therapy
- Access to peer-support interventions and those that support healthy relationships and understanding of consent. Access to peer support forums for both children and young people and their parent/carers are encouraged during MSU admission and as part of discharge planning.
- Interventions and activities that support young people and their support networks to counter-act negative self-image or lack of ambition.

MSUs will also provide a spectrum of **offence related interventions** commensurate with significant risk presentations, which may include programmes for sex offending, fire setting aggression reduction if indicated by the risk and needs assessment.

Interventions should be sequenced according to need and readiness and delivered within a developmentally sensitive framework, in accordance with best available evidence and/or National Institute for NICE guidelines.

Alongside these activities, MSUs will deliver:

- Robust assessment of clinical risks and development of risk formulation.
- Management of physical health care.
- Prescribing and monitoring of drugs and their side effects in line with National Institute for Care and Clinical Excellence (NICE) guidance. Clear guidelines and policies need

to be in place on the use of 'as needed' medication (also known as pro re nata or PRN medication) and Rapid Tranquilizations, reviewed regularly by the clinical team and service pharmacist.
- A graded programme of s17 leave (where appropriate).
- Developmentally appropriate and specifically care planned activities provided on and off the ward such as, art, drama, dance, music, gym, sports, and group games.

Trauma-Informed Approaches

There is strong evidence that trauma-informed services are foundational in supporting this cohort of young people, as well as ensuring the resilience of the workforce. MSUs should operate on a continuum of services that recognise and appropriately respond to trauma to prevent escalation of needs and risks. This should include trauma-informed practice as standard and appropriate trauma-informed training available to 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 at war. In aligning with the secure estate, Secure in-patient services will work within the principles of the Framework for Integrated care (SECURE STAIRS). See **Appendix 3** for more information.

Care Programme Approach (CPA)

All MSUs should work to an agreed multidisciplinary approach. CPA remains the recommended approach for children and young people who are not subject to the CETR process, to provide a consistent framework for supporting children and young people across a national footprint.

Care Planning

MSUs will provide comprehensive assessment, multidisciplinary formulation and monitoring / management of mental health plans, carried out in close partnership with professionals already involved in the case, as well as the child or young person and their parent/carers wherever possible. The care plan must reflect the young person's needs in the following domains:

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

Case Co-ordination:

- MSUs must support case management from NHSE/NHS Lead Provider Collaborative Case Managers.
- All young people in the MSU must have a community Care Coordinator linked to community CYPMH team local to the child or young person's originating area, who must remain updated throughout the admission period and is expected to remain involved with the young person's care.

- For restricted patients, MSUs must ensure compliance with the Ministry of Justice requirements.
- For young people who are subject to input from the Youth Justice Services, reviews of orders including remand reviews must be facilitated and may be undertaken jointly with MDT reviews.
- 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's Act.

Leave

Leave is important in helping young people maintain family and community relationships while in an in-patient setting and is an important element of the transition to outpatient care. Each planned leave must be risk assessed and managed with due regard for the service's duty of care to the child or young person and the commissioning body's statutory duty of care.

The plan for leave must be included in the overall care plan made prior to any leave being taken and must be agreed with the care co-ordinator/commissioner/Case Manager. The planning process must also consider how leave can effectively support transition to another setting, where a child or young person is not returning to their community.

For young people with additional restrictions, the Ministry of Justice (MOJ) must be involved in all discussions regarding leave and provide the necessary permissions prior to any leave being taken. Leave for detained patients can only be agreed by the Responsible Clinician under s17 of the MHA.

Leave of up to 2 days should be encouraged, to support young people to maintain positive relationships within their family and community. Any leave over 2 days at any time, or greater than 5 days in total during an admission, must be agreed with the NHS England and PC Case Manager.

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 that 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.

Enhanced Observations

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. Enhanced Observations will in normal circumstances be part of the contracted level of general care. All MSUs must adhere to robust organisational policies regarding enhanced observations.

Physical Healthcare and emergencies

MSUs 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.

Routine physical healthcare should be provided by junior medical staff and physician's associates under supervision. There must be access when necessary to paediatric and more specialist medical provision; and access to wider multi-disciplinary healthcare team such as dentist, physiotherapy, optician and dietician.

5.5 Education

Educational Provision

All 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. In all cases the education provided should be in accordance with what is commissioned and funded by the local authority.

The standard of education arranged by the local authority must meet standards in statutory guidance for local authorities on alternative provision. 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 developmentally appropriate teaching in English, maths and science (including IT) that offers access to education equivalent to mainstream schools.

The education must be available full-time, with individual timetables developed in the young person's best interests - taking account of their needs and circumstances. The full guidance can be accessed here:
https://www.gov.uk/government/publications/alternative-provision

and

https://www.gov.uk/government/publications/education-for-childrenwith-health-needs-who-cannot-attend-school

Expectations for Health Providers and Commissioners:

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

In addition to the formal education offer children and young people should be offered a range of developmentally appropriate and specifically care planned activities provided on and off the ward. These may include a range of group and solo activities and such as art, drama, dance, music, gym, sports and group games.

Special Educational Needs and Disabilities

Where a young person has an Education, Health and Care Plan (EHCP) of special educational needs, the education provider should contact the local authority responsible to establish both the provision required whilst the young person is in the MSU and any additional funding available. The provider must ensure that the child or continues to access the education and

support specified within their EHCP plan, which may sometimes require a review or revision of the plan. **See Appendix 5** for more information.

5.6 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. 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 any form of child exploitation including child sexual exploitation (CSE) or child criminal exploitation (CCE) or modern slavery.
- have neurodiverse needs including learning disability, autism, ADHD, acquired brain injury (ABI), or TIC disorders (e.g. Tourette's).
- have speech and language needs.
- experience gender dysphoria or gender identity challenges.
- misuse drugs or alcohol in a harmful way.
- display Harmful Sexualised Behaviour.
- have been excluded from education and/or are at risk of being long-term not in education, employment and training (NEET).
- have insecure legal status in the UK or are deemed 'illegally in the country'.
- do not have English as first language and/or are from an ethnic minority group.
- are pregnant.

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, 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, 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 secure setting.
- what physical healthcare or specialist healthcare may be required, beyond what can be offered within an MSU and how local relationships, service level agreements and referral pathways can be used to ensure each child and young person's individual needs are met.
- 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.

Ethnicity
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 and evidence how they can effectively respond when a child's ethnicity has 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.
- Their knowledge of mental health services and interventions may differ from their peers.
- 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, 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, CQC requirements and QNIC standards.
- Raise the profile of the five good communication standards Microsoft Word - RCSLT Good standards v 8 Nov 13

Gender Identity
All Services should refer to NHSE guidance for transgender provision.

When a transgender young person arrives in hospital any prior medical treatment for gender dysphoria must be continued, if the individual wishes, until their gender specialist has been consulted. Young people with gender dysphoria should have access to the same care that they would expect to receive from the NHS if they had not been sent to hospital. If a transgender young person in hospital wishes to begin gender reassignment, the pathways are clearly outlined in the guidance so that staff can support the child or young person to be referred to a Gender Identity Clinic.

A transgender young person will be placed in a mixed gendered secure setting, when possible, as this environment allows them to express themselves in a gender fluid way - which minimises risk to self and others. Placement decisions are made by the assessing clinician/ team and

reviewed on a case-by-case basis. The wishes of the young person are considered alongside safeguarding factors and risk assessments.

5.7 Environment

The provider must meet the following standards in relation to the **Service Environment**:

- The premises and the facilities generally are young person and family friendly and 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 children, young people, staff and visitors.
- A care environment in which children and young people's 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.
- Children and young people accessing MSUs are often supported at a distance from their home. It is vital that family and carers are able to remain involved and to provide support to their children and young people throughout their stay. Therefore, MSU providers should offer sleep over facilities nearby to the ward. This may take the form of onsite overnight provision, or funding a suitable alternative such as a nearby hotel. All MSUs should have a clear policy in place – which is explained to children, young people and their families and carers – on when such accommodation will be made available.
- providers should be expected to evidence how they make reasonable adjustments to screening, assessment, intervention, environment, and communication approaches for young people with neurodiversity.
- deliver appropriate risk managed gender living areas, ensuring there is sufficient national provision for girls and those recognised as transgender, ensuring that girls have access to appropriate peer groups within MSUs.

Clinical spaces

- All clinical spaces should provide reasonable adjustments and ensure equity of treatment see NHS England » Reasonable adjustments
- All building and clinical space should adhere to NHS England » Health building notes
- All in-patient environments must have a consistent approach to reasonable adjustments and avoid ‘blanket restrictions’ including access to mobile phones, bedrooms etc.

- MSUs should be delivered in line with the 'Restraint Reduction network' and 'CQC's' guidance on blanket restrictions.

Seclusion Facilities
MSUs must have appropriate facilities for the management of young people who require periods of care in seclusion/away from the main group to appropriately manage the level of risk they pose to others. Seclusion or restraint of a person is used only as a last resort intervention to prevent imminent harm to the child or young person, or another person. Every effort must be made to ensure that no young person is secluded longer than is strictly necessary.

Clinical spaces and treatment must be in line with the Mental Health Act code of practice on seclusions other relevant guidance.
Restraint Reduction Network launches Blanket Restrictions Toolkit in partnership with National Quality Improvement Taskforce
and
Code of practice: Mental Health Act 1983 - GOV.UK (www.gov.uk).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

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

Long-Term Segregation
If a child or young person under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation and all activities must comply with the Code of Practice of the Mental Health Act 1983, above.

5.8 Discharge and Continuity of Care

Discharge & Transfer
Discharge is the point of highest risk for many children and young people, as layers of security and support change. Therefore, whether a child or young person is returning to the community or transferring to another secure environment, MSUs must ensure discharge is:

- **Well-planned**, supported by timely, multi-agency working and strong communication.
- **Graduated** – allowing children and young people to test out and familiarised themselves with their new environment, to prevent the perception of 'cliff edges' in support.
- **Individualised** – dictated by a child or young person's needs and circumstances.
- **Planned early** – professionals need to consider the likely transition or discharge plan for a young person as close to the point of referral into the service as possible and transition planning should be ongoing.

Discharge standards:

- A responsible CYPMHS or Adult MH team, including an allocated Responsible Clinician, must be in place before the start of a discharge process.

- Services should have contingency discharge planning prepared in the case a tribunal, as there may be the case of an unanticipated discharge.
- Young people and their support networks must be involved in discharge planning and discharge plans must respond to what young people want, while considering individual circumstances and how to maximise their protective factors.
- 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.
- MSUs should provide appropriate post-discharge follow up – including attending the first post-discharge MDT.

When planning a discharge, MSUs must actively involve the catchment area services from the child or young person's home area. The service must ensure that the organisations responsible for aftercare under s117 are involved in discharge planning and decision-making. The MSU must convene at least one Section 117/pre-discharge meeting before the start of the discharge process, which should be led by the community services and include input from:

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

Discharge from MSU must **follow published guidance** including:

- Mental Health Transfer Guidance.
- The procedure for the referral for assessment, and transfer to and from hospital (under Part III of the Mental Health Act 1983) of a child/ young person held in custody in England.
- Good practice guidance 2021 and the Code of Practice to the Mental Health Act 1983 (MHA) (particularly chapter 19 relating to children and chapter 22 relating to people in custodial settings).

Should include joint assessment of contextual safeguarding risks outside young people's homes, as well as safeguarding risks that may exist within their family networks. This will necessitate close working between community FCAMHS services and local Community Safety Partnerships, schools, social care teams and other partners involved in the delivery of positive environments for children and young people and specific interventions for individuals.

All transfers of detained patients between in-patient settings must comply with section 19 of the MHA.

Clinically Ready for Discharge

The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an in-patient setting. There are three key criteria which need to be met before the MDT can make this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan.

- The MDT must also have involved any services external to the provider in their decision making where these services will play a key role in the young person's ongoing care e.g. social care teams, housing.

Delayed Discharge
If a child or young person is discharged from the service after the point they are clinically ready for discharge, this is considered a delayed discharge. 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.

Accurate recording on the National Case Management System of Estimated and Delayed discharge dates are essential to supporting the young person's discharge.

6.0 Workforce

Staffing

To effectively address the underlying causes of offending behaviour and risks inherent within individual experiences and circumstances, care programmes should be overseen by a Consultant Psychiatrist and draw on multidisciplinary expertise, including:

- Psychiatrists
- Psychologists
- Registered nurses/ mental health nurses
- Learning disability nurses
- Occupational therapists
- Creative therapists (art/music/drama)
- Family therapists
- Social workers
- Speech and language therapists
- Dietician

The team should have specialist mental health and forensic experience in the assessment and treatment of complex, high-risk young people. 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.

Staff should have access to regular clinical supervision, reflective practice and safeguarding supervision as appropriate to their role.

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.
- Reflective practice and clinical supervision sessions are regularly taken up by the workforce.
- 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.

7.0. Safeguarding

Safeguarding

Young people in MSUs, especially those with a learning disability or autism are often vulnerable, with high levels of dependence, but low levels of trust. This is also particularly true of some children in the care of the Local Authority. 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.

Addressing issues of Contextual Safeguarding in home/local environments are critical to effective transition back to the community. MSU's will ensure this is part of the discharge plan and processes and that appropriate relationships are developed with Local Authority safeguarding teams to enable this.

8.0 Experience of Children and Young People Accessing the Service

Involvement of Parents/Carers and family network

Family/carer involvement must include, if appropriate:

- rights to visits and phone calls with family/carers.
- involvement with family/carers in providing a history.
- involvement in assessments, home visits, welcome visits.
- where appropriate a wide range of other involvement including carers assessments parent carer events, parent psychoeducation and training, celebration events, school events.

- involvement of family/carers in appropriate treatment and planning for discharge.
- Family carers are supported and made aware of their rights of access and support including through **carers contingency plans** and other resources for unpaid carers
- Are encouraged and supported to give feedback to the service.

Advocacy

All children and young people detained under the Mental Health Act have the right to:

- An Independent Mental Health Advocate, irrespective of their age.
- Access to information that is developmentally appropriate and available in a variety of forms.
- Access to advocacy and appropriate information for their families/support networks.

Children and young people should be given relevant information about complaints, restrictive practice, advocacy, legal advice, safeguarding and the role of the Care Quality Commission (CQC). This information should be readily available (including in accessible formats) to them throughout their detention.

Wherever possible, the whole treatment plan should be discussed with the patient. Children and young people should be encouraged and assisted to make use of advocacy support if they want it. This may include independent mental health advocacy services under the Mental Health Act (see Code of Practice) but may be other Advocacy services or healthcare professionals where appropriate. Where children and young people cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration. All providers should be able to evidence they have robust processes in place where concerns are raised, especially regarding restrictive practice.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1139561/SEND_and_alternative_provision_improvement_plan.pdf

9.0 Standards and Legislation

National Standards

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.

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

- Code of Practice to the Mental Health Act and Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- Mental Capacity Act 2005
- Care Act 2014
- Special Educational needs and Disability (SEND) Code of Practice (2015)
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 2003
- Department of Health Offender Mental Health Pathway 2005
- The Autism Act 2009
- Mental Health Units (Use of Force) Act 2018
- The Mental health Units (Use of Force) Act 2018
- 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.

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 legislation
- UN Convention on the rights of the Child.
- National Collaborating Centre for Mental Health (NCCMH) report on 'Meeting the needs of young adults within models of mental health care'.

All NHS Providers should adhere to ' Working in Partnership with People and communities' (May2023), statutory guidance on working with people and communities: this 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.

All assessment and treatment provided by services must comply with all relevant NICE and QNIC best practice guidance.

Guidance on the needs of children and young people with an EHCP should be followed ensuring appropriate transitions at every stage of education provision.

Security Standards

MSUs must operate within a comprehensive set of physical, procedural and relational security measures, practices and policies that must comply with standards and requirements set by QNIC, CQC and the Mental Health Act Code of Practice. Management of conditions of medium security must be maintained.

Operational policies and procedures must comply with Mental Health Act Code of Practice requirements.

Appendices

1. **Desktop Literature Review**
2. **Additional Service Functions**
3. **Secure Stairs**
4. **Dispute Resolution**
5. **Educational Provision**
6. **Interdependent Services**

Abbreviations and Acronyms

ACES: Adverse Childhood Experiences
CCE: Child Criminal Exploitation
CETR: Care Education and Treatment Review
CGAS: Children's Global Assessment Scale
CLA: Children Looked After
CPA: Care Programme Approach
CSE: Child Sexual Exploitation
CYPMH: Children and Young Peoples Mental Health
CYPMHCM: Children and Young People Mental Health Case Manager
CYPMHS: Children and Young People Mental Health Service
CYPSE: Children and Young People Secure Estate
EHCP: Education Health and Care Plan
FCAMHS: Forensic Children and Young People Mental Health Service
HSS: Highly Specialised Services
MDT: Multidisciplinary team
MHA: Mental Health Act
MHLDA: Mental Health, Learning Disability and Autism
MOJ: Ministry of Justice
MSU: Medium Secure Unit
NEET: Not in Education, Employment and Training
NICE: National Institute for Health and Care Excellence
QNIC: Quality Network for In-patient standards
PRN: as needed (pro re nata)
PTSD: Post traumatic Stress disorder
SCH: Secure Children's Home
SEND: Special Educational Needs and Disabilities
SSQD: Specialised Services Quality Dashboard
STC: Secure Training Centre
YJS: Youth Justice Service
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.

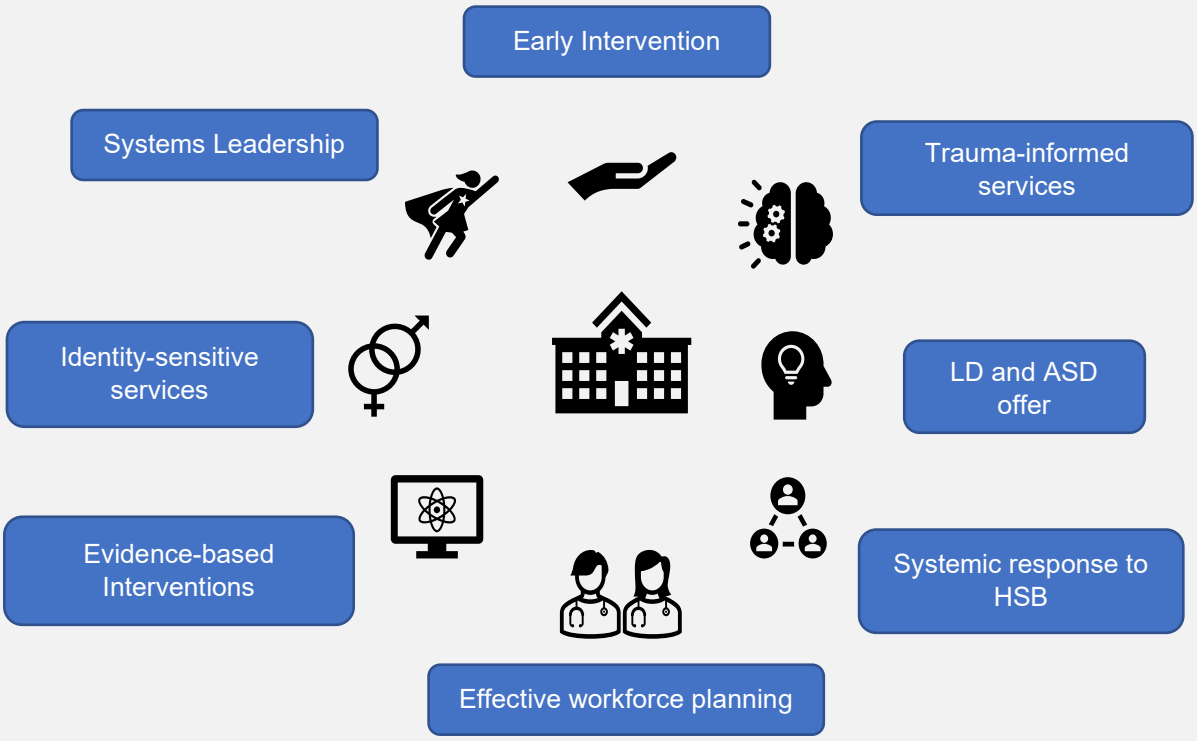
Family and carers: references to ‘family and carers’ is to mean the family members, partners, friends, neighbours or other members of a person’s social network, who provide support to a person with mental health needs. This includes those acting as a person’s attorney or as a deputy appointed by the 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

The commitment to increasing community-based alternatives to in-patient care is well-established in national policy and the NHS Long-Term Plan. The findings of the 2023 Desktop Literature Review support the trajectory of these changes and encourage bold action to deliver against these aspirations.

However, it is recognised that change will not be immediate – nor will the development of alternative care negate the statutory requirement for secure care for young people sentenced by the Youth Courts. In the meantime, the findings of the Review aim to improve the experience of care for those accessing forensic services. The Review has identified 8 themes for action (seen in the diagram below) within existing service provision.



Appendix 2 – Additional Service Functions

McGuire identified six principles for effective programmes when supporting young people with forensic presentations (McGuire, 2013):

- The intensity should match the extent of the risk posed by the offender.
- A focus on active collaboration, which is not too didactic or unstructured.
- Close integration with the community.
- Emphasis on behavioural or cognitive approaches.
- Delivered with high quality training and monitoring of staff.

- Focus on the proximal causes of offending behaviour (peer groups, promoting current family communication, and enhancing self-management and problem-solving skills), rather than the distal causes (early childhood).

Care, Education and Treatment Reviews (CETR)

Building the Right Support (2015) and the NHS Long Term Plan (2019) set out what young 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 at times of crisis 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 children and adults in mental health in-patient services
- avoid inappropriate admissions to mental health in-patient settings
- develop responsive, person-centred services in the community.

A CETR is a person-centred review to ensure the care (education) and treatment and support needs of the individual person and their family are met, and that barriers to progress and/or discharge are challenged and overcome.
https://www.england.nhs.uk/learning-disabilities/natplan/
https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/#heading-1

All children, young people or adults with autism and those with a learning disability are required to have a community C(E)TR if they have been admitted to or are considered to be 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.

Clinical Networks

The MSU Clinical Network provides a single national coordinated referral and admission pathway into individual MSUs, to ensure equity of provision and improve access to timely assessment and intervention. The network also supports workforce development and works to improve the alignment between MSUs and related services including FCAMHS and CYPSE. The network provides consultation and support to ensure children and young people can be supported in the least restrictive setting.

Clinical Lead

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

Membership

All Providers of MSUs are required to be active members of the network. Patients 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. This will include the provision of business support to the weekly referrals meeting.

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.

Appendix 3 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.

S	**Scoping:** The presenting situation is assessed with clarity around the child or young person's pathway and life narrative.
T	**Targets:** Staff, children and young people and the 'home' environment agree on the goals for the child or young person's time within the secure setting.
A	**Activators:** All children and young people have an agreed psycho-bio-social, developmentally informed, multi-factorial formulation (understanding not based on diagnosis) that clarifies what activates problems for them.
I	**Interventions:** Specialist and core interventions, driven by the formulation and incorporating the risk assessment. Ensuring interventions are tailored to each child or young person's risks and needs with content, intensity and timing of the intervention specified.
R	**Review and revise:** Clear 'real-life' outcome monitoring by the secure setting and 'home', including the frequency and severity of high risk behaviours and of movement towards goals, regularly evaluated using a formulation-based approach at multidisciplinary reviews.
S	**Sustain:** Sustainability planning from the outset around maintaining goals upon release and the transition to 'home' or other services.

Appendix 4: Dispute Resolution

On rare occasions, the referring clinical team may not agree with the outcome of, and recommendations made by the clinical referrals network.

In such circumstances the following steps should be taken:

i. The clinical network must instigate a clinician-to-clinician discussion regarding any differences of opinion.
ii. If the respective clinicians are unable to agree an outcome, the referral, clinical information, and recommendations made by the Clinical referrals network are reviewed by the NHSE Mental Health Lead and Mental Health Case Manager involved in the referral to establish the reasons for the dispute.
iii. Additional information may be required which includes information about the child or young person's current presentation and behaviour, outcomes of recent assessments of the patient and referrals made to other services.
iv. The Mental Health Case Manager must attend the patient's MDT meeting to assist with the decision.
v. A decision is made by the respective NHS England Mental Health Lead that the access assessment should stand or that the case should go forward to arbitration.
vi. Where a dispute relates to a recall to hospital under the MHA, decisions can be made outside the dispute procedure so recall to hospital is not delayed.

Arbitration Process

- If the Dispute Resolution process fails to resolve the difference of opinion, an arbitration process must commence. The outcome of arbitration determines the final position.
- The arbitration process involves NHS England seeking advice from a Consultant Psychiatrist with experience of working with children and young people in forensic settings, unconnected to the referrer or access assessment service.

- The advising Consultant Psychiatrist must review all relevant clinical information, including the access assessment report and form a view on the suitability of the recommendations made. This view and subsequent recommendations must be shared with the respective NHS England Mental Health Lead and Case Manager.
- In providing advice, the independent consultant must clearly state the rationale for their decision. The independent consultant's recommendation is final.
- If the final recommendation is for the patient to be admitted to secure in-patient services, NHS England must notify the appropriate secure service. Should the service not be able to admit, an alternative placement must be identified.

Appendix 5: Educational Provision

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. 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.

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

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 based on an agreement in respect of each individual Secure, 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.

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.

The education provider should establish relationships with relevant schools, colleges and other education providers to support the young person's transition into specialist and secure mental health services. Education provider should liaise while a young person is a patient of specialist mental health services and their aftercare and transition back to their usual place of education.

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.

Appendix 6 – Interdependent Services

MSUs are part of a suite of services that meet the needs of young people with mental health difficulties and 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.

Individual MSUs 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.

National Interdependencies

Interdependent services at national level include:

- Nationally recognised providers of specialist secure young person medium and low secure in-patient care for young people experiencing mental health or neurodevelopmental needs, 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 FCYPMHS providers
- Other providers of highly specialist residential or educational care for young people.

Regional and Sub-regional Interdependencies

Interdependent services at regional and sub-regional levels include:

- Local providers of secure mental health or neurodisability or other in-patient care for young people or those providing other secure care on youth justice or welfare grounds
- Commissioners of FCAMHS and community children's mental health services (including Learning Disability and neurodevelopmental) services, Local Authorities and NHS England and Integrated Commissioning Boards · NHS England and PC Case Managers · Public Health Teams within Local Authorities, in respect of their role to establish local need through Joint Strategic Needs Assessment.
- Senior managers in children's social care in different local authorities
- Youth justice (YOT) services and youth and crown courts

- Children and young people's Liaison and Diversion Services
- 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. CYPMHS, 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.