# STATES OF JERSEY

# CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) (S.R.5/2014): RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

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**Presented to the States on 31st July 2014**
**by the Minister for Health and Social Services**

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**STATES GREFFE**

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**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) (S.R.5/2014): RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES**

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| **Ministerial Response to:** | S.R.5/2014 |
| **Review title:** | Child and Adolescent Mental Health Services (CAMHS) |
| **Scrutiny Panel:** | Health, Social Security and Housing Scrutiny Panel |

## INTRODUCTION

I wish to thank the Health, Social Security and Housing Scrutiny Panel on this comprehensive and detailed report informed by an External Expert, users of the services and their carers.

I accept that whilst there are many positives identified in the report, it also sets out clear concerns and significant challenges.

We are not alone in these challenges. The Policy Report "Enough is enough" published in June 2014 for the Centre for Social Justice is a report on child protection and mental health services for children and young people in Britain. It paints a similar picture. Its' overarching recommendation is that a Royal Commission be established in the next Parliament to radically re-think and advise on the wholesale re-design of social care and statutory mental health services for vulnerable children and young people.

I am absolutely passionate about the need to provide the best possible care for all children and young people, including those who need our more specialist services, such as CAMHS.

However, I am aware that the report makes difficult and, in parts, worrying reading.

Therefore, prior to this formal response to the Panel, I set out in a letter to the States Assembly on the 30th June 2014, my clear and unequivocal commitment to taking forward the action plan set out by the External Expert and recommended by the Panel.

In particular, I am taking immediate action to –

- Recruit external experts to support and deliver improvements across the Children's Service while substantive appointments are made.
- Review and strengthen service governance and day-to-day management through increased resources and more effective use of information technology.
- Work across agencies (States departments such as Education and the Voluntary and Community Sector) to develop a clear and agreed vision for the universal services available to all young people and their families and for the specialist CAMHS services provided by my department.

- Develop a clear communication plan to ensure that young people and their families know what support is available to them and how they can access it.
- Commence work immediately on the creation of a new Adolescent Unit in Robin Ward (previously planned for 2016) and ensure the unit has access to the right specialist input.

The CAMHS team are professional, committed and very hard working. There has however been a significant increase in the demand for their services that has brought into sharp relief the need for both more resources and for a fundamental review of the needs of young people coping with mental health issues.

These resources will be provided and that review will be undertaken because I am determined that we will make the changes necessary to ensure that our vulnerable young people are provided with the services they deserve.

I know that the Minister for Education, Sport and Culture and the Minister for Home Affairs will join me, as Chair of the Children's Policy Group, in providing the political drive and oversight that will be necessary to deliver new and enhanced Universal and Specialist services for young people and their families.

Below, I have provided detailed responses to each of the Panels' findings and recommendations.

**FINDINGS**

| | **Findings** | **Comments** |
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| 1 | The majority of parents told the Panel their experience of the CAMHS service was one of little positivity with an overall lack of holistic support resulting in a feeling of isolation throughout the process (**section 1.3**). | It is always concerning when anyone using services feel they have not had the support they wish. It is recognised that many parents who are quoted within the report had concerns around managing aggression and behavioural issues within the home. This is an issue that needs to be addressed by comprehensive CAMHS and H&SS Children's Services. It will be essential for partner agencies to work with HSSD in addressing this under the auspices of the children and young people's strategic framework. (Partner agencies in this context include the Department of Education, Sport and Culture (ESC), the States of Jersey Police (SoJP), the Probation Services as well as voluntary and charitable sector organisations such as NSPCC and Mind Jersey for example). The department also intends to explore the possibility of developing a Behavioural Support service which would work with other professionals in providing support and guidance to parents who are managing children and young people who present with very challenging behaviours particularly aggression.<br><br>Subsequent to the report production some service users have spoken to both team members and managers about their positive experiences of the |

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| | | service contrary to what they have heard reported. It is therefore important to balance the concerns heard by the panel with the positive experiences of many other services users. |
| 2 | Specialist CAMHS sits within the 4 tier system and it is important it is viewed as a specialist service within the overall Comprehensive CAMHS environment and its role is understood. | This is an important principal when considering these recommendations as the responsibility for the mental wellbeing of all our children and young people sits across a range of agencies and the voluntary sector. It is recognised that there is a need for specialist CAMHS to both develop new links and strengthen existing relationships with their comprehensive CAMHS partners. (Partner agencies in this context include the Department of Education, Sport and Culture (ESC), the States of Jersey Police (SoJP), the Probation Services as well as voluntary and charitable sector organisations such as NSPCC and Mind Jersey for example).<br>The Comprehensive CAMHS agenda is in line with national policy development that identifies the need for comprehensive CAMHS to be delivered via all tiers of service to provide timely, integrated, high quality multidisciplinary health services for children and young people. |
| 3 | Jersey CAMHS comes under the Children's Service Directorate which incorporates all Children's Services (**section 2.2**). | Children's Service incorporates Children's Social Work, residential services and CAMHS. Paediatrics, including community paediatrics sits within hospital services. |
| 4 | The Panel believes 18 months without a registered family therapist is unacceptable and is very concerned the importance of family therapy is being overlooked (**section 3.1**). | The service recognises the importance of family therapy and the majority of the clinicians have training and experience of systemic family therapy but not to Master level. Unfortunately recruitment and retention of appropriate professionals has been difficult and therefore a decision was made to train a local professional who is committed to the service and the island. Her training will be fully completed in 2 years. There is also investment in providing some training for other clinicians to enable a team approach. |
| 5 | The Specialist CAMHS team feel overwhelmed with the change in demand on service due to the increase on referral rates for urgent and emergency assessment of individuals. This increase in demand requires CAMHS to review the services | Increases in young people self-harming leading to greater urgent and emergency assessments has become a national concern (WHO, health behaviours in school aged children 2014).<br>The recognition of the pressures that the CAMHS team is under is welcomed.<br>H&SS have been a leader within the States in the development of the Jersey Lean System and |

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| | provided (**section 3.4**). | managers and clinicians are keen to embrace this model and in conjunction with Tees, Esk and Wear Valleys NHS Foundation Trust, will hold a series of Rapid Process Improvement Workshops (RPIW) with stakeholders. The organisation is already in the process of preparing for these workshops that will commence in August 2014. |
| 6 | The lack of a full range of care pathways needs to be addressed without delay. Intervention is not taking place as frequently as it should at tiers 1 and 2 resulting in cases being left unsupported (**section 3.5**). | Children Services are keen to work with partner agencies to support the development of tier 1 and 2 services as part of comprehensive CAMHS. There is already a model of good practice involving supervision and consultation by specialist CAMHS staff for professionals working in tiers 1 and 2 which can be further developed with the formalisation of care pathways across the tiers. (Tiers 1 and 2 include G.P.s, teachers, psychologists and counsellors working in schools and primary care for example). |
| 7 | The general lack of accurate information and statistics for month on month referrals makes it difficult to gain an understanding of the overall caseload or when a case should be closed (**section 3.6**). | It is recognised that more detailed and accurate data would be of benefit to the service in managing demands. It would however be appropriate to base case closure on statistical information and an assessment of need. |
| 8 | The majority of the recommendations from the Young Minds Report in 2006 have not been fully implemented (**section 4.1**). | Documentary evidence provided to the Scrutiny Panel review showed that, of the 17 recommendations made in the Young Minds Report, 15 had been acted upon following publication of the report. It should be recognised that the Young Minds Report was published in 2006 and there has been significant change in this area in the following 8 years. Inevitably, in some areas the recommendations are no longer as appropriate or have been superseded. |
| 9 | The official definition and description of CAHMS provided by the Health and Social Services Department should be the service parents and users expect to be available (**section 4.2**). | This is always the aim of CAMHS and should be a basis to monitor provision. The service is looking to develop more effective ways to access service user and carers views which will include agreeing a meaningful definition and description. |
| 10 | Parents found it frustrating that they could not access the excellent support service from Autism Jersey without a formal diagnosis and as a | Diagnosis of Autism Spectrum Disorders (ASD) is carried out by a multi-agency team which includes Paediatricians, Educational Psychologists, Speech and Language Therapists and CAMHS professionals. This cross departmental group is known as the Team |

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| | result, felt unsupported by the Department of Health and Social Services (**section 5.2**). | for Assessment of Autism and Social Communication (TAASC). In the past parents have accessed Autism Jersey (AJ) when their child had been identified as having social communication difficulties and had not required a diagnosis. If the situation has changed the organisation would wish to work with AJ to see how best to support parents when their child has significant social communication difficulties but do not have a formal diagnosis. |
| 11 | The Panel believe the approach of the YES Project achieves results and is meeting the needs of vulnerable children and young people who seek advice (**section 5.4**). | The Youth Enquiry Service (YES) provides one to one counselling, drop in services for young people as well as on-line advice. It is an important part of tier 2 CAMHS and have links to specialist CAMHS. This provision, with school counselling, give young people wider choices as to how to address their mental health needs. |
| 12 | Mind Jersey offer support to adults with mental health issues and their families however, no similar service for families with children and young people is currently provided (**section 5.5**). | Meetings are already commencing with Mind Jersey to look at the possibility of extending their support to young people and their parents. |
| 13 | The Panel is aware of a number of local organisations who support parents and children with mental health issues. These groups must be included in any service development by the Department of Health and Social Services due to the fact they have first-hand experience of the difficulties faced by many families (**section 5.5**). | H&SS are committed to working with voluntary agencies and support groups for children, young people with mental health issues and their carers in developing services. The department would always encourage any group that feel they do not have an effective voice to contact managers or the Minister to discuss how best to develop links. |
| 14 | Due to the lack of necessary systems in place to collate data, CAMHS is unable to manage demand, capacity and its caseload effectively. In the absence of the relevant data and based on Royal College of Psychiatrists recommendations, the Panel's advisor believed CAMHS has capacity to manage the number of | It is recognised that currently there is no effective IT system for collecting the data needed to support effective capacity management and that this needs to be considered alongside other mental health services as part of the external mental health review.<br>The Royal College of Psychiatrist published their report – *Building and sustaining specialist CAMHS to improve outcomes for children and young people: Update of guidance on workforce, capacity and functions of CAMHS in the UK* in November 2013. This discusses the complexity of developing guidance on workforce planning. Currently CAMHS |

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| | referrals being accepted and could manage its caseload and deal with the capacity to meet the increase in referrals with an improved framework of case management (**section 6.1**). | has 13 WTE clinical staff. The data on caseload management assumes that every clinician is working directly with families full time and does not allow for other roles such as intensive support (where an individual young person may receive the equivalent of 1 member of staff's time over the week) consultation, supervision, training, service development and input into multi-agency work. However it is recognised that the service needs to review it caseload management and capacity. |
| 15 | The Panel has concerns that following the initial referral to CAMHS the expectations of parents, children and young people could be raised even though there was no guarantee they would be seen and offered treatment (**section 7**). | Clear guidance is required for professionals with regard to referral for assessment that may or may not lead to treatment by the specialist CAMHS team. Consideration of referral processes are essential in developing the care pathways with tier 1 and 2 services as previously suggested. Referral pathways will be part of the Rapid Process Improvement Workshops. |
| 16 | Once a referral had been made by a Professional, CAMHS request further information from the patient and family resulting in the wait for routine appointments being lengthy with unnecessary delays. The waiting time for an appointment has more than doubled over a year from 6 weeks to 14 weeks (**section 7**). | CAMHS send out standardised questionnaires to families when a referral is received in line with the practice of many similar services in the UK. The questionnaires enable –<br>1. Screening for risk which facilitates bring appointments forward if significant risk is identified.<br>2. Collecting clinical information in a systematic way to inform planning for the assessment.<br>3. Gathering information of the young person and parents views, family members and school attended to inform the planning for the appointment and also indicating if further information is needed.<br>In the vast majority of cases the questionnaires are sent with the appointment and therefore do not effect waiting time.<br>The increase in waiting time has been due to both the increase in number of referrals and the greater levels of severity and complexity of the referred problems. Effort has been made to manage demand and reduce wait times by introducing a triage team which is now starting to have an impact. Due to the changes already made to deal with the demand the waiting time has reduced to 10 weeks for first appointment, with the aim to bring this down further. This is not dissimilar to many services in the UK. It is better than some but not as speedy as others. The department is committed to finding new ways of |

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| | | managing referrals.<br>NHS service in Scotland in January 2014 reduced there waiting time targets from 26 weeks to 18 weeks for access to CAMHS. In England the waiting time target has been 18 weeks since 2010. |
| 17 | Currently there is a lack of detailed information available on the number of admissions into the service of vulnerable children and young people who have self-harmed or suffering from other behavioural or mental health condition (**section 7.1**). | Issues related to availability of data have been addressed previously. |
| 18 | It is imperative that the service has a systemised approach to recording activity so that this can be closely monitored, ensuring quality standards do not slip (**section 8.1**). | This is agreed as discussed previously. |
| 19 | Feedback on the effectiveness of treatment and outcomes are not currently available due to the infancy of the new system and insufficient data. The Panel is disappointed this practice was not implemented sooner (**section 9**). | Obtaining good outcome measures for CAMHS has challenged services across the UK and considerable work has been undertaken to agree recommended data sets. Specialist CAMHS is now collating data in line with other services in the UK so that comparative data will be available. It recognised that systems to enable service user feedback and outcome data are also a challenge for several services in the UK. |
| 20 | Due to the general lack of holistic support received from CAMHS and other agencies, families are suffering. Siblings have been separated and have had to live outside the family home and instead of an overall family approach to caring, the focus tends to be on the individual rather than the family unit (**section 10**). | It can be a challenge for services and families to try and meet the competing needs of different family members and the ethos, based on best practice guidance, is to maintain children within their own homes.<br>CAMHS always endeavours to works systemically and it is rare that a young person or child would be seen without contact, review and advice to their carers; however issues related to mental capacity and levels of risk will influence delivery of care. Frequently joint sessions would be offered to the young person and their parents.<br>Families' expectations of services and what is seen as acceptable vary and a challenge to staff is to provide the flexibility of response that is required. |

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| | | It is recognised that specialist CAMHS with partners within comprehensive CAMHS need to be clearer as to what they can provide within their agreed remit. |
| 21 | The Panel has serious concerns about the time taken to diagnose children who may be on the autistic spectrum, with the waiting list from referral to diagnosis of 9 months. The Panel believed the closure of the waiting list due to full capacity was unacceptable (**section 11.1**). | The time taken from referral to diagnosis will vary considerably from case to case depending upon the nature of a child's presenting skills and difficulties. A number of steps have been undertaken to improve the length of time between acceptance of a referral and feedback to parents on the outcome of the multi-disciplinary diagnostic assessment. As part of P.82/2012 investment, co-ordination of TAASC assessment has been moved under the Child Development Centre with increased administrative support for the team. Work is currently being undertaken to streamline the assessment and feedback process and improve communication and support to families during the diagnostic assessment process. From June 2014, all families have been given access to the Family Care Co-ordinator based at the Child Development Centre for information and support around the diagnostic process.<br><br>Since December 2013, all referrals accepted by the team are allocated a target date for feedback to the family on diagnostic assessment. For referrals accepted in 2014 the average time between acceptance of referral to target feedback date is an average of 5.29 months with a range of range 2.3 months to 8.8 months. |
| 22 | The Panel is extremely disappointed that mental illness is not held in the same regard as physical illness. Diagnosis of mental health still proves to be difficult and pathways are unclear. Without a diagnosis, support is not offered and the needs of undiagnosed children and vulnerable young people are not met (**section 11.3**). | A recent UK policy document "No Health without Mental Health" highlights that mental health must have equal priority to physical health. This is an ongoing challenge for mental health services across the life span. H&SS through P.82/2012 are enhancing a wide range of services to ensure that mental health issues are given equal priority with physical conditions.<br><br>Children presenting to mental health services do not necessarily have a formal mental health condition but may still need support. Often when there is an emerging mental health condition the diagnosis may not initially be clear and may take time to become more apparent. Specialist CAMHS endeavours to provide services based on need rather than diagnosis. When there is a formal diagnosis the service will use best practice guidance to inform interventions (e.g. NICE guidance). |

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| 23 | Stigma is an important issue that must be addressed, otherwise children and young people are less likely to seek support for their mental health needs (**section 13**). | The emphasis on removing stigma is welcomed and the ongoing work between mental health services, public health, education, Mind Jersey and Samaritans to address this needs to remain a priority. |
| 24 | Although P.82/2012 is a 10 year plan, the specific area of children and young people's mental health does not seem to be a priority. As a result little will be done to address and bring to the fore increasing mental health issues in children and young people (**section 13**). | Phase 1 of P.82/2012 created a range of service enhancements for children, and Phase 2 addresses children's mental health as a priority. The additional investment into the child health system in Phase 1 remains relevant to mental health as the research evidence shows that the priorities for investment are likely to have positive impact on children's mental health.<br>Early Interventions improve a child's social and emotional capability. Health economists have calculated that a return of up to 3 to 7 times the original investment could be achievable by the time the young person is 21 years of age.<br>Phase 1 included mellow parenting, family care co-ordinator, Samares children centre, Sustained Home Visiting and increased access to primary care for under 5s which are all part of a tiered comprehensive CAMHS model.<br>Phase 2 of P.82/2012 identifies further investment for mental health services in 2016-2019 that will be informed by the completed mental health service review. CAMHS is an important part of the mental health service review and as such will be the focus for future service redesign and service improvement. |
| 25 | It is difficult to determine at present whether additional resource would find a solution to the existing problem of workload (**section 15.1**). | The Royal College of Psychiatrist published their report – *Building and sustaining specialist CAMHS to improve outcomes for children and young people: Update of guidance on workforce, capacity and functions of CAMHS in the UK* in November 2013. This discusses the complexity of developing guidance on workforce planning. Currently CAMHS has 13 WTE clinical staff. The data on caseload management assumes that every clinician is working directly with families full time and does not allow for other roles such as intensive support (where an individual young person may receive the equivalent of 1 member of staff's time over the week) consultation, supervision, training, service development and input into multi-agency work. However it is recognised that the service needs to review it caseload management and capacity.<br>This is an important question which will be addressed |

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| | | both by the more immediate Rapid Process Improvement Workshops and the full mental health review. These will look at the service's capacity in relation to Jersey's need and what, if any, further resources are required. In the meantime some additional resources have been provided to help to bring down the waiting time and meet the increasing demands. |
| 26 | In the absence of alternative accommodation the paediatric ward within the general hospital is used to receive children and young people with a wide range of mental health problems (**section 16**). | It is recognised that this is not ideal however on a small island it is not possible to have a specialised unit. Other islands and areas in the UK also use the paediatric wards for similar needs and this is currently been reviewed.<br>The majority of children and young people are admitted after episodes of self harm and both NICE and College of Psychiatrist guidance recommends that they are admitted under the care of the paediatric service over night for review by CAMHS clinicians the following day.<br>The plans to provide an adolescent area on Robin ward have been brought forward to commence in 2015 in order to provide a more appropriate and safer environment. |
| 27 | Parents spoke positively about the work of the States of Jersey Police in helping parents to deal with potentially very difficult situations within the home environment, especially outside of normal working hours (**section 17.2**). | H&SS has a good working relationship with the States of Jersey Police and recognises the very important contribution they make to supporting families in crisis and managing risk to young people.<br>When a young person is aggressive and their behaviour cannot be contained by their carers the police are the only agency that has statutory powers to intervene and this is often an important first step in managing the situation before other services are able to intervene. These partnership arrangements will be further considered within the mental health review. |
| 28 | A subgroup has been formed to specifically look at accommodation for all individuals who have mental health problems and it was hoped the sub-group would report on their findings later in the year (**section 17.3**). | The Head of Crime Services is leading a group looking at Places of Safety. Plans to refurbish existing facilities to meet this need have been completed and a broader review of the mental health estate in the context of the new Hospital development is underway. |
| 29 | There is no clear designated place of safety for young people in Jersey and little clarity around what a designated place of safety | Keeping children and young people safe is initially the responsibility of their carers, when the risk become too great a partnership is needed between carers and professionals from a range of agencies to develop a plan to minimise the risks to the young |

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| | should be. Although Orchard House is an adult facility, it has been used in the past to house vulnerable youngsters under the age of 18 (**section 17.4**). | people. Their needs can be very different and therefore staff and accommodation resources have to be used flexibly to meet these needs.<br>The mental health review will be considering how best to meet the needs and minimise risks for individual with acute mental health difficulties including young people. |
| 30 | The Education Department has a major part to play within Comprehensive CAMHS and it is important the relationship between Education and Specialist CAMHS is strengthened (**section 18**). | The Education department is a key stakeholder within Comprehensive CAMHS and is aware of the importance of strengthening existing links.<br>CAMHS clinicians deliver the required clinical supervision for all school counsellors and regular consultation is offered to MAST professionals.<br>CAMHS continue to work collaboratively with Education in the development of policy and guidance and joined up care pathways about how schools should respond to self-harm or risk issues amongst pupils. |
| 31 | Although the establishment of a multi-agency safeguarding hub was extremely positive, the length of time it has taken to establish was disappointing as it was a recommendation from the 2006 Young Minds Report (**section 19**). | This is incorrect. MASH are a relatively new development across the UK. The first MASH was trialled in Devon in 2010. Many UK local authorities are yet to develop their MASH services. |
| 32 | The responsibility of early intervention does not just lie with Specialist CAMHS and all stakeholders need to understand their role (**section 20.1**). | This finding is welcomed and fundamental to the development of a sound comprehensive CAMHS model. The Minister and managers within H&SS look forward to working with colleagues from other departments in moving this forward. |
| 33 | There is a gap in provision for emerging mental health problems and the point at which Children and Young People attend at CAMHS with acute mental health problems. Early intervention and prevention are key to more positive outcomes for children, young people and families (**section 20.1**). | H&SS recognises the need for all partners to work together to further develop comprehensive CAMHS and support the development of tier 1 and 2 services with a clear documented care pathway. This is further highlighted in other responses. The mental health review will help to identity appropriate models which are likely to include IAPT (Improving Access to Psychological Therapies) for children and young people. |

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| 34 | The Panel has concern that there could be vulnerable young people from ethnic minorities who are not able to gain immediate access to the service due to communication difficulties (**section 21**). | The service recognises this is an area that should be further addressed both through the service redesign and mental health review. |
| 35 | Once a child or young person is under the administration of CAMHS and receiving medication, only CAMHS professionals can prescribe that medication. Information received by the Panel from witnesses seemed to indicate that medication seemed to be the first choice of treatment (**section 22.1**). | Best practice guidance for a range of mental health conditions recognises the need for medication but always in the context of other support and therapy. |
| 36 | Most parents did not believe their child was being re-assessed on a regular basis and as a consequence remained on the CAMHS register with no pathway or solid plans for future development (**section 24**). | Many children and young people receive brief interventions set out in an agreed plan. The service recognises that fuller written documentation would be helpful for service users and colleagues and this will be addressed in the service redesign. The service also wishes to work with service users to better understand how best to communicate and monitor treatment plans for those that are in the service for more prolonged periods with greater clarity with regard to the frequency of review. |
| 37 | All stakeholders raised concerns over the lack of an appropriate out of hour's service. As the Children's Service has overall responsibility of CAMHS and the treatment for mental health issues, the Panel was very disappointed that a suitable out of hour's service was not being provided (**section 25**). | The department has an agreed pathway for out of hours provision agreed by both Hospital Paediatricians and States of Jersey Police.<br>It is acknowledged that an on call service provided by specialised CAMHS would be ideal, however it was recognised by Young Minds that this is not feasible within a small community.<br>The Royal College of psychiatrists and other bodies also state that in smaller services CAMHS on call is not viable and endorses the type of arrangements in place in Jersey. |
| 38 | Concern was raised that there was no clear guidance from CAMHS about what information could be shared with families resulting in parents feeling uninvolved in their child's care. The Panel | Confidentiality is discussed at the first appointment with young people and their carers. When any CAMHS professional has concerns about confidentiality or consent this is discussed with senior clinicians.<br>Most young people are happy to have their parents |

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| | has concerns that not enough attention is given to how the situation affects the family as a whole (**section 26**). | involved in their treatment and even those who are initially reluctant will often agree following discussion and support to sharing of information.<br>This is recognised within the UK as a difficult area as young people mature, develop greater independence and autonomy over a period of time while also still cared for by their parents.<br>The introduction of a Mental Capacity Law will provide greater clarity although the tension will still remain.<br>Provision of written information about capacity in relation to confidentiality and consent for under 18 year olds will be developed within H&SS. |
| 39 | Currently the Island does not have a Mental Health Capacity Law to address matters of confidentiality for those suffering from a mental health condition (**section 26.1**). | A Mental Capacity Law is currently a priority for the department and work is ongoing with the law officers department to facilitate this. In the meantime the organisation has ratified a mental capacity policy and training is being rolled out to support this.<br>There are some discrepancies between UK best practice and the current legal situation in Jersey for under 18 year olds and practice guidance is being drawn up for practitioners. |
| 40 | In general, transitions between child and adult services could be better managed. Although the Panel recognises the need for continuity, there must be a more seamless practice in place to allow vulnerable young people to make the transition into adult mental health services (**section 27**). | Over recent years there have been increased numbers of young people moving from CAMHS to adult services including those with developmental disorders. A transition pathway is currently under development with Adult Services and the Mental Health review will consider the interface between services and how to improve the service user experience and minimise any anxiety or distress at these difficult times. |

**RECOMMENDATIONS**

*Please note recommendations 1-28 are from the Panel's expert advisor*

| | Recommendations | To | Accept/ Reject | Comments | Target date of action/ completion |
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| | **The Minister for Health and Social Services should ensure the following –** | | | | |
| 1 | 1.1 Articulating a vision<br>CAMHS staff needs time to develop their vision and strategy going forward, this needs to reflect changing demand and changing workforce. The team would benefit from a facilitated team building day to develop and gain clarity on their vision (**section 3.3**). | | Accept | As a first step a Lean approach will be taken to redesign the current service in line with the increased demands. Agreement of a vision with stakeholders will be a priority within a series of Rapid Process Improvement Workshops (RPIW) commencing in August 2014. This will be further developed with stakeholders as part of the mental health review. | 1st Facilitated workshop completed w/c 18th August 2014 |
| 2 | 1.2 Strategic planning to reflect current demands<br>Increased demand requires a shift in provision by CAMHS. CAMHS needs to be sure of its role within children's services not just those provided by health and social care but with wider interdependent partners, for example acute care colleagues, education colleagues (**section 6.1**). | | Accept | To be addressed within the RPIW and Mental health review. | 12 months |
| 3 | 1.3 Development of protocols regarding working together across directorates<br>The children's directorate includes social care and health. There is an advantage within the structure to develop clear pathways and joint working opportunities to address the needs of children, young people and | | Accept | To be addressed within the RPIW and Mental health review. | 18 months |

| | Recommendations | To | Accept/ Reject | Comments | Target date of action/ completion |
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| | their families who may need provision from both sets of services. This can be led by Senior Management who have oversight of several services which naturally work together (**section 2**). | | | | |
| 4 | 1.4 Defining and developing care pathways<br>The development of streamlined care pathways for eating disorders, neurodevelopmental disorders and transition to adult services would benefit the team, fellow professionals and those who use the service. There would also be the advantage of applying joint working opportunities to these pathways (**section 3.4**). | | Accept | Pathways are already in development and this process will continue in conjunction with partner agencies. | 18 months |
| 5 | 1.5 Develop CAMHS communication and marketing strategy<br>CAMHS has a website containing information about its provision, this should be regularly updated, ensuring that it is widely publicised. CAMHS management should link with the Directorate communications office to develop a marketing strategy and communication plan to ensure understanding of stakeholders and families around the CAMHS vision and offer. An emphasis should be placed on marketing Specialist CAMHS business so that stakeholders and families understand the service and don't develop expectations which cannot, and should not, be delivered by a specialist CAMH service (**section 3.3**). | | Accept | This recommendation is fully accepted but a more realistic 6 month time scale will be actioned to allow for the development of a communication strategy in line with the initial planned work to redesign the service. | 6 months |
| 6 | 1.6 Strengthen leadership for CAMHS, clarity about role and direction of travel for service | | Accept | A new management structure is being developed for CAMHS | 3 months |

| | Recommendations | To | Accept/ Reject | Comments | Target date of action/ completion |
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| | CAMHS would benefit from a management team who are experienced in change management and strategic working to drive forward future plans for the service and embed within the children's directorate. There should be a developed philosophy of being outward facing to halt the perception that Jersey CAMHS is isolated and works in a silo as was often reported by witnesses. This needs to be modelled by management. CAMHS management should have sufficient knowledge and understanding with the authority to be able to support effective and efficient multi-agency delivery of CAMHS (**section 3.5**). | | | enhancing their ability to carry through the changes and strengthen their position within the organisation whilst maintaining the delivery of the service.<br>Senior managers within H&SS will be supporting CAMHS professionals in developing the service and provide additional skills in change and risk management. | |
| 7 | 1.7 Professional mix<br>The team need to ensure professional mix and provide a service which accounts for skills, competencies and capabilities of its team members. | | Accept | The initial statement of staff mix will be identified within 6 months and implemented within 18 months. To be addressed within the RPIW and Mental health review. | 18 months |
| 8 | 1.8 Refresh supervision framework to ensure that any concerns about practice are addressed<br>Ensure that a supervision framework is established which includes managerial supervision, caseload management and recognition of training needs. The framework needs to ensure that cases are being managed adequately and staff are receiving appropriate support and guidance. The team's case load is excessive which indicates lack of management of demand and capacity. Difficulties in recruitment to an island need to be | | Accept | Supervision is central to the work of the team and encompasses clinical, case load management and managerial supervision. The exact nature of this is informed by the requirements of the different professional bodies. All team members also have annual appraisals which will look at training and development needs.<br>Demand and capacity will be reviewed as part of the RPIW. | 6 months |

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| | observed. Ensuring skill mix management will support staff being developed to provide appropriate interventions which respond to needs of children accessing service (**section 6.1**). | | | | |
| 9 | 1.9 Refresh Operational Policy for CAMHS to ensure its fit for purpose<br>With change in demand and provision, the operational strategy should reflect this. | | Accept | The operational policy will be updated in line with the redesign of the service. | 6 months |
| 10 | 2.1 Demand and capacity management model to be introduced<br>The introduction of a capacity and flow model such as Choice and Partnership Approach (CAPA) will allow for a more systemised approach to managing demand and skill mix (*CAPA is explained in more detail later in this report under the chapter "Models relevant to CAMHS"*). The team will have to invest time in training for this and introducing this model as a systemised approach to manage demand. This approach was independently evaluated in 2009 and the benefits have been clearly recognised (**section 28.1**). | | Accept | The most appropriate model to meet the needs of the island will be explored through the planned modelling exercises. Jersey size and geographical isolation provides some challenges to these models due to the lack of Tier 4 intensive and specialist services so that through put is significantly impacted on by meeting the needs of children and young people who require intensive support. | 12 months |
| 11 | 2.2 Training programme for workforce which is reflective of demand<br>As recruitment of individuals with specialised skills is a challenge, the team will need to ensure that they have an up-to-date skills analysis to identify deficits and plan how to address these. CAPA can also assist with this (**section 28.1**). | | Accept | A training plan is already in place which includes Family Therapy and Cognitive Analytical Therapy training for several team members, whole team training in Dialectic Behavioural Therapy and continued updating in child protection and risk assessments.<br>Thought is already been given to the training | 18 months |

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| | | | | needs for next year which will be informed by the future reviews. | |
| 12 | 2.3 Affiliation to a national body such as CAMHS Outcomes Research Consortium (CORC)<br>CORC provide a suite of measures and will assist with training and implementation<br>The team can benchmark, receive training for staff and ensure that an outcomes approach is central to service provision (**section 29**). | | Accept | CAMHS have used this resource to inform their outcome measures to ensure they can be compared with the UK. Once a more robust data management system is developed CAMHS will be in a position to affiliate to CORC. | 6 months |
| 13 | 2.4 Quality management and standard setting<br>Governance and accountability needs to be refreshed by the development of a quality framework which could include audit activity. Quality standards will need to be identified which fit to wider corporate objectives and NICE guidelines.<br>The introduction of a risk register will also be helpful for the team to ensure safe services. The team should keep a risk log which keeps a record of identified governance and quality risks, how they will be mitigated and when they need to be escalated. Quality frameworks can also include management of learning post incident or complaint as well as how the team benchmarks itself against the Directorate quality standards.<br>Establishing a clear relationship with the Safeguarding Board can be built into the framework, to strengthen accountability and the governance framework together with development of information sharing protocols which link together various services with | | Accept | The governance framework will be further developed through the RPIW and Mental health review.<br>CAMHS clinicians are involved in regular audit meetings with their peers.<br>The organisation is in the process of ensuring that risk registers are in place across all services including CAMHS.<br>There is an open approach to reviewing case management in order to improve practice.<br>Team members have readily engaged in learning opportunities through internal and external reviews post incidents.<br>One of the senior clinicians is a member of the Safeguarding board. | 6 months |

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| | defined working together agreements and pathways including a communications strategy (**section 8**). | | | | |
| 14 | 2.5 Referral pathway<br>Clarity around referral criteria is imperative to safe working practice. CAMHS should develop its inclusion and exclusion criteria based on the existence of definable mental disorders and impact of family and social functions. Process mapping the referral process to ensure efficiency and clarity and refreshing referral paperwork and consideration of making this accessible online (**section 3.5**). | | Accept | This will be addressed with the RPIW. | 6 months |
| 15 | 2.6 Develop evidence about team's performance<br>Collating data which reflects performance is imperative to understand activity versus demand and to influence any future investment. Senior Management may also like to consider putting in place some performance targets, for example an acceptable waiting time for first appointment and a reporting mechanism (**section 3.6**). | | Accept | To be addressed immediately within the RPIW with more detailed development as part of the Mental health review. | 6 months |
| 16 | 2.7 Ensure all staff understand and communicate the scope of confidentiality agreements with children, young people and their families<br>Confidentiality agreements are in place in each child, young person and their families clinical file. Staff are au fait with Fraser guidelines (**section 26.1**). | | Accept | Currently confidentiality is discussed at the first appointment with a young person and their family and in future, will be provided as a written document. All staff are au fait with Fraser guidelines and issues about confidentiality are regularly discussed by the team and with other professionals. | 3 months |

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| 17 | 2.8 Statutory versus private work<br>All staff should be aware of conflict of interest around private practice and adhere to any guidelines from the Directorate around this. It was evident from information gleaned from witness interviews that at times this practice had become a point of confusion for service users. | | Accept | Very little private work is carried out by CAMHS professionals. Staff will however be reminded of organisational policy which will be monitored. | 3 months |
| 18 | 2.9 Development of a detailed action plan<br>An action plan around future developments for CAMHS should be formulated and agreed and signed off by the Director of Children's Services. Regular reviews and reports of its progress need to be in place. | | Accept | The action plan will be informed and developed through the RPIW. | 4 months |
| 19 | 3.1 Identify early intervention and early help for children, young people and their families<br>Map the resources across Jersey who contribute to children, young people and their families emotional health and wellbeing to understand the pathways and resources currently available (**section 20.1**). | | Accept | This work was started by the Children and young people's strategic framework (C&YPSF) and will be discussed by the Child Policy Group with agreed actions being taken forward in the CYPSF led by the Chief Minister's Department. | 3 months |
| 20 | 3.2 Refresh the working arrangements between Education Psychology and Specialist CAMHS<br>Explore the potential for teamwork around the child arrangements and the implementation of the common assessment framework, defining the role Specialist CAMHS would play into this. This would create great opportunities for joint working arrangements. There should be an emphasis on | | Accept | There are currently good working relationships between the 2 services with regular meetings between senior clinicians however this could be further formalised with agreed protocols.<br>Work is underway to develop a Jersey Common Assessment Framework with partners from the Safeguarding | 6 months |

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| | working across agency boundaries and within a variety of settings (**section 18**). | | | Board | |
| 21 | 3.3 Supporting schools and primary care<br>Explore the potential for providing specialist support to primary care and education through a consultation model. A referral screening approach could also be implemented situated in community settings. Training packages can be developed with Educational Psychologists for teaching staff in the recognition and management of mild mental health problems (**section 18**). | | Accept | To be addressed with key partners such as ESC and G.P's in the RPIW, the Mental health review and the Primary Care Review. | 12 months |
| 22 | 3.4 Ensuring accessibility and provision for individuals who have additional needs<br>For example those with a physical or learning disability, new comers to Jersey and those from Black, Asian and Minority Ethnic backgrounds. Provision of information which promotes accessibility for all (**section 21**). | | Accept | To be addressed within the RIE and Mental health review. | 6 months |
| 23 | 3.5 Development of self-harm and risk of suicide guidelines<br>A multi-agency protocol should be implemented to assist those who work with, or support, children and young people in how to recognise risk of self-harm or suicidality and which outlines a subsequent course of action (**section 19**). | | Accept | The Prevention of Suicide Strategy is currently been updated with young people's issues seen as a key priority.<br>As a first step a multi-agency working group has been set up to address the issue of providing support to young people, parents and families in preventing and managing emotional and mental crises. The group have been charged with working together to | 12 months |

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| | | | | identify some short term and near immediate actions that will address key issues of concern. There will be a focus on developing key messages and information in recognising emerging distress and crises in order that young people, parents, families and support workers can act early to prevent further and escalating distress. A summary of all available services and opportunities provided across departments and agencies that can support young people's emotional and mental health will be compiled. | |
| 24 | 3.6 Development of a stepped care model<br>Develop a model in collaboration with afore mentioned colleagues which targets vulnerable CYPF and offers an early help early intervention approach with a clear pathway to more specialised need if deemed necessary (**section 19**). | | Accept | This will be addressed within the mental health review and is central to the C&YPSF. | 18 months |
| 25 | 4.1 Communication and relationships<br>The liaison role between the paediatric ward sister and CAMHS should continue. The protocol should be refreshed and re launched to ensure that all parties follow its guidelines. There should be a consistent response from the on-call provision which needs to be signed off and enforced by the Medical Director (**section 17.1**). | | Accept | The benefits of the liaison role are well recognised and respected both by the paediatric and CAMHS staff and will continue to be supported. | 3 months |

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| 26 | 4.2 The consideration of a Registered Nurse for mental health to be employed to be ward based<br>This role could oversee CAMHS patient risk management plans and provide consultation, supervision and training to ward staff (**section 17.1**). | | Accept | The possibility of employing a nurse with dual training in both mental health and children has been considered and will be further reviewed. | 12 months |
| 27 | 4.3 The implementation of risk training for all staff<br>A risk training programme could be set up to engage staff from CAMHS and paediatrics, an example of this could be STORM which has different levels of training (**section 17**). | | Accept | The majority of CAMHS staff have completed STORM training. The organisation is currently considering the most appropriate risk training packages for staff working with adolescences which will be offered across agencies. | 12 months |
| 28 | 4.4 Development of a joint risk plan between paediatrics and CAMHS so that all the potential and actual risks are identified<br>This should be jointly agreed with supporting paperwork so plans can be written up and shared with professionals and families (**section 17**). | | Accept | Currently a pathway is in place with recommendations as to how a joint care plan is developed and what needs to be considered including risk. The services will now develop standardised paperwork to support this process, particularly addressing the identification and reduction of risk. | 3 months |
| 29 | The Panel believed a charity not unlike Young Minds would be beneficial to help the Island's vulnerable children and young people and communication should be entered into with other agencies to assess what could be made available (**section 4.1**). | | Accept | H&SS would welcome the development of a charity to support young people's mental wellbeing. As a first step meetings have been set up with the director of Mind Jersey. | 12 months |
| 30 | The Health and Social Services Department should actively | | Accept | H&SS will invite local organisations who | 6 months |

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| | engage with those local organisations who support parents and children with mental health issues to improve outcomes. This should involve CAMHS attendance at monthly meetings with an agenda and action list. Full partnership with other agencies should also be encouraged together with more user engagement (**section 5.5**). | | | support parents and children with mental health issues to meet with officers to look at the best way to take this recommendation forward.<br>The mental health review will hold service user, their carers and other stakeholder central to the process. | |
| 31 | Support needs to be put in place for individuals who are undiagnosed but are presenting with problems (**section 11.3**). | | Accept | The department supports the need for the island to have a fully developed comprehensive CAMHS pathway to meet the needs of the range of mental health needs of children and young people across all 4 tiers and welcomes the opportunity to develop this with partner agencies both as part of the mental health review and within the children and young people strategic framework. | 18 months |
| 32 | More work around promoting positive mental health needs to be done. Early intervention is key and mental health service-users and professionals should come into both primary and secondary schools to help educate children. An on-going commitment to raising awareness should be implemented by the Department of Health and Social Services in particular with the Department of Education, Sport and Culture. Engagement with children and young people as ambassadors for mental health should be encouraged (**section 13**). | | Accept | There is already ongoing work in promoting mental wellbeing across all sectors through partnerships between public health, C&SS and partner agencies and the voluntary sector.<br>Early intervention has been delivered as part of P.82/2012 and is recognised as essential in preventing the development and escalation of mental health problems within children and young | 12 months |

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| | | | | people. Whilst Phase 1 also introduces talking therapies for adults, Phase 2 will deliver talking therapies for children and young people.<br>The mental health review is tasked with looking at these issues across all ages. | |
| 33 | Children and Young People's mental health should be given priority within the next stage of the Health Transformation Programme 2016 – 2018, Caring for Each Other, Caring for Ourselves (**section 14**). | | Accept | Phase 2 does indeed give priority to mental health initiatives for children and young people. The Department is committed to ensuring that the best possible support is provided to children and young people with mental health problems and their families. The forthcoming mental health review will inform the further development of services through the Health Transformation Programme 2016 – 2018. | 36 months |
| 34 | As the Department of Health and Social Services is undertaking its own review into mental health services, the Panel expect a designated place of safety will be a priority within that piece of work (**section 17.3**). | | Partially accepted | The Head of Crime Services is leading a group looking at Places of Safety. Plans to refurbish existing facilities to meet this need have been completed and a broader review of the mental health estate in the context of the new Hospital development is underway. | 24 months |
| 35 | Discussion should be had with the Hospital Managing Director to utilise the private ward in the | | Not Accepted | The facilities and staffing within the private wing are not | |

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| | hospital as a short term measure to accommodate children and young people presenting with serious mental health issues. Discussion should also be had with CAMHS professionals to become involved in the feasibility studies for both the new hospital and the new police station to ensure adequate facilities are provided for the future (**section 17.4).** | | | suitable for children and young people presenting with serious mental health issues. Rather than reducing risk it is likely to increase risk to this population. However the department is keen to use all its Estate as flexibly as possible to meet the needs of this population. | |
| 36 | Comprehensive family therapy programmes need to be implemented and available to parents and families led by a registered family therapist (**section 23**). | | Accept | The Department accepts the importance that Systemic Family Therapy is embedded within CAMHS and has a current plan to further increase the skills of all the clinicians and provide a locally trained registered family therapist. While the training is undertaken the department has agreed with a CAMHS registered family therapist to provide supervision to the team. | 24 months |
| 37 | A CAMHS specialist should be accessible 24/7. A suitable out of hours rota and service plan should be implemented without delay to ensure the needs of children and vulnerable young people are met (**section 25**). | | Not Accepted | The department has an agreed pathway for out of hours provision agreed by both Hospital Paediatricians and States of Jersey Police.<br>It is acknowledged that an on call service provided by specialised CAMHS would be ideal, however it was recognised by Young Minds that this is not feasible within a small community.<br>The Royal College of psychiatrists and other | |

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| | | | | bodies also state that in smaller services CAMHS on call is not viable and endorses the type of arrangements in place in Jersey. | |
| 38 | The changeover between children and young people to adult services needs to be reviewed to ensure a seamless transition. This should take account of individual's needs (**section 27**). | | Accept | A transition pathway is being developed and will be further refined through the mental health review. | 12 months |
| 39 | Adopt the action plan from the Panel's advisor and commit to delivering the proposed improvements within the allocated time. | | Accept | This plan has been accepted in full within the specified time line except for slight modification in a couple of areas as indicated due to the need to ensure completion of the full service redesign work. | 18 months |
| 40 | Within the next 18 months, ensure that the recommendations contained within the Young Minds report from 2006 are fully implemented. | | Accept | The majority of the Young Minds recommendations have been acted on following publication of the report. The nature of the recommendations means that some are ongoing. There is an updated action plan to further develop the recommendations which has been shared with the Scrutiny Panel. These are likely to be modified following the mental health review. | 18 months |
| 41 | Publish a 6 monthly report on progress of these implementations and present it to the States. | | Accept | | 6 months |
| 42 | Commit to the commissioning of a detailed independent review of the CAMHS service commencing | | Partially accept | The external mental health review will be completed in early | 24 months |

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| | January 2016 (which will allow time for the implementation of the above). This should consider all aspects of the CAMHS service and determine what progress has been made by the Department and other agencies in delivering the necessary service improvements as highlighted by the Panel's advisor and the Young Minds report. | | | summer 2015 and it is felt that a further review of CAMHS in January 2016 would be too early. The timing of any follow up review would be part of the mental health reviews recommendations. | |

**CONCLUSION**

*Minister for Health and Social Services*

I would like to thank the Scrutiny Panel for shining a light on these difficult issues. It has recognised that there is an absence of comprehensive and up-to-date data, and many unknowns in terms of the risk factors to which children are being exposed. Schools must take their place alongside others, in ensuring that a collective responsibility is taken towards all vulnerable children and young people across our community. It is imperative that effective Voluntary Sector Organisations are also brought fully into the fold. Every effort must be made to engender the faith, trust and confidence of vulnerable parents, children and young people in the system. Roles, duties, responsibilities and limitations need to be clearly defined, understood and recognised.

**I wish to conclude this response** by recognising the efforts, commitment and perseverance of the professionals, day in, day out, across the specialist mental health service and social care. They are remarkable. They are doing their upmost in trying to deliver a quality service to our vulnerable children and young people, under intense pressure and scrutiny of both the public and the media. It would be understandable if CAMHS clinicians and social workers were feeling demoralised given the pressures and challenges that they face. They need to feel valued, safe and supported in their roles.

We need a sensitive, thoughtful and compassionate approach, keeping parents and vulnerable children and young people in mind, and working with a sense of integrity to do the best for each one of them. They must be firmly placed at the forefront of decision making, and parents' voices must be heard and listened to appropriately. So too must those of their children for these children are the parents of tomorrow.