STATES OF JERSEY

MENTAL HEALTH STRATEGY (2016 – 2020): PLANNING TOGETHER, FOR OUR FUTURE

Presented to the States on 17th November 2015
by the Minister for Health and Social Services

STATES GREFFE

2015 Price code: H R.122

REPORT

Ministerial Foreword

Mental health and wellbeing really is everyone's business. Jersey is no different. We know that –

- one in 4 people will experience a mental health problem at some point in their lifetime; one in 6 adults have a mental health problem at any one time
- one in 10 children aged between 5 and 16 years has a mental health problem; many continue to have mental health problems into adulthood
- among people under 65, nearly half of all ill-health is mental illness.

In other words, nearly as much ill-health is mental illness as all physical illnesses put together. There really is no health without mental health.

Mental health problems can have a wide-ranging impact for individuals in a number of areas of their lives, including: housing, education, training, physical health and relationships with family and friends. It affects people of all ages and cultural backgrounds.

Investment has already been made to improve and develop services, but addressing the impact of mental ill-health and emphasizing the importance of mental wellbeing for citizens, for local services and for the economy of our Island continues to be a priority.

This strategy sets out our vision for –

- promoting mental wellbeing
- preventing mental ill-health
- for services that will most effectively meet the needs of people with mental health conditions which can assist them in their recovery.

It identifies the areas for change needed across Jersey so that we can ensure high quality mental health services for Islanders, no matter when they need them.

As the ministerial team for Health and Social Services, we know that there has already been a considerable amount of work undertaken in producing this Strategy. We would like to thank everyone involved in contributing to its contents, and look forward to their support in the future as we begin the journey of implementation. With your help we are confident we can make a positive difference to people's lives.

Senator A.K.F. Green, M.B.E.	Minister for Health and Social Services
Deputy P.D. McLinton of St. Saviour	Assistant Minister for Health and Social Services
Connétable J.M. Refault of St. Peter	Assistant Minister for Health and Social Services

Executive Summary

In 2012 the States Assembly endorsed the Strategic Plan for Health and Social Services called: *Health and Social Services: A New Way Forward* (P.82/2012). The vision described an integrated health and social care system and a programme of change that will meet the challenges facing the Island's Health and Social Services, whereby services are safe, sustainable and affordable; and where –

- Services are 'wrapped around the individual', with a single point of access for patients/service users and for care professionals, and individuals making informed choices and caring for themselves as much as possible.

- More health and social care services are available in individuals' homes, and in community and primary care settings, with services provided by a range of professionals and care designed for the individual.

- Efficient, effective, productive, integrated care which is received in the most appropriate place, provided by the most appropriate professional.

- Telehealth, telecare and telemedicine as part of an integrated set of services.

- Improved identification of those individuals who are in need or at risk, with a holistic assessment of health and social care needs.

- Care provided in less institutional settings, including an increase in fostering for children.

- Improved value for money and robust contract management. Services available from a greater range of organisations, with the Voluntary and Community Sector and other providers having opportunities to provide more care, and individuals having more choice and control over the care they receive.

- A workforce which is better developed and deployed, with more services available locally wherever practical and affordable. Patients will be encouraged to support one another, and individuals will receive care from a range of professionals, including therapists and nurses.

As part of this transformation programme, a system-wide review of mental health services has been conducted using innovative participatory approaches, which have included –

- a Citizens' Panel to identify key building blocks for the future system

- 'Action Learning Sets' of frontline practitioners and service users to identify practice challenges

- customer voice exercises, which enabled people who have used services to describe what went well and what could have gone better

- a system-wide engagement event, which used participatory approaches such as 'open space' to test and endorse the findings of the review process.

These approaches have led to new insights into the challenges facing mental health. The different dimensions of these challenges were summarized in 9 emerging themes –

- securing joint working across the mental health system
- developing the workforce
- awareness-raising, prevention, early help and support for young people and children
- improving the money-flow in the system to follow the service user
- enabling workplace mental health interventions
- building educational approaches to recovery
- improving the service environment
- developing mental health services in the criminal justice system
- establishing outcomes, quality and measurement
- culture and leadership.

This work has informed the development of 5 priorities of the Mental Health Strategy, which offers a comprehensive strategic direction for future whole system development –

1. Social Inclusion and Recovery
2. Prevention and Early Intervention
3. Service Access, care co-ordination and continuity of care
4. Quality Improvement and Innovation
5. Leadership and accountability.

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SECTION ONE

Here and now

1.1 Introduction

This Mental Health Strategy identifies 5 high-level priorities for –

- promoting mental wellbeing
- preventing mental ill-health
- delivering services that will most effectively meet the needs of people with mental health conditions.

Building upon evidence and views gathered from practitioners, from service users and using innovative methods of public and service engagement, it sets out the challenges and the proposed transformation of services and support.

Jersey has a continuously changing population profile. The overall population is predicted to continue to grow over the next 10–15 years. Within that growth are some important trends, in particular that by 2030 the number of people aged 85 or over will have more than doubled. In the same timeframe, the number of people aged 65 or over will comprise just over 23% of the total population of the Island..

One in 4 people will experience a mental health problem at some point in their lifetime; and one in 6 adults have a mental health problem at any one time.[1] One in 10 children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.[2] Among people under 65, nearly half of all ill-health is mental illness. In other words, nearly as much ill-health is mental illness as all physical illnesses put together.[3] People with severe mental illnesses die on average 20 years earlier than the general population.[4] The increase in people living longer is likely to see an increase in the number of people living with dementia, as well as other long-term limiting conditions.

50% of lifetime mental health problems have already developed by the age of 14.[5] The transitions from childhood to adulthood and then to older age are all important stages in an individual's life, perhaps even more so if they experience mental health problems.

A large body of evidence now ties experiences in early childhood with health throughout life, particularly in adulthood.[6] Strong evidence also demonstrates that it is possible to turn vicious cycles into paths to health, by intervening early.[7]

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[1]McManus S., Meltzer H., Brugha T. *et al.* (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* Leeds: NHS Information centre for health and social care.

[2]Green H., McGinnity A., Meltzer H. *et al.* (2005) *Mental Health of Children and Young People in Great Britain, 2004* Basingstoke: Palgrave Macmillan.

[3]The Centre for Economic Performance's Mental Health Policy Group (2012) *How Mental illness loses out in the NHS:* London School of Economics.

[4] No Health without Mental Health, Department of Health 2011.

[5] No Health without Mental Health, presentation, O'Connor, Dr. S. RCPsych.

[6] *Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America.* Braveman P. and Egerter S. for the Robert Wood Johnson Foundation, 2008.

[7] Issue brief 1: early childhood experiences and health, Braveman P. for the Robert Wood Johnson Foundation, 2008.

Identifying and addressing mental and physical health needs in early years and with children and young people will help lay the foundations for improved wellbeing and reduce reliance on statutory services later in life.

Mental health problems can have a wide-ranging impact for individuals in a number of areas of their lives, including: housing, employment, education, training, physical health and relationships with family and friends. It affects people of all ages and cultural backgrounds.

Mental health problems in Jersey are present across all sectors of the population. Some of the determinants of mental ill-health are also significant across the Island. These include high levels of alcohol use, misuse of substances, social isolation and access to employment and housing.

This highlights the need to ensure that through this Strategy and its intentions, the aim should be to identify and where appropriate, address the needs of all sections of the population.

The importance of public mental health and wellbeing is now well recognized to prevent mental ill-health through population-based interventions to –

- reduce risk and promote protective, evidence-based interventions to improve physical and mental wellbeing
- create flourishing, connected individuals, families and communities.[8]
- develop population-based interventions to create conditions that promote mental health and wellbeing that enhance population wellbeing in general and reduce incidence of mental health problems more effectively then interventions targeted only at at-risk/vulnerable individuals.[9]

As well as adopting a life-course approach, this Strategy is about how the other departments, service users and the citizens of Jersey can work together to promote and improve wider public mental health and wellbeing, reduce stigma and discrimination and achieve greater equity between mental and physical health. The Strategy reflects these changes; the local imperatives as well as the policy and legislative requirements placed on health and social care.

The development of a Mental Health Strategy, which includes wellbeing, is the start of a process of development, innovation and delivery that will help to –

- promote population mental health and wellbeing
- improve the range of and access to mental health services
- achieve States of Jersey policy imperatives
- deliver good outcomes and improved value.

[8] No Health without Mental Health, Department of Health, 2011.
[9] A new approach to reducing disorder and improving wellbeing – Perspectives on Psychological Science 4 (10):108-111 Huppert, F. 2009.

The priorities identified within the Strategy have been informed by other parts of the Health and Social Services transformation programme which include the 'Out of Hospital' System, Sustainable Primary Care and the Acute Services Strategy. Joint working established during the Strategy development period will continue into the implementation planning. In addition, the mental health legislative and estate programme plan has also been an integral part of the Strategy development process.

The Strategy has been delivered at a time of financial constraint in Jersey. The costs of mental health services and the ongoing pressure on public finances mean that all services will continue to be scrutinised for value for money as well as clinical effectiveness. To deliver effective mental health services, the Health and Social Services Department (HSSD) will develop its focus on what delivers the best outcomes, and from that make informed decisions about how best to invest the resources available. HSSD will work together with its partners to review our spending, but retain a focus on improving mental health services across Jersey.

1.2 Policy and legislative précis

In conducting the review and in developing this Strategy, consideration has been paid to a number of policy and reform objectives and imperatives. A short précis of the relevant areas is set out here. It is not an exhaustive list, but is intended to provide a broad view of the policy context.

Health and Social Services: A New Way Forward – P.82/2012

In common with jurisdictions and countries across the world, Jersey faces significant challenges in ensuring the availability of high-quality health and social care within a financially affordable sum. There are also some unique challenges, for example workforce pressures, limited services in the community, clinical viability and cost pressures due to diseconomies of scale. All health and social care systems are reforming and changing to meet the challenges of demand, cost and quality. In addition to this, all systems are spending increasing amounts year on year, on health and social care.

Health and social care services are continually developing in order to improve quality and maintain safety. However, changes will not be able to keep pace with increases in demand, due to a combination of significant ongoing funding pressures and the scale of challenges which Jersey faces in the next 10 years. A system-wide view is required, with significant strategic service investment.

P.82/2012 describes the vision of a health and social care system for Jersey which is safe, sustainable and affordable. This followed the publication of R.63/2011: *Health and Social Services Review May 2011: Caring for each other, Caring for ourselves – Consultation Paper*, presented to the States on 31st May 2011; and R.82/2012: *Health and Social Services White Paper: Caring for each other, Caring for ourselves – Public consultation*, presented to the States on 26th June 2012.

Those 2 documents outlined the agreed strategic principles and the proposed key investments in service and system redesign required to meet the existing and future known service gaps and challenges.

In particular, P.82/2012 made the case for delivering more health and social care services in community and primary care settings. It also advocated for multi-disciplinary services where teams are comprised of a range of professionals, with a focus on a more holistic approach to assessment, and interventions and services that are evidence-based, efficient, effective, productive, integrated and provided in the right setting by the right people.

P.82/2012 has already brought about investment directly into mental health services with the establishment of Jersey Talking Therapies and a service redesign of Alcohol Services.

An implementation plan has also been agreed for the development of community mental health services for older people, including those with dementia.

There has also been investment in children's early intervention services delivered by Health Visitors during the first few years of childhood.

Jersey Talking Therapies is a new service offering psychological therapies for people over the age of 18 years who feel anxious, worried, low or sad. This can include people who have issues such as depression, anxiety, obsessive compulsive disorder, phobias, panic and post-traumatic stress disorder or are drinking up to 15 units of alcohol daily.

The redesigned alcohol service is now able to offer increased opportunities for detoxification and relapse services in non-hospital settings, and has extended the choice and increased the efficacy of relapse prevention programmes available to people recovering from alcohol dependence.

'Maternal Early Childhood Sustained Home Visiting' improves child and maternal health and wellbeing by providing a structured, evidenced-based programme of sustained support in the home for families at risk of poorer maternal and child health and development outcomes.

The full document can be found at:

http://www.statesassembly.gov.je/AssemblyPropositions/2012/P.082-2012.pdf

Sustainable Primary Care

In the adoption of P.82/2012 the States Assembly agreed –

> "*to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval –*
>
> *(i)* ……
>
> ***(ii) proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists) …***".

The demands on health and social services are changing. The growing number of older people, the rising demand for Children's Adolescent Mental Health Services and mental health services are recognised as requiring a new approach to the provision of primary (as well as secondary) care services. In particular, a new approach must deliver care,

treatment and support closer to home, enable people to be independent and exercise choice and control over that care.

The development of a Primary Care Strategy and a new model of primary care that are to be safe, sustainable and affordable, offering value for money, is a central element of reform.

The Sustainable Primary Care Programme will set out a vision for the future that includes –

- An inclusive registration system

- Funding mechanisms that have long-term viability, support and incentivise the provision of care out-of-hospital, optimise access and equality, and give value for money for the States and for Islanders

- A flexible workforce model designed to deliver high-quality care across integrated care pathways, with the right staff and teams providing modern, accessible care in the right locations

- Information Technology that facilities an Integrated Care Record and provides data to support clinical decision-making and assessment of quality, including patient-reported quality outcome measures.

By January 2015 a set of 'principles' for sustainable Primary Care had been produced through a series of workshops that took place in the latter part of 2014. Work is now ongoing to develop the strategy, by identifying the elements of a new model for Primary Care.

The next steps of the programme include modelling different scenarios based on the agreed principles. The results of this work will generate insights as to the strengths and weaknesses of particular scenarios and inform future service models. The Strategy will be completed by the end of August, with a public consultation following in the autumn of 2015.

The "Out of Hospital" System (OOH)

The concept of the "Out of Hospital" system is a direct result of P.82/2012. The overarching aim is deliver a person-centred approach which –

- enables people to stay in their own homes
- increases people's quality of life and independence
- reduces demand on hospital and long-term care beds
- improves clinical outcomes
- delivers value for money.

Services are promoted through partnerships, including primary care, community voluntary sector and statutory services. The benefits of such an approach are twofold, in that it builds greater community resilience and reduces individual dependence on services. In time, services will be able to focus on those who need them most; this reduces demand for building-based services, including institutional forms of care and support, such as hospital, residential and nursing home services.

The next steps for this service development will be to include elements of mental health services which will integrate into the service model. In the first instance, this will include the Older Adult Mental Health Liaison Service, followed by integrated pathway development in long-term conditions which will address people with co-morbidities including depression, anxiety and dementia.

The Future Hospital Project

The States of Jersey has considered the options for change and consulted with Islanders about the way forward. The Future Hospital Project is taking forward a series of plans for redevelopment of the Hospital.

As part of the development of the Future Hospital, mental health issues are being carefully considered. For example, the project is committed to dementia-friendly wards; the Emergency Department will have facilities to provide a place of safety for vulnerable children and adults to be assessed and helped to access appropriate services.

Community Social Services Estates Planning

The provision of safe, suitable accommodation from which services operate has been acknowledged as an area that requires development in Jersey. A series of proposals and plans are in train to address particular service needs, most of which require some degree of capital investment in order to be realised.

The need to re-provide the existing adult acute inpatient service in more suitable accommodation has been identified as a priority. The option of co-location with older adult inpatient service provision is being explored. Alongside this there are also proposals for the relocation of day services for people with dementia, and through vacation and refurbishment, the provision of updated accommodation for some community teams.

A detailed mental health estates strategy will be developed that will identify the longer-term mental health inpatient and community services requirements in relation to buildings and office accommodation.

Regulation of Care Law: proposals

In 2006 the States of Jersey acknowledged that the current legislation regulating health and social care was outdated and no longer fit for purpose.

It is proposed that the existing legislative framework for the regulation of health and social care in Jersey should be replaced with a single enabling Law, supported by specific Regulations and codes of practice.

This will provide clear, modern definitions of regulated activities and provide for the comprehensive regulation of nursing agencies, domiciliary and primary care, including care provided by the States, within the same framework. It will require those managing services or working with people in need of health and social care to have appropriate qualities, skills and expertise to be safe and competent practitioners. It will also enable clear, comprehensive and enforceable standards to be set for the provision of different types of care to be set.

The Law will establish a new independent Commission that will command public confidence to regulate the provision of health and social care and promote improvements in standards of care. The Commission will be established in 2016 and will lead a phased implementation of regulatory reform.[10]

Long-Term Care Benefit

Jersey faces a substantial increase in both the number and proportion of older residents over the next 30 years, with care costs predicted to more than double by 2044. The introduction of a Long-Term Care Scheme was designed to share long-term care costs more fairly across the community; and the scheme established a clear and simple process to help individuals and their families understand the choices available and plan for the cost of long-term care.

The scheme provides financial support to Jersey residents who have significant long-term care needs and who are being cared for either in their own home or in a care home.[11]

A considerable number of claimants for this new benefit will have mental health needs and will qualify for the benefit. It is important that support is in place for people to realise the opportunity of constructing a package of care that is personalised to them. This represents a significant shift in service provision and learning for claimants and service providers remains ongoing.

Mental Health Law review and capacity law

Jersey's Mental Health Law is currently being reviewed. During the next 2½ years HSSD will be working with the Law Officers' Department (LOD) to deliver both a new Mental Health Law and a Mental Capacity Law.

There is a recognised need for fit-for-purpose legislation which can address the deficits of the existing Mental Health (Jersey) Law 1969 and the Criminal Justice (Insane Persons) (Jersey) Law 1964 (the "1964 Law"), alongside an urgent need for Jersey to comply with the European Convention on Human Rights (Right to liberty). There is also a need for appropriate powers for courts to deal with cases involving Mentally Disordered Offenders ("MDOs") and to replace the 1964 Law.

The proposed new Mental Health Law has a number of key guiding principles –

- The establishment of new definitions and roles to ensure higher standards of care and better decision-making.
- Nominated Representatives and Nearest Relatives to give greater choice, but ensure efficacy of the Law.
- Compulsory detention for treatment revised to provide new, shorter time periods before each review of detention giving better protection for those detained.
- Changes to leave of absence to encourage recovery and increased treatment in the community, subject to appropriate safeguards.

[10] Regulation of Care Law: proposals, States of Jersey, May 2013.
[11] Long-Term Care (States Contribution) (Jersey) Regulations 2013.

- Express provision about consent to treatment and safeguards on compulsory treatment to provide greater clarity for professionals and better protection for vulnerable patients.
- Provision for mental disordered offenders and replacement of the Criminal Justice (Insane Persons) (Jersey) Law 1964 to provide appropriate powers for the Courts to divert people from the criminal justice system where appropriate.
- Continuing the role of the Mental Health Review Tribunal and maintaining and enhancing existing safeguards.

There has been no legislative framework to assess and support people who lose capacity in accordance with their human rights, and the development of a Mental Capacity Law will address this gap.

The Capacity Law has a number of guiding principles –

- Test for assessing capacity and best interests to ensure better and more consistent decision-making.
- Lasting Powers of Attorney (LPA) to enable people to plan for their future.
- Powers for the Royal Court to make decisions and appoint delegates, thus enabling decisions to be made in contentious cases and where there is an absence of an LPA.
- Advanced decision to refuse treatment to provide better protection for patients and guidance for staff, and respecting people's wishes and dignity.
- Clarifying when restraint can be used, thus ensuring human rights compliance and providing greater safeguards for patients and staff.
- Capacity and Liberty (CAL) assessments and authorisations, thus ensuring human rights compliance and safeguards for patients and staff.
- Wilful neglect and ill-treatment, introducing a new offence that will provide more comprehensive protection for vulnerable people.

The developing and drafting of the legislation is ongoing and a significant body of work remains to be undertaken. At present, it is anticipated that both pieces of legislation will be enacted by spring 2018.

The Independent Jersey Care Inquiry

The Independent Jersey Care Inquiry has been set up to establish what went wrong in the Island's care system over many years and to find answers for people who suffered abuse as children.

The hearings will be held in public, although at times the Panel may hear evidence in private session. The hearings will start in due course, once all necessary arrangements are in place. At present the Inquiry Team is collecting evidence from potential witnesses. These include people who were in care, those who worked in Jersey care services or came into contact with them, whatever their perspective.

The Inquiry Panel wants to build up as full a picture as possible so that it can then be in a position to make recommendations, ensuring that the Island's care system is fit for its purpose of caring for vulnerable children and young people.

One of the key tasks for the Independent Care Inquiry that is set out in its terms of reference is to set out what lessons can be learned for the current system of residential and foster care services in Jersey, and for third-party providers of services for children and young people in the Island.

In addition, the Independent Care Inquiry is also required to report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster-care and other establishments run by the States, and whether these issues affect the safety of children in the future.

Recent reports that link to this Strategy

Suicide Prevention – A Strategic Framework for Action

As a cause of early death, suicide represents a real public health problem for our community. Many more years of life are lost by suicide than other more common causes of death that tend to occur later in life.

The framework acknowledges that suicide is not an inevitable outcome and that it can be prevented. This document scopes the nature and size of the issue of suicide in Jersey and proposes ways of reducing it. It recognises that the prevention of suicide is a shared responsibility, requiring a breadth of sustained approaches and actions across services, agencies and the community.

It identifies 4 high-level objectives on which to base future actions:

Objective 1: Improve mental health and wellbeing in vulnerable groups.

Objective 2: Reduce stigma about suicidal feelings.

Objective 3: Reduce the risk of suicide in high-risk individuals.

Objective 4: Improve information and support to those bereaved or affected by suicide.

Further to Ministerial approval for the endorsement of the framework, an action plan will be developed and integrated into the implementation plan for the Mental Health Strategy.

Child and Adolescent Mental Health Services (CAMHS) – Scrutiny Report

In June 2014 the Health, Social Security and Housing Scrutiny Panel published the report of their review of CAMHS in Jersey. The Scrutiny Report built upon work undertaken by a specialist adviser who was commissioned to advise on improvements to services provided to children, young people and their families who need to access specialist CAMHS in Jersey. This followed on from a review conducted by the charity 'Young Minds' in 2006.

The Scrutiny Report required that a range of changes and improvements be taken forward, in particular these related to –

- Early intervention
- Emergency access and in-patient services
- Governance and information management.

The Scrutiny Panel also made 10 specific recommendations in the Report that directly addressed areas of concern in relation to gaps in service.

The full report can be found at –

http://www.statesassembly.gov.je/ScrutinyReports/2014/Report%20-%20CAMHS%20-%2016%20June%202014.pdf

In response to the Scrutiny Report, the CAMHS team spent a week working with experts in LEAN methodologies, with a view to redesigning the service. Partner agencies were involved in this process. The redesigned service model is now established and has led to significant improvements, including reducing waiting time for a first appointment, which has dropped from 14 weeks to under 3 weeks, and more efficient processing of referrals.

A range of clinical pathways have been developed to ensure that treatment is evidence-based and benchmarked to monitor the effectiveness and efficiency of the provision. Work has been completed to standardise questionnaires to monitor outcomes and satisfaction with the service. Planning is in place to benchmark the service against national outcome data through the CAMHS Outcomes Research Consortium (CORC).

Also being developed is a fully implemented Systemic Family Therapy service for children and young people with significant mental problems, and their families, so that therapeutic intervention can be targeted to all family members when required. The recommendations made by 'Young Minds' have now been implemented or superseded.

The Ministerial Response to the Scrutiny Report was published in July 2014 and can be found at –

http://www.statesassembly.gov.je/ScrutinyReports/2014/Ministerial%20Response%20-%20CAMHS%20-%2031%20July%202014.pdf

Disability in Jersey

A commitment to the development of a disability strategy was made by the States of Jersey in early 2014. Prior to that, a range of work is being conducted to establish the prevalence, profile and perceptions relating to disability through a focused research project. It has 3 main aims –

- To achieve an accurate set of data about the number and types of disability in Jersey.
- To understand more about the lives of Islanders with a disability.
- To identify the needs and aspirations of Islanders living with a disability.

This work is expected to be completed by October 2015, with a view to informing the Strategy, which is expected to be complete by early 2016.

Acute Services Strategy

This Strategy is part of "*Caring for each other, caring for ourselves*" and has been developed in the context of the changes described in the Future Hospital plans. It sets out proposals for the development of service models that will enable the delivery of acute care services to Islanders, drawing upon best practice examples, and has 3 core objectives –

- Avoiding patients being admitted to hospital when safe and effective alternatives can be provided.
- Treating patients as effectively and efficiently as possible when they are admitted.
- Discharging or transferring them in a timely way when they are ready to go home or to an 'out of hospital' service.

It is important that all parts of the community have equitable access to acute health care at time of need. Research evidence shows that people with enduring mental health problems have poorer health outcomes than comparative groups in the population. In addition, people with co-morbidities presented challenges to acute health care services where the focus remains on one particular area of health or illness.

1.3 Overview of the Current Mental Health System

In planning for the future and considering the priorities for change in relation to mental health services, it is important to consider a range of other associated information and data. In particular an understanding of the composition of the population, the demography and the current or predicted levels of prevalence for particular conditions is helpful when considering service development that can respond to those changes.

Population – demography

A census of the population of Jersey was held on 27th March 2011: the total resident population of the Island on this date was 97,857.

Table One – Population from 2011 Census

Age	Male	Female	Total
0	509	522	1,031
0 – 4	1,957	2,027	3,984
5 – 9	2,470	2,382	4,852
10 – 14	2,729	2,573	5,302
15 – 19	2,863	2,632	5,495
20 – 24	3,006	2,938	5,944
25 – 29	3,351	3,354	6,705
30 – 34	3,670	3,566	7,236
35 – 39	3,615	3,610	7,225
40 – 44	4,183	4,180	8,363
45 – 49	4,187	4,170	8,357
50 – 54	3,536	3,662	7,198
55 – 59	2,955	3,087	6,042
60 – 64	2,832	2,818	5,650

Age	Male	Female	Total
65 – 69	1,938	2,110	4,048
70 – 74	1,732	1,900	3,632
75 – 79	1,343	1,550	2,893
80 – 84	822	1,183	2,005
85 – 89	446	779	1,225
90 – 94	115	368	483
95+	37	150	187
Totals	**48,296**	**49,561**	**97,857**

Source: http://www.gov.je/Government/Census/Census2011/Pages/index.aspx

Table One shows that the largest population age-group is currently between 40–49 years. There are a greater proportion of females in the older age-groups (65+), which reflects the increased life expectancy of women over men at these ages, with particular pressure on mental health services for younger people and older adults.

Approximately 27% of the population of Jersey are under 25, and 16% of the population are aged 65 and over.[12]

The States of Jersey Statistics Unit estimate that the proportion aged 65 and over in the population will increase over the coming years, which will consequently increase demand on local health services.

Population density

Jersey has an area of 119.5 km^2 at high tide. This translates to a population density of 828 people per square kilometre in 2012. A third of the Island's population lived in St. Helier at the time of the Census.

Dependency ratio

The Jersey dependency ratio for year-end 2012 was 48%, meaning there are 48 dependent children and adults for every 100 of working age. Essentially, for every one child or person of pensionable age, there are 2 people of working age.

Under a population projection scenario, which maintains the current registered population, this ratio will increase to 66% in the medium term (2035). So, in future, Jersey is likely to have a higher proportion of dependent children and adults in its population (66 for every 100 of working age by 2035).[13]

Population growth

Table Two sets out the predicted growth in the population of Jersey up to 2030. It shows that by 2030 the number of people aged 85 or over will have more than doubled. Looking more broadly, the number of people aged 65 or over will have grown by over 10,000, and will comprise just over 23% of the total population of the Island. Those aged 15–64 will comprise just under 62% of the total population of the Island by 2030.

[12] Report on the 2011 Jersey Census – States of Jersey Statistics Unit 2012.
[13] Jersey's Resident Population – States of Jersey Statistics Unit 2012.

The total population of Jersey will increase by just over 8% by 2030 to 106,200, a growth of just over 8,000 people. This growth in population, and its pattern, highlights the challenges that public service reform in Jersey is designed to address.

Table Two

Population projected to 2030 – States of Jersey

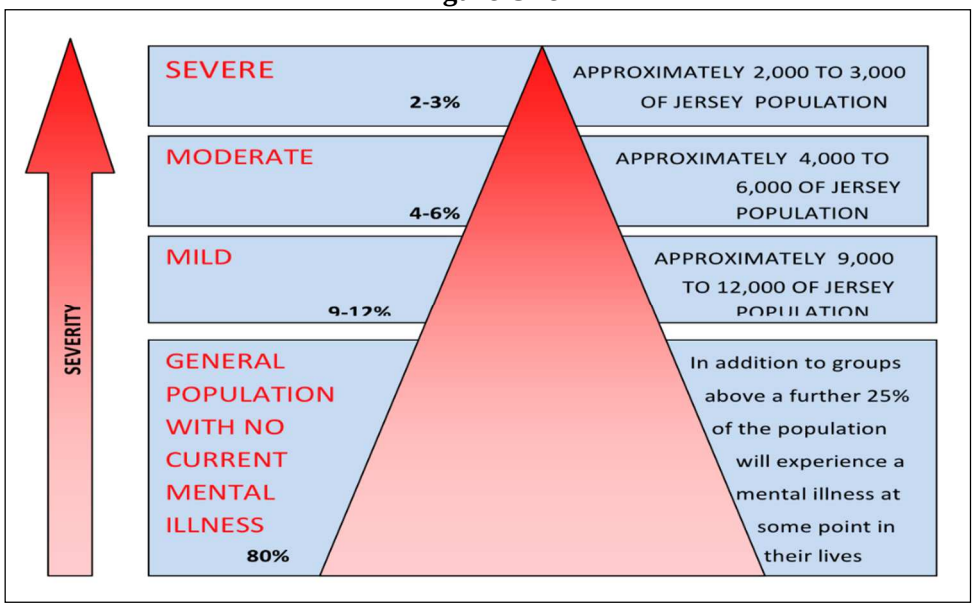
	2011	2015	2020	2025	2030
People aged 0 –14	15,169	15,800	15,900	15,600	15,300
People aged 15 – 24	11,439	11,300	11,300	11,300	11,600
People aged 25 – 34	13,941	13,100	12,900	13,000	12,700
People aged 35 – 44	15,588	14,500	14,000	13,600	13,600
People aged 45 – 54	15,555	16,400	15,100	14,000	13,800
People aged 55 – 64	11,692	12,700	14,400	15,200	14,100
People aged 65 – 74	7,680	9,000	10,300	11,200	12,900
People aged 75 – 84	4,898	5,500	5,900	7,200	8,200
People aged 85+	1,895	2,200	2,800	3,400	4,000
Total population aged 0 – 14	**15,169**	**15,800**	**15,900**	**15,600**	**15,300**
Total population aged 15 – 64	**68,215**	**68,000**	**67,700**	**67,100**	**65,800**
Total population aged 65 and above	**14,473**	**16,700**	**19,000**	**21,800**	**25,100**
Total population – all ages	**97,857**	**100,500**	**102,600**	**104,500**	**106,200**

Table Two – 2011 population data taken from the Census. All projections taken from States of Jersey Population Projections 2013 release

Estimates of future prevalence of mental illness

The figure below shows the estimated percentages and numbers of people who may experience mental illness in the population of Jersey over a 12-month period. This number is broken down by severity, based on diagnosis, disability and chronicity. The estimates of prevalence demonstrate the need to have a range of mental health services that can respond effectively to different levels of mental health need. It also shows the importance for integrated services to ensure that people have a smooth transition between different levels of service.

Figure One



Source: Contact Consulting (Oxford) Ltd. 2015 based on modelling used in COAG National Action Plan on Mental Health 2006–2011

Figure One shows that the majority of the Jersey population is not currently diagnosed with a definable mental illness. However, from that group statistically around a quarter may develop some form of mental illness at some stage in their life. This has been a factor in the development of preventative forms of care and the raising of awareness so that emerging mental illness can be identified. This enables early interventions to be provided to reduce longer-term reliance on statutory services. It also demonstrates that general practice is key in identifying emerging mental illness in the vast majority of the population.

Mild forms of mental ill-health may be present in around 12% of the population, and many of these cases will be supported by primary care. Where appropriate liaison with secondary care and other services is in place, this segment of the population should not require the sustained input of specialist services.

Mental ill-health at the moderate and severe tip of the diagram shows that a relatively small percentage of the population should experience mental illness that requires specialist intervention from secondary care services.

Overall, the figure shows that approximately 21,000 people may experience some form of mental ill-health at some point, highlighting the need for the right range of services to meet those needs.

Table Three

People aged 15 – 64 predicted to have a mental health problem, by age, projected to 2030, States of Jersey

	2011	2015	2020	2025	2030
People aged 15 – 64 predicted to have a common mental disorder	10,982	10,948	10,899	10,803	10,594
People aged 15 – 64 predicted to have a borderline personality disorder	307	306	305	302	296
People aged 15 – 64 predicted to have an antisocial personality disorder	239	238	237	235	230
People aged 15 – 64 predicted to have psychotic disorder	273	272	270	268	263
People aged 15 – 64 predicted to have two or more psychiatric disorders	4,911	4,896	4,874	4,831	4,737

In 2011 there were 10,982 people predicted to have a common mental health disorder, this figure is set to reduce by 3.5% in 2030 to 10,594. Whilst the predicted number of people to have a common mental health disorder reduces, the percentage of the total population within the same age range remains at a constant level at around 21%.

The trend illustrated by the figures within those people with a common mental health disorder is mirrored within the figures for those people predicted to have a borderline personality disorder. The reduction through the period 2011 to 2030 is slightly higher at 4% from 307 down to 296, but again given the reduction in the total population aged 15 – 64 in the same time period, the proportion of those predicted to have a borderline personality disorder remains constant and in line with this.

The pattern is repeated through the rest of the table, with reduced numbers of the population predicted to have a mental health problem through the period to 2030. This is counter-intuitive to the current demand for access to services if taken in isolation, but as has been shown, the reduction is in line with the projected reduction in the total population and therefore the demand as a percentage of that population remains the same.

Table Four

People aged 65 and over predicted to have depression, by age, projected to 2030, States of Jersey

	2011	2015	2020	2025	2030
People aged 65 – 74 predicted to have depression	635	745	852	927	1,067
People aged 75 – 84 predicted to have depression	435	488	524	639	728
People aged 85 and over predicted to have depression	154	178	227	275	324
Total population aged 65 and over predicted to have depression	**1,224**	**1,411**	**1,603**	**1,841**	**2,119**

The numbers is this table relate to predicted prevalence of mild to moderate depression.

An overall increase of 73% can be seen in those aged 65 and over predicted to have depression, rising from 1,224 people in 2011 to 2,119 in 2030.

The greatest increase in those predicted to have depression can be seen in the age cohort 85 years and over, showing an increase of 110% from 154 in 2011 to 324 in 2030.

The total number of those people aged 65 and over predicted to have depression stands at around 8% of the total population in the year 2011. Whilst there is an increase of those predicted to have depression in 2030, this figure stands at a little over 8% of the total population aged 65 and over in 2030, and is therefore a real terms constant level of demand between 2011 and 2030.

Table Five

People aged 65 and over predicted to have severe depression, by age, projected to 2030, States of Jersey

	2011	2015	2020	2025	2030
People aged 65 – 74 predicted to have severe depression	157	184	211	230	264
People aged 75 – 84 predicted to have severe depression	159	179	191	234	266
People aged 85 and over predicted to have severe depression	74	86	109	133	156
Total population aged 65 and over predicted to have severe depression	**389**	**449**	**511**	**597**	**686**

There is predicted to be a steady increase in those aged 65 and over to have severe depression between 2011 and 2030. The number of people over 65 years predicted to have severe depression was 389, with this number rising by just above 76% to 686 people in 2030.

The greatest overall rise can be found in those aged 85 and over, which shows a predicted rise of around 111% through the period 2011 to 2030.

A 26% rise is predicted for those aged over 85 in the period between 2015 and 2020. This is the single greatest increase that can be seen anywhere on the table of predictions.

The predicted increases shown in Tables Four and Five should also be seen in the wider context of the possible current or future usage of other forms of health and social care and the potential presence of co-morbidity (other health conditions experienced alongside mental ill-health). The parity of mental health in relation to physical health therefore comes into sharper focus when considering the likely rise in prevalence, and practitioners will need to be equipped to identify and meet these needs.

Table Six

People aged 65 and over predicted to have dementia, by age, projected to 2030

	2010	2015	2020	2025	2030
People aged 65 – 74 predicted to have dementia	229	258	311	316	354
People aged 75 – 84 predicted to have dementia	429	498	573	683	812
People aged 85 and over predicted to have dementia	489	566	730	936	1,181
Total population aged 65 and over predicted to have dementia	**1,147**	**1,322**	**1,614**	**1,935**	**2,347**

See footnote[14]

Rates for men and women with dementia are as follows:

Age range	% males	% females
65 – 69	1.5	1.0
70 – 74	3.1	2.4
75 – 79	5.1	6.5
80 – 85	10.2	13.3
85 – 89	16.7	22.2
90+	27.9	30.7

See footnote[15]

Table Six highlights a 104% increase between 2010 and 2030 in the population over 65 predicted to have dementia from 1,147 to 2,347. The increase in predicted numbers of those with dementia is also a real-term increase when measured against the total population for those aged 65 and over.

The age cohort that illustrates the most significant increase is within those aged 85 and over, where an increase of 141% can be seen from 489 to 1,181 between 2010 and 2030.

[14] Figures calculated using Jersey population model 2009 & Alzheimer's Research UK, Defeating Dementia statistics 2012.

[15] The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia, prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.
The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.
To calculate the prevalence rates for the 90+ population, rates from the research for the 90 – 94 and 95+ age-groups have been applied to the 2006 England population to calculate the numbers in each age-group; the sum of these groups is then expressed as a percentage of the total 90+ population to establish the predicted prevalence of the 90+ population as a whole.

Table Seven

People aged 15 – 65 predicted to have a drug or alcohol problem, by age, projected to 2030, States of Jersey

	2011	2015	2020	2025	2030
Total population aged 15 – 65 predicted to have alcohol dependence	4,092	4,080	4,062	4,026	3,945
Total population aged 15 – 65 predicted to be dependent on drugs	2,319	2,312	2,302	2,281	2,237

The table shows a decrease in the number of people predicted to have alcohol dependence from 4,092 in 2011 down to 3,945 in 2030. As a proportion of the total population, the number of people predicted to have alcohol dependence remains constant at around 3% throughout the same time period.

This pattern of projection is repeated within the table among those predicted to have a dependency on drugs, with the figures reducing through the time period, but remaining at a constant level when set alongside the total population projections.

Alcohol use has been recognised as a particular issue in Jersey, and the annual Alcohol Profile contains more detailed information about rates of drinking among the Island's population. Around 2% of all deaths annually are caused by deaths from alcohol-specific causes, such as alcoholic liver disease and alcohol poisoning, and account for around 300 years of life lost each year.

Deaths caused specifically by alcohol have increased in the past decade in Jersey. In 2012 there were 13 deaths from such causes. Over the past 3 years there has been an average of 12 alcohol-specific deaths each year, giving a death rate of 11.2 per 100,000 head of population (2010 – 2012). The majority of these deaths were due to chronic liver disease, accounting for 9.9 per 100,000 of the overall rate of 11.2 per 100,000.[16]

Co-morbidity

People with long-term physical health conditions who are often the most frequent users of health and social care services often experience mental health problems. This can lead to poorer health outcomes and reduced quality of life.[17]

Depression is 2 to 3 times more common in a range of cardio-vascular diseases. People with diabetes are 2 to 3 times more likely to have depression than the general population, and mental health problems are approximately 3 times more common among people with chronic obstructive pulmonary disease.[18]

[16] Alcohol Profile for Jersey, Health and Social Services, States of Jersey January 2014.
[17] Long-term conditions and mental health, The King's Fund 2012.
[18] *Ibid.*

In Jersey, 10% of the population has a long-term illness or condition that affects their day-to-day life. The top 3 causes of death in Jersey are ischemic heart disease, stroke and lung cancer.[19] This suggests that there is a high likelihood of significant co-morbidity in relation to mental ill-health. Given that mental health services in Jersey, as in many other places, are separate from physical health services, there remains a challenge in responding to mental health and physical health needs with any degree of parity.

Parity of esteem is a principle that is increasingly being adopted, whereby mental health is given the same priority as physical health. By doing this, the range of co-morbidities is more easily identified, and interventions that seek to support the whole person, rather than individual diseases or disorders, can be delivered.

Child sexual abuse, trauma and mental health

It is becoming clear, from the evidence presented by neuroscience, that it is experiences laid down throughout our childhood that provide the blueprint for our future mental and physical wellbeing. Emerging research[20] supports the case for the development and provision of mental health services that are trauma-informed. Key principles include, but are not limited to –

- Child sexual abuse (CSA) is linked to many mental health disorders, as well as self-harm and other non-psychiatric problems such as substance misuse; making lines of treatment diverse and requiring co-ordination.

- The likelihood of suffering from a mental illness in adulthood is increased 4 times if there is experience of CSA.

- Experience of multiple abuse or complex trauma in childhood can affect child development, with consequential impacts on health, educational achievement, and work and life chances.

- Personality disorder is increasingly associated with sexual abuse: 91% of patients with borderline personality disorder reported being sexually abused.[21]

- NICE Guidance on PTSD (2006) reported that 50% of people with simple trauma had co-morbid affective disorders, anxiety and substance misuse.

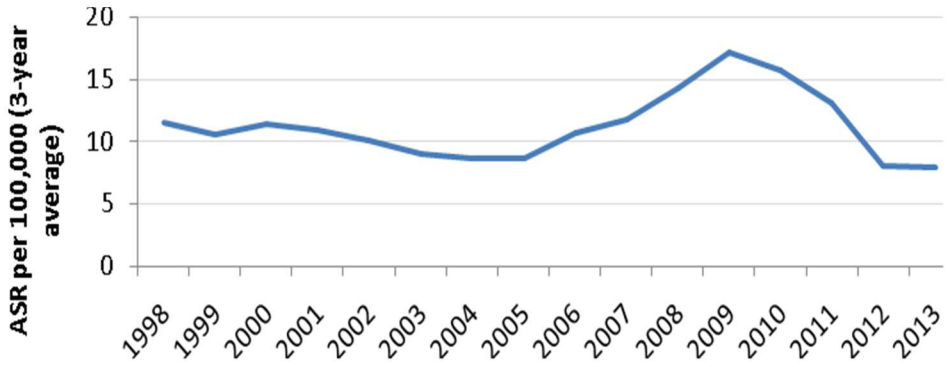
- Professionals working with children and young people and with adults with a mental illness need to sensitively and routinely enquire about patients' experience of trauma and be confident that, when necessary, they can respond in a ways that are helpful and healing.

[19] Jersey Annual Health Profile 2014.
[20] National Centre Social Research: 2014: Violence, Abuse and Mental Health in England: Preliminary Evidence Briefing.
[21] (Zannarini Et al, 1997, 2000).

Suicide

Graph One shows the rate of suicide in Jersey from 1998 to 2012, using 3-year rolling averages. This shows a peak in suicides in 2009 (17 per 100,000), which then reduces between 2010 and 2013 (8 per 100,000). Due to Jersey's small population, suicide rates can fluctuate year to year. Three-year rolling averages are an average of the current year and the 2 previous years. Doing this allows trend data to be seen.

Graph One: Rate of suicide in Jersey from 1998 to 2012



The most recent rate for suicide in Jersey is 8 per 100,000. This is lower than the most recent available European rate, which was 12.3 per 100,000 in 2010.[22]

Community Mental Health Services – An overview of services

Throughout the review process, a range of data and information has been provided which describes different aspects of the community mental health services. This information has included –

- In-patient bed usage and length of stay information
- Community Mental Health Services
- G.P. prescribing for mental health
- Current capacity for Nursing and Residential Homes
- Overview of Mental Health Services Provided by Community Voluntary Sector mental
- System performance data ('Making Care Appropriate to Patients' Survey)
- Workforce information
- Financial information.

In this section, the data made available is presented and analysed to provide insight into trends or common themes, and to highlight issues relating to the performance or quality of services that have informed thinking about how to address gaps or build on strengths within the existing system.

[22] Preventing Suicide in Jersey: A Strategic Framework for Action (2015).

Adult Mental Health In-patient services

Orchard House is a 17-bed acute admissions Unit for adults (aged 17 – 65 years) experiencing acute mental illness or disorder. The Unit also provides in-patient support for people experiencing acute episodes of mental ill-health who are in H.M. Prison La Moye. Orchard House received a total of 180 admissions in a 12 month period, of which 59% (101) were male. In the same 12 month period there were 183 discharges. Overall the ward operated at 80% of capacity.

The majority of those admitted (59%) were directly from their usual place of residence, 26% from other wards or departments of H&SS, and 10% were admitted by the Police. The average length of stay was 2 – 3 weeks, but with a range from less than a day to 52 weeks. The majority (74%) were discharged to home.

Maison du Lac provides a daily therapeutic recovery-based programme of activities, tailored to meet the individual needs of people using in-patient facilities. No usage data has been supplied.

The Liaison Service received 583 referrals, of which 340 (58.3%) were from A&E, and only 15% from General Practitioners.

The Clairvale Recovery Unit with 10 beds received 36 admissions within the 12-month period and had 36 discharges, maintaining an average occupancy rate of 87%.

Older Adult Mental Health In-patient beds

Cedar Ward is a 14-bedded acute mental health unit providing an in-patient assessment service primarily for older adults with functional mental health needs. In the course of 12 months there were 58 admissions, of whom around two-thirds (37) were female. In the same 12-month period there were 47 discharges. These figures include 6 return admissions during the data capture period. The average length of stay at discharge was 103 days, representing a range from 3 days to 876 days. Whilst the average stay for female patients was shorter than for male, they made up the majority of those within the longest period.

The majority of patients discharged (51%) had a stay of 56 days or less, but there was a significant cluster (8%) with stays of 197 days or longer. Overall, the ward operated at 95% capacity. The majority of admissions (53%) and of discharges (55%) were from or to the patient's home address.

Beech Ward is a 10-bedded acute mental health unit providing assessment of dementia and cognitive impairment. Traditionally focused on patients 65 years of age or over, it currently focuses on presenting condition rather than age. In the course of 12 months there were 53 admissions, of which 58.5% were female. In the same period there were 41 discharges. These included 2 return assessment admissions. Two admissions were for respite care. Average length of stay (excluding respite stays which averaged 7 days) was 73 days, with a range from 3 to 286 days. The majority of patients had a stay of between 29 and 84 days. Overall, the ward operated at 99% of capacity.

The majority of admissions (56%) came from the patient's home address, with 22% coming from a General Hospital ward and 18% from community residential homes. Only 20% were discharged to home, with the largest number (32%) going to community residential homes, 24% going to Oak Ward and 12% to Maple Ward.

Maple Ward is a 16-bedded continuing care/intermediate care ward for individuals with complex mental health requirements, for whom return home or transfer to other long-term setting is not currently possible, due to the level of mental health support they require. In the course of 12 months there were 23 admissions, of whom around two-thirds (15) were female. In the same 12 months there were 11 discharges. These figures include one patient re-admitted during the period under study.

The average length of stay was 419 days, representing a range from 149 days to 1,427 days. Male patients had a substantially longer average stay at 526 days, compared with 312 for female patients, but this average may be distorted by a small number of male patients with very long stays. The majority of female patients spent between 6 months and a year on the ward. Overall the ward operated at 99% capacity.

The overwhelming majority (86%) of patients were admitted from a mental health assessment ward, with the remainder being admitted from a community nursing home. 22% of patients died whilst patients on Maple Ward, with a further 11% being discharged to General Hospital wards. 34% continued their care on Oak Ward and 22% in a community nursing home.

Oak Ward is a 26-bedded continuing care ward for individuals with complex mental health requirements, for whom return home or transfer to another long-term setting is not currently possible due to the level of mental health support they require. In the course of 12 months there were 32 admissions, of which around 60% (19) were female. In the same 12 months there were 10 discharges. There were 8 admissions for respite care; all of these were male patients. The average length of stay for those discharged during the year (excluding respite stays which averaged 7 days) was 312 days, with a range from 3 to 1,738 days.

The majority of patients had a stay of between 29 and 84 days. Overall the ward operated at 85% of capacity. The majority of admissions (69%) came from a mental health assessment ward, with 15% from General Hospital wards and 18% from Maple Ward.

Unlike the NHS, Jersey continues to provide continuing nursing care beds which extend stays within In-patient Units. When comparing the older people's assessment beds, Cedar Ward and Beech Ward, with the statistics from the NHS Benchmarking Network, the UK mean length of stay for older adult wards was 72 days, compared to 73 days in Beech Ward and 103 days in Cedar Ward.

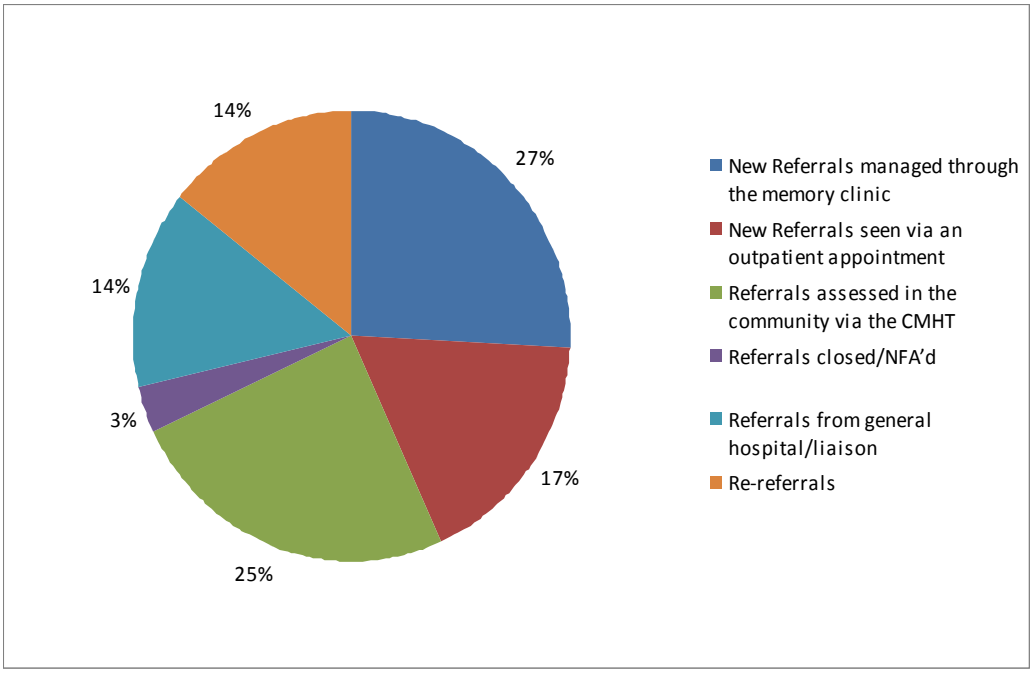
The data therefore suggests that the average length of stay is comparable. What it does not indicate is the appropriateness of ongoing provision of continuing nursing care within hospital environments.

Community Older Adult Mental Health service

The main function of the current multi-disciplinary team is to provide an integrated, whole-systems, person-centred assessment, treatment, care-planning, and ongoing management to older adults and their carers; either living in their own home or within a health service care setting. The memory assessment and diagnosis service is an integrated part of the team, with a focus on early diagnosis and support to families. The memory service is accredited by the Memory Service National Accreditation Programme (MSNAP).

The team works closely with G.P.s and other professionals to provide advice, information and training, to equip them with basic knowledge and skills to work with the service user group.

Graph 2: Referral activity to the Community Mental Health Older Adult services (June 2012 – June 2014)



Mental Health Liaison service

The Mental Health Liaison service offers early and timely assessment and interventions for people who are in crisis and experience mental health problems. The standard response time is within 30 minutes. The person will initially be assessed by a Registered Mental Health Nurse and, if required, supplemented by additional assessments from a Staff Grade Doctor, Consultant Psychiatrist and/or a Social Worker. The Liaison Service is accredited by the Royal College of Psychiatrists. In 2013 there were 563 new assessments made by the service, with 270 people attending follow-up appointments. There was an upward trend in referrals during 2014.

Table Eight

Sources and number of referrals for Mental Health Liaison service (2013)

Source of Referrals													
Referrer:	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
A&E Department	32	23	29	27	20	21	25	20	36	30	41	36	**340**
General Practitioner	7	8	6	7	5	11	9	8	2	5	7	13	**88**
Police	2	2	0	1	1	1	0	1	2	0	6	2	**18**
Emergency Assessment Unit or Jersey General Hospital	7	7	5	3	12	15	5	11	11	5	19	16	**116**
Other	1	0	1	1	0	2	3	1	2	6	4	0	**21**
Total	**49**	**40**	**41**	**39**	**38**	**50**	**42**	**41**	**53**	**46**	**77**	**67**	**583**

Community Mental Health team

The Community Adult Mental Health Team is composed of mental health professionals from medical, nursing, social work, occupational therapy and psychology backgrounds. The team is supported by an Operational Manager, Clinical Team Leader, Consultant Nurse and Clinical Lead (Medical).

People referred to the team are experiencing a range of mental health or emotional difficulties, such as anxiety, psychosis, bipolar disorder and depression. Referral is managed through the Single Point of Referral for Community Services. Routine referrals are managed through a weekly multi-disciplinary referral and allocation forum.

Table Nine

Source and number of referrals to Community Mental Health team (2013)

Referrer:	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
General Practitioner	39	42	41	36	29	27	43	28	32	29	46	24	**416**
Peri-natal	5	2	3	4	1	2	1	1	5	2	2	4	**32**
Medical Consultant	0	2	0	0	0	1	0	0	0	0	0	0	**3**
Psychology	0	0	0	1	1	3	0	0	2	1	0	2	**10**
General Hospital Wards	0	0	0	0	0	2	1	0	0	0	0	0	**3**
Prison	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Other	0	1	4	2	0	3	1	2	0	3	4	2	**22**
Total	**44**	**47**	**48**	**43**	**31**	**38**	**46**	**31**	**39**	**35**	**53**	**32**	**487**

Children and Adolescent Mental Health Services (CAMHS)

The statistical data available in relation to CAMHS is limited. In the year 2013, 446 referrals were received. Information suggests that the largest numbers of referrals came from adolescents from the age of 14 and 17; this cohort represents around three-quarters of the total referrals, and peaks among those who are 15 at the point of referral. Referrals among those between 6 and 10 years of age run in the low to middle-thirties for each age cohort, rising to mid-forties to 50 per year for those in each year of age from 11 to 13.

There appears to be some seasonal variation in referrals that may have a degree of convergence with the school year, but the data is too imprecise to draw a definite conclusion.

Primary Care Activity – Mental Health

Primary care has an important role to play in delivering mental health services. General Practitioners have been an important key gateway to services. An indicator of mental health activity in primary care has been the extent of prescribing for certain mental health conditions. In the future it is hoped that with better coding and integrated information technology systems, more detailed analysis of primary mental health care will be able to be identified.

Table Ten

Total number of prescription items dispensed for drugs used in mental health (2011 – 2014)

Total number of prescription items dispensed for drugs used in mental health										
Number of prescription items dispensed	**Alcohol dependence**	**Opioid dependence**	**Antipsychotics (including depot injections)**	**Drugs for mania/ hypomania**	**Antidepressants**	**Anxiolytics**	**Hypnotics**	**Drugs for dementia**	**TOTAL**	**% annual growth**
2011	416	27	5,229	1,620	76,333	15,292	27,383	2,986	**129,286**	
2012	426	39	5,451	1,591	81,240	15,683	25,256	3,725	**133,411**	**3.2%**
2013	507	16	5,815	1,561	87,427	16,367	25,042	4,036	**140,771**	**5.5%**
2014	628	10	6,408	1,605	91,053	15,587	23,044	4,607	**142,942**	**1.5%**

Jersey Talking Therapies (JTT)

This new service was launched in December 2014. The aim of JTT is to offer Islanders a service staffed with professionally trained therapists who will support them through a range of psychological therapies. Common mental health problems which someone might seek treatment for include anxiety, depression, obsessive compulsive disorder, phobias, issues to do with alcohol, and post-traumatic stress disorder. It is for people

aged 18 and over. Referrals to the new service began in September, and 740 referrals have been received so far, mainly from G.P.s, with an average of 54 referrals a week. To date, a total of 154 people have been successfully discharged, while others are receiving ongoing therapy.

Mental Health and a place of safety

In Jersey the Mental Health (Jersey) Law 1969, under Article 47, gives Police Officers the power to remove a person who appears to be suffering from a mental disorder and is in need of immediate care and control, and who is in a public place and is apparently a danger to him/herself or to other people, to a 'place of safety' where they may be assessed by a doctor. In Jersey there is no designated place of safety other than States Police Headquarters to detain people who are considered at risk of self-harm or harm to the Public.

In Jersey, mental health assessments are requested by Forensic Medical Examiners (FME) for detainees they consider to be in need of hospital treatment for either self-injurious behaviour or concerns regarding serious mental illness. H&SS provides a mental health assessment service 24 hours a day and can be contacted by the FME as required.

Care of the vulnerable in any society is a joint responsibility. The table below shows the rising number of vulnerable people being detained in Police custody as a place of safety.

Custody - place of safety	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2012	13	3	12	7	5	7	8	3	1	3	9	9	80
2013	5	4	3	2	5	6	8	11	6	2	7	7	66
2014	8	8	5	9	10	10	18	10	2	6	4		90
Total	26	15	20	18	20	23	34	24	9	11	20	16	236

In Jersey 90 people per 100,000 head of population were removed to a place of safety in 2014, whilst in England during 2014, 42 people per 100,000 were removed to a place of safety.[23]

Return to work initiatives

The Social Security Department helps jobseekers back into work and aims to improve the prospects of finding sustainable work for all people, including those with poor mental health. The Department recognises that being out of work is detrimental to health and wellbeing, and its policies reflect the additional barriers faced by people with a mental illness.

The 'Work Right' and 'Occupational Support Unit' support jobseekers with significant employment barriers. The teams work in partnership with other agencies such as Jersey Employment Trust and Jersey Talking Therapies.

A new assessment structure will ensure bespoke support is offered to those with the most challenging circumstances. Those who, initially, are considered to be unable to benefit from an employability provision due to severe barriers such as dependency and violent offending, are provided support from the Occupational Support Unit in

[23] Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983, Review Report and Recommendations, Department of Health, Home Office, 2014.

partnership with other agencies to enable them address and manage their issues. People who have limitations meaning they are potentially employable, but a long way from work (problems such as addiction, a criminal record, long periods of unemployment, long periods of poor health) are assigned an Employment Adviser who will work closely with them. Their Adviser will agree actions and goals, and will identify suitable and realistic employment opportunities and training to address barriers such as motivation, literacy or communication skills. As people progress closer to work, they are given specific skills training and more intensive job-seeking support.

Jersey Employment Trust (JET)

The primary role of JET is to assist people with a disability or long-term health condition (including mental health) to find and sustain open employment. JET is made up of a number of specialised support services which enable people to access a flexible range of options that can be tailored to their specific needs. Recent figures show a significant increase of referrals for individuals with a mental health condition (from 35 referrals in 2012, to 93 in 2014, going onto 100 referrals for the first 6 months of 2015), mental health now make up approximately 25% of JET's total caseload.

JET recognizes the need for mental health support, recovery and employability for the overall health of an individual. As such, within JET's services is a Wellbeing Support Unit, which is made up of 2 health professionals, implementing evidenced-based practice in mental health intervention and support. This includes, primarily, up-skilling JET staff with education, training and mentoring in mental health, to manage identified barriers or issues with referred clients. Other areas of support include education, training, advice and one-to-one support for clients in developing essential skills to either maintain employment or meet prospective employment needs. This intervention has laid the foundation for effective support and is evident in the increase in sourcing and supporting paid job placements across all sectors (from 80 in 2013 to 152 in 2014, and in 2015 JET is on target for 200 paid job placements), with 28% of those placements being with a client with a defined mental health condition.

As an adjunct to the increased prevalence of referrals for clients with a mental health condition, JET recognises co-morbidity of mental health with other long-term health conditions, and therefore refer to the Wellbeing Support Unit for guidance. The Wellbeing Unit will then assess and support accordingly, to either provide clients and support staff with support measures or to liaise with H&SS for other support.

Overview of the Community and Voluntary Sector – Mental Health Services

MIND (Jersey)

MIND Jersey is an independent local charity that provides support to people living with mental illness. It sponsors the activities of an Independent Mental Health Advocate who provides invaluable support and advice, ensuring that those in need are heard and listened to. During October 2013 and October 2014, the charity received 268 referrals to its Mental Health Advocacy service and supported 154 people under 65 and 114 people over 65 with choices about treatment, understanding their rights, and accessing information about their care and treatment. The charity also delivered 500 hours of training during the same period, playing an active role in the delivery of professional training ahead of changes to mental health law and capacity law.

The charity employs a family and carers' support worker who works closely with the families and friends of people experiencing mental health illness. MIND Jersey has recently introduced a Peer Support scheme, run by volunteers who have lived through the experience of mental health problems.

MIND Jersey also campaigns for a greater public understanding of mental illness and works closely with the statutory services, seeking to influence decisions and policy that might lead to improvements in the range of mental health services provided. An area for early attention and investment is in relation to mental health services that should be provided to young people, as it is recognised that early and low-intensity interventions can be very effective.

Jersey Alzheimer's Association

Jersey Alzheimer's Association provides help and support to local people with dementia and their families. The charity has a 'drop-in' office in St. Helier and employs a full-time Educator to teach about dementia in a wide variety of settings. One of the services offered is the Saturday Club, which is held every week from 9 a.m. until 3.30 p.m. at the Poplars Day Centre, and is open to anyone who has dementia. This facility enables up to 25 families and carers to have a break whilst the person with dementia is cared for in a safe and stimulating environment by our Person-Centred Dementia Care trained staff. The charity also operates an answerphone Helpline, and provides weekly 'art as therapy' and music therapy classes. JAA works alongside H&SS staff to provide a monthly dementia café and weekly swimming class too. The total cost of providing the charity's services is £200,000 per annum, 90% of which comes from public donation.

Youth Enquiry Services

The Youth Enquiry Service (YES) helps young people access information and advice so that they can make informed choices on a range of issues in their lives. YES is a 'One-Stop Shop' for young people to access free, independent and confidential support and counselling via the drop-in centre, by phone, text, e-mail and through its website.

Open to all young people aged 14 – 25 years, YES offers a universal access point to targeted and specialist services, supporting young people on a diverse range of issues that are frequently inter-related, such as –

- social welfare issues, e.g. benefits, housing, debt, employment
- mental and emotional health issues, e.g. depression, low self-esteem
- self-harm, family problems and stress
- wider personal and health issues, e.g. relationships, sexual health, drugs and alcohol, healthy eating
- practical issues, e.g. careers, money management, independent living skills.

The following table shows the increase in referrals and appointments made by the service between 2008 and 2014.

Number of new counselling referrals in 2008 (May – Dec)	Number of new counselling referrals in 2009 (Jan – Dec)	Number of new counselling referrals in 2010 (Jan – Dec)	Number of new counselling referrals in 2011 (Jan – Dec)	Number of new counselling referrals in 2012 (Jan – Dec)	Number of new counselling referrals in 2013 (Jan – Dec)	Number of new counselling referrals in 2014 (Jan – Dec)	Total
12	49	71	90	92	125	158	597
Number of counselling appointments in 2008 (May – Dec)	Number of counselling appointments in 2009 (Jan – Dec)	Number of counselling appointments in 2010 (Jan – Dec)	Number of counselling appointments in 2011 (Jan – Dec)	Number of counselling appointments in 2012 (Jan – Dec)	Number of counselling appointments in 2013 (Jan – Dec)	Number of counselling appointments in 2014 (Jan – Dec)	Total
31	213	474	607	735	919	1,266	4,245

Shelter Trust

Aztec House provides 'walk in' emergency accommodation with provision of 35 units of accommodation. This includes the 'Drunk and Incapable Unit' accommodation consisting of 4 secure single-occupancy rooms situated at Aztec House.

Strathmore provides emergency single-occupancy accommodation with provision of 16 accommodation units for homeless young adults aged between 16 – 25 years.

Evans House provides single-occupancy accommodation for a maximum of 22 people. It offers medium-term settled accommodation and resettlement support for previously homeless people now aged over 25 years. During 2014, the bed occupancy was approximately 50%.

Midvale Road provides 17 self-contained single-occupancy studio flats for medium-term accommodation and resettlement support for previously homeless people now living independently. During 2014, the bed occupancy was approximately 65%.

Residential and Nursing Home provision

There are a range of nursing and residential homes. The table below shows that there is a total capacity of around 950 residential and nursing beds available in the private sector. There are 4 nursing homes that offer placements for people with a diagnosis of dementia, and one nursing home that has 4 beds for people with dementia. There are 2 residential homes that offer respite care.

Table Eleven

Estimate of Private Nursing and Residential Beds

Name	Nursing/ Residential	Category of home	Total capacity
Glanville	Residential	Elderly	29
Glanville	Residential	Elderly (Respite)	0
Glenferrie	Residential	Elderly	9
La Haule	Residential	Elderly – Dementia Care	55
Lavender Villa	Residential	Elderly	20
Les Hoûmets	Residential	Elderly	26
Maison La Corderie	Residential	Elderly	32
Maison La Corderie	Residential	Elderly (Respite)	32
Pinewood	Residential	Elderly	48
Ridout House	Residential	Elderly	9
Ronceray	Residential	Elderly – Dementia Care	25
St. Helier House	Residential	Elderly	56
Stuart Court	Residential	Elderly	28
Little Grove	Nursing	Elderly	31
Palm Springs	Nursing	Elderly	25
Beaumont Villa	Nursing	Elderly – Dementia Care	4
Beaumont Villa	Residential	Elderly – Dementia Care	20
Clifton	Nursing	Elderly	27
Clifton	Residential	Elderly	7
Highlands Luxury Residential Care	Nursing	Elderly	15
Highlands Luxury Residential Care	Residential	Elderly	19
Jeanne Jugan Residence	Nursing	Elderly	14
Jeanne Jugan Residence	Residential	Elderly	66
Lakeside	Nursing	Elderly	28
Lakeside	Residential	Elderly	39
Lakeside Manor	Nursing	Elderly	15
Lakeside Manor	Residential	Elderly – Dementia Care	40
L'Hermitage	Nursing	Elderly	24
L'Hermitage	Residential	Elderly	17
Maison St. Brelade	Nursing	Elderly	49
Maison St. Brelade	Residential	Elderly	2
Silver Springs	Nursing	Elderly	34
Silver Springs	Residential	Elderly	33
St. Ewolds	Nursing	Elderly	5
St. Ewolds	Residential	Elderly	61
			944

Residential respite for people diagnosed with Dementia – Pilot Project

Having access to regular respite for carers supporting family members with dementia is extremely important. As part of the investment in the first phase of P.82, a pilot scheme was set up to increase carers' access to respite services.

Respite involves providing a care service in the individual's home, allowing the carer to go out and attend social activities and reduce social isolation, or to remain at home but not be responsible for the care needs of their loved one. These types of packages can include weekly sitting services, 24 hour home care, and weekly overnight care.

For those people who received residential care, wherever possible the carer was given the residential care home of their choice for the period of respite.

Dementia respite provision is available to carers of adults with dementia irrespective of the age of the person living with dementia. During 2014 there were 2 main types of short break/respite provided –

- Residential respite: There were 34 people accessing residential respite with a total of 873 days over 10 different residential homes.

- Community respite: There were 15 people accessing community respite with approximately 1,717 hours used over 8 independent domiciliary care providers.

There remains anecdotal evidence, including that from Jersey Alzheimer's Association, that the demand for respite care continues to outstrip supply, and may continue to do so as incidence rates rise.

Making care appropriate to patients (MCAP) data

As part of a wider system reform, the Oak Group[24] were commissioned by H&SS to conduct a study of service outcomes across Health and Social Services. The findings were first presented in December 2014 and give an insight into how the system is performing as a whole. The key areas of note in relation to mental health are set out here, and were presented during the action learning set process as a means of contextualising participants' practice challenges.

Overall key themes

- Of the 75 mental health patients reviewed, 36% of admissions and 55% of continuing days of stay were "non-qualified". That is to say admission and continuing stay were unnecessary for the effective treatment of the patient.

- Overall, 73% of non-qualified days could have been provided in a supported living environment.

[24] The Oak Group supplies medical intelligence to increase efficiency in providing health care by ensuring that patients receive the right care in the most appropriate care setting.

- Reviewing the reasons that blocked a patient from receiving the correct service level, the Oak Group Report identifies –
    - Nursing home: clinician records predominate.
    - Home with support services: discharge issues are most important.
    - Residential: alternate care issues are the majority.
    - Out-patient services such as crisis intervention, detox services, and secondary care: alternate care issues are dominant.

What the data shows in relation to processes leading to admission

- 63% of admissions came through transfers from other wards or hospitals. Of these, 33% were "non-qualified".
- 23% came from direct CPN referrals, of which 53% were unqualified.
- 14% of admissions came from other sources.

What the data shows in relation to discharge planning

- Only 7 of 75 (9%) of patients had some discharge planning notes that were done after admission.
- None of the dementia patients had a discharge plan.
- 4 of 75 (5%) of patients had an estimated date of discharge (EDD).

None of the dementia patients reviewed had an EDD.

What the data shows in relation to alternatives to admission

- 24% of primary reasons for the occurrence of a "non-qualified" day, when the patient could have been treated at a lower level of care, related to the inadequate availability of alternative service levels.
- 81% of non-qualified admissions could have been prevented by providing a supported living environment.
- 95% of non-qualified days related to dementia could have been avoided with a supported living environment.
- 52% of acute non-qualified days could have been avoided with a supported living environment.
- 25% of non-qualified acute days required a variety of out-patient mental health services.

Conclusions that may be drawn from the MCAP data

- That the mental health service is more focused on admission than discharge.
- That early pro-active planning for discharge and continuing care planning (where appropriate) is under-developed.
- That a substantial proportion of those admitted, or retained as in-patients, might have been effectively treated in other environments.
- That there is a shortage of housing-based alternatives to provide a safe and appropriate context that offers an alternative to admission and in-patient care.

Mental Health Workforce

In common with other jurisdictions, Jersey faces workforce challenges. A summary of local workforce data was presented during the review process. It was recognised that this data was not complete, and therefore benchmarking it appropriately is difficult. However, 4 key issues arose from the review of that information –[25]

- Low staffing numbers
- Low attrition in all services, i.e. few starters and leavers through the year
- High sickness levels
- An ageing workforce; loss of experienced staff, and difficulties in recruitment.

Low staffing numbers

Staffing in health and social care is relatively light, and highly reliant on very small numbers of individuals. This is an issue, as many health and social care staff are approaching retirement age. There are relatively low numbers of staff involved in mental health services compared to similar-sized populations (or localities) in other services in the UK across mental health services. This was borne out by stakeholders who consistently referenced workforce capacity pressures. This has the potential to create a limited career structure in an area of health care not always regarded as a popular specialism. This may have had some impact on the quality of staff providing services, and will probably mean that those with the necessary level of expertise and skill are more stretched.

[25] As with other data provided and reviewed, there were some discrepancies; in this case this was in relation to staffing numbers in services that did not match across various sources of data.

Low attrition rates

Attrition (staffing turnover) is currently very low in adult and children's mental health services, i.e. 5.7% and 4.6% respectively. Across health services generally, turnover would normally be in the region of 10% to 14%. High turnover means new staff with fresh ideas coming into an organisation, and at the same time maintaining services safely whilst retaining skills and expertise. The situation in services for older people is slightly better, in that attrition is around 9.6%; however this would still suggest a relatively static workforce. Insights gained from stakeholder interviews and the shared experiences of frontline staff attending 'Action Learning Sets' suggest similar patterns across other statutory and large voluntary sector services.

Often in circumstances where attrition is low, there is also a propensity towards '*this is how we do it here'*. In the stakeholder interview process, a clear theme was an expression of a culture of paternalism and that over many years custom and practice had developed that, when set alongside the low turnover and lack of incoming staff with experience of other systems, created one that was hard to change in terms of the approach to practice and service delivery. This perceived reluctance to change may have a negative impact on new staff, in that there could be a risk of them feeling marginalised and therefore unlikely to stay long enough for any new ideas to be adopted.

High sickness absence levels

Using the English NHS as a benchmark, sickness targets have been set at 3% with a number of providers now achieving around 2% to 2.5% sickness absence. On average 1% of sickness equates to approximately £1 million in additional costs to health care organisations.

Currently, the sickness level in the Jersey mental health services is running at around 7%. The impact of this is likely to be adverse in terms of quality, capacity and morale. It is not currently possible to offer a comparison with sickness absence rates across primary care and community voluntary sector organisations.

Ageing workforce

The age demographic of staff working in mental health services has been an issue for some time, and not only in Jersey. The same trend is likely to be seen across primary care and community voluntary sector organisation. The current pressures and those over the next decade locally are those related to experienced staff reaching retirement age and being lost to the service. This will leave gaps in skills, knowledge, competence and management capacity.

1.4 The financial landscape

Although savings were made in the mental health budget between 2011 and 2013, mental health has been relatively protected from the impact of previous budget challenges. Investment has been made, some of which has been a direct result of the priorities set out in R.82/2012: *Health and Social Services White Paper: Caring for each other, Caring for ourselves – Public consultation*.

That investment has included resources to develop 'Jersey Talking Therapies', a new service being delivered in partnership between H&SS and Jersey MIND. The service provides psychological therapy and interventions for people experiencing common mental health problems such an anxiety or depression.

White Paper monies have also been used to invest in the 'Maternal Early Childhood Sustained Home-Visiting' (MESCH) service. MESCH is a structured programme of sustained nurse home visiting for families identified to be at risk of poorer maternal and child health and development outcomes. It is being delivered by the Family Nursing and Home Care charity as part of a comprehensive, integrated approach to services for young children and their families.

However, the financial landscape in Jersey is changing. Like many health and social care economies where secondary care is resourced through public funding raised by taxation, Jersey faces the challenge of providing high-quality services at a time when the allocation of public resources, and the provision of new investment, is more limited than has perhaps been the case in the past.

As part of the review process, figures for mental health service budgets were reviewed, and the following section sets out in summary the key messages from the analysis of the figures presented.

The scope for further investment will, in the view of most stakeholders, need to be balanced with a sharper focus on productivity and effectiveness, and working in new and innovative ways that will cost the same or less.

Taking the budget figures for Mental Health Services from each of the 3 divisions: Children and Adolescents, Adults and Older Adults; the combined budget for Mental Health Services for 2014 was £20,513,663.

Of this budget, the CAMHS and the adult mental health service budgeted to spend a combined total of £3,516,054 on 'out of areas' placements in the UK.

Children and Adolescent Mental Health Service (CAMHS)

The total budget for CAMHS in 2014, which combines on-Island services and UK placements for children, was £2,624,365, an increase of £390,523 between 2012 and 2014.

Of this spend, £1,810,210 relates to UK placements of children, which is an increase from the out-turn figure for 2011 when the budget of £1,360,210 was overspent by £422,904. This increase in spend reflects the priorities that were being tackled in this timeframe in relation to the care of children with mental health problems in Jersey.

Adult Mental Health Services

The total budget for Adult Mental Health Services in 2014 was £11,074,790, an increase of £1,256,892 over 2013 when there had been a negative variance against budget of £127,125.

The structure of budget lines makes the attribution of costs to particular service configurations challenging as some lines relate to specific services and others to elements that may contribute to more than one aspect of service.

For example: in estimating the cost of in-patient provision for Orchard House what proportion of the costs shown as "In-patient team clinical lead" should be attributed. The headline cost for the 17-bed Orchard House in-patient facility is budgeted at £1,263,275 which, when taken with the bed occupancy data, shows an occupied bed cost of £251-60p per night.

The budgeted cost for UK placements for adults fell from £1,827,004 in 2011 to £1,705,844 in 2014.

Older Adult Mental Health Services

The budget for Older Adult Mental Health Services rose from £5,513,575 in 2012 to £6,814,508 in 2014, an increase of 23.6%. Around 60% of that increase is accounted for by exceptional items such as building works at Clinique Pinel.[26] The out-turn figures have shown negative variance against budget in each of the years for which we have complete data: £224,788 in 2011, £124,067 in 2012 and £100,944 in 2013. These deficits have been driven by the financial performance of in-patient provision.

Beech Ward has moved from deficit to around break-even, but Cedar, Oak and Maple Wards have all shown negative variance against increasing budgets. These 4 wards represent around 55% of the total budget for Older Adult Mental Health Services.

The financial position in Jersey means that the sustainability of health and social care services is a key issue, and mental health cannot stand to one side of that. To do new things, or to maintain those that are effective, may mean stopping doing other things. Innovation and changing practice will be at least as important and valuable as any future investment arising from the implementation of this strategy.

[26] In 2014 the budgets of all services were impacted by the implementation of a 9% salary increase for nursing staff.

SECTION TWO

Insights from the review process

2.1 Summary of the approach taken for the review

In order to fully understand the potential options for providing high-quality mental health services in the future, a system-wide review was completed to guide the development of the mental health strategy. Without a whole-system review, it would have been difficult to identify service areas that are performing well, when compared to other jurisdictions, and which service areas are not. This would have meant an increased risk of future services delivering poor patient experience and poor treatment outcomes. A full description and report of each element of the review is provided in the Appendices to the Strategy. An overview is provided here, along with the key insights gained from each element of the review process –

- *Phase 1 (Preparation)* A desktop needs assessment of public mental health needs with further description of current spend and activity of existing mental health services was completed. Stakeholder interviews were also conducted with directors and senior managers from across the mental health system.
- *Phase 2 (Citizen Jury)* A Citizens' Forum was convened to collect perspectives from the Public and identify the key building blocks that should underpin any future mental health system.
- *Phase 3 (Learning Sets)* Action learning sets were set up and clustered around 4 focus areas, which will include prevention (building reliance); early intervention (nipping problems in the bud); acute intervention (when things take a turn for the worst); recovery and support (what helps us cope). Each action learning set will meet 5 times over the course of the review period.
- *Phase 4 (Customer Voice Exercise)* A range of methodologies were used to engage service-users and gain insights into their experience and viewpoint.
- *Phase 5 (Engagement Day).* An invited audience of 110 key stakeholders to test and shape emerging themes which have been developed as a result of previous work during the review. Resulting detailed themes were then used to inform priorities which featured in the Mental Health Strategy.

2.2 Key insights

2.2.1 Stakeholder Interviews

The following is a summary of the key issues and our impressions arising from the interviews, grouped by theme:

Culture and practice

- Culture was highlighted as a key factor in the way services have been designed and operated over the years. The consistent word used to describe services was 'paternalistic'. This is borne out by a clearly articulated commitment to help and support people, but it was reported that this commitment is sometimes misdirected and leads to an over-reliance and long-term dependence on support from statutory services.

- The ability to engage in positive risk management was reported to be limited; and an overly-cautious approach that focuses simply on safety further promulgates a paternalistic approach to the provision of services.
- It was reported that the threshold for the receipt of services is not well-defined. This in turn was felt to cause considerable problems in relation to capacity management, waiting times, inappropriate referral and moving people on to other services.
- People's expectations about services and what they should receive remain high.
- It was reported that the services are still heavily dominated by a medical approach to intervention.
- Change has tended to be organisationally driven, rather than led by the needs of the population. The need to engage in a culture change was felt to be overdue, but it was recognised that this will not be the work of a moment, and would require not only support and sign-up, but sustained focus.

Quality and Governance

- It was reported that that governance systems have not been well developed, but that work was in train to address this.
- It was felt by some that there remain issues in relation to professional and clinical leadership and how this is structured, operationalised and fed into any system of quality assurance and governance.
- Some concerns persist among stakeholders about the robustness of regulation and oversight of professionals.
- There was agreement that data is variable in quality and that there has not been enough focus on outcomes.

Recruitment, retention and leadership

- It was reported that a skills gap remains across the range of professions, and that services were heavily slanted towards a medical model of leadership and practice.
- Attracting new people to work in the Island remains difficult for a range of reasons; including cost of living, concerns about professional atrophy, a glut of specialists and a dearth of generalists.
- According to some stakeholders, the balance of roles needs to change, and a more diverse professional workforce is needed that can work in a multi-disciplinary way. Although work is underway, the lack of a mental health workforce plan or strategy, allied to the lack of accurate data about the workforce composition, was recognised as a deficit that impedes strategic planning.
- The need to strengthen both clinical and managerial leadership across the system in order to lead and build sustainable change was reported during the interviews. Hearts and minds will need to be captured if the ideas developed in coming months are to be implemented, and it was agreed that 'champions' will be needed to lead and support the change process.

Finance and information

- Although savings have had to be made, it was recognised that mental health has been relatively protected from the impact of previous budget constraints.
- Investment has been made in mental health, and this was widely recognised, notably in relation to Jersey Talking Therapies. The scope for further investment will, in the view of most stakeholders, need to be balanced, with a sharper focus on productivity and effectiveness, and working in new and innovative ways that will cost the same or less.
- The financial position across the Island means that the sustainability of services is a key issue, and it was recognised that mental health cannot stand to one side of that. To do new things, or to maintain those that are effective, will mean stopping doing other things. In other words, it was felt that the need to decommission should not be overlooked when thinking about what might be re-commissioned or newly commissioned. Innovation and changing practice will be at least as important (and valuable) as any investment.

Primary care

- Primary care featured consistently in the discussions with stakeholders, and this reflects the importance of the work being led elsewhere by H&SS on sustainable primary care for Jersey.
- There was concern among stakeholders that the 'perverse' incentives in the current system have had an impact on the nature of intervention, a reliance on a pharmacological model, and a sense of poor engagement and communication between primary and secondary care.
- It was reported that communication between primary care and secondary care requires improvement from both sides. A clear wish to engage G.P.s in a meaningful debate about joint working, risk management and developing the links between physical and mental health was expressed throughout.

Prevention

- Stakeholders consistently cited the need to invest upstream in more effective prevention services, with the aim of reducing the need for statutory services in the future.
- Views differed about the nature of 'early intervention' and how this might be delivered, but there was a recognition of the need for a balance to be struck between 'statutory' early intervention for young people who require some form of support because they have symptoms of illness, and the need to develop a set of prevention interventions that may be more of a Public Health-led approach that seeks to reduce stigma and raise awareness.
- Stakeholders believed that the role of schools, the Education Department, and employers in developing and delivering a programme of preventative action would need to be explored if a more resilient community is to emerge in Jersey.

2.2.2 The building-blocks of a better future mental health system

These building-blocks were developed and agreed by the Citizens' Panel and then used as an ongoing reference point for the other elements of the review, including the shaping of the key themes that emerged in the ALS, Customer Voice and Engagement Day discussions.

THE BUILDING-BLOCKS

1. Continuity of care and services working well together

(a) Services need to be integrated.

(b) Someone who comes back to you and someone you know and trust.

(c) Co-ordination of services, working together holistically, but to do this there needs to be an awareness of all that is involved in mental health.

2. Accountability

(a) Complaints about patient care; who do you complain to? What can be done? Are staff disciplined if they have broken care guidelines, etc.?

(b) Is psychiatry a job for life? Can you lose your job for bad performance – high suicide rates/bad feedback from patients/please ask for feedback?

(c) Bad practice: psychiatrists who perform badly, issue wrong prescriptions, call you by the wrong name when it's on the computer in front of them and they have known you for years. Who do you complain to when they all stick together?

(d) Accountability in mental health services to address complaints about staff.

3. Not tolerating stigma amongst the Public and professionals around people with mental health problems

(a) Challenging stigma education.

(b) Being non-judgmental.

(c) There needs to be education on mental health (what it is ...).

(d) Why do general clinicians need to know mental health diagnosis when it is not necessary for physical diagnosis, as this causes stigmatisation and often defers from an actual physical diagnosis, i.e. 'it's all in your head'?

(e) Why is the Mental Health Services Department separated from the General Hospital? It makes stigma more prevalent and creates difficulty then getting to the pharmacy.

(f) Physical health of mental health sufferers can be overlooked by medical staff who effectively 'stigmatise' the patient as having mental health issues.

(g) Medical staff need to be more understanding and treat patients as human beings, involve the patient in treatment where possible, and not refer to patients as a 'revolving door'.

4. Adequate numbers of trained and well-supervised people working in mental health, with suitable working conditions

(a) No 24 hour local mental health support on the phone.

(b) Hospital casualty staff need better training.

(c) We need a system that considers the future demographics: e.g. ageing population, therefore increased risk of dementia; e.g. alcohol and drug use.

(d) We need a system that learns from elsewhere, e.g. links with Guernsey and the UK.

(e) The need for staff at school to be aware of/look out for mental health issues in children.

(f) Key workers in schools with children with behavioural problems need training and support. Staff need to be compassionate.

5. Recognise how high the suicide rate is in Jersey

(a) Suicide prevention: what would it look like?

(b) The shock and horror of unexpected suicide here in Jersey in a very small community is hard to describe. There is a massive need for a bereaved family to receive professional support; counselling at the right time is so important.

(c) Could there be a local advertising campaign that highlights the effects of suicide and informs people of support available to encourage them to tell someone if they have suicidal thoughts?

6. Recognise the causes of mental health problems (e.g. unemployment, stress, loneliness, isolation)

(a) Some people can't afford a G.P. appointment.

(b) Challenge loneliness and isolation.

7. Speedy response at the time of need, with someone coming back to you

(a) Need emergency cover 24/7.

(b) Need improvement to services.

(c) Long waiting times need to be shortened.

(d) Timely action to every inquiry.

(e) Someone who comes back to you.

(f) Transition from different services and departments needs to be easier.

8. The need for confidentiality

(a) Someone you know and trust.

(b) Trust and confidentiality in medical staff.

9. A focus on prevention, including investment

(a) Learning mindfulness.

(b) Family/friends and support for them.

(c) Use exercise to promote wellbeing.

(d) We need to recognise that the children with behavioural problems now in schools are the future of our mental health resources.

(e) Robust anti-bullying protocols in schools and companies.

(f) Preventative therapies: relaxation, etc., promote wellbeing before the tipping-point.

(g) Build self-esteem.

(h) Educating children to pursue happiness, follow their dreams, not to listen to other people's negativity, set their goals, dream big, build self-esteem and resilience.

(i) Helping make sure children develop coping strategies but also learn from experience.

(j) Prevention: ante/post-natal input, meditation/massage.

(k) Education for children with behavioural problems, CAMHS is under-resourced.

(l) Family and home support, build up the parent.

10. Easily accessible information about services and where to find help and support

(a) It would be very useful to have a list of G.P.s who have an interest/ speciality in mental health, as my previous G.P. was unaware of what was available from the Psychology Department.

(b) A big need for a central access point to gain information and direction for your issues.

(c) Need to publicise available helplines.

(d) Need doctors to explain to me what is happening to me and what prescribed pills will do? (e.g. side-effects and addictive nature).

(e) Some people don't know what support is available.

(f) There should be a Centre where people can go when they need help. That Centre should be able to advise what direction to go in.

(g) G.P. availability.

(h) Who to speak to?

(i) Central point of where to find information?

(j) If the States of Jersey weren't so selfish my friends would still be here.

11. Value and support the role of people and organisations outside the formal/ state system (e.g. families and carers, friends, church, charities, work, youth services, etc.)

(a) Support for carers, meetings and respite care.

(b) Needs to be a whole system that incorporates 'non-mental health' services, i.e. church/exercise/family/charities.

(c) Support for carers and family, as sometimes they are the most useful.

(d) Volunteering, giving something, getting something back.

(e) There needs to be support for Jersey-based (e.g. MIND) charities, not UK-based charities (like Macmillan Cancer research).

12. Explore, offer and invest in different therapies/support and ways of delivering them, because one size doesn't fit all

(a) Family support services (e.g. The Bridge) should get funding from the state, but not if it means it loses its independence.

(b) People have been trained in family therapy, but family therapy is not available; it needs to be.

(c) Possibly the reason there is not higher bed occupancy at Orchard House is because mental health staff deny access on principle when some patients with recurring problems/emergencies are unsafe and need respite/a place of safety, because 'we don't take people into hospital now'/ 'call me in a week'; by which time the patient was: "so low couldn't use the phone, no-one called back to check on me".

(d) Accessibility to services and visiting transport (voluntary/bus/hospital transport).

(e) Exercise referral.

(f) Goal programme.

(g) Schema therapy, resolves maladaptive coping strategies for those who need it.

(h) Bereavement counselling for children and for family problems.

(i) Jersey Talking Therapies.

(j) One size does not fit all, some people need respite from life, to keep them safe, albeit briefly, i.e. hospital admissions.

(k) Use Internet as a resource (but recognise not everyone has computers).

(l) Mental health forum support.

(m) Teach 12-step philosophy.

(n) Peer-to-peer support.

(o) Group therapy.

(p) Complementary therapy, flower remedies, aromatherapy, reiki therapy.

(q) Parents should listen to their children and acknowledge their feelings and needs.

13. The need for choice

(a) Need to be able to choose my CPN.

(b) Want to be involved in care planning and have choice about the services to be received.

14. Support in the workplace

(a) Society needs awareness of different mental illnesses.

(b) Being open with employers about capabilities helps with expectations of both parties, supportive staff and colleagues.

(c) Trust and confidentiality in employer.

(d) Employer being knowledgeable and understanding.

(e) Raising the profile of mental health, especially in the workplace.

(f) Being employed.

The building blocks are further illustrated and supported by the personal testimony of Citizen Panel members and through case vignettes. These are included in the full report of the work of the Citizens' Panel, which can be found at **Appendix 2**.

Findings from the Customer Voice exercise

The Customer Voice exercise had 3 elements: an online survey, focus groups, and one-to-one interviews. The key findings from the 3 elements of the exercise have been aggregated and are set out here in summary form.

Summary of survey findings

Two hundred and twenty-two people completed the online survey between 19th January 2015 and 6th February 2015. The survey generated a great deal of interest with varied reactions, including some critical feedback, but positive feedback from individuals around the subject areas. The key response results are set out here, along with quotes to provide context and corroboration –

- 91% of respondents thought that joint working and partnerships were key to improving mental health outcomes and experiences.
    - *"I wish things were more joined up"*
    - "*When people talk across boundaries and work together it improved our care no end*"
    - *"Why can't they just work together?"*

- 78% of respondents thought that all mental health services in Jersey could be more recovery-focused.
    - "*There's so many recovery-based things my son would enjoy but the whole things needs to be more ambitious"*
    - "*Recovery centres and colleges could be run between users and charities"*
    - *"Create a recovery centre/college co-managed with us and carers"*

- 87% of respondents thought there was not enough mental health intervention in primary care.
    - "*Some G.P.s have a lack of understanding around mental health issues"*
    - *The cost of going to a G.P. really puts people off, if you have to go back to chase things or because things have got worse then we have to pay again"*

- 94% of respondents thought early intervention was essential.
    - *"The school counsellor was a good port of call when you didn't know who else to ask for help it's a pity there isn't more of them"*

  - *"There was no children's crisis service – would be good to have someone you could call if you were in crisis"*

- 88% of respondents thought that there was not enough mental health promotion in Jersey.
  - *"Employers need so much more education around mental health"*
  - *"Becoming a peer support worker was a real job and gave me a proper purpose"*
  - *"My colleagues just had no clue what to say to me"*

- 8% of respondents thought that service users should have their views listened to routinely.
  - *"We often don't know what questions to ask to get the answers we need in terms of getting the right care and support for Dad"*
  - *"How do we know whether it's good quality or not?"*
  - *"The culture needs to change from being a defensive system to being open and all about improvement"*

- 97% of respondents thought that the families of people using mental health services should have their views listened to.
  - *"Communication is often poor if not terrible"*
  - *"We have to fight to be engaged with and it's exhausting"*
  - *"We want to be involved in our own care and that's that"*
  - *"We need a much bigger voice and we need to believe that the politicians and managers are actually going to change things when we speak out"*

- 75% of respondents thought that people using mental health services in Jersey would benefit from more choice.
  - *"There needs to be proper investment in mental health services"*
  - *"We need more choice of what the money gets spent on"*
  - *"The lack of social care providers is a real issue"*

- 81% of respondents thought that mental health services in Jersey do not respond quickly enough to people's needs.
  - *"There was a long wait for an appointment for my initial assessment even though I was already in the system and involved with other services."*
  - *"The waiting list is a huge issue"*
  - *"How can they tell me to be 10 minutes early and then be over 25 minutes late themselves?"*
  - *"My CPN is really responsive and gets back to me really quickly"*
  - *"There wasn't really a wait to get assessed by CAMHS"*

The responses to the survey link closely with the building blocks developed by the Citizens' Panel, and to the overarching themes to have emerged from the other elements of the review. The response rate was extremely high for a survey of this kind in a mental health setting.

The interviews and focus group sessions built upon the survey findings, which were monitored and analysed throughout the exercise.

The key issues which emerged from the interviews and focus groups were –

The importance of customer feedback should not be underestimated. Service Users and their family carers and supporters want to give feedback safely, and want to be engaged in their own care and the development of services.

There are examples of good work and committed staff. There was a great deal of praise for individual mental health professionals from all settings and teams.

Waiting times for services remain a cause of concern for customers, with waits for psychology being highlighted as significant issue.

Recognising and responding to the needs of carers and the provision of support and bespoke respite care is an outstanding need in the view of many customers and their families.

Customers report that the provision of early intervention and support is a gap, particularly in schools; however, the work of school counsellors is highly valued and was particularly praised.

The quality and safety of buildings from which services are delivered matters to customers. Examples of poor quality environments, inappropriate reading material in waiting areas and poor décor in service settings were all issues for customers.

Customers hold the perception that adult mental health staff in all settings have very low morale and that their wellbeing is a problem. This was expressed in terms of customer concern for those staff, and a recognition of the environments and circumstances in which they have to work.

Communication on every level between professionals and customers was highlighted as a priority area for improvement.

Customers and carers want to see the services grow stronger, be better resourced and build on current strengths. They value what they have, but want to see it developed, invested in and for it to improve.

SECTION THREE

The Strategy for Mental Health: our vision for the future

3.1 The key strategic themes

The process of review has highlighted consistent issues and themes running through the activities of the Citizens' Panel, action learning practice challenges, and the Customer Voice exercise. This enabled the establishment of a set of key themes that were further developed during the Engagement Event –

- Securing joint working across the mental health system.
- Developing the workforce.
- Awareness-raising, prevention, early help and support for young people and children.
- Improving the money-flow in the system to follow the service user.
- Enabling workplace mental health interventions.
- Building educational approaches to recovery.
- Improving the service environment.
- Developing mental health services in the criminal justice system.
- Establishing outcomes, quality and measurement.
- Culture and leadership.

These 9 themes were then further distilled to create 5 overarching areas of strategic priority for mental health and wellbeing in Jersey. Each area of intent is further supported by examples of relevant research or best practice drawn from the literature review conducted by the Health Services Management Centre, alongside other relevant examples. A case vignette that has relevance to the area of strategic intent is included to underpin it via the sharing of lived experience and personal testimony, followed by a summary of areas for consideration to meet each priority.

By presenting the areas of strategic intent in this way, the Strategy demonstrates a golden thread that runs from the insights generated by the review process towards the priorities identified in the Strategy, thus closing the circle from review to strategic intention.

KEY PRIORITY 1: Social inclusion and recovery

Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers that lead to social exclusion, such as stigma, negative public attitudes and discrimination in health and community settings.

Mental health service providers should work within a framework that supports recovery, both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person's strengths, including coping skills and resilience, and capacity for self-determination. This may require a significant cultural and philosophical shift in mental health service delivery.

Building Blocks	Emerging theme
Not tolerating stigma	Building educational approaches to recovery
Recognising the impact of suicide	Enabling workplace interventions
Understanding the causes of mental illness	Securing joint working across the system
Customer Voice	
78% of respondents thought that all mental health services in Jersey should be more recovery-focused	
88% of respondents thought that there was not enough mental health promotion in Jersey	

The supporting evidence from literature

Anti-stigma interventions have been associated with a small, but significant reduction in personal stigma. Educational interventions alone, or when combined with other interventions, are generally associated with a reduction in personal stigma for different types of mental illness diagnosis. One example of good practice in the delivery of events to raise public awareness around mental health issues to reduce stigma has been delivered by the Australasian Centre for Rural and Remote Mental Health (ACRRMH). ACRRMH organised mental health 'roadshows' aimed at increasing awareness of mental health issues.[27]

Recovery-focused services are a central component to making health services fit for the 21st Century. At the heart of the concept of recovery is a set of values about a person without the continuing presence of mental health symptoms. Recovery emphasizes the importance of hope in sustaining motivation and supporting expectations of an individually fulfilled life. In 'Making Recovery a Reality' (Shepherd *et al.*, 2014) the authors argue that recovery does not necessarily mean cure. Instead, it focuses on "the unique journey of an individual living with mental health problems to build a life for themselves beyond illness ('social recovery'). Thus, a person can recover their life, without necessarily 'recovering from' their illness.".

[27] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.

Peer support is an emerging area of good practice. It may involve social, emotional or practical support. In the area of mental health, peer support is considered as important in building on shared experiences and developing empathy, and is focused on an individual's strengths. The Mental Health Foundation defines peer support as the "help and support that people with lived experience of a mental illness or a learning disability are able to give one another".[28]

An example in practice is the 'Brighter Futures' project, which worked across 3 areas in Scotland to pilot a peer-mentoring approach for isolated older people. The project was led by the Mental Health Foundation in partnership with Glasgow Association for Mental Health (South Glasgow), Recovery Across Mental Health (RAMH) (East Renfrewshire), and Seniors Together (South Lanarkshire).[29]

The aim of the project was to work with older people to deliver a peer-mentoring service aimed at improving the wellbeing and the quality of lives of more isolated older people, through enhancing their social networks and enabling meaningful community engagement through, for example, universities, arts groups, exercise classes and faith community groups. The outcomes of the project included improvements in self-esteem for all participants; and 74% of the participants reported improvements in perceived social isolation.

Case vignette

When R was discharged from Orchard House she felt quite lost, not ready to go back to work but wanting to build towards that day when she could get a job again and feel able to cope with it. R had really enjoyed sessions in the recovery centre while she was in hospital, but now she was home, transport was difficult and she just couldn't face going back to the same building for anything. R used to be very involved in music in her younger days and kept thinking about how she would like to be able to do music again in a safe but mainstream environment, and how some Pilates and meditation would help too.

Going to a totally 'everyday' setting without some moral support felt like a step too far, and there was nothing that she knew of in the community where she could work on her recovery and support others with theirs. R also welcomed the idea of learning from others who had been through similar experiences, and over time wanted to help others who had experienced mental ill-health.

What we will do

- We will continue to work using engagement and participative approaches such as the Citizens' Panel and action leaning sets to deliver the priorities identified in this Strategy.

- We will work with other States of Jersey Departments, Community and Voluntary Sector organisations and local businesses to address issues of mental health and wellbeing in the workplace, by developing an awareness-raising programme.

- We will work towards the establishment of a Recovery College which is service user-led with support from mental health organisations and professionals.

[28] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.
[29] *Ibid*

- We will review the evidence from IMRoC and the other extensive work conducted in the UK, and seek advice from recovery experts to help deliver this change.

- We will place the concept of recovery at the centre of all mental health-related training and practice development across the life course in mental health services.

- We will work with service providers to establish the principles of a recovery-based approach which will be embedded within all policies, protocols, strategies and processes.

- We will work closely with the Public Health Department and the Community and Voluntary Sector to build a co-ordinated programme of mental wellbeing awareness delivered with the aim of reducing stigma and discrimination.

KEY PRIORITY 2: Prevention and early intervention

Mental health promotion, prevention and interventions need to include consideration of the spectrum from health and wellbeing to mental health problems to mental illness. The range of service options needs to include those illnesses that are most often managed within the primary care sector, as well as those that may require greater specialist involvement. Services should be provided on the basis of need, not diagnosis or whether an illness is common or uncommon. Service options need to be responsive to the needs of different age-groups, including young children and older people, and to the differing needs of those who suffer particular illnesses.

Building Blocks	**Emerging theme**
Speedy response at the time of need	Awareness raising, prevention, early help and support for children and young people
Increase the focus on prevention	Improving the Service Environment
Support in the workplace	Enabling workplace interventions
Customer Voice	
81% of respondents though that mental health services in Jersey do not respond quickly enough to people's needs *94% of respondents thought early intervention was essential*	

The supporting evidence from literature

Evidence was demonstrated in Canada and Australia to support the development of awareness, prevention, early help and support for mental health and young people, which highlighted the importance of school-based educational programmes to prevent, reduce stigma from, and identify mental health issues in, young people. The emergence of web-based services to support access to mental health support was also demonstrated.[30]

[30] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., March 2015.

An example practice can be found in Canada, where the development of the 'Mental Health and High School Curriculum Guide' (Teen Mental Health, 2015) has resulted in the development of school-based resources to support mental health literacy in schools, defined as –

- Understanding how to obtain and maintain good mental health;
- Understanding mental disorders, their identification and treatments;
- Decreasing stigma;
- Understanding how to seek help effectively.[31]

The Canada school-based mental health programmes focus on positive psychology and positive mental health. Initiatives emphasize health promotion and illness prevention strategies, including safe and supportive environments; student engagement/ empowerment through engagement in school activities; resilience and self-determination.[32]

The Centre for Mental Health published findings relating to the benefits of investing in mental health services for children and young people. They found that the most common mental health conditions affecting children and young people are conduct disorder (i.e. severe behavioural problems), anxiety, depression and attention deficit hyperactivity disorder (ADHD).[33]

The review of the evidence showed that for all these conditions there are interventions that are not only effective in improving outcomes, but also good value for money; in some cases outstandingly so, as measured by the surplus of measurable economic benefits over the costs of intervention.[34]

Case vignette

L went to see her G.P. to talk about her mental distress; the appointment was short and she didn't feel like it was worth the £40. The doctor said he would refer her on to the mental health service and that she was to go home and wait. Two weeks later L was assessed, and although she was beginning to self-harm she ended up on a waiting-list for 10 months for psychology.

During that time, things just got worse, not sleeping or eating, and the cutting was getting more risky all the time. L considered going back to the G.P., but the £40 just didn't seem worth it, as she didn't think that the doctor had any interest or experience in mental health.

L knew that the Hospital's Emergency Department (A&E) would have to see her if she went there, and so one evening when she was feeling suicidal and had cut herself badly, she walked in a dreamlike state into the Hospital. The staff in the reception of the Emergency Department were kind and efficient and the

[31] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., March 2015.
[32] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.
[33] Investing in Children's Mental Health – Khan, L., Parsonage, M. & Stubbs, J., CFMH, February 2015.
[34] *Ibid*

building looked so much better than when she had been there before. The nurses attended to her cuts and then she was put in the 'Mental Health' quiet waiting-room.

L became anxious and more distressed and was admitted into Orchard House, and ended up with an elongated stay before being discharged and getting the psychology treatment that she had needed months earlier. L maintains that if she had been able to access out-patient psychology sooner, she would never have needed an in-patient stay.

What we will do

- We will continue to develop integrated care as part of the Out-of-Hospital and Sustainable Primary Care programmes, to ensure G.P.s have rapid access to mental health services across all ages.
- We will work with the Primary Care Body and Primary Care Medical Director to put in place a continuous professional development programme to further inform and educate G.P.s and other primary care professionals in relation to mental health and wellbeing.
- We will continue to develop primary care-based mental health services, such as Jersey Talking Therapies, that have been shown to address mild and moderate needs both directly and through support to G.P.s.
- We will put a greater focus upon early intervention with children and young people, and develop services to specifically address their needs with less need to resort to residential solutions.
- We will work with MAST teams in Schools and Colleges to develop an education-based programme of mental health and wellbeing awareness-raising.
- We will work with key service providers so that that all sites to which the Public have access provide a range of information about the services offered at that site, as well as information about other services, including mental health advocacy and the services provided by voluntary and community organisations.

KEY PRIORITY 3: Service Access, Care Co-ordination and Continuity of Care

While recognising that different service types and locations are important, services across the spectrum of age and need should be developed and delivered in a way that reduces the risk of people falling through gaps, that reduces unnecessary duplication and complexity, and promotes information-sharing. This depends on both collaboration between services at all levels, and integrated models of service delivery.

Building Blocks	Emerging theme
Continuity of care with services working well together	Securing joint working Mental health services in the criminal justice system
Easily accessible information about services and where to find help and support	Awareness-raising, prevention, early help and support for children and young people

Building Blocks	Emerging theme
Adequate numbers of well-trained and supervised staff	Developing the workforce
Customer Voice	
87% of respondents thought there was not enough mental health intervention in primary care *91% of respondents think joint working and partnerships are key to improving mental health outcomes and experience*	

The supporting evidence from literature

A study of a multi-professional approach to care delivery; structured management (non-clinical case worker); scheduled patient follow-ups, and enhanced inter-professional communication. This approach was found to deliver improvements in patients with depression or anxiety when supported by a collaborative care model compared to usual care. Collaborative care was associated with improvement in depressive symptoms.[35]

Evidence to support Police Officers to deal with individuals presenting with mental health issues, and the benefits of cross-sector working, are present in the literature. A briefing by the Centre for Mental Health (Bather *et al*, 2009) argued that "Police officers need more and better training in mental health issues.".

An example in practice has been the establishment of Street Triage pilots in the UK: in these schemes, mental health professionals provide on-the-spot advice to Police Officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person's condition, or appropriate information-sharing about a person's health history.

The aim is, where possible, to help Police Officers make appropriate decisions, based on a clear understanding of the background to these situations.

The need for better mental health care in prisons has been evident for some time, and mental health in-reach teams have developed to provide a range of services to ensure equivalence of access for prisoners. They have also enabled closer liaison between Prison staff and health professionals.

There is some evidence to indicate that the use of Mental Health First Aid is a potentially useful approach to training that would help the Police and Prison staff in dealing with mental health needs. Mental Health First Aid is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem. In the same way as we learn physical first aid, mental health first aid teaches you how to recognise those crucial warning signs of mental ill-health.[36]

[35] Characteristics of Effective Collaborative Care for Treatment of Depression, Coventry *et al* (2014) in Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.
[36] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.

Developed in Australia in 2000 and now internationally recognised in 23 countries, the MHFA course teaches people how to recognise the signs and symptoms of common mental health issues, provide help on a first-aid basis, and effectively guide those towards the right support services.[37]

Case vignette

L was arrested on a Class A drugs charge and remanded on bail. During this time, he drank quite heavily, as he was scared and couldn't see another logical approach to escaping the fear of a prison sentence. He lost his job, his flat, his friends, and his life, as he knew it. He was seen at Drugs and Alcohol Service (referred by G.P.) but only attended a couple of appointments, as he was not ready to stop self-medicating through alcohol.

L saw a Probation Officer once before sentencing. Sentence was eventually passed and he received a 2½ year prison sentence. Due to the nature of his charge being drug-related, L saw a counsellor from the Drugs and Alcohol service on a weekly basis whilst at La Moye. L appealed his sentence, not the verdict but the sentence.

L's case was heard and he was released, having the sentence turned over to community service, 3 ½ months after his imprisonment.

L had a sentence plan in place, which if had he had served his full term, would have been executed and included pre-release preparation. As it was, his sudden release came as a total surprise with no support for return to the real world. 3½ months was long enough to become institutionalised to an extent, and L was very shocked and frightened by his release.

L doesn't feel that he was shown a duty of care on his release. He does not however hold anyone individually accountable for this, as he believes that he should never have broken the law. L does feel that it is an area that needs to be addressed. L feels that it was the single most disturbing incident of his life. L fell through the cracks in the system; he is still dealing with the long-term impact of having a criminal record and trying to return to the working world.

What we will do

- We will work with primary and secondary care professionals, service users and managers, to review current service models to ensure an improved focus on assessment, diagnosis treatment and recovery based in community settings. As part of this work, we will establish integrated care pathways supported by a coherent co-ordination function across key services.

- We will develop further 'partnership' arrangements with a provider to secure a more consistently accessible and cost-effective forensic medium and low secure mental health in-patient service.

[37] MHFA England.

- We will work with service providers to review and implement protocols to ensure more effective transition between services; e.g. between CAMHS and adult services and between adult and older people's services; between the criminal justice system and mental health services.

- We will review and consider the most appropriate model for Consultant provision. Specifically, whether a Consultant should continue to be the responsible clinician for community service users during any in-patient stay.

- We will establish clear information sharing protocols between primary and secondary care, as well as with external agencies. This will enable more effective sharing of relevant information about service users and their needs, their care plans and risk factors.

- We will explore the role of a specific service to provide early intervention and support to children and young people who are experiencing their first episode of mental illness.

- We will work with the Home Affairs Department to establish an appropriate site and operational service model for a Place of Safety in Jersey. This will include specific provision for medical and nursing support within the Place of Safety when it is occupied.

- We will work with key service providers, including the Probation Board and the Courts, to review the existing provision of Court Liaison and Diversion services for people with mental health needs, with a view to developing a business case for the establishment of an improved service.

- We will work with the Home Affairs Department to explore and develop a model for an efficient, sustainable and safe mental health Prison service at H.M.P. La Moye, using evidence-based multi-disciplinary in-reach models.

KEY PRIORITY 4: Quality improvement and innovation

Quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. As such, this places an emphasis on the provision of services that should produce positive outcomes for service users and make the best use of current knowledge and technology, whilst seeking to innovate.[38]

Mental health services, whether in the primary care sector or specialist sector, cannot be provided as a 'one size fits all' across the age range. Our community is rich in diversity. It embraces cultural and religious differences. This brings many strengths and opportunities, but we also need to recognise the challenges faced at times by some within our community. There should be demonstrated cultural competency in the planning and delivery of responsive and high-quality mental health services.

[38] Quality Improvement in Mental Health, WHO 2003.

Building Blocks	Emerging theme
Value and support the role of people and organisations outside statutory services	Securing joint working Developing the workforce
Explore, offer and invest in different therapies and support because one size doesn't fit all	Improve the money-flow in the system to follow the service user
Need for choice	Improve the service environment Building educational approaches to recovery
Customer Voice	
75% of respondents thought that people using mental health services in Jersey would benefit from more choice *98% of respondents thought that service users should have their views listened to routinely*	

The supporting evidence from literature

Several frameworks have been developed to inform the measurement of outcomes and quality in mental health services and the factors which enable service transformation. Fossey and Parsonage (2014) describe a framework for measuring outcomes and performance in liaison psychiatry, to be used for such purposes as accountability, performance management and service improvement. They suggest the need for a 'balanced scorecard' approach, including a mix of measures or indicators drawn from the 3 dimensions of structure, process and outcome and covering multiple outcomes.[39]

An important example of practice is the 'Enhancing the Healing Environment' programme. Led by 'The King's Fund', it encouraged and enabled multi-disciplinary teams to work in partnership with service users to improve the environment where care was delivered. It put service users at the heart of design, and challenged both thinking and attitudes to the delivery of care, as well as highlighting the important role that the physical environment can play in supporting innovation in service delivery and in improving the patient experience.[40]

The programme, which was evaluated, has now concluded. Further work is now being led by the University of Worcester in relation to environments specific to people with dementia.[41]

Case vignette

B found the waiting area so disturbing that he almost didn't get to see the professional he was waiting for. The magazines on display were old and inappropriate, and on the front page of one had a sleazy heading about domestic violence towards men being less significant for individuals

[39] Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M., HSMC, March 2015.
[40] Sharing success in mental health and learning disabilities: The King's Fund's *Enhancing the Healing Environment* programme 2004–2008, The King's Fund 2008.
[41] www.kingsfund.org.uk

experiencing it than for women. B felt disrespected, vulnerable and as if his whole story had been exposed somehow.

The poster on the wall made him feel worse, as it described how aggression towards staff would not be tolerated. As he sat there, he wondered if he was unsafe; his personal experiences of violence meant that the poster scared him, and he reflected on how vulnerable he was in that moment. Once he had realised that the other people waiting didn't look remotely violent, he became annoyed at the tone in the poster, the inference that staff needed to be safe, but not patients.

In the times B sat in the waiting area and over time, he planned more constructive and valuing wording for the poster and had thoughts of all the positive mental health publicity that could be available instead of magazines; and how with a small amount of investment the whole waiting experience could be valuing and calming.

What we will do

- We will work with clinicians to review the thresholds for access to all mental health services and ensure these are explicit within operational policies. These will also be clearly communicated to service users, referrers and the Public.

- We will work with clinicians to develop operational protocols between all mental health services to ensure more seamless transition, but also to ensure effective joint working, transfer of cases and co-ordination of responses, particularly at times of crisis.

- We will develop a greater choice of interventions and services wherever possible, and make clearer those choices for all who use mental health services.

- We will work with the Strategic Housing Unit and other Housing providers to –

    - develop housing and support options for older people, including those with dementia, to reduce the reliance on residential and nursing home care, delivering care close to home and increasing independence.
    - provide both greater choice through an appropriate range of housing options for young people and adults.

- We will engage with workforce experts and Directors of Services to establish a plan for workforce development, which will include a more detailed review of current staffing, in order to support a diverse, trained, skilled and appropriately experienced workforce across all areas of mental health. This work will include an exploration of the role the independent and private sector workforce.

- We will refresh and establish training, both mandatory and voluntary, to develop a renewed and updated programme that will better meet the needs of professionals in their daily practice.

- We will implement a robust recruitment and retention plan which will be supported by effective preceptorship/mentoring/coaching arrangements.

- We will work Service Directors to establish a productivity-based approach to innovation, to assist in improving efficiency and effectiveness.

- We will work with Jersey Property Holdings and service providers to complete an audit of in-patient and community services sites which will provide an accurate assessment of their fitness for purpose. This will include review of potential risks to patient, staff and visitor safety. As a minimum, it will be expected that there is sufficient space for confidential discussions between staff; and between staff, service users and carers.

- We will establish a task and finish group to progress a suitable option for the re-provision of the adult in-patient services at Orchard House.

- We will produce a service map for service users and their families, which will describe the various mental health services, how they link to each other, and information about how to contact them.

- We will establish a joint mental health and criminal justice forum. This will be comprised of mental health service senior management and representatives of H.M.P. La Moye, the Probation Service and Jersey Police. It will serve as a forum for addressing operational issues and concerns, as well as providing oversight in relation to service developments.

- We will establish a joint programme of training and development between criminal justice services and mental health services, so that each may gain a deeper and more detailed understanding of each other's services, roles, responsibilities and priorities.

- We will establish a mentoring programme, focused on equipping Prison staff, Police and Probation colleagues with the skills to identify and respond to the signs of mental illness, complemented by a similar approach to equip mental health service staff to better support those with offending backgrounds and those who are resettling in the community.

- We will work with key service leads across public and voluntary and community sector organisations to establish a common understanding and shared approach to risk, its assessment and management. As part of this work –

    - Current risk assessment and risk management approaches will be reviewed and updated.
    - Common approaches to positive risk management will be established, with guidance on how to include positive risk management into joint care planning with service users and their carers (where appropriate).

- We will develop a robust Quality Assurance and Governance system for mental health services in Jersey, which will provide accountability back to senior management, who in turn can then be held to account for the quality of services.

- We will introduce a quality framework that will include –
    - Compliance (standards being met, regulatory, statutory and outcome measure compliance is being achieved).
    - Assurance (risks to the service, including its value, and ensuring that goals are identified and managed).
    - Improvement (services are being improved and transformed in line with agreed priorities, and that innovation is supported and encouraged).
- We will produce an annual Quality Report for the Public, which will incorporate –
    - Patient safety (including serious incidents and near misses).
    - The effectiveness of treatments that patients receive.
    - Patient feedback about the care provided.

KEY PRIORITY 5: Leadership and Accountability

Families and carers should be informed, to the greatest extent consistent with the requirements of privacy and confidentiality, about the treatment and care provided to the consumer, the services available and how to access those services. They need to know how to get relevant information and necessary support. The different impacts and burdens on paid and unpaid carers need to be acknowledged.

Effective leadership, both operational and strategic, should be central to the process of transformative change and the embedding of a culture that seeks to promote co-production, recovery and independence within mental health services.

Building Blocks	**Emerging theme**
Develop clear lines of accountability	Establishing system outcomes, quality and measurement Developing the workforce Improving the money-flow in the system to follow the service user
Not tolerating stigma amongst the Public and professionals around people with mental health problems	Developing the workforce
Adequate numbers of well-trained staff working in suitable conditions	Improve the service environment Enabling workplace mental health interventions
Customer Voice	
91% of respondents think joint working and partnerships are key to improving mental health outcomes and experience *57% of respondents felt hopeful about the outcomes of the Mental Health Services Review*	

The supporting evidence from literature

In *Service Transformation – Lessons from Mental Health* (Gilbert *et al*, 2014) the factors that enabled change to happen in mental health were explored. Among these was the need for high-quality, stable leadership to manage change, handle unexpected demands and results, and ensure integration of expertise, both within the organisation and among voluntary and independent providers.

The King's Fund has found that the business case for leadership and engagement is compelling: organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress.[42]

An emerging evidence base is developing around the role of workplace mental health interventions. In their debate piece for the BMC Psychiatry in May 2014, La Montagne *et al* review the evidence to support an integrated approach to workplace mental health, and the authors argue that to realise the greatest population mental health benefits, workplace mental health intervention needs to –

- comprehensively protect mental health by reducing work-related risk factors for mental health problems – including job insecurity, bullying or psychological harassment, low social support at work;
- promote mental health by developing the positive aspects of work, as well as worker strengths and positive capacities;
- address mental health problems among working people regardless of cause.

The conclusion reached is that, in practice, an integrated approach to workplace mental health can expect near-term improvements in mental health literacy, to be followed by longer-term improvements in working conditions and job quality – given adequate organisational commitment, support, and time to achieve organisational change. These changes should, in turn, lead to improvements in mental health and wellbeing.

Case vignette

J had struggled with low moods and anxiety ever since he started secondary school, and none of his teachers seemed to recognise what was happening for him; however, when he was in Year 10 his teacher referred him in to see the school counsellor, which was incredibly helpful, and although he still felt very unwell, there was a sense that someone was listening and understood what was he was going through. After a few months, his school counsellor suggested that Joe might need some more specialist help and also access to youth services for ongoing support.

J was referred and accepted into CAMHS and also linked into the Youth Enquiry Service. J got on well with both his psychologist and psychiatrist at CAMHS, and although he was now diagnosed as having depression, anxiety and OCD, he felt that his needs were being met. He had access to some art therapy, which really helped. When things went well, people really talked to

[42] Report from The King's Fund Leadership Review 2012.

each other and knew what other services would be appropriate, and things seemed joined up for J.

At the end of his time at CAMHS he was transferred on to Adult Mental Health and discovered that there was almost no transition or proper handover; his CAMHS worker just said that J had to move on in 2 weeks and that was that.

When J arrived at his first appointment in adult services, he discovered that although they were nice, they knew nothing about him and J had to tell his story all over again on several occasions. J wished that people had talked more about his transition, and that both children's and adult mental health services had planned the change with him.

What we will do

- We will establish a multi-disciplinary Community of Practice for Mental Health, which will include service users and carers and support practitioners from different disciplines not only to work together, but to explore how they are accountable to each other.

- We will conduct a detailed review of current mental health spend for Jersey, which will cover public, non-profit and the private sector. This will create a baseline from which to build plans for future funding.

- Building on mechanisms used in P.82/2012 and this mental health strategy, we will develop effective service improvement mechanisms which engage effectively with professionals and the Public.

- We will work towards a defined set of outcome measures for mental health services across the life course. The agreed metrics will seek to measure the impact and success of services and interventions against agreed criteria. This will inform future outcomes-based models to drive further improvement.

- We will establish a monitoring system that regularly audits and reviews defined outcome measures and identifies trends and areas for ongoing improvement, as well as shaping new outcome measures.

3.2 Our intentions and next steps

This Strategy has been developed as a result of P.82/2012 '*Health and Social Services: A New Way Forward*'. It is consistent with the vision presented in our Green Paper from May 2011; and the subsequent White Paper from June 2012: '*Health and Social Services White Paper: Caring for each other, Caring for ourselves – Public consultation*' – providing care closer to home, in the right place at the right time, applies equally to mental health services as it does to other areas of health and social care.

Our intention is to make this a reality, starting with the development of a clear and deliverable implementation plan, to take forward this Strategy in a phased way that will help deliver the vision approved by Islanders and the States Assembly.

This Mental Health Strategy has been developed through a number of deliberative steps. Engagement has played a pivotal part in the process that has led to the 5 priority areas. The 'golden thread' of issues that link the Building Blocks, the emerging themes, and the areas of strategic intent, have all been informed or developed by people who work in, use, or have an interest in, mental health services in Jersey.

The process has demonstrated the value and importance of that engagement, reaching out beyond professionals, to the Public, service users and other organisations in the community and voluntary sector, to seek and include their views. In addition, by engaging with staff from the mental health services and allied agencies, including primary care, and enabling them to learn together and create change from the ground up.

Our intention is to continue this engagement and extent this way of working to other areas of strategy development.

The development of this Strategy has also highlighted the importance of being able to access good quality information to inform future planning, and the vital role that culture and leadership will play in shaping the way in which the areas of strategic intent are taken forward.

This strategy sets the priority areas for the future delivery of mental health and wellbeing services in Jersey. Implicit in these is a commitment, from all involved, to enhancing recovery and sharing a common set of values about promoting high quality, outcome-driven services. The changes required to make these intentions a reality will need to happen within a more constrained financial settlement, and will require partnership at all levels in order to be successful.

Our intention is to be clear on the benefits as a result of this Strategy, both in terms of quality and value for money.

The work underpinning this Strategy has identified a number of current issues which can be acted on in the short term. **Our intention** is to begin to act on those issues in a timely manner where we can.

The **next step** now is to begin a communication process with Islanders and key organisations before finalising the Strategy in late-June. An implementation plan will then be developed which sets out priorities for action over the next 5 years, with detailed costs and clear links to other strategies, such as Sustainable Primary Care.

Acknowledgements

The States of Jersey would like to express its thanks for the help and support given to us throughout the process. In particular, the citizens of Jersey, particularly those who have lived experience of mental health issues, for working with us so openly and enthusiastically.

We could not have successfully completed this piece of work without the knowledge, help and expertise of colleagues from both the community and voluntary sector and in other States of Jersey departments, giving up their time to give their input.

Thanks also to Contact Consulting and the University of Birmingham, whose expertise and knowledge have helped to make the process the success it has been.

SENATOR A.K.F. GREEN, M.B.E.

Minister for Health and Social Services

APPENDIX 1

Jersey Mental Health Services Review
Report of the work of the Citizens' Panel

Prepared by:

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Introduction

It is now widely accepted that the involvement of members of the Public is central to effective policy-making, service design and delivery. Many of the issues which government must address are hugely complex. This means that to allow meaningful community involvement to happen, members of the Public must be given plenty of time and space to be able to consider the issue before reaching conclusions.

This report is a summary of the efforts of the States of Jersey to start to achieve this through the organisation of a Citizens' Panel in October/November 2014. The aim of the Panel was to enable a diverse group of Jersey residents to consider the 'mental health system' on the Island as it is, and to then identify the 'building blocks' that need to be at the heart of a mental health system for the future.

The approach

The Citizens' Panel is loosely based upon the model of the Citizens' Jury. The Panel is an opportunity for a broad cross-section of the community to come together to share their experiences and opinions and to 'deliberate'. This means learning from each other, challenging each other and eventually drawing conclusions together. The thinking behind it is that once people have this shared experience, they are better able to draw conclusions that go beyond their own needs and instead to consider what is best for the wider Public. Some people call such processes 'mini-publics'.

Who was involved?

The Citizens' Panel was managed and facilitated by Contact Consulting.

Essential to the success of the project was the need to recruit a diverse group of people from across the Island. The group is not representative, but does reflect the diversity of people living on the Island. In order to recruit participants, the following steps were followed –

(a) The design of recruitment letters (see Appendix) explaining the project and inviting people to complete a simple one-page form to take part. Completed forms could be returned by post, via e-mail or over the phone.
(b) As an incentive all applicants were offered a £20 voucher for each session they attended.
(c) Applicants were given the choice of an afternoon or evening slot and were offered assistance with travel, child care or any other support that might make attendance difficult.
(d) 1,000 recruitment letters were distributed across the Island. This was done randomly through Jersey Post.
(e) Letters and forms were also distributed through local organisations, including Mind Jersey and the Jersey Alzheimer's Association.
(f) Outreach work was also conducted over 2 days at the Bridge Centre and the Contact Centre in order to increase diversity and reach some people who may not have received the original letter.

Over 70 applications were received. Twenty-five people were selected to reflect the diversity of the local population. In preparation for the sessions all participants (except one) were spoken to on the phone.

The sessions

The sessions ran for 2½ hours on 4 evenings at the St. Paul's Centre in St. Helier, Tuesday 28th and Wednesday 29th October and Tuesday 4th and Wednesday 5th November (6:30–9:00 p.m.). Twenty-two people attended all of the 4 sessions, including the following –

- 13 women and 9 men;
- 6 people aged between 18–30, 5 people aged between 31–40, 4 people aged between 41–50, 3 people aged between 51–60, and 5 people aged over 61;
- people from Grouville, St. Brelade, St. Clement, St. Helier, St. Lawrence, St. Martin and St. Saviour;
- people who described themselves as currently experiencing mental health problems, people who have experienced mental health problems in the past, and people who said they have not had any mental health problems.

Each session was designed in a way that enabled participants to share their experiences and opinions and to build their knowledge and understanding, before finally producing a set of building blocks for a future mental health system.

Session 1

After a brief ice-breaker, participants formed groups to look at maps of different parts of the Island. Using the maps they then discussed what helps people's mental health/wellbeing and what hinders people's mental health/wellbeing. These were then plotted on the map and discussed. This activity enabled people to think about the state system of support, as well as other forms of support on the Island.

Session 1: Mapping activity

Other Panel participants worked on a 'tree' activity, which enabled them to identify the root causes of some of the problems with the present system (the roots), at the same time as identifying what is working well at the moment (the shoots). The session finished with the group writing and agreeing a set of rules for how the group should work together from now on.

Session 2

The sharing of experiences continued in Session 2, with people drawing their own 'wellbeing rivers'. Participants drew a river to represent their lives or part of their lives. Their different experiences of mental health/wellbeing throughout their lives were represented by using different river features, e.g. rapids, calm water, dams, etc. In recognition of the fact that we effect change by building on things that work, as well as addressing things that don't, participants reflected on times when things were going well, in addition to times when they weren't. Some of the group also continued to work on the tree activity. After having reflected upon their learning from these 2 activities, the group then started to identify the building blocks which must form the basis of our future mental health system (the foundations).

Session 3

The third session more closely resembled a classic Citizens' Jury session. Three guests were invited to present to, and be questioned by, the group, in an effort to build the group's understanding of how the 'formal' system operates at present, and to start to test out some of their building blocks.

The following people presented to the group –

- Dale Harrison (Consultant Psychiatrist)
- Tracy Wade (Consultant Psychologist)
- Stephen Le Quesne (MIND Ambassador).

Session 3: Dale Harrison presents to the group

Each guest was given 10 minutes to present to the group. All Citizens' Panel participants were equipped with red cards, which they could show to the presenter if they felt language was too complex or they needed clarification. After the presentation had finished, the speaker was asked to leave the room while the participants split into small groups to talk through what they had heard and to write questions for the speaker. The speaker was then invited back into the room for a question and answer session. The questions asked during these sessions are listed in Appendix 1 to this report.

Session 3: small group discussions

Session 4

The final session started with participants reflecting on the previous day's session through a one-on-one speed-dating type of activity. The group then reflected on all the activities from the previous 3 sessions, in order to theme their thoughts, to refine the existing building blocks, and to write some new ones. In order to better illustrate their building blocks, participants were asked to try and illustrate them with personal stories.

The remainder of this report documents the 'Building Blocks' that the Citizens' Panel believes need to underpin the future mental health system.

The building blocks are in no particular order. They are illustrated by personal stories *(in italics)* and also by some 'background thinking'. The points under the 'background thinking' headings are some of the thoughts of the Panel members that led to the building block being identified.

1. Continuity of care and services working well together

'Silkworth Lodge saved my life. Their 'business model' (if you can have such a thing for care) was without parallel. The same gentleman that initially assessed me saw my graduation. From 15 weeks of in-house primary care delivered by professionals and support staff in recovery, for me in my recovery, through to the 'bridge to normal living' provided by second and third stage care has got me to my (very nearly) first year clean. What I feel is of paramount importance here is the continuity of care. I still attend Silkworth weekly, on a Thursday evening, for 'aftercare' with other people in recovery, who have been through Silkworth and with one of the councillors who practices there. The operation is run by a business professional (finance) which I think is key. Mental health provision is a business and needs to be run as such. My name is Rachel and I am an Alcoholic Addict. My name is Rachel and I am alive to write this because of Silkworth.'

'I have suffered from anxiety/depression for over 20 years including several breakdowns/admissions to St. Saviour's/Belcroute. I had to request being able to see the same psychiatrist otherwise allocated different ones and have to re-tell history every time.'

'The importance of follow-up care after visiting G.P. and receiving medication ... … going home with no support and waiting to see if the medication works is not good enough.'

'When I sought the help of a CPN, I ended up being 'counselled' by the social worker for mental health. I asked if I could see someone else, i.e. CPN, but was told they are interchangeable, i.e. social workers/CPN!'

'An 86 year-old woman suffering from Alzheimer's falls and hurts herself, leaves her gas hob on, melts her electric kettle on the gas stove, can't cook for herself and feels alone despite regular visits from family members. The gas company have been called out twice to switch off the gas. The medical staff feel that she is not a danger to the Public, seeing her a couple of times per week. This needs to be addressed as it's just not right!'

Background thinking

(a) Services need to be integrated.

(b) Someone who comes back to you and someone you know and trust.

(c) Co-ordination of services, working together holistically, but to do this, there needs to be an awareness of all that is involved in mental health.

2. Accountability

'I met my boyfriend at Orchard House, he came in on a suicide attempt and was on heroin replacement and had used other drugs and I had bipolar. He was discharged after 2–3 weeks and had social phobia due to everyone thinking everyone was talking about his suicide attempt – he wasn't given adequate support after discharge and he had been discharged to stay at his uncle's flat, because of being unwell and being unable to cope with his situation he was asked to leave, his uncle disowning him, and found a bedsit to stay in. I then had been discharged to stay at Clairvale, when I met him he was suicidal he had a rope in his pocket and planned to kill himself. I decided to stay with him because I was worried to leave him, when I left him a week later for a few hours, I later found him in the woods with a rope, suicide messages on Facebook and written on his skin. Luckily he told I and my mum took him out to dinner and she said we could stay in Grouville with her because he couldn't handle bumping into addicts/dealers in town. The Police later came round because of suicide messages on Facebook and persuaded him to come to A&E because they wanted him sectioned. We waited at least 2 hours before a registrar psychiatrist arrived and community nurse, they spoke to him for about half an hour and he came out and told us he should go back to my mum's house. We were desperate for him to be sectioned as we could not provide 24 hour care. I had just come out of Orchard House, now the doctor decided he could be discharged into my care – which my community nurse and psychiatrist thought was hugely inappropriate. About a week later he shot himself in the head – a miracle that he survived – had 2 operations – fractured his skull. Why did it have to come to that when at A&E after the Police brought him in my mum said our concerns but we were asked to leave for causing disruption – they refused to take our concerns on board and were very rude, but our concerns were proven to be valid, no apology.'

Background thinking

(a) Complaints about patient care; who do you complain to? What can be done? Are staff disciplined if they have broken care guidelines, etc.?

(b) Is psychiatry a job for life? Can you lose your job for bad performance – high suicide rates/bad feedback from patients/please ask for feedback?

(c) Bad practice: psychiatrists who perform badly, issue wrong prescriptions, call you by the wrong name when it's on the computer in front of them and they have known you for years. Who do you complain to when they all stick together?

(d) Accountability in mental health services to address complaints about staff.

3. Not tolerating stigma amongst the Public and professionals around people with mental health problems

'I have heard the term 'revolving door' when referring to patients like myself who have recurring illness.'

'M has been involved with mental health services since the age of 20. She experienced severe back pain as a consequence of her occupation. Because she was engaged with mental health services, the back pain was discounted. Much later, a friendly Occupational Therapist referred her, and after 20 years of severe pain and deterioration in her condition she was properly diagnosed. She spent 6 months in hospital and had multiple operations. Because her back pain was attributed to her depression she had suffered.'

Background thinking

(a) Challenging stigma education.

(b) Being non-judgmental.

(c) There needs to be education on mental health (what it is ...).

(d) Why do general clinicians need to know mental health diagnosis when it is not necessary for physical diagnosis, as this causes stigmatisation and often defers from an actual physical diagnosis, i.e. 'it's all in your head'?

(e) Why is the Mental Health Services Department separated from the General Hospital? It makes stigma more prevalent and creates difficulty then getting to the pharmacy.

(f) Physical health of mental health sufferers can be overlooked by medical staff who effectively 'stigmatise' the patient as having mental health issues.

(g) Medical staff need to be more understanding and treat patients as human beings, involve the patient in treatment where possible, and not refer to patients as a 'revolving door'.

4. Adequate numbers of trained and well-supervised people working in mental health with suitable working conditions

'I worked in the special needs service and wanted to train for NVQ level qualification. I worked for 2 years and was not even placed on the waiting list for training due to the lack of registered nurses to monitor my progress and training.'

'The staff in the hospital are not trained to understand people with Alzheimer's (memory loss) although they were told when someone was admitted.'

'I have found that nurses and carers in mental health need to work shorter shifts, 12 hour shifts are too long.'

Background thinking

(a) No 24 hour local mental health support on the phone.

(b) Hospital casualty staff need better training.

(c) We need a system that considers the future demographics: e.g. ageing population, therefore increased risk of dementia; e.g. alcohol and drug use.

(d) We need a system that learns from elsewhere, e.g. links with Guernsey and the UK.

(e) The need for staff at school to be aware of/look out for mental health issues in children.

(f) Key workers in schools with children with behavioural problems need training and support. Staff need to be compassionate.

5. Recognise how high the suicide rate is in Jersey

Background thinking

(a) Suicide prevention: what would it look like?

(b) The shock and horror of unexpected suicide here in Jersey in a very small community is hard to describe. There is a massive need for a bereaved family to receive professional support; counselling at the right time is so important.

(c) Could there be a local advertising campaign that highlights the effects of suicide and informs people of support available to encourage them to tell someone if they have suicidal thoughts?

6. Recognise the causes of mental health problems (e.g. unemployment, stress, loneliness, isolation)

'I had my drink spiked and have no memory of events. I pleaded guilty to charges. I lost my job, relationship, home. I was homeless for 9 months. There was no support from Income Support for 9 months, then I was pressured to find work. Job applications were rejected, I suffered a breakdown and wanted to end my life.'

Background thinking

(a) Some people can't afford a G.P. appointment.

(b) Challenge loneliness and isolation.

7. Speedy response at the time of need, with someone coming back to you

'When in crisis I spoke to CPN who told me 'we don't take people into hospital now, call me back next week', when I asked for respite/safety/admission to hospital. I deteriorated and didn't call back, no-one checked to see if I was ok.'

'I attend a recovery course which lasts 6 weeks and I found it useful.'

'In the middle of the night I was suffering from insomnia and mania, I was desperate for someone to talk to, racing painful thoughts, crying. I was not allowed to drive because of strong medication, staying at sister's house (with 4 children) don't want to make noise to wake them, cannot handle the silence.

I called the switchboard at the hospital, 'Who can I talk to?' They say I can only talk to the nurse if I go to A&E. I can't ask my sister to drive, get a taxi? Are there any helplines I can call? No, Samaritans closed. Call Orchard House, they are too busy to talk, call Clairvale House, they are not busy but refuse to talk. Please could there be a 24 hour helpline manned by community staff or Clairvale without the inconvenience of going to A&E?'

'Silkworth House, rapid response, one week from initial meeting to being taken in.'

'M looks after her father who has dementia. She cares for him at home until last May of this year. For 5 months she had been asking for respite care. Support was a monthly CPN visit. It took an admission to acute care to get him respite. This shows a lack of respite beds and community nurses to support older people and their carers. With an ageing population these challenges will only increase.'

Background thinking

(a) Need emergency cover 24/7.

(b) Need improvement to services.

(c) Long waiting times need to be shortened.

(d) Timely action to every inquiry.

(e) Someone who comes back to you.

(f) Transition from different services and departments needs to be easier.

8. The need for confidentiality

'D had a history of depression and other mental health issues as a teenager. His problems at work came to a head following bullying by his manager. He was given time off, but was anxious that a prolonged period of absence would draw attention to the nature of his problem. Against G.P. advice he returned to work, but only a few weeks later he was dismissed. He took another job, but after a short while someone from his previous firm arrived and he became anxious that the history from his previous employment would become known. When he needed a day off to deal with a domestic emergency he was told not to return, and suspects this was because information relayed by this person influenced the judgement of his new employer.'

Background thinking

(a) Someone you know and trust.

(b) Trust and confidentiality in medical staff.

9. A focus on prevention, including investment

'I have been bullied all through school and in some workplaces, had resilience skills/DBT skills been part of school experience, my mental health issues/need for services may have been reduced/not required.'

Background thinking

(a) Learning mindfulness.

(b) Family/friends and support for them.

(c) Use exercise to promote wellbeing.

(d) We need to recognise that the children with behavioural problems now in schools are the future of our mental health resources.

(e) Robust anti-bullying protocols in schools and companies.

(f) Preventative therapies: relaxation, etc., promote wellbeing before the tipping-point.

(g) Build self-esteem.

(h) Educating children to pursue happiness, follow their dreams, not to listen to other people's negativity, set their goals, dream big, build self-esteem and resilience.

(i) Helping make sure children develop coping strategies but also learn from experience.

(j) Prevention: ante/post-natal input, meditation/massage.

(k) Education for children with behavioural problems, CAMHS is under-resourced.

(l) Family and home support, build up the parent.

10. Easily accessible information about services and where to find help and support

'Carer's assessment: I agreed to this at Overdale. Six weeks later I had 3 calls from somewhere advising me that I was down for a carer's assessment. After the third call, approximately 3 weeks later I was contacted by the assessor and made arrangements. Three-monthly assessments suddenly changed to 6 monthly assessment because someone was sick.'

'A positive, I have made contact with someone at HSS regarding my problem and they are going to get back to me, Hurray???'

Background thinking

(a) It would be very useful to have a list of G.P.s who have an interest/speciality in mental health, as my previous G.P. was unaware of what was available from the Psychology Department.

(b) A big need for a central access point to gain information and direction for your issues.

(c) Need to publicise available helplines.

(d) Need doctors to explain to me what is happening to me and what prescribed pills will do? (e.g. side-effects and addictive nature).

(e) Some people don't know what support is available.

(f) There should be a Centre where people can go when they need help. That Centre should be able to advise what direction to go in.

(g) G.P. availability.

(h) Who to speak to?

(i) Central point of where to find information?

(j) If the States of Jersey weren't so selfish my friends would still be here.

11. Value and support the role of people and organisations outside the formal/ state system (e.g. families and carers, friends, church, charities, work, youth services, etc.)

'When I start talking stuff gets around. I have trust issues. I have two mates who I talk to, they are like sisters. When my head gets to breaking point I go quiet and cut my arms. What helps is talking to my mates … … she has a thing that helps me stop cutting, she slaps my arms and then hugs me. I think there should be more training on mental health for people who work in the Shelter Trust.'

Background thinking

(a) Support for carers, meetings and respite care.

(b) Needs to be a whole system that incorporates 'non-mental health' services, i.e. church/exercise/family/charities.

(c) Support for carers and family, as sometimes they are the most useful.

(d) Volunteering, giving something, getting something back.

(e) There needs to be support for Jersey-based (e.g. MIND) charities, not UK-based charities (like Macmillan Cancer research).

12. Explore, offer and invest in different therapies/support and ways of delivering them, because one size doesn't fit all

'I first started schema therapy (which is just what I need) in 2000. The therapist retired in 2001 and it hasn't been possible to resume this therapy til 2014 (a waste of 13 years when my life could have been so much more on an even keel).'

'My mother had pain and stress and was offered time in a free 'Health Farm' type environment to prevent escalation into a mental health problem. Prevention better than cure (not in the UK).'

'The use of mindfulness with issues especially pain management, i.e. pain causes depression, depression causes pain. I used this when taught at the pain clinic for severe back pain.'

'DBT (Dialectical behaviour therapy) helped so much.'

'I appreciated art therapy on Belcroute Ward, it opened up new horizons for me.'

'As I have difficulties in going out (from time to time) I found it easier when Belcroute in town than having to use bus from St. Saviour's.'

Background thinking

(a) Family support services (e.g. The Bridge) should get funding from the state, but not if it means it loses its independence.

(b) People have been trained in family therapy, but family therapy is not available; it needs to be.

(c) Possibly the reason there is not higher bed occupancy at Orchard House is because mental health staff deny access on principle when some patients with recurring problems/emergencies are unsafe and need respite/a place of safety, because 'we don't take people into hospital now'/ 'call me in a week'; by which time the patient was: "so low couldn't use the phone, no-one called back to check on me".

(d) Accessibility to services and visiting transport (voluntary/bus/hospital transport).

(e) Exercise referral.

(f) Goal programme.

(g) Schema therapy, resolves maladaptive coping strategies for those who need it.

(h) Bereavement counselling for children and for family problems.

(i) Jersey Talking Therapies.

(j) One size does not fit all, some people need respite from life, to keep them safe, albeit briefly, i.e. hospital admissions.

(k) Use Internet as a resource (but recognise not everyone has computers).

(l) Mental health forum support.

(m) Teach 12-step philosophy.

(n) Peer-to-peer support.

(o) Group therapy.

(p) Complementary therapy, flower remedies, aromatherapy, reiki therapy.

(q) Parents should listen to their children and acknowledge their feelings and needs.

13. The need for choice

'Partner has Tourette's Syndrome and sees a psychiatrist at the clinic. They are only treated with medication. There is no specialist on the Island. They need to have other therapies to help with their condition, these are available in the UK. They were promised a referral 2 years ago, this has not happened. They need an outlet e.g. gym/sports but this is not affordable or offered. They need choice as the medication is not helping moods. Tourette's reactions and the work situation leads to more stress.'

'Dr. Dale Harrison mentioned the first port of call in a crisis (out of hours) is out of hours G.P. However, as I am on benefits and having seen the rates they charge I do not feel this is an option, which leaves A&E/Police which I am not sure are the best options to someone feeling suicidal/unsafe.'

14. Support in the workplace

'I had M.E. that the G.P. diagnosed. I was working at the time, nobody at work knew what was wrong, but I couldn't work as well as I could. I was off work for 10 months and became depressed, I was also looking after 2 kids. My immediate boss was quite difficult and didn't want me to go back. He was horrible and didn't want to offer any support from him. Eventually I got support from my senior manager who helped me return to work. The whole period was really stressful. In the end I returned to work part-time and then full-time working until I was 60 years. Returning to work really helped my recovery, support of G.P. and workplace was crucial to me.'

'HR were very flexible offering to meet me when off-site at places outside of the workplace, e.g. This really helped as I had a huge fear of going back into the office. They would regularly ring me to 'catch up', which felt genuine and supportive and there was a continuity with my personal HR contact. The partner in my team was also tremendously supportive and did not judge me at all. In fact he normalised what I was going through by sharing personal stories. I always felt supported and it helped a lot.'

Background thinking

(a) Society needs awareness of different mental illnesses.

(b) Being open with employers about capabilities helps with expectations of both parties, supportive staff and colleagues.

(c) Trust and confidentiality in employer.

(d) Employer being knowledgeable and understanding.

(e) Raising the profile of mental health, especially in the workplace.

(f) Being employed.

Other issues identified by the Panel

Strong and effective leadership at the top and in all departments, and high expectations of all staff.

Additional stories

Story 1

'My brother became noticeably ill and deteriorated within a period of about 6 months. He was suffering with paranoia, severe OCD and he was hallucinating. I went to our G.P. who had known us both since we were children, and told him that I was deeply concerned for my brother, but he explained he was unable to do anything unless my brother himself attended the surgery asking for help.

By its nature mental illness is not apparent to the one who is suffering from it, so having my brother voluntarily asking for help was not likely. His condition became much worse, his OCD was so severe he could only take 5 steps forward before taking 2 back, getting anywhere took hours, even if we did make it down the street, he was sometimes compelled to go back and touch a bush or plant, it was very difficult for him to function on any normal level.

He was not able to take proper care of himself, he was sleeping in woods and on the beach, he was deeply disturbed and was writing reams of words, he thought my son was Jesus, and was suffering immensely, unable to wash or care for himself, his face was burnt and blistered from the sun, and his hands cracked and dried.

I had to drive around looking for him, in woods and in the bays, to take him food and warm clothing and try to get him to come home with me, which was very difficult, he would often sleep outside. His hallucinations were severe and it was extremely worrying to know he was outside in all weathers. My family did not recognize how serious his condition was, he had been suffering for approximately 3 years at this point, and my family often felt he was simply being difficult, and so he was falling out with them, and they sometimes took offence at his increasingly erratic behaviour. I was still unable to get him any medical help at all as he would not present himself at the G.P.

One night my mother called the Police as she was concerned that he was sleeping outside in a storm, 2 officers arrived at my house at around 1 a.m. in the morning to look for him, they would not accept that he was not with me, or that I was equally concerned about him, and proceeded to search my house, including kitchen cupboards, looking for him. My brother is almost 6 feet tall so it was unlikely that he would be found in such places, however they were very insistent and I was very distressed that their attitude was that of officers looking for a dangerous criminal.

I implored them to please not hunt my brother down like an animal, I explained that he was extremely ill, that he was a gentle and quiet person by nature, and he would be utterly terrified to find the Police looking for him in this manner. Unfortunately, my pleas fell on deaf ears and my brother called me from the psychiatric unit the following day, crying and begging me to help him, he was petrified, he said the Police had chased him through the woods and he had been forcibly brought to the unit. He was pleading

with me to come to him and they were threatening to tie him down and inject him if he didn't comply and take the medication he was given.

It was a terrifying experience for him, and I wish there had been some way for me to get him medical assistance before it came to this, he had suffered so terribly and I feel this is something that needs addressing. I found his Psychiatrist Dr. Hendrix was excellent in his treatment of my brother, he explained to myself and my mother what my brother's condition was, and he allowed my brother to come and stay with me on his release from the psychiatric clinic. He did relapse, but it was much easier now to get him assistance and he was able to get the help he needed and have his medication regulated to better suit his condition.

It has been a difficult recovery for my brother, but he has come far, the staff at A were amazing and helped my brother to gain some independence. The Housing Department were also excellent in assisting him, and I cannot fault the sheltered housing units that are provided for people suffering from long-term mental illness. I feel the standard of care in this regard is second to none. When he went for a holiday with my father they even called to see if he was alright as he hadn't been seen for a few days.

It will be a long road for my brother and he may never recover fully from his illness, but he has a much better quality of life now. I hope that steps may be taken to support those who suffer with mental illness, in being able to get assistance without having to present themselves at the G.P.

Perhaps doctors could be called by family on a casual basis to the house and be able to observe the person who it is felt is ill, with a view to getting them early treatment before their condition deteriorates. I hope the good service the Island provides to the mentally ill can continue, and continue to improve. Many thanks for reading.'

Story 2

This was spoken by a young man who was in St. Saviour's on 2 occasions in the past 7 years and who wishes to remain anonymous:

'St. Saviour's was a place of terror and torment. There is no compassion. They don't treat you like a human being. They treat you like a combination of chemicals, it was like being kidnapped by the CIA or something. They just pump you full of drugs. No-one said: 'you will get out of here when you are well'. I didn't know if I would ever get out. No-one was kind to me. No-one asked me how I was feeling. During a consultation with one of the doctors, I told him he looked depressed. He got angry and said 'That's it, you're going to be kept in for one year'. At St. Saviour's they don't really care about you. The drugs make you so tired that you lose your confidence. I was not told what my illness was. One of the doctors was discussing his sex life with a staff member one evening, when I was sat in reception reading the Bible. The same doctor said to me during a consultation: 'Your sister is a Muslim, your mother is a Krishna and you're a Christian, it's no wonder you're in the state you're in'. I was terrified the whole time I was there. Eventually I was told I could go and live in a flat if I could find one. I was allowed out for 2 hours to find a flat. My dad took me in his car. We only found a flat which was full of dampness. I was sent to Clairvale. I told a staff member: 'I'm only here because I couldn't find a flat'. He became angry and shouted at me: 'You're here because you have special needs'. Because of the way they treated me they didn't win my

trust. Being sent to the organic farm was pretty awful. It caused me stress. I felt cut off from society when I was there. All my dignity was gone at Clairvale, I felt I was being watched all the time. The second time at Clairvale was not so unpleasant as the first. There were different staff there. The kindest thing anyone said to me was by a lady nurse there, she said: 'You didn't ask for this illness'. The second time at St. Saviour's there was a Christian male who had genuine kindness. He treated me like a human being.

I was a vegetarian then and they gave me meat to eat. I couldn't digest it, I had stomach-ache all the time. I had a realisation a few days ago that the staff at St. Saviour's really want to help you.

I would like to relate the experience of trying to get help for my brother who was later diagnosed with schizoaffective disorder.'

Appendix 1: questions asked in Session 3

Questions asked of Dale Harrison

1. If there was a significant increase in budget, where do you think the money should be spent?

2. What's the biggest challenge facing adult mental health services?

3. Is there a place where people who self-harm can go to talk to someone about it?

4. Lack of care in the community – how do you change your CPN without going to the Minister of Health?

5. How well are people in La Moye with mental health issues looked after, would they be in Prison in the first place if there was adequate provision?

6. Any plans to increase respite beds for the elderly and community liaison at home?

7. How long from G.P. referral to mental health services (for under-65s) before the first appointment/triage?

8. How do mental health services plan to educate younger generations on the danger of mental health issues?

9. Is the timescale appropriate for treatment?

10. What provision is there for G.P.s (that is confidential – this is Jersey?!) who need help/counselling to keep them well to practice well?

11. How do you educate employers about mental health issues?

12. Is it possible for mental health services to provide better support in the workplaces?

13. How can the prevention agenda be extended into schools?

14. Why can't my G.P. admit me straight to Orchard House when I'm not well?

15. Will the Island be able to cope in the coming years? Ageing population?

16. There used to be 2 wards in adult mental health with about 20 beds each; now there is one ward with 16 beds which sometimes overflows and people have to share rooms or are asked to leave before they are ready. Do you think there need to be more in-patient beds?

The following questions were not asked due to a shortage of time

1. Is the age-based division of services appropriate for dementia sufferers, in view of the possibility of pre-senile dementia?

2. Are there any plans for increased respite services? Especially dementia

3. Treatment for post-traumatic stress?

4. After in-patient care there needs to be sufficient support in the community and gradual integration, do you agree?

5. If someone has a schizoid disorder how can we get help for them?

6. How well does mental health care flow through the 3 stages?

7. For the long-term unemployed with mental health problems could there be more facilities available in the community to avoid social exclusion and depression? Can we put this into practice?

Questions asked of Tracy Wade

1. One problem is that carers don't know what support is available for them, how can this be?

2. Could there be support groups with different mental disorders that are led by the psychological services on an ongoing basis?

3. Do you plan to have wellbeing courses for children in schools?

4. One end of the ship does not know what the other end is doing. Lack of information between departments. How can this be improved?

5. Is there any support for young children whose parents are involved with D&A?

6. Are the 3 hour MIND Jersey workshops online or are they in groups?

7. Will you provide family therapy/group work?

8. Will the new Jersey Talking Therapies help people transition between CAMHS to adult mental health?

9. What type of support have you got for children whose parents have depression?

10. How is the service referral pathway being advertised to the general Public?

11. Is Jersey tackling the issue of young citizens like me of commitment of suicide due to mental health problems where they feel they can't see anyone or are refused help?

12. How does one know how to access these services other than through their G.P.?

13. How does JTT link in to support in the workplace?

14. Any plans to roll out Talking Therapy for under-18s?

15. Have they enough therapists to cope with all the referrals?

16. Are there any support groups for sufferers of mental health issues?

17. Is there any support for staff who work in the Shelter Trust who support people with mental health?

18. Would Jersey Talking Therapies identify an alcoholic/addict and be able to re-direct that individual to D&A/AA or NA/Silkworth to address addiction issues prior to addressing underlying issues?

19. How can we provide more psychological services to the under-18s?

20. Post-traumatic stress from the war, etc. does not seem to be dealt with in Jersey. Are there plans to bring treatment over or referrals overseas? How will this service help carers to cope?

Due to time constraints, the questions asked of Stephen Le Quesne were not written but instead were asked directly. As a result, these questions have not been recorded.

Appendix 2: recruitment letter

Mental Health Service Review

Planning together, for our future

States of Jersey

Dear Sir / Madam

This letter is an invitation for you to take part in a local **Citizens Panel** which will help consider a range of issues which are important to looking after our mental health and wellbeing in Jersey. You have been randomly selected to take part in the Panel which will take place over 4 sessions in October/November. We are recruiting 25 people who live in Jersey to talk about mental health services and wellbeing on the island. You do not need to have any kind of special knowledge or experience about this issue. We want to bring together a diverse group of people to share opinions and consider what needs to happen to make sure that services work well together to look after our mental health.

The panel is funded by the government, and will be run by an independent organisation that has lots of experience of running similar panels. The panel is happening now because it is part of a review of Jersey's mental health services which will help consider and recommend future services to the Health Minister.

The sessions will take place on Tuesday 28th and Wednesday day 29th of October and Tuesday 4th and Wednesday 5th of November, either in the afternoon or evening (depending on when most people are available) at the St Pauls Centre in St Helier. Everybody that attends the panel will receive a **£15.00** shopping voucher this means a total of **£60.00** for coming along to all 4 sessions. The vouchers can be spent in a number of local shops. If you are interested in coming along please fill in the very short application form that is attached to this letter. If you are worried about child care or any support needs you may have don't worry, there is money available to help with this, just let us know on the form. We want to do everything we can to make it easy for you to come.

Please fill in the application form and send it back to us via mentalhealthservicesreview@gov.je If you still have questions or would like to talk this through some more, please call Andrew Heaven on 01534 442251 or Peter Bryant (the panel facilitator) on 07855 341480.

We really hope you are interested in joining this exciting initiative and look forward to hearing from you.

Kind Regards

Andrew Heaven
Mental Health Services Review – Project Lead
Service Redesign & Delivery
Maison Le Pape
The Parade
St Helier
JE2 3PU

Peter Bryant
Citizens Panel facilitator
E Mail: pbinclusion@btinternet.com

APPENDIX 2

UNIVERSITY OF BIRMINGHAM

Contact Consulting

States of Jersey

Mental Health Service Review
Action Learning Report

Executive Summary

Five action learning set days provided a powerful networking group of practitioners who have started to create both cultural and substantive change from the centre of their practices and across the mental health system. The rich outputs including practice challenges, assets, strategic themes, questions, learning outcomes and impacts from specific practice improvements demonstrate what is possible when people with first-hand practice knowledge and motivation join together to make a difference. The sets provided a core activity and learning hub that allowed the other important dimensions of the review (stakeholder interviews, citizen panel and customer voice) to be heard, digested, challenged and then inform their actions and projects undertaken to address the project challenges and emergent themes. This report contains the journey towards and through the five action learning sets, including the outputs, outcomes and impacts and suggestions offered by the action learning set members on how to sustain and build on the social movement that they have started. Continuing to build on and sustain the social capital generated through this intervention presents the States of Jersey mental health services with a challenge as expectations have been raised across the system. Not all learning set members will want to continue this tough journey and should be allowed a graceful exit with full appreciation for their contribution but it is recommended those that do should be recognised as a change leadership cadre, the movers and shakers, who with appropriate support for their professional development can take the service forward in line with the review's strategic recommendations to a system that is fully fit for purpose. What should be encouraging is that everything they need to do this in terms of assets is available on the island – it just needs their leadership, a collective leadership, backed by the senior leadership to make it all work in service of the people suffering with mental health problems.

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1.0 Introduction

The overall aim of the action learning sets is to improve service user experience and outcomes by building change to services from the centre of practices. Changes to address practice challenges (PC) are based on the shared knowledge of the participants - mental health practitioners from the statutory, private, not for profit, and voluntary sectors on the island. The artists who produced artwork for the engagement day depicted the learning set participants as protestors or activists and indeed this is exactly what they are – brave souls who put themselves forward to protest that things have to change and who are prepared take action to improve services. The fact that the learning sets were over-subscribed by 50% gives an indication of the commitment to change across the island's mental health services. It is this commitment that the action learning sets are designed to harness and channel in service of forming the bedrock of the strategy and gaining traction on specific areas for improvement towards a new service model. That new service model is encapsulated by the building blocks from the Citizens' Panel (CP) and the themes that were generated as part of the ALS activities.

The objectives were

- To frame a series of discrete practice challenges (see appendix 1) that contribute to the overall MH strategy moving forward
- For practitioners to take *action* to address the practice challenges leading to *learning* and then review at each learning set meeting so their actions and learning are refined and projects to address the practice challenges are progressed towards substantive impact.
- To engender motivation for change within the practice based communities that the participants belong to through initiation and ownership of ideas and projects
- To build networks and shared learning around four 'focus areas' of mental health services: public mental health, early intervention, acute and crisis and recovery and support
- To provide data output in the form of project outlines, themes, assets and questions that feed into the overall strategy.

Each learning set was designed to allow participants to work as a group to define, analyse and reach conclusions to management and leadership issues being faced at individual and organisational levels. Each participant identified key improvements (practice challenges) in their part of the mental health system which they wish to bring about during the course of the review. Five action learning set meetings provided a forum for discussing how to achieve these improvements, and for applying their learning to these workplace situations.

The action learning sets were clustered around four focus areas: prevention (building reliance), early intervention (nipping problems in the bud), acute intervention (when things take a turn for the worst), recovery and support (what helps us cope). Practitioners were recruited who have ownership of the practices in each of these areas to join action sets of 10 -12 participants. This was above the recommended number of 6-8, however each area was oversubscribed, and the client wanted to maximise exposure to the action learning process.

The five action learning set meetings comprised running the four focus area sets in parallel, each facilitated by a consultant who has expertise in the areas of mental health, personal and organisational development, leadership and action learning. At

the start of each learning set day a 'stimulus seminar' was provided. These seminars were on different topics related to the review.

The outputs from the learning sets based on the discussions across all four sets over five meetings were:

- Specific practice challenge projects (appendix 1)
- Assets or strengths that exist on the island to support and augment statutory mental health services.
- Strategic themes
- Questions for the service as a whole
- Outcomes and impacts from taking action to address the practice challenges
- Ideas for sustaining the network moving forward.

These outputs are summarised in the main body. All the practice challenge outlines are contained in Appendix 5.

This report is structured as follows:

- Action learning background
- Approach to setting up the learning sets
- Outputs and analysis
- Evaluation of the ALS programme and sustainability moving forward
- Conclusions
- Recommendations

2.0 Background to Action Learning

Professor Reg Revans, the founder of action learning, when working as a young academic in Cambridge in the 1920s, noted that student managers were relatively passive and lacked energy in the classroom, yet came to life when they discussed their own 'back home' problems with one another in the breaks. He formed groups or 'learning sets' for the specific purpose of engineering a social exchange in which managers learned with and from one another during the diagnosis and treatment of real problems.

In the 1960s, Revans was appointed as Britain's first professor of industrial administration. Professor Revans, who died in 2005 in his nineties, was an influential business thinker internationally and the principles of action learning are used extensively in management and leadership development.

What is action learning?

"Action learning is a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done" (*McGill & Beaty, 2001:11*).

Individuals engaged in action learning work on real work issues and openly reflect on their experiences with a view to taking subsequent action. An underlying principle is that the individual knows their own issue or problem better than anyone else and remains responsible for it.

Active reflection on such issues/problems is often neglected with the operational pressures of day-to-day work, yet is vital in a fast-changing environment with emerging challenges. Reflection, coupled with commitment to action on a work-

focused issue within a group of peers who will offer support and challenge, can lead to powerful decisions and outcomes.

"There is no learning without action and no action without learning" (Reg Revans)

Action Learning is based on the premise that taking action (i.e. doing something) and learning (i.e. understanding more) are interdependent; it is not possible to act without opening up the potential to learn, and it is not possible to learn and understand if you do not act or try things out.

In other words: to learn and understand, we need to take action; to act effectively, we need to learn. Learning is focused at four levels:

1. About the problem which is being tackled;
2. About what you are learning about yourself;
3. About the process of learning itself i.e. "learning to learn"
4. About your relationship with other group members as you learn

Action learning sets are small groups of peers (usually 6-8) who are willing to offer as well as seek help from one another in a supportive and confidential learning environment.

The Action Learning set uses a structured facilitated process for exploring issues relating to each participant's area of work. For the participants, action learning involves identifying a situation they want to develop, change or improve – a situation that is significant enough to act as a vehicle for learning.

The process of sharing the issue with a group of fellow learners (the learning set) enables a person to tap into the ideas and experiences of peers and gain different and deeper insights. This increased understanding then provides the impetus for *action*, i.e. applying what has been learnt at the same time as bringing about change. At the end of a session, each person has a clear and specific set of action points to which they have committed themselves as a result of the learning set meeting, and which they will report back and reflect at the next meeting. In working on these 'real issues' with other individuals, people were able to reflect on and plan the actions that they want to take in their work place on an on-going basis.

To this end, for each Action Learning set, members are asked to identify a situation they want to develop, change or improve. A situation that:

- involves them directly
- is current
- requires them to take a decision or carry out action

The form at appendix 3 was provided to help them frame their practice challenge including personal outcomes, service outcomes, impact and the connection to the building blocks.

3.0 Approach to setting up and running the learning sets

During September 2014 expressions of interest were invited from practitioners from different services. Respondents were asked to frame a project challenge using the form shown in appendix 3. Approximately 64 were received which was many more than we needed for the learning sets. We reviewed the practice challenges proposed

and a final list of participants was identified according. Final recruitment was based on the relevance of the practice challenge to the strategic issue, achieving a professional diversity within the groups and the availability of people to attend all the learning sets. Those people not offered an initial place were put on a reserve list and were also invited to stay part of the process by attending the Engagement Event on the 3rd March.

The organisations represented in each of the learning sets are listed below. MIND (Jersey) have worked with their service user representatives to ensure service users are participating in the learning sets.

	Learning Set			
	Public Mental Health	Early Intervention	Acute and Crisis	Recovery and Support
Organisation	MIND (Jersey)	HSSD - CICS Team	Home Affairs - Police	MIND (Jersey)
	The Resilience Development Company	Jersey Youth Service - YES Project	Children's Service (MASH/CIRT)	Jersey Alzheimer's Association
	Jersey Post	Employment & Social Security	Children Adolescent Mental Health Services	Psychology & Assessment Service
	GP Lister Surgery	Acute/Liaison Community Mental Health Team	Paediatrics/Robin Ward	Public Health Department (Registration & Inspection)
	MIND Jersey	Educational Psychology	Probation & Aftercare Services	Occupational Therapy / Adult Mental Health
	Home Affairs - Police	Family Nursing Homes Care	Adult Mental Health Services	Older Adults Community Mental Health Services
	Jersey Blind Society	Adult Mental Health Services	Adult Mental Health Services	Employment & Social Security
	Jersey Hospice (Community Bereavement Service)	MIND (Jersey)	Adult Community Social Services (Autism Service)	Adult Community Social Services (Autism Service)
	Public Health Department (Health Improvement)	Jersey Police	GP, Atlantic Surgery	GP, Health Plus
	Triumph over Phobia (Jersey)	GP Lister Surgery/Manager Brook Jersey	Family Nursing & Home Care	Jersey Employment Trust
			HMP La Moye	Service User

Practice Challenges

Each member was encouraged to identify ideas, innovations and key improvements in their workplace and the community which they wish to bring to fruition during the course of the learning sets. These were called practice challenges and are all listed in appendix 2 and detailed in appendix 5. The action learning set meetings provided

a forum for discussing how to achieve these improvements, and for applying improvement concepts and tools to mental health service delivery.

Action learning sets present challenge to learning set members through the style of questioning. So rather than an outsider constructively challenging, the challenge comes mainly from within the system and in this case from within the community of practices and receivers of healthcare from the system which means there is more chance that the challenge will be received and acted upon.

The facilitator initially modelled a style of questioning in tune with the ethos of the action learning set so that inexperienced set members can learn from an experienced practitioner. The basic ethos was no advice giving, no veiled solutions and no judgements in the form of leading questions. An appreciative understanding and empathic approach has been found from previous experience to lead to greater challenge to set members and the system as a whole.

Structure

- Icebreaker – getting to know each other (first set only)
- Agree ground rules about how to work together (first set only)
- Seminar stimulus e.g. Citizen Panel outcomes
- Introduction to Action Learning and the method
- Practice run (first set only)
- Share the time out, so that everyone gets a turn
- Each member 'presents', i.e. briefly describes, a problem they would like to work on
- The Set helps that person to explore the problem
- Open questions are usually most helpful – see typical questions in Appendix 4
- Avoid giving advice
- Ensure that the presenter has an action plan
- Spend time after each person's turn and/or at the end of the meeting to discuss what has been most useful about the process to the presenters

Dates, Stimulus Seminars and Feedback

The dates of the five learning sets are given below. For each of the five learning set days five 'stimulus seminars' were provided. The sets provided a learning hub that allowed the other important dimensions of the review (stakeholder interviews, citizen panel and customer voice) to be heard, digested, challenged and then inform their actions and projects undertaken to address the project challenges. Themes, assets and questions were captured at the end of each learning set and the consultancy team worked alongside the client to amalgamate those into a set of strategic themes to inform the whole review process. Feedback of the emerging themes was provided

at Learning Set 4 which through comments from the LS participants resulted in further refinement of the themes.

1. 11 November 2014 – 'Citizen Panel Building Blocks' (PB report ref …) and 'Stakeholder Interviews' (SA report ref…)
2. 2 December 2014 – Citizen Panel member stories and building block discussion groups (PB)
3. 6 January 2015 - Understanding what we know and how to use it – information as a lever for change (SA ref…)
4. 2 February 2015 – Customer Voice (AHo ref…), Strategic Links to Practice Challenges (Directors) and Emerging Themes Feedback (AHe)
5. 25 March 2015 – Final report summary for feedback and refinement (AHe and SA)

Learning set time would always follow the seminar input and give participants time to discuss the inputs in the context of their practice challenges through questions such as: What does this mean for my area of work? What are the implications for my practice challenge? In this way the knowledge conveyed in the seminars was transferred into practice through the learning set process.

Detailed Method

Check In: How is everyone in the group? Explore immediate reactions to the stimulus seminar.
Presenter: presents their practice challenge (PC). Other members are asked to keep silent and actively listen. The presenter summarises at the end of the presentation what they would find helpful for peers to focus on (10 mins)
'Tabloid Headlines' members offer a subjective and immediate response (What does your gut say is the 'nub' of the issue?) (1 min)
Insightful Questioning: the most important skill – asking insightful questions – as a way of using constructive challenges to help the PC owner achieve a deeper understanding as well as convey empathy. Basic principles are that supporting the person sharing is not the same as agreeing, use of open questions and no advice giving (20 mins)
(Within this time, if the presenter is getting stuck i.e. not finding her/his own solutions, they can opt to use some of this time to ask group members about their experiences in a similar context or to sit out of the group and listen to the others debating the issue)
Presenter: Feeds back to the group those questions that s/he found helpful and not so helpful, why and what thoughts they led to. States what actions s/he will take as a result of this. Group members stay silent and actively listen during this feedback. (10 mins)
Group: Final thoughts on risks of proposed actions/decisions; checking in whose interests the actions/decisions are being made with a focus on the process. (5 mins)

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At the end of the learning set time: **Take outs:** Agree what can be taken out of the group in terms of themes, identified assets and questions (5 mins) **Check out:** How are we now? Recognition that some questions might uncover emotional vulnerability so care is shown to ensure people are feeling ok to drive home etc. (5 mins)

Timetable

Each learning set day was structured and timed approximately as follows:

10.00: Introductions and process/principles of the learning sets (reducing in elaboration as the participants become familiar with the process)

10.30: Input 'seminar' by one or more presenters

11.15: Coffee break

11.30: Learning set time

12.30: Lunch and networking

13.15: Learning set time

14.15: Summary themes arising from each learning set

15.00: Coffee break

15.15: Q&A with the presenters (exploring issues raised for practice by the learning set discussion)

16.00: Final summing up and feedback

16.30: Close

Preparation

Members were asked to do preparatory work for each action learning meeting, based on reading and support materials made available to them as part of the review. They were also asked to bring and maintain a personal journal documenting their own progression towards agreed actions and for noting actions agreed by others.

In addition to reading any material sent in advance we asked learning set members to fill in the form at appendix 3 to enable them to structure their thoughts on their practice challenge projects, personal outcomes, organisational improvements and service user impact as well as links to the CP building blocks. Sometimes the project to address the practice challenges was unclear to a participant at the start and so through the first set they explored the challenge and were then supported in gaining

clarity on the actions, outcomes and impact. In some cases the issue shifts or changes as the set helps the presenter gain clarity and we asked the members to keep the forms updated with their latest thinking.

4.0 Outputs and Analysis

The outputs are broken down into practice challenges, themes, assets, questions. The analysis narrative explains how all these outputs came together to form the final nine strategic themes to guide the work towards a new mental health service strategy.

Practice Challenges
The practice challenges are listed in appendix 1 and a full outline for each can be found in appendix 5

Themes
The themes generated from each of the learning set days are listed below. These themes were generated by each of the groups separately and fed back to the group in a plenary session at the end of the learning.

ALS 1:

- **The learning set strengthened existing links:** we are already working together to some extent but the learning set gave us structure and a purpose.
- **Awareness of what people do** really helps to take projects forward in a way that connects with and gains commitment from stakeholders
- **Appetite to 'public focus' the service:** using the citizen panel building blocks
- **Strengthening communication** was a salient theme and the learning set helped to clarify what that means in practice
- **Strong sense of collaboration:** making it more specific
- **Collective sense of will to improve services for all:** the learning set approach enables us to see that others are keen to make change happen
- **Getting the physical environment right** for service users and staff
- **Getting clarity around roles, responsibilities and concepts** such as care coordination is essential
- **Developing services that empower and enable people:** not to be dependent on them that includes giving users and carers all the information they need, stepping up and down services as an when needed, moving to a less paternalistic model and embracing recovery
- **We need to have uniformity of access** based on need
- **Systemic working needs to be improved**
- **Working effectively to support people with comorbid needs** is a priority
- **The need to take a more holistic approach**
- **How can we work in partnership more effectively**
- **We need to recognise and develop the interdependence** between our services both in the sector and beyond
- **Addressing the skills gap and workforce balance**
- **Being clearer about what our services do and what they don't do**
- **Move away from silo working**

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ALS 2:

- **Reducing Stigma:** this is especially prevalent in the workplace. We need to normalise mental health. Ten years ago we didn't talk about breast cancer, maybe in the future we will be talking about mental health as openly. We need to tackle the cultural stigma that exists in many organisations.
- **Communication and the organisational barriers:** is where a lot of the problems stem from but it is hard sometimes to know what different stakeholders need and want in terms of information and in what format that would most beneficial for patients. Sometimes it is about asking for what you require in terms of communication rather than assuming it can't be provided. This applies between all agencies including statutory, voluntary, community and the private sector. There is a lack of understanding of the changes that are happening across the sector and what impact those changes are having and will have. We are going through a period of change and if we don't understand what's happening it leads to anxiety
- **Perceived culture and organisational form** being a barrier to innovation and empowerment in States of Jersey MH services
- **Gaining fair and equal opportunities for employment**
- **Goodwill masking underlying problems**: because workers are committed to meeting the needs of their 'client group' and therefore going along with, and making up for inadequate systems.
- **Strategic changes required:** each person could identify things they could do and make a difference but there is also a need for strategic changes.
- **People have experienced a lot of 'tinkering' with services** – either bolting something on or making minor adjustments e.g. the sort of changes that come with each new manager wanting to make their mark. None of these changes have made a significant difference to the difficulties faced.
- **Changes are needed at the root of the systems:** culturally formed assumptions about how it has always been done, e.g. greater emphasis on underlying structures that are based on the flexibility to bring different disciplines and different services together as a way of working with issues that cannot be met by economies of scale.
- **The need for improved access to information about the different services**: what is available (and who refers, as this is not clear): how do we do this? However if we do achieve this we need to ensure that the increased access to information about different services is not at the expense of the protocols that exist for referrals, otherwise it will end up being a free for all and the loudest voices will get attention first.
- **Need for prevention and early help.** We need to invest in a consistent model of prevention and prove the economic worth of investing in prevention. e.g. resilience in schools.
- **Getting the right help when you need it**: we need enough people early enough.
- **Money flow in the system does not benefit patients**. There is a reluctance to address this issue because it is a little like shooting yourself in the foot financially (for GPs) and there is an assumption that it is being dealt with at a higher level. To take this on as a minister or policy maker might make you unpopular.
- **Under funded, hard-working agencies:** agencies outside of health and social care: are where a lot of work takes place but they are often under-funded or under-resourced

ALS 3:

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- **The balance of risk** and how it's approached by different agencies including senior accountability
- **Organisational tensions** – priorities/pragmatism & operations versus strategy – not lowering our gaze in terms of outcomes
- **What is the role of inpatient services** – appropriate balance of containment/risk management and therapeutic engagement and intervention
- **Static Workforce** – lack of attrition reduces choice
- **Continuity of care**: consistency is required
- **Interconnectivity of health and criminal justice system** – interactions and effects
- **Integration** within services as well as across organisations
- **Information sharing** between services, children to adult in particular
- **Timeliness of discharge**
- **The narrow middle**: lack of options for discharge or admission avoidance
- **The challenge of cross departmental changes** and differing focus or priorities
- **Level of influence of other agencies** on health and social services – leverage, saying no and setting boundaries
- **Out of hours care**: lack of provision across health including mental health
- **Disaggregation of information technology systems:** makes accessing information more difficult
- **Court diversion**: what can we learn from the Bradley report – links to other criminal justice plans around custody based nurse(s)
- **Information gathering, sharing and the use of information:** We don't understand as much as we'd like about the state of the island's mental health. In order to provide services that address need we need good information. What need is there? There is a need for a shared vision of what we want to measure and how we do it. In order to achieve this we need a breadth of measures which will allow us to assess the success of mental health strategy and actions. This will ultimately lead us to better outcomes.
- **Engaging well with people from different cultural groups:** Are we truly engaging with others? One way of addressing this is the need for more people from different cultural groups to have key positions within HSS to act as conduits of information to and from clients and services.
- **Stigma:** hugely influences mental health on the island and must be addressed.
- **Partnership working**: moving away from silos is the key to improving outcomes and experiences for Customers, e.g. developing the recovery centre as a partnership between MH services, third sector and people with lived experience
- **Joined up system**: the top of the system and the service user facing aspects of the system need to more coherent and joined up
- **A focus on outcomes and experiences:** currently a great deal of service data gathered focuses on inputs and processes rather than outcomes and experiences

ALS 4

- **Young people**: we need clarity on what young people's voices are being heard as part of the review (and what about parents).

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- **Staying involved in the process**: we need to be much clearer about what happens after the CP/ALS/Engagement Day and before the strategy is written.
- **Role of the LS moving forward**: there should be additional opportunities for us in the future to check a draft strategy before it is implemented (it's not good enough that only the scrutiny committee checks it).
- **Measured outcomes**: need to be attached to this strategy
- **Awareness and education**: of mental health amongst the population. What's the strategy for this? There is too much focus on illness. E.g. we have heard from Chris what his departmental
- **Stigma:** how can we address stigma when we still have St. Saviours (is this in itself an example of stigma (i.e. exclusion from the new hospital)
- **GP's and mental health:** we need an increased awareness of mental health so that people feel comfortable coming to the GP. The GP is the 'gatekeeper to the door'. MIND have asked who are the mental health friendly GPs? What is the role of receptionists in this? Do we need to explore the stigma attached to certain terms e.g. support vs counselling? Possible actions: i) mental health champions in GP practices? (What would their role be?) ii) awareness raising resources in GP surgeries (MIND videos on the TV system, Facebook, newsletter, leaflets)
- **Wellbeing in the workplace:** a lot of the problem is a genuine misunderstanding. Our experience shows it is possible to start to change the culture in an organisation e.g. through the people that others turn to in an organisation (not just line managers). E.g. the Hospice staff getting support from each other not just from the line manager.
- **Importance of how decisions** are made, the role of collective professional risk sharing
- **Knowledge transfer** - how do we share what we know - identifying training gaps
- **Cultural change**: and the impact of P(p)olitics on that
- **How to incentivise primary and secondary care:** to work differently - what commissioning levers can we pull
- **Specification of services**: what we do and what we don't do
- **Move away from a personality driven system:** that allows blocking of change
- **How to develop crisis services that can respond** - lack of a place of safety
- **We have made progress** - success has been achieved in two of the practice challenges in this group - how can we share and celebrate this?

ALS 5

This was the wash up session for the series and came after the strategic themes were identified. Therefore the focus was on asking for feedback on the developing strategic themes, gathering outcomes and impacts arising from the practice challenges, understanding how participants wish to sustain the network moving forward and how to celebrate the successes. These outputs are covered after the outputs and analysis section as that is where they fit in the overall action learning report narrative and because they contain the participants' evaluation of what their practice challenge activity has achieved and views on sustaining the momentum created by the whole ALS process.

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Assets
The assets identified from the first four learning sets are listed below

- **The Mental health Service Review ALS groups & partnership:** representative from different organisations working together and supporting each other to make a difference. Assets emerging from the action learning sets include:
  - The people in the learning sets and those that they can influence back in their organisations
  - Shared knowledge and synergies that exists in each of the learning set groups
  - Attitude and commitment across the learning sets of wanting to make a difference
  - Well informed about projects and initiatives that have been tried elsewhere and have proven to be successful or not
  - Information and research data gathered as a result of the practice challenge activity. The practice challenges are leading people to undertake a great deal of information gathering via, surveys, evidence producing, qualitative and quantative studies. This will produce a rich seam of intelligence that could be shared and used to inform further change.

- **WEMWBS (Warwick-Edinburgh Mental Well-being Scale)** , a tool to measure mental wellbeing, developed by Edinburgh and Warwick University and currently used on the island
- **Families and carers** are an untapped resource in the system. Recognising that with appropriate knowledge and skills training (e.g. as provided by MIND in the 'Triangle of Care' programme) they can be a valuable asset. Feedback is that families and carers often feel shut out of providing support once a person enters the system. There is a political dimension to this as families have been the subject of recent political debate
- **MIND:** independent support to understand different mental health problems, drugs and treatment, helping others with mental health problems, tips for everyday living, guides to navigate services and helplines. Resources: DVDs, Peer Support workers
- **YES** (Youth Enquiry Service) which offers a very successful service model meeting the mental health needs of young people through counselling and mentoring or signposting them to other services that can help. The advantage of the service is that it is not explicitly about mental health and therefore there is no stigma attached to attending even though many young people with mental helath problems are helped by the service.
- **Ex clients** who through their own experiences can support others in navigating the mental health system and finding the right support at the right time.
- **Communicare building**
- **The Recovery Centre**
- **Churches with rooms** that are ideal for community MH recovery sessions
- **The workforce:** staff can provide useful resource and expertise to effect changes
- **Other agencies and departments** could help not only deliver stronger partnerships but also assist in being agents of change via collaborative working etc.
- **Local Media**
- **Citizens**
- **Voluntary sector**

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Questions

The following questions were raised during first the 4 learning sets:

- How do we get people to 'buy in' to the mindset that sustained partnership (e.g. the action learning sets) is essential and desirable?
- What are the priorities for prevention?
- What does a 'mental health friendly GP' service look like?
- How do we change established paradigms and habits particularly in those who have the real power to make changes
- Will the senior people in our organisation take this seriously and give it support?
- Can we share our contacts and expertise across the learning set groups to assist colleagues in taking their projects forward?
- How can we get the voice of young people so we can hear what they need for their mental health (especially prevention)? We should also hear from parents. These voices must be incorporated into the review.
- What do we do about challenge and project crossover/collaboration and duplication between learning sets?
- What do the clients want out of the service? What worked for them and what doesn't?
- Will we get involvement and support from the top of the system?
- How can spread the learning set methodology into other areas of the system and even other systems on Jersey?
- How will we link the CP and the ALS together?
- How can we best support each other and share our expertise on particular projects within our learning set?
- Should our services span someone life course or how will we manage transitions better?
- How do we measure the impact on young people if we haven't heard their opinions?

Analysis

The analysis was carried out in four iterations as follows. First the client (Andrew Heaven) looked at all the outputs above including the practice challenges and created a first stage synthesis into a set of strategic themes. He also mapped the practice challenges onto a strategic priority vs ease of implementation chart (see appendix 2) All the practice challenges rated medium to high against existing strategic priority. About 50% rated as easy to implement (these are classified as 'quick wins') and the other half required more investment (which are classified as 'worth going the extra mile'). Second, the themes were presented to the ALS groups at the fourth learning set day and feedback received and incorporated. Third the ALS consultancy team carried out a validation process against all the outputs listed above plus the other activities (Citizen Panel, Stakeholder Interviews, and Customer Voice) making adjustments to some of the themes and adding a few more. Third the themes were presented at an engagement day on 3 March 2015 to an audience of 120 people from across the services and including the CP group members and each theme was developed further in 9 separate discussion groups. The themes and bullets presented at that event are listed below:

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- Securing the joint working across the Mental Health System
  - Integrated Service Models
  - Tools for Integrated Working
  - Right place right time

- Building Educational Approaches to Recovery
  - Orientating the wider mental health system
  - Complement clinical & psychological treatment
  - Reducing reliance on a one size fits all medication and hospital based approach
  - Personal choice and joint decision making

- Developing the Workforce
  - Working differently requires new skills
  - Inclusive approaches to learning will help build capacity within the workforce
  - Continue to challenge stigma & discrimination

- Awareness, prevention early help and support for mental health in children and young people
  - Universal approaches to building emotional resilience across Jersey
  - Different models and settings (including schools) to deliver children's mental health services
  - Early awareness & where needed, intervention works, & reduces future demand

- Criminal Justice and Mental Health
  - Reaching vulnerable people with experience of multiple exclusion
  - Achieving equality of provision (parity)
  - Reducing reoffending and supporting rehabilitation
  - Supporting recovery as a model
  - Effective Diversion

- Workplace Mental Health
  - Challenging stigma & discrimination
  - Signposting to early interventions
  - Supporting recovery as a means of developing independence and promoting resilience

- System Outcomes, Quality & Measurement
  - Informed planning and quality improvement
  - Understanding outcomes for patients / public
  - Using what we measure to inform development
  - Reducing inefficiency within the system
  - Celebrating what we do well & sharing the learning

- Money Flow
  - Moving resource to enhance patient outcomes
  - Refocusing investment upstream
  - Enhancing choice and personalised services
  - Aligning Wider Social Policy

- Service Environment

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- Valuing those who attend (*and work*) in the service
- Builds & maintains confidence in the service provided
- Safety and quality
- Will help people stay engaged
- Signposting to other support

5.0 Evaluation and Sustainability (ALS5)

ALS 5 was the finale not just for the ALS series but for the mental health service review. The draft of the full strategy including themes outlined above was presented to whole group in plenary as the stimulus input seminar and then over the course of two action learning sessions the following questions were addressed:

- What are the outcomes and impacts from work done to date on the practice challenges?
- What role do participants believe they should have in supporting the implementation of the strategy and furthering their practice challenges?
- What will be required to sustain the network (communities of practice) and practice changes moving forward?
- How can we celebrate the successes?

The answers provided below are an amalgamation of feedback from each learning set group and a plenary discussion which followed.

What are the outcomes and impacts from work done to date on the practice challenges?

The outcomes are listed under two headings: learning (personal and organisational) outcomes and practice challenge outcomes and impact.

Learning outcomes:

- Feeling optimistic about the strategy and what it will achieve as practice challenges have already made a difference
- I feel more confident that my practice challenge is achievable. I think the strategy will strengthen my/our arguments when trying to achieve goals.
- Developing thinking and process for developing outcome measures within a partnership approach
- Better understanding of mental health (including my own)
- I now feel that anyone presenting an obstruction to provision/progress will be exposed by the process of implementing the strategy
- Good to connect with others in the group and gain feedback etc.
- Recognise the importance of developing mental health initiatives as my practice develops
- Has motivated me to think about other practice challenges e.g. walking group, support programme for children / young people
- The realisation that there are many local resources that can be promoted
- The feeling that people (in the ALS) are on the side of each individual participant is reassuring

- Lots of good learning and information has been shared
- Relational aspect has been key to the process
- Skills transfer between ALS membership
- Learning how to remove blockages in the system
- Need to maintain the bottom up approach to problem solving
- The practice challenge is completely finished with a very successful outcome. Tanya is feeling really positive.
- The learning set process helped in the exploration, definition and in the Planning of how to successfully implement a training programme
- The learning set group has supported in growing a more integrated network
- Changed level of involvement in multi-disciplinary processes for individuals.
- The learning set has changed practices.
- The ability to call on the learning set members to be part of a focus group developing the new models e.g. incapacity benefit.
- The learning set enabled participants to have the confidence and permission to 'get on' and make the changes.

Practice Challenge Outcomes and Impacts

Most of the practice challenges have borne fruit. These are some of the highlights mentioned by the participants:

- The recruitment of a new role to the Maternal Early Childhood Sustained Home Visiting (MECSH) team – a person to liaise between new mothers and mental health agencies for those that need support.
- Incorporation of room for a psychologist / counsellor within new build plans
- Training for line manager and staff (first aid, mental health, better understanding of tools)
- MIND Jersey have endorsed children and young people in the MIND project plan.
- Have set up a training group for volunteers to deliver pre-bereavement support.
- Mental health/ill health questions now being included within life opportunities /disability survey.
- Joined up working with other states departments and private sector (e.g. procedures support for managing stress in the workplace)
- Mental health awareness workshop/talks have been made young people friendly.
- Critical stress management for line managers and others including culture, values and behaviours
- Hopeful of the review on the collection / collation of self-harm data from emergency department
- Identified positive measures for mental health in JASS, i.e. WEMWBS v do you have friends that can help? How often do you socialise?
- Improved relationships between police and Hospital Emergency Department (ED) through the instigation of a new forum and information sharing
- Exchange programme where police constables spend time in ED and nurses spend time with the police
- Meeting set up on 8 April to give approval for a 136 safe holding suite
- Talking therapies will soon have access to the GP computer system, Egton Medical Information Systems (EMIS)

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- Jersey Quality Improvement Framework (JQiF) payments to GPs now happening so they are not just reliant on funding from patient appointments
- Various media can be used to increase MH information to patients such as Facebook, newsletters, leaflets and practice education boards.
- This way of working (network/ALS/communities of practice) helps to reduce suspicions and enable joint working
- MH and Self Harm awareness training for schools rolled out for first cohort and has evaluated well and has been set up as a routine CPD offer to teachers
- NQTs have now had MH awareness training covering 'What is school's role in MH?' and 'What is happening to own wellbeing?'
- These training programmes have been enriched and expanded due to the ALS work
- Feeling better equipped at signposting people as knowledge has grown of what is available through the different agencies
- Liaison meetings between ED and police now happening on a regular basis which are improving relationships and breaking down barriers
- Exchange scheme set up where police can work on the ED ward and nurses can work with the police service so that both can gain a better appreciation of the work they undertake
- Place of safety detention (136) suite proposal now being considered at a meeting with decision makers on 18 April 2015
- STORM (Suicide Training of Risk Management) training for police officers initiated from conversations that occurred at the ALS meetings
- Proposal put to Minister on MH disability awareness/showcase event involving psychiatric services
- Proposals produced for funding and gained ideas for accessing other funding streams
- Changes to a building environment: new furniture, carpet and a front door. The magazines are now appropriate and there is a cultural shift noticed with service users being more involved in giving feedback. The notice on the wall is going to be changed centrally and so all buildings will have a more sensitively worded statements about violence and aggression not being tolerated.
- Designed a training programme that will help people revisit their values and build resilience and increase wellbeing as one of the outcomes.
- New systems for engagement between mental health services and Jersey Employment Trust.
- The changing of social policy and the law around sickness benefits has progressed to the point of getting the ideas into the medium term plan and is hoping that he might be released to work on it full time.
- Recovery activities run out in community settings working between occupational therapists, the third sector and in the near future with service users. This is still in its infancy and the hope is that the strategy will give a real push toward recovery oriented services being progressed more quickly.
- Created a new policy and process for people accessing the mind hardship fund and it will be available for people who need help paying for GP appointments, food, travel to sessions etc. The learning set helped to explore how people

should access the fund and what the process could be, the money will now be available through mental health workers and a plan is being put in place to address the issue of future income generation for the fund

- A potential model whereby care coordination could be provided in primary care settings rather than secondary care and that CPNs could be based in GP surgeries to bring the care of people with dementia fully into the community. This practice challenge will take a great deal of joint working, senior sign up and project management to deliver and the hope it that it will feature in the implementation plan and for a community of practice to be created around this crucial and cross cutting issue.
- A new post will be targeted around reducing stigma and promoted recover (living well with dementia) through educational approaches. This practice challenge links really well with the wording in the emerging theme around educational approaches to recovery.
- The designing of a vision and plan for the delivery of alcohol and drug support to people in primary care is now in place and this practice challenge has led to a range of new ways of working within primary care.
- Engaging of mental health practitioners in the regulatory processes in Jersey is now complete with significant change in practice and policy within the review process of residential and nursing home care. A new practice challenge is being created to increase the user and relative involvement in the assessment of nursing and care homes.

What role do participants believe they should have in supporting the implementation of the strategy and furthering their practice challenges?

- To act as a go-between, between strategy writers and people providing services for example acting as a link between strategy writers and GP practices to 'try stuff out' that features in the strategy.
- To ensure connectivity: making sure that other pieces of work e.g. the suicide framework is congruent with the mental health review. Encouraged to take responsibility for connectivity from strategic level to practice.
- Making sure the strategy works: ensure the perception and emphasis of the strategy is right for example including the importance of mental health and its contribution to life.
- By testing out some of what we do (and what is proposed) with the people we work with (e.g. MIND's youth participation group 'Children and Young People in MIND').
- Making sure their practice challenges are moving forward (and updating or producing new forms).
- Sharing the learning from practice challenges.
- A means to have our valuable skills, perspectives and knowledge heard and acted upon.
- Not necessarily within AH's gift to deliver all the changes (e.g. changes associated with schools education initiatives or funding for MH charities) therefore would it be appropriate to set up a strategy implementation governance/

steering group made up of ALS participants who represent the agencies that contribute to all aspects of MH (education, police, third sector etc.)

- Some participants could not see a role for themselves moving forward unless the work undertaken on the practice challenges was recognised and people were given time and resources to take them forward.
- Recognition needed that this is not going to be a step change ribbon cutting exercise to a whole new world but a gradual movement that means we will get there eventually. Low turnover on the Island means that cultural change can be a slow process. However, some systems may need to just be switched off and replaced with new systems that align with the strategy moving forward.
- Some participants are forging ahead with changes as part of their practice challenges and have seen concrete differences to their services e.g. the recruitment of a new role (MESH) to the health visiting team – a person to liaise between new Mothers and mental health agencies for those that need support.
- Some participants felt uncomfortable about moving forward with the practice challenges as other strategies were in conflict with what they were trying to achieve e.g. continuity of care with a single point of contact taking patients through a care pathway (a care co-ordinator approach). This was in conflict with other strategies that opposed the idea of a single point of contact even though service users had asked for this.
- Roles are changing all the time so any practice challenge strategy needs to take account of those changes.
- We have to get the right links in the management structure to embed the change
- Capturing the outcomes from the challenges going forward and building on them

What will be required to sustain the network (communities of practice) and practice changes moving forward?

The set members concluded that they need to continue to meet in some form and their suggestions on what form that could be are given below. There was strong consensus that they can continue to ensure connectivity, continue working with the right people, checking that the strategy is going the right way and continue the momentum.

- Bi annual project review meetings with a mix of ALS participants and managers present so that they can work together to take existing and new and practice challenges forward in line with the new strategy.
- Defining the role of the network/communities of practice within the strategy so that it has clear mandate moving forward in the implementation of projects to support the realisation of a new MH service model.
- Strategy implementation steering group that represents the make-up of the MH system: ALS participants who represent the agencies that contribute to all aspects of MH (education, police, third sector etc.) This would affirm that ALS participants (practitioners) are truly the authors of the strategy.
- Explore whether or not the groups should be shuffled as it would be useful to look at what some of the other practice challenges are and see similar initiatives.

- A project manager (PM) should be appointed to oversee the programme of practice challenges and to drive the changes forward. ALS participants to be accountable to the PM
- Communication strategy to go alongside the implementation plan so that people across the system are aware of what is happening.
- On-line forum
- Open Space session to identify subgroups from the existing network to work on specific projects that would support the strategy (could be combined with the MH strategy launch day
- Project Management and other skills (e.g. leadership and change management) for the people running practice challenges and larger work groups to help them overcome obstacles
- Project Manager to oversee the whole programme of projects in support of the strategy implementation

How can we celebrate the successes?

The following suggestions were made:

- Yoga on paddle boards
- Mindfulness session
- Meal at the Quayside pub followed by clubbing session at the Mimosa
- Mental Health Launch Day in May 2015 to launch the strategy and work on putting together and prioritising the practice challenges and other cross cutting projects that would support the strategy implementation. Select a few projects to do really well rather than trying to do everything.
- MH Day to coincide with World MH Day (10 October):
    - Morning- ALS network participants review existing and identify new practice challenges that align with the strategy. Formation of new cross cutting work groups to take specific projects forward
    - Afternoon and evening – users, carers etc. invited to participate in the review of the practice challenges and strategy moving forward

There was no final decision made on the celebration event but it was agreed that a proposal would be put the group in the near future.

6.0 Conclusions

The rich outputs in terms of assets mapping, strategic themes generation and their actions and outcomes and impacts against specific practice challenges demonstrate what is possible when people with the right knowledge and motivation come together to make a difference. The sets provided a core learning and activity framing hub that allowed the other important dimensions of the review (stakeholder interviews, citizen panel and customer voice) to be heard, digested, challenged and then inform the actions and projects undertaken to address the project challenges and contribute to the emergent themes. This report contains the journey towards and through the five action learning sets, including an evaluation by the set members of the outcomes and impacts and their ideas on how to sustain and build on the social movement that they have started. In a way the five action learning set days only scratched the surface of what is possible in terms of generating a powerful network of practitioners to create both cultural and substantive change across the mental health system. It has not been plain sailing for all participants and not all will want to continue this tough journey - they should be allowed a graceful exit with full appreciation for their contribution but those that are keen to continue can be regarded as the future change leaders, the movers and shakers, who with appropriate support for their professional development (e.g. project management, leadership, change management skills) can take the service forward in line with the review's strategic recommendations to a system that is fully fit for purpose. What should be encouraging is that everything they need to do this in terms of assets is available on the island – it just needs their leadership, a collective leadership, along with senior leadership backing to make it all work in service of the people suffering with mental health problems. Continuing to build on and sustain the social capital generated through the ALS intervention will be important for States of Jersey mental health services as expectations have been raised across the system.

7.0 Recommendations:

The overarching recommendation is to create and sustain a group of prime movers and shakers, a Change Leadership Cadre (CLC), a community of practice that continues to drive change beyond the life of the action learning sets. In line with the Kings Fund (2010) recommendation this would be a true distributed leadership group (across all sectors) that people want to be a part of and that will give something back to them in terms of continuous professional development (CPD) as well maintain momentum toward a new service model. Specific recommendations building on the suggestions from the participants are as follows:

- Continuing to harness the social capital generated by the learning sets by supporting the suggestions that have arisen from ALS 5.
- Appoint a Programme Manager to project manage the whole programme of projects (existing and new practice challenge activities) in support of the strategy implementation
- The formation of a 'change leadership cadre' (CLC) from the people who want to continue their activities to address the practice challenges and be a part of leading the strategy and cultural change required. This would be a defined role with a clear mandate and authority. The specific ways CLC members could be involved are:
    - Bi annual project review/ workshop meetings with a mix of ALS participants and managers present so that they can work together to take existing and new and practice challenges forward in line with the new strategy.

  - Strategy implementation steering group membership drawn from the CLC that represents the make-up of the MH system (education, police, third sector etc.)
  - Form subgroups to work on specific projects, in support of the strategy, that cut across and draw on a mix of members from the existing four ALS groups
  - Communicate with and lead their own communities of practice (back at their home organisations) to a greater understanding of the issues at stake and continue with project managing existing and new practice challenges aligned to the strategy.

- A bespoke CPD programme (preferably accredited) as professional development for the CLC role including project management, leadership, cultural change management, team resilience building and assets mobilisation skills. Learnings sets would also be a recommended component of the programme to support the continued application and transfer of their learning into service improvements.
- Putting the evaluation (outcomes and impacts) of the action learning process to work in service of system improvement thus creating a virtuous cycle. This could be through research/evaluation reports on specific practice challenge activities and then presentation back to the learning sets or workshops as 'stimulus seminars'
- A well thought through communication strategy to go alongside the implementation plans so that people across the system are aware of what is happening. This would also support the meshing of different strategies and reduce the potential for them conflicting with each other.
- Allow those people that no longer wish to be part of the CLC and take forward practice challenges a graceful exit (with full appreciation for their contribution) and to be replaced by new recruits into the CLC (from those that applied but were not originally shortlisted)
- Set up a combined strategy launch and celebration event to recognise the practice challenge achievements made by ALS participants and others.

Baker's (2011) study found that high-performing healthcare organisations had a number of characteristics in common, including having quality as a core goal, using information to guide improvement, developing organisational skills to support performance improvement, and having learning strategies that test improvement and scale it up when it succeeds. This is precisely what the ALS work has offered as a seed and by implementing these recommendations it can grow into a mental health system that everyone on the island can be proud of.

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Appendix 1: Practice Challenges

Stakeholder	Participant Name	Practice Challenge
No	**Public Mental Health**	
1	Liz Kendrick-Lodge	Mind Jersey address stigma and discrimination to and by young people in Jersey e.g. Survey, Education projects in schools, Road shows, film?
2	Emma Ogilvie	Develop further pilot programmes on resilience within schools and workplaces to improve individual wellbeing
3	Joe Dickinson	Integrate and extend 'call & check service'
4	Dr Jenny Sykes	Raise awareness within the surgery setting to reduce the stigma attached to mental health issues (leaflets, videos, TV other information etc)
5	Lesley Darwin	Carry out HSE stress indicator tests to support AXA referrals early on
6	Sarah Shaw	What models of integrated mental health care could offer responsive support to service users for life changing diagnosis
7	Jan Sims	To provide a pre-bereavement service for terminally ill clients and their families
8	Martin Knight	Measuring protective factors for population mental wellbeing
9	Celia Scott Warren	Ensure patients are offered effective treatments
No	**Early Intervention**	**Practice Challenge**
10	Clare Cook	Promote inclusion of customers with mental health problems in the remit of the CICS/React service

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11	Vicky Twohig	To produce a report of YES work, and secure funding to expand service
12	Sam Woods	Addressing the issue of benefits working against people with MH issues returning to work
13	Liz Auld	Co-constructed care plans and collaborative working
14	Jayne Stallard-Moore	Early help in schools and colleges: identification of need, analysis of resilience/protective factors, matching/mobilising resources and support,
15	Michelle Cumming	Introduce the role of a mental health worker to support the Maternal Early Childhood Sustained Home Visiting programme
16	Dr Kate Wilson	Better information sharing between secondary and primary care
17	Zainab Kadhim	Better access for GPs to contact specialist service for advice and support before the referral to the service
18	Mark Coxshall	Difficulty when dealing with people in crisis in need of medical assistance, mental health assessment and wider support who are under the influence of alcohol or drugs.
19	Stephen McCrimmon	Carers not getting support early enough and/or not being advised of Carer support services.
	Crisis & Acute Care	**Practice Challenge**
20	Patricia Winchester	Extend advocacy service to prison and CAMHS
21	Alli Tandi	Better comms / clarity between AMHS and choldrems service - re families where adult has diagnosis AND children
22	Dr Carolyn Coverley	What approaches will determine whether an island or off island placement best meets client's needs?

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23	Linzi Gilmour	Managing acute/crisis admissions within the paediatric environment. Children often admmitted as a place of safety but unfortunately the ward is an unsuitable environment
24	Mike Cutland	Improve collaboration between Mental Health Services and the criminal justice system
25	Mike Swain	How can inpatient care ensure better integration with community Mental Health system
26	Sonya Hurley	Lived experience – how do we ensure the service user's voice is heard and central to all practice
27	Dr Sarah Zohadi	work together to ensure that people with Autism gain better access to the mainstream mental health services
28	Helen Miles	Jersey has inappropriate facilities for 'place of safety' needs;Infrastructure investment required to mitigate the risks of dealing with vulnerable detainees in a policing environment
29	Tia Hall	Integrating mental health work across primary care services at points of crisis including rapid response and the wider out of hospital services
30	Andy Buttimer	Review of current in-reach psychiatric services at HMP, clarifying roles of staff when prisoner is in-patient at OH and establishing clear guidelines and protocols when transferring prisoners
	Recovery	**Practice Challenge**
31	Beth Moore	Accessing our MIND (Jersey) support fund as part of recovery
32	Mark Blamey	Reducing stigma around dementia care and develop new community-owned projects to achieve this
33	Dr Luke Shobbrock	Better understanding of psychologically informed approaches to patient care and recovery be better integrated and applied within Jersey's Adult Mental Health service

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34	Dave Luscombe	formal process of engagement with advocacy, service user groups, experts by experience to support the inspection process and that enhances the qualitative assessment
35	Louise Ogilvie	How can the Recovery centre based next to Orchard House, for in-patients and community clients engage people, be developed further
36	Tania Heaven	How can care co-ordination be better defined, resourced and implemented to offer appropriate support people with mental health needs? Can a model of care co-ordination be designed for multi service/ organisational use?
37	Will Lakeman	Scope alternative structure of future Social Security incapacity benefit system (both short-term and long-term, STIA and LTIA)
38	Dr David Bailey	How can we provide better long-term care for problem drug users
39	Lee Bennett	Continual development of partnership working across services, agencies and employers, maintaining person centred support and choice. Job retention as a key area of support
40	Tanya Mulligan	Adopt a more welcoming environment in patient areas e.g. chairs, magazines, signs, etc

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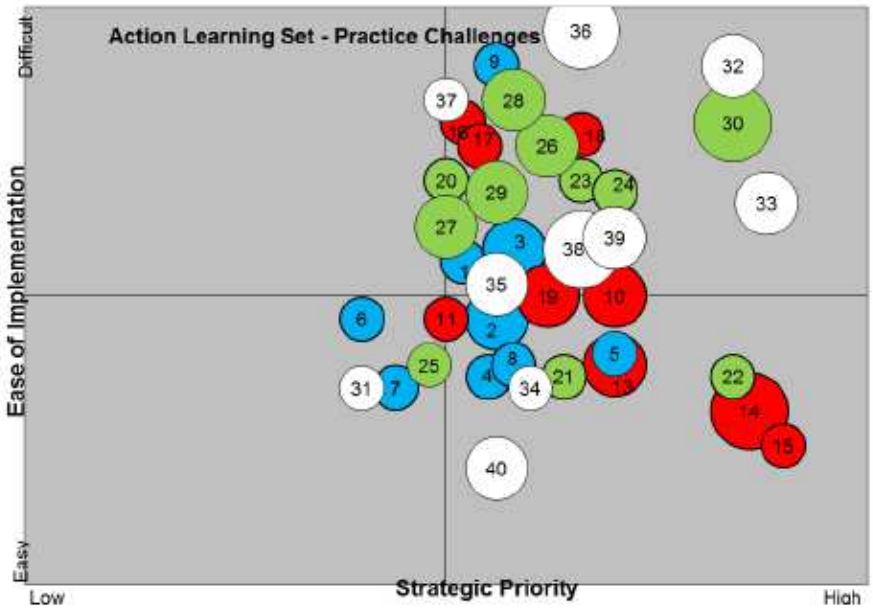
Appendix 2: Mapping of project challenges onto strategic priorities



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Appendix 3: Outline of project Challenges

Practice challenge outline

Personal outcome

Organisational outcome

Service user impact

Building block linkage

Job Title and Organisation	
Name	

Please email completed forms to Andrew Heaven: A.Heaven@health.gov.je

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Appendix 4: Typical Learning Set Questions

Clarifying questions:
What are you trying to achieve?
What would it be like if the problem/ issue was resolved?
How do you want it to be?
What would it look like?
Who would be affected?
How do you see it now?
What works well now?
What makes it work well?
Who might help you?
Where might you get information?

Probing questions:
Can you explain more?
What exactly do you mean by X?
How do you know?
Can you give an example?
Because?
Everyone?
Always?
Who are 'they'?
How do you feel?
What assumptions are you making?

Action:
So what can you do next as a result of this discussion?
What are your options for action now?
What criteria are you going to base decisions on?
What are the pros and cons of that option?
Where could you get more information about this?
Who else could you talk to that might have an interest in this?
What are you going to do next?
What are you going to do before the next meeting?

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Appendix 5: Practice Challenge Outlines

Public Mental Health (PMH)

PMH PC1

Issue to be addressed or a project outline
Definition of resilience: The ability to bounce back from adversities and continue to move towards our goals. Feeling good and functioning effectively whilst experiencing positive relationships and a strong support network. There are three areas to work on when developing resilience – physical, mental and emotional. How do we develop resilience within our local community to improve individual resilience and wellbeing, enable healthier and more sustainable communities and assist workplaces in supporting improved resilience and wellbeing?

Organisational outcome
Statutory services need to work together with businesses and charitable organisations to work in partnership towards a plan for preventative low level interventions within the community with a focus on accessible, relevant and practical resilience skills. The overall aim to prevent ill health happening in the first place by using an approach that targets the majority of the population through programme delivery in schools and the business community. Developing a comprehensive resilience programme is not all about emotional regulation, it is about developing the necessary skills to facilitate and support change. Bounce forward – not bouncing back! Drawing on the experiencing within business ensures we also provide a link with employment skills and ensure the skills taught are relevant within the workplace.

Personal outcome
After presenting my proposal to my learning action group I have decided to organise a resilience programme for early 2015 and invite members of the review panel for feedback on the proposed programme to gain buy-in to the project. I have also completed a schools pilot through VCJ who are now looking at resilience training their teachers and the students in 2015.

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Service User, cost or environmental impact

As per the stakeholder feedback "the role of schools, the education department and of employers in developing and delivering a programme of preventative action will need to be explored if a more resilient community is to emerge in Jersey.

According to findings by the Joint Commissioning Panel for Mental Health 2013;

Promoting personal resilience skills within the local community will support the reduction of mental disorder and poor wellbeing and produce a broad range of benefits associated with improved resilience and wellbeing. This will subsequently deliver large economic savings by reducing the costs of mental disorder through prevention and early intervention.

A schools programme will address the concerns over early mental illness

"50% of lifetime mental illness arises by the age of 14"
"40% of young people experience at least one mental disorder by the age of 16"

by helping to reduce emotional and behavioural problems and the risk of suicide by flushing out those pupils who need further support. According to the UK's recent Department of Health report; for every £1 spent on school based social and emotional learning programmes £84 is saved.

Developing resilience within the workplace will increase productivity at work and reduce absenteeism and burnout. Resilience initiatives will also raise awareness of what positive mental health looks like and help negate the stigma associated with mental illness. For every £1 invested, £10 is saved on work based mental health promotion.

Impact on Mental Health System Building Blocks

Building Block:

1 & 4 - A greater understanding of what it means to be resilient and the importance of resilience and mental wellbeing, addresses the stigma associated with mental illness and promotes personal/workplace accountability/responsibility for overall resilience and wellbeing.

2 - Addresses the need for more support in the workplace by providing a common language and skills framework to manage stress, uncertainty and adversity.

5 - Resilience training for mental health professionals helps support their own personal resilience and ultimately benefit the end user.

7 - A resilience programme would address adversities such as stress, unemployment

and provide practical skills to not just survive but to thrive.

12 - It would support the building block concerned with "explore, offer and invest in different support and ways of delivery because one size doesn't fit all"

Evidence gained by the stakeholder feedback called for the strengthening of managerial leadership. Effective leadership is not all about technical skills. Leaders and managers need to be able to start by understanding how to lead 'themselves' and develop strong relationships and the ability to nurture others and lead teams through challenge and adversity. They need to be emotionally intelligent and resilient! Resilient Leadership needs to be as much on the agenda as developing it within schools!

Job Title and Organisation	Director – The Resilience Development Company
Name	Emma Ogilvie

PMH PC2

Issue to be addressed or a project outline

To provide a pre-bereavement service for terminally ill clients and their families.

Organisational outcome

Providing this service will have an impact on numbers of clients requiring post-bereavement sessions - less people needing to access the service or those accessing needing to attend smaller number sessions.

Personal outcome

Ongoing improvements within the Bereavement Service

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Service User, cost or environmental impact
Better mental health post-bereavement

Impact on Mental Health System Building Blocks
• A focus on prevention • Explore/invest in different therapy – one size doesn't fit all • Adequate numbers of trained and well supervised people working in mental health

Job Title and Organisation	Bereavement Service Manager
Name	Jan Sims

PMH PC3

Issue to be addressed or a project outline
How can I reduce the stigma attached to mental health issues within my patients

Organisational outcome
To collate information from local services to understand what resources are available to general practice and patients. **Think of ways to raise awareness within in the surgery- for example short videos on waiting room TV, leaflets etc. Try and incorporate new ideas to my new practice**

Personal outcome
I am still collecting information. As my practice develops I can try and incorporate mental health issues as we go. Currently it is too early to focus on this.

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Service User, cost or environmental impact
Hopefully the patients will feel that they can discuss mental health issues more openly which should impact them on a personal level. Cost will need to be considered. The Co-operative group is pro health initiatives so help will be available.

Impact on Mental Health System Building Blocks

Job Title and Organisation	GP at Co-operative medical care
Name	Dr J Sykes

PMH PC4

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Practice Challenge

Issue to be addressed or a project outline

- To extend the use of Call&Check in Jersey.
- Develop ways/methods of engaging with groups both professional and voluntary and to find ways of working together.
- To extend the awareness on and off island of the Jersey Post Call&Check Community Service.

Organisational outcome

- Develop Call&Check in to an established product offering of Jersey Post.
- Develop a strategy for evolving the Call&Check service within Jersey Post.
- Broaden Jersey Post's appetite for innovation.

Personal outcome

To achieve my goal of making Call&Check an accepted tool in community care both in Jersey and abroad.

Service User, cost or environmental impact

As part of a community care package it is hoped that Call&Check can make the lives of islanders that are ageing, lonely or with disabilities more cared for and integrated within the community.

Impact on Mental Health System Building Blocks

By adapting an inclusive structure for supporting /monitoring/caring for mental health patients this will hopefully result in more sustainable/positive outcomes.
(See attachment)

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PMH PC5

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Practice Challenge

Issue to be addressed or a project outline

How can we ensure that people of all ages who suffer from mental health problems are offered effective treatments?

Organisational outcome

Appropriate and timely help from the professional mental health services would enhance our work with OCD and phobia sufferers. Updated information on a Health & Social Services website regarding personnel and protocol for referrals

Personal outcome

Individuals with severe OCD or other mental health problems may not be able to attend the self help Group. Also, those under 18 may need help at CAMHS. It is frustrating if a person feels ignored or 'in limbo' for him/her and for me.

Service User, cost or environmental impact

Treatment for OCD and phobias is cost-effective. A recovered member/patient can resume family and social life, and return to work. A persons mental well-being is the main gain

Impact on Mental Health System Building Blocks

This supports the building blocks: An adequate number of trained people in mental health, a speedy response at the time of need and easily accessible services and where to find help and support. A focus on prevention, investment and the need for choice.

Job Title and Organisation	CHAIRMAN/ TRIUMPH OVER PHOBIA (TOP) LEADER
Name	CELIA SCOTT WARREN

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PMH PC 6

Issue to be addressed or a project outline
Early intervention of stress and stress related absences. How to keep employees suffering with stress / mental health in the workplace and how we can support them to remain in the workplace. Carry out HSE stress indicator tests to support AXA referrals early on.

Organisational outcome
Change the culture so that there isn't a fear or silence around mental health. Reduce absence rate, reduce attrition rates, increase manager's knowledge about mental health and stress in the workplace. Increase staff wellbeing. Create a culture where managers have a key role to play in creating and maintaining a positive place to work that will support mental health and wellbeing.

Personal outcome
Develop and support a culture where open and honest communication is encouraged, create a safe environment for staff to disclose their own mental health problems. Gently encourage and support employees suffering from mental health back into the workplace. Encourage a good work life balance.

Service User, cost or environmental impact
Reduce sickness costs, encourage protected time when managers are available for staff to come and speak to them. Increased productivity and a happier workforce. Reduce the cost of Social Security benefits.

Impact on Mental Health System Building Blocks
This will impact on all of the mental health building blocks. Speedy appointment times for people who require immediate referrals will place a strain on the mental health system, however this may be offset by early intervention and the costs on other services and the individuals family and friends from a personal perspective.

Job Title and	HR Manager – States HR

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Organisation	
Name	Lesley Darwin

PMH PC 7

Issue to be addressed or a project outline

Mind Jersey is committed to taking action to help end mental health stigma and discrimination and improve understanding of mental illness. As part of our wider campaign we will be addressing the issue of stigma and discrimination by and to young people. Young people living in a community where stigma and discrimination exists means they are less likely to identify, manage and seek support for their mental ill health and will ultimately be the difference between life and death.

Practice Challenge: What approaches can Mind Jersey take to address the issues of stigma and discrimination to and by young people in Jersey?

- Stigma Survey?
- Education projects in schools?
- Roadshow?
- Film?
- Multi-agency approach?
- Participation?

Organisational outcome

Reduced Stigma and misunderstanding about mental ill health.

Improve practice towards young people with mental health problems.

Promote the recovery of good mental health.

Personal outcome

Service User, cost or environmental impact

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Improved understanding about mental health and illness amongst young people and those working with young people in Jersey. Increase in help seeking behaviour amongst young people Young people are mindful of their own wellbeing Increased awareness of mental health issues amongst the community Mental health problem is prevented from developing into a more serious state

Impact on Mental Health System Building Blocks

Job Title and Organisation	Service Development Manager Mind Jersey
Name	Liz Kendrick-Lodge

PMH PC8

Issue to be addressed or a project outline
How do we measure mental wellbeing in Jersey? Traditionally measures have relied on a medical model such as the incidence and presence of mental illness and use of related pharmacotherapy. How can we work towards measuring some more of the more positive factors such as the presence of factors protective of mental health?

Organisational outcome

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Available tools to measure outcomes and monitor progress that encompass a broad multi-dimensional and holistic view of mental health and emotional well-being.

Measures that support actions with a focus on prevention, early intervention and inclusion.

Sharing of wider service level data across statutory and non-statutory agencies and departments

Increased availability of qualitative measures to compliment the quantitative

Identification and clarification of specific groups where mental health could be improved.

The beginnings of some economic analysis

Personal outcome

Pink, fluffy and soft is turned into something tangible that can be held on to, be seen and described.

A path through the grey and murky swamp of rather subjective measures.

Service User, cost or environmental impact

A broader picture of holistic Mental health and wellbeing and related need within communities

Services that can be more responsive to known local need as well as anticipating future requirements

A picture which more resembles the lived experience of managing and improving mental health, inclusion, self care and quality of life.

An understanding of related help seeking behaviour that can be used to increase early help and support within the community as well as access to specialist services.

Impact on Mental Health System Building Blocks

1. Accountability
Works to provide a robust framework on which to measure and monitor progress of strategic action

6. Recognise how high the suicide rate is
Provides wider measures that may relate to and impact on suicide rates. Measures factors know to protect individuals and reduce or balance out risk of suicide

7. Recognises the causes of mental health
Provide positive measures of protective elements. Measuring protective factors that can determine/support positive mental and emotional health

9. A focus on prevention
Availability of tools that measure positive aspects of mental health. Measures that

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don't wholly rely on medical model with an illness focus. **11. Value and support wider community roles** Measures that recognise the value of social connectedness on emotional and mental health.

Job Title and Organisation	Head of Health Improvement
Name	Martin Knight

PMH PC9

Issue to be addressed or a project outline
What models of integrated mental health care could offer responsive support to service users i.e. talking support for those with impaired vision who are told they will never regain their sight / it will get progressively worse / nothing further medically can be done to help them.

Organisational outcome
Jersey Blind Society needs to continue to build working relationship with Eye Dept so that more integrated support is possible. JBS needs to change its name to something positive so that patients aren't further dismayed by being referred on to the Jersey Blind Society just after being told bad news about their sight. Eye Dept to promote free phone support services (RNIB and Macular Society) in large print posters and pamphlets and information from consultants. JBS needs to develop its base to provide appropriate working space / environment for new staff and clients in order to expand support available. JBS to fund training for clients to become counsellors – possibility of employing them to man a telephone helpline at some point in future. JBS to investigate use of bereavement support / counsellors, with additional training in vision impairment, for a role in Eye Dept to talk to patients after appointments about their thoughts / experience and to stay in touch / refer on afterwards as appropriate / requested. This to be discussed with Eye Dept at a later date.

Personal outcome
I have learnt that bereavement support workers, who are not necessarily trained counsellors, nevertheless have skills which would definitely support clients / patients going through crisis at point of diagnosis and after. I have chased up the Eye Dept and requested that more is done to promote help-lines in the department.

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Service User, cost or environmental impact
Jersey Blind Society already working on a name change / marketing. JBS one year into funding counselling training for 2 clients, but course is 3 -4 years. JBS is at planning stage re developing Westlea site into dedicated support centre. Once offices (and rehabilitation rooms) completed more staff to be employed which will enable more to be accomplished in conjunction with Eye Dept, at which point, if not before, key staff from both services to meet to discuss how best to provide talking support in Eye Dept, where space for such support may not currently exist. Confirmation received from Eye Dept that they will be displaying more information about support phone lines and consultants are advising about these services. Costs at this stage either minimal (ie displaying appropriate information) or welcomed by JBS which has money and willingness to develop its service. Cost to Eye Dept to employ / have on site a talking support service unknown at this juncture. JBS also organises events to bring together V I children and parents to provide mutual support and enjoy activity, and facilitates support groups, though these have, to date, been run for self-advocacy or social ends rather than offering emotional support at times of crisis.

Impact on Mental Health System Building Blocks
Prevention: recognising the causes of mental health problems – ie unemployment, stress, disintegration of relationships, loneliness, isolation, loss of independence, loss of ability to do things spontaneously, feelings of powerlessness, feelings of losing sense of identity etc can all stem from life changes around sight loss. Rehabilitation can support independence but someone to engage with and talk through the shock and re-evaluation of self and future plans could potentially prevent initial depression becoming clinical. Speedy response: recognising that patients probably have only heard bad news in diagnosis and are in shock. Response to loss of sense of vision is bereavement. Many stages of bereavement and patient may initially be in denial or too angry to engage with support so support must be offered regularly and in a friendly and informal way so that patients not frightened off by offer of counselling (which would also be available on referral). Easily accessible information: a stronger working relationship with Eye Dept would provide more integrated support / information. A pack providing information on all support services around visual impairment, including Education and Jersey Employment Trust, Workwise would help inform patients that support is available throughout their lives. Accessible information about phone helplines would provide support to patients who need immediate support.

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Job Title and Organisation	Community Worker, Welfare and Advocacy
Name	Sarah Shaw

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Early Intervention (EI) ALS Practice Challenges

EI PC1

Issue to be addressed or a project outline
To promote inclusion of customers with mental health problems in the remit of the CICS/React service

Organisational outcome
Enhance awareness of the CICS/React service across the organisation including mental health teams Develop working relationships across teams to make customer experience seamless

Personal outcome
To ensure customers with mental health needs are included in CICS/React criteria To be mental health lead at CICS/React team To represent CICS/REACT at meetings with mental health teams To provide information & support to team colleagues on mental health aspects of service provision commissioned by CICS/React team

Service User, cost or environmental impact
Reduce stigma for customers with mental health needs Ensure customers with mental health needs have equitable access to service of CICS/REACT team To promote holistic assessments for benefit of customers including considerations of psychosocial interventions

Impact on Mental Health System Building Blocks

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Assist continuity of care for customers with teams & services working together Provide a speedy response Provide easily accessible information for customers, carers, third sector

Job Title and Organisation	Senior Social Worker CICS/REACT team
Name	Clare Cook

EI PC2

Issue to be addressed or a project outline
Poor incoming communcation between other agencies and GPs Services to email practice managers informing them of the service's involvement with the patient. Practice managers to code this information onto the EMIS web patient file Other agencies to ensure lengthy letters are summarised at their end with bullet points so that the GP can just read a quick summary rather than having to read pages and pages.

Organisational outcome
Better information sharing Safer practice

Personal outcome
GPs would know who was actually involved with their patient and could contact the agency to find out more if they would like

Service User, cost or environmental impact

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Better for service user more joined up working

Impact on Mental Health System Building Blocks
Working together accountability

Job Title and Organisation	GP
Name	Kate Wilson

EI PC3

Issue to be addressed or a project outline
Early help in schools and colleges: identification of need, analysis of resilience/protective factors, matching/mobilising resources and support, consultation/use of outside agencies, record keeping/monitoring/evidence of impact etc

Organisational outcome
Clear support pathways, mapping of skills and resources and identification of gaps, fair and equitable access to support, clear systems and protocols, clear lines of accountability and responsibility, ongoing training and professional development offer, transparent and accountable management and supervision systems

Personal outcome
Development and delivery of training on mental health and emotional wellbeing in tandem with CAMHS and vol sector partners. Involvement in reviewing and transforming the emotional well being/mental health offer at Tier 1 and 2 across pre-school, school and college provision

Service User, cost or environmental impact

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Impact on Mental Health System Building Blocks
Successful managing down of need. Appropriate referrals/requests for consultation reducing load and therefore waiting times for specialist servcies Building resilience and coping amongst children and young people. Up-skilling the education workforce to support emotional well being and mental health within the boundaries of their remit by improving skills and confidence and providing a good support and training offer in this area of work.

Job Title and Organisation	Educational Psychologist Educational Psychology Service
Name	Jayne Stallard-Moore

EC PC4

Issue to be addressed or a project outline
Co-constructed care plans and collaborative working

Organisational outcome
Improved care planning for individual client group offering best practice collaboration between individual and organisation

Personal outcome
Develop more robust system for care planning and improve collaborative working

Service User, cost or environmental impact

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Improve client experience and ownership of care planning

Impact on Mental Health System Building Blocks
More user friendly Increased collaborative between client, carers and all agencies

Job Title and Organisation	Community Mental Health Nurse Specialist CMHT
Name	Liz Auld

EI PC 5

Issue to be addressed or a project outline
The States of Jersey Police (SOJP) regularly encounter difficulties with the process of detention and assessment for people in crisis and who have made threats to self-harm or take their own life. Once detained, the SOJP can encounter significant delays when taking people in crisis to the Emergency Department (often having to wit with detained persons for hours pending assessment). The SOJP also encounter difficulty when dealing with people in crisis who are under the influence of alcohol or drugs which often means them being refused admission to hospital leaving the SOJP with no option but to take them into police custody (cells) in order to keep them safe. The impact on police resources is significant and can lead to an officer being pulled from street duties to maintain observation on a detained person. The current system does not appear to consider the best interests of the person in need of support and it is through efforts of those involved (predominantly the police who are available 24/7) that intervention has prevented harm coming to many. The fact remains that police cells are not the most appropriately placed to cater for people who are clearly in need of medical assistance, mental health assessment and wider support – regardless as to whether they are under the influence of alcohol or drugs.

Organisational outcome

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- Potential for unlawful detention by SOJP dependent on circumstances and application of powers
- Focus on customer needs and appropriateness of relevant agency taking primacy
- Detraction of finite police resources from other matters from what is a medical matter
- Demand of work in this area outgrowing available resources
- Conflict between police and health staff

Personal outcome

- Genuine desire in wanting to do what is best for people who need medical assistance
- Acknowledgement that whilst available 24/7, the police are not well placed or should be expected to lead on such matters.

Service User, cost or environmental impact

- Mental Health services not always being readily availed to those that need it
- Appropriate provisions to assess and care for people in need not readily available. Police cells are no appropriate
- The Criminal Justice process is not the appropriate route, notwithstanding if deemed to have capacity any criminal investigation does need to be followed up

Impact on Mental Health System Building Blocks

The following building block areas are in my view impacted upon. Whilst the SOJP are absolutely committed to getting people help, it cannot be right that expectations are placed on the police to compensate for inadequate provisions around the safe locating of people in need of medical assessment ultimately for mental health assessment.

- **Accountability** – Recognising that we have a duty of care to help someone in crisis and aligned to the police primary function of saving life
- **Continuity of care** – Wanting the best for an individual in order that their needs are considered as primary concern, regardless of their fitness to detain through drugs or alcohol
- **Adequate numbers of trained and well supervised people working in mental health** – Utilising finite resources and detracting from the many other operational commitments when effectively plugging the gap for wider inadequate facilities
- **Recognise how high the suicide rate is in Jersey** - This is

reflected in the significant growth in welfare concerns that the SOJP now attend and who are expected to deal with. It is not always clear that this level of concern is shared

- **A focus on prevention including investment** – The SOJP aim to be as proactive as possible in getting people the support that they need which includes early assessment and/or treatment that remains victim focussed.

Job Title and Organisation	Police Inspector - States of Jersey Police
Name	Mark Coxshall

EI PC 6

Issue to be addressed or a project outline
To introduce the role of a mental health worker to support the Maternal Early Childhood Sustained Home Visiting programme. This is an intensive health visitor home vising programme which begins in the antenatal period and until the child is aged 2 years. Its main focus is on child health and development, maternal health and well-being and enabling aspirational parenting. The approach is based upon a partnership model of working. The mental health worker will have a core profession such as nursing or social work and in addition will have a counselling qualification and experience. They will support the family in the home setting and for a defined time period with the ultimate aim of enabling, building resilience and where necessary 'bridge the gap' for the client into other services such as 'Talking therapies' , G.P, Psychiatric services and based upon individual needs.

Organisational outcome
The role of the Mental health worker will enable the health Visitor to focus upon achieving the outcomes of MECSH and maintaining the integrity of this preventive programme. Health Visitors often find themselves dealing with multiple family issues. For clients on MECSH programme this will allow the health visitor to remain focussed upon child development, enabling confidence in parenting and assessing maternal wellbeing throughout. Meanwhile, the Mental Health work can support where there is identified need and facilitate access to other agencies when required. Liaison with health Visitors will be vital so that families are seen in a continuing holistic way. Working in partnership with GP, psychiatry and talking therapies will be essential to success.

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The mental health worker and health visitors will utilise validated tools in partnership with clients to assess the mental health needs of adults.

A focus upon prevention will be emphasised in this approach with early identification of need and prompt referral to other services where necessary.

Support will occur in the home and therefore be easily accessible.

Personal outcome:

Satisfaction of bridging a gap in services, strengthening a Health visitor programme and potentially enabling a seamless client journey where mental health support and intervention is required.

Service User, cost or environmental impact

Financial cost met by programme and in terms of prevention of mental health issues escalating, a significant saving to health service budgets.

Impact on Mental Health System Building Blocks

Addresses:

- 5. Adequate numbers of trained and well supervised people working in mental health
- 7. Recognise the causes of mental health
- 9.A focus on prevention
- 10. Early accessible information about services
- 11. Explore different sources of support
- 13. Offer choice to clients

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Job Title and Organisation	Operational lead for child and family Services – Family Nursing and Home Care
Name	Michelle Cumming

EI PC 7

Issue to be addressed or a project outline
Carers not getting support early enough and/or not being advised of Carer support service. Carer Awareness sessions to be delivered with information on Carer Support service and referral advice.

Organisational outcome
Accessing more carers in which we develop our services around their needs. If accessed sooner the distress in which current carers come into contact with us might be less which would allow us to direct resources to other needed areas for carers.

Personal outcome
Supporting the carers is in the best interest of all including the Carer Support Service as this makes for a healthy service for the new carer to receive support

Service User, cost or environmental impact
Carers accessing support at first available opportunity can alleviate some of their distress making communicating with the health professionals less challenging and allow them to provide healthier support to their loved ones if their own needs are being met.

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Impact on Mental Health System Building Blocks

Job Title and Organisation	Mind Jersey
Name	Stephen McCrimmon

EI PC 8

Issue to be addressed or a project outline
We discussed the need for securing funding to be able to maintain the current services that YES offers and once this is done also look at how we can use YES to support more young people to access the relevant service for their needs.

Organisational outcome
The aim is to put together a report outlining the work that is carried out by YES and how this fits in with other partner agencies. Funding secured for YES and possible expansion of services (long term goal)

Personal outcome
To try and consolidate the work we do – the service feels stretched at the moment as it is so well used by young people- we want to be able to continue to provide support for young people but need to secure funding. I want to produce a paper that sets out what we do, what we'd like to do and what we need in order to make it happen and then look at what are realistic goals.

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Service User, cost or environmental impact
Funding needs to be secured – not sure where from yet

Impact on Mental Health System Building Blocks

Job Title and Organisation	Senior Youth Worker/Team Leader for jersey Youth Service
Name	Vicki Twohig

EI PC 9

Issue to be addressed or a project outline
The project is to link the gap between the General Practice and the Psychiatric services, my project would be looking at a pathway where the GPs could contact the specialist service for advice and support before the referral to the service happens

Organisational outcome
The pathway would hopefully help reduce the number of referrals to the psychiatric services. This will help manage the mild cases through the GPs.

Personal outcome
Service improvement and offering high quality of care not only to patients using our service but also patients in the General Practice

Service User, cost or environmental impact

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For service users having that continuity of care from the family doctor would be of great benefit,

Impact on Mental Health System Building Blocks
Reducing the number of referrals will hopefully reduce the input of patients into the service and that would have a positive impact on the Mental Health system building block

Job Title and Organisation	Staff Grade Psychiatrist, HSSD
Name	Zainab Kadhim

Crisis and Acute (CA) Practice Challenges

CA PC 1

Issue to be addressed or a project outline
Better clarity with regard to process for communication between Adult Mental Health and Children's Service. In particular, where an adult has a mental health diagnosis or is undergoing assessment, and there are children within the family, then joint work should be undertaken regarding the plan for any contact. Joint risk assessments could be undertaken.

Impact on Mental Health System Building Blocks

Organisational outcome
For Children's Service – less emergency action needed. All parties aware of plan and able to be party to that plan.

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Personal outcome

Service User, cost or environmental impact

Job Title and Organisation	Senior Practitioner, Children's Service
Name	Alli Tandy

CA PC2

Issue to be addressed or a project outline
1.Review of current in-reach psychiatric services at HMP. 2.Clarifying roles of staff when prisoner is in-patient at OH. - 3.Clearer guidelines and protocols when transferring prisoners.

Organisational outcome
-Auditable and accountable approach to mental health provision at HMP -Making best use of what clinical time is available by adhering to the appointments system. This in turn will help avoid wasting escorting prisoner officer's time and minimise disruption to the prison regime. -Improve relationships Improving feedback and communication between services Whilst the role of the bed watch staff is primarily that of security, staff are also likely to have substantial knowledge of the prisoner, in some cases they may have known them for many years. This knowledge isn't used in the documentation of the

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prisoners' care. Using this knowledge would help the clinical and nursing staff in a similar way to that of asking a patient's relative.
This would help improve working relationships between the two organisations

Clearer guidelines/care planning for the prisoner when discharged back to our care, this currently is inconsistent –helpful guidelines may include being able to advise prison officers and senior management as to what constitutes symptoms of mental illness and what is considered behavioural.

Training delivered by adult mental health and involvement in the management plans of prisoners could be considered.

More involvement with prison security staff regarding assessment of risk whilst prisoners are in patients both before and during the admission.

Currently many of the therapeutic interventions are carried out in another building, the prisoner will not be allowed off the ward and may spend much of their admission in the acute area.

Personal outcome
?

Service User, cost or environmental impact
Should not have any additional costs to either service. The impact should have a positive impact for service users in terms of service delivery & outcomes.

Impact on Mental Health System Building Blocks
Unsure

Job Title and Organisation	Healthcare Officer at States of Jersey Prison Service
Name	A Buttimer

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CA PC3

Practice Challenge

Issue to be addressed or a project outline
What approaches will determine whether an island or off island placements best meet clients needs.

Organisational outcome
Development of policy/guidance regarding the most effective interventions for individuals in crisis and at significant risk due to mental illness including **1. thresholds for** • Normal service • Special package of care by Island staff with/without specialist consultation • Special package of care on island by UK services • Off island placements **2. Cost/benefits** • Benefits of being treated in own community v levels of skill available for different presentations • Staff available with/ability to develop relevant skills v impact on other clients care when staff transferred to special package of care • Having and maintaining staff skills on island v accessing specialists in the UK • Island community's ability to deal with difference and unusual behaviours v treatment in own community • Identification of appropriate individual accommodation which requires full staffing v use of other facilities which are not ideal but are staffed (e.g. young people – Robin/Orchard House/Greenfield are used but not ideal) • Level of risk to self and others v better potential outcomes • Providing better care through development of specialist team v cost of teams particularly when variable demand • Off island treatment maybe optimal for acute crisis or specific treatment modality v challenge of reintegration back to jersey **3. Ownership** • Need for investment (not necessarily financial) and ownership not just by mental health services but by wider organisation, other States departments, 3rd Sector and the community • No one service can address this issue in isolation • Fundamental shift in how mental health viewed by all • Do we need underlying systems to be redefined? *So that we define a solution that has the optimal outcome for the service user, using local resources wherever possible with access to additional resources as required*

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but not impacting on other service users care due to withdrawal of staff or increased financial restraints due to cost of package.

Personal outcome
Better understanding of drivers for decision making around high cost placements Clarity around when to consider off island placement for young people and relationship developed with a good provider Resolution of conflict associated with pressure to provide intensive package on island from normal community resources and continuing with BAU. Development of creative solutions underpinned by local policy and support of organisation.

Service User, cost or environmental impact
As stated above

Impact on Mental Health System Building Blocks
Any high quality solution is likely to require additional staffing drawn from current compliment or new posts and additional funding this may therefore impact on the development of preventative and early intervention service. Any solution will need to dove tail into the overall strategy with a clear step up/down model. Skills required to provide packages of care can be different to community/inpatient treatment; level of skills to support complex/unusual mental health presentations maybe different and therefore staff skill sets may need to be extended and maintaining skills will also be an issue.

Job Title and Organisation	Consultant Child and Adolescent Psychiatrist, Lead Clinician CAMHS
Name	Carolyn Coverley

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CA PC4
Practice Challenge

Issue to be addressed or a project outline
Jersey has inappropriate facilities for 'place of safety' needs; Infrastructure investment required to mitigate the risks of dealing with vulnerable detainees in a policing environment;

Organisational outcome
Domain integrity – mental health to be dealt with by the Health Service and not the Criminal Justice System

Personal outcome
Reduce the challenges faced by Police Custody staff in the day to day management of vulnerable people.

Service User, cost or environmental impact
Mitigate the risk to service users and staff of the impact of suicide and self-injurious behaviour following police contact.

Impact on Mental Health System Building Blocks

Job Title and Organisation	Director of Criminal Justice
Name	Dr Helen Miles

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CA PC5
Practice Challenge

Issue to be addressed or a project outline
Managing acute/crisis admissions within the paediatric environment. Children often admitted as a place of safety but unfortunately the ward is an unsuitable environment. Staff do not feel that they are suitably qualified to look after children with mental health issues.

Organisational outcome
For children/young people to be nursed in an appropriate setting with appropriately trained staff. For the experience for the child/young person to be a holistic one.

Personal outcome
To have the confidence that as a health care professional I can offer children and young people with mental health issues the best possible care within my working environment.

Service User, cost or environmental impact
Whilst paediatric input and environment is required, the present ward environment is currently compromising a child/young persons care and treatment. Children are often isolated in order to keep themselves and other patients on the ward safe. This can be detrimental to their recovery and health needs.

Impact on Mental Health System Building Blocks

Job Title and Organisation	Junior Sister – Robin Ward
Name	Linzi Gilmour

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CA PC6
Practice Challenge

Issue to be addressed or a project outline
To improve collaboration between Mental Health Services and the criminal justice system through provision of a Community Psychiatric nurse

Organisational outcome
For offenders within the criminal justice system to receive appropriate screening, assessment and intervention at key stages: arrest and detention, court appearance , whilst undertaking a community sentence and whilst serving a prison sentence

Personal outcome
My personal outcome would be job satisfaction at contributing to a significant service development.

Service User, cost or environmental impact
Goal would be to provide quicker assessments and treatment pathways for people within the criminal justice system . Not sure if this would require new staff but some reconfiguring of services should be considered.

Impact on Mental Health System Building Blocks
Not quite sure what this means but I would argue that acute care might be avoided by earlier and more appropriate interventions. This type of approach could also make a contribution to community safety as well as enhancing the safety of the prison

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Job Title and Organisation	Assistant Chief Probation Officer
Name	Mike Cutland

CA PC7

Practice Challenge

Issue to be addressed or a project outline
To improve collaboration between Mental Health Services and the criminal justice system through provision of a Community Psychiatric nurse

Organisational outcome
For offenders within the criminal justice system to receive appropriate screening, assessment and intervention at key stages: arrest and detention, court appearance , whilst undertaking a community sentence and whilst serving a prison sentence

Personal outcome
My personal outcome would be job satisfaction at contributing to a significant service development.

Service User, cost or environmental impact
Goal would be to provide quicker assessments and treatment pathways for people within the criminal justice system . Not sure if this would require new staff but some reconfiguring of services should be considered.

Impact on Mental Health System Building Blocks

Not quite sure what this means but I would argue that acute care might be avoided by earlier and more appropriate interventions. This type of approach could also make a contribution to community safety as well as enhancing the safety of the prison

Job Title and Organisation	Assistant Chief Probation Officer
Name	Mike Cutland

CA PC8
Practice Challenge

Issue to be addressed or a project outline
Extend advocacy service to prison and CAMHS

Organisational outcome
Robust organisational structure Well trained team prepared and skilled to work with range of issues and to cope with increased capacity work

Personal outcome
Less pressure on me to do it all so reduced stress Able to delegate Lead and work with a team rather than alone

Service User, cost or environmental impact
Will have significant financial cost £150k+ Improved support for service users Transparency for service providers, reduce exposure to litigation and complaints Avoid potentially damaging issues which would affect the Island's reputation

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Impact on Mental Health System Building Blocks
3 Continuity of care 4 Stigma 10 Accessible information and support

Job Title and Organisation	Independent mental health advocate
Name	Patricia

CA PC9

Practice Challenge

Issue to be addressed or a project outline
Extend advocacy service to prison and CAMHS

Organisational outcome
Robust organisational structure Well trained team prepared and skilled to work with range of issues and to cope with increased capacity work

Personal outcome
Less pressure on me to do it all so reduced stress Able to delegate Lead and work with a team rather than alone

Service User, cost or environmental impact

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Will have significant financial cost £150k+ Improved support for service users Transparency for service providers, reduce exposure to litigation and complaints Avoid potentially damaging issues which would affect the Island's reputation

Impact on Mental Health System Building Blocks
3 Continuity of care 4 Stigma 10 Accessible information and support

Job Title and Organisation	Independent mental health advocate
Name	Patricia

CA PC10
Practice Challenge

Issue to be addressed or a project outline
Lived experience-how do we ensure the service user's voice is heard and central to all practice development so that their experience is meaningful to them

Organisational outcome
Person-centred care would be consistent and embedded throughout adult mental health services Ongoing qualitative audit of mental health services from the service user perspective via the FACE Your Treatment and Care tool

Personal outcome

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Service User, cost or environmental impact
Service users should receive a consistent and compassionate approach that sees them as an individual and builds on recovery and independence Person-centred approaches should have the least impact on a service user's life; it supports the person to keep in contact and work with their personal responsibilities to the degree they are able to at the point of first onset, crisis, relapse, recovery Cost-medium to long term should see positive impact on costs as person-centred care moves away from traditional paternalistic models of care therefore supporting community-based packages of care

Impact on Mental Health System Building Blocks

Job Title and Organisation	Community Mental Health Nurse/Practice Development AMHS
Name	Sonya Hurley

CA PC11

My practice challenge I will bring to the Action Learning Set will be :

(See over the page for examples of challenges, the list is not exhaustive!)

Integrated working across primary care services at points of crisis including rapid response and the wider out of hospital services. Capacity and deprivation of liberty issues.

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My Name: Tia Hall

Organisation / Service Area: FNHC

Contact Telephone Number: 443673

Recovery (R) Practice Challenges

R PC1

Beth Moore tba

R PC2
Practice Challenge

Issue to be addressed or a project outline
More formal process of engagement with advocacy, service user groups, experts by experience to support the inspection process and that enhances the qualitative assessment and processes that are undertaken

Organisational outcome
Standards being more effectively monitored and aligned with the recognised standards and objectives that are to be followed by providers and that aims to promote mental well being

Personal outcome
Continuing professional development and up to date practice issues highlighted and reinforced with engagement with key agencies, providers and tertiary services such as advocacy and commissioners of a variety of mental health services

Service User, cost or environmental impact
Improved service provision

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Impact on Mental Health System Building Blocks
Standards being effectively monitored, scrutinised and measured within the recognised standards and objectives as aligned with all sectors involved with the provision and promotion of mental health

Job Title and Organisation	Professional and Care Regulation Team, Public Health
Name	David Luscombe

R PC3
Practice Challenge

Issue to be addressed or a project outline
BEYOND RECOVERY How can we provide better long-term care for problem drug users (a lot of overlap exists for those with long term mental health problems)? Support for acute problems of recovery for problem drug users is in my opinion good. There is generally a short waiting list for assessment and treatment. Those more urgent cases for substitute prescribing are fast tracked. However, once people are stable and their substitute prescribing is reduced as the current legislation is not for maintenance prescribing. Longer term, problem drug users face difficulties with finding employment due to stigma, previous problems with the criminal justice system, lack of educational attainment, lack of motivation or simply lack of support. There are other area's in which problem drug users need support and these include, housing, physical and mental health needs, financial support or simply moral support or help with structuring their lives, facilitating them engaging in areas of support. This latter area I feel is of great importance, as the various agencies which provide support have a bunker mentality, if people do not keep an appointment for the Hospital for example then they are simply sent another one, if this is to an old address then they quickly are lost to follow up. Providing support with housing and employment may have a positive effect on long-term outcome.

Organisational outcome

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A problem drug user, from the point of first contact with the Alcohol and Drug Services / acute mental health services would be allocated to a named support worker.

This worker would need to work with that individual in order to try and maintain continual contact, for example, knowing other family or friends who would know their whereabouts.

This person would need to have knowledge of services available to problem drug users and be able to offer a holistic approach to that individual.

A knowledge of training and educational needs and what services can be provided if required, what psychological services are available for support, third sector support for drug users and families, a knowledge of the financial support available to them via Social Security or charities.

As well as an individual approach, if provided a specific centre in which support groups could meet, have mutual support, provide a venue for education such as basic literacy / numeracy / form filling etc. as well as other group centred therapies such as cooking / art and other life or life fulfilling skills.

Measurable outcomes could include a reduced DNA rate for appointments, greater employment, greater skill acquisition, reduced relapse rate and improved mental health.

There may be an incentive for financial support in return for engaging in the form of food vouchers / support for dental and medical care within primary care and clothing.

Personal outcome

People being supported would have a greater engagement in services providing care for their mental and physical health.

Greater support for gaining skills and employment.

Support in keeping appointments with other agencies such as probation.

Support from third sector agencies providing support.

Facilitating the individual in recovery, friendship and support.

Service User, cost or environmental impact

Service user cost – this would simply be their time to engage.

Cost to society and the criminal justice system may well be in the savings made in preventing relapse and therefore the indirect cost to society from the criminal justice system / treatment of acute medical problems or long term costs of chronic diseases such as Hepatitis C or HIV within the community.

Another example would include the cost of admission for dental clearances versus preventative care from primary dental services. The cost to individuals in the form of self-esteem / employability from poor dentition is significant. At present they have o get quotes for dental care and ask Social Security for support.

Impact on Mental Health System Building Blocks
The current survey being done by the Alcohol and Drugs Service will provide a current more accurate assessment of the numbers of problem drug users. This would enable a more accurate assessment of the numbers of workers needed. A business plan would identify costs. This may be possible to be shared with the third sector. Utilisation of existing resources such as the Alcohol and Drugs Service / Mental health services would reduce building costs. The Drug Trafficking Confiscation Fund may be available for funding also, assuming this is still available.

Job Title and Organisation	Doctor, General Practitioner and prescribing Doctor for the Alcohol and Drugs Service
Name	Dr David Bailey

R PC4
Practice Challenge

Issue to be addressed or a project outline
1 Ensuring and enhancing community based services in line with the white paper (caring for each other, caring for ourselves 2012) 2. Continual development of partnership working across services, agencies and employers, maintaining person centred support and choice 3. Job retention as a key area of support

Organisational outcome
Wellbeing role to be included in broader Multi-disciplinary meetings. Risk Management to be included Case co-ordination from mental health services to impact greatly (positively) on existing client referral processes within JET. (clarity of information)

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Personal outcome
Clearer choices for possible support Definition of Wellbeing role within JET (It is a new developing role) Less frustrations in receiving/gaining client information sharing

Service User, cost or environmental impact
Client receives a broader, more 'joined' support Reduction in sigma Possible reduction in monetary costs (less paperwork/time required)

Impact on Mental Health System Building Blocks
Clearer vision in case co-ordination Less impact of cost Clearer view of 'holistic' support for client

Job Title and Organisation	Wellbeing support co-ordinator Jersey Employment Trust
Name	Lee Bennett

R PC5

Practice Challenge

Issue to be addressed or a project outline
How can the Recovery centre based next to Orchard House, for in-patients and community clients engage people, whilst giving the right balance of educational and social sessions?

Organisational outcome

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More service users engaging and fulfilling their recovery goals. Service-users knowing that they can take part in/run art/craft sessions or any sessions that they have particular interests in. Patients spending more time off the ward, resulting in shorter in-patient stays. More community clients accessing activities, aiding recovery and taking pressure off other professionals. More service users preparing themselves for Jersey Employment Trust by engaging in increasing confidence, learning new skills.

Personal outcome
Fulfilling work helping support people and gain vocational skills. A sense of achievement - supporting people to grow in confidence, and distract themselves away from illness. A sense that I am helping someone identify an interest or skill and using to help others on their journey.

Service User, cost or environmental impact
Very low cost dependent on what activities are provided. Currently we use the budget at the Recovery centre and source natural things to aid with floral work making cost minimal.

Impact on Mental Health System Building Blocks
The recovery centre has currently on offer for mental health service users from the ward and the community, yoga, mindfulness, health eating sessions, service users led groups, exercise, a library, computer with wi-fi, some educational groups, gardening, relaxation. A lot of the building blocks focused on things that were not available, and the Recovery centre has the majority of these on it's lists. There are obvious problems with people not liking where the building is situated but we have found that if we find session's people enjoy this seems to become less significant.

Job Title and Organisation	Senior 2 Occupational Therapist
Name	Louise Ogilvie

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R PC6
Practice Challenge

Issue to be addressed or a project outline
How can psychologically informed approaches to patient care and recovery be better integrated and applied within Jersey's Adult Mental Health service?

Organisational outcome
A greater understanding of psychological models and approaches throughout the organisation and its wider networks of informal care Improved inter-disciplinary working and better communication within AMHT Regular supervision and case consultation led by psychologists A system that values and embraces the role of psychological approaches in promoting recovery and well-being Shift in emphasis within AMHT from mental illness to wellness and recovery agenda

Personal outcome
Improved relationships with Mental Health Service colleagues More effective joint working and greater impact with same amount of resources Limited one-to-one resources prioritised for those with the most complex needs

Service User, cost or environmental impact
More efficient use of limited resources Potential to reach a greater number of clients through group work and indirect contact Promote client choice by offering a wider range of options for support

Impact on Mental Health System Building Blocks
5) Enhanced training and supervision for AMH staff 10) Improved information about services and sources of help and support 11) Value and support informal networks through support and education 13) Encourage a wider choice of approaches for working with Mental Health clients

Job Title and Organisation	Counselling Psychologist, Adult Mental Health Service
Name	Dr Luke Shobbrook

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R PC7

Issue to be addressed or a project outline
Reducing stigma around dementia care and how to develop new community-owned projects to achieve this.

Organisational outcome
Identify key priorities through dialogue with those directly affected by dementia. Create a 'dementia friendly' Island. Ensure effective use of White Paper dementia services funds (and also funds donated to JAA by the public). Best use of the newly appointed JAA Educator's time. Set up a 'working group' and identify 'dementia champion/s' to assist in raising awareness and educating the public at large. Increase the membership of JAA's Friendship Group as well as JAA's volunteer base. Continued close co-operation with HSSD, as 'critical friend', & other agencies and voluntary organisations.

Personal outcome
Gain a better understanding of the needs of people with dementia and care providers in Jersey. Enable development of JAA fundraising strategy to secure regular income flow in order to provide sustainable services.

Service User, cost or environmental impact
Greater engagement by members of the public with JAA and HSSD so as to obtain information and support concerning dementia. Establish what would encourage people to seek help. Increase *timely* diagnosis of dementia by GPs and the Memory Clinic. Create a Dementia Strategy for Jersey. Include dementia within Public Health and Education policy and promotion: emphasis on care as well as cure*.

Impact on Mental Health System Building Blocks - all are relevant
1. Accountability 2. Support in the workplace 3. Continuity of Care 4. Adequate number of trained and well supervised people working in mental health system 5. Not tolerating stigma amongst the public and professionals around people

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with mental health problems

6. Recognise how high the suicide rate is in Jersey *(NB re: carers' needs)*
7. Recognise the causes of poor mental health e.g. unemployment, stress, loneliness, isolation
8. Speedy response at the time of need with someone coming back to you
9. A focus on prevention including investment *see* above*
10. Easily accessible services and where to find help and support
11. Value and support the roles of people and organisations outside the formal government services e.g. family, carers, friends, church, work, youth services
12. Explore, offer and invest in different therapies/support and ways of delivering them because one size doesn't fit all
13. The need for choice

Job Title and Organisation	Manager of Jersey Alzheimer's Association
Name	Mark Blamey

R PC8

Practice Challenge

Issue to be addressed or a project outline

Care co-ordination:

- How can care co-ordination be better defined, resourced and implemented to offer appropriate support people with mental health needs?
- Can a model of care co-ordination be designed for multi service/ organisational use?

Organisational outcome

- Care co-ordination better defined models explored/ considered for use across the organisation.
- Patients do not receive care co-ordination for longer than necessary.
- Model of care co-ordination to be considered to make best use of resources and to ensure efficiency and effectiveness of care co-ordination service.
- Possible future discussion on whether care co-ordination should remain a function of secondary care, or move to become a primary care function.

States of Jersey - Mental Health Service Review - Action Learning Report

Personal outcome
• Specialist mental health skills are not diminished by having to take on more 'generalist' skills needed to act as a care co-ordinator.

Service User, cost or environmental impact
• Patients needs negotiated with them- practice could become less prescriptive and less 'risk averse' with an appropriate model of care co-ordination. • No environmental impact anticipated

Impact on Mental Health System Building Blocks
Building Blocks: • 1,3,5,8,11,13.

Job Title and Organisation	CMHN CMHT- older people
Name	Tania Heaven

R PC9

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States of Jersey - Mental Health Service Review - Action Learning Report

Recovery

Practice Challenge : Psychology Department

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Culture and Environment

Issue to be Addressed or Project Outline
Culture and Environment - Importance of Relationships and Physical Environment **Relationships** Adopting a more welcoming and helpful environment where you feel cared for and supported. Well trained/skilled/empathic staff - Empowering clients with informed choices of services available and ways these services can be delivered/accessed -Attitude of Professionals- Stigma around people with mental health - society takes the lead from professionals (needs a similar attitude to those who suffer with cancer. Child dying with cancer vs a child dying of anorexia) **Physical environment** Improvements required overall - Furniture - Building - Signs -Using less triggering wording e.g Please Respect Yourself and Others whilst attending this Department to keep it safe for all (treatment may be withheld and you will be prosecuted for verbal or physical abuse against staff written in smaller writing at the end, so it's not confrontational or defensive. - Magazines more appropriate material for reading available in waiting area i.e Self Help material - Choice for Clients- Does this environment fit for all? - consideration of Person Centred Planning around use of the service

Organisational Outcome
- Better attendance, fewer appointments missed - Greater satisfaction scoring (anonymous online survey?) - Less defensive/ aggressive clients/ less staff assaults - Provides continuity of care where required - If you are dealt with effectively the first time around it will reduce the need/demand for subsequent connections with other services too, such as Police, Pain clinic, A&E etc - More satisfied clients leads to greater job satisfaction for staff and pride in their work

Personal Outcome
Clients feel more comfortable about using the Service, improves relationships, helps build purpose & value in to their lives, confidence, self empowerment, respect, safety, support, trust, as you are held in a secure stable, safe relationship emotions become more contained.

Service User, Cost or Environmental Impact
Service User - As Client access an appropriate Service this will reduce visits to A&E in crisis, Less time for Sickness, less self medication with drugs and alcohol Cost - Cost effective on all services in the long term (future) i.e return to work, self sufficiency, breaks the inter-gerational cycle Environmental Impact - minimal

3 4 5 7 9 10 12 13

Physical Environment, Stigma / Patient Centred

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Practice Challenge : Psychology Department

Impact on Mental Health System Building Blocks
This project outline meets building blocks 3,4,5, (7 is a prerequisite to reducing stigma as if you have the staff who understand the causes they are less judgmental and more understanding at the outset, 9, 10, 12, and 13

Job Title and Organisation	RCCO Short Break Service for Children with Special Needs / Service Advocate
Name	Tanya Mulligan

R PC10
Practice Challenge

Issue to be addressed or a project outline

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Structure of Social Security incapacity benefit system (both short-term and long-term, STIA and LTIA) is not ideal in terms of outcome for people off work for long periods of mental illness. People are unable to work whilst in receipt of STIA and therefore intervention and assistance may come too late at shft to LTIA benefit. This results in long-term joblessness, and poor outcomes for people on Income Support.

Issue to be addressed is whether early intervention, targeted intervention or fundamental change to system can prevent people from long-term unnecessary absence from the working world.

Organisational outcome

Decrease numbers of people who do not work because of long-term incapacity allowance award. Increase support to people already in this bracket and receiving Income Support.

Personal outcome

Consider legislation changes (long-term objective) that can change incapacity benefit to i prove help to people with mental illness and hopefully reduce jobless numbers.

Service User, cost or environmental impact

No cost as such.

Impact on Mental Health System Building Blocks

Recognise cause of mental health (unemployment)

Job Title and Organisation	Policy principal, Social Security
Name	Will Lakeman

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APPENDIX 3

Jersey Mental Health Services Review
Customer Voice Listening Exercise

Full Report

Prepared by:

Amy Hobson
Associate Consultant
Contact Consulting

1. Introduction

The Customer Voice process was a series of listening opportunities whereby people with lived experience of using Mental Health Services in Jersey, and their families, could speak openly about what has worked well, what they would change, and what the key priorities are.

Customer Voice will be woven through the Mental Health Services review like a golden thread, and from the many conversations will come a significant need for listening and responding.

> *"Courage is what it takes to stand up and speak, courage is also what it takes to sit down and listen."*
>
> Sir Winston Churchill

What the Customer Voice exercise was

- To hear views and experiences of customers.
- To compare findings with those generated by the Citizens Panel and Action Learning Set process.
- To explore how customers would like the future of Mental Health services to look.
- To test how involved customers would like to be in ongoing service development.

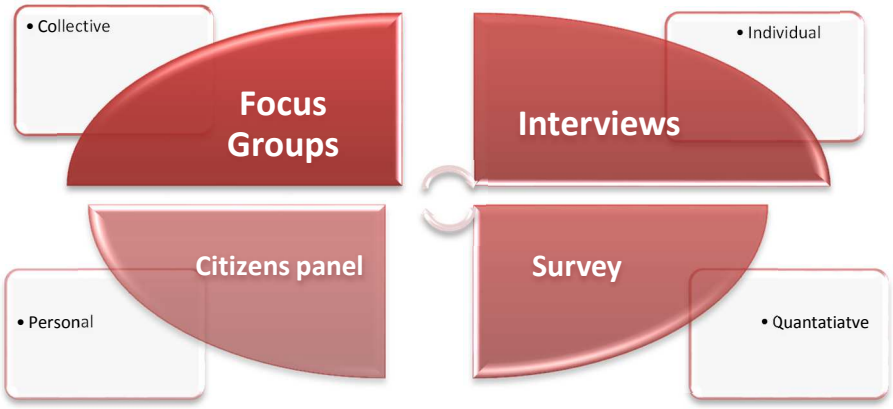
What the Customer Voice exercise wasn't

- To fully represent all customers or all experiences.
- To replace local customer engagement or involvement.
- To only hear critical or negative experiences.
- To be a full-blown piece of research.
- To be a longitudinal study of customer and carer views.

2. Approach and products

The approach was one Appreciative Inquiry, and gathered a breadth of information from as diverse a user group as possible. The aim was to hear from customers in all types of situations with a range of experiences, views and suggestions. The approach focused on strengths and learning, as well as hearing about the challenging or difficult journeys individuals have been on.

The 4 key elements of the process



Products

The products that have been created as a result of the customer voice listening exercises include –

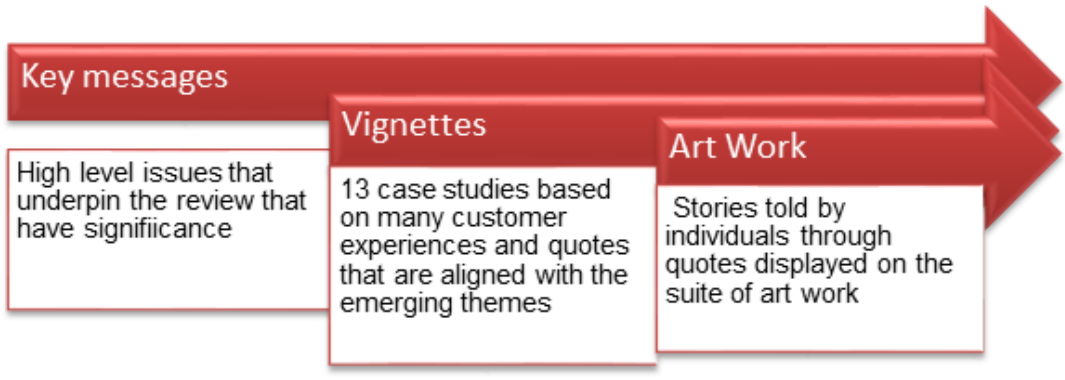
- A range of quotes that were used in art form on the engagement day.
- A golden thread of customer voice running through the Mental Health Services Review final document.
- 12 case studies/Vignettes blended from a range of users' stories linked to the emerging themes and the additional themes identified through the customer voice process that aligned with those identified in the literature review.
- A suite of artwork and quotes aligned to the review and the recommendations.

3. Methodology

A range of listening exercises with individuals and small groups, complemented by a survey underpinning the qualitative information with quantitative data was the approach used. The customer voice exercise aims to amplify the voice of people, and their families, with lived experience of using Mental Health services. The work has been written up in 2 sections –

1. Offering key messages that customers involved in the process believe need to be heard and responded to in the future Strategy.
2. Providing non-identifiable direct quotes, data from the survey and case studies/Vignettes using factual local information from customers and carers. These will illustrate and add examples to the Emerging Themes.

Method	Service User Group	Numbers
One-to-one Interviews Face-to-face and by telephone. Interviews ranged from 45 minutes to 90 minutes in duration	Adults Family Carers of people with dementia Family Carers of children/young people Family Carers of adults Children and young people MHA Lawyer Peer Support workers Advocates People who experienced the criminal justice system Total one-to-one interviews =	21 14 6 5 11 1 2 3 3 66
Focus Groups Held with groups of 5–6 people. 60 minute duration	• Adult Service users • Children/young people • Family Carers	1 group 1 group 1 group
Written Feedback Each piece of e-mailed feedback was sender-generated and personal	• MHA Lawyer • Second Opinion Consultant Psychiatrist • Advocate • Citizens' Panel member • Family Carer • Adult service users	1 1 2 1 2 3
Survey The 10 statements were derived from the Citizen Panels Building Blocks	• Open to all Users and Carers hosted on the States of Jersey website as part of the Mental Health Services Review pages	222 surveys undertaken by individuals

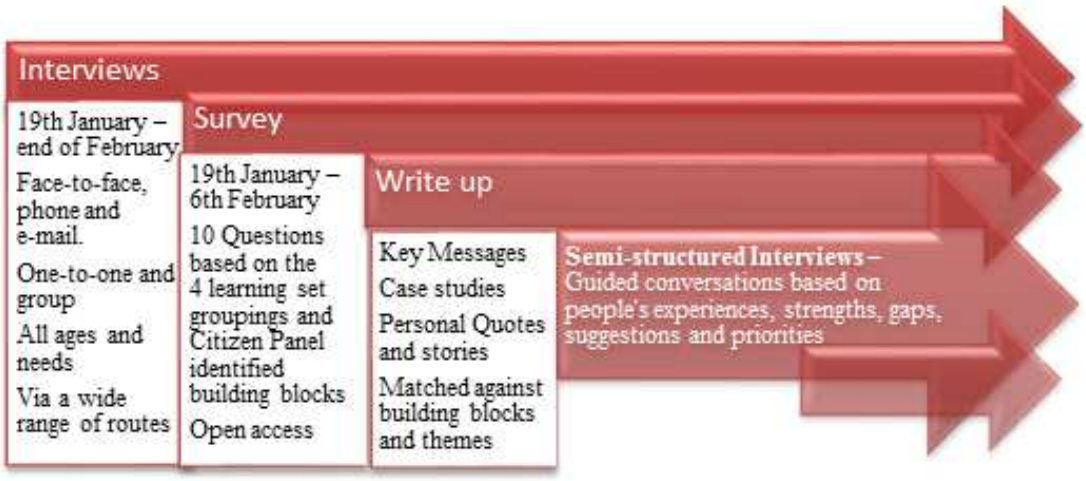


The Process

Semi-structured interviews – Guided conversations based on people's experiences, strengths, gaps, suggestions and priorities

Survey – A short questionnaire using the Building Blocks generated by the Citizens' Panel, comprising 10 statements with a 5 point scale from 'Strongly Agree' through to 'Strongly Disagree'.

Focus groups – Used guided conversation methodology and giving more people a chance to engage.



Consent

Each person involved in the process had the review and exercise explained, and consent was gained for their comments and experiences to be used in a non-identifiable way. No-one was interviewed unless it was deemed that they were able to give meaningful consent.

4. Reflections on the process

- **One-to-one interviews**

  The interconnectivity between Islanders and people's desire for anonymity was very powerful. Almost all individuals had some level of anxiety regarding being identified by professionals, other Islanders and their own circles. This was an issue that coloured many conversations; and ensuring that rapport was built and some trust gained was essential in enabling people to speak freely. When designing future mainstream and routine engagement systems, this will need to be considered.

  Individuals seemed very happy to talk freely once they believed that it was 'safe' to do so; people offered information readily and openly, and a great many of the people interviewed had a good insight into how services are run, how they have developed over the years, and how things could be improved.

Individuals wanted their story to be told, and there was a sense of isolation from many people. The belief that they were a lone voice raising issues was very apparent. Individuals appeared surprised and heartened to hear that other people in Jersey had similar views or experiences as themselves.

- **Focus groups**

The focus groups were powerful, with a number of examples of individuals offering support to each other, using open questions and helping other group members engage. There was a real dynamic vibrancy within the groups, and it certainly supports the idea that people with lived experience and family carers are ideally placed to offer support, coaching and advice to each other as part of the future strategy.

- **Survey**

The survey generated a great deal of interest with mixed reactions, including some very critical feedback around the use of language, 'Mental Health' speak, lack of context at the start of the survey, and no method of adding free text into it as part of the feedback process. There was also positive feedback from individuals around the subject areas; the links to the main review and the response rate was extremely high for a survey of this kind in a mental health setting.

The learning has been significant, and it clearly demonstrated the need to design and implement engagement activities such as surveys with the target audience, and that there is a huge opportunity for future activities like this to be undertaken in co-production with customers. It was also apparent that people were not used to being asked for feedback and were anxious to have their say just in case it didn't happen again. This view was strongly corroborated by the interviews and focus groups.

- **Logistics**

The people in the third sector charities and voluntary groups who helped organise the interviews and focus groups were incredibly helpful, and offered their time and buildings willingly and warmly. There was an obvious rapport between the people involved in running the charities and their members. There were a number of individuals who got involved in the customer voice listening process through other routes, seeking out for themselves the route to give feedback and share their stories. There seemed to be a strong community ethos around carers of adults and older people with dementia, but less formal support networks available for family carers of young people and children using CAMHS.

There was feedback that even more face-to-face interviews would have been welcomed, particularly for carers of people living with dementia; although the richness of information gathered from the telephone interviews conducted easily matched that gathered from the face-to-face interviews. Often the feedback was that a telephone call fitted into people's lives more easily, and on reflection both face-to-face and telephone contact worked equally as well, depending on the individual.

5. Key messages

- Service Users and their family, carers and supporters want to give feedback safely and want to be engaged in their own care and the development of services.
- Great deal of praise for individual mental health professionals from all settings and teams.
- Waiting times for psychology are a significant issue.
- Carer support and bespoke respite is an outstanding need.
- Early intervention and support is a gap, particularly in schools, but school counsellors are praised.
- The physical environment and location of services is an issue.
- The is a view from customers that adult mental health staff in all settings have very low morale and their wellbeing is a problem.
- Communication on every level between has been highlighted as a priority for improvement.
- There are quality and consistency issues within the workforce and systems that need addressing.
- Users and carers want to see the services grow stronger, be better resourced and build on current strengths.
- The charity sector offer a welcomed and highly valued support service.

6. Customer Feedback aligned to Emerging Themes

Theme	**Vignette**	**Quotes**	**Suggestions**
The emerging theme identified through the MHSR process and additional themes identified through Customer Voice exercise and literature review.	A case study created exclusively from experiences and feedback from the Customer Voice exercise presented in the form of a vignette. Each case study is a blend of many people's experiences and is non-identifiable.	Direct quotes from Customers, quotes that represent many other similar statements made by others interviewed. No isolated views have been included.	Ideas and suggestions that have been generated by Customers, some wording has been paraphrased, but the final wording was checked with the individuals who generated each idea initially, and with Customers who raised the issue subsequently.

Securing joint working across the Mental Health System

Vignette

J had struggled with low moods and anxiety ever since he started secondary school, and none of his teachers seemed to recognise what was happening for him; however, when he was in Year 10 his teacher referred him in to see the school counsellor, which was incredibly helpful, and although he still felt very unwell, there was a sense that someone was listening and understood what was he was going through. After a few months, his school counsellor suggested that Joe might need some more specialist help and also access to youth services for ongoing support.

J was referred and accepted into CAMHS and also linked into the Youth Enquiry Service. J got on well with both his psychologist and psychiatrist at CAMHS, and although he was now diagnosed as having depression, anxiety and OCD, he felt that his needs were being met. He had access to some art therapy, which really helped. When things went well, people really talked to each other and knew what other services would be appropriate, and things seemed joined up for J.

At the end of his time at CAMHS he was transferred on to Adult Mental Health and discovered that there was almost no transition or proper handover; his CAMHS worker just said that J had to move on in 2 weeks and that was that.

When J arrived at his first appointment in adult services, he discovered that although they were nice, they knew nothing about him and J had to tell his story all over again on several occasions. J wished that people had talked more about his transition, and that both children's and adult mental health services had planned the change with him.

Survey

- **91% of respondents think joint working and partnerships are key to improving mental health outcomes and experiences.**

Quotes

"I wish things were more joined up."

"When people talk across boundaries and work together it improved our care no end."

"I had to repeat my story once I got to the adult service – they didn't seem to know much about me or what was going on."

"The right hand often doesn't know what the left hand is doing."

"Why can't they just work together?"

"I fell between the gaps."

"Our CAMHS worker told me that my son would get no help at all from Adult Mental Health."

“I had to tell my story so many times.”

“There is a transition cliff and I fell right off it.”

“Some people have all the knowledge and some have very little, could we spread it out a bit?”

“My Adult Mental Health worker slagged off CAMHS.”

“When I went to the Youth Enquiry Service they seemed to glue things together for me.”

“The CPN who works with us is amazing and when it is working well it feels seamless.”

“I felt safe because the people that were helping me worked together.”

“That doctor went out of their way to work out what I needed and talk to all the right people.”

“The mental health advocate works in such a joined up way it’s so refreshing.”

“My peer support worker helps me make sense of the complicated system.”

“Adult Services didn’t continue with the work I was doing with CAMHS.”

“My CAMHS worker was happy to work with my counsellor at YES who put the referral in.”

“The school counsellor signposted me to other agencies which is how I ended up at YES.”

Suggestions from customers

- Care co-ordination available for anyone needing it regardless of age.
- Closer working with Primary care, schools and other services.
- Spread and embed the Triangle of Care Model.

Improving the service environment

Vignette

B found the waiting area so disturbing that he almost didn’t get to see the professional he was waiting for. The magazines on display were old and inappropriate, and on the front page of one had a sleazy heading about domestic violence towards men being less significant for individuals experiencing it than for women. B felt disrespected, vulnerable and as if his whole story had been exposed somehow.

The poster on the wall made him feel worse, as it described how aggression towards staff would not be tolerated. As he sat there, he wondered if he was unsafe; his personal experiences of violence meant that the poster scared him, and he reflected on how vulnerable he was in that moment. Once he had realised that the other people waiting didn't look remotely violent, he became annoyed at the tone in the poster, the inference that staff needed to be safe, but not patients.

Week after week, B sat in the waiting area and over time, he planned more constructive and valuing wording for the poster and had thoughts of all the positive mental health publicity that could be available instead of magazines; and how with a small amount of investment the whole waiting experience could be valuing and calming.

Quotes

"They weren't open enough."

"They were closed on the weekends."

"They could do with improving their facilities, i.e. the look of the place. They need to make it look more welcoming."

"Although the Police are better, the use of handcuffs and the moulded seat in the Police van is just barbaric when people are ill and vulnerable."

"Access was difficult as appointments were held up at Overdale and it was harder to get there in bad weather/winter months."

"Location wasn't great – when I was 16 I didn't know where it was and couldn't ask my parents as they didn't know I was attending."

"We need a separate place for young people to be admitted – not Orchard House or Robin Ward – neither of those places is appropriate."

"The main hospital is not set up for mental health issues – there is no privacy there."

"Orchard House is just not set up properly for mental health act tribunals, as a lawyer I have had to discuss cases with clients in the kitchen, corridor and what felt like a cupboard."

"The Recovery Centre needs to be more local to people who aren't in hospital, maybe we need two."

"The sound-proofing is awful in some rooms and I have overheard all sorts of conversations while waiting to be seen."

"I saw 6–7 empty bottles of vodka in the bush outside the hospital and they were there for days even after I mentioned it, I cleared them myself in the end."

"The texting and e-mailing system works well."

"The look and feel of A&E is loads better now."

"The YES building is good and central."

"I quite like having the psychiatric hospital out of the way and with grounds to walk in, it feels private and discrete."

Suggestions from Customers

- More community and everyday settings used.
- Increased Mental Health awareness literature and publicity across Jersey.
- Redesign of Mental Health settings with users.
- Signage to be co-produced with users and carers.

Building educational approaches to recovery

Vignette

When R was discharged from Orchard House she felt quite lost, not ready to go back to work but wanting to build towards that day when she could get a job again and feel able to cope with it. R had really enjoyed sessions in the recovery centre while she was in hospital, but now she was home, transport was difficult and she just couldn't face going back to the same building for anything. R used to be very involved in music in her younger days and kept thinking about how she would like to be able to do music again in a safe but mainstream environment, and how some Pilates and meditation would help too.

Going to a totally 'everyday' setting without some moral support felt like a step too far, and there was nothing that she knew of in the community where she could work on her recovery and support others with theirs. R also welcomed the idea of learning from others who had been through similar experiences, and over time wanted to help others who had experienced mental ill-health.

Survey

- **78% of respondents thought that all mental health services in Jersey could be more recovery-focused.**

Quotes and suggestions

"Recovery Centre, they used distraction techniques and I had access to occupational health services and they had good sessions on offer, i.e. Mindfulness."

"There is so many recovery-based things my son would enjoy but the whole things needs to be more ambitious."

"There is so much we can learn from each other, I could help others and in turn that would help my confidence."

"There are lots of local people who would volunteer to do recreational and educational things at a recovery centre."

"Why can't people using services or people who used to use services run the recovery place together?"

"I couldn't believe how much brilliant stuff was in the recovery centre but hardly anyone used it."

"Couldn't recovery here be about a way of being rather than a centre?"

"Mindfulness and stress reduction sessions would be brilliant and we could have more of them."

"I want to know that there is somewhere I can go forever if needed, that is all about me being well not being ill."

"Could we run a big arts project across Jersey as a recovery thing?"

"Recovery centres and colleges could be run between users and charities."

"Create a recovery centre/college co-managed with us and carers."

"Grow use of volunteers for running recovery sessions in activities, e.g. golf, fishing, cycling, music, social media and mindfulness."

"Increase the number and range of peer support workers."

Developing the Workforce

Vignette

R was diagnosed with Dementia in 2012 and her husband listened carefully to all the information he and his wife were given. One thing during that time that really would have helped would have been a Dementia support worker. Their friend told them that there used to be one and how useful it was. Both R and her husband thought that having someone to support them through the journey would have been brilliant. The CPN and Doctor were great, but to have more of an everyday person to talk to really regularly who could link them into the support they needed would have made the whole process easier. They even wondered if these hypothetical Dementia support workers could be based in a charity but trained and supervised by clinical experts.

Survey

- **87% of respondents thought there was not enough mental health intervention in primary care.**

Quotes

"The CPNs in the liaison service are a bit hit and miss, if you see a good one you are fine, but if they are 'old school' then you know you have to see them again the following day and it will be no help at all."

"Some G.P.s have a lack of understanding around mental health issues, e.g. offers of inappropriate medication, i.e. sleeping pills when I was age 14."

"When I told a nurse about my sexual abuse she said 'Yes but was it actually serious abuse?' "

"We just need more psychologists and maybe not even the fully trained ones but workers managed by the psychologists."

"The Adult Mental Health staff seem very low and unhappy, even the good ones."

"I was shouted at in Orchard House by a nurse, the manager made them apologise to me but it felt terrible."

"I was properly told off like a child by a stressed and stern CPN in A&E."

"There could be so much more support out in the community."

"We need more Talking Therapies."

"My social worker had real boundary issues and told me all about her private life, that was just weird."

"After I tried to commit suicide a Doctor said 'Are you going to try that again? I do hope not, you could be dead you know."

"My husband and I have found the dementia professionals to be outstanding."

"I wouldn't be alive today if it wasn't for the skills of the nurses, doctors and psychologist who help me."

"I wish there was more social care support workers and those peer support workers."

"My psychologist was truly amazing."

"The staff in CAMHS are very kind and helpful."

"Most of the staff at Orchard House are nice."

"The advocate seems very skilled."

"The nurses texting and e-mailing and doing phone-calls is very flexible and is a life-saver."

The Youth Enquiry Service is brilliant."

"The attitudes of Police Officers have improved so much they are some of the most respectful professionals now."

"Police are some of the best professionals I've encountered."

"Some of the Adult Mental Health nurses are really good – they will talk to you and have good knowledge."

"I used to get a really good response from my CPN when I would contact her outside of my appointment times/out of hours."

Suggestions from customers

- Service user and carer-run training sessions for practitioners.
- Wellbeing interventions for staff in Mental Health settings.
- Advanced communication and engagement skills training for practitioners.
- Develop Mental Health First Aid in schools.
- Increase training for teaching staff on Mental Health issues.
- Simplify referral and access issues for children and young people.

Awareness-raising, prevention and early help and support for children and young people

Vignette

When S's daughter R was in primary school, S noticed that she had very few friends to ask home to play, and that R struggled to make friends or find people to play with. When children did come home, R would end up cross with them and occasionally hit them or just wander off and leave them. In secondary school things became worse and R's behaviour became more extreme, with her walking out of classes, associating with much older children and getting in trouble for swearing and stealing from other pupils. R eventually ended up getting involved with alcohol, drugs and inappropriate relationships with adults. At this time, CAMHS and the Police and a range of other specialist services became involved.

S feels strongly that R needed far more help at an early age, and that if school staff had been trained and supported to work with R differently, and if R herself had access to emotional regulation and other early interventions, that the level of acting out and distress R experienced as an adolescent could have been significantly reduced.

Survey

- **94% of respondents thought early intervention was essential.**

Quotes

"They reassured me my parents wouldn't find out but then sent me a letter with the CAMHS stamp and address on the back of the envelope so my parents found out I was attending."

"There was no transition period and I wasn't introduced to my new worker till I turned up to the appointment at adult mental health."

"We are not just a number or a 'child' – we want to be treated as people by people who care and will look at us as individuals."

"The school counsellor was a good port of call when you didn't know who else to ask for help it's a pity there isn't more of them."

"There was no access to a psychiatric hospital. The first time I was 15 and put into Robin Ward. At 17 I was put into Orchard House."

"When I turned up for an appointment at CAMHS I was told it was my last and they introduced me to my new worker at adult services."

"I was supposed to see the psychiatrist one more time before moving to adult but that never happened."

"There was no children's crisis service – would be good to have someone you could call if you were in crisis."

"It felt like there was a lack of training/understanding on Robin Ward from the Ward staff and I was admitted there because of my mental health."

"If my daughter had had the right help when she was very young none of this might have happened."

"CAMHS accidentally sent text reminders to my mum for my appointment and I didn't want my mum to know I was going there. I asked them to text me instead but they didn't. It wasn't until my counsellor from YES asked them to change it that they took notice."

"There were really young children on the same ward as me, which wasn't appropriate for either of us."

"My son's teachers really struggled and just wanted to know what to do with him when he was distressed."

"I wasn't scared to access YES and I got an appointment quickly."

"YES referred me to CAMHS which I needed – and they supported me to access the service, i.e. met me to walk me there for my first appointment."

"CAMHS Staff were nice."

"The staff were very reassuring – I was 16 and didn't want my parents to know I was attending and they assured me they didn't need to know."

"It felt safe being in the school to get help I needed."

"You could use the school counsellor's first name."

"The counsellor wasn't a teacher."

"The school counsellor supported me with other school issues – my attendance was really low and she worked with me to increase it."

"I got on well with the CAMHS psychologist – she was awesome. She was easy to talk to. She was very understanding and tried to help. She was interested in what I had to say and worked to support me."

"The psychiatrist was good – I was offered art therapy so they found out what I was interested in and offered me therapy to suit that as I'm quite arty. I was really pleased to have been offered that."

"They spoke to me during the appointments not at my social worker."

"I like being able to chat to the youth workers before going in for my counselling appointment."

Suggestions from customers

- Mental Health First Aiders in schools.
- Pupils having access to mental wellbeing and resilience training techniques.
- Additional training and support for all relevant professionals in signs, symptoms and support required for young people in distress.

Developing mental health services within the criminal justice system

Vignette

L was arrested on a Class A drugs charge and remanded on bail with monthly appearances in the Magistrate's Court. During this time, he drank quite heavily, as he was scared and couldn't see another logical approach to escaping the fear of a prison sentence. He lost his job, his flat, his friends, and his life, as he knew it. He was seen at Drugs and Alcohol Service (referred by G.P.) but only attended a couple of appointments, as he was not ready to stop self-medicating through alcohol.

L saw a Probation Officer once before sentencing. Sentence was eventually passed and he received a 2½ year prison sentence. Due to the nature of his charge being drug-related, L saw a counsellor from the Drugs and Alcohol service on a weekly basis whilst at La Moye.

L appealed his sentence, not the verdict but the sentence. L's case was heard and he was released, having the sentence turned over to community service, 3 ½ months after his imprisonment.

L had a sentence plan in place, which if had he had served his full term, would have been executed and included pre-release preparation. As it was, his sudden release came as a total surprise with no support for return to the real world. 3½ months was long enough to become institutionalised to an extent, and L was very shocked and frightened by his release.

L doesn't feel that he was shown a duty of care on his release. He does not however hold anyone individually accountable for this, as he believes that he should never have broken the law. L does feel that it is an area that needs to be addressed. L feels that it was the single most disturbing incident of his life. L fell through the cracks in the system; he is still dealing with the long-term impact of having a criminal record and trying to return to the working world.

Survey

- **91% of respondents think joint working and partnerships are key to improving mental health outcomes and experiences.**

Quotes

"I was transferred to Orchard House in a Police van (was coming straight from the Police cell), which didn't feel good."

"The Police never told me they were taking me to Orchard House – they just said they were taking me to hospital so that was quite distressing when I realised where I was going."

"There was some animosity between Police and mental health services."

"We need more after-care."

"There needs to be more options for people rather than just the courts and prison sentences."

"Some Police Officers made you feel like a criminal even though they were there due to my mental health. They responded to me as a criminal not someone who was unwell."

"There is a lack of knowledge around Mental Health Act Tribunals in Orchard House."

"The approach to tribunals is very lax."

"So many people in the prison system have alcohol and drug issues, not to mention mental health problems, I know I did."

"We still use handcuffs when other places really wouldn't."

"The Policeman was kind and supportive and I was so relieved."

"My Probation Officer helped me plan and talked regularly to my CPN."

"Things seem to be changing for the better."

"Every time the Police turn up they know my wife and talk to her quite normally, which helps."

Suggestions from customers

- More awareness-raising for criminal justice staff.
- Joint workers and joint projects.
- Celebrate the things that have improved over time, such as approach used by Police Officers.

Enabling workplace mental health interventions

Vignette

B found it difficult to cope with the death of her parents and her children leaving home all in the same 18-month period; she found herself struggling to sleep and not being able to concentrate at work. After a number of months she started to notice that her line manager seemed unhappy with her, and that the other people in her office were no longer chatting to her like they used to. B realised that she had also had much more sick time than before and her line manager had made several remarks about 'it not being good enough' and 'it's not as if you have children at home to look after'.

After many months of this situation, B's manager asked to see her and told her that her work had stopped being of an 'acceptable standard' and that she wasn't the fun person she used to be. B found herself crying in her manager's office and unable to stop. It was then that her manager asked if she had been depressed before and suggested that she visited her G.P. B went to her G.P. and ended up having many months off sick and accessing counselling and medication.

On her return to work her colleagues apologised and explained that they hadn't realised what was happening to B, and wished that they had access to some more training and awareness-raising around mental health so that they could have acted differently towards her and been supportive.

Survey

- **88% of respondents thought that there was not enough mental health promotion in Jersey.**

Quotes

"My colleagues just had no clue what to say to me."

"I wanted to go back to work but I needed it be a very gentle re-introduction."

"Employers need so much more education around mental health."

"I lost my job and I was humiliated."

"Now I have had depression what do I say to employers?"

"The benefit system works against me working."

"My G.P. said I would never work again."

"Work used to be my whole life."

"I wanted to go back but I just couldn't face the people."

"With my record and history, no-one is going to take a chance on me."

"Jersey Employment Trust were just what I needed."

"Becoming a peer support worker was a real job and gave me a proper purpose."

"I get up and go to work now and it feels great, even though I have to travel and it's hard work."

Suggestions from customers

- Introduce workplace Mental Health First Aiders.
- Grow Mental Health awareness within workplaces.
- Change the system so that people can return to work in a phased way.
- Grow the recovery centre.

Establishing system outcomes and quality measurements

Vignette

K had used a range of mental health services over a long period of time, and had seen them develop and change in many ways. K was someone who had needed several admissions to hospital over the years and had experience of using mental health services in the UK as well. K knew that he had a whole host of information that the staff and management would find useful in improving mental health care. He had been thinking for some time that he would like to be part of a group of people with lived experience of mental ill-health who could co-ordinate regular feedback on patient experience. He talked to a lot of other patients who were keen to share their experience, and even be part of teaching mental health staff about how it feels to be a patient and what could make things better.

The idea of patient experience being taken seriously and listened to systematically made K feel like he could add something to the system and be part of improving services and outcomes for Jersey people. K was just waiting for this to be an idea that the service would generate themselves, so that he could be part of service improvement.

Survey

- **8% of respondents thought that service users should have their views listened to routinely.**

Quotes

"We often don't know what questions to ask to get the answers we need in terms of getting the right care and support for Dad."

"How do we know whether it's good quality or not?"

"The culture needs to change from being a defensive system to being open and all about improvement."

"Are the right outcomes measured?"

"If we were part of the quality assurance formally it would be better."

"Honest feedback would help them improve things, but people are too afraid they will have their care affected negatively if they criticise."

"I am worried that if I gave them feedback I would be labelled and my child wouldn't get the care needed."

"If we complained, would Dad suffer as a result? It's always a risk."

"The quality of information and communication systems is poor."

"The charity I am supported by makes a big difference and it would be good if we could measure that impact."

"I think we need better quality and more social care and respite providers."

"I want to be part of the plan of care for me, and I don't want to have to sit in a room with loads of professionals as I then can't have my say."

Suggestions from customers

- Agree outcomes with each service user in a shared plan.
- Gather outcomes and experience and quality data routinely.
- Share the outcomes and experiences data regularly with patients and carers and plan service improvements together.

Improving the money-flow in the system to follow the patient

Vignette

R needed full-time care from his brother E. R had been diagnosed with Dementia 6 years ago and had found the service he received very helpful and the clinical staff expert and kind. More recently, E had found himself physically caring for R 24 hours a day, and it was becoming very hard to manage the house they shared as well as the care R needed from day to day.

Respite options had been offered on more than one occasion and they even tried a place so that E could have a break. What E needed was more flexibility so that he could get out of the house to do something for himself and have a social care support worker sit with his brother. R found leaving the house very distressing, and so having support at home was the best solution for him.

E also needed help with the gardening and house maintenance. It was very clear to him that it would have been much more helpful if he could have had access to a small but flexible pot of money, to spend on what support he needed when he needed it. He wanted to be able to employ his neighbour to sit with E and pay their sister to give up her part-time job to do the cleaning and washing. E believes that if the money in the system followed the patient, it would have been much easier to cope with a full-time caring role**.**

Survey

- **75% of respondents thought that people using mental health services in Jersey would benefit from more choice.**

Quotes

"There is just not enough money in the system."

"It's a small cloth on a big table, whichever way you pull it there is no way of covering the whole table."

"There needs to be proper investment in mental health services."

"There is way too much money spent on medication and not enough on support for people."

"The lack of social care providers is a real issue."

"We don't know how the money moves round the system."

"We need more choice of what the money gets spent on."

"The staff do a lot with very little money."

"The money needs to be moved upstream a bit, more prevention and early help."

"The cost of going to a G.P. really puts people off; if you have to go back to chase things or because things have got worse, then we have to pay again."

"My G.P. is good, we don't pay anywhere near the £40 that others pay, and often if you go back soon you don't pay again, I am told that's not the same for others."

Suggestions from customers

- Formal help with Primary care costs.
- More flexible respite and support at home.
- Health budgets families hold.
- A crackdown on prescribing to put into prevention.

Access to a responsive and timely service

Vignette

L went to see her G.P. to talk about her mental distress; the appointment was short and she didn't feel like it was worth the £40. The doctor said he would refer her on to the mental health service and that she was to go home and wait. Two weeks later L was assessed, and although she was beginning to self-harm she ended up on a waiting-list for 10 months for psychology.

During that time, things just got worse, not sleeping or eating, and the cutting was getting more risky all the time. L considered going back to the G.P., but the £40 just didn't seem worth it, as she didn't think that the doctor had any interest or experience in mental health.

L knew that A&E would have to see her if she went there, and so one evening when she was feeling suicidal and had cut herself badly, she walked in a dreamlike state into the Hospital. The staff in A&E reception were kind and efficient and the building looked so much better than when she had been there before. The nurses attended to her cuts and then she was put in the 'Mental Health' quiet waiting-room.

L became anxious and more distressed and was admitted into Orchard House, and ended up with an elongated stay before being discharged and getting the psychology that she had needed months earlier. L maintains that if she had been able to access out-patient psychology sooner, she would never have needed an in-patient stay.

Survey

- **81% of respondents thought that mental health services in Jersey do not respond quickly enough to people's needs.**

Quotes

"There was a long wait for an appointment for my initial assessment even though I was already in the system and involved with other services."

"It has taken a long time for treatment to be offered. I was in hospital in November 2014 and am still waiting to be seen by the psychologist. Seeing CPN at the moment."

"YES isn't open all week or at the weekend."

"How can it take so long to see a psychologist when you are on the Urgent list?"

"We need more respite and flexible social care, we have to wait so long."

"If you attempt suicide you get seen sooner, lots of us know that that's what we need to do to get help."

"The waiting list is a huge issue."

"How can they tell me to be 10 minutes early and then be over 25 minutes late themselves?"

"If have actually cut myself I will get help, if I am on the brink of cutting myself and don't want to, I have to wait."

"Sometimes you ring and ring and no-one gets back to you."

"There is very little support for my children and they thought I would be better by now, things take a long time and they have taken the brunt of that."

"7 day weeks and longer hours of opening would help things not get to a crisis situation."

"The flexibility of the texting and e-mailing support has been amazing."

"My CPN is really responsive and gets back to me really quickly."

"More virtual, non-face-to-face help like using the Internet would be good."

"Having someone to call just to talk when it's the middle of the night would help."

"We never have to wait to be in contact with the advocate or the peer support worker."

"G.P.s seem to be responsive and you don't have to wait weeks for an appointment."

"There wasn't really a wait to get assessed by CAMHS."

"We saw the dementia psychiatrist really quickly."

Suggestions from customers

- Introduce more self-help and web-based support.
- Have a G.P. with special interest in Mental Health in each practice.
- Increase access to psychology provision for all, and at lower levels of need.

Engagement and inclusion of users and their families

Vignette

F had supported his son P with his significant mental illness for many years, and was well aware of his relapse signature and that alcohol played a key part in his self-medication, but also his mental health deterioration. F wanted to be part of his son's care plan and actively attempted to work with the professionals involved. Sometimes this worked well, but often he was not communicated with and left feeling like a nuisance.

F wanted the staff to use the 'Triangle of Care' and engage actively with him and other family members. There just didn't seem to be the appetite to engage and include patients in that way, and even less so with families. F hasn't seen his son for some time now, as the last time that P was becoming unwell and his drinking was increasing, F told a clinician who promised not to let P know that the information had come from his father. The next thing F knew was when P arrived at his house intoxicated, and seriously assaulted him because the professional had written to him explaining that his father had shared his concerns with the clinical team. F believes that the consequences of this breach of confidentiality have been devastating.

F's relationship with his son had always been healthy until recently, and if the care system had engaged users and carers more sensitively, the situation in his family may not have happened.

Survey

- **97% of respondents thought that the families of people using mental health services should have their views listened to.**

Quotes

"Communication is often poor, if not terrible."

"I hear about things that directly affect me and my son third-hand quite often."

"The Triangle of Care links the individual, family and professionals together, but that seems lost here."

"We have to fight to be engaged with and it's exhausting."

"I was listened to by my psychologist but I don't think the people at the top ever really listen to us."

"We want to be involved in our own care and that's that."

"It's all about the therapeutic relationship, adult to adult, and only tiny bits of the system get that."

"We need a much bigger voice and we need to believe that the politicians and managers are actually going to change things when we speak out."

"MIND have engaged me in a way I didn't think was possible."

"I have been part of this dementia charity for a very long time, and they will always fight for clients to be properly involved in direct care and developments."

"Things have to change, there has to be a sea change, we need to be heard."

"We could make things better together."

"Carers don't want to break the services, they are all we have got, we want to make things better but we have to be included properly to do that."

"There is some great stories of the positive relationships and partnerships between clients and workers, but we don't celebrate them enough."

"I have felt engaged and involved in the care of my relative, and that was down to the way the Doctor and nurses work with us."

Suggestions from customers

- Have regular user and carer reference groups with statutory services.
- Increase number of peer support workers.
- Design service changes in co-production with users and family carers.
- Grow formal support groups for families using CAMHS.
- Routinely gather and use feedback and show people that they are listened to.

Tackling and reducing stigma

Vignette

G has been caring for his wife M for the last 7 years, and over this time she has needed more help and support. G and M lived very active lives, and as time has gone on their social circle has dwindled. At first people were sad to hear that M had dementia and offered kind words; however, there was often a sense that M's life was now over as a result of the diagnosis. They noticed that people stopped asking them to dinner quite as often, and that friends forgot to include M in the newsletters regarding their Bridge nights.

G was finding that M was getting more frustrated and outspoken, and he felt that he couldn't ask neighbours or friends to sit with her when he went out, just in case there was a difficult incident. M loved shopping, and even when other aspects of her life seemed forgotten to her, G noticed that M loved to walk around the shops and pick things up to look at them. G and M found themselves in a difficult position when a woman working in a shop became quite cross with M for picking up cushions and commenting loudly on the price and colour.

After a couple of embarrassing situations in cafés and shops, G decided not to take M out again and they found themselves at home with fewer and fewer visitors. M's CPN had always been very helpful, and linked G into their local dementia charity, who offered G a huge amount of support and helped him realise that the stigma he and his wife had faced was not uncommon, and that there was a growing movement of people wanting to challenge stigma and raise awareness around living with dementia, but that there was a really long way to go.

Survey

- **57% of respondents felt hopeful about the outcomes of the Mental Health Services Review.**

Quotes

"There is a stigma attached to being in Orchard House which is still affecting me now."

"I wouldn't be embarrassed to have a physical illness but here it is not okay to have a mental illness."

"I face stigma and prejudice all the time, and the worst thing is often it's from mental health staff themselves."

"I have felt patronised by services and made to feel stupid."

"The pressure not to have anything wrong is all around us, we are scared that on such a small Island everyone knows our business, and a mental health problem is not something to be proud of."

"Professionals seemed to judge me for taking the overdose."

"It's all so hush-hush here that I didn't know others had experienced the same thing as me until I came to MIND."

"The stigma for people with a drug problem is huge, but add in a mental health problem and there is no hope of people understanding it."

"It's embarrassing and humiliating and often unnecessary to have the Police cars pull up outside your house when they need admitting."

"There needs to be better supervision for staff to deal with their own baggage and hang-ups as it spills onto us sometimes."

"The charity I am part of is fighting stigma very hard."

"There are times when I have felt really valued and equal, which is so different to how mental health services were years ago."

"YES have helped me not feel so embarrassed about stuff."

"Our CPN has really helped us not to feel ashamed of what's happening."

"People are starting to talk more about stuff like this in school and that helps."

"We all need to stick together and tackle stigma head on."

Suggestions from customers

- Enable prominent/high-profile Jersey people to speak out safely about their own lived experience.
- Have a Jersey Mental Health day every year that is a 'festival' celebrating mental wellbeing.
- Re-introduce Dementia advisers.

APPENDIX 4

Mental Health Service Review Literature Search

Background

In common with other jurisdictions, Jersey faces significant challenges in ensuring the availability of affordable, quality mental health and social care services. There are also some unique challenges; for example, workforce pressures, limited services in the community, clinical viability and cost pressures due to diseconomies of scale.

In order to fully understand the potential options for providing high-quality mental health services in the future, a comprehensive review is required to guide the commissioning, service improvement and integration of services for mental health. The resulting Strategy and Action Plan will clearly describe the future system-wide model, and will provide a realistic timescale for future actions.

Proposal

As part of the Mental Health Service Review, a synthesis of current mental health service models is required to inform the priorities and recommendations of the review. This is particularly important given the likely influence of parallel work-streams that are being progressed alongside the review, e.g. review of primary care, modernisation of mental health law, and planning for a new future hospital.

Aim

To provide a current synthesis of mental health service models which have been used to organise and inform mental health systems and service delivery.

Objectives

To review relevant published and grey literatures –

- To judge the relevance of the literature available using a critical appraisal framework.
- To summarise the results obtained and search for strong themes that emerge from the literature.

Outputs

- To provide a detailed report that provides a map of existing documents in the area and identify areas and priorities for future research.
- To provide a Powerpoint presentation that summarises the key findings of the literature search.

Timelines

The literature search will be completed by Friday 30th January.

APPENDIX 5

Mental Health Implementation Group – Terms of Reference

Mental Health Review Group – Membership	
Rachel Williams (Chair)	Director of System Redesign and Delivery
Jocelyn Butterworth	CEO, Jersey Employment Trust
Susan Devlin	Managing Director, Community and Social Services
Chris Dunne	Director, Community Services Adults
Ian Dyer	Director, Community Services Older Adults
Dr. Miguel Garcia	Consultant Psychiatrist
Rose Naylor	Chief Nurse
Andrew Heaven	Deputy Director, Commissioning
Sarah Howard	Deputy Director, Finance
Helen Miles	Task Force Lead 1001 Days
Margaret Dennison	Interim Director, Community Services Children
Karen Paul	Out of Hospital System Redesign Lead
Bernard Place	Project Director, Future Hospital
Julian Radcliffe	Principal Educational Psychologist
Dr. Kate Wilson	Primary Care Body Representative
Brian Snell	Citizen Panel Representative
Sarah Jordan	Citizen Panel Representative
Beverley Edwards	Head of Informatics
Jill Byrne	Interim Director of Governance and Nursing Practice
Lee Bennett	Senior Wellbeing Practitioner (Jersey Employment Trust)
Martin Knight	Head of Health Improvement

Mental Health Implementation Group members are responsible for:

Leadership

- Provide senior stakeholder direction and oversight to the implementation, to ensure it stays in line with the overall vision, aims and objectives
- Providing strategic leadership to those programmes of work that they are accountable for and/or involved in
- Advising on strategic fit and policy direction, both for their own areas and across the system, including interdependencies with other strategies

Momentum and Purpose

- Providing challenge and critical thinking
- Testing and advising on applicability of service models and plans to Jersey
- Receiving and reporting regular updates from Project Teams for which they are responsible
- Providing guidance to the Project Teams regarding pace, engagement and communication
- Ensuring those programmes of work that they are accountable for and/or involved in progress to time and deliver the intended outputs and/or benefits
- Reviewing key deliverables prior to submission to the Strategic Steering Group
- Ensuring that they or their named deputy attend each meeting to ensure consistency and momentum

Communication and Collaboration

- Acting as a communications conduit to influence and inform senior stakeholders, and to represent the views of their stakeholders
- Creating and maintaining a collaborative environment in which the Mental Health Strategy is able to progress and succeed
- The Implementation Group will not be deemed quorate when there is no representation present from either (i) Service Redesign and Delivery; (ii) Community Social Services; (iii) Community Voluntary Services

Decision-making

- Achieving shared decision-making within the group

Frequency of Meetings

- The Mental Health Implementation Group will meet every quarter commencing from 8th June 2015
- The frequency and membership of the Group will be reviewed in June 2016
- The Service Redesign and Delivery Administrator will take responsibility for booking the room, circulating the agenda and circulating the minutes

Invitation List For MHSR Engagement Day

Corporate Directors x 8
Julie Garbutt
Rachel Williams
Jason Turner
Tony Riley
Rose Naylor
Helen O'Shea
Susan Turnbull
Damian Allen

MHSR Advisory Group Members x 13
Bernard Place
Chris Dunne
Ian Dyer
James Le Feuvre
Jo Olsson
Kate Wilson
Mark Blamey
Miguel Garcia-Alcaraz
Patrick Geoghegan
Sarah Howard
Tracy Wade
Amy Taylor (HSS)
Carolyn Coverley

Transition Board Members (not already included) x 11
Alison Rogers
Dr. Philippa Venn
Helen O'Shea
Jonathan Williams
Karen Paul
Louise Journeaux
Martyn Siodlak
Nick Lyons
Richard Bell
Jim Hopley
Zoe Cameron

Citizens' Panel x 21
Adrian Le Fondré
Anthony Nolan
April Hamel
Brian Snell
Charles Towers
Dale Jeffery
Daniel Walker
Ina Markova
Jade Wilson
Jane Le Sueur
Jonathan Payn
Kelly Da Silva
Liz Harrison
Liza Choudhury
Mandy McGinn
Mary Ayles
Nicola Mackereth
Paul Garrett
Rachel Cornford
Sarah Jordan
Tanya Tupper

Action Learning Sets x 41
Liz Kendrick-Lodge
Emma Ogilvie
Joe Dickinson
Dr. Jenny Sykes
Lesley Darwin
Sarah Shaw
Jan Sims
Martin Knight
Celia Scott-Warren
Beth Moore
Mark Blamey
Dr. Luke Shobbrook
Dave Luscombe
Louise Ogilvie
Tania Heaven
Will Lakeman

Assumpta Finn
Dr. David Bailey
Mr. Lee Bennett
Tanya Mulligan
Clare Cook
Vicky Twohig
Sam Woods
Elizabeth (Liz) Auld
Jayne Stallard-Moore
Michelle Cumming
Zainab Kadhim
Stephen McCrimmon
Mark Coxshall
Dr. Kate Wilson
Patricia Winchester
Alli Tandy
Dr. Carolyn Coverley
Linzi Gilmour
Mike Cutland
Mike Swain
Sonya Hurley
Dr. Sarah Zohhadi
Tia Hall
Helen Miles
Andy Buttimer

Action Learning Set Expressions of Interest x 16
Pauline Ward
Lee Haywood
Lesley Darwin
Julie Vibert-Jones
Lee Turner
Dr. Laura Posner
Emma Lawrence
Liz Kendrick-Lodge
Patricia Davenport
Dr. Alessio Agostinis
Diane Coppins
Revd. Maureen Turner
Jake Bowley
Dr. Fredrick Rudd
Gary Posner
Claire O'Toole

Facilitators x 7
Steve Appleton
Nigel Appleton
Mervyn Conroy
Pete Bryant
Amy Hobson
Andrew Heaven
Melanie Drummond