Healthcare Specification: CYPSS Chapter 8 Mental Health and Neurodisability Care and Intervention

Secure Settings for Children and Young People

(Under 18s)

NHS England and NHS Improvement

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Secure Settings for Children and Young People (Under 18s)

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Introduction

Healthcare Specification for Services for Children and Young People (Under 18s) in Secure Settings. Emotional and Mental Health within a Framework for Integrated Care (SECURE STAIRS).

CYPSS Standard 8: Mental Health and Neurodisability Care and Intervention

http://www.rcpch.ac.uk/cypss

The Overarching Specification should be read and incorporated in any tender, alongside this document.

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<td>Relevant outcomes frameworks</td>
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Children and young people's health outcomes framework (Jan 2014)
Available at: http://fingertips.phe.org.uk/profile/cyphof

Report of the children and young people's health outcomes forum – Mental Health Sub Group (July 2012)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf

NHS Outcomes Framework Domains and Indicators
https://files.digital.nhs.uk/80/C2138A/nhs-out-fram-ind-nov-18-pub-sched.pdf

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Public Health Outcomes Framework
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N.B. The terms "child" or "children" will be used throughout this specification to include all children and young people under 18 years of age.
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Outcomes expected from service delivery	• Safeguarding of and improvement in the mental health and emotional wellbeing of all children within the secure setting including:
	  o Prevention or reduction of morbidity associated with mental health and learning disability.
	• Reduction in children engaging in behaviours that resulted in them entering the secure estate and any other potentially harmful behaviour, including but not restricted to, aggression/violence towards others and/or self-harm, during their stay in the setting.
	• Reduction in likelihood of children engaging in behaviours that resulted in them entering the secure estate and any other potentially harmful behaviour including, but not restricted to, aggression/violence towards others, self-harm and substance misuse, on their return to the community.
	• Reduction in vulnerability to all forms of exploitation including, but not limited to, sexual exploitation and criminal exploitation.
	• Shared psychologically informed, multi-factorial formulation (child's story) developed for every child (to include information from the Comprehensive Health Assessment Tool (CHAT) and where indicated, a neuropsychological assessment) to facilitate a shared understanding of the activators of issues that led to entry into the secure estate.
	• Children to contribute, and have access, to the development of the multi-factorial formulation to enable an understanding of individual activators which increase the likelihood of them engaging in potentially harmful behaviour.
	• Bespoke intervention plans (across disciplines, ranging from care and education staff-led interventions to specialist mental health interventions) in place for each child based on their individual formulation, current guidelines, evidence base and sequenced according to risk/need.
	• Clear "destination-targets" identified collaboratively from the multi-factorial formulation and sustainability planning from the outset, to maintain goals upon transition to the community, another secure setting or the adult secure estate, related to the reason(s) for entry into the secure estate.
	• Improvement in health, social and family functioning to further reduce the likelihood of the child engaging in potentially harmful behaviour following transition to the community, to include direct work with families/carers (wherever possible). Where this is not possible, the Youth Offending Team should be engaged.
	• Access for all children, their families and carers to professionals experienced in child and adolescent mental health in the secure setting as required throughout their stay.
	Embedded mental health practitioners at each secure setting offering increased support to staff and children.
	Examples include:
	  o High visibility and availability of mental health trained staff;
	  o A point of contact and a resource for secure setting staff and children at the secure setting;
	  o Providing informal support/ reflection/ training to secure setting staff through increased integrated MDT working;
	  o Increasing confidence amongst secure setting staff in managing complex behaviours;
	  o Working collaboratively, knowing a particular group of children in detail, becoming experts in how those children function within the secure setting and developing relationships that can be used as vehicles of change.
	• Continuity of care and plans for sustaining gains for children both entering and leaving secure settings through clear CHAT discharge plans, named healthcare leads/Care Programme Approach co-ordination, to include pre-transition engagement with community services where required.
	• Where transition is to adult services, a comprehensive transition plan to be in place, to include pre-transition engagement with adult services.

- Healthcare staff contribute to the recruitment, development and sustaining of an emotionally resilient secure setting staffing group able to work effectively and compassionately with highly challenging children.
- Healthcare staff providing training, supervision, reflective practice and support to health and non-health staff to improve the mental health and wellbeing of all children, as detailed in the secure setting's comprehensive mental health and neurodisability strategy**.**

The SECURE STAIRS key principles and outcomes are outlined below.

Whilst 'SECURE' elements focus on staff and establishing and maintaining effective foundations, 'STAIRS' outlines the key elements of a child's pathway whilst they are placed in the secure setting.

- **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 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's pathway and life narrative.
- **T – Targets:** Staff, children and the "home" environment agree on goals for the child's time within the secure setting.
- **A – Activators:** All children have an agreed psycho-bio-social, developmentally informed, multi-factorial formulation (understanding not based on diagnosis) that clarifies what activates problems for the child.
- **I – Interventions:** Specialist and core interventions, driven by the formulation and incorporating the risk assessment. Ensuring interventions are tailored to each child'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 frequency and severity of high risk behaviours and of movement towards goals, regularly evaluated using a formulation-based approach at multi-disciplinary reviews.
- **S – Sustain:** Sustainability planning from outset around maintaining goals on transition to "home" or other services.

Indicators of performance

Indicators of performance:

Indicator	Description
D06K01	The % of referrals to specialist mental health provision
D06K02	The % of referrals to specialist mental health provision and accepted onto the caseload
D06K03	The % of children on the specialist mental health caseload who have a structured management plan
D06K04.1	The % of children with Acquired Brain Injury (inc TBI)
D06K04.2	The % of children with Autistic Spectrum Disorder
D06K04.3	The % of children with Learning Difficulties/Educational Needs

	D06K04.4	The % of children with Learning Disability
	D06K05	The % of children with Speech & Language Communication need(s)
	D06K06	The % of children at risk or presenting with self-harm injuries or suicidal ideation that have been assessed by mental health within 12 hours
	D06K07	The % of children on constant supervision that received a mental health assessment within 24 hours of the notification of the constant supervision commencing
	D06K08	The % of children on constant supervision who have received a mental health assessment and have a treatment care plan in place
	D06K10	The % of children separated from their main location who have had a healthcare plan within 24 hours of admission
	D06K11	No. of children who are assessed for admission to hospital under Section 2 of the Mental Health Act and detained
	D06K12	No. of children who are assessed for admission to hospital under Section 3 of the Mental Health Act and detained
	D06K12.1	No. of children who are assessed for transfer under Section 47 of the Mental Health Act and transferred
	D06K13	No. of children who were assessed for transfer under Section 47 of the Mental Health Act and are awaiting transfer
	D06K13.1	No. of children who are assessed for transfer under Section 48 of the Mental Health Act and transferred
	D06K14	No. of children whose transfer to hospital under the Mental Health Act was within 7 calendar days from assessment
	D06K15	No. of days children waited for transfer to hospital under the Mental Health Act
Service principles (aims and objectives)	The development of a whole establishment approach to health and wellbeing, including understanding and the promotion of "every interaction matters", maximising opportunities to support children to address their needs, including increasing awareness of mental health issues, emotional wellbeing and overall psychological understanding of child development, attachment and trauma and their needs across the secure setting. Attention should be paid to the clear duties that the secure setting and staff have to the children in their care: to safeguard and promote their welfare (see Overarching Specification), to promote their health and emotional wellbeing, and to take account of their specific needs as children, making reasonable adjustments where required. Needs assessments should be documented and regularly updated. Attention should be paid to the specific duties that local authorities have towards Looked After Children (LAC) in secure settings, including those placed in secure accommodation: to safeguard and promote their welfare; to make use of relevant services for these children in the same way that a parent/carer would; to take into account the wishes and feelings of children and their parents/carers and to have regard to children's religion, racial origin, cultural and linguistic background before making any decision about them.	

	Individual care and treatment plans should be guided by a psychologically informed and multi-factorial formulation, developed with the child, family/carers (where possible) and multi-agency professionals to ensure a shared understanding and collaborative working. Any treatment/ interventions should reflect national clinical guidance, current evidence bases and should be sequenced and co-ordinated according to the risk and need. There should be effective information sharing systems (see Overarching Specification) in place between those providing mental health interventions and those providing other types of interventions in the secure setting, as separation of record keeping and poor communication make it impossible to provide a truly holistic service[1]. There should be a weekly multi-disciplinary meeting to review the formulation-based care planning, understanding of the child and the current active interventions and progress made. These meetings should be documented clearly. Children, families/carers and communities should be requested, encouraged and supported to use their knowledge, experience and insight to design and evaluate the services that are on offer, the way that they are delivered and their accessibility and relevance, using a co-production approach. Services should work with families/carers and systems around the child, as far as possible, to optimise family and system functioning. The child's rights should be respected and they should be given choices about their care wherever possible. There should always be consideration of the continuation of mental health pathways and other necessary services which would impact on a child's emotional wellbeing. Services after a deprivation/restriction of liberty ends are vital in ensuring that any gains made are sustained in a meaningful way following transition therefore effective communication is essential between services. Transition and sustainability of any changes facilitated should be considered from initial formulation and through a formulation-based approach at multi-disciplinary review during all stages of a child's stay. Data collection relating to mental health needs, interventions **and outcomes** should be collected in the setting. Commissioners should systematically require and providers provide, activity and outcomes data for the purpose of contract and performance monitoring, contributing to national evaluations, national audit processes as well as case studies and quality audits. Healthcare providers will be expected to submit data in line with national requirements to measure throughput as well as quality. Services must be provided in a way that allows capacity and capability to respond to changes in health needs of children within the secure setting or changes to national health policy.
Details on the establishment (secure setting capacity etc)	For commissioner to fill in
Data on need	For commissioner to fill in

[1] Healthy Children, Safer Communities, DH 2009

Service description and core expectations for meeting the emotional and mental health needs of children under 18	The mental health needs of children (all those under 18 years) in secure settings are known to be considerable, severe and complex, with rates of psychosis, self-harm and suicide well above those of other children. There are high rates of Looked After Children with histories of abuse, neglect and trauma and experience of separation and loss. There are complicating factors of substance misuse, neurodisabilities and learning difficulties, and of the children's distress and anxiety at being locked up and away from home[2]. The service should deliver a fully-embedded child and adolescent mental health service which meets the emotional and mental health needs of all children accommodated within the secure setting, incorporating plans for both in-hours and "out of hours"[3], based on clinical need. The services within the secure setting should be visible both to staff and children and accessible both in terms of venue and timings of sessions. Staff working in mental health services for children in secure settings should be trained in child and adolescent development and mental health. The children are entitled to service provision that is **at least** equivalent to that available for children living in the community, within the constraints of the secure environment. Social vulnerability factors of the cohort such as bereavement, loss, homelessness, abuse, being a young parent, experience of bullying/harassment, exposure to domestic violence and other adverse childhood experiences should be considered in assessing the level of mental health service provision required. Strategic planning and commissioning of mental health services are particularly important for children held in secure settings given their vulnerability and the opportunity for addressing their unmet health and welfare needs. Due to the short time frame that may be available, the service should be designed to enable rapid assessment of previously undiagnosed mental health issues and comprehensive assessment of overall emotional wellbeing resulting in a multi-factorial, psychologically-informed formulation that can guide interventions for the child's stay in a secure setting. The strategic planning must also consider the links to services following transition to the community, another secure setting or adult secure setting to ensure sustainability of any gains made. All children within the secure setting should be seen by and have access to a mental health service throughout their stay. Mental health practitioners are named members of multi-disciplinary teams/support teams and embedded at each secure setting, offering increased support to staff and children. It should be clear to children what the mental health service comprises and who to talk to about it, in a format that is accessible to those with low literacy levels, whose first language is not English or who have other learning or communication difficulties with reasonable adjustments made where appropriate to ensure both communication and facilitation of service provision. All staff working directly with the children should have awareness of the mental health team and access to their support and supervision as required. The multi-disciplinary team (MDT) should have expertise in the neurodevelopmental disorders and learning difficulties/disabilities that children in secure settings can present with. The MDT should also have expertise in psychologically informed, multi-factorial formulation.

[2] Promoting mental health for children held in secure settings, DH 2007
[3] After 5pm and at weekends

	Regular multi-disciplinary formulation meetings should take place chaired by the unit manager/senior residential staff member (as representative of the therapeutic parent) with representation from: • Residential staff/ care worker/ custody care officer/ allocated officer; • Mental health worker/ clinical psychologist; • Case worker/ keyworker; • Education liaison workers; • Forensic psychology staff; • Primary healthcare and/or substance misuse staff; • Safeguarding staff. The meetings should be used to compile each child's multi-factorial formulation (child's story), discuss each child's formulation and progress, ensure formulation-based care planning across the whole system, review targets, intervention plans, alignment and sequencing, and develop whole system understanding of the needs of all children. Mental health services should offer sufficient support, regular supervision and reflective practice to staff (both within and external to health services) to ensure they feel cared for, are resilient and have an opportunity for reflection and understanding. This will enable staff to consolidate their training and a psychologically informed understanding of formulation, formulation-based care planning, 'every interaction matters', and reflective practice in promoting the best possible care for children within the secure setting. Mental health staff should be part of any health promotion meetings and activities to promote health across the secure setting. There should be a flexible needs-based model for structuring child and adolescent mental health services whilst in a secure setting and for care after transition from a secure placement, including transfer to inpatient or adult services. In secure settings, responding to children's mental health needs and any neuro-disability is crucial to meeting their overall needs. Mental health awareness requires a whole establishment approach and would include: • Age-appropriate information available to the child; • Training in mental health awareness, child development and attachment, and trauma awareness should be available for staff across the secure setting (not just healthcare staff); • Participation in health promotion activities across the secure setting; • Expert contribution to case reviews; • Promoting access to activities likely to benefit emotional health and wellbeing as informed by the multi-factorial, psychologically-informed formulation for each child (such as physical exercise, art etc). This includes providing advice on whether practice and policies are adversely affecting the emotional health and wellbeing of children in the secure setting; • Systemic and individual support to the secure setting staff on assessment, formulation, formulation-based care planning, support and supervision of 'every interaction matters' interventions, applying theory to practice, and enabling reflective practice across the setting;

- Providing local authorities and/or courts with information (where necessary) to help inform long term planning and placement decisions for children.
- Identifying and making reasonable adjustments to ensure appropriate care delivery where required.

Within the mental health team it is necessary for there to be sufficient senior clinician time to ensure psychologically-informed multi-factorial formulations are developed for each child and that these are used to plan and sequence interventions in a collaborative manner across all staff groups.

The senior clinician will be expected to have the skills and training to:

1. Oversee specialist assessments of all children based on complex data from a variety of sources including psychological and neuro-psychological tests, self-reported measures, rating scales, direct and indirect observations and semi-structured interviews with children, residential staff, family/carers and others involved in the child's care.

2. Oversee formulation and implementation of plans for the management and treatment of the issues leading to the decision to place the child in a secure setting, including formal psychological treatment where appropriate, based upon the child's needs, in the context of the family and wider system, with consideration of sustainability on transition, employing methods of proven efficacy.

3. Evaluate and make decisions about treatment options.

4. Ensure supervision of both health and secure setting staff, to support staff and assist in embedding training, applying theory to practice, a psychologically informed understanding of formulation, formulation-based care planning, 'every interaction matters' and reflective practice in promoting the best possible care for children within the secure setting.

In addition there will need to be sufficient staffing in place to provide access to the range of evidence-based specialist mental health interventions, both pharmacological and psychological, required by this group of children. Evidence for specialist mental health staffing levels needed to meet this requirement should be based on:

- Epidemiological and within-unit data regarding prevalence of particular presenting problems;
- National guidelines regarding evidence-based interventions (National Institute of Health and Care Excellence etc);
- National staffing guidance for Child and Adolescent Mental Health Services (British Psychological Society guidance on Using Applied Psychologists Effectively in the Delivery of CAMHS, Royal College of Psychiatrists' guidance on Building a Comprehensive CAMHS).

The CHAT (Comprehensive Health Assessment Tool) should be used as a reception health screen for all children entering the secure setting to assess individual health need and for those needing a full mental health assessment, this should be undertaken within CHAT timeframes. The data from CHAT can also be used as a starting point for population of a health and wellbeing needs assessment for the secure setting. The data from these assessments can be used to better inform the commissioning of health services in future. There should be a plan in place to ensure staff who will need to access CHAT are trained to use it and that new staff can be trained as part of their induction when other staff move on.

The service provided should meet the following standards:
Healthcare Standards for Children and Young People in Secure Settings (2019):
https://www.rcpch.ac.uk/sites/default/files/2019-06/rcpch_healthcare_standards_for_children_and_young_people_online1.2.pdf
The standard for Mental Health and Neuro-disability Care and Intervention (Standard 8) is detailed in full below.

8. Mental health and neurodisability care and intervention
8.1 Each secure setting has a comprehensive mental health and neurodisability (including speech, language and communication) strategy outlining the contributions of all staff to supporting and improving the mental health and wellbeing of children. 8.1.1 The strategy incorporates a multi-disciplinary approach and is part of the secure setting's health strategy. (See 12.1).
8.2 The healthcare team includes a multi-disciplinary Children and Young People Mental Health Service (CYPMHS) team appropriate to the needs of the children. 8.2.1 The secure setting receives consultation, advice, supervision, support and training from the integrated CYPMHS team. 8.2.2 All children will have a psychologically underpinned formulation, from a multi-disciplinary team with a mental health practitioner embedded. Dedicated and timely access to psychiatric and psychological input is available from the integrated CYPMHS team, through which other professional services may be accessed. This may include occupational therapists, speech and language therapists, primary mental health workers, a clinician with neuro-disability expertise and Community Forensic CYMPHS[4]. (See 10.3.1). 8.2.3 There is a lead mental healthcare professional responsible for overseeing mental health provision within the secure setting.
8.3 Before intervention begins, mental health and neurodisability need is assessed (see 4.5) and a healthcare plan is developed (see 5.2).
8.4 A range of evidence-based mental health interventions is offered and delivered according to individual needs. 8.4.1 Care of children on medication with a diagnosis of serious mental illness and complex cases (taking account of accumulating or multiple needs which may not individually meet thresholds) takes place within the Care Programme Approach (CPA). The CPA is continued for those children subject to CPA on entry to the secure setting. 8.4.2 Practitioners actively engage parents/carers in care and interventions where appropriate. 8.4.3 Practitioners support children to take responsibility for their actions and nurture their independence as part of their therapeutic plan. 8.4.4 Specific interventions are offered for managing severely difficult behaviour. 8.4.5 Mental health services should be available to support children who have experienced violence, abuse and/or adverse childhood experiences as clinically indicated. (See 4.5.2). 8.4.6 Specific evidence-based interventions are offered for addressing the root cause of, and managing, sexually harmful behaviour.
8.5 A range of evidence-based neurodisability interventions is offered and delivered according to individual needs. 8.5.1 This includes, but is not limited to, interventions for the following: • Traumatic brain injury;

[4] Previously known as CAMHS

	• Speech, language and communication difficulties; • Attention deficit hyperactivity disorder; • Learning disabilities and educational needs; • Autistic spectrum disorder.
	8.6 Children at risk of self-harm or suicide are provided with individual care and support. 8.6.1 Personal factors or significant events which may trigger self-harm are identified in the child's healthcare plan and discussed with all staff. 8.6.2 A range of evidence-based interventions is offered and delivered to address the underlying causes of self-harming behaviour. 8.6.3 All incidents of self-harm or attempts to self-harm are recorded and referred to the named safeguarding lead. (See 2.3).
	8.7 If clinically indicated, children identified with serious and complex problems, are transferred (under the Mental Health Act 1983) to inpatient units that meet their individual needs with effective continuing care. A care, education and treatment review should be undertaken ahead of the move. 8.7.1 The supporting CYPMHS team is aware of the referral criteria and process to access adolescent mental health in-patient services and have contact details for their closest unit so potential referrals can be discussed at the earliest opportunity.
Dependencies	Health commissioners and providers need awareness of the requirements of the relevant legislation and guidance governing particular secure settings such as The Youth Offender Institution Rules 2000, The Secure Training Centre Rules 1998 and National Minimum Standards for Children's Homes (See references below). Prescribing should be based on national guidance but may need to be adapted for use in a secure setting where medicines are open to abuse or where they may pose a high risk of overdose. There should be a medicines management policy[5]. Clinicians should clearly document their decision making regarding medications and if departing from guidance, the rationale for this must be recorded.
Rights of the Child	**The United Nations Convention on the Rights of the Child (UNCRC)** should underpin the specification. This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information amongst other matters. Children have said that they need: • Vigilance: to have adults notice when things are troubling them; • Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon; • Stability: to be able to develop an on-going stable relationship of trust with those helping them; • Respect: to be treated with the expectation that they are competent rather than not; • Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans; • Explanation: to be informed of the outcome of assessments and decisions, and reasons be given when their views have not met with a positive response;

[5] CYPSS Standard 6.4

	• Support: to be provided with support in their own right as well as a member of their family; • Advocacy: to be provided with advocacy to assist them in putting forward their views.
Safeguarding children (Working Together to Safeguard Children, 2018)	Effective safeguarding arrangements in every local area should be underpinned by two key principles: • Safeguarding is everyone's responsibility. For services to be effective, each professional and organisation should play their full part; • A child centred approach. For services to be effective they should be based on a clear understanding of the needs and views of children. Safeguarding is everyone's responsibility. Everyone who works with children has a responsibility for keeping them safe. No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action. All those working with children should be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern. Working Together to Safeguard Children (HM Government 2018) sets out how organisations should work together and the actions to be taken when abuse or neglect is known or suspected. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf Safeguarding children in the secure setting is of critical importance. Secure settings must have current safeguarding policies and procedures in place, which are subject to appropriate monitoring and review by a safeguarding committee and are legislatively compliant. (See the Overarching Specification and Standard 2).
Useful links and guidance	
Relevant legislation/ links to services for children	• **Working Together to Safeguard Children (2018)** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf • **Children Act (1989)** https://www.legislation.gov.uk/ukpga/1989/41/contents • Ensure compliance with **Children Act 2004 Section 10** duty to co-operate to improve wellbeing and to safeguard and promote the welfare of children. • **Section 11 of the Children Act 2004** places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

	• **Healthy Child Programme 0-5 (2009)** Pregnancy and the first five years. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf • **Healthy Child Programme 5-19 (2009)** Young people 11-16 Healthy Child Programme schedule-universal and progressive programme provides an evidence based programme detailed as a good practice outline. https://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf • **Health Child Programme 0-19: Health visitor and school nurse commissioning** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686928/best_start_in_life_and_beyond_commissioning_guidance_1.pdf • **Special educational needs and disability code of practice: 0-25 years** Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf • **Guidance for health services for children and young people with Special Educational Needs and Disability (SEND) (2018)** https://www.england.nhs.uk/wp-content/uploads/2018/07/send-health-services-children-young-people.pdf • **Mental Health Act (1983)** https://www.legislation.gov.uk/ukpga/1983/20/contents • **Mental Health Act Code of Practice (1983)** https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
Relevant Inspection Frameworks for secure settings	Alongside the Healthcare Standards for Children and Young People in Secure Settings (2019) (www.rcpch.ac.uk/cypss) providers also need to ensure compliance with the relevant inspection framework for the secure setting i.e. YOIs, STCs and SCHs. The relevant inspection framework should be frequently reviewed as part of all multi-disciplinary team meetings to address recommendations and ensure all areas for improvement are being progressed. Each secure setting is inspected on an annual basis. **HMIP Inspections for Young Offender's Institutions framework** https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf

Her Majesty's Inspectorate of Prisons (HMIP) is an independent statutory organisation which reports on the treatment and conditions of those detained in young offender institutions.

HMIP inspects Young Offender Institutions for children under age 18 annually. HMIP works jointly with other inspectorates such as the Office for Standards in Education, Children's Services and Skills (Ofsted), Care Quality Commission (CQC) and the Royal Pharmaceutical Society. This joint work ensures expert knowledge is deployed on inspections and avoids multiple inspection visits.

Inspections carried out by HMIP contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel Inhuman or Degrading Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies, known as the National Preventive Mechanism (NPM), which monitors the treatment of and conditions for detainees. HMIP is one of several bodies making up the NPM in the UK.

All HMIP reports include a summary of an establishment's performance against the model of a healthy prison. The four tests of a healthy prison are:

- **Safety:** children, particularly the most vulnerable, are held safely;
- **Respect:** children are treated with respect for their human dignity;
- **Purposeful activity:** children are able and expected to engage in activity that is likely to benefit them;
- **Resettlement:** children are prepared for their release into the community and helped to reduce the likelihood of re-offending.

Under each test HMIP makes an assessment of outcomes for children and therefore of the establishment's overall performance against the test. In some cases this performance will be affected by matters outside the establishment's direct control which need to be addressed nationally.
Further detail of the criteria under each of these tests for Young Offender Institutions for children under 18 can be found online.
https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/11/Childrens-Expectations-FINAL-261118-2.pdf

Joint Inspections of Secure Training Centres
The framework for inspections of Secure Training Centres (STCs) is available at:
http://ofsted.gov.uk/resources/inspections-of-secure-training-centres-framework-for-inspecting
Please note the STC inspection framework is currently under review. A new framework will be published in April 2019.

The inspection of Secure Training Centres is undertaken jointly by Ofsted, HMIP and CQC in consultation with the Youth Custody Service for England and Wales, and the Ministry of Justice. Each Secure Training Centre is subject to an annual inspection in accordance with a service level agreement with the Youth Custody Service and Ministry of Justice, acting on behalf of the Secretary of State for Justice.

The timing of an inspection is influenced by an assessment of:

- The outcomes of previous inspections;

- Advice or information provided to the inspectorates by the Secretary of State, the Ministry of Justice and/or the Youth Custody Service;
- Other relevant information received by Ofsted, HMIP or CQC.

Where there are significant concerns about a secure training centre between the annual inspections, an additional inspection may be carried out if requested by the Ministry of Justice and/or Youth Custody Service.

The inspection framework includes evaluation criteria to describe what "good" looks like in the judgement of overall effectiveness, taking into account:

- Safety of children;
- Promoting positive behaviour;
- Care of children;
- Achievement of children;
- Resettlement of children;
- Health of children;
- Effectiveness of leaders and managers.

The experiences and progress of children in all areas of their lives are central to the inspection.

Inspectors use the descriptors of good as the benchmark against which to grade and judge performance.

Inspectors make their judgements on a four-point scale:

1. Outstanding
2. Good
3. Requires improvement
4. Inadequate.

Ofsted Inspections of Secure Children's Homes:

Ofsted uses the Social Care Common Inspection Framework (SCCIF) for the inspections of Secure Children's Homes. https://www.gov.uk/guidance/social-care-common-inspection-framework-sccif-children-s-homes-including-secure-children-s-homes

For full inspections of secure children's homes, Ofsted will be assisted by an inspector from CQC in Ofsted's evaluation of health services provided for children. For interim inspections of secure children's homes, Ofsted may request the assistance of a CQC inspector if there are health related matters where the inspection would benefit from CQC's input. CQC is responsible for regulating registered healthcare providers.

Inspections under SCCIF make judgements on overall experiences and progress of children, taking into account:

- How well children are helped and protected;
- The effectiveness of leaders and managers;
- Outcomes in education and related learning activities.

Inspectors will use the descriptions of what "good" looks like as the benchmarks against which to grade and judge performance.

	The areas of required evidence and what "good" looks like are set out in chapter five of the SCCIF. Inspectors will make their judgements on a four-point scale: 1. Outstanding 2. Good 3. Requires improvement 4. Inadequate. **Inspections of Secure Schools** At the time of creating these specifications the inspection framework for Secure Schools was not yet confirmed. .
References for commissioners	**Five Year Forward View for Mental Health (2016)** https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf **Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing (2012)** http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf **THRIVE Framework for Children and Young People** https://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf One example of mental health services is the THRIVE model, which helps to implement a whole system approach. The framework outlines groups of children and the sort of support they may need, drawing a clearer distinction between treatment on one hand and support on another. The model conceptualised five needs-based groupings for children with mental health issues and their families: • Thriving – prevention and promotion; • Getting advice – signposting, self-management and one of contact; • Getting help – goals focused, evidence informed and outcomes focused intervention; • Getting more help – extensive treatment; • Getting risk support – risk management and crisis response. **The Children and Young People Secure Estate National Partnership Agreement (2018)** https://www.england.nhs.uk/publication/the-children-and-young-people-secure-estate-national-partnership-agreement/ **Healthy Children, Safer Communities (2009)** http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109772.pdf Mental health problems in children do not manifest themselves as clearly as they do in adults. They can emerge in ways that are less easily defined or diagnosed – for example, through behaviour problems, emotional difficulties, substance misuse or self-harm. This can lead to underestimates of the extent of mental health problems in certain groups of children. The mental health

needs of children in the Youth Justice System overall are three times greater than for their peers in the general population, with increasing severity and complexity of need for those in custodial settings.

Preventing suicide in England: A cross government outcomes strategy to save lives (2012)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

The Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPOA) simplified the previous remand framework. All children aged 12-17 are subject to the same remand provisions and all remanded children are treated as looked after by the local authority designated by the court when remanded securely. More details can be found here:
http://www.justice.gov.uk/youth-justice/courts-and-orders/legal-aid-sentencing-and-punishment-of-offenders-act-2012

The Young Offender Institution Rules 2000
http://www.legislation.gov.uk/uksi/2000/3371/contents/made

The Secure Training Centre Rules 1998
http://www.legislation.gov.uk/uksi/1998/472/contents/made

The Children's Homes (England) Regulations 2015
http://www.legislation.gov.uk/uksi/2015/541/pdfs/uksi_20150541_en.pdf

Guide to the Children's Homes Regulations including the quality standards
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/463220/Guide_to_Children_s_Home_Standards_inc_quality_standards_Version__1.17_FINAL.pdf

National Standards for Youth Justice Services
http://www.justice.gov.uk/downloads/youth-justice/yjb-toolkits/victims/national-standards-youth-justice-services.pdf

Human Rights Act (1998)
https://www.legislation.gov.uk/ukpga/1998/42/pdfs/ukpga_19980042_en.pdf

Equality Act (2010)
https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

Care, Education and Treatment Reviews for Children and Young People- Code and Toolkit (2017)
https://www.england.nhs.uk/wp-content/uploads/2017/03/children-young-people-cetr-code-toolkit.pdf