States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health, Social Security and Housing Scrutiny Panel

Child and Adolescent Mental Health Services (CAMHS)

Presented to the States on 16th June 2014

S.R.5/2014

CONTENTS

Glossary of Terms

- CAMHS – Child and Adolescent Mental Health Services
- CORC – CAMHS Outcomes Reach Consortium
- CAPA – Choice and Partnership Approach
- CYPF – Children, Young People and their Families
- NICE – National Institute for Health and Care Excellence
- NHS – National Health Service
- MASH – Multi Agency Safeguarding Hub
- YES – Youth Enquiry Service
- SPOTT – Support for Parents of Troubled Teens
- RCP – Royal College of Psychiatrists
- ADHD – Attention Deficit Hyperactivity Disorder
- TAASC – Team for Assessment of Autism and Social Communication
- ENCO – Educational Needs Co-Ordinator

CHAIRMAN'S FOREWORD

Mental health is not just the business of CAMHS, it is everybody's business.

"Every Child Matters" is a mantra that should be adopted by everyone. Children are our future and it is vital that we care for all their needs. This includes providing the necessary support to them to help them deal with the complexities of mental health. We must do more to ensure that our children are encouraged to speak openly about the difficulties they are facing. Greater emphasis needs to be placed on addressing the stigma attached to those people who suffer with mental health issues.

We must not lose sight of the fact that the whole family can be affected by a child's behavioural and mental health problems. We have a duty to help these families and to provide timely and appropriate support to assist them through these potentially difficult times.

Services need to be tailored to meet the need of the individuals in the same way as we provide for those suffering with physical conditions.

We are grateful to all those parents and others who took the time to share their views and experiences with us. This has helped us to appreciate the difficulties faced by individuals suffering with mental health issues and those closest to them.

It is the Panel's intention that this review will bring some positive improvement to the lives of those affected by mental health problems and their families.

We would like to acknowledge the contribution made by the professionals within the Health Department and other key stakeholders in assisting us with our review. We are also grateful for the support and advice given by our advisor, Francesca Tummey, who has helped us to understand what parents and children should expect from a good Comprehensive CAMHS service.

Finally we would like to thank our Scrutiny Officer, Janice Hales for the considerable amount of work she has undertaken to help complete this report to whom we are extremely grateful.

It is our hope that the Minister will not only accept our recommendations but will fully commit to delivering the necessary improvements for a CAMHS service we can all be proud of.

Deputy Jackie Hilton
Vice-chairman of Health, Social Security and Housing Scrutiny Panel

Terms of Reference

Child and Adolescent Mental Health Services (CAMHS)

1. To assess the current assistance and available services for children, adolescents and their families to include:-

    a) Comparison of existing available services to those in other jurisdictions

    b) To determine if the existing available services are compliant with EU Regulations

    c) To assess if the off island resources used by the Department meet the needs of the individual

2. To identify the role of service users and service providers and identify any matters that may need to be followed up and reviewed to include:-

    a) The relationship with individuals and organisations whom CAMHS buys services from

    b) The long term monitoring of individuals and organisations who provide this service

3. To examine existing resource and man power provisions

4. To examine the systemic planning and explore how the existing service matches the case load

PANEL MEMBERSHIP

The Health, Social Security and Housing Panel comprised the following Members:

Deputy Kristina Moore, Chairman

Deputy Jackie Hilton, Vice-Chairman

Deputy James Reed

Lead Member of the Review

This review was led by Deputy Jackie Hilton, the Vice-Chairman of the Panel due to Deputy Kristina Moore being on long term leave due to illness.

Expert Advisor

The Panel appointed the following expert advisor:

Francesca Tummey works as an advisor with Associate Development Solutions who offer bespoke and expert interventions for Child and Adolescent Mental Health Services (CAMHS). Previously she has worked as the West Midlands Regional Development Worker out of National CAMHS Support Service and was the national lead for CAMHS/ Early Intervention in Psychosis. She has much experience in running complex, transformational change programmes, as a clinical practitioner and operational lead for CAMHS and children's services. She has also been an expert advisor and performance reviewer for several CAMH services offering solutions and achievable action plans.

EXECUTIVE SUMMARY

In 2013, the Panel became aware of concerns from service users that not enough support was available to assist the Island's vulnerable young children and people with mental health issues. The reported increase of the effects of psychoactive substances (known as legal highs) on young people and the sudden deaths of two young males who were known to CAMHS brought these concerns to a much higher level and the Panel believed a thorough review of CAMHS was required.

Child and Adolescent Mental Health Services (CAMHS) is a name given to services provided for children and young people in the mental health arena with the National Service Framework in the UK setting the standard for CAMHS best practice. CAMHS should offer a multi-disciplinary service that is accessible, timely and integrated to offer effective assessment, treatment and support for children, young people and their families. There is no one size fits all CAMHS and it is therefore important that the service provided in Jersey meets the Islanders needs rather than mirror services in other jurisdictions. Although the National Service Framework has no jurisdiction in Jersey, the overall CAMHS service is likely to be influenced by it.

CAMHS do not have the necessary systems in place to record and collate data and as a consequence, caseloads are difficult to manage effectively. The Panel was informed the demand for the services of CAMHS is rising with a significant increase in referrals over the last 9 to 12 months. This increase was initially seen as a blip however, it has become clear that it is much more sustained with the waiting time for an appointment increasing from 6 weeks to 14 weeks in a year. The Panel was also informed that the number of open cases stood at 600 in February however this figure could not be relied upon as it had not been checked for some time. This information was updated to 732 in May raising concern with the Panel that due to the lack of monitoring, the actual number of open cases could not be verified.

An independent review was undertaken in 2006 by a UK charity called Young Minds regarding the CAMHS Service in Jersey resulting in a number of recommendations. The Panel was disappointed to learn that the majority of these recommendations had not been fully implemented and were in fact areas of concern some 8 years later. The absence of a registered family therapist for 18 months indicated that the importance of family therapy is being overlooked and parents reported an overall lack of holistic support stating their experience with CAMHS has left them feeling isolated and on a lonely journey. The Panel understood the general feeling from parents was a lack of confidence in the services provided by CAMHS which was unacceptable and an overview of services provided was urgently required.

The Panel identified that there was no designated place of safety to accommodate children and vulnerable young people in Jersey. Children and young people were being accommodated at the Paediatric Ward in the General Hospital and situations had occurred in the past where the police cells or interview rooms at Rouge Bouillon Police Station have been used. As a priority, the Panel feels that appropriate accommodation must be obtained to address this need as demand for mental health services for children and young people increase.

Accessing CAMHS is only possible through a referral from a professional and the CAMHS service operates on a 9-5 basis, Monday to Friday. Many parents expressed feeling desperate at weekends or evenings with nowhere to turn and were left with little choice but to call the States of Jersey Police or the Accident and Emergency Department. Agencies involved with CAMHS also voiced concern that they did not have an out of hours CAMHS specialist to contact instead having to rely on whoever was on duty at the General Hospital. The Panel do not understand how the complexities of mental health can be viewed as a 9-5 illness and would like to see a service provided that is appropriate for the needs of the Island and the individual.

The Panel believe the Department of Health and Social Services should actively engage with local organisations and key stakeholders who support parents and children with mental health issues. Inconsistencies between stakeholders seem widespread and there is a general misunderstanding of the services offered by CAMHS.

Although the Panel heard from parents who had received a positive service from CAMHS, the overwhelming majority reported the service received as negative. It is clear that improvements to the overall CAMHS service need to be made.

The Panel expect the Minister to deliver all of the recommendations contained within this report to make the CAMHS service in Jersey fit for purpose. The safeguarding of vulnerable children and young people must be a priority.

KEY FINDINGS

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)**

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.

3. Jersey CAMHS comes under the Children's Service Directorate which incorporates all Children's Services **(section 2.2)**

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)**

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 provided **(section 3.4)**

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)**

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)**

8. The majority of the recommendations from the Young Minds Report in 2006 have not been fully implemented **(section 4.1)**

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)**

10. Parents found it frustrating that they could not access the excellent support service from Autism Jersey without a formal diagnosis and as a result, felt unsupported by the Department of Health and Social Services **(section 5.2)**

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)**

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)**

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)**

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 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)**

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)**

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)**

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 behavioral or mental health condition **(section 7.1)**

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)**

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)**

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)**

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)**

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)**

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)**

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)**

25. It is difficult to determine at present whether additional resource would find a solution to the existing problem of workload **(section 15.1)**

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)**

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)**

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)**

29. There is no clear designated place of safety for young people in Jersey and little clarity around what a designated place of safety 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)**

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)**

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)**

32. The responsibility of early intervention does not just lie with Specialist CAMHS and all stakeholders need to understand their role **(section 20.1)**

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)**

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)**

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)**

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)**

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)**

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 has concerns that not enough attention is given to how the situation affects the family as a whole **(section 26)**

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)**

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)**

RECOMMENDATIONS

Please note: The Panel worked closely with its advisor, Francesca Tummey, and has subscribed to each of her recommendations on CAMHS. The Panel believe these recommendations cover the key areas that need to be addressed within CAMHS and rather than duplicate these recommendations in its own report, the Panel has decided to limit recommendations in the body of the Panel report to those areas not covered by the advisor. As a consequence, the Report is not in the usual Scrutiny format where recommendations usually follow findings after a chapter.

The advisor's Report can be found appended to this report under Appendix 2 and a list of all the recommendations are copied below.

The Minister for Health and Social Services should ensure the following –

1. Specialist CAMHS – service provision

1.1 Articulating a vision

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)**.

1.2 Strategic planning to reflect current demands

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)**.

1.3 Development of protocols regarding working together across directorates

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 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)**.

1.4 Defining and developing care pathways

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)**.

1.5 Develop CAMHS communication and marketing strategy

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)**.

1.6 Strengthen leadership for CAMHS, clarity about role and direction of travel for service

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)**.

1.7 Professional mix

The team need to ensure professional mix and provide a service which accounts for skills, competencies and capabilities of its team members.

1.8 Refresh supervision framework to ensure that any concerns about practice are addressed

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 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)**.

1.9 Refresh Operational Policy for CAMHS to ensure its fit for purpose

With change in demand and provision, the operational strategy should reflect this.

2. Recommendations Governance and information management

2.1 Demand and capacity management model to be introduced

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)**.

2.2 Training programme for workforce which is reflective of demand

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)**.

2.3 Affiliation to a national body such as CAMHS Outcomes Research Consortium (CORC)

CORC provide a suite of measures and will assist with training and implementation
The team can benchmark, receive training for staff and ensure that an outcomes approach is central to service provision **(section 29)**.

2.4 Quality management and standard setting

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.

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.

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 defined working together agreements and pathways including a communications strategy **(section 8)**.

2.5 Referral pathway

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)**.

2.6 Develop evidence about team's performance

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)**.

2.7 Ensure all staff understand and communicate the scope of confidentiality agreements with children, young people and their families

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)**.

2.8 Statutory versus private work

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.

2.9 Development of a detailed action plan

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.

3. Recommendations – Early Intervention

3.1 Identify early intervention and early help for children, young people and their families

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)**.

3.2 Refresh the working arrangements between Education Psychology and Specialist CAMHS

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 working across agency boundaries and within a variety of settings **(section 18)**.

3.3 Supporting schools and primary care

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)**.

3.4 Ensuring accessibility and provision for individuals who have additional needs

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)**.

3.5 Development of self-harm and risk of suicide guidelines

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)**.

3.6 Development of a stepped care model

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)**.

4. Recommendations - Emergency access & inpatient provision

4.1 Communication and relationships

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)**.

4.2 The consideration of a Registered Nurse for mental health to be employed to be ward based

This role could oversee CAMHS patient risk management plans and provide consultation, supervision and training to ward staff **(section 17.1)**.

4.3 The implementation of risk training for all staff

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)**.

4.4 Development of a joint risk plan between paediatrics and CAMHS so that all the potential and actual risks are identified

This should be jointly agreed with supporting paperwork so plans can be written up and shared with professionals and families **(section 17)**.

Panel Recommendations

1. 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)**.

2. The Health and Social Services Department should actively 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)**.

3. Support needs to be put in place for individuals who are undiagnosed but are presenting with problems **(section 11.3)**.

4. 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)**.

5. 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)**.

6. 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)**.

7. Discussion should be had with the Hospital Managing Director to utilise the private ward in the 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).**

8. Comprehensive family therapy programmes need to be implemented and available to parents and families led by a registered family therapist **(section 23)**.

9. 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)**.

10. 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)**

Overarching Recommendations

In *addition* to the above recommendations, the Panel has made a number of overarching recommendations which it believes will address the key areas of concern within CAMHS.

1. Adopt the action plan from the Panel's advisor and commit to delivering the proposed improvements within the allocated time.

2. Within the next 18 months, ensure that the recommendations contained within the Young Minds report from 2006 are fully implemented

3. Publish a 6 monthly report on progress of these implementations and present it to the States

4. Commit to the commissioning of a detailed independent review of the CAMHS service commencing 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.

Action Plan

Action Plan – time line – refer to report for detail		
Service Provision		
1.	Articulating a vision	Within 3 months
2.	Develop CAMHS communication and marketing strategy	Within 3 months
3.	Strengthen leadership for CAMHS, clarity about role and direction of travel for service	Within 3 months
4.	Refresh supervision framework to ensure that any concerns about practice are addressed	Within 6 months
5.	Refresh Operational Policy for CAMHS to ensure its fit for purpose	Within 6 months
6.	Strategic planning to reflect current demands	Within 12 months
7.	Development of protocols regarding working together across directorates	Within 18 months
8.	Defining and developing care pathways	Within 18 months
9.	Professional mix	Within 18 months
Governance and information management		
10.	Ensure all staff understand and communicate the scope of confidentiality agreements with CYPF	Within 3 months
11.	Statutory versus private work	Within 3 months
12.	Development of a detailed action plan	Within 3 months
13.	Affiliation to a national body such as CAMHS Outcomes Research Consortium (CORC)	Within 6 months
14.	Quality management and standard setting	Within 6 months
15.	Referral pathway	Within 6 months
16.	Develop evidence about teams performance	Within 6 months
17.	Demand and capacity management model to be introduced	Within 12 months
18.	Training programme for workforce which is reflective of demand	Within 18 months
Early Intervention/ tiers 1 and 2		
19.	Identify early intervention and early help for CYPF	Within 3 months
20.	Refresh the working arrangements between Education Psychology and Specialist CAMHS	Within 3 months
21.	Ensuring accessibility and provision for individuals who have additional needs	Within 3 months
22.	Supporting schools and primary care	Within 12 months
23.	Development of self-harm and risk of suicide guidelines	Within 12 months
24.	Development of a stepped care model	Within 18 months
Emergency access & inpatient provision		
25.	Communication and relationships	Within 3 months
26.	Development of a joint risk plan between paediatrics and CAMHS so that all the potential and actual risks are identified	Within 3 months
27.	The consideration of a Registered Nurse for mental health to be employed to be ward based	Within 12 months
28.	The implementation of risk training for all staff	Within 12 months

1. Introduction

"Mental Health is not just the business of CAMHS, it is everybody's business"[1]

1.1 Background

There is no simple answer as to why some individuals become mentally unwell or develop mental illness, and others do not. Numerous factors can impact on an individual's mental health for example lifestyle factors, peer pressure, family structure.

In 2013, the Panel decided to undertake a review into mental health. The Panel had been aware that this was an area that had been neglected over the years. On closer inspection, it became apparent that in order to carry out an effective mental health review, the Panel would have to focus in one area. The Panel was conscious that the Department of Health and Social Services had agreed to undertake its own review into mental health with the attention being on the mental health service as a whole. With this in mind, the Panel became aware that concerns had been raised by service users and it seemed as if not enough was being done to assist the Island's vulnerable children and young people. This was brought to the Panel's attention through reports from parents of children who used CAMHS and the reported increase of the effects of new psychoactive substances (also referred to as legal highs) on young people. The sudden deaths of two young males in 2013 who were known to CAMHS also brought the concerns to a much higher level.

The Panel is expecting the Department of Health and Social Services to provide a much more detailed approach to reviewing mental health issues which had a small impact on the Panel's Terms of Reference. This required the Panel reluctantly to some degree, discount item 1c (to assess if the off island resource used by the Department meet the needs of the individual) from its report due to the fact this information would be provided by the Department of Health and Social Services in its overall review. This in turn allowed the Panel to focus purely on the Jersey CAMHS service.

In addition to its own findings, this report incorporates the key issues raised by the Panel's specialist advisor.

1.2 Background from Expert Advisor

This report has been undertaken to understand the function and purpose of specialist CAMHS in Jersey. The CAMHS Specialist Advisor has worked with the Health, Social Security and Housing Scrutiny Panel to compile a document which includes the advisors recommendations. The aim is to advise on improvements to services provided to children, young people and their families who need to access specialist CAMHS in Jersey.

Comprehensive CAMHS is a global term incorporating anyone who has a responsibility for the emotional health and wellbeing of children and young people; the ethos being that this is everyone's business. The Department of Health in the UK in its priorities and planning framework (2003 – 2006) reported an assumption that all CAMHS would provide a comprehensive service which included mental health promotion and early intervention by 2006. From this the National Service Framework for Children, Young People and Maternity Services (2004) set out standards for this delivery, stating that

"all children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families".

[1] Minister for Health and Social Services – Public Hearing 3rd February 2014

These standards continue to be upheld as good practice, setting out the premise for integrated pathways and collaborative working which cover the range of children's mental health problems. The National Service Framework expects that provision will be a multi-disciplinary CAMHS service that is accessible, timely, integrated and of high quality and that it offers effective assessment, treatment and support for children young people and their families. Comprehensive CAMHS organises itself across 4 tiers with the specialist element spanning tiers 2 and 3, as described by the NHS Health Advisory Services (1995). Typically tier 3 is multi-disciplinary in nature and Jersey CAMHS reflects this model offering a team which currently has 14.5 full time equivalent clinicians.

In 2006 Jersey CAMHS was reviewed by Young Minds who prescribed a set of recommendations which were bespoke to Jersey CAMHS. It is noted that some of these recommendations are still apparent today. Although the Department of Health and Social Service has devised an action plan around a series of the recommendations and implemented some of these, there is still scope to develop further in areas.[2]

1.3 The Review

On announcing the review, the Panel received in excess of 50 submissions from service users who were keen to share their experience of CAMHS in Jersey. The majority of these submissions raised serious concerns about the service received and the key themes indicated that improvements needed to be made. The Panel also spoke to, and received submissions from a number of CAMHS stakeholders and although it did not receive submissions from all of them, the Panel was satisfied with the cross section of stakeholders it did speak to and it was clear that there was a considerable degree of consistency in the messages given.

Some of the key issues from parent's who had children that used the services of CAMHS was one of little positivity, lack of holistic support and lack of clarity around their child's condition. Concerned parent's made the following statements:-

"*….nowhere to go, nowhere to turn, no help or support. I have been the mother, the family therapist, the support network trying to keep our family together….*"[3]

"….how can a mother sum up the impact of trying to understand the complexities mental health? I would ask a question and felt I never got a clear answer to anything. There was nothing that gave me confidence…."[4]

"….We felt we had to agree because there was no-one else, we had nobody else to consult at that time. We should have been able to consult with some other doctor and the fact there were no registrars and no house officers, nobody else, and psychologists are not medical doctors and we were just left there. We did not know what questions to ask and had to agree with whatever was put in front of us…."[5]

"….they are not looking at the family in crisis. There is no holistic approach and there seems to be no plan…."[6]
"….much more needs to be done to bring all the services together to work with and alongside each other so children do not fall through the cracks…."[7]

The Panel conducted several transcribed meetings with stakeholders and service users and were provided with operational detail regarding the delivery of CAMHS. This information was analysed to elicit themes and the advisor also spent two days in Jersey

[2] Specialist Advisor Report
[3] Private Hearing – Witness 7
[4] Private Hearing – Witness 4
[5] Private Hearing – Witness 3
[6] Private Hearing – Witness 1
[7] Written submission 2.14

facilitating informal meetings with professionals who influence the pathway for children, young people and their families through Jersey CAMHS.[8]

Finding:
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.

1.4 What is CAMHS?

The Definition of CAMHS

Child and Adolescent Mental Health Services (CAMHS) is a name given to services provided for children in the mental health arena. CAMHS is broken down into Specialist CAMHS and Comprehensive CAMHS and are often organised around a 4 tier system. Tier 3 services are referred to as Specialist CAMHS and the staff come from a range of professional backgrounds. The breakdown of the 4 Tier System is discussed in the next chapter.

2. THE 4 TIER SYSTEM[9]

In the 1990s, a four-tiered model was used to describe the CAMHS system. Since then, this model has been used as a framework for commissioning and delivering services.

The following describes in more detail the services provided at each tier of the CAMHS operation.

Tier 1 – Child and adolescent mental health services at tier 1 are provided by practitioners working in universal services who are not mental health specialists. This includes:

- GPs
- health visitors
- school nurses
- teachers
- social workers, and
- youth justice workers and voluntary agencies

Tier 1 practitioners are able to offer general advice and treatment for less severe problems. They contribute towards mental health promotion, identify problems early in the child or young person's development and refer to more specialist services.

Tier 2 – Mental health practitioners at tier 2 level tend to be CAMHS specialists working in teams in community and primary care settings (although many will also work as part of tier 3 services). They can include, for example:

- mental health professionals employed to deliver primary mental health work
- psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

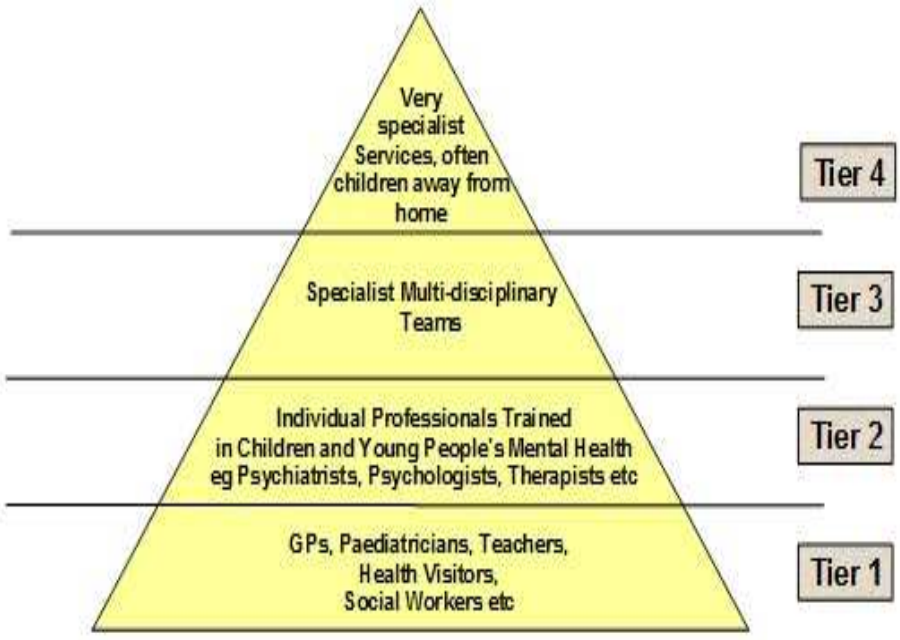
Tier 2 practitioners offer consultation to families and other practitioners. They identify severe or complex needs requiring more specialist intervention, assessment (which may lead to treatment at a different tier), and training to practitioners at tier 1 level.

[8] Specialist Advisor Report
[9] http://www.icptoolkit.org/child_and_adolescent_pathways/about_icps/camh_service_tiers.aspx

Tier 3 – Tier 3 services are usually multidisciplniary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Team members are likely to include:

- child and adolescent psychiatrists
- social workers
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
- occupational therapists, and
- art, music and drama therapists

Tier 4 – encompasses essential tertiary level services such as intensive community treatment services, day units and inpatient units. These are generally services for the small number of children and young people who are deemed to be at greatest risk (of rapidly declining mental health or serious self harm) and/or who require a period of intensive input for the purposes of assessment and/or treatment. Team members will come from the same professional groups as listed for tier 3. A consultant child and adolescent psychiatrist or clinical psychologist is likely to have the clinical responsibility for overseeing the assessment, treatment and care for each tier 4 patient.



Comprehensive CAMHS

Comprehensive CAMHS is a global term incorporating anyone who has a responsibility for the emotional health and wellbeing of children and young people; the ethos being that this is everyone's business. The Panel found that during the course of its review, there were inconsistencies from the groups and agencies who had a responsibility to Comprehensive CAMHS and it seemed the overall CAMHS service was misunderstood. An example of this was found during the referral process where professionals made direct referrals to the CAMHS team at tiers 2 and 3 when in some instances the referrals could or should have

been addressed at tier 1. The Panel found that not enough seemed to be happening at the lower tiers to intervene and prevent problems from developing which resulted in the majority of services going straight to tier 3. This is explored in more detail under the chapter Early Intervention.

The Panel questioned the Education Psychologist regarding the various tiers of services.

"….Tier 2 services are where it is still quite targeted and preventative. CAMHS, like every other service, has a dilemma around early intervention in that every service would aspire to a more preventative tier 2 service, which is where you try and catch things before they escalate too high. But when you are a limited resource like CAMHS or any other service, the challenge is making sure that you do not spend all your time redirecting all your resources into top-end, complex, specialist statutory work because you are pulling the resources that you have, which are finite, away from where you really want them. So if you get sucked up into your specialist services all the time, you cannot do the tier 2 preventative work that you need to stop it getting there in the first place, and that is the challenge…."[10]

Specialist CAMHS

Although Comprehensive CAMHS organises itself across all 4 tiers, Specialist CAMHS spans tiers 2 and 3. Typically tier 3 is multi-disciplinary in nature and Jersey CAMHS reflects this model offering a team which currently has 14.5 full time equivalent clinicians. It is important to understand where Specialist CAMHS sits within the 4 tier system however, it is also important that it is viewed as a specialist service within the overall Comprehensive CAMHS environment and its role is understood.

Tier 3 services provide care in the majority of cases requiring specialist input. The aim is to have a team led by a consultant psychiatrist, although other models exist and there is limited evidence of what system works best. It is suggested that there should be a consultant psychiatrist for a total population of 75,000, although in most of the UK this standard is not met.[11] Jersey currently has 2 psychiatrists for a population of 100,000.

Unlike the UK, Jersey CAMHS comes under the Children's Service Directorate which incorporates all of Children's Services. This puts Jersey CAMHS in a good position to work closely with other areas of the Children's Services.

Finding:
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.

Finding:
Jersey CAMHS comes under the Children's Service Directorate which incorporates all Children's services.

2.1 CAMHS in the UK

CAMHS in the UK is generally provided by NHS services and commissioned through local agreements led by Clinical Commissioning Groups. These arrangements can differ in regions and localities, with commissioning bodies making decisions regarding the provision of services across the tiers, based on local needs assessments and standards as set out in the National Service Framework for Children Young People and Maternity Services (2004).

There is no one size fits all CAMHS service. The National Service Framework for Children expects that the CAMHS provision will be a multi-disciplinary service that is accessible,

[10] Public Hearing with Minister for Education, Sport and Culture – 24th February 2014
[11] http://en.wikipedia.org/wiki/Child_and_Adolescent_Mental_Health_Services

timely and integrated and offers effective assessment, treatment and support for children, young people and their families. It is therefore important that the service provided in Jersey meets the Islanders' needs rather than mirror services in other jurisdictions.

2.2 Comparisons with other jurisdictions

Although the principles of CAMHS are the same, the Panel has looked at other jurisdictions to determine how they compare to the existing service in Jersey.

2.3 CAMHS in Guernsey

In 2012, Guernsey published a research report called "Mental Health and Well Being in Guernsey and Alderney"[12] This report describes in detail the background to CAMHS in Guernsey, a brief description of which is below:-

The Child and Adolescent Mental Health Service in Guernsey was established in 1993 on the appointment of a Child & Adolescent Psychiatrist. Prior to this, children with mental health difficulties were seen either by an Adult Psychiatrist or a Psychiatrist with some child experience employed by the Education Department. Over the last 18 years, CAMHS has gradually employed more clinicians and now has a well-established multidisciplinary team. From this generic tier 3 team, sub-specialties have arisen; for example an ADHD clinic; a Community Clinic dealing with tier 2 difficulties and participation in the Autism Spectrum Disorder Assessment Team.

The CAMHS Outreach Team was set up in 2011 to provide intensive and rapid interventions for young people presenting with severe mental health difficulties, including eating disorders, with the specific aim of reducing the number of young people requiring off-island hospital care.

Unlike most UK services, CAMHS in Guernsey has no primary mental health workers working alongside primary care to offer early support. The development of such a service has recently been established for adult mental health as a strategic priority.

The summary of the strategic vision is:-

- promote good mental health and wellbeing;
- provide accessible and acceptable support for people as they live their lives and timely, respectful and effective intervention, in partnership, when needed, with an expectation of recovery and rehabilitation;
- recognise that a focus on prevention and early intervention is crucial in giving people the best chance to recover from an episode of mental illness; and
- improve outcomes and reduce the incidence of long term mental health problems

2.4 CAMHS in the Isle of Man

The CAMHS service in Isle of Man is based on the site of the general hospital and all building/utility costs are incorporated within the Department's Estates Services Directorate.

They offer talking therapies and medication and may offer help on an individual, family or group basis. They also provide advice, consultation and support to schools and other organisations that work with young people.

In the Isle of Man around 1 in 10 children and young people have problems with their mental health or emotional wellbeing at some stage. Mental health problems are more common than you might think - three children in every classroom have a mental health

[12] http://www.gov.gg/CHttpHandler.ashx?id=80295&p=0

problem. This means that you are not alone, and many of these young people will have appointments with CAMHS too.

A brief indication of what is involved in the initial stages of attending CAMHS with various links offering more information and advice into mental health issues is detailed below and is based on what is offered in the Isle of Man. Although this information has been copied directly from the Isle of Man website under Health, the Panel feels it important to include what is offered in other Island jurisdictions to make comparisons.

What is an assessment?
An initial assessment is where you meet a professional from CAMHS and they will listen to you and ask you about your current difficulties. They will help you and your parents/carers think about the best way to help you with your difficulties

You may wish to bring someone with you e.g. family member, friend or someone they work with *e.g. support worker, or the young person may feel they want to attend the appointment on their own. However, we do encourage additional support from an appropriate adult. In some cases, we may also invite the referrer or additional persons around the child or young person e.g. Support Worker, Teacher, Pupil Parent Advisor, that we feel would help contribute to the assessment.*

After this meeting *you may have;*

- *Further* contact *with CAMHS*
- *Advice without further contact with CAMHS*
- *Information* about *other services which may be more useful to you*

If you do have further contact with CAMHS you will have more meetings with a worker from CAMHS and they will work with you and your family to help you address the difficulties you are experiencing.

What is confidentiality?
CAMHS is a confidential service which means not telling other people what you tell us unless you agree to us doing so because it would be helpful. However, the exception to this is if the CAMHS professional is concerned for you or others then they will have to share it to keep everybody safe.

What is consent?
This means agreeing to something that affects you. The person you see in CAMHS should check that you agree with the help they are suggesting and explain the possible choices if you do not agree. Informed Consent means that you fully understand what you are agreeing to.

What is a referral?
This is when an adult who knows you such as a doctor or teacher asks a CAMHS professional to make an appointment to see you so they are able to offer help and support to you.

What is..?
Here you will find information about mental health and mental health problems, how to cope with your feelings about it and where you can get more information and advice.

- *Abuse*
- *Anger issues*
- *Anorexia nervosa*
- *Anxiety and phobias*
- *ADHD*

- *Autism & Asperger's*
- *Bipolar disorder*
- *Bulimia*
- *Bullying*
- *Depression*

- *Mental illness in family*
- *OCD*
- *Post-traumatic stress*
- *Schizophrenia*
- *Self-harm*
- *Young Minds -Self-harm*[13]

	Jersey	Guernsey	Isle of Man
Population of under 18's	20,000	12,000	17,000
Psychiatrists	2	3	1.8
Psychologists	5	3 + 1 assistant	1.8
Art Therapist/Occupational Therapist	0.5	0	0.8
Psychotherapists	0	0	1.8
Nurses	5	6	1.8
Social Worker	1	1	
Other	3 (team manager and 2 secretaries)	5 (administration)	2.8 (admin support) 0.8 Manager
Total fte	16.5	19	11.6

3. EXISTING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

3.1 What does Jersey have?

The Panel initially sought to understand what was offered by the CAMHS service on the Island by looking at information provided by the Department of Health and Social Services Mental Health support in Jersey for young people is from the age 2 – 18 with CAMHS supporting children from the ages of 5 through to 18. Information on the States of Jersey website states that a pre-school support service is in place for children aged 2-5 which offers support, help and advice to parents and carers in the development of their pre-school child who has special educational needs. It also offers advice to nursery provisions. Referrals to both are through a range of professionals which include GP's, health visitors, education psychologists, paediatricians, and so on. Once a child reaches 18, they go through a transition period before accessing support from the Adult Mental Health Services. The transition process is discussed later in this report.

[13] http://www.gov.im/categories/caring-and-support/mental-health-service/child-and-adolescent-mental-health-service

Who works in Specialist CAMHS in Jersey?

Many different types of professionals work together in CAMHS.

With CAMHS professionals, their aim is to:

- Assess what might be causing mental health difficulties
- Offer support, treatment and ideas about how to make things better.

Every CAMHS team will be slightly different, but usually consist of the following:-

Psychologists

Psychologists help families and children understand difficulties in their lives by exploring how they affect thinking, behaviour, emotions and physical health. Psychologists can also complete assessments which look at memory, concentration, attention and other thinking skills.

Psychotherapists

Psychotherapists work with individuals or families to talk through their difficulties and help them understand what might be causing them. With younger children this could involve play.

Family therapists

Family therapists assist family members to express and explore difficult thoughts safely, to understand each other's experiences and views, appreciate each other's needs, build on family strengths and make useful changes in their relationships and lives.

Child and adolescent psychiatrists

Psychiatrists are medically trained and as well as working with children and families to think about what might be causing difficulties, they can diagnose mental illness and prescribe medication.

Nurses

Nurses working in CAMHS are trained to care for and support young people. They can prescribe medication.

Social workers

Social workers in CAMHS teams help support therapeutic work with families who are referred to the CAMHS team.

The current CAMHS team in Jersey comprises of

- 2 x Child and Adolescent Psychiatrists
- 5 x Psychologists
- 0.5 x Art Therapist
- 6 x Mental Health Nurses
- 1 x Social Worker
- 1 x Team Manager
- 2 x Secretaries/Receptionists

At the time of writing this report, an agency CAMHS nurse had been recruited for 6 months to help manage the current demand. A locum team manager had also been recruited for a period of 6 months. The Panel was also made aware that the family therapist had left the service in 2012 and an existing CAMHS psychologist was undertaking formal accredited

training which will lead to registration as a family therapist. This was likely to happen in Autumn 2014.

The Panel was disappointed that there was currently no-one registered to offer family therapy and in addition, the position had been vacant for 18 months.

Finding:
The Panel believe 18 months without a registered family therapist is unacceptable and is very concerned the importance of family therapy is being overlooked.

3.2 CAMHS Best Practice

CAMHS best practice is set out by the Children's National Service Framework.

The National Service Framework for Children, Young People and Maternity Services (Children's National Service Framework) is a 10 year programme intended to stimulate long-term and sustained improvement in children's health. It aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood.

The Children's National Service Framework is aimed at everyone who comes into contact with, or delivers services too children and young people.

Although the Children's National Service Framework has no jurisdiction in Jersey, it is likely to be used as a reference point by the Department of Health and Social Services in Jersey as it represents a consensus of what good practice should be. It is also likely that professionals coming to Jersey and those being trained off Island will increasingly be influenced by the framework. The CAMHS standard includes a number of key principles:-

- Developmentally appropriate services - 0-18 with flexibility in the arrangements for 16-18 year olds
- Evidence-based practice
- Trained and competent workforce - including tier 1 practitioners
- Critical mass of staffing - offering the full range of treatment models and providing a timely service
- Accessibility – appropriate, as near to home as possible and in less stigmatising locations
- Users' views - both adult and child users to be consulted and involved in service development
- Development of care pathways for specific conditions
- Audit and outcomes – routine evaluation to inform service development[14]

At the heart of the Children's National Service Framework is a fundamental change in thinking about health and social care services. It is intended to lead to a cultural shift, resulting in services which are designed and delivered around the needs of children and families using those services, not around the needs of organisations.

The Department of Health and Social Services has also referred to the National Service Framework in its yearly business cases as "*it helps establish clear national standards for services to improve quality and reduce unacceptable variations in standards of care and treatment"*.[15]
In 2006, the Department of Health and Social Services commissioned Young Minds to produce a Report relating to Jersey CAMHS. The Young Minds Report refers frequently to

[14] National Service Framework for Children, Young People and Maternity Services
[15] Department of Health and Social Services Business Case - 2009

the National Service Framework and agreed it should be an important reference point but that full compliance should not be expected.[16] (Presumably because it has no jurisdiction in Jersey and was being used as a guideline). The Young Minds report is discussed throughout this report.

3.3 How does Jersey CAMHS compare to best practice?

Although the Panel's advisor informed it that Jersey Specialist CAMHS reflected the best practice model, she also commented on subjective observations from CAMHS team members who were feeling overwhelmed with the change in demand on service due to the increase on referral rates for urgent and emergency assessment of individuals. The advisor also made reference to the added expectation and pressure on the service due to the two youth suicides on the Island in 2013.

The advisor also told the Panel this increase in 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.

Health provision in Jersey is aimed at addressing the needs of an Island community and therefore it can be potentially difficult to benchmark against UK services. There are obvious differences between CAMHS in Jersey and CAMHS in the UK with Jersey having specific challenges to providing comprehensive CAMHS on an island.

It is important that the CAMHS service is promoted to show what is actually on offer. As previously mentioned in this report, the Panel noticed that the Comprehensive CAMHS team was unclear of what the Specialist CAMHS core business was and as a result, the Specialist CAMHS service was being overwhelmed. As referrals continue to rise, better understanding of Comprehensive CAMHS should be provided by CAMHS management working with the Department of Health and Social Services and other key stakeholders. A communication plan should be implemented to ensure families and key stakeholders are clear of the difference between Comprehensive and Specialist CAMHS and understand what to expect.

Finding:
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 provided.

3.4 Where are the gaps?

There are a number of gaps between Jersey CAMHS and what is deemed to be best practice with the main area around the development of appropriate care pathways. Throughout the review, it became clear there was a poor understanding of the difference between Specialist and Comprehensive CAMHS and poor communication between all Comprehensive CAMHS stakeholders. However, with the implementation of the Multi Agency Safeguarding Hub (MASH) the Panel hoped the services would be more involved and a greater understanding of all services would develop. MASH is discussed in more detail later in this report. Presently there still seems to be a lack of clarity around what services should be covered by Comprehensive and Specialist CAMHS. Specialist CAMHS seem to be working outside of the remit of tiers 2 and 3 and as a result, have become stretched across all 4 tiers.

As discussed previously in this report and in more detail under Early Intervention, there appears to be a gap in services provided in the lower tiers where early intervention should

[16] Young Minds Report

take place and children and young people are being referred directly to specialist CAMHS at tier 3.

It is expected that CAMHS should offer a service to children from the ages of 5-18 however, the Panel received an unconfirmed report that this was not always the case and in some situations, young people remained with CAMHS until well after their 18th birthday. Although these cases were in isolation, this could impact on caseloads being managed effectively and cause an increase in waiting times with some children left without specialist support. When questioned around this area, the CAMHS staff explained that they felt responsible for these individuals and in some cases, did not believe they were ready for the transition to adult mental health services.

Referrals to Jersey CAMHS from a professional become the responsibility of CAMHS once they have been received by the CAMHS team. This is in contrast to CAMHS best practice where referrals are assessed by CAMHS before being taken on and "owned". CAMHS in Jersey have the responsibility immediately to a child that may not require specialist service which adds to the workload of the CAMHS team as each referral has to be assessed before being taken on or signposted to another area of Comprehensive CAMHS.

Another prominent gap between Jersey and CAMHS best practice was recruitment. With Jersey being unable to draw from a large specialist workforce, CAMHS found recruitment difficult which added to an already increasing workload.

Finding:
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.

3.5 What is missing?

Following receipt of written information from the Department of Health and Social Services, the Panel became aware the CAMHS team lacked the systems to provide accurate information and statistics for month on month referrals. Without the ability to monitor referrals on a monthly basis, the Panel has concern that the analysis of increase/decrease in activity would be impossible to manage resulting in a lack of understanding of the overall caseload, particularly when the Panel was told the number of open cases to CAMHS had increased from 600 in February 2014 to 732 in May 2014. The Panel also had concerns that there were no clear rules as to when a case was closed. There seemed to be a lack of overall clarity from the team regarding its core business resulting in a loss of focus on what Specialist CAMHS was. Greater emphasis needs to be placed on managing the change as necessary to drive forward the future plans and the monitoring of outcomes.

Finding:
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.

4. IMPROVEMENTS

4.1 Previous Recommendations – what has been done

Young Minds are a UK based charity which offers information and advice to children and young people regarding mental health issues. They also provide expert knowledge to professionals, parents and young people through their Parents' Helpline, online resources, training and development, outreach work and publications.

Young Minds is accessible through its website www.youngminds.org.uk and provide the following services:-

- Mental health information and advice
- telephone helpline
- live online chat
- email advice services for parents
- training for professionals (calendar available online)
- stories, links, news and blogs
- quarterly magazine

In 2006, the Department of Health and Social Services engaged the services of Young Minds to undertake an external service review into Jersey CAMHS in 2006.

This report suggested some 17 recommendations which were broken down into key areas:-

- High priority areas for development
- What could be done now with existing resources
- What could be done soon by shifting around existing resources
- What could be done with new monies

The Panel wrote to the Department of Health and Social Services to ask which of the 17 recommendations had been implemented and the status of those which had not and was extremely disappointed with the response. The majority of the recommendations had not been fully implemented and in fact, were still current issues some 8 years later. As a consequence, some of the recommendations made by Young Minds in 2006 have been duplicated within this report.

One of the main concerns highlighted by the Panel's advisor was the lack of available data and data collation. This was highlighted in 2006 by Young Minds and unfortunately is an area which still requires attention. CAMHS utilises the electronic data collection system FACE however, the Department confirmed this system was due to be updated to enable it to generate more sophisticated reports. The Panel found that basic information is not readily available with data being collated for operational needs and offered to strategic managers as and when required. The Panel's advisor explores this in more detail later in this report under Governance and Information Management and highlights the consequences of not having an up to date system in place.

Another area of recommendation within the Young Minds report was that family therapy should be developed with expertise amongst CAMHS staff to lead to a potential increase in capacity. Throughout the Panel's evidence gathering, a number of parents expressed the lack of family support and overall holistic care reporting extremely lengthy waiting lists – if therapy was in fact actually offered. One parent informed the Panel that they were told CAMHS was an assessment centre and a diagnostic centre who did not offer any other kind of support. Other parents who did receive family therapy reported a lack of understanding from the professional to the fact that the parent would have to offer support to the child throughout its life and seemed to concentrate on the here and now with no thought for the future.

Although a family therapist was appointed to CAMHS in 2010, the person in this post left the service in 2012 and was not replaced. This resulted in the service being halted. While family work is continuing within the team, formal practice is not being carried out by CAMHS due to the vacant post. CAMHS has informed the Panel that a psychologist has

been undertaking appropriate training which will be completed by September 2014 however, the Panel is unclear what, if anything, is being provided at the moment.

The Panel is disappointed that although family therapy was recorded as a recommendation in the Young Minds report in 2006 to be developed, it seems a low priority and as a result, families are suffering.

As Jersey is an Island with a relatively small population and a manageable number of children, it seems that it is well placed to develop the single children's information system that is one ambition of Every Child Matters on the mainland. [17]

Every Child Matters was implemented in the UK in 2003 following the death of a child. Its aims are to provide support to children up to the age of 19, regardless of background to:-

- Stay safe
- Be healthy
- Enjoy and achieve
- Economic wellbeing
- Positive contribution

The Panel believed a charity not unlike Young Minds would be beneficial to help the Island's vulnerable children and young people.

The Panel was also aware of an Education and Home Affairs Scrutiny Sub-Panel Student Suspension Review meeting held in 2009 which was attended by the Consultant Child and Adolescent Psychiatrist of CAMHS and the Directorate Manager of Mental Health Services where it was said

"….within the Williamson implementation plan there is significant resources that will be flowing through for psychological and emotional wellbeing for children and young people or children and families within the Island, which will be very much ... the emphasis will be on C.A.M.H.S. They will not necessarily be within the Child and Adolescent Mental Health Services but, for example, psychology to support, looked after children, neuropsychology, family therapy, cognitive behaviour therapy, so there is a whole cluster of increase of psychological and emotional therapy that we can start rolling out because of the implementation ... the States approved a sort of implementation plan…."[18]

Finding:
The majority of the recommendations from the Young Minds Report in 2006 have not been fully implemented.

Recommendation:
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.

4.2 What should CAMHS deliver

Definition of CAMHS in Jersey

The local definition of the Child and Adolescent Mental Health Service in Jersey is clearly defined on their website – a summary of which is below.

[17] Young Minds Report
[18] Transcript from Public Hearing with Health and Social Services and Education and Home Affairs Sub Panel – 20th November 2009

CAMHS is a mental health assessment and therapeutic service for children and young people (up to the age of 18) and their families. The service is based at Royde House in St Helier. CAMHS offers assessment, diagnosis and treatment for children and young people suffering from:

- emotional difficulties
- behavioural difficulties
- relationship difficulties
- developmental difficulties
- other mental health disorders (eg psychosis, eating disorders)

CAMHS can help with a range of difficulties which impact on day-to-day activities. These can include:

- low mood or sad thoughts and feelings which do not go away. These can be caused by trauma (possibly following separation, loss or abuse) or severe depressive illness (which may involve thoughts of self-harm)
- worries and concerns for example anxiety disorder or obsessive compulsive disorder (rituals and repetitive thoughts that will not go away)
- brain development disorders for example attention deficit hyperactivity disorder, social and communication difficulties, and tic disorders
- other illnesses which are less common in young people eg anorexia nervosa, bulimia nervosa, bipolar disorder and psychosis

Accessing CAMHS

CAMHS can be accessed through referrals from one of the following professionals:

- general practitioners (GPs)
- consultant paediatricians / hospital doctors
- health visitors and school nurses
- school counsellors
- educational psychologists / education support team
- social workers
- youth action team / residential services
- Educational needs co-ordinator

Professionals write to CAMHS to give more information about the problems the patient is having and if required, CAMHS will normally write to the patient and family for further information. The referral is considered by the CAMHS team who will then offer an initial assessment, suggest a more appropriate service or provide the patient with written advice.

It should be noted that CAMHS are responsible for the patient from referral by the professional and not from CAMHS acceptance.

At the initial assessment, the patient is met with 1 or 2 of the CAMHS team members. The initial assessment allows CAMHS to gather more information and assess any concerns so that a plan of therapeutic intervention can be developed. This may take place with CAMHS or with other services.

The CAMHS team members include:

- child and adolescent psychiatrists
- specialist CAMHS nurses
- social workers
- clinical psychologists
- secretaries

What happens after the initial assessment?

After the initial assessment, CAMHS can offer a variety of treatments or refer to more appropriate agencies.

Treatment may include:

- individual therapy
- family therapy
- parent counselling
- group therapy (where children, young people or carers with similar difficulties are seen together in groups)

The person the patient meets will depend on their needs. CAMHS often work with schools, the Children's Service and other agencies that work with young people, to assist them to help you.

Where and when will the appointment be?

Appointments are generally at Royde House (this may take place with CAMHS or with other services), although home or school visits may be offered in certain circumstances.

CAMHS is open between 9am and 5pm, Monday to Friday. CAMHS try to arrange appointments at convenient times, although most appointments take place during the normal working day. [19]

The official definition and description of CAHMS provided by the Department of Health and Social Services should be the service parents and service users should expect however, throughout the course of its review, the Panel heard from witnesses who did not believe this was being delivered to the level described. In particular, CAMHS appointment times need to be more flexible to accommodate working parent.

Finding:
The official definition and description of CAHMS provided by the Health and Social Services Department should be the service parents and service users should expect to be available.

[19] www.gov.je/health/mental/children.aspx

5 OTHER AGENCIES

5.1 What is in place

The Education system has a huge part to play in Comprehensive CAMHS and this is discussed in more detail later in this report. The Panel heard from a number of other agencies who offer services and support to children and vulnerable young people.

5.2 Autism Jersey

Autism Jersey was founded in 2005 by a group of parents, all of whom have children with autism. Autism Jersey is the largest organisation supporting people with autism in the Channel Islands. They provide support for families, individuals and carers, a Befriending scheme and training. They also have an adult social club which meets twice a week and a structured and supportive life and social skills programme. They run parent drop-ins, social events and fund raising events throughout the year and also provide short break services.

Autism Jersey champion full and inclusive lives for people with autism and pride themselves in being proactive in raising awareness about autism across the Island.

Autism Jersey is firmly established and is helping to make the needed changes to local education, social security, health care and law enforcement agencies and establishments in order to ease the difficulties faced by people with autism.

Services provided by Autism Jersey:-

- Training for families, friends, professionals and employers
- The Befriending Scheme
- Social Events for Children
- Youth Club opportunities through the Youth Inclusion Project
- Opportunities for parents to get together
- One stop shop for autism
- Lending library of autism related resources
- Holiday play scheme for children with autism
- Social opportunities with the Adult Social Club
- LINX project for siblings
- Life and Social Skills Training

Autism Jersey is run as a charity and as well as receiving a set amount of funding by the States, rely heavily on donations, sponsorship, grants and support. Although some parents had nothing but praise for the support that Autism Jersey provided to their child, others found it frustrating that they could not access this excellent support service without a formal diagnosis from the Team for Assessment of Autism and Social Communication (TAASC team). TAASC is discussed in more detail later in this Report.

Finding:
Parents found it frustrating that they could not access the excellent support service from Autism Jersey without a formal diagnosis and as a result, felt unsupported by the Department of Health and Social Services.

5.3 The YES Project (Jersey Youth Service)

The Youth Enquiry Service (YES) first opened in 2008. As well as offering a drop-in service for young people they also provide one-to-one counselling as well as online advice on a

broad range of issues. YES was developed by the Youth Service in partnership with the Jersey Youth Trust. It was created to support young people aged 14 - 25 with any issue that affects them. YES works with young people on any issue, for example, homelessness, benefits, advocacy work, crime, education, parenting, leaving care, drugs & alcohol, issues around sexuality, emotional health, relationships, sexual health and rights & responsibilities.

Young people are central to the service of YES and have a right to quality information, advice and counselling services.[20]

The YES Project employs 6 counsellors who come in as and when required. Appointments with YES need to be pre-booked however, they do offer specific drop in times of Monday to Friday between 12 and 6 and Wednesday between 3pm and 6pm. During these times, a counsellor will be on duty to ensure any queries are addressed. YES also offers advice over the phone and over email.

In 2013, YES had 156 new clients and numbers have increased every year since its opening in 2008. Out of the 156 new clients, 125 have attended for counselling. Unlike CAMHS and other agencies, a diagnosis is not necessary and self-referral is possible to YES. Referrals can also be made by professionals. YES pride themselves on being able to offer what it is the young person needs and are flexible with appointments leaving it up to the young person to decide how often they want to access the service. Appointments are usually made with 10 – 14 days.

Senior Youth Worker – YES Project

"….for me I think once a young person has made the decision to access us for that kind of support it is good to get them in as quickly as possible…."[21]

The YES Project – Service Statistics 2008 – 2013[22]

Year	2008	2009	2010	2011	2012	2013	2014 (Jan/Feb)	Total
Number of new clients	34	97	119	130	132	156	44	712
Number of visits to YES	97	547	844	1085	1728	1777	399	6477
Number of new counselling referrals	12	50	72	91	93	125	41	484

Finding:
The Panel believed the approach of the YES Project achieved results and was meeting the needs of vulnerable children and young people who seek advice.

5.4 Mind Jersey

Mind Jersey is an independent local charity that provides support to people living with mental illness. Their vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental illness fairly, positively and with respect.

Although affiliated with Mind in the UK, Mind Jersey retains its independence, both financially and operationally. All money raised by Mind Jersey stays in Jersey for the benefit of Island residents. Their affiliation ensures that they meet Mind's quality standards of governance and service delivery, follow best practice models of involving local people in

[20] http://www.yes.je/about-yes.aspx
[21] Public Hearing with the YES Project – 10th March 2014
[22] Statistics from YES project – 10th March 2014

their community – people who have had experience of mental illness – and provide good quality services.

Mind Jersey provides information, support and practical help to anyone with mental health problems. These are some of the ways that Mind can help:

Information: Mind can provide information on mental health conditions ranging from how to deal with stress to severe mental illnesses such as Schizophrenia.

Advocacy: Mind can help you voice your choices about treatment, understand your rights or reach out to sources of support with their advocacy services.

Carer and Family Support: Mind supports the families, carers and friends of those who are affected by mental health problems. Mind can help you understand your loved one's illness and how best to support them.

Residential Services: Mind can offer practical advice about day to day living with mental illness to anyone, and offer a residential service for eight people who have an enduring mental health illness. Mind also offer independent accommodation where they act as an "understanding" landlord.

Peer Support: Living with a mental illness can feel very isolating, the benefits of peer support are widely acknowledged in helping experience and recovery. Mind Jersey has launched a peer support service to help those in the Jersey community experiencing mental distress.

Awareness Raising: Mind believe mental health is everyone's business. Whether you are an individual wishing to increase your knowledge about mental health or an organisation looking for training for your staff, there will be a course for you.

Signposting: Mind can provide support and information for health professionals and the general public. They can partner with other organisations or we can help signpost you to a number of additional local and national support services.[23]

Throughout the course of its review, the Panel was aware of the lack of support being offered holistically to children and young people suffering with mental health problems and although Mind Jersey focus on providing support to adults with mental health issues and their families, no similar service for those under the age of 18 was in place that could offer support to families in need. Mind expressed interest in providing such a support service and although the Panel was aware of the charity Young Minds which provided support to vulnerable children and young people in the UK, there was currently no support service in Jersey.

Chief Executive – Mind Jersey
"….We do not have the remit or the resources to service younger people at this stage, but it is something we would be very interested in considering…."[24]

Mind explained that many of the people that seek support in the work that they do would undoubtedly have been served by CAMHS in the past and as they transfer into adulthood, some of them would come the way of Mind.

Carer Support Manager, Mind Jersey
"….There are a few families who have come to us and said that when their loved one went through the C.A.M.H.S. experience that they felt, for them themselves, the family, the mum

[23] http://www.mindjersey.org/about-mind-jersey
[24] Public Hearing with Mind Jersey – 3rd February 2014

and dad, that they could have done with some external support at that time, they felt it would have been helpful…." [25]

Finding:
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.

5.5 Support for Parents of Troubled Teens (SPOTT)

SPOTT was set up in 2013 by 2 parents who were experiencing difficulties with teenagers as a support group for parents in similar situations. SPOTT exchange ideas and information, and help each other with practical solutions. What SPOTT hope to offer is a listening ear, knowledge that you are not alone, confidentiality, and the advice of other parents.[26]

SPOTT hold meetings on the last Wednesday of every month and the Panel attended a SPOTT meeting in February 2014 during the course of its review. The Panel hoped that this new group will be encouraged to share their experiences with the Health and Social Services Department as they have first-hand experience of the difficulties faced by many families with children facing mental health issues and are well placed to help identify necessary service improvements.

Finding:
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.

Recommendation:
The Health and Social Services Department should actively engage with those local agencies who support parents and children with mental health issues. 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.

6. WAITING LISTS AND APPOINTMENTS

6.1 Caseload

In February 2014, the Panel was informed that the CAMHS open caseload stood at 600 however, at the time of drafting this report, the Panel was told that CAMHS had 732 open cases. The Panel was alarmed at the difference and although time has not allowed for the Panel to understand why the number of cases has increased so dramatically, it is of the view that due to the lack of systems available to CAMHS to monitor its caseload, this information cannot be relied upon.

Of the parents the Panel spoke to, many thought the waiting list was too long with some waiting 5 – 6 weeks to see the CAMHS specialist after waiting 5 months for the referral. One parent had tried to send their child privately as there was such a long wait at CAMHS to get any support.

When questioned as to why the waiting times were so long, the Panel was informed that CAMHS work to a 6 week appointment period however, with the recent increase in referrals, this had increased to an 11 week period. The Panel asked what was being done to address this issue.

[25] Public Hearing with Mind Jersey – 3rd February 2014
[26] www.spottjersey.co.uk

Child Psychiatrist – CAMHS

"….We are prioritising our caseload; we are also looking at getting some additional staffing in. Unfortunately finding specialist staff to come and support us has been very difficult so we have looked to bring in some specialist staff to help…."[27]

The Panel received some information from the Department of Health and Social Services in May 2014 showing the average routine waiting times over the past 12 months. The Panel is alarmed that the waiting time has increased from 6 weeks to 14 weeks over the course of the year. A copy of this information is tabled below.[28]

Month 2013 – 2014	Average Routine Waiting Time
April 2013	6 weeks
May 2013	7 weeks
June 2013	9 weeks
July 2013	12 weeks
August 2013	10 weeks
September 2013	11 weeks
October 2013	11 weeks
November 2013	11 weeks
December 2013	13 weeks
January 2014	13 weeks
February 2014	14 weeks
March 2014	14 weeks

Following its call for evidence, the Panel received a written submission from a medical practice raising concerns with how long it takes vulnerable patients to be seen stating *"…the timescale of children with potentially serious mental health issues to be seen can go into months which we find quite worrying…"*[29]

The Panel's expert advisor commented on the high number of caseloads that CAMHS had open to them:-

The current waiting time for an appointment is currently 14 weeks on average, which is double the time waited last year. It is reported that emergency or urgent cases are seen within 24 hours or 7 days respectively. The overall data should be explored to understand the significant increase over the past 12 months.

The team have a high number of cases open to them; 732 (May 2014). The number of referrals to CAMHS for the period between April 2013 – March 2014 was 495. Of these referrals 453 were accepted as requiring an assessment. During that period the highest number of referrals were received during July 2013 at 48 and the lowest in August 2013 at 24.

Using Royal College Psychiatrists (RCP) guidelines (2013) and assuming that 50% of a clinician's time is spent in administrative activity e.g meetings, paperwork etc and if each child and young person is seen for an average of 10 sessions, then a clinician could see an average of 39 new cases each year. Therefore if we assume that the referral period of 2013 – 2014 is an average year, than each clinician has had the capacity to see an average of 31 new cases per year. This is below Royal College Psychiatrist guidelines and suggests that currently Jersey CAMHS has enough capacity to manage the number of referrals being accepted. The focus would need to be on discharging and managing current case loads.

[27] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[28] Written correspondence from the Department of Health and Social Services – 19th May 2014
[29] Written submission 2.53

There was also a reported difficulty in transferring and 'letting go' of patients when they reach 18 due to a concern of where the individuals needs will be met in future. An unconfirmed report was that there were young people still being seen by CAMHS at age 21. However, it was reported that colleagues within adult mental health services were receiving training on how to address presentations which are common to CAMHS but may need further input in adulthood; e.g ADHD. For a service to run effectively demand and capacity must be managed, haphazard flow through the system prevents easy access to the service and subsequently a waiting list may develop. With the team reporting pressure from urgent appointments, managing the team's case load and throughput is imperative to meet demand and expectation and also support staff's capability. To assist with this, staff need adequate supervision to discuss case work, case management and other professional issues. Jersey does not have a large workforce to draw from around recruitment, so maintaining a clinician's skills and ensuring that the skills match the demand is imperative. The Royal College of Psychiatrists (2013) recommend maximising clinical effectiveness by streamlining processes and delivering evidence based interventions, especially during times of increased pressure on services.[30]

Based on these findings, the Panel believed CAMHS could manage their caseload and deal with the capacity to meet the increase in referrals with an improved framework of case management.

Finding:
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 relevant data and based on Royal College of Psychiatrists recommendations, the Panel's advisor believed CAMHS has capacity to manage the number of 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.

7. REFERRALS

It is not possible to self-refer to CAMHS. As previously mentioned in this report, referrals are made by a professional. Once the referral has been made, CAMHS request further information from the patient and family in the form of a questionnaire to assist in providing the appropriate staff to attend the young person on their initial assessment.

The Panel queried why, if a young person had already been seen by a professional, further assessments needed to be done by CAMHS via a questionnaire as surely this would hold up the process. The Panel was informed that the questionnaires were screened by the CAMHS referral team to ensure no risk had been missed that had not been identified by the professional.

The Panel received a written submission from a medical professional stating that *"…most organisations are happy to accept a referral with details of the presenting complaint included in the original letter but with CAMHS normally a form is sent later and in addition to being onerous, tends to slow the overall process of referral…."*[31]

The Panel was concerned that expectations could be raised by parents, children and young people when filling in the initial forms from CAMHS following referral as it was not an indication the child or young person would be offered therapy. One parent told the Panel that they had spent a long time filling in form after form, doing different profile tests only to be told "*sorry, we cannot help you*" with no explanation.

[30] Specialist Advisor Report
[31] Witness 2.31

In addition to the 700+ open cases, CAMHS also offer consultations and supervision to staff (planned and ad-hoc as needed) so will often be offering advice, support and signposting to a wide range of other staff who work with clients not necessarily known/open to CAMHS.[32]

It is not clear how this additional workload and signposting impacts on the Specialist CAMHS services.

There are three levels of referral which range from 1-3 with 1 being the highest. Referrals are usually received as written however, stage 1 emergencies can be referred over the telephone and a patient is usually seen within 24 hours.

The Panel asked for the timeframes and exactly what happens when a child is referred.

Child Psychiatrist – CAMHS
"….we have written referrals. If it is an emergency, that is different and we take telephone referrals. We do have a system where anybody that is referred as an emergency will be seen within 24 hours. If it is an urgent referral, within the week and then we have our routine ones…."

Deputy J.A. Hilton
"….Who decides what is an emergency? Who makes the initial decision?...."

Child Psychiatrist – CAMHS
"….Every day it comes through, we have a duty worker who will look at the referral. We then have one of the senior clinicians who is also available to discuss any ones that come through that are concerning. So it is made at that level. Referrals then go to a referral meeting. So once a week all referrals are looked at and, again, just looking at priorities and if there are risk factors there…."[33]

Finding:
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.

Finding:
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.

7.1 Recent Increase

"….Community studies vary a lot but I know for young people they talk at probably one in four will have self harmed at some point…."[34]

At a Public Hearing with the Minister for Health and Social Services in February 2014, the Service Director of Children's Services told the Panel that there had been a significant increase in referrals to CAMHS during the last 9 to 12 months whilst stating that self-harm had increased across other jurisdictions in the western world and interestingly, youth offending, had decreased. Initially, this peak in referrals was seen as a blip as peaks and troughs are not unusual on a small Island however, by the time the increases had carried through to the 6-9 month stage, it became clear that it was much more sustained.

[32] Letter from Department of Health and Social Services to HSSH Scrutiny Panel – 22nd January 2014
[33] Public Hearing with the Minister for Health and Social Services – 3rd February 2014
[34] Public Hearing with the Minister for Health and Social Services – 3rd February 2014

In October 2013, UK statistics revealed an alarming rise in children who self-harm. These figures show that in the past year, NHS hospitals treated more than 18,000 girls and 4,600 boys between 10 and 19 after they had deliberately harmed themselves – a rise of 11 per cent. During the same period, cases involving children between 10 and 14 rose from 4,008 to 5,192 – a rise of 30 per cent.[35]

It has been reported by the head of ChildLine, that the increase in cases has been dramatic. In 2011/12, self-harm appeared for the first time in the top five main concerns for 14 year olds. This dropped further to 13 year olds in 2012/13, indicating that more young people are self-harming at a younger age. While some headlines have blamed a society increasingly obsessed with body image (which may help account for why girls are more prone to self-harming), the head of ChildLine believes a more serious problem is the 24/7 online culture. "In my day, if someone was bullied, they could find escape at home, but that isn't available now. Before you know it, something you said in confidence to one friend, or something unkind that someone else has said about you, is up there in neon lights for anyone to read for any amount of time."[36]

It should be noted that the Panel tried unsuccessfully to obtain local statistics from the Department of Health and Social Services which showed the number of admissions into the service of vulnerable children and young people that have self-harmed or been admitted for any other behavioral or mental health condition. In the absence of these statistics, the Panel has had to rely on UK figures to give examples.

Finding:
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 behavioral or a mental health condition.

8. GOVERNANCE AND INFORMATION MANAGEMENT

The Panel's advisor researched a great deal into how the CAMHS team monitored quality and performance.

Jersey CAMHS use an electronic recording system called FACE and some statistics are collated on a quarterly basis, although the services acknowledges that an undated version of this system is required to provide the team with much needed data. The team also described a difficulty with data collection due to not having sufficient administrative support. It is imperative that a service has a systemised approach to recording activity, so that this can be monitored, ensuring that quality standards do not slip. It would be helpful if the team were to develop a dashboard; this would be a summary of performance data e.g referrals, time waited from referral to treatment etc. This system would measure, monitor and manage information in order that the team becomes focussed on its activity to provide future strategy, goal setting, risk management and evidence to support any workforce increase. CAMHS can then transform from a reactive to a proactive service.

Referrals are accepted from any professional source and the Panel was informed that referrals are accepted as soon as they arrive at CAMHS. There is provision for a referrer to discuss a referral with a 'Duty Officer', referrals are triaged and if considered routine are put aside to be discussed in the weekly team meeting. This creates a potential delay in the process, in addition CAMHS should not 'own' referrals until they are clear that the problem can be treated by the service. Therefore the referrer should still be responsible for the referral until an agreement for assessment by CAMHS is given.

[35] NHS statistics
[36] www.childline.org.uk

Consideration of the pressures unique to Jersey as an island should be actively addressed. There is not the scope of services in Jersey as there is on the mainland and as previously mentioned there are challenges around recruiting to an appropriately skilled workforce. However there are also distinct advantages to smaller services by creating flexibility, exploring opportunity for integrated pathways and encouraging a culture of inclusivity and transparency. A specialist approach to managing mental health problems in children, young people and their families should be provided through effective multi-agency working across the children's directorate, education services and the voluntary sector. This approach should be informed by arising and changing need in order to provide services that are accessible and delivered by an adequate and skilled workforce. In the Health and Social Services White Paper (2012) there is an expectation declared that services will wrap around each other to ensure a robust service to children, young people and their families.

Ensuring that the service is mindful of quality will support this approach. One of the Consultant Psychiatrists currently leads on audit and this activity is already in place within the team. How audit findings are disseminated and implemented are not so clear. Yet having this ethos of learning is a positive aspect. The team also use outcome measures, an example of which is 'strengths and difficulties questionnaire', this is good practice. Expanding the suite of outcome measures will be advantageous, as understanding children, young people and their families progress and experiences of services can be used to improve practice and the service.

Finding:
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.

9. FEEDBACK

CAMHS have a range of forms that are distributed to patients and their families prior, during and on completion of treatment. There are two questionnaires sent prior to the first appointment which are addressed separately to the family and the young person. These are department specific and request information about the nature of the problem, family structure, other services involved and school attended. Users struggled to understand the need for both of these questionnaires and were of the opinion that much more useful information could be extracted prior to appointments.

Questionnaires used at and following the first appointment are industry standard and are used to measure change and receive service user feedback. The system of using the questionnaires to record feedback was implemented last year and do date, CAMHS do not have sufficient data to provide a report. Once it becomes available, CAMHS have said this data will be used to compare the outcomes with other services in the UK. The Panel is concerned that there do not seem to be any up to date results to monitor the effectiveness of treatment and outcomes.

Finding:
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.

10. HOLISTIC APPROACH TO CARING

A holistic approach to caring is focusing on all aspects of the person's life.[37] When a child is in distress, it is undeniable that this will have an impact on the siblings, parents and wider family circle. During its investigation, the Panel heard from parents who have felt

[37] www.knowledgex/camh.net

and still feel, completely unsupported as a family throughout their child's illness and experience with CAMHS.

When the Panel questioned the Minister for Health and Social Services on the holistic approach to care, it was informed that CAMHS offer family work and meet with the family as a whole.

Child Psychiatrist – CAMHS
"….We offer family work and we will meet with the family as a whole. We will also meet with parents. Quite often what we would do is have 2 therapists involved so somebody might be working with the young person and somebody with the parents and then bringing them together. We would also then be working with some of our partners so it might be with social workers, it might be with people in education, sometimes we talk to G.P.s who might be supporting the parents…." [38]

The Panel was concerned by this statement as it seemed to contradict what witnesses had shared during the Panel's call for evidence. One parent told the Panel *"….there is family therapy but the waiting list is very long…."*[39] again giving the Panel concern that the waiting times for Specialist CAMHS services was extensive. The majority of parents felt let down with expressions of being on a distressing, lonely and emotional journey with some parents stating relationships with their partners had broken down and they were having to live separate lives.

"….But our family is falling apart, really. My husband and I have been living as a separated couple in the house for a year, because the stress and strain has become too much…." We are actually exploring now ... we are planning on leaving the Island, because we feel that there is nothing in place for our son here, and we feel that we may be - he may be - better served in the UK rather than here, and that is the point we have got to as a family and I think that is quite sad.[40]

"….My husband and myself live apart. We are still married but we have to live apart because he is not [ ]'s biological father and at one point CAMHS was saying that it was my husband's fault that [] was so unsettled. He had the finger pointed at him so he lives on his own in a flat and I have to keep the family together, which again has had further implications because we are still married but because we do not live together it has had implications with income tax. It has had implications with income support as well. So the last 10 years for us has been sheer hell, absolute hell, and there has been many a time where I have wanted to pack a bag and go. If you phone CAMHS and you tell them that, like I said before, they are on the phone to Social Services saying the children are at risk. I have 3 other children…." [41]

Other parents spoke of siblings being unable to live with the family due to the stress and strains of illness with no one taking accountability for the family case. One parent told the Panel

"…I have had to fight for years to get any sort of help and it has torn us apart. At the moment my youngest child has lived with his Nan for the past 8 weeks as he cannot be in the same house as his brother…"[42]

The Panel asked each of the witnesses what could be improved and amongst others, a common theme was more support for families. One parent told the Panel *"….Support, I suppose. Not blaming parents. Parents are in shock. We did not expect this…."*[43] with

[38] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[39] Witness 7
[40] Witness 7
[41] Witness 11
[42] Written submission 2.14
[43] Witness 12

another saying *"….There is no overall consideration as to the family dynamics and how, for example, maintenance of those family dynamics will maintain the problem…."*[44]

Finding:
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, focus tends to be on the individual rather than the family unit.

10.1 Blaming Parents

The Panel heard on more than one occasion where parents believed they were being blamed for their child's condition and having to adopt "broad shoulders" when listening to their parenting skills being criticised for fear of their child's treatment being compromised. At times, parents told the Panel they had to convince themselves that it could not be their fault as their other children had turned out "normal". Some parents had been offered parenting courses whilst others were told it was exam pressure or a teenage phase which would pass.

11. DIAGNOSIS AND TREATMENT

11.1 Diagnosis of Autism

Although a diagnosis is important, the most important issue is defining the problem.[45]

At its Hearing with the Minister for Health and Social Services, the Panel was informed that the diagnosis of Autism does not fall solely under CAMHS – the responsibility lies with The Team for Assessment of Autism and Social Communication (TAASC).

TAASC is a multi agency team which includes professionals who work in the following services:-

- CAMHS
- Paediatrics
- Educational Psychology
- Speech and Language Therapy
- Occupational Therapy

In February 2014, at the time of the Public Hearing with the Minister for Health and Social Services, the Panel learned that the waiting time from referral to diagnosis of autism was 9 months. The Panel also learned that the waiting list for diagnosis of autism had previously been closed due to the high volume of referrals. The Panel asked why the waiting list had been closed.

Child Psychiatrist - CAMHS
"….I think there was a discussion about calling it closed, in fact there was about a 3 month period where we were not allocating any cases while we were catching up because the referral rate had gone up from an average of about 15 a year to over 30 a year. Again it is another one that had doubled. We thought that was going to be a blip, we have had blips before, but it has continued now…."[46]

The Panel did not consider a 9 month waiting list acceptable and was extremely alarmed that the "waiting list for the waiting list" had been closed due to high volume. Furthermore,

[44] Witness 1
[45] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[46] Public Hearing with Minister for Health and Social Services – 3rd February 2014

the Panel had serious concerns about the lack of provision to diagnose children who may be on the autistic spectrum.

Deputy J.A. Hilton – Hearing with Minister for HSSD
"….where children are in mainstream primary school, for instance, where there is no additional support, they are just, it would seem to me, left floundering without that diagnosis. A waiting list, referral to diagnosis hopefully, of 9 months is just unacceptable…."[47]

The Panel pressed further for reasons why the waiting list was so long and was told that *"….compared to many specialist services in the U.K. where you could wait 18 months to 2 years for a diagnosis. It is still better than U.K. services…."*[48]

The Panel heard from a parent who had been advised by the Education Department that it may be better to see a specialist privately as there was nothing else that could be done at that level for the child.

Deputy J.A. Hilton:
"….So initially it was suggested to you that you should see somebody privately ...."

Witness
"….Yes. So we did. We took him to see, I think at the time - the gentleman has left now - but we went to see [ ] privately, who, because we had had lots of losses in the family, sort of thought that maybe his behaviour was due to this. We spent an hour with [ ] and he sent [ ] out of the room and he said to me: "Have you ever considered Asperger's?" He said: "I am not making a diagnosis. I am just saying that I have spent an hour with your child and he is presenting as a child who has these needs. Have you not been referred to the CAMHS service? Have any of these things happened?" I said: "No…."

Deputy J.G. Reed:
Sorry to interrupt. What age was your child at this point?

Witness
This was around the 8 years old at this stage and this was because he started expressing these suicidal thoughts ...

Deputy J.A. Hilton:
Were you in the States school system at that point?
Witness:
Yes, yes.

Witness:
"….So he suggested that I sort of read up about Asperger's and sort of had a look at it, but he suggested very strongly that he wanted us to go through the States system, because that is where we would get the support. He did not feel it was appropriate ... he said: "There is a system in place. You can get a diagnosis. You can get support." We had several more visits with him because we were trying to build up my child's self-esteem, because I was more concerned at this stage that he was expressing suicidal thoughts, and eventually we agreed that we would go through the system, so I then had to contact my GP and he did a referral to the CAMHS service. So we were referred to CAMHS There were several tests done between the ... we did something called a Conners report, Conners test, which was the teacher does one and we do one. At this stage, reflecting back, I am a little bit confused why we did not have a diagnosis at the time from the initial one, but I cannot comment on that; there is obviously other reasons. I believe they sent someone into

[47] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[48] Public Hearing with Minister for Health and Social Services – 3rd February 2014

school to observe him at the time, because at the time they were questioning some kind of autistic spectrum disorder. After several meetings and sessions, it was felt that he would be referred on to the TAASC Team, which specialise in diagnosing children on the autistic spectrum…."

The Panel was further informed that following the recommendation that the child be referred to the TAASC team, the parent received correspondence stating the waiting list for the TAASC team had closed:-

"….I had received a letter from CAMHS, basically saying that [ ] had been removed, they had closed the waiting list for the TAASC Team and [ ] had been removed from the waiting list and therefore they were not ... you know, he would not be going forward to be diagnosed because the team were too full, to capacity…."[49]

Finding:
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.

11.2 Diagnosis of other conditions

The Panel was unclear as to how illnesses other than autism were diagnosed. During its evidence gathering, the Panel heard from a number of parents who believed if their child had been given a diagnosis, they would have had access to a number of services which would have helped and supported the child's condition. The Panel also heard from parents who were concerned that there did not seem to be a pathway for mental illness patients in the same way there was for physical illness with a number of parents making comparisons to breaking a limb and knowing what to do next whereas with mental illness, there did not seem to be anywhere to go.

The Panel questioned the importance of diagnosis with the child psychiatrist for CAMHS.

Child Psychiatrist – CAMHS
"….I think quite a lot of our young people might not have a diagnosis. A diagnosis can be really important but a number of young people present with a range of problems which might be more descriptive to them because early on in the presentation it is not always clear what a diagnosis might be…."[50]

The Panel asked Mind Jersey to comment on what they thought regarding a lack of diagnosis

Carer Support Manager, Mind Jersey:
"….I was just going to say one of the challenges I think the services have is that many years ago you used to try and get a diagnosis quickly and there were a lot of people out there with diagnoses that they should not really have owned, because it was maybe a one-time episode. The other thing is that the mental health experience can change so professionals have also got that to think about as well. So, again, one of the frustrations that families get is: "Well, why can they not do this? Why will they not just put them up there?" They really have to go through the National Institute for Health and Clinical Excellence guidelines, really, when they are treating somebody and then somewhere in the middle of that the presentation can change, the symptoms can change. So whereas they might be looking at something in the beginning that is a behavioural disorder, further along the line they might then start to see something that is more of an underlying illness. So it is

[49] Witness 7
[50] Public Hearing with Minister for Health and Social Services – 3rd February 2014

a wee bit more difficult, whereas if you go with just a physical ailment you generally know what the pathway is going to be; that can twist and turn within mental health…."[51]

11.3 Timely Diagnosis

The Panel heard on more than one occasion how parents had to muddle through without a diagnosis for their child. Although some parents had received a diagnosis from a private consultant, this was not recognised by CAMHS and without the diagnosis from the CAMHS Specialist Service, support was not offered for the illness. One parent told the Panel that their child had been on the register of CAMHS from 2008 until 2012 before transferring to the adult mental health services and in those 4 years, was not given a diagnosis even though the parent was told one was pending.

The Panel found it difficult to understand how a child or young person could be left for such a long time without any sort of recognition of their illness and although it understood the complexity of making a diagnosis within the mental health sphere, it was disappointed to learn that without a diagnosis, there did not seem to be any support available to meet the needs of the children and vulnerable young people who remain undiagnosed.

The Panel was also disappointed that mental illness does not seem to be held in the same regard as physical illness with both illnesses appearing to be at opposite ends of the health service.

Finding:
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.

Recommendation:
Support needs to be put in place for individuals who are undiagnosed but are presenting with problems.

12. EVIDENCE OF MENTAL HEALTH DISORDERS IN CHILDREN

In the UK, reliable information about the prevalence of mental health disorders in children has recently become available. The report by Meltzer et al for the Office of National Statistics (ONS, 2004) shows that 9.6% of children and young people in the UK between the ages of 5 and 16 have mental disorders. Boys are more likely to have a mental disorder than girls with 10% boys and 5% girls having a mental disorder aged between 5–10 years. The proportions change to 13% boys and 10% girls aged 11-16 years.

The number of young people in lone-parent families have double the rate of disorder compared with two-parent families, in reconstituted families rates were 24% compared with 9% in families with no step children, 17% of children with a parent with no educational qualifications compared with 4% of those with parent with a degree-level qualification and 20% against 8% where parents were not in full-time paid employment.[52]

Economic disadvantage, disability benefit receipt, routine occupational groups, living in social housing and deprived areas all contributed to higher rates of mental health problems with young people.[53]

[51] Public Hearing with Mind Jersey – 3rd February 2014
[52] Meltzer et al for the Office of National Statistics (ONS, 2004)
[53] ONS Report – Mental Health of Children and Young People in Great Britain 2004

During the course of the review the Panel was unable to uncover similar reliable evidence about the prevalence of mental health disorders in children and young people on the Island.

13. STIGMA OF MENTAL HEALTH

Evidence suggests that teenagers hold the most stigmatised views around mental health and that experiential approaches are most effective in reducing stigma. There is limited evidence to support the effectiveness of media campaigns alone. As attitudes around mental health are picked up by children at an early age there is a strong argument that reducing stigma by focusing on mental health promotion in the early years could help shift future generations' perception of mental health and encourage a new era where people talk about their emotional health as they do their physical health. Anti-stigma work would need to involve parents as evidence suggests that stigma around mental health is picked up by children from their parents and that all adults, such as teachers, should model behaviours related to attitudes about mental health[54].

It is vital to be aware of the stigma attached to mental ill-health amongst children and young people. It has been shown repeatedly that stigma is an important issue for young people[55] and it may prevent them from accessing the support they need. Stigma is an important issue that needs to be addressed, otherwise children and young people are less likely to identify and seek support for their mental health needs, and the opportunities for early intervention and promotion of positive mental health may be lost. Consequently, children and young people enter the mental health system to receive more specialist and intensive – and more expensive – support.

The Panel questioned the Minister for Health and Social Services asking what was being done to raise the awareness around mental health.

The Deputy of St. Ouen:
"….What have you done to address the stigma of children with mental health issues?..."

The Minister for Health and Social Services:
"….I think the more you talk about it and raise those issues, the understanding by society in general ... because it is all our problems, it is not just the Health service and Social Services problems, or Education, it is everybody's problem. I think I am beginning to understand the issue that our young people have, whether it be drugs, alcohol or whatever, or the peer pressure that they get, it is raising the awareness, understanding what is behind it and trying to do something about it…."

The Deputy of St. Ouen:
"….Obviously as the Minister for Health and Social Services, what part are you yourself and your department playing in dealing with the stigma that is attached?..."

Managing Director, Community and Social Services:
"….Part of it is the direct input with children and also the indirect input. For example, if we are talking about young people in substance abuse it is not just about directly working with young people, it is not just about directly working with Education so they can work with young people, it is about working with the parents, providing the parents a guide to drugs so that they can have a conversation with children. As the Minister says, it is about people openly talking about things and the best way to talk about things is to be well informed…."[56]

The Panel was disappointed that not enough was being done to promote early intervention and address the issues around the stigma of mental health. The Panel believed the

[54] Children and Young Peoples Mental Health Coalition - 2010
[55] Woolfson et al., 2008; NCSS, 2010; YoungMinds 2010
[56] Public Hearing with the Minister for Health and Social Services – 3rd February 2014

Department could do more to raise awareness and improve the public understanding of mental health problems.

Finding:
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.

Recommendation:
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 ongoing commitment to raising awareness should be implemented led by the Department of Health and Social Services in partnership with Department of Education, Sport and Culture. Engagement with children and young people as ambassadors for mental health should be encouraged.

14. BUDGET

P.82/2012 – Health and Social Services, A New Way Forward was lodged on 11th September 2012. This proposition contained the proposals to approve the redesign of health and social care services in Jersey by 2021. P.82/2012 was debated and approved in October 2012.

Following the Green Paper consultation which led to the development of P.82/2012, eight service areas, and priority areas within these, were identified. These were based on:

- Current / imminent capacity pressures
- Green Paper feedback
- Strategic importance
- Whether the service change is a 'critical path' building block for future service changes

Eight 'crosscutting' enablers were also identified, these being the essential elements that support change. Considering the previously agreed prioritisation criteria and understanding the current and future challenges for each area, priority schemes were identified in each Service Workstream:

- Healthy Lifestyles - Alcohol
- Services for Children – Early Intervention (0-5 years)
- Hospital Services – Strategic Partnerships for Renal and Oncology
- Adult Mental Health – Improving Access to Psychological Therapies
- Older Adult Mental Health - Dementia
- Intermediate Care
- Long Term Conditions – Chronic Obstructive Pulmonary (COPD), Chronic Heart Disease (CHD), Diabetes
- End of Life Care

The Panel understood that although P.82/2012 was a 10 year plan, there did not seem to be any priority given to the specific area of children and young people's mental health. In addition, there was little mention of investment in this area throughout the proposition.

Specialist CAMHS existing budget is £1,316,925 which includes staffing of 14.5 clinicians and 2 administration staff members. Other areas of expenditure are the rental of Royde House (£98,000) and medication (£60,000) annually. It should be noted that

Comprehensive CAMHS has an additional budget which will cover some of the agencies discussed within this Report and sections of the Education Department.

Finding:
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 mental health issues in children and young people.

Recommendation:
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.

15. RESOURCES

15.1 Staff

As mentioned previously, there are 14.5 full time equivalent clinicians currently working at CAMHS. In addition to this, there are 2 administration staff to cover reception and secretarial duties. The Panel heard that due to the increased demand for CAMHS services, the Department planned to increase capacity within the service within 2014. However, the Panel also heard that *"….having more resources to recruit more staff does not mean you will get more staff because it is a particularly difficult area to recruit to at the moment…."* [57]

The Child Psychiatrist from CAMHS went on to say:-

"…We are prioritising our caseload; we are also looking at getting some additional staffing in. Unfortunately finding specialist staff to come and support us has been very difficult so we have looked to bring in some specialist staff to help…."[58]

When the Panel discussed CAMHS resource with its advisor, it was informed that demand and capacity needed to be better managed. With the team reporting pressure from urgent appointments, managing the team's caseload and throughput is imperative to meet demand and expectation and also support staff's capability.[59] Until further work is undertaken by the Department to resolve issues identified in this Report and also mentioned in the 2006 Young Minds report it is difficult to determine whether additional resource would find a solution to the existing problem of workload

Finding:
It is difficult to determine whether additional resource would find a solution to the existing problem of workload.

16. EMERGENCY ACCESS & INPATIENT PROVISION

The Panel's expert advisor reported the following:-

Specialist CAMHS rarely send a young person off the island for the purpose of tier 4 admission. This is positive due to the negative social and developmental effects that an external placement can have on a child or young person. However the team rely strongly on the paediatric ward to accommodate young people who are identified as at risk. There are good relationships between the paediatric ward team and specialist CAMHS with the ward sister attending meetings at CAMHS on a weekly basis. The ward team reported that

[57] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[58] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[59] Specialist Advisor Report

on occasion young people are accommodated for considerable amounts of time. This has been challenging for the ward staff who are not mental health trained yet do have to manage observation and intervention with children and young people who fall under the remit of CAMHS. There is limited amount of agency nursing or bank nurses to support this. The ward itself is not set up to accommodate children/young people with mental health problems for a variety of reasons which include difficulty in observing due to layout of the ward, physical health problems of other children on the ward and in addition the age range which the ward serves. There is a documented pathway in place between CAMHS and the paediatric departments dated 2012. However, there was an inconsistent response from CAMHS and paediatrics regarding psychiatric support out of hours, with overall view that it was dependent on who was on call impacting on the quality of the support the ward received. A review of the working arrangements around on-call and the use of the paediatric ward is needed and a risk plan developed to clearly indicate plans to reduce and /or mitigate risks should they arise.

Finding:
In the absence of alternative accommodation the paediatric ward within the General Hospital is used to receive children with a wide range of mental health problems.

17. PLACE OF SAFETY

A designated place of safety is a term used under the Mental Health Act 1983, an Act of the Parliament of the UK. It is used to safely hold an individual until they can have a mental health assessment.

The Panel listened to many reports from parents and stakeholders about what they believed to be the inadequacy of safe places to hold vulnerable young people during times of crisis. The Panel heard from one parent whose young adult could not remain at home due to reoccurring violent episodes however, there was no suitable accommodation available, nor any proposals and the young adult had to sleep in a car.[60]

17.1 Robin Ward

Robin Ward is the paediatric ward within the General Hospital which caters for all children from birth up to the age of 17. It is the only child friendly ward on the Island and for many young people it is the only appropriate environment with staff that are skilled to deal with children. Throughout its gathering of evidence, the Panel received statements saying the facilities in Robin Ward were not fit for purpose and the mixture of vulnerable young people with babies was not ideal. In addition, the Panel undertook a fact finding visit with its expert advisor to the ward, neither of whom believed it to have adequate facilities.

The Panel questioned the Minister for Health and Social Services regarding the facilities and was informed that under U.K. guidance from the Royal College of Psychiatrists, a National Institute for Health and Clinical Excellence states a young person under 17 who takes an overdose should be admitted to a paediatric ward under the care of paediatricians. The Panel went on to ask what other facilities could be used in these situations:-

The Deputy of St. Ouen:
"….Can I ask, Minister, is anything stopping you or your department from using some of the single private rooms in the private wing to provide short-term accommodation for these young people, instead of Robin ward….?"

The Minister for Health and Social Services:
"….Not that I can think of off the top of my head. I would have to go and ask Helen that question but then it goes down to risk assessment and it is the clinician decision at that

[60] Witness 1

time when they are admitted to Accident and Emergency, that is the most overriding thing to make sure that wherever they go they have been risk-assessed, and wherever they go to make sure that they have staff who are fully trained to be able to cope with their particular problems at that particular time. That is important. Rather than where they go, it is making sure that there are the staff and that they are properly assessed…."[61]

17.2 Rouge Bouillon Police Station

The Panel heard high praise for the work that the States of Jersey Police undertook in relation to assisting in difficult situations for parents dealing with children with behavioural issues. The Panel also heard that at times, children with behavioural and mental health issues who were prone to violent outbursts at home left parents with no choice but to call the Police service. The Panel was interested to understand what happened in these situations and was alarmed to discover that police cells in Rouge Bouillon had been used to hold vulnerable youngsters due to lack of adequate facilities. The Panel was also made aware that young people who come into custody and are under the care of CAMHS do not have access to a member of CAMHS out of hours.

Deputy J.A. Hilton:
"….I think what I am getting at is that if you have a young person who comes into custody who you are aware are already under the care of CAMHS, would it be ... I would have thought it would have been better for the young person concerned if you had access to CAMHS or somebody from CAMHS who could assist you in dealing with the person that has been brought into custody…."

Head of Crime Services:
"….That would not be an unreasonable expectation, I guess. But, as I said, I would not want you to think that we cannot access appropriate ... and we do, either through the on call social worker or direct to the hospital who would arrange for appropriate mental health assistance…."[62]

The Panel asked the Police if, over the years and due to the current increase in mental health illness amongst children and young people, they felt they had to deal with matters outside of their remit. The Police replied that although they have had to develop softer skills over the years to deal with current situations, they now have access to other support services however, they did say they felt their duties when managing mental health issues were outside of the remit of managing law and order.
The Panel asked what they believed could be done to address the issues:-

The Deputy of St. Ouen:
"….If that is the case, what practical thing could be done to help address that issue…?"

Head of Crime Services:
"….Potentially a suitably qualified health professional embedded in custody. That might be an option but, of course, that comes at a cost. That funding is not currently available to us. I know 1 or 2 other authorities, because of the throughput, they can perhaps justify that and there are embedded health professionals within custody settings now, certainly in some UK larger metropolitan forces. But that clearly assists because it would be quick and immediate and you would get a very timely response and assessment in respect of the vulnerable person as they presented…."[63]

The Head of Crime Services explained how each case was judged on its own merits and the welfare and vulnerability of the child would always come first *"….I guess a custody officer on occasions, maybe because of the real vulnerability, he or she may say: "Right, I*

[61] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[62] Public Hearing with SoJ Police Department – 13th February 2014
[63] Public Hearing with SoJ Police Department – 13th February 2014

am not going to put you in the cell, I will tie up a couple of police officers and we will go and sit in an interview room." But you will understand, it can sometimes be an elongated period and every case is judged on its own merits. But a young person would not be locked in an interview room and left as an alternative to a cell. That would not happen because an interview room is not appropriate…."[64]

Finding:
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.

17.3 Appropriate Accommodation for the Future

The Panel learned that the Head of Crime Services was the Deputy Chair to Glenys Johnston, the Joint Independent Safeguarding Board Chair for Children and Adults, who had been asked to form a subgroup in 2014 to specifically look at accommodation, not exclusively for children but more appropriate accommodation for individuals who have mental health problems.

The Head of Crime Services gave further background:-
"….in particular with children because we recognise that a police station, a custody block is the last place you want to be taking a vulnerable ... a young person. But in the absence of alternative accommodation outside core hours sometimes we are left with little or no choice. In particular where a family are in crisis and they are unable to deal with their youngster sometimes. As a place of safety - that is the term we use - then a police station the custody block is the last point of resort. At that point we would then seek to engage colleagues from health and social services, our force medical examiner in order to undertake a proper diagnosis and help to manage the needs of the vulnerable young person…."[65]

It was hoped the Head of Crime Services as the lead of this group would be able to report findings at some stage this year.

Finding:
A subgroup has been formed to specifically look at accommodation for all individuals who have mental health problems. The subgroup would report in their findings later in the year.

Recommendation:
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.

17.4 Orchard House

Orchard House is an inpatient service for adults with an acute mental health problem requiring hospitalisation. It is based at Orchard House on the St Saviour site.

Orchard House provide 24 hour care to people whose mental health care cannot be provided safely in the community. It would be classed as offering tier 4 services.

The unit has 14 beds. It has capacity for a dedicated psychiatric intensive care unit which can provide flexible accommodation for people who need high levels of care.

[64] Public Hearing with SoJ Police Department – 13th February 2014
[65] Public Hearing with SoJ Police Department – 13th February 2014

Orchard House work closely with colleagues in community mental health teams to ensure that (where appropriate) on discharge patients have an identified community worker and a package of care is in place.[66]

Although Orchard House is an adult facility, it has been used in the past to house vulnerable youngsters under the age of 18. One service user explained that on turning 17, they needed to be admitted to a secure facility. Having previously been admitted to Robin Ward, they were now deemed too old to be admitted and as a consequence, they were admitted to Orchard House.

Witness 13
"….I quite like Robin ward so I did not mind being on there too much…."

Deputy J.A. Hilton:
"….Because there was just children there and you found it non-threatening?..."

Witness 13
"….Yes, Orchard House was a completely different experience. I really hate it there…."

As the Department of Health and Social Services is undertaking its own review into mental health and overall facilities will form part of this, the Panel expect priority will be given to what accommodation will be provided to teenagers as a place of safety.

Finding:
There is no clear designated place of safety for young people in Jersey and little clarity around what a designated place of safety 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.

Recommendation:
Discussion should be had with the Hospital Managing Director to utilise the private ward in the hospital as a short term measure to accommodate children and young people who present with serious mental health issues. CAMHS professionals should be involved in the feasibility studies for both the new hospital and the new police station to ensure adequate facilities are provided for the future.

18 THE EDUCATION SYSTEM

As previously discussed in this report, Comprehensive CAMHS relies on anyone who has a responsibility for the emotional health and well-being of children and young people – the ethos being that it is everyone's business. The Education Department have a huge part to play in this role and it is important the pathway between Education and CAMHS is defined.

The Panel asked how information was shared between CAMHS and the Education Department and was informed that if a referral is made through a school to CAMHS, CAMHS will then share information with the school however, if a referral is made by a GP or other professional, the information will be treated as confidential with nothing being shared with the school.

Business Manager, Schools and Colleges:

"….No, I think the referrals made in by schools, the feedback goes back to schools. So where the overlap occurs, if the school refer into the CAMHS service, CAMHS then work with the school or the officers within the school to share that information. Obviously, it is

[66] http://www.gov.je/Health/Mental/Pages/Adult.aspx

highly confidential so there is a challenge there. If the referral goes through to CAMHS in another fashion, via the parent or the G.P., that is private to that family and that child. Usually around these issues they are pretty confidential…."[67]

Although the Panel was aware that information sharing could be complex and at times there may be no benefit to sharing information with the school environment, it was concerned an overall, wrap around treatment package was not being provided to the vulnerable child and young person and the fully Comprehensive CAMHS service was missing.

The Panel also heard from an education professional through a written submission who stated that:-

- Referrals/feedback to schools and parents needs to be quicker
- Recommendations can be vague and need to be more precise and more directly related to a school environment
- Everytime a school refers a student, feedback should be provided on a face to face basis as opposed to paper feedback
- Schools need to be aware of any follow sessions and any action points which are not always made clear
- Wrap around service needs to be more fully developed which includes other agencies and parents and is conducted through face to face meetings and not just emails/letters/phone calls[68]

The Education Department form part of tiers 1 and 2 and if a child is being managed under tiers 1 and 2, it is not always necessary for them to be part of Specialist CAMHS and Specialist CAMHS would not expect to be notified by the school of each and every case that comes under tier 1. The Panel had difficulty understanding the strength of partnership between the Education System and CAMHS and believed this could be improved. The Panel was of the opinion that the education psychologist could be more closely linked to CAMHS assessments and treatment so that the child experienced a more holistic treatment pattern in school and at home.

Most parents commented that although they thought the Education Department was very helpful, it seemed to lack the skillset and knowledge to deal with children with behavioural problems. The Panel heard from one parent whose child was labelled as "naughty" for a number of years in primary school before being diagnosed with ADHD. There was concern from the parent that the primary school did not seem experienced to look further into the problem with the child and to label them naughty was easiest.

This particular parent had this to say as an improvement
"….I would like to raise awareness for teachers so that perhaps they can spot these children, rather than labelling them naughty, perhaps they can spot them and put them through a process, whatever process that may be. I would like CAMHS to be able to have some support services to refer on to that does not have a waiting list that is 12 months long…."[69]

Finding:
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.

[67] Public Hearing with Minister for Education, Sport and Culture
[68] Written submission 2.20
[69] Witness 7

18.1 Primary Schools

It should be noted that primary schools do not have school counsellors although secondary schools do.

Any issues at primary school are dealt with at the first instance within the school environment through work with the educational needs coordinator and the classroom teacher to manage within the environment. There is also a behaviour and wellbeing team that works across all primary schools, based on a very structured identification structure that those individuals, key workers and behaviour support teachers, work directly in supporting the children in their schools with their own teachers.[70]

In the Young Minds report which was undertaken in 2006, it was recommended that an information sharing protocol be developed between specialist CAMHS and their partners. This led to the creation of the Multi-Agency Safeguarding Hub (MASH) which is explored in the next chapter.

19. MULTI AGENCY SAFEGUARDING HUB (MASH)

Following the recommendation from Young Minds in 2006, on 19th September 2012, a new umbrella partnership was set up to coordinate and manage safeguarding concerns regarding children and young people in Jersey.

The Multi-Agency Safeguarding Hub (MASH) is made up of representatives from a number of States' Departments and other agencies to provide a single contact point for members of the public, families or professionals to discuss any concerns that they may have.

The Jersey MASH involves:

- States of Jersey Police
- Health and Social Services / The Children's Service
- Education, Sport and Culture
- Family Nursing and Home Care

By bringing these different agencies together in one place, it ensures that information is shared as early as possible with responses being timely and coordinated. A new joint MASH database will ensure that information can be collected to allow targeted support.

There are also key links to 'virtual partners' such as Housing and the Probation and After-Care Service. It is anticipated that the MASH will grow to provide a hub for adult safeguarding in the future.

The setting-up of the MASH in Jersey follows a number of successful launches in different parts of the UK, including Devon, Norfolk, Birmingham and London.

The establishment of the MASH has been supported by Jersey's Joint Safeguarding Partnership Board.

"The Safeguarding Partnership Board fully endorses the establishment of a local MASH," said the Board's Independent Chair, Glenys Johnston. "*This is an encouraging development and shows the Island's continuing commitment to safeguarding its children*."[71]

The Department of Education, Sport and Culture is part of MASH and works with them at 3 levels:-

[70] Public Hearing with Minister for Education, Sport and Culture
[71] http://www.gov.je/News/2013/Pages/JerseyMASHLaunched.aspx

- On a daily basis an Educational Welfare Officer sits within the MASH team at the Bridge. This is an important role as this officer completes the school-facing research for all relevant enquires.
- On a weekly basis the Senior Educational Welfare Officer attends the operational managers' meeting with colleagues from the other departments, including the Police, Social Workers, Health and Children's Services.
- On a monthly basis, the Head of Inclusion attends the Strategy Group meeting with other senior colleagues from across departments.[72]

The Panel believed the establishment of a multi-agency safeguarding hub was extremely forward thinking and positive but was disappointed in the length of time it had taken to establish. However, as it was still in early stages and few statistics are available, it is difficult for the Panel to assess its effectiveness.

Finding:
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.

20. EARLY INTERVENTION

Throughout the course of its review, the Panel heard that families seemed to have to reach crisis point before any intervention took place.

20.1 Early Intervention/ tiers 1 and 2

The Panel was informed by its advisor that:-

The responsibility of early intervention does not just lie with Specialist CAMHS. Other agencies must be involved if Comprehensive CAMHS is able to provide the services necessary to meet the overall CAMHS objective. There is a finite resource for providing early help and early intervention for emotional wellbeing and mental health problems for children, young people and their families in Jersey. There appears to be a gap of provision for emerging mental health problems and when children and young people present at CAMHS with acute mental health problems. With joint planning, provision at tiers 1 and 2 could be developed further to become more prominent.

Jersey CAMHS currently provides a degree of input for mild to moderate and emerging mental health problems. Many of the schools have counsellors who have supervision provided by CAMHS. CAMHS currently provide clinical supervision to school counsellors who are resident in many of the secondary schools, this seems to be a historic arrangement. Specialist CAMHS need to better define their role in relation to tiers 1 and 2 and the service they provide which should be based on enabling primary care and education staff to support children, young people and their families with emerging problems.[73]

Finding:
The responsibility of early intervention does not just lie with Specialist CAMHS and all stakeholders need to understand their role.

The majority of parents with children who use, or have used the services of CAMHS were certain that they believed their child showed the traits of having a condition from a very

[72] Letter from Minister of Education, Sport and Culture to HSSH Scrutiny Panel – 19th March 2014
[73] Specialist Advisor Report

early age. The majority of these parents were also astounded that no diagnosis was given until many years later, if at all.

The Panel received evidence from a parent who worked within the Health Service and explained that even having access to contacts, she had "struggled". This particular parent raised concerns regarding her child's overall behaviour and described when she spoke to the school for assistance regarding her 8 year old child:-

"….I would really like to talk to you about my child. I do not know if he is behaving like this because he is being bullied. I do not know if he is behaving like this because he has dyslexia and has issues with understanding" and I had read that, you know, you can have these sort of reactions, you know: "I do not know if this is a loss thing" and I was basically told that there were 360 children in that school and that was him that was the problem and nobody else, they were all perfect, which again was not the result I was after. I wanted to find out what we could do to support this child, because at the end of the day, whether you think he is naughty or not, there is a child…." "….But at this stage, because I did not have a diagnosis, I was just told that I was dealing with a naughty child, I did not know where to go or who to see. So eventually the Educational Needs Co-Ordinator (ENCO) spoke to me and said: "Have you thought about going to see a psychologist privately, because there is nothing we can offer you…." [74]

The Panel believed the area of early intervention was paramount in a child's future and if problems were recognised early enough, it would be extremely beneficial to the child's well being. This was also reflected by the Executive Director of Mind Jersey.

Executive Director – Mind Jersey

"….My colleagues can talk in a bit more detail about the sorts of things that happen, but a really important thing that Mind nationally and Mind Jersey is doing is really pushing the preventative agenda in support of early interventions. I have no doubt as a scrutiny panel you have heard that many times before, but it is absolutely worth restating that if you intervene as early as you can when people are first thought not to be so well, be it with a physical health or a mental health issue, then there is a lot of evidence to suggest that you can do some very beneficial work and begin the process of potential recovery much sooner…."[75]

Finding:
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.

The report which was undertaken by the Panel's advisor included additional recommendations in this area. The advisor believed that joint formal working arrangements needed to be developed and recommended the working arrangements between Education Psychology and Specialist CAMHS are refreshed to explore the potential for team working around the child arrangements and the implementation of the common assessment framework, defining the role Specialist CAMHS would play into this. The advisor also recommended closer working across agency boundaries and within a variety of settings. This should be applied across all agencies who work within CAMHS and not just education.

The advisor thought the development of self- harm and risk of suicide guidelines should be made available to assist those who work with or support children and young people in how to recognise risk of self- harm or suicide and which outlines a subsequent course of action.

[74] Witness 7
[75] Public Hearing with Mind Jersey – 3rd February 2014

The advisor also recommended supporting schools and primary care through the exploration of potential for providing specialist support to primary care and education through a consultation model. Training packages could be developed with Educational Psychologists for teaching staff in the recognition and management of mild mental health problems. This could be provided by Specialist CAMHS and Education Psychologists developing a range of training packages aimed at understanding and identifying emotional and mental health problems. These would be aimed at primary care and school staff.

The consultation model could be developed with tier one responding to their need for example discussions about when to refer to specialist CAMHS or where else to sign post or supporting an education professional to support a child or young person with emotional problems.

21. ETHNIC MINORITIES

Throughout the course of its review, the Panel wrote to the Department of Health and Social Services on a number of issues. One of these issues was to ask how minorities access CAMHS if English is not their first language. The Department informed the Panel through written correspondence that there was a member of staff who was bi-lingual however, it was clear that it was not always appropriate to use staff to translate during clinical sessions as individuals are more trusting of independent persons speaking in their own language. Where English is not a first language, an interpreter will be provided. However, it was not clear to what extent the fluency of English had to be before provision of an interpreter. The Panel was also informed that the corporate leaflet for CAMHS was being re-formatted and it was hoped to develop a range of appropriately translated family friendly leaflets.

Given the cosmopolitan nature of our community, the Panel has concerns that there could be vulnerable young people from ethnic minorities who are not able to gain immediate access to the service.

Finding:
The Panel is concerned 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.

22. MEDICATION AND TREATMENT

The Panel is aware that mental health can be treated in a number of ways either through behavioural therapy or prescription of medication. However, the Panel accept it is difficult to say which is better as it is expected that each individual is dealt with on a case by case basis. It is therefore difficult to predict how, when and to what degree someone is going to get better.

22.1 The Treatment Offered by CAMHS

The Panel questioned the Minister for Health and Social Services around the different available treatment offered by CAMHS. The Panel was told that CAMHS offer a range of different therapeutic models plus art therapies and work with whole families around behavioural advice and behavioural management and work. The Panel was also informed that CAMHS might work within schools, advising schools, and also then use medication with roughly 20% of all CAMHS cases being medicated however, because of the lack of available information and statistics from CAMHS, the Panel was unable to verify this.

During the course of its evidence gathering, the Panel heard complaints from parents that medication seemed favoured over therapy and little evidence to support alternative therapies was provided. Parents also complained about having little or no choice but to have their child take medication with some as young as 7. In addition, some parents had experienced situations when medication seemed to constantly change and in some

instances, children would be required to have a 2 week break from their medication which was timed to take place over the school holidays. The Panel was informed that one child was told at the age of 14 by a CAMHS psychiatrist that it was that child's choice whether or not to take their medication. As a consequence, the child now refuses to take medication and engagement with CAMHS has become difficult as a result. The Panel was also informed that a parent had expressed concern that medication was making their child worse and stated to CAMHS they wanted the child off the medication however, the parent did not believe they were getting any support from CAMHS and decided to reduce the dosage gradually themselves.

"….we started to reduce the dosage gradually on our own and slowly started to get our son back. This could have been totally the wrong decision but we were so desperate with nowhere to turn we followed our instincts before we lost our child…."[76]

The Panel was of the opinion that the range of alternative therapies mentioned by CAMHS on its website was not being used to its full extent and medication seemed to be the first port of call.

It should also be noted that once a child is under the administration of CAMHS and receiving medication, only CAMHS professionals can prescribe that medication. The Panel heard that a number of parents were concerned that when visiting their child's GP, the service seemed very distant as the GP did not seem to have any control or influence over the child's prescribed medication. However, when the Panel raised this with the Department, it received a comment stating that some of the medications prescribed by child psychiatrists are not on the GP prescribing list.

Finding:
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.

23. FAMILY THERAPY

Throughout this report, the Panel has presented evidence from parents who did not believe that family therapy was being offered or if it was, the waiting list was too long or the therapy inadequate. The Panel raised this issue with the Department and received this written response.

Formal family therapy is offered at the clinic at Royde House as the building has the capacity needed due to more than one therapy room being required. Family therapy is generally delivered by a specialist team which is led by a qualified practitioner. However, at the time of writing this report, formal therapy was not being delivered by CAMHS as the registered qualified practitioner had left the service. A psychologist had been undertaking formal accredited training which will lead to registration. The psychologist will then be in a position to lead a multi disciplinary group by Autumn 2014.

Although it is being suggested that family therapy is being provided, the Panel is disappointed that no-one is responsible for providing formal family therapy and it does not seem to be seen as a priority. The Panel is also concerned that the lack of emphasis placed on family therapy moves more towards medication being prescribed and is concerned parents will feel they have little or no choice but to agree if their child is to get better.

[76] Witness 2.19

Recommendation:
Comprehensive family therapy programs need to be implemented and available to parents and families led by a registered family therapist.

24. ONGOING MONITORING

CAMHS is responsible for children up to the age of 18. Once a child is diagnosed, CAMHS told the Panel "*we do have some young people, particularly say within our A.D.H.D. clinic who are well managed, well stabilised but if they are on medication we would review them every 6 months.*"[77]

Some cases would be more frequent with some children having a few hours a week with the CAMHS team or be under locational special packages. In other cases, there might be 1 or 2 staff who are dedicated to one young person, depending on their condition.

This message was in contrast to what the majority of parents who spoke to the Panel believed. One parent whose child was being seen every 6 months did not believe it was a follow up appointment but purely to receive more medication. Most parents did not believe their child was being re-assessed and was staying on the CAMHS register with no pathway or solid plans for future development.

Throughout the course of its evidence gathering, the Panel found little or no evidence of locational special packages being provided on Island. The Panel also found that most children and young people did not have a specific care package in place with little attention being paid to the ongoing day to day monitoring of the child and young person.

Finding:
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.

25. OUT OF HOURS SERVICES

CAMHS is operated from its premises in Royde House on Monday to Friday from 9am to 5pm. The Panel was interested to know what happened outside of these hours and questioned the Minister for Health and Social Services at its Public Hearing. The Panel was informed that "….*there is cover for CAMHS 24/7 but that is provided by paediatrics and adult mental health. So for somebody under 17 it would be the consultant paediatrician in the first instance. So any young person would be taken to Accident and Emergency, the consultant paediatrician would be involved, if necessary they can then access the adult mental health service and jointly manage that young person. A 17 year-old would be seen by the adult mental health service. The CAMHS service provides every day 2 hours on bank holidays and weekends, so we are available for 2 hours a day to see anyone that has been admitted and provided specialist advice….*"[78]

The majority of submissions the Panel received raised concerns surrounding the out of hours service. Most parents could not access a CAMHS team member out of core business hours and found themselves in desperation. Of the feedback the Panel received, there did not seem to be an emergency number for Parents to call and the advice received from CAMHS to parents was to phone the hospital or go to A&E. The Panel was able to call Dr Mark Jones, a Paediatrician at the General Hospital to a Public Hearing and asked what he thought of this arrangement:-

[77] Public Hearing with Minister for Health and Social Services – 3rd February 2014
[78] Public Hearing with Minister for Health and Social Services – 3rd February 2014

The Deputy of St. Ouen:
"….Are you aware that CAMHS has been advising parents to phone the hospital if they have a problem out of hours…."?

Consultant - Paediatrics, Health and Social Services:
"….No, I am not aware of that…."

The Deputy of St. Ouen:
"….Do you think that is appropriate advice to give or would you believe that there are other ways of dealing with the issue…."?

Consultant - Paediatrics, Health and Social Services:
"….I would say that that would not be an appropriate arrangement because we have no agreement for that arrangement so it would be an unexpected call upon our service…."[79]

The Police Department also raised concerns about the challenges they face due to the lack of out of hours services

Head of Crime Services:
"….Most healthcare is delivered during core hours and when we are responding to incidents of this nature outside core hours, so overnight, it inevitably can present some additional challenges to us…..I know some of my uniformed colleagues, and certainly in custody, sometimes get frustrated about the timeliness of a response from partners but it is about recognising other demands, other challenges, appropriate risk assessment and prioritising. Certainly out of hours there is not a limitless pot of mental health specialists…."[80]
Bearing in mind the Children's Service has overall responsibility of CAMHS and the treatment for mental health issues, the Panel was disappointed that a suitable out of hours service was not being provided.

Finding:
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.

Recommendation:
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.

26. CONFIDENTIALITY

The Panel was made aware of the issues confidentiality raised when a child comes of age and needed clarification as it was unsure as to what age full confidentiality was implemented. A number of parents were also unclear of the age of when children had right of confidentiality. Parents expressed feeling very alone and vulnerable when not involved in the care of their children. When pressed in this area, the child psychiatrist of CAMHS stated that at the age of 18 individuals have a clear right of confidentiality however, depending on the situation, it can happen as early as mid-teens.

The Panel found this information troubling and was concerned that there were no clear boundaries leaving parents in a situation where they had no control or knowledge over

[79] Public Hearing with Paediatrician on 24th March 2014
[80] Public Hearing with SoJ Police Department – 13th February 2014

what was entailed in their child's care. The Panel had concerns that too much attention was paid to the rights of the child rather than how the situation affected the family as a whole.

Finding:
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 has concerns that not enough attention is given to how the situation affects the family as a whole.

26.1 The Fraser Guidelines

When deciding whether a child is mature enough to make decisions, there is often discussion around whether a child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. Fraser Guidelines were set up in 1985 following Mrs Victoria Gillick taking her local health authority to court in an attempt to stop doctors from giving contraceptive advice to under 16 year olds without parental consent. The guidelines were set out by Lord Fraser in his judgement of the Gillick case and since then, are widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The Guidelines are as follows.

Consider:-

- *Has the young person explicitly requested that you do not tell their parents/carers about the treatment that they are receiving?*
- *Have you done everything you can to persuade the young person to involve their parent(s)/carer(s)?*
- *Have you documented clearly why the young person does not want you to inform their parent(s)/carer(s)?*
- *Can the young person understand the advice/information they have been given and have sufficient maturity to understand what is involved and what the implications are? Can they comprehend and retain information relating to the treatment and the services, especially the consequences of having or not having the treatment and intervention in question?*
- *Can they communicate their decision and reasons for it?*
- *Is this a rational decision based on their own religious belief or value system?*
- *Is the young person making the decision based on a perception of reality? E.g. this would not be the case for a chaotic substance misuser.*
- *Are you confident that the young person is making the decision for themselves and not being coerced or influenced by another person?*
- *Are you confident that you are safeguarding and promoting the welfare of the young person?*
- *Without the service(s), would the young person's physical or emotional health be likely to suffer?*
- *Would the young persons' best interests require that the treatment happens and the identified services and support provided without parental consent?*

You should be able to answer YES to these questions to enable you to determine that you believe the young person is competent to make their own decisions about consenting to treatment and sharing information and receiving services without their parent's consent. You should record the details of your decision making.[81]

Unlike the UK, Jersey does not have a mental capacity law in place which makes it difficult to have clear defined law regarding confidentiality. When the Panel questioned the Minister for Health and Social Services at a Public Hearing, it was told that CAMHS follow clear guidance from medical bodies about confidentiality which followed Gillick guidelines. However, the Panel was concerned that parents expressed serious concern about being kept in the dark about their child's condition. Parents also expressed there was no clear guidance from CAMHS about what information could be shared with families. The Panel was told the following:-

Child Psychiatrist:
"….What we generally say as soon as a young person has recognised their high incapacity, so that could be mid teens, but it depends on the individual child and young person. We always work very hard to say: "It would be really important to share this with your parents." We would still offer support to parents, we may not be able to disclose all the information however what we always say is if a child is of significant risk, so if they are making threats to maybe kill themselves, we would be very clear with the young person that we would be talking to their parents or a carer…."

Deputy J.A. Hilton:
"….So you said mid teens, so is there a possibility that a child of maybe 15 years old could turn around to you and say: "I do not want you to discuss this with my parents" and you would go along with that?..."

Child Psychiatrist:
"….Depending what "this" is…."

Finding:
Currently the Island does not have a Mental Health Capacity Law to address matters of confidentiality for those suffering from a mental health condition.

Recommendation:
Appropriate mental health legislation should be brought to the States as a matter of urgency.

27. TRANSITION PERIOD

Currently, the transition age from CAMHS to adult mental health services is 18. The transition period usually begins when a patient is 17 and 3 months to ensure they are prepared for adult mental health services at 18 however, the Panel found this was not always the case and as previously mentioned, the CAMHS team had difficulty in transferring and letting go of patients when they reach 18 due to a concern over where the individuals needs will be met in the future.

Transition from adolescence to adulthood is one of the most important times in a young person's life. This corresponds with a number of life changes, such as moving from a family home or a foster home into independent living, or moving from education into employment, unemployment, or further education. For young people with complex needs who are using health and social services, this may coincide with the transition from young people's

[81] http://www.nspcc.org.uk/Inform/research/briefings/gillick_wda101615.html

services into adult services. Transitions between child and adult services are often poorly managed. If a young person has been poorly prepared for the transition, and lacks emotional resilience and external support networks, then they may struggle to cope with the transition[82]

Mind Jersey also expressed concern around the importance of this challenging time stating more could be done to make this transition as smooth as possible.

Chief Executive – Mind Jersey
"….So we think there are things that could be done with adolescents in particular and certainly in the age range 16 to 23, which I see as more of a continuum; the 18 switchover is entirely arbitrary. If you think about young people in any case, all young people, whether they have physical or mental health issues, 16 to 23 is a very challenging time around physical changes, moving perhaps from full-time education into work or not into work, possibly going away to higher education if they are able to do that, or not. Moving out from home possibly for the first time, getting into serious relationships, very often for the first time. So forget any of the other things that are going on, it is a stressful time for all young people and we think there is more that could be done and we would be keen on seeing how we might help in that to provide a continuum and to give some signposts for all young people, really, in terms of the support that they might access into the future…."[83]

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.

Finding:
In general, transitions between child and adult services could be better. 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.

Recommendation:
The changeover between children and young people to adult services needs to be reviewed to ensure a seamless transition. This should take account of the individuals needs.

28. MODELS RELEVANT TO CAMHS

28.1 Choice and Partnership Approach (CAPA)

CAPA is a clinical system that has been implemented in many CAMHS, including learning disability teams in the UK, Australia and New Zealand, Belgium and Canada. It is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management.

CAPA is focused on the service user and their family. The stance is collaborative and provides choices. For the clinician there is a shift in position from an 'expert with power' to a 'facilitator with expertise'. There are 11 key components, including a change in language, team job planning, goal setting, care planning and peer supervision.

CAPA is most effective if all 11 components are in place. Implementation, quality and sustainability will be impaired if they are not. Two Foundation Items relate to leadership and team away days, essential for implementation and sustainability. The details of the components are given elsewhere. Here is the summary list:

[82] Children and Young People's Mental Health Coalition, 2010
[83] Public Hearing with Mind Jersey – 3rd February 2014

Foundation Component

1. Management and Leadership

Choice Components

2. Language
3. Handle Demand
4. Choice Framework

Transfer to Partnership Components

5. Full Booking to Partnership
6. Selecting Partnership Clinician by Skill

Partnership Components

7. Core and Specific Partnership Work
8. Job Plans

Letting Go Components

9. Goal Setting and Care Planning
10. Peer Group Supervision

Foundation Component

11. Team Away Days

Many services have gone on to implement CAPA and statistics show that its use has improved the user experience, accessibility and staff satisfaction. [84]

The finer details of CAPA are too extensive to put into this report however, further details on CAPA and its methods can be viewed on its website www.capa.co.uk. The Panel's expert advisor recommended the implementation of CAPA as it would be extremely beneficial to the Jersey CAMHS and would help improve service and case load management immensely. This is discussed in more detail under the appended section of Governance and Information Management - Recommendations.

29 CAMHS OUTCOMES RESEARCH CONSORTIUM (CORC)

CORC are a grassroots learning collaboration of mental health professionals from 70 services across the UK and Scandanavia committed to ensuring that young people and their families receive the best help possible. Since October 2011 CORC have been commissioned by the Department of Health to centrally collate and analyse outcomes from the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) initiative. CORC offer free training to their members, consultancy to interested parties and advise government. They are currently collaborating with the Evidence Based Practice Unit on free Masterclasses in Embracing Uncertainty when Reasoning about Outcomes. They offer specific training in using patient reported outcome measures to improve service effectiveness (U-PROMISE). The Panel's expert advisor believed that Jersey CAMHS would benefit from affiliation to a national body such as CORC to assist with benchmarking, training and implementation of services.

[84] www.capa.co.uk

30 CONCLUSION

The CAMHS service in Jersey is not delivering the level of support required for the Island. As a consequence, families continue to suffer and vulnerable children and young people remain unsupported. With the reported increase in demand for mental health services for children and young people, a shift in focus of the services offered by CAMHS is required.

The Panel believe there is a need for CAMHS to refresh its services and partner engagement between Specialist and Comprehensive CAMHS requires immediate attention. The general lack of care pathways available and the lack of intervention at tiers 1 and 2 has the outcome of cases being left unsupported.

Parents reported the overall lack of holistic support and families had become estranged through stress with siblings being unable to live in the family home. Parents said their experience with CAMHS had left them feeling isolated and on a lonely journey.

The Panel believe the introduction of a Mental Health Capacity Law would assist greatly in addressing some of the problems highlighted within this report and although the Panel is aware that this is currently being drafted, it is long overdue.

The Panel is aware that the Department of Health and Social Services is undertaking its own review into mental health and look forward to this piece of work being published. Although this report has focused solely on the services of CAMHS, the Panel is aware that the mental health arena as a whole requires a review and hope that both reports will result in changes to the mental health culture that are so desperately needed.

30.1 Advisor's conclusion

Comprehensive CAMHS in Jersey should be provided through effective multi-agency practice in order to provide services that are accessible and delivered by an adequate and skilled workforce. The CAMHS offer should reflect local need and changing demand. Interventions related to prevention and early interventions are a priority and need to be available to all children, young people and their families but not be just the jurisdiction of Specialist CAMHS (tier 3). All services who work with children and young people should consider their role in the support of the emotional wellbeing and mental health of children in Jersey. Future development of services should focus on the need for the development of specialist health promotion initiatives and early intervention directed at the mental health and emotional wellbeing of children, young people and their families in Jersey and owned by all those who work and associate with children.

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Review Hearings

The Panel held the following Hearings:

Public Hearings
Monday 3rd February 2014
Deputy A.E. Pryke, Minister for Health and Social Services
Mind Jersey

Thursday 13th February 2014
States of Jersey Police

Monday 24th February 2014
Deputy P. Ryan, Minister for Education, Sport and Culture

Monday 10th March 2014
Autism Jersey
Jersey Youth Service
Monday 24th March 2014
Paediatrician – General Hospital

Private Hearings

Tuesday 28th January 2014
Witness 1
Witness 2
Witness 3

Thursday 30th January 2014
Witness 4

Friday 31st January 2014
Witness 5
Witness 6
Witness 7

Thursday 6th February 2014
Witness 8

Friday 7th February 2014
Witness 9
Witness 10
Witness 11

Wednesday 12th February 2014
Witness 12

Thursday 20th February 2014
Witness 13

Written submissions

The Panel received in excess of 50 written submissions from CAMHS service users. In addition, the Panel received the following from stakeholders:

- FCJ Primary School
- Victoria College
- Triumph Over Phobia
- Haut Vallee School
- Mind Jersey
- Castle Quay Medical Practice
- Brighter Futures
- New Vision Therapy
- Le Quennevais School
- Springfield School
- St George's Preparatory School
- Chief Probation Officer
- David Place Surgery
- Windsor Medical Practice
- Island Medical Centre
- Indigo House Surgery
- Grands Vaux Primary School

Appendix 1: Young Minds Report – Jersey CAMHS Service Review 2006

Appendix 2: CAMHS Report by Specialist Advisor

Young Minds Report

Advisor Report

CAMHS Specialist Advisor Report – May 2014

Background

This report has been undertaken to understand the function and purpose of specialist CAMHS in Jersey. The CAMHS Specialist Advisor has worked with the Health, Social Security and Housing Scrutiny Panel to compile a document which includes the advisors recommendations. The aim is to advise on improvements to services provided to children, young people and their families who need to access specialist CAMHS in Jersey.

Comprehensive CAMHS is a global term incorporating anyone who has a responsibility for the emotional health and wellbeing of children and young people; the ethos being that this is everyone's business. The Department of Health in its priorities and planning framework (2003 – 2006) reported an assumption that all CAMHS would provide a comprehensive service which included mental health promotion and early intervention by 2006. From this the National Service Framework (NSF) for children, young people and maternity services (2004) set out standards for this delivery, stating that

"all children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families".

These standards continue to be upheld currently as good practice, setting out the premise for integrated pathways and collaborative working which cover the range of children's mental health problems. The NSF expects that provision will be a multi-disciplinary CAMHS service that is accessible, timely, integrated and of high quality and that it offers effective assessment, treatment and support for children young people and their families (CYPF). Comprehensive CAMHS organises itself across 4 tiers with the specialist element spanning tiers 2 and 3, as described by the NHS Health Advisory Services (1995). Typically tier 3 is multi-disciplinary in nature and Jersey CAMHS reflects this model offering a team which currently has 14.5 whole time equivalent (WTE) clinicians.

In 2006 Jersey CAMHS was reviewed by Young Minds who prescribed a set of recommendations which were bespoke to Jersey CAMHS. It is noted that some of these recommendations are still apparent today, although the service has devised an action plan around a series of the recommendations, implemented some of these and acknowledges that there is still scope to develop further in areas.

Health provision in Jersey is unique to address the needs of an island community and therefore CAMHS cannot be wholeheartedly benchmarked against UK services but some comparisons have been made in this report to help inform future

provision. There are obvious differences between CAMHS in Jersey and CAMHS in the UK with Jersey having specific challenges to providing comprehensive CAMHS on an island. A particular issue the team spoke about was recruitment and retention, at times posing an issue with the challenge of sustaining a multi-disciplinary workforce who use evidence based interventions which can respond to the ever changing needs of CYP. There are also the challenges around collaborative working which are explored throughout this paper although Jersey health services do strive to provide effective partnership working across all agencies and this practice should continue to be the focus of effective and efficient future delivery of CAMHS in Jersey.

Process

The Panel conducted several transcribed meetings with stakeholders and service users and were provided with operational detail regarding the delivery of CAMHS. This information was analysed to elicit themes and the advisor also spent two days in Jersey facilitating informal meetings with professionals who influence the pathway for CYPF through Jersey CAMHS.

Specialist CAMHS – service provision

Subjective observations from team members were that they were overwhelmed with the change in demand on service; they have experienced increased referral rates for urgent and emergency assessment of individuals deemed higher risk to themselves or others. There was also the added expectation and pressure on the service due to the sudden deaths of two young males on the island, in the past 12 months. Due to these articulated changes to the demands on the service, there is a need for clarity regarding the teams 'business' in order for it to re-focus its overall response and develop a vision which in turn will dictate the future direction of travel for the team and how it defines itself in relation to the wider directorate. The current waiting time for an appointment is currently 14 weeks on average, which is double the time waited last year. It is reported that emergency or urgent cases are seen within 24 hours or 7 days respectively. The overall data should be explored to understand the significant increase over the past 12 months.

The team have a high number of cases open to them; 732 (May 2014). The number of referrals to CAMHS for the period between April 2013 – March 2014 was 495. Of these referrals 453 were accepted as requiring an assessment. During that period the highest number of referrals were received during July 2013 at 48 and the lowest in August 2013 at 24.

Using Royal College Psychiatrists (RCP) guidelines (2013) and assuming that 50% of a clinicians time is spent in administrative activity e.g meetings, paperwork etc and if each CYP is seen for an average of 10 sessions, then a clinician could see an average of 39 new cases each year. Therefore if we assume that the referral period of 2013 – 2014 is an average year, than each clinician has had the capacity to see an average of 31 new cases per year. This is below RCP guidelines and suggests that currently Jersey CAMHS has enough capacity to manage the number of referrals being accepted. The focus would need to be on discharging and managing current case loads.

There was a reported difficulty in transferring and 'letting go' of patients when the young person reaches 18 due to a concern of where the individuals needs will be met in future. An unconfirmed report was that there were young people still being

seen by CAMHS at age 21. However, it was reported that colleagues within adult mental health services were receiving training on how to address presentations which are common to CAMHS but may need further input in adulthood; e.g ADHD. For a service to run effectively demand and capacity must be managed, haphazard flow through the system prevents easy access to the service and subsequently a waiting list may develop. With the team reporting pressure from urgent appointments, managing the teams case load and throughput is imperative to meet demand and expectation and also support staff's capability. To assist with this, staff need adequate supervision to discuss case work, case management and other professional issues. Jersey does not have a large workforce to draw from around recruitment, so maintaining a clinicians skills and ensuring that the skills match the demand is imperative. The Royal College of Psychiatrists (2013) recommend maximising clinical effectiveness by streamlining processes and delivering evidence based interventions, especially during times of increased pressure on services.

Recommendations

- Articulating a vision
    - CAMHS staff need 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.
- Strategic planning to reflect current demands
    - Increased demand requires a shift in provision by CAMHS. CAMHS needs to be sure of its role within childrens services not just those provided by health and social care but with wider interdependent partners e.g acute care colleagues, education colleagues.
- Development of protocols regarding working together across directorates
    - 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 CYPF 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.
- Defining and developing care pathways
    - 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
- Develop CAMHS communication and marketing strategy
    - 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.

- Strengthen leadership for CAMHS, clarity about role and direction of travel for service
    - 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
- Professional mix
    - The team need to ensure professional mix and provide a service which accounts for skills, competencies and capabilities of its team members
- Refresh supervision framework to ensure that any concerns about practice are addressed
    - 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 teams case load is excessive which indicates lack of management of demand and capacity. Difficulties in recruitment, to an island needs to be observed. Ensuring skill mix management will support staff being developed to provide appropriate interventions which respond to needs of children accessing service
- Refresh Operational Policy for CAMHS to ensure its fit for purpose
    - With change in demand and provision the operational strategy should reflect this

Governance and information management

Jersey CAMHS use an electronic recording system called FACE and some statistics are collated on a quarterly basis, although the services acknowledges that an updated version of this tool is required to provide the team with much needed data. The team also described a difficultly with data collection due to not having sufficient administrative support. It is imperative that a service has a systemised approach to recording activity, so that this can be monitored, ensuring that quality standards do not slip. It would be helpful if the team were to develop a dashboard; this would be a summary of performance data e.g referrals, time waited from referral to treatment etc. This system would measure, monitor and manage information in order that the team becomes focussed on its activity to provide future strategy, goal setting, risk management and evidence to support any workforce increase. CAMHS can then transform from a reactive to a proactive service.

Referrals are accepted from any professional source and the panel were informed that referrals are accepted as soon as they arrive at CAMHS. There is provision for a referrer to discuss a referral with a 'Duty Officer', referrals are triaged and if considered routine are put aside to be discussed in the weekly team meeting. This creates a potential delay in the process, in addition CAMHS should not 'own' referrals until they are clear that the problem can be treated by the service. Therefore the referrer should still be responsible for the referral until an agreement for assessment by CAMHS is given.

Consideration of the pressures unique to Jersey as an island should be actively addressed. There is not the scope of services in Jersey as there is on the mainland and as previously mentioned there are challenges around recruiting to an appropriately skilled workforce. However there are also distinct advantages to smaller services by creating flexibility, exploring opportunity for integrated pathways and encouraging a culture of inclusivity and transparency. A specialist approach to managing mental health problems in CYPF should be provided through effective multi-agency working across the children's directorate, education services and the voluntary sector. This approach should be informed by arising and changing need in order to provide services that are accessible and delivered by an adequate and skilled workforce. In the Health and Social Services White Paper (2012) there is an expectation declared that services will wrap around each other to ensure a robust service to CYPF.

Ensuring that the service is mindful of quality will support this approach. One of the Consultant Psychiatrists currently leads on audit and this activity is already in place within the team. How audit findings are disseminated and implemented are not so clear. Yet having this ethos of learning is a positive aspect. The team also use outcome measures, an example of which is 'strengths and difficulties questionnaire', this is good practice. Expanding the suite of outcome measures will be advantageous, as understanding CYPF progress and experiences of services can be used to improve practice and the service.

Recommendations

- Demand and capacity management model to be introduced
    - 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. 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.
- Training programme for workforce which is reflective of demand
    - 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.
- Affiliation to a national body such as CAMHS Outcomes Research Consortium (CORC)
    - CORC provide a suite of measures and will assist with training and implementation

    - The team can benchmark, receive training for staff and ensure that an outcomes approach is central to service provision

- Quality management and standard setting.
    - 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.
    - 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.
    - Establishing a clear relationship with the Safeguarding Board can be built into the framework, to strengthen accountability and the governance framework
    - Development of information sharing protocols which link together various services with defined working together agreements and pathways including a communications strategy.
- Referral pathway
    - 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
    - Refreshing referral paperwork and consideration of making this accessible online
- Develop evidence about teams performance
    - 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 e.g an acceptable waiting time for first appointment and a reporting mechanism.
- Ensure all staff understand and communicate the scope of confidentiality agreements with CYPF
    - Confidentiality agreements are in place in each CYPF clinical file
    - Staff are au fait with Fraser guidelines
- Statutory versus private work
    - 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.
- Development of a detailed action plan

- 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

Early Intervention/ tiers 1 and 2

There is a finite resource for providing early help and early intervention for emotional wellbeing and mental health problems for CYPF in Jersey. This responsibility does not just lay with specialist CAMHS. CAMHS should not be a standalone service when it comes to emotional problems and a positive approach to providing a strategy which embraces understanding of emotional wellbeing is wider than just statutory health services. The involvement of adult mental health, community, voluntary sector, social care, primary care, education and youth justice services in order to develop strong partnerships and proactively support CYPF assisting with the early detection of emerging needs. As discussed in the MIND report (2006), there are benefits to using a Primary Mental Health Worker model to provide an education, consultation and training approach and the liaison role with external providers.

Jersey CAMHS currently provides a degree of input for mild to moderate and emerging mental health problems. Many of the schools have counsellors who have supervision provided by CAMHS. There is opportunity to develop this into a model of consultation and liaison where specialists provide support to these individuals rather than providing direct work. Educational Psychology input is provided on the island but the relationship between this service and CAMHS needs to be better defined in order to embrace early identification and preventative work and exploit the obvious opportunity to utilise both services for the benefit of CYPF. CAMHS currently provide clinical supervision to school counsellors who are resident in many of the high schools, this seems to be a historic arrangement. Specialist CAMHS need to better define their role in relation to tiers 1 and 2 and the service they provide and then stick with this offer which should be based on enabling primary care and education staff to support CYPF with emerging problems.

CYP Improving Access to Psychological Therapies (IAPT) advocates outcomes focussed stepped care approach, this is also endorsed by NICE. A stepped care approach works across the CAMHS tiers and is CYP driven and attends to outcomes. CYP who have emerging or are vulnerable to emotional health and wellbeing problems are targeted at the earliest opportunity and are supported by a range of services collaborating together in order that the CYP receives intervention from the right person, at the right time and in the right place. Many times this means developing an integrated approach with the school workforce. CYP spend a lot of time in education environments and education staff are in a key position to identify emerging problems and tackle them early. Emotional and mental health problems can be targeted early through a collaborative early intervention approach and then if necessary stepped up to Specialist CAMHS.

Recommendations

- Identify early intervention and early help for CYPF
    - Map the resources across Jersey who contribute to CYPF emotional health and wellbeing to understand the pathways and resources currently available
- Refresh the working arrangements between Education Psychology and Specialist CAMHS

    - Explore the potential for team 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 working across agency boundaries and within a variety of settings
- Supporting schools and primary care
    - 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
- Ensuring accessibility and provision for individuals who have additional needs
    - For example those with 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
- Development of self-harm and risk of suicide guidelines
    - A multi-agency protocol should be 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
- Development of a stepped care model
    - 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

Emergency access & inpatient provision

Specialist CAMHS rarely send a young person off the island for the purpose of tier 4 admission. This is positive due to the negative social and developmental effects that an external placement can have on a child or young person. However the team rely strongly on the paediatric ward to accommodate young people who are identified as at risk. There are good relationships between the paediatric ward team and specialist CAMHS with the ward sister attending meetings at CAMHS on a weekly basis. The ward team reported that on occasion young people are accommodated for considerable amounts of time. This has been challenging for the ward staff who are not mental health trained yet do have to manage observation and intervention with children and young people who fall under the remit of CAMHS. There is limited amount of agency nursing or bank nurses to support this. The ward itself is not set up to accommodate children/young people with mental health problems for a variety of reasons which include difficulty in observing due to layout of the ward, physical health problems of other children on the ward and in addition the age range which the ward serves. There is a documented pathway in place between CAMHS and the paediatric departments dated 2012 and this process includes provision of a CAMHS worker ‘oncall’ for 2 hours per week everyday including weekends and bank holidays. This system appears to work well except when psychiatrist advice is required. There was inconsistency of opinion from CAMHS and Acute, of the quality of the response from CAMHS and paediatrics regarding this support out of hours, with overall view that it was

dependent on who was on call impacting on the type of support the ward received. A review of the working arrangements around oncall and the use of the paediatric ward is needed and a risk plan developed to clearly indicate plans to reduce and /or mitigate risks should they arise. There has been a suggestion by CAMHS that a new pathway is developed for 16 – 18 year olds, this needs to be developed in collaboration with representatives from paediatrics, CAMHS and adult mental health.

Recommendations

- Communication and relationships
    - The liaison role between the ward sister and CAMHS should continue
    - The protocol should be refreshed and relaunched 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
- The consideration of a Registered Nurse for mental health to be employed to be ward based
    - This role could oversee CAMHS patient risk management plans and provide consultation, supervision and training to ward staff
- The implementation of risk training for all staff
    - 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
- Development of a joint risk plan between paediatrics and CAMHS so that all the potential and actual risks are identified
    - This should be jointly agreed with supporting paperwork so plans can be written up and shared with professionals and families

Conclusion

Comprehensive CAMHS in Jersey should be provided through effective multi-agency practice in order to provide services that are accessible and delivered by an adequate and skilled workforce. The CAMHS offer should reflect local need and changing demand. Interventions related to prevention and early intervention are a priority and need to be available to all CYPF but not be just the jurisdiction of Specialist CAMHS (tier 3). All services who work with children and young people should consider their role in the support of the emotional wellbeing and mental health of children in Jersey. Future development of services should focus on the need for the development of specialist health promotion initiatives and early intervention directed at the mental health and emotional wellbeing of CYPF in Jersey and owned by all those who work and associate with children.

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