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Improving Health, supporting Justice

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**Improving the emotional and psychological wellbeing and mental health of children and young people in contact with the youth justice system in Yorkshire and Humber**

**Regional Commissioning Model**  
**High Level Workforce Development Strategy**  
Document 3 of 4 (updated December 09)

# Improving the emotional, psychological wellbeing and mental health of those in contact with the Youth Justice System Yorkshire and Humber

## Document 3 of 4: High Level Regional Workforce Development Strategy

This workforce strategy has been produced in order to support the commissioning of all services for the emotional, psychological and mental health needs of this population in the YH region. It is recommended that locally services should now be reviewed in the light of the requirements that are set out below.

See also:

Document 1: High Level Regional Service Specification

Document 2: High Level Regional Care Pathway

Document 4: Regional Quality and Performance Indicators (available January 2010)

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## Background

In autumn 2007 a mapping exercise was undertaken by Offender Health and Social Care, (part of the Yorkshire and Humber Improvement Partnership) looking at the provision of mental health and emotional wellbeing resources in the five children's secure units that then existed in the Yorkshire and Humber Region (Sutton Place Secure Children's Home in Hull has subsequently closed). This established that with some specific exceptions, the emotional wellbeing and mental health needs of children and young people aged 10 – 18 were, broadly speaking, not being met. Services were patchy and inconsistent and did not meet the guidance set out in the DH/YJB Commissioning Framework, *Promoting the mental health of children in secure estate* (March 07), which recommended a strategic regional approach to commissioning mental health services for this population of vulnerable children. Further mapping of mental health resources available in the community (to Youth Offending Teams) and consultation with young people in the youth justice system confirmed that provision in the community was also patchy and in some places inadequate.

From March 2008 Yorkshire and Humber Specialised Commissioning Group, together with match funding from The Youth Justice Board and The Department of Health (Offender Health) nationally, and Regional CAMHS, supported two year's further work to develop a consistent regional approach to commissioning for the mental health and emotional wellbeing of children in contact with the youth justice system.

## The Regional Commissioning Model

Following extensive consultation it was agreed that the regional model would:

1. Adopt a **pathway approach** – incorporating the needs of children (10 – 18 yrs) wherever they are in contact with the YJS in Yorkshire and Humber;
2. Be **comprehensive** – and include emotional wellbeing and/or mental health needs at universal, targeted and specialist levels (or CAMHS tiers 1 -4);
3. Incorporate **regional commissioning** in the form of overarching principles, standards and guidelines (service specification, care pathway, workforce development, and performance indicators) with **local commissioning** in the form of needs analysis, specific investment, contracting and procurement arrangements;
4. Be **integrated and mainstreamed** – with commissioning for the emotional wellbeing and mental health of this vulnerable group being located in the structures and arrangements for Children's Trusts.

## This document

This High Level Regional Workforce Strategy is one of four key components of the Regional Commissioning Strategy for improving the emotional and psychological wellbeing and mental health of children and young people in contact with the youth justice system in Yorkshire and Humber.

The other components are

Document 1: High Level Regional Service Specification

Document 2: High Level Regional Care Pathway

Document 4: Regional Quality and Performance Indicators (available January 2010)

Together the documents describe a strategic regional approach to commissioning for this vulnerable group of children (10 – 18 yrs). This guidance on the kinds of services and resources that should be available also applies to children and young people in contact with the YJS with dual diagnosis e.g. learning disability and/or other additional complex needs including alcohol/substance misuse, self harm, ADHD, forensic mental health problems.

This Workforce Development Strategy defines a number of key areas for consideration locally, when assessing if the range of skills, roles and workforce capacity required to meet the expectations set out in the High Level Care Pathway and Service Specification are available. As such it provides a template against which local workforce development needs can be appraised.

This strategy has been linked in to other plans for the development of the children's workforce and CAMHS in the YH region. In order to be sure that any child in the YJS in YH with emotional, psychological or mental health needs gets support and care from the right staff, with the right skills, in the right place, at the right time, then some level of development to the **13 key areas** described below will be necessary in most parts of the region.

Broadly speaking, the changes needed can be categorised as:

- (A) Training and development of existing staff**
- (B) New ways of working by existing staff**
- (C) New roles**
- (D) Increased staffing**

Every effort has been made to incorporate relevant national guidance but this is regularly updated and commissioners and providers will need to check for the latest publications to supplement the information below. It is acknowledged that some areas (eg health) may have been more thoroughly covered than others.

<b>Common abbreviations used in this document:</b>	
CAF – The Common Assessment Framework	MH – mental health
CAMHS – Child and adolescent mental health services	NCG – National Commissioning Group
CJS – the Criminal Justice System	OHSC – Offender Health and Social Care
CPA – The Care Programme Approach	YH – Yorkshire and Humber region
CYP – Children and young people	YHIP – Yorkshire and Humber Improvement Partnership
ECM – Every Child Matters	YJS – The youth justice system
EPWBMH – emotional and psychological wellbeing and mental health	YOI – Young offender institute
	YOS – Youth offending service
	YOT – Youth offending team

The structure and layout of this plan is based on a model developed by National Workforce Projects

## Step 1 - Defining the strategy:

### Purpose

As a consequence of the findings of regional service mapping, and the recommendations of national policy, a high level commissioning model has been developed in order to improve the emotional and psychological wellbeing and mental health (EPWBMH) of children and young people (CYP) in contact with the Youth Justice System (YJS) in Yorkshire and Humber (YH) and their families/carers. This document sets out the key workforce developments that need to be considered in order to support the regional care pathway and service specification and to ensure effective services for vulnerable children and young people (10 – 18yrs) in contact with the YJS in the region.

### Scope

In order to deliver the improvements that are required, there needs to be a corresponding development of capacity, confidence, and competence in certain aspects of the wider children's workforce, as well as in the specialist workforce that delivers more targeted and specialist emotional wellbeing and mental health services to CYP, including those who are in contact with the YJS.

This strategy therefore includes recommendations that are designed to have impact at universal, targeted and specialist levels. It directly addresses some very specific areas (e.g. aspects of the youth justice system where the NHS is the lead commissioner) whereas elsewhere (for example recommendations for training of the wider children's workforce), the intention is to act as a contributing influence, enabling commissioning partners such as LAs, PCTs and the YJB to achieve strategic policy and good practice targets in relation to the needs of vulnerable children and young people across the region.

### Ownership

Ownership of the plan primarily needs to be with the relevant commissioners and service providers locally. This includes PCT and LA commissioning mechanisms for the emotional wellbeing and mental health of children and young people (Children's Trusts). At a regional level this includes Government Office YH, NHS YH, YH Specialised Commissioning Group (SCG) and the Youth Justice Board, who have all been partners in the work that developed the overall regional commissioning model.

**From a strategic workforce perspective, the evidence suggests that there are 13 key areas requiring attention:**

1. **Universal children's workforce:** there are many groups of staff (e.g. teachers, youth and community workers, housing, employment and primary care practitioners) who are in contact with CYP sometimes on a daily basis but do not have a specialist role in terms of emotional wellbeing or mental health. With suitable support and training, this wider, universal children's workforce is able to take a more consistent and proactive role in early identification and support of CYP with EPWBMH needs who are in formal contact with the YJS, or at risk of it
2. **Universal level within CJS and YJS:** staff groups in the CJS/YJS systems who work at 'universal level' (e.g. police, front line staff in secure units, Forensic Medical Examiners, magistrates) often lack the specific training and confidence to identify when a young person has EPWBMH needs or problems and to respond appropriately. As a result opportunities for early assessment/intervention are significantly reduced
3. **Primary mental health care:** In secure and community settings alike, primary healthcare professionals do not always have the skills and confidence to offer basic MH promotion and other primary mental health care interventions, e.g. screening assessment and support to CYP, with a resulting tendency to over rely on specialist workers, placing avoidable pressure on CAMHS
4. **Early assessment:** effective access to early assessment for EPWBMH needs of CYP is not readily available to the police and other agencies
5. **Capacity in Youth Offending Teams:** Increased capacity is needed in YOTs to identify and respond more effectively to CYP with EPWBMH needs (YOT practitioners use ASSET if concerned about a CYP's MH but studies suggest ASSET is not always reliable/effective in capturing need). Not all YOT staff have same level of confidence in identifying or responding to CYP with EPWBMH needs
6. **CAMHS in YOTS:** YOT teams in YH have very variable input from specific CAMHS workers who are members of the YOT team
7. **Access to CAMHS:** in some areas 'generic' CAMHs and other secondary health workers lack capacity/confidence to respond to the EPWBMH needs of CYP in contact with the YJS. Traditional (ie clinic or centre based) working practices are not always

conducive to engaging with the more vulnerable and at risk CYP

8. **CAMHS in secure settings:** Some children's secure units in YH currently have very limited access to CAMHS input and struggle to provide the range of targeted and specialist interventions that is required. This is currently most problematic in East Moor SCH (Leeds), but no unit has access to a full multidisciplinary team including (for example) clinical psychology, nursing, occupational therapy, arts therapists, mental health social work, CAMHS consultant psychiatrist, and SLT therapists. Historically there has been only limited health and social care needs assessment in some secure settings so resources have developed in a service rather than a needs led fashion. This is exacerbated by the high levels of CYP from OOA in the YJS
9. **Forensic CAMHS:** There is very limited access to Forensic CAMHS expertise in many parts of YH. In addition to the clinical issues this raises, staff and practitioners are not able to access expert consultation, support and supervision, thereby limiting capacity to manage and contain CYP's needs
10. **CYP friendly services:** service user consultation indicates that statutory services including CAMHS do not always operate in a CYP friendly manner, and that there is a lack of continuity/outreach by workers in secure settings and follow up in the community. There is not always support for practical matters like housing and employment, which CYP find especially important when leaving secure units
11. **Third Sector:** There is inconsistent and often inadequate use of third sector provision and therefore the third sector workforce (and the range of interventions and supports it can offer) is underrepresented at various stages in the care pathway.
12. **Tier 4 forensic in patient units:** There are no tier 4 forensic inpatient units in YH and this means that children always go outside of YH for placement, which can last many months. These units have varied working cultures and it is unclear how to influence this. Re-entry back into the child's hometown is frequently difficult, and there is a need to develop new and improved ways of working around these transitions
13. **Regional governance:** The proposed regional care pathway and service specification will require monitoring and managing and this could involve the creation of new roles to have oversight of the regional model e.g. case managers, system coordinator, 'or boundary spanners'

Each of these areas is now expanded upon in the steps that follow:

## Step 2 - Mapping service change

### Goals and benefits of change

The overall goal of this strategy is to ensure that there is in place the workforce needed in order to improve the emotional and psychological wellbeing and mental health of children and young people in contact with youth justice system in the Yorkshire and Humber region, or at risk of it. In addition, a number of key outcomes have been defined in the Regional High Level Service Specification:

#### **Outcomes for children and young people:**

Increased/earlier access to EPWBMH services; Earlier assessment; Consistent provision; Reduced health inequalities; Improved engagement; better coordination of care; Increased positive health outcomes; Reduced future need for health and social care; Reduced vulnerability/ risk

#### **For families and carers:**

Increased awareness of routes to help and care; Advice and support to be able to respond positively to their children's EPWBMH needs;  
Increased involvement in therapeutic interventions where appropriate

#### **For staff:**

Increased competence, confidence and capacity; Increased training, consultation, support and supervision; Increased awareness of services and resources in the community

#### **For the system as a whole:**

Reduced health inequalities ; Improved access; Increased integration and partnership working; Reduced re-offending and risk of offending; Better performance monitoring; Reduced cost of crime; Economies of scale; Reduced referrals to tier 4 forensic units

## Key drivers and constraints

### **General drivers:**

Public Service Agreements (especially PSA 12) and National Indicators (see the High Level Service Specification for a complete list)  
The Children Act 2004, Every Child Matters, The Commissioning Framework for Health and Wellbeing, The Children and Young People's Plan, The Youth Crime Action Plan, Promoting the health of looked after children, DH 2002;; Healthcare Standards for Better Health – Commissioning core standard 2, Safe Guarding;

### **Specific drivers (local):**

Review of the Qualifications and experience requirements for job roles in YH, YJB 2009  
CAMHS Workforce Plan for Yorkshire and Humber, 2009;  
Healthy Ambitions: Children's Clinical Pathway NHS YH, 08;  
YHIP project to develop a Regional Strategic Commissioning model (07 – 09)  
Emotional Wellbeing at Wetherby YOI, (Leeds PCT) Dec 2008  
CANA (Barnardo's) Consultation with Service Users and families in the YJS in YH 08  
Not Working and Not Together, Case Audit of CYP in Secure Settings in YH 02

### **Specific drivers (national):**

Health Children, Safer Communities, DH Strategy and action plan for health and wellbeing of those in contact with the YJS (anticipated Dec 09)  
The Bradley Report, DH, 2009  
Actions Speak Louder, The second review of healthcare in the community for young people who offend, 2009  
Securing better health for children and young people through world class commissioning - A guide to support delivery of *Healthy lives, brighter futures: The strategy for children and young people's health*, DCSF 2009  
2020 Children's and Young People's Workforce Strategy DSCF 2008;  
YJB Workforce Strategy 2008 – 11;  
Brighter Futures, Next Steps for the Children's Workforce, 2008;  
NHS Next Stage Review – A High Quality Workforce, DH 2008;  
National CAMHS Review: Children and Young People in Mind, 2008;  
Promoting the mental health of children held in secure settings – a framework for commissioning services DH 2007;

New Ways of Working in Mental Health, DH 2007

Common Core of Skills and Knowledge for the Children's Workforce, ECM, 2006

Ten Essential Shared Capabilities – A framework for the whole of the MH workforce;

The National Service Framework for Children, young people and maternity services, DH 2004

### **Constraints**

There is a confusing array of commissioning arrangements across the Youth and Criminal Justice Systems in relation to health and social care. This means that different lead commissioners are involved, depending where a young person is in the criminal/youth justice system at any given time. This has an ongoing impact on the provision of health and social care

Investment and development are also affected by features of the criminal justice system that are beyond the control of regional or local agencies e.g. the high level of YJS placements that are out of region (approximately 30% of those in secure settings) and the frequently 'hard to engage' nature of the client population. There are no tier 4 forensic CAMHS beds in YH so CYP with this level of need are all placed out of the region, occasionally in costly private placements. Broader constraints include pressure on limited funds and competing priorities faced by all health and social care commissioners

**Current baseline - components of the children's workforce in the 13 key areas:**

**1. At the most universal level – the wider children's workforce in YH, i.e. all of those staff potentially in contact with at risk/vulnerable children and young people:**

This is a very large workforce including teachers, primary care practitioners, and youth and community workers. It is beyond the scope of the project to do more than ensure that its recommendations for improving the emotional and mental health of young offenders are incorporated into development plans for the wider children's workforce. There is no attempt to give a baseline for the size of this workforce in this paper, and further work will need to be done locally in this respect.

**2. Universal level staff groups within the YJS and CJS:**

Staff who are likely to be in contact with vulnerable/at risk CYP but who are not specialist youth or mental health workers. This includes police custody officers, magistrates, forensic medical examiners, officers and other front line staff in secure units, and so forth, and this is essentially a training agenda – one that has recently been emphasised by the findings of the Lord Bradley Report DH 2009. Potentially a large number of staff and further work locally and regionally is needed to establish a baseline.

### 3. Developing the role and contribution of primary care staff – in the community and in secure settings:

#### a. Baseline Primary care CAMHS in the community

Establishing a baseline of current capacity in terms of primary care CAMHS capacity in the community needs to be undertaken in each locality. The NHS YH Children’s Clinical Pathway work is relevant to this, and the contribution of this strategy is to ensure that partners locally take into account the needs of CYP in contact with the YJS or at risk of it when developing primary care CAMHS.

#### b. Baseline Primary care resources in YH Children’s secure units

The table below gives some figures for primary health care resources in the four YH secure units as of October 07. Resource levels and readiness to offer universal/targeted MH interventions varies and is complicated by the fact that these resources tend to be commissioned/contracted completely separately from CAMHS. Further work is required locally in order to assess the levels of primary care mental health in secure units and whether the current resource/model is effective in terms of improving children’s emotional wellbeing and mental health:

**Primary care resources in children’s secure units in YH as of October 07**

East Moor	Aldine House	Wetherby YOI (Inc Keppel Unit)	Rivendell Unit
<p>GP as needed</p> <p>2x15 hrs general nurse (1 is RMN)</p>	<p>1 x Primary Care nurse, 2 x half days per wk</p> <p>GP as required</p> <p>Access to on call services where necessary but very rarely have to use this. Usually use paramedics instead due to nature of unit.</p>	<p>Has separate and sizeable GP and nurse primary care team but not linked to mental health (currently commissioned in a different part of the PCT from CAMHS)</p> <p>Primary care team historically has had very limited focus on PCMH. Primary Care and specialist MH Functions currently not well integrated.</p>	<p>1 x RGN +GP flexible</p> <p>MH Practitioner will adopt primary care MH approach with support from GP if necessary.</p>

#### 4. Ready access by the police and other agencies to assessment and early intervention for EPWBMH needs of CYP

Whilst there is evidence of some pilots and local arrangements in some parts of YH (e.g. Sheffield), there is not a clear picture available of the approach across the region to ensuring early access to assessment and/or intervention at this key point in the pathway. YHIP OHSC is currently (autumn 09) scoping access to health care in police custody suites.

#### 5. Increasing confidence and capacity of all YOT practitioners to identify and respond more effectively to CYP with EPWBMH needs

Current levels of YJB staff in YOT teams in YH 08/09 (ie does not include health staff. Further work is needed to establish existing skills and capacity in relation to EPWBMH. See also *Actions Speak Louder Than Words*, the 2009 report from CQC on access to health and social care in the community by young offenders

YOT	Operational manager (FT)	Operational Managers (PT)	Practitioners (FT)	Practitioners (PT)	Total
Barnsley	6	0	29	6	41
Bradford	9	0	57	14	80
Calderdale	4	0	32	9	45
Doncaster	3	1	58	6	68
East Riding	4	0	20	5	29
Hull	6	0	39	0	45
Kirklees	5	0	42	6	53
Leeds	15	3	96	14	128
N E Lincs	3	0	23	2	28
N Lincs	3	1	20	5	29
N Yorkshire	10	4	50	20	84
Rotherham	5	2	32	8	47
Sheffield	14	0	65	37	116
Wakefield	6	0	41	0	47
York	3	0	14	8	25
<b>Total</b>	<b>96</b>	<b>11</b>	<b>673</b>	<b>140</b>	<b>920</b>

## 6. Access To CAMHS by YOT - PCT contributions to YOTS in YH – Staff) and funding

The extent of PCT contribution varies significantly, in keeping with the national picture, but this table does not reflect additional MH resources that may be accessed by the YOT. Currently, PCT contribution is agreed locally and may not take the form of a MH worker, and where there is a MH worker, it is not known if this is CAMHS or adult MH. Further work needed to clarify this.

Team	Total acute and non acute MH assessments 06/07 ( <i>figures no longer collected regionally/nationally</i> )	Total PCT financial contribution (inc staff) (09/10)	Staff (WTE) (08/09)	MH staff – NB NOT ALL CAMHS	% of total population under YOT supervision (08/09 figures)
Barnsley	72	74,355	2	2 one funded via YJB RAP grant	7.2%
Bradford	40	106,000	2	0	5.6%
Calderdale	41	78,396	2	0	6.4%
Doncaster	74	1371,35	2	1	4.7%
East Riding	11	48671 plus approx 23000 from LA CAMHS grant	1	1	3.9%
Hull	18	158,500	2	1	9.5%
Kirklees	87	146,565	3	0	7.2%
Leeds	69	158,567	4 (RAP grant pays for 1 WTE)	3	10.6%
N. E. Lincs	29	10,465	1	1	8.6%
N. Lincs	19	56000 (08/09 figure)	1	1	8.8%
N. Yorkshire	52	120,156	1.7 (fte)	1	3.5%
Rotherham	64	108,720	1	0	7.5%
Sheffield	104	206,000	2	2	6.6%
Wakefield	43	72,262	1	0	4.2%
York	54	68,316	1	1	3.6%

**7. Capacity of generic CAMHS to offer services to CYP in contact with YJS (or at risk of it):**

Anecdotally there are reports of CAMHS teams being reluctant to see CYP who are in contact with the YJS, for example by insisting that young offenders should only be seen by specialist Forensic CAMHS. Also, traditional, clinic-based outpatient systems limit take up from those who are hard to engage. Many vulnerable CYP have histories of repeat DNAs in respect of CAMHS and consequently failing to receive a service. There is currently no data on the extent of demand or the workforce implications of adopting a more flexible or 'assertive outreach approach', but this sort of development is strongly recommend in *Children and young people in mind*, the final report of the National CAMHS Review, 2008. Further local work needs to be carried out to quantify the impact of this locally, but it should be recognised that the most vulnerable CYP can frequently struggle to access CAMHS and other children's services.

**8. Access to CAMHS resources - based in or accessible to secure units in YH (2008) – Current baseline**

As can be seen from the table below, there are considerable differences in terms of the CAMHS resources available to the children's secure units in YH, and there is historically no clear benchmark or process for ensuring consistency or equity of access. Consequently provision has been service led and not needs led. This should now be reviewed – see also High Level Regional Service Specification:

East Moor (36 beds)	Aldine House (8 beds)	Wetherby (inc Keppel Unit)	Rivendell Unit (26 beds)
<p>1 x Psychiatrist, 2 sessions per month</p> <p>Access to Leeds CAMHS limited</p> <p>Some limited input from Wetherby CAMHS team (Leeds PCT)</p>	<p>1 x Psychiatrist, 1 day per wk, plus on call psychiatrist if required</p> <p>2 x Psychologists, 1 day per wk each</p> <p>From Community Forensic CAMHS, funded by Sheffield LA</p>	<p>In reach team is part of Leeds CAMHS:</p> <p>1 Manager - RMN</p> <p>2 Senior practitioners RMN - full time</p> <p>2 Dramatherapist - 1 full time, 1- 18hrs</p> <p>1 Art psychotherapist - 18 hrs</p> <p>2 Senior nurses RMN - full time</p> <p>2 RMN's - 1 full time (temporary contract), 1- 22.5 hrs</p> <p>1 Learning disability nurse - full time (temporary contract)</p> <p>2 Support workers - 30 hrs &amp; 18hrs</p> <p>1 speech &amp; lang therapist - 2 sessions a week (temporary)</p>	<p>Unit MH practitioner can work at more specialist level (Tiers 2 - 3)</p> <p>Historically no CAMHS input – but good MH in reach accessed via Adult MH services:</p> <p>1 x Psychiatrist, 1 x session per wk from adult MHIR Service)</p> <p>Referrals can be made to Psychologists. And clinical nurse specialists Good support from Adult MHIR team (SWMHT)</p> <p>NB New community forensic CAMHS team being commissioned by Wakefield PCT (as of 04/09)</p>

**9. Access to Forensic CAMHS– current baseline in YH children’s secure units (access by YOTS to forensic CAMHS not yet mapped regionally)**

East Moor	Aldine House	Wetherby inc Keppel	Rivendell
Forensic (Tier 4) assessments only accessed via in pt unit eg Roycroft (Newcastle) or Gardner Units (Manchester)	Two days per week input from Community Forensic CAMHS, psychiatrist and clinical psychologist	Forensic (Tier 4) assessments only accessed via in pt unit eg Roycroft (Newcastle) or Gardner Units (Manchester)	Access to Forensic Psychiatrist (Employed by SW MHT); also development of new Community Forensic CAMHS team from April 09

No comprehensive mapping of access to forensic CAMHS in the community has been undertaken and commissioners are advised to review local provision in the light of the needs of CYP in contact with the YJS

**10. CYP friendly services - changes to service delivery and working practices:**

Service user consultation locally indicates that CYP and their families want more continuity, more CYP friendly working practices, and more support around practical matters like housing and employment. This is supported by national guidance (eg *National CAMHS Review – Children and Young People in Mind, 2008*) Improvements could take a number of forms; very difficult to assess WF implications regionally however, as this depends on local practice and development. The following should be considered if not already in place:

- Build in consultation with CYP and their families, especially from hard to reach communities, and incorporate findings into service redesign
- Support greater CYP friendly ways of working statutory services including CAMHS eg opening hours, appt times, travel and meeting arrangements
- Increase the ability of secure unit MH staff to ‘outreach’ i.e. support vulnerable CYP in their re-entry to the community
- Need for more MH support workers roles to undertake practical activities with CYP
- Increased links co-working with third sector providers (see also below)

**11. Increase opportunities for third sector provision:**

Current EPWBMH inputs from third sector occur in three out of the four units in YH. It is well known that some service users

prefer the approach of non statutory agencies and the third sector is often well placed to provide tailor made and alternative services that are vital to wider EPWBMH e.g. crèches, advocacy, counselling, anti-bullying programmes, and supports for diversity and special needs. In addition these services can provide CYP with links and pathways into community resources and help with practical matters. Projects and services in the community are more widespread but there is not currently up to date baseline in terms of current activity from a workforce perspective, and again this is another area that needs to be reviewed locally.

#### 12. Tier 4 forensic in patient placements outside of YH:

There is an ongoing review of tier 4 referrals across YH via the regional Specialised Commissioning Group. Tier 4 Forensic in patient services are nationally commissioned. Where not eligible for national funding private placements are often commissioned. This is another area where the local WF strategy has only limited influence on improvements to the units involved and the way they operate. There is however opportunity to review local workforce issues around the re-entry of CYP back to their home town after spending time out of region, especially in the light of the Regional High Level Care Pathway.

#### 13. Regional governance - new roles to oversee implementation of the regional specification and care pathway:

There will possibly over time be a need for some regionalised aspect of service provision that emerges from the work of this project and the combined recommendations of the *Bradley Report*, *The National CAMHS Review*, and the new strategy for the health and wellbeing of those in contact with the YJS – *Healthy Children, Safer Communities*. This will need to be taken forward by local commissioners collaboratively in due course. It is not possible to give a baseline for the workforce implications at this stage.

### Current performance measures

These vary depending which part of the overall 'young offender health and social care pathway' you are looking at. The Care Quality Commission inspects YOTS, Her Majesty's Prison Inspectors YOIS, and Ofsted looks at Secure Children's Homes. There are national measures in place for YOT staff and front line staff in secure units via the YJB, which do refer to mental health and emotional wellbeing (Key Practice Indicators). Also, YOTs have to complete data returns to the centre but figures for MH referrals and assessments are no longer required. Performance measures for CAMHS and specialist CAMHS working with CYP in the YJS vary across YH. **Please refer to the 4<sup>th</sup> component of the YH Regional Commissioning Strategy – Quality and Performance Indicators (January 2010)**

## Step 3 – Defining the Required Changes to Workforce

The key categories of development that is recommended are:

- (A) training
- (B) new ways of working
- (C) new roles
- (D) increased staffing

? Indicates that the need for this type of development is unclear and further work is needed locally

Workforce component and the changes that are required	Development required			
	A	B	C	D
1. Increasing the awareness and confidence of the wider children’s workforce to be able to identify vulnerability and risk in terms of the EPWBMH of CYP in contact with the YJS or in danger of this, and increasing their knowledge of how to respond appropriately. The development of confidence and competence in the wider children’s workforce, in terms of children’s emotional, psychological and mental health, is a wider strategic aim for the region in keeping with ECM and the Children’s Plan. The particular needs of CYP in contact with the YJS, in the community or in secure settings, should be incorporated into this wider objective	*	*		
2. Reviewing and developing the role of primary care practitioners (in the community and in secure units) in relation to promoting EPWB and MH, assessing and treating CYP with common, universal level EPWBMH needs, and referring for specialist assessment and intervention (CAMHS) if required	*	*	*	

3. Increasing the awareness and confidence of all CJS and YJS staff who come into contact with CYP so that they are able to identify CYP who have EPWBMH needs, feel confident in making an initial response able to refer on to and access the appropriate services, and get help/advice/support when they need it				
4. There should be ready access to assessment by CAMHS staff or suitably qualified YOT staff for all CYP with EPWBMH needs, in all police custody suites in YH, via a single point of contact	*	*	*	*
5. Clarification of the roles of all YOT practitioners in relation to identifying and supporting CYP with EPWBMH needs and role extension in terms of being able to undertake initial screening and assessment of these needs	*	*		
6. Ensuring that all YOTS in YH are able to access timely consultation, assessment and intervention for CYP with EPWBMH needs via dedicated CAMHS practitioners for that team	*	*	*	*
7. Ensuring that all CAMHS teams and CAMHS practitioners in YH are confident and supported to assess and offer appropriate interventions as required to CYP who have had contact with the CJS/YJS but who do not have specifically forensic MH needs, and are able to offer assertive outreach for these and other CYP who find services hard to access	*	*		?
8. Ensuring that <b>all</b> children's secure units in YH have adequate and ready access to specialist and targeted multidisciplinary CAMHS, including Learning Disability; this to include the support and administrative roles required to ensure best use of specialist staff time and skills. Where required, CAMHS staff working in secure units are able to offer continuity via outreach	*	*	*	*

<p>9. Ensuring that Forensic CAMHS expertise (training, consultation, supervision, assessment and intervention) is readily available in all geographical areas of YH and in community settings as well as secure units, so that community services and interventions are developed alongside and as alternatives to in patient models</p>	*	*	*	*	
<p>10. Ensuring that all children’s services and CAMHS teams in YH operate in a CYP friendly way, especially in the nature, timing and location of meetings, have mechanisms for involving children in consultation and design, and can provide help with, or referral on to services that can offer, practical support , e.g. in terms of housing and education/employment, via effective signposting and similar initiatives</p>	*	*	*	?	
<p>11. Increasing the role and contribution of the of the third sector workforce with CYP in contact with the YJS to facilitate access to a wider range of interventions to improve their EPWBMH, both in secure units and in the community</p>	*	*	*	*	
<p>12. Increasing influence over national commissioning processes in relation to tier 4 forensic in patient units by seeking best fit with the YH service specification and care pathway. Ensuring that there are systems, services and roles in place to support young people returning to YH after discharge from such units</p>		*	*		
<p>13. Ensuring that the new regional care pathway and service specification are adequately facilitated and monitored in terms of performance management of the regional commissioning framework, and in the provision of case/care management to support the individual journey through the combined health, social care and criminal justice systems</p>		*	*	*	

## Next Steps

Further work remains to be done by commissioners locally in order to determine which of the above steps should be prioritised and to provide more detail in terms of the resources and investments required. For example

- Establishing current baselines
- Defining and quantifying training
- Ensuring access to advice, supervision and consultation – estimating demand
- Being very clear about the impact of the 13 recommendations in terms of investment in new staff and resources
- Translating the above into specific types of staff and WTE amounts

## Productivity and efficiency

Increased confidence and effectiveness of the wider children's workforce via training, and increased access to expertise via support and supervision for groups such as primary care staff (for example) increases capacity at the universal and primary levels, and can reduce pressure and demand on more specialist, targeted and expensive service providers and resources.

Similarly, ensuring that all generic CAMHS are able to respond to CYP in the YJS with non forensic MH needs extends the current role of some teams and this will have a positive impact on the demand for specialist forensic staff

Ensuring better access to specialist forensic CAMHS expertise across the region will increase the ability of CAMHS and other practitioners to manage need without recourse to out of area assessment and placement

Above all, ensuring early access to assessment and effective intervention for EPWB&MH problems and needs for all children and their families who come into contact with the YJS will have a measurable impact on the cost of offending, reoffending, and use of health and social care services in adult life

## Step 4 - Understanding workforce availability

It is beyond the scope of the current project to assemble the required data and undertake analysis of the broad and specific workforce dynamics (for example, in terms of workforce forecasting, demographics, supply options, recruitment and retention, cost and impact of training, retraining or recruitment etc). Arguably local or sub regional information is going to be more relevant in making specific plans.

Strategic workforce information about the region is available from Skills for Health:

<http://www.skillsforhealth.org.uk/nations-and-regions/england-yorkshire-and-humberside.aspx>

Up to date workforce intelligence is contained in this report on the region:

[http://www.skillsforhealth.org.uk/nations-and-regions/~media/Resource-Library/PDF/LMI\\_Yorkshire\\_report.ashx](http://www.skillsforhealth.org.uk/nations-and-regions/~media/Resource-Library/PDF/LMI_Yorkshire_report.ashx)

A wide range of data on the children's health and social care services and resources including CAMHS across the region are available here:

<http://www.childrensmapping.org.uk/results/regionalprofile.php>

Various data and labour market statistics can be found here:

<http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=1944>

## Step 5 - Developing an action plan

Whilst there are advantages in having a high level, overarching, regional strategy, local initiatives to undertake some of the required changes and improvements by PCTS, LAs, and other agencies such as the Police, the YJB and the voluntary sector are already ongoing, and can and do occur on a more ad hoc basis. For example:

- in relation to area (2) Offender Health and Social Care YH is establishing a trainer post that will be able to provide some child and adolescent MH modules to front line staff who are in contact with CYP at different points in the CJS/YJS
- in relation to areas (5) (9) and (10) Wakefield PCT has invested in a community forensic CAMHS team to work into the secure unit (Rivendell) and to also provide wider support and input to vulnerable CYP in the YJ and LAC systems and the agencies that work with them in the community
- In relation to area (3) and (8) Wetherby YOI has made considerable progress over the past two years, with the opening of the Keppel Unit and a CAMHS day unit, and working practices resulting from the YOI's participation in a Whole System emotional and mental health review commissioned by Leeds PCT

Further work now needs to be undertaken by commissioners locally to take these strategic workforce recommendations forward. This includes agreeing priorities, getting more information about local or sub-regional baselines and specific gaps, being clear about any overlapping or linked initiatives, especially in terms of the wider children's workforce, understanding accurate costs of any necessary investments, action planning and change management, including clinical and practitioner engagement, consulting with children and young people and their families/carers, and above all ensuring that the plans to develop the workforce that deals specifically with those with emotional and mental health needs in contact with the YJS are incorporated into mainstream workforce plans and development schedules locally.

## **Step 6 - Implement monitor and refresh**

Once the high level strategic recommendations in this plan have been considered by the relevant commissioning partners and other stakeholders and revised/customised to local needs and emerging national guidance as necessary, an action plan for implementation, monitoring progress and review should be devised and set in motion

This will need to include performance measures for assessing the benefits, and ways of identifying and rectifying any unintended consequences, as well as a timescale for review.