YoungMinds Consultancy & Training

Jersey CAMHS: Service Review

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YoungMinds wishes to thank all those who contributed to this report their experience and opinions, information and documents, advice, time, administration and refreshments. We take responsibility for the final report and any shortcomings. We very much hope it will contribute to the development of CAMHS services in Jersey.

1. EXECUTIVE SUMMARY

1.1 In January 2006 the Mental Health Directorate of the States of Jersey Department of Health and Social Services commissioned Young Minds to undertake a review of Specialist Child and Adolescent Mental Health Services (CAMHS) in Jersey. The review is to include:

- The range and quality of service provision.
- Remit and referral criteria
- Effectiveness of cross-agency working arrangements
- The arrangements for children with learning disabilities and mental health problems
- Current arrangements for intensive work, inpatient and residential care and on-call services.

1.2 Overall we found a picture similar to many areas in the United Kingdom, a CAMHS team with a number of highly professional and dedicated staff providing helpful services to children who gain access to the service. The speed and flexibility of response to high priority cases would be the envy of a number of services on the mainland. The high quality accommodation provides an excellent environment to enhance the sensitive and difficult work of the staff. These features of CAMHS in Jersey are on a level with the best on the mainland. We have identified a number of changes necessary to put specialist CAMHS on a stronger footing in Jersey and which would make progress towards the achievement of the CAMHS standard in the Children's National Service Framework (NSF) in England.

1.3 We have pitched our recommendations in the current context of children's services in Jersey. While our remit has been to review specialist CAMHS, priorities for specialist CAMHS cannot be set in isolation from related services for children and young people which are the responsibility of child health, social services for children and special needs, adult mental health, and education. To quote the NSF: '*The lack of provision in one service may impact on the ability of other services to be effective. Partnership working is an essential requirement of high quality service provision*' (Department of Health, 2004, page 7).

1.4 We see three key risks to the effective delivery of CAMHS in Jersey:

- The isolation of specialist CAMHS from the wider world of children's services
- The isolation of a single consultant child psychiatrist whose clinical and managerial burdens are not sustainable over the longer period
- The lack of rigour in current supervision and governance arrangements.

1.5 Professionals in Jersey in general have more autonomy and are less accountable. They have more power to respond flexibly to needs as their professional judgement directs. Our impression is that therefore services in Jersey are more variable, sometimes better and sometimes not. There is an absence of systems to identify and lever up low standards.

Governance arrangements caused us some concern in a service more than usually faced with risks associated with isolation.

1.6 The Children's Executive has been set up to reduce fragmentation of services and therefore, with the Mental Health Directorate, should play a leading role in ensuring recommendations arising from this report are implemented. This would be a broadening of the remit of the Children's Executive and additional membership would be required, particularly from child health, to carry through the CAMHS agenda.

1.7 In common with other reviewers of children's services on the island, we have identified fragmentation as a key issue to tackle. There is a substantial overlap between the children described as having severe emotional and behavioural disorders and those who require child and adolescent mental health services. It would not make sense to construct new coordinating mechanisms to drive through our recommendations in such a closely related service area. It would be more effective and efficient in our view to consider some additions or reform of the way the current Children's Executive works.

1.8 We think that CAMHS could be strengthened in a number of ways.

This section gives broad outline of high priority areas for development.

1.9 Inter-agency

- Clarification of the remit of specialist CAMHS within the broader range of children's services in the four-tier model
- Attention to the gaps in service below the specialist team, perhaps through the development of Primary Mental Health Workers
- Strengthening links to other children's services through joint appointments following the model of the Youth Action Team (YAT), for example looked after children
- Consultation with partner agencies about the balance of specialist CAMHS staff time dedicated to direct clinical work and to advice/training/liaison which will enhance the CAMHS expertise of tier 1
- Development of care pathways for specific conditions with relevant stakeholders including families
- Development of information sharing protocols with partner agencies about individual families
- Co-ordination and strengthening of fragmented services for learning disabled children with mental health problems.

1.10 Specialist Team

- Development of activity data to inform management and stakeholders
- Additional training, support and supervision for the specialist team to offset the inherent risks of professional isolation,
- Development of a systematic approach to supervision, case and clinical audit, and external review to ensure that current resources are deployed to best effect.
- Developing systematic processes to ensure the views of service users influence service delivery
- Increasing the capacity and expertise of the specialist CAMHS team by recruiting a second consultant psychiatrist to focus on the 16 and 17 year olds, the secure unit and intensive packages of care.

- Ensuring that future recruitment to the team moves Jersey towards providing a comprehensive service by covering all treatment modalities.
- Recognition of the role of the voluntary sector and strengthening its contribution to the four-tier model.

This section makes some proposals about the sequencing of our recommendations.

1.11 What could be done now within current resources

- Review Did Not Attends (DNAs)
- Locate family therapy in Royde House
- Clarify referral criteria and remit through Children's Executive which will identify gaps between services, and place CAMHS within children's services system on the island
- Develop a shared plan for dealing with/managing any gaps identified
- Develop care pathways for specific conditions
- Develop and implement a management information system that allows for efficient oversight of caseloads and the aggregation of data to be disseminated to partner agencies.
- Look for opportunities to include voluntary sector, for example, designing user feedback
- Develop information sharing protocols with partner agencies about individual families
- Ensure robust audit and supervision arrangements are in place across specialist CAMHS and including the schools counsellors
- Clarify school counsellors' role and management arrangements, considering overlap with any future Primary Mental Health Worker role.

1.12 What could be done soon by shifting around existing resources

- Introduce system of user feedback in consultation with Jersey Focus, voluntary sector groups, and Youth Forum once it is active, analytical work to be done centrally
- Provide more training at Tier 1, for example self-harm which is a concern to children's services, schools, residential workers and Brook counsellors.
- Allocate the additional resource following the Social, Emotional and Behavioural Difficulties (SEBD) review to a post for looked after children
- The staff training policy should be updated with a transparent and dedicated budget.
- Set up a virtual team for learning disabled children with child health, special needs and special education to map areas of expertise and develop a plan to address gaps in expertise and service on a multi-agency basis.

1.13 What could be done with new monies

- Employ a second consultant psychiatrist
- Employ Primary Mental Health Workers, with a focus on minority communities, and partly located in different venues, for example large GP surgeries and the voluntary sector
- Implement plans for a more coherent service for learning disabled children
- Develop the full range of available therapeutic models and professional backgrounds
- Look to different models of joint appointments to reduce the fragmentation of services faced by families.

1.14 These are not distinct phases as needs assessment and gap analysis will be necessary preparatory work before allocation of any new monies.

2. INTRODUCTION

The Commission

2.1 In January 2006 the Mental Health Directorate of the States of Jersey Department of Health and Social Services commissioned YoungMinds to undertake a review of Specialist Child and Adolescent Mental Health Services in Jersey. The review is to include:

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- Current arrangements for intensive work, inpatient and residential care
- On-call services.

The YoungMinds Approach

2.2 YoungMinds has undertaken many similar reviews and bases its work on a number of principles:

- *Child and Adolescent Mental Health Services (CAMHS) are multi-agency and multi-professional*. The specialist CAMHS team, often referred to as tier 3, is at the core of local CAMHS but is part of a broader system of children's services that make direct impacts on children's mental health. These community-based services for children are described as tiers one and two of a CAMH service. (See **Appendix A** for a diagram of the four-tier comprehensive CAMHS model). Our commission in Jersey has a specific focus on specialist CAMHS but the extent to which specialist CAMHS can work effectively is strongly influenced by the effectiveness of all four CAMHS tiers on the island.

- *CAMHS is everybody's business*. This has become something of a mantra but the phrase contains an important truth. All professionals working with children have a role to play in the promotion of a child's mental health; their interaction with the child can strengthen the child's resilience or increase the child's susceptibility to mental health problems. In addition many professionals working with children have a role to play in helping the child address problems of day-to-day living and referring to more specialist levels of help should problems become more serious. Mental health problems in children are too common for there to be a realistic expectation that referral to a specialist team should always be the automatic or first choice for professionals faced with a child with mental health problems.

- *A child- and family-centred view*. YoungMinds advocates the importance of the participation of children, young people and their families in the planning, monitoring and delivery of services. This is integral to the Children's NSF, which states that: '*The views of service users are systematically sought and incorporated into reviews of service provision*.' *Access for all* to CAMHS is a fundamental principle and underpins the CAMHS standard in the Children's NSF in England. There is often not a close association between level of mental health need and access to mental health services. Some groups of children who are particularly susceptible to mental health problems tend to

have lower levels of access, for example learning disabled children, children from hard-to-reach and disaffected social groups and ethnic minority families.

Fieldwork

2.3 Fieldwork took place in March 2006. Our approach is to gain perspectives from different groups of stakeholders in health, education, social services and user and community groups, in order to gain a sharp focus on local issues. We interviewed people from different levels in organisations sector from front line to chief executive. We interviewed 65 people about a quarter of whom were service users. Please see **Appendix B** for a table of groups of people who contributed to our fieldwork.

2.4 In addition we sent questionnaires to GPs and head teachers to ensure that their views influenced the findings of the review. We received responses from seven GPs but many responses represented the views of the GP practice rather than just the individual.

2.5 On 3 March there was a midway review of the project, which provided the opportunity for feedback of our initial impressions and to ensure that the consultancy was on track.

2.6 On 29 March there was a very useful stakeholder event which had two primary purposes, first to provide a reality check on the emerging findings from our fieldwork and second to agree some priorities for the future development of CAMHS in Jersey.

2.7 While we have not been able to interview everyone with an interest in CAMHS in Jersey we are satisfied that we have spoken to a good cross section of stakeholders and there has been a considerable degree of consistency in the messages given to us. However it was most unfortunate that the review took place at a time when the team manager, obviously a central figure, was on compassionate leave.

The Children's National Service Framework in England

2.8 YoungMinds and the commissioners of this review discussed the relevance of the Children's NSF and agreed that it should be an important reference point but that full compliance should not be expected. In legal terms the NSF has no locus in Jersey, but we refer to it frequently because:

- It represents a professional consensus of what good practice should be
- Professionals coming to the island and those being trained off island will increasingly be influenced by the NSF
- The health and social services business plan 2005 refers to the standards in the NSFs, specifically the (adult) mental health NSF (Department of Health, 1999) and it would not seem reasonable to give different emphasis to the NSFs for adults and children.

The report

2.9 This report provides the policy framework for England and Jersey, summarises the evidence about the prevalence of mental health problems, refers to some factors specific to Jersey and outlines CAMHS on the island, refers to user perspectives on the island as well as the mainland before describing our findings in each of the areas detailed in our commission. We have attempted to keep this report reasonably brief as requested.

3. POLICY FRAMEWORKS ON THE ISLAND AND MAINLAND

3.1 Jersey Strategic Plan

3.1.1 Jersey States Strategic Plan 2005–2010, agreed in June 2004, sets out nine key strategic aims with underpinning commitments (States of Jersey 2005a). This document provides the framework for our understanding of the policy direction for Jersey. Our recommendations address the aims and commitments in the Plan and in particular will support the aim to invest in Jersey's youth (pages 25-26) by contributing to the reduction of health problems associated with young people through earlier identification and intervention as well as access to a full range of treatment modalities.

3.1.2 Of particular relevance to our report are the following statements in the Strategic Plan:

- To improve access to services and co-ordination with greater equity, greater integration of health and social care (op cit page 16)
- To provide levels of care which compare favourably with accepted professional standards (op cit page 18)
- To encourage the integration of services for more effective delivery
- To develop a performance management culture with one success indicator being a more customer focused workforce (op cit page 36)
- To value the voluntary sector (and cut duplication).

3.1.3 The over-riding policy imperative in the fiscally prudent States of Jersey is to balance income and spending. This requires close scrutiny of public expenditure.

3.2 Health and Social Services Business Plan 2005 and the Kathie Bull report

3.2.1 The Health and Social Services Business Plan (States of Jersey, 2005b) is the means for this department to deliver its contribution to the Strategic Plan. The main focus for the development of children's services has been the report by Kathie Bull, *Review of Principles, Practices and Provision for Children and Young People with Emotional and Behavioural Difficulties and Disorders in the Island of Jersey*, often referred to as the SEBD report (Bull, 2002).

3.2.2 The summary of recommendations arising from this and subsequent reports by Kathie Bull lists a number of actions to provide a wider range of effective interventions for children with severe emotional and behavioural difficulties and to improve the co-ordination of these interventions. Kathie Bull's remit was to review existing practices and provision for children with emotional and behavioural difficulties (EBD) and our remit is to review specialist CAMHS but we should not forget we are addressing the needs of very largely overlapping populations. This fact should not be obscured by our different focus and use of language. From January 2003, Kathy Bull's remit was extended to include the services EBD children receive from each agency, including CAMHS. This appears to recognise the potentially key role CAMHS can play in delivering the best possible mental health interventions to reduce the

risk of emotional and behavioural problems in children becoming chronic and persistent in adulthood.

3.3 Relevant recommendations from the SEBD report

- Set up Children's Executive with responsibility for and oversight of all matters relating to children in need
- Develop a strategic plan
- Establish statistical database
- Establish new secure facility
- *"The Child and Family Service (CFS) be re-designated as a child, adolescent and family mental health service with roles and responsibilities clearly delineated within the four-tiered model and transparent to all would be and actual clients. Any remit for this service in managing referrals from other agencies, at present Children's Services, Education and Home Affairs regarding under-18s who offend or challenge the system be diverted to a specialist psychiatric service to be based in the new facility. The current work of CFS nurse therapists to be reviewed. This to ensure that one year from January 2003 tier 1 work which should fall to maintained secondary schools is transferred to the new in-school services to be developed within the same time scale*".
- All secondary schools should have their own specialist support service.
- Additional CAMHS input to the multi-agency campus to include an additional child and adolescent psychiatrist and two nurses focusing on children and young people with conduct disorder, unsupportive family backgrounds, a tendency to misuse drugs and exhibiting offending behaviours. Initially a two-bedded facility on campus was proposed. The aims were to reduce the likelihood of being treated off island, to reduce pressure on children's and adult inpatient beds and to provide capacity to help on an outpatient basis to other young people in residential care.

3.3.1 The SEBD review has triggered an ambitious and radical change programme in children's services to tackle some long-standing problems, for example the fragmentation of services and the overuse of residential homes. Apart from one additional post coming on stream this year the CAMHS recommendations in the SEBD report have not been resourced. However, the investment in Kathie Bull's work was substantial and a change programme is underway. We have shaped our recommendations to be consistent with the current direction of change and have also we identified many similar problems to address.

3.3.2 The 2005 Business Plan states under a heading of *Target/ What will success look like?*, services for children with emotional and behavioural difficulties are better coordinated, and that resources are targeted towards effectively and efficiently meeting the needs of children with SEBD. We agree these are desirable targets.

3.3.3 There are also plans underway in the mental health directorate which are relevant to the delivery of improved CAMHS for example the commitments in the Business Plan:

- To develop clinical psychology with more cognitive behavioural therapy (States of Jersey 2005b, page 13)
- To review and expand psychiatric liaison service (op cit page 14)
- To aim for DNA rate for all clinics to be less than 5% (op cit page 15).
- To develop working relations with service users, with the success measure proposed of involvement of users in service development (op cit page 27).

3.3.4 In policy and practice development CAMHS has to keep one eye on the mental health agenda, primarily driven by adults, and the other eye on the broader children's agenda which tends not to think mental health unless prompted to do so.

3.3.5 Another important concurrent development is taking place in community child health services. The external review commissioned from the Royal College of Paediatrics and Child Health found that children's services in Jersey are fragmented with multiple and incompatible information systems and weaknesses in clinical audit (issues also identified in this report). Our review of specialist CAMHS has an interface with two important areas with the children's health review, services for learning disabled children and the identification and treatment of ADHD. The Royal College review was founded on the principles of the Children's NSF and there are unsurprisingly themes shared by the children's health and the children's mental health reviews.

3.4 Policy in England

Every Child Matters

3.4.1 The Department for Education and Skills website tells us:

"*Every Child Matters: Change for Children is a new approach to the well-being of children and young people from birth to age 19. The Government's aim is for every child, whatever their background or their circumstances, to have the support they need to:*

- *Be healthy*
- *Stay safe*
- *Enjoy and achieve*
- *Make a positive contribution*
- *Achieve economic well-being.*

This means that the organisations involved with providing services to children - from hospitals and schools, to police and voluntary groups - will be teaming up in new ways, sharing information and working together, to protect children and young people from harm and help them achieve what they want in life. Children and young people will have far more say about issues that affect them as individuals and collectively."

3.4.2 The Every Child Matters programme aims to ensure that services are organised around the needs of children and families and not around the convenience and traditions of service providers. Through common assessment, shared information systems and integrated organisational structures Every Child Matters aims to reverse the fragmentation of services which confuses families, wastes limited public resources and is at root of most of the recent failures in safeguarding children. Instead the vision of services is child centred, with the voice of the user central to individual interventions and service design, and the effective and efficient deployment of public resources dedicated to improving actual outcomes for children and families.

3.4.3 Two important new posts have been made to champion children's issues in Government and the country, the Children's Minister first appointed in 2002 and the Children's Commissioner first appointed in 2005. The intention is that these high level appointments will provide sustained support for children in need and be powerful advocates inside and outside Government to ensure that the recent flood of policy pronouncements lead to perceptible improvements to children's lives.

National Service Framework (NSF) for Children, Young People and Maternity Services

3.4.4 The Children's National Service Framework is the means by which the Every Child Matters programme will be achieved in health. The NSF was published in September 2004 and includes the standards against which children's services will be inspected. It contains five core standards, promoting health and well-being, supporting parenting, user centred services, growing into adulthood (transition) and safeguarding. In addition there are six standards addressing children in hospital, ill children, disabled children, mental health and psychological well-being, medicines and maternity.

3.4.5 Standard 9 covers the mental health and psychological wellbeing of children and young people. It states:

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

3.4.6 The standard outlines the following vision for the future:

- An improvement in the mental health of all children and young people
- That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems
- That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

3.4.7 It is important to remember the NSF is a framework, it is not a blueprint. It allows for and encourages flexibility: different areas will achieve the standards in different ways. However the CAMHS standard includes a number of key principles:

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

3.4.8 Since 1998 the Government in England has allocated additional funding to CAMHS in recognition of the short fall of services in relation to demand. The Treasury strongly supported the allocation of this funding because untreated mental disorder in childhood often

leads to persistent mental disorder in adulthood, a lifetime of social exclusion and failure to achieve economic self-sufficiency. In the three financial years from 2003/04 to 2005/06 the Government allocated an additional £300 million to CAMHS.

3.4.9 The NSF is planned as a ten-year programme of change and so services are not expected to achieve all standards immediately. However the additional funding has been allocated to CAMHS in order that comprehensive services are available in each area. (See **Appendix C** for description of comprehensive CAMHS). A performance management system has been introduced to monitor progress. To simplify the administrative burden that such monitoring entails three proxies have been used for a comprehensive CAMHS, services for 16 and 17 year olds, emergency out-of-hours cover and services for learning disabled children.

3.4.10 In Wales and Scotland there has also been substantial attention to CAMHS with the publication of the NSF in Wales in 2005 largely reflecting the English model. In Scotland the *Framework for Children and Young People's Mental Health* (2004) outlines a good enough CAMHS and develops a shared vision and shared ownership of CAMHS linking with the Scottish report Health for All Children – particularly around primary prevention and early intervention.

3.4.11 On the mainland there is recognition that the substantial and sustained investment in CAMHS is leading to measurable improvements although much progress remains to be made before a comprehensive CAMHS is available in all areas (Department of Health, 2006). In England a substantial and costly apparatus of support has been established to promote and monitor progress towards the establishment of a comprehensive CAMHS. For example the National CAMHS Support Service has undertaken a wide range of initiatives to improve services, but this has cost well over £1m per annum.

3.4.12 These developments on the mainland may well have implications for Jersey in terms of public and professional expectations. The injection of resources as well as the mainland focus on CAMHS policy and performance management could lead to Jersey lagging behind with possible adverse effects on Jersey presenting a competitive career option for professionals in demand.

4. EVIDENCE OF NEED

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

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

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

Table 1: Prevalence of mental disorders in 5-16 yr olds by age and sex 2004 (ONS 2004)

Age	**5–10**			**11-16**			**All children**		
	Boys	**Girls**	**All**	**Boys**	**Girls**	**All**	**Boys**	**Girls**	**All**
Type of disorder									
Emotional	2.2	2.5	2.4	4.0	6.1	5.0	3.1	4.3	3.7
Conduct	6.9	2.8	4.9	8.1	5.1	6.6	7.5	3.9	5.8
Hyperkinetic	2.7	0.4	1.6	2.4	0.4	1.4	2.6	0.4	1.5
Less common disorders	2.2	0.4	1.3	1.6	1.1	1.4	1.9	0.8	1.3
Any disorder	10.2	5.1	7.7	12.6	10.3	11.5	11.4	7.8	9.6

4.4 The sampling on which this research is based covered the United Kingdom but not Jersey. From what we know about factors associated with higher risks of mental health disorder, it could be argued that rates of mental health disorders in Jersey will be lower:

- Lower indices of social deprivation
- Less exposure to some drugs.

4.5 It could equally be argued that rates could be higher:

- Alcohol use
- Parental absence because of high work commitments
- Lack of support for some families whose extended family is in the UK or European mainland.

4.6 Our view is that the UK research is very likely to provide good estimate of prevalence and should be used for service planning in Jersey. Applying the ONS prevalence rates to Jersey gives the following estimates of mental health disorders for 5 to 16 year olds.

Table 2: Estimated level of mental health disorders in Jersey

	5-10 (all)	**11-16(all)**	**All**
Emotional	144	300	444
Conduct	294	396	690
Hyperkinetic	96	84	180
Less common	78	84	162
Any disorder	612	844	1476

4.7 Planning services also requires an interest in time trends in child and adolescent mental health problems. Are higher percentages of children and adolescents suffering from mental health problems and therefore likely to need services? This appears to be the case from research reported to the Nuffield Foundation in 2001. Examining data collected on cohorts of 15 and 16 year olds over the last three decades the researchers concluded '*the results clearly showed that the mental health of adolescent in the UK declined overall across this period'*. This trend specifically refers to disorders of conduct, anxiety and depression.

4.8 It is not only evidence of need that is likely to determine demand on services. In common with many other areas of health care identification of certain conditions and of children at risk is improving and knowledge of effective interventions is developing which fuel public and professional expectations of what a CAMHS service should provide.

5. THE JERSEY CONTEXT WITH OUTLINE OF SERVICES

5.1 Jersey is an island community one hour's flying time from the mainland of the UK. Its population at the end of 2004 was 87,700 with 15,664 aged under 16 at the census in March 2001. There is on average just under one thousand children in each year group.

5.2 We were struck by the apparent paradox of high public expectations of service and high expectations of a continuing low tax base, despite some inescapably higher costs associated with provision in an island community. Out of area placements of all kinds are particularly costly, for health, not only the cost of the hospital admission itself but the associated costs of visiting the patient and the travel necessary to make plans for a return home.

5.3 There is a further paradox in that a number of interviewees commented that they found Jersey a highly intrusive society into family life while at the same time promoting the values of self-sufficiency. We were told that 40% of island youth was processed through the parish hall system.

5.4 Professionals in the UK and elsewhere have tended to become more specialised, in part to keep abreast of increasing knowledge, but this option is not available in a small community where the population base is insufficient to support all specialisms. Jersey relies on the flexibility and creativity of it staff to provide services.

5.5 There is an evident high risk of professional isolation on Jersey. Single specialists are common. Recruitment appears increasingly difficult and some staff in children's services are appointed to posts for which they would probably not be competitive on the mainland. For both of these reasons training and professional supervision are doubly important but the costs of providing these are higher.

5.6 The burden of inspection and performance management is much lighter in Jersey with much being left to the individual practitioner. While this has the advantage of enabling front line professionals to get on with the jobs for which they trained it has the potential disadvantage of allowing poor practice to persist for too long without challenge**.** The creativity and occasional irritation of constructive challenge is not built into practice in Jersey as systematically as on the mainland. Health and Social Services have invited the Health Care Commission to monitor services in Jersey and there is now a timetable agreed.

5.7 There are currents of change in Jersey, primarily resulting from the SEBD report but CAMHS also has to take account of policy and practice changes in mental health and child health. The commitment of the resource of staff time will be essential at different levels of CAMHS to generate momentum for change and ensure CAMHS is considered in concurrent change programmes.

Outline of services

5.8 We have not intended to undertake a definitive description of all services that touch on children's mental health and what follows is a very brief outline of the services that we have identified as the main contributors.

5.9 The island is served by one specialist CAMH team, which is centrally based in St. Helier. The team is led by the sole consultant child psychiatrist and the senior CAMHS nurse, who reports to the modern matron. The rest of the team consists of one clinical child psychologist (not in post at the time of this report), five WTE nurses, one social worker, one full-time senior secretary/administrator and one clerical assistant. Data provided for the SEBD report showed

that referrals increased from 240 a year in 1995 to 423 in 2001. Royde House data shows in 2002, 2003 and 2004 there were 408, 363, and 538 referrals respectively. In 2005 there were 317 referrals, which does not include emergencies, eating disorder, complex needs team or ADHD referrals. Different components of the health service, primarily GPs, provided nearly two-thirds of the referrals, education referred 22%, social services 10%, with youth justice, self-referral and others accounting for the remaining 4%.

5.10 At the time of the review there were four school counsellors in the non-fee paying/non-selective states secondaries, formally supervised by the consultant child psychiatrist. Two of these counsellors were part of MASTs; the plan is for the other two schools to develop MASTs in September 2006. This summer term 2006 a school counsellor has been appointed to work between two of the fee-paying schools and the selective state school. Links with the feeder primaries were not very evident.

5.11 Educational services, which support children with learning and behavioural difficulties, run alongside the schools and nurseries, identifying children with problems at a young age and putting supports in place for them, including ensuring they are placed at schools which are resourced to deal with their difficulties.

5.12 In 2005 Social Services looked after about 120 children on average at any one time with about 40 living in children's homes. The average number of children on the child protection register in the first half of 2005 was 25, and in 2004 there were between 450 and 500 active cases in children's services at any one time.

5.13 In addition to these children's services, disabled children are served by Special Needs services that provide respite, services for children and young people with autistic spectrum disorders, and an intensive behavioural support service.

5.14 The Bridge is a new venture which provides a multi-agency centre to support vulnerable families, mainly from the immediate locality but other families do have access. The Bridge brings together both statutory and voluntary sector services and is the base for Jersey Child Care Trust.

5.15 Parenting Support, which reaches out into the community through early years facilities and schools, is based at The Bridge and the programme manager offers a service to all comers as well as a Webster-Stratton based service to targeted groups.

5.16 Important additional services are offered by the voluntary sector, including the Minden Place counselling and youth service, Autism Jersey, the Brook Counselling service, the ADHD parents group and the NSPCC's Pathways project. The Pathways project is not based centrally and serves a needy housing estate population east of St. Helier. The Brook had 8000 contacts with children and young people last year and is very well known indeed to them as a source of help and advice.

5.17 Schools also provide much that is supportive of children's mental health, for example A Quiet Place, Circle Time and breakfast clubs.

CAMHS in Guernsey and Isle of Man

5.18 Guernsey with a population of just under 60,000 has a CAMH service consisting of 2.5 psychiatrists, three clinical and one educational psychologist, and 1.5 nurses. One of the psychiatrists has a specific remit for looked after children, and one of the psychologists has a specific remit for learning disabled children. Despite this larger resource, Guernsey does not provide intensive packages of care like Jersey and tends to make more use of inpatient admissions.

5.19 The Isle of Man has 8 clinicians, 5.6 full time equivalents, 1 full time consultant psychiatrist, 1 full time clinical psychologist, 1 psycho-drama specialist, 1 full time psychotherapist for looked after children, 2 nurse specialists (both 0.8), a clinical assistant to help with ADHD clinic, an occupational therapist (0.8) and a service manager (0.6). The child population of the Isle of Man is about 17,000.

Table 3: Clinical Staffing levels Jersey and comparators

	Jersey	Guernsey	Isle of Man	Royal College et al
Population	87,000	60,000	75,000	100,000
Psychiatrists	1.0	2.5	1.0	2.5 (Royal College of Psychiatry)
Psychologists	1.0	4.0	1.0	5.3 (British Psychological Association)
Psychotherapists	-	-	2.0	1.25 (York, 2005)
Nurses	6.0	1.5	1.6	2 per consultant (York, 2005)
Social workers	1.0	-	-	-
Others	-	-	0.2 (clinical assistant)	-
Total Full Time Equivalents (FTEs)	9	8	5.8	

6. USER PERSPECTIVES

The National Picture

6.1 The potential benefits of appropriately and genuinely consulting with service users and carers on service design and planning include better targeting of resources, better uptake of services, and greater success in reaching hard to engage groups. There is also some evidence that participation improves clinical outcomes (CAMHS Innovation Projects in Street, 2005)

6.2 Participation can range from full child initiated shared decisions with adults through the less participatory consultation and informing of young people. The Participation Ladder (Sherry Armstein in Street 2005) is a useful tool in understanding what level of involvement might be possible and appropriate in any given situation. The involvement of children and young people in the development of a comprehensive CAMH service is resource-consuming and needs proper planning and facilitation. UK Government policy now requires that user views are sought and acted upon across all service areas (Children's NSF 2004 and Every Child Matters 2004). This can be a token exercise unless sustainability is built in and resources allocated accordingly.

6.3 Research on children and young people's views of services typically finds adverse comment on the formality of clinic services, being patronised, not listened to, being discharged for non-attendance and resenting what seems like intrusiveness of questions in an intake/assessment interview (Street and Herts 2005, S. Laws 1999 Involving Children and Young People in the Monitoring and Evaluation of Mental Health Services, Healthy Minds 6). Most, but not all, young people tend to prefer addressing their mental health problems with people in the community whom they know and trust, older adolescents being the hardest group to engage effectively with a traditional CAMH service.

The Local Picture

Young people and families using the specialist CAMH team

6.4 We met with 15 service users who inevitably had a range of experiences and views. All had received a response within a reasonable timescale, even if it did not seem so to them, and appeared to feel that they could re-connect with the team in future if necessary.

6.5 Some users were full of praise for the service that they had received in crises; others felt that they had waited too long for an initial assessment and diagnosis. It was clear that families had made strong relationships with particular therapists and that very flexible responses had been possible.

6.6 A common theme was just how important CAMHS were to the families involved. For families who engaged quickly and who benefited substantially phrases such a 'life-savers' were used. For families where the outcomes had not been so positive feelings ran quite high, again because the possibility of effective treatment for a child in distress is so incredibly important.

6.7 Families greatly appreciated the efforts of CAMHS staff to care for their children on the island. In general they found the staff and environment at Royde House welcoming, but a bit scary for one or two children.

6.8 Families thought liaison between the specialist CAMHS team and the school could be improved, both in the assessment and the follow-up. Better use could be made at assessment of

information already held about their children within the school, and educational psychologists could play a valuable role in drawing the specialist treatment and child's school life together. Families did not feel that there was much of a sense of teamwork between therapists and school.

6.9 We were not able to meet with families who had not attended or who had been unable to access CAMHS effectively for a range of reasons. A DNA audit would be necessary to provide insight into their views.

6.10 In 2002 there was a survey of client satisfaction with 39 responses. There were very positive ratings of how families were treated by clinic staff and the majority of families felt better able to manage their problems. However a quarter of the young people did not feel comfortable attending the service and a third of families did not feel they had a better understanding of the problems after their attendance. There has not been a further survey of user views.

7. FINDINGS

7.1 Overall we found a picture, similar to many areas in the United Kingdom, of a CAMHS team with a number of highly professional and dedicated staff providing helpful services to children who gain access. The speed and flexibility of response to high priority cases would be the envy of a number of services on the mainland. We thought that the high quality accommodation at Royde House provides an excellent environment to enhance the sensitive and difficult work of the staff.

7.2 The range and quality of service provision

7.2.1 As in most other places in the British Isles, Jersey CAMHS is not able to meet the mental health needs of children and young people identified by schools, GPs, health visitors, social services, and voluntary sector agencies. There is a mismatch between what specialist CAMHS is able to do and the expectations of referring agencies. This becomes a source of tension that is played out, probably repeatedly, in relation to individual cases, as there is no formal meeting where differences of expectations can be addressed.

7.2.2 Service users, in common with patients across all disciplines and localities, find that generally they have to wait longer than they want and expect for appointments and treatment. Jersey does well enough and very well in some aspects by comparison with England. The 2004 CAMHS mapping exercise showed that 51% of patients waited less than four weeks, 31% less than three months, 11% less than six months and 7% over six months for an initial appointment (http://www.camhsmapping.org.uk/2004). The data are not specific about waits for treatment but indicate that 39% waited over six months.

7.2.3 Agencies are unsure how to cope with vulnerable families and children whom they felt needed a specialist CAMHS intervention but who fall below the access threshold. Much is facilitated on a personal basis, between people who know each other well and can lift the phone and discuss a case prior to referral. When this happens referrals are more appropriate and tend to be accepted by the team. However some professionals, for example GPs, reported that they found it impossible to make a successful referral to CAMHS of cases they deemed appropriate.

7.2.4 There was also concern about the effectiveness of the services currently offered in reaching some vulnerable families. We were made aware of instances where families had not attended their appointment, often for a variety of practical reasons - the difficulty for some people of getting into St. Helier, taking time off work and even in reading the appointment letters. We are concerned that these families are registered as DNA and do not receive the service they need. This is not solely the responsibility of specialist CAMHS who do go back to the referrer in such cases, but as a whole the system seems to be unresponsive to children in these circumstances.

We recommend a review of DNAs with an exploration of the reasons and consideration of options for improvements.

7.3 Referrals and Case Loads

7.3.1 The specialist team has raised thresholds to cope with demand as they are unable to meet many of the needs presented to them. This has been particularly true over the last year when they have been carrying long-term vacancies of key personnel. Referrals peaked at 538 in 2004 and raising the threshold last year contributed to the reduction of referrals in 2005 to 317 excluding the categories listed in para 5.9 above. (The database gives an overall figure of 380 but there are doubts about the reliability of this figure). A key aspect of meeting demand from new referrals is efficient management of throughput of cases. We have not seen evidence of this. The information provided about the nurses does not give a full picture of their work. At best it shows that the nurses had ten appointments per week. Subsequent information from a review of nurses' diaries from January to March 2006 shows that they averaged 12 appointments per week with two DNAs. It originally appeared to us from the data that once referrals have been accepted by CAMHS they are held there for a long time. 124 new cases appeared to generate 3170 follow-ups - that is, 25 attendances on average for each child. However, on further discussion we learned that cases closed over the last three months were roughly equal to cases opened, which suggests an appropriate through-put and that, on average, cases were seen about four times. There have been difficulties in adapting the Health and Social Services data collection system to provide more comprehensive data for CAMHS.

7.3.2 Activity data by staff do not appear to be routinely available or used as a management tool in ensuring efficient use of resources.

7.3.3 The Royal College of Psychiatrists' consultation paper (2005) suggests that CAMHS capacity calculations should be based on 40 new referrals per WTE per annum. This should allow services to respond quickly, offer flexibility in service delivery and provide evidence based treatments for long enough for the benefits to be apparent. The Jersey CAMH team experienced a slightly higher number than this in 2005 – approximately 47 new referrals per WTE, assuming that all posts were filled, which was not the case. In addition to managing this higher number the Jersey team has to put significant resources into high-level support of very challenging patients, a particular need and priority for an island community, which has to be factored in to calculating reasonable caseloads in Jersey.

We recommend that activity data are routinely collected, are available to the staff group and reported to management quarterly, providing the basis for an annual report for stakeholders.

7.3.4 While we have an impression of a service under pressure and unable to meet demands, current data does not provide strong evidence that existing resources are being used most effectively.

7.4 Looked After Children and other children in need

7.4.1 In common with most services in England, there are particular groups of children with high levels of need who require special attention. Looked after children are an important example. There are examples in the UK of CAMHS creating dedicated posts to work closely with social services to support these vulnerable young people (Learning from the CAMHS Innovation Projects 2003). The Isle of Man established a small, dedicated service in 2004. The proposals in the 2005 Social Services Business Plan to develop fostering and reduce the reliance on residential care are more likely to be successful given sufficient CAMHS capacity to support the foster children and their carers in the community. This substantial investment in a fundamental change in policy for looked after children requires joint investment to ensure the level of CAMH support which is key to the Treatment Foster Care model being piloted in England.

We recommend that there should be a joint appointment between children's services and CAMHS to work directly with looked after children and to develop the mental health understanding and competence of their carers.

7.4.2 This would be a similar arrangement to the joint appointment with YAT which works well. We support the plans for further investment in this work. The earlier interventions that these arrangements allow have the potential to reduce the load at the heavier end of the service.

7.4.3 The challenge of meeting the mental health needs of abused and neglected children requires a joint approach from CAMHS and children's services. With a social worker now in post there is greater capacity to address some of these needs, not least by developing an understanding of the remit of each agency for the mental health of abused children.

7.5 Range of treatment modalities

7.5.1 We are concerned that the CAMHS team is unable to offer the full range of treatment modalities such as child psychotherapy and creative therapies, as well as a sufficient cognitive behavioural therapy and family therapy.

7.5.2 The SEBD report also mentioned the key role which can be played by family therapy and the limited provision on the island. The small family therapy clinic has a considerable waiting list and uncertainties about accommodation.

7.5.3 Greater integration of the family therapy service could achieve a number of benefits; service users would have ready access in very suitable accommodation, and more joint work and case discussion could lead to the enhancement of family therapy skills among the CAMHS team. There could also be benefits for improved data collection and administrative support. The extent of integration would be subject to negotiation depending on existing contracts and optimum supervision arrangements.

We recommend that the family therapy clinic is based in Royde House which should help develop family therapy expertise amongst the staff and lead to a potential increase in capacity.

7.5.4 The makeup of the current team is unusual with a greater preponderance of nurses than would be expected in a similar-sized team on the mainland. This is partly for historical reasons as this establishment is based on the time when there were inpatient beds but no community service. Because of the importance of treating quite serious levels of mental illness on the island, if at all possible a strong cohort of nurses or others with competence at working residentially remains necessary. In future recruitment we recommend that the person specification emphasises skills, for example cognitive-behavioural therapy (CBT), family therapy or psychotherapy, as well as having an appropriate professional background. To achieve flexibility in having the skill base to offer a full range of treatment modalities to families in Jersey, it is important that the CAMHS budget is pooled under one heading except for specified shared posts. Such an integration of the budget would help recruitment to any future Primary Mental Health Worker posts that could attract nurses, social workers, or other mental health professionals.

7.6 School counsellors and Primary Mental Health Workers

7.6.1 The five school counsellors are making a much-needed contribution to CAMHS, filling – to some extent – the felt gap between schools and the specialist team and referring on when necessary. The counsellors are variously qualified and some are able to undertake significant pieces of work with mentally disordered young people with some supervision from the child psychiatrist and elsewhere, extending the reach of CAMHS effectively. They also offer support to the school staff, work with parents as necessary and run groups. Integral to their work is liaison with other agencies, mainly through the Multi-Agency Support Teams (MASTs), which struggle with social work representation. It is important that the MASTS are fully staffed, including filling the social work posts, as they provide a safety net and early identification function for troubled children.

7.6.2 We detected insufficient supervisory support for the counsellors who require opportunities for regular group and individual supervision. An early opportunity should be sought to clarify the respective management and supervisory roles and responsibilities of the agencies involved with them.

7.6.3 In view of this pattern of development, the counsellors have become more like Primary Mental Health Workers. Whilst the practitioners themselves are enjoying this variety, it is reducing the amount of counselling time available to pupils. We suggest, therefore, that two Primary Mental Health Worker posts be created as an integral part of the specialist CAMH service - linking with the MASTs and the counsellors, and able to work at the interface between CAMHS and other referring agencies to meet the unmet demand. The Children's NSF and associated policy sets a requirement for one such team in every locality (Children's NSF 2004 and *Improvement, Expansion and Reform* 2002). These Primary Mental Health Workers, whom we recommend should be geographically based, will link with the primary schools and nurseries and offer additional support to schools, groups, voluntary and statutory agencies. Some schools like Mont à L'Abbé with high levels of need are outside the current remit of the school counselling service. (For further information about the role of the Child Primary Mental Health Worker see Gale et al, 2004).

We recommend giving consideration to setting up bases out of St Helier such as with pathways and in outlying GP surgeries. The creation of primary mental health worker posts would provide a bridge between services at tiers 1 and 2/3.

7.7 Minority Communities

7.7.1 The potentially different needs of the newer Jersey communities, most notably Portuguese and Polish residents, many of whom are unqualified in housing terms, should be considered. It would appear that these families are disproportionately disadvantaged and the children have a higher risk of mental disorder. Ethnicity data are not collected, and so we do not know how well founded is the concern expressed to YoungMinds that minority communities may not be finding it easy to access CAMHS.

If Primary Mental Health Worker posts are developed we recommend this as an opportunity, skills permitting, to recruit from a minority community.

7.8 Tier 1 Needs

7.8.1 There is a general need for greater mental health awareness at tier 1, amongst for example youth workers, teachers and voluntary sector staff. On the whole schools were investing in the mental health/emotional well-being of their pupils with some primary schools wanting to establish nurture classes to offer some sanctuary to troubled children. Funds were not available for this development however and there is the risk that classes may be established which are not able to follow rigorously the recognised nurture pattern. We suggest that the States funds a pilot nurture class, which is monitored by a multi-agency steering group including CAMHS, in order to understand fully the nurture role and resource requirements (Boxall 2003).

Infants

7.8.2 There are currently no plans to develop an infant mental health service which tend to be quite rare across the UK but have significant benefits for families, young people and communities at large. A 'virtual' team is required across primary care and CAMHS for infants (YoungMinds 2004, http://www.youngminds.org.uk/policy/documents.php). This is an area that the States Health and Social Services Directorate may want to consider in future, especially in view of the emerging evidence that the crucial developments taking place in the infant brain set a pattern for future behaviour (Balbernie 2001).

Parenting

7.8.3 The parenting service based at The Bridge does sterling work and is referred to by a range of other agencies as well as offering direct access to parents. We think it would be very helpful to prioritise parenting classes for groups or families whose children are at greater risk of developing mental health problems, for example parents of learning disabled children and parents with mental health problems.

7.8.4 The Bridge itself is a significant project with capacity, providing resources for service co-ordination are maintained, to draw disparate agencies together to provide a truly seamless service for the community. It is essential that CAMHS remains involved with this development, which could become a prototype for similar ventures across the island.

Young adults

7.8.5 Currently 16 and 17 year olds are accepted by adult mental health if they are out of education and by CAMHS if they are in education. There is some flexibility, for example with CAMHS more likely to work with young people with developmental disorders and adult mental health more likely to see young people with major psychiatric disorder. While the education criterion may appear to provide a clear-cut distinction, it is widely seen as confusing because the educational status of young people is often unclear when their lives are in such turmoil as to require a referral to CAMHS. We recommend that all young people up to their 18th birthday are referred to CAMHS with involvement from adult mental health as requested by CAMHS. This is consistent with the policy frameworks in England, Scotland and Wales. The implementation of this recommendation will have resource implications, as CAMHS will be primarily responsible for an age group where there is increasing prevalence of serious mental health disorders.

7.9 Remit and Referral Criteria

7.9.1 One of the strongest messages from our fieldwork was that other children's services do not have a clear idea of the remit of specialist CAMHS, nor much beyond anecdotal information of what they do.

7.9.2 The decision in April 2005 to change referral criteria caused some disquiet amongst fellow children's services. The letters announcing this decision were based on the understandable need to restrict demand to more nearly match current resource levels. The fall-out from these letters has highlighted the importance of consultation on roles and priorities with all stakeholders. We have seen a CAMHS Specifications document, which is a helpful beginning, but it appears to be a draft and we do not know whether it has been subject to consultation, approved and disseminated.

7.9.3 CAMHS are subject to multiple demands, mostly in relation to seeing children individually or with their families. Referrals come from many different sources within different sectors. Only the CAMH service itself has an overview of demand. There are also multiple demands ranging from requests for training on aspects of children's mental health (which is much appreciated by stakeholders), to membership of a project group to ongoing consultation and advice on groups of children with potential very high levels of disturbance. Juggling these demands can be achieved more effectively if the remit for CAMHS is negotiated, transparent and there is feedback on activity to referring agencies.

We recommend that the CAMH service consults on the draft specifications document and that it negotiates with its partners about reasonable expectations of feedback, both on an individual case basis with client consent, and about overall activity levels.

7.9.4 It is not only amongst partner agencies that there is little awareness of what CAMHS actually does.

We recommend that reporting mechanisms be established up to the Executive Board and three ministers. This should include activity information and an annual presentation to develop better understanding of CAMHS at the chief executive and ministerial level.

7.9.5 The report by Dr. Geller (2006), writing on behalf of The Community Children's Services Steering Group, set out the intention for all children's services to be 'pathway-based', meaning that the family's journey is supported '*as they experience services through the provision of high quality care, delivered by teams which link together seamlessly to assure the best outcome for families using the services'*.

We recommend that CAMHS be pro-active in the development of care pathways for specific conditions agreed with relevant stakeholders including families.

7.9.6 Dr Lenton's report (2005) echoed the SEBD report's concerns about multiple and fragmented information systems. Dr Geller stresses that '*information systems will be vital in delivering coordinated pathways of care'*. As Jersey has such clear boundaries and a manageable number of children, it seems that it is well placed to develop the single children's information system that is one ambition of Every Child Matters on the mainland. (For further information, please see http://www.camhs.org.uk/default.aspx?q=doas&c=2 or http://www.everychildmatters.gov.uk/resources-and-practice/search/EP00037/). It is beyond the brief of the YoungMinds team to comment on IT issues, but we would suggest that an island-wide system be established on the principle that the child and family are at the centre and design follows their needs, rather than design following organisation imperatives.

We recommend that this work be undertaken within the remit of the Children's Executive to ensure that it links closely to other work to implement the SEBD review. It is essential that the implementation of recommendations arising from this review takes place in tandem with the child health review.

7.10 Effectiveness of cross-agency working arrangements

7.10.1 We heard of many examples of good joint working on individual cases at the front line. Staff from partner agencies found co-working on cases particularly effective, providing families with a multi-agency co-ordinated service, as well as staff developing CAMHS expertise and knowledge of how partner organisations operate. Staff from other services for children appreciated training they had received from specialist CAMHS.

7.10.2 However on the whole we found specialist CAMHS a rather isolated service, with few formal links to other services and with too little information disseminated about the work it does. Stakeholders often mentioned the importance of CAMHS and commented positively on particular clinicians, but there was no sense of CAMHS as an essential component of a system of children's services. We found an over-reliance on personal relationships and a reluctance to formalise inter-agency working arrangements. It would not be cost effective for a jurisdiction like Jersey to allocate substantial resources to the development of protocols and inter-agency agreements but, as we recommend in paragraphs 7.1 and 7.2, there should be:

- Agreement about basic activity information necessary to inform stakeholders
- A negotiated agreement about the remit of CAMHS
- Care pathways for specific conditions agreed with relevant stakeholders including families.

7.10.3 The specialist CAMH service has become rather isolated with insufficient understanding and appreciation of its role amongst other children's services. However there are services where links with CAMHS are good, and where there is a developed understanding of the contribution CAMHS can make alongside other children's services. The nurse therapist role in the YAT is a

good example. We think the 'default' position for any new appointment is that is should be a shared appointment with another children's service. This could range from a jointly funded post with location spilt between Royde House and another centre accessed by the public for children's services, for example a special school, to an entirely health funded post with a dedicated outreach component. High priorities for such shared appointments would be a mental health specialist for looked after children, Primary Mental Health Workers and a specialist in Learning Disability part-located at Mont à L'Abbé.

7.10.4 We do not think the isolation from children's services is a function of being managed within the mental health directorate as, until recently, CAMHS was part of children's services. Wherever CAMHS is placed organisationally, it has to look to adult mental health and children's services and links have to be built across organisational divides. We think there is little merit in relocating CAMHS in children's services. Time devoted to major organisational upheaval takes time away from negotiating the type of agreements mentioned in 7.3.2 above.

7.10.5 Families in particular commented that CAMHS had not made full use of information about their children already available at school. It seemed that education psychology in particular could be more closely linked to CAMHS assessments and treatment so that the child experiences a more holistic treatment pattern in school and at home.

7.10.6 There was some frustration in partner agencies that they do not know what is happening following a referral to CAMHS and that if they were better informed they could be doing more to support a child's treatment. There was recognition about the importance of confidentiality, but sometimes parents were said to want more joint working and had not been asked for permission to share information.

We recommend that an information-sharing protocol be developed between specialist CAMHS and their partners.

7.11 ADHD Clinic

7.11.1 The ADHD clinic is currently run by CAMHS with careful assessment by the specialist nurse and consultant psychiatrist. This condition has such a major impact on a child's functioning in school we would see it as a golden opportunity for joint education/CAMHS activity, with education support workers and educational psychologists contributing to both the assessment and advice to teachers on management of these children. Such joint work could also have the benefit of improved consistency in managing the child's behaviour in school and at home. We also suggest that the prescription of medication be passed to GPs so that it is integrated with other aspects of health care, leaving the CAMHS team to focus on specialist techniques such as parent training courses.

7.12 The arrangements for children with learning disabilities and mental health problems

7.12.1 In Jersey there are a number of services that might help with the mental health problems of learning disabled children, for example the intensive support service, a hospital paediatrician, educational psychology or specialist CAMHS. We were told that, although specialist CAMHS does not officially see children with learning disabilities, individual clinicians do provide treatment. It was broadly agreed that children with learning disabilities including autistic spectrum disorders are less well served. Services are in organisational silos and do not wrap around the child. The small number of specialists would provide a more family-friendly service if there were clear pathways for specific conditions showing the contribution different professionals make to the care of children.

7.12.2 These pathways should clearly show the public in Jersey how to access a service. Such a pathway will be based on the principle of the equal right of a disabled child to treatment and supersede the present informal arrangements whereby some children appear to get in as a result of special pleading. There appears to be a surprising level of fragmentation, bearing in mind that the key players know each other. Amongst the professionals we interviewed there was not a shared view of what was an appropriate referral for which service. This must make understanding the system very difficult for families.

7.12.3 There is no shared register of disabled children, nor a shared information system. The numbers of disabled children are quite small and many are known to a small network of professionals from birth, but those working with older children commented that children with Special Educational Needs (SEN) and disabilities can fall through the net.

7.12.4 There is a limited community paediatric service with health visitors, part of the Family Nursing and Home Care service, but no community paediatricians. This means that work often undertaken by paediatric services in the UK falls to CAMHS. The implementation of the YoungMinds review and the outcomes of the concurrent review of paediatric services should be dealt with together. There is a shortfall in meeting the mental health needs of disabled children. Addressing these needs has to be negotiated at the interface of child health, special education and CAMHS. Although our focus is on children with learning disabilities we heard concerns about arrangements for children with physical impairments who are at higher risk of developing mental health problems. In Jersey there appears to be a shortfall of clinical psychology provision that generally has specific expertise in developmental delay.

7.12.5 There is some unmet need for short-term breaks and after-school provision for families with disabled children. This is an issue beyond the precise remit of our project, but is a likely source of increased pressure on families, depleting their own resilience and increasing the likelihood that they will seek other sources of support.

7.12.6 The specialist CAMHS team is not closely involved with Mont à L'Abbé school with its population of over 90 disabled children, many of whom have high levels of emotional and behavioural disorders. A visiting consultant clinical psychologist from Madrid, Dr Pilar Martin, provides highly valued expert advice in devising and monitoring behaviour plans for children who on the mainland would often be in 39- or 52-week residential provision. Dr Martin was introduced to the school via a parent some years ago and comes to Jersey four times a year, spending about three days in the school. Her contract with education is reportedly rather fragile and liaison with her is rather hampered by her domicile in Madrid. While it is a good example of Jersey's creative flexibility in response to particular need at the special needs school, it does not promote a holistic and co-ordinated response to Jersey children.

We recommend a 'virtual team' model drawing on interested and appropriately skilled members of the specialist CAMHS, paediatricians, special needs service with close links to SEN, with consultation arrangements in due course on the mainland.

7.12.7 This virtual team should map its areas of expertise, which are considerable, developing a short and longer-term training and development plan to address identified gaps. The complex needs team is a commendable flexible multi-agency response, but is focused on complex needs and so will not include most learning disabled children.

7.12.8 While we are clear that services for children with learning disabilities are not adequate, the detail of plans for service development must take account of the child health review and be negotiated with a number of key stakeholders, including social services special needs, clinical psychology, Jersey Autism, Mencap and special education, including the head teacher of Mont à L'Abbé [1].

7.13 Current arrangements for intensive work, inpatient and residential care and on-call services.

7.13.1 Children and young people with more serious mental health problems, for example attempted suicide, received prompt and responsive support from specialist CAMHS when they were referred by accident and emergency or a hospital ward.

7.13.2 Historically there was an inpatient unit on Jersey, and when this closed, children who required admission for mental health problems went to the mainland. At one time there were arrangements for them to be admitted to an adolescent unit at Southampton. Later there was a further arrangement with the Maudsley Hospital, South London. Neither of these proved satisfactory, because of either the difficulties in obtaining a prompt response to a request for admission or the clinical outcome, and the children and their families found the lengthy separation difficult and counterproductive.

7.13.3 More recently the CAMHS team, with support from the Mental Health Directorate, has developed a more innovative and user-friendly approach. At a time when the intensity and range of a child's difficulties would seem to warrant admission, a personalised package of care is devised that can be delivered at an appropriate location: the family home, children's ward or a slightly separate area of the adult mental health admission ward. These arrangements are rated a success by the professionals and by families, and admissions to the mainland have decreased dramatically, except on rare occasions when a highly specialised assessment is required.

7.13.4 This work does have a significant impact on the routine CAMHS workload, as the consultant and nursing team need to put time aside from regular commitments to provide the intensive package. The success of these packages is dependent on flexible and speedy changes in working practice with additional nurse input from adult mental health. So far, they have been required about three or four times a year; it is difficult to see how the service would cope if more than one child at any one time needed such a package. It is not clear how this work is reflected in activity data; it seems to be subsumed under routine clinic attendances if it appears at all. Since these packages are resource-hungry and represent a substantial financial saving, we would suggest that they are logged more clearly. They are a significant

[1] Jersey is not alone in providing insufficient mental health services for families with learning disabled children. In England, the Department of Health is monitoring progress towards the Public Service Agreement for access to comprehensive CAMHS by the end of 2006. Three proxy indicators have been selected as being representative of progress towards a comprehensive CAMHS as defined in the Children's National Service Framework. The percentage of Primary Care Trusts that were commissioning these services for autumn 2005 was: 24/7 emergency service - 81.2%, CAMHS for those with a Learning Disability - 49.8% and service for 16/17 year olds - 71.9%.

extra duty for the consultant who is already over-performing in terms of routine outpatient attendances and we consider that they add to the case for a second consultant; it would be impossible to deliver an intensive package if the consultant were on leave.

We recommend that a second consultant be appointed to focus on intensive services.

7.13.5 The on-call service is an essential element of an intensive package; however we are not convinced that it is well used or necessary on a routine basis. Other island communities that we have heard about do not offer on-call by CAMHS and we would question whether this is a good use of limited resources. We recognise that having an out-of-hours service is an essential component of the comprehensive service envisaged by the Children's NSF on the mainland, but we are mindful of the need to consider the applicability of the NSF in relation to demands arising from a community the size of Jersey.

7.13.6 A secure residential resource is currently being developed by Social Services to provide eight beds for children who will presumably have challenging behaviour and are likely to have a number of co-morbid mental health problems. Psychiatric nurse input is envisaged for this unit. It is not clear how it will impact on the use of intensive packages of mental health care and the need for consultant psychiatrist input, but the latter may well increase. Nevertheless some admissions off-island may sometimes be necessary.

7.13.7 The establishment of an eating disorder team on the island has had a significant impact on the need for hospital admission for both adults and children, with a marked reduction on the paediatric ward.

7.14 Involvement of service users

7.14.1 Again in common with many mainland services, in Jersey there is no system for gathering user feedback about their experience, nor any user involvement in planning service development. The client satisfaction questionnaire in 2002 was a good but isolated exercise. In England the Health Care Commission is expecting to see evidence of user feedback in all its service improvement reviews. The NSF (Department of Health, 2004) description of a comprehensive service states that '*…delivery of services should be informed by a multi-agency assessment of need which incorporates (among other things) the views of all stakeholder including those of children, young people and their families'*.

We recommend that feedback forms be routinely issued and followed up, collated and including in audit and any service review. They should be analysed away from Royde House if at all possible.

We recommend the forms be developed in association with users and with the voluntary sector.

7.14.2 We recommend that at each stage of service development the question of how best to elicit service user views is considered. There is a number of ways of doing this, from exit questionnaires to fully supported user planning groups that are a sustainable part of the annual planning round.

7.15 Governance

7.15.1 Professionals in Jersey in general have more autonomy and are less accountable. They have more power to respond flexibly to needs as their professional judgement directs. Our impression is that therefore services in Jersey are more variable, sometimes better and sometimes not. There is an absence of systems to identify and lever up low standards. Governance arrangements caused us some concern in a service more than usually faced with risks associated with isolation.

7.15.2 Dr Geller's report on child health makes reference to governance and the need for robust clinical and managerial arrangements. She identifies a need for continuous improvement in governance which, drawing on Simon Lenton's work (2005), is described as doing the right things, in the right way, to the right people, at the right time, with an optimal outcome.

7.16 Supervision

7.16.1 Supervision arrangements appear informal and occasional, rather than systematic and rigorous. It seems that some cases drift without clear plans for their conclusion or review. This is probably masking a poor use of resources and is potentially dangerous.

7.17 Audit

7.17.1 Perhaps because of the absence of key staff over the last year the focus on audit appears to have slipped back. We have read the Suicide Prevention and Care Pathway Audit (2004), which was a thorough examination of practice including local analysis, national information and service user views. We have also read the following audits: school counselling (2004), feeding clinic audit (2004) and case audit evaluation 2002(?).

7.17.2 The lack of rigorous clinical audit allows different approaches to be used by different practitioners for the same disorders. We think a programme of both case and clinical audit should be established covering the work of all members of the team so that reviewing practice becomes routine.

7.17.3 The Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) was introduced from 1 March 2003, but it has not been possible to present any outcome HoNOSCA data for this review. The processes of internal audit and external accountability would be greatly assisted by the use of HoNOSCA data.

7.18 External reviews

7.18.1 External reviews do not happen regularly and cannot be a comprehensive means of ensuring effectiveness of service, especially when the review is relatively brief and the reviewers have little data to rely on, for example samples of user views, copies of recent audits, management information data, HoNOSCA scores. Unlike the Isle of Man, Jersey has been fortunate not to have experienced a tragic case leading to a high-level review that would delve in detail into services caring for children. The lack of robust governance arrangements would leave Jersey vulnerable to criticism should such a situation arise.

We recommend a systematic approach to supervision, case and clinical audit, and external review.

7.19 Staffing and Training

7.19.1 Activity data does not appear to be routinely available for the specialist team and does not appear to give a full picture of the work of the specialist team.

7.19.2 Some thought needs to be given to the optimum balance between clinical, managerial and administrative time in the specialist team. As we have said above, our review has unfortunately taken place at a time when the team manager who has been on compassionate leave so these issues could not be discussed. We are making recommendations about improved management information, audit, and inter-agency working but it is not clear to us given the staff working at the time of our review who would have the capacity and authority to drive forward the necessary work. In the Isle of Man the CAMHS manager post provides capacity to undertake managerial tasks without taking away from clinical time.

7.20 Role of consultant psychiatrist

7.20.1 There is a danger of the consultant child psychiatrist being over-stretched. She is required to represent the service, to provide advice and consultation, sit on working parties and act in a management role as well as see children referred as soon as possible. Dr Coverley does undertake some continuing professional development and has met the requirements of the Royal College of Psychiatrists in this respect. Some peer supervision is provided by meeting with colleagues in Guernsey on a roughly quarterly basis. We would like to see enhanced opportunities for peer supervision and consultation. There do not appear to be opportunities for teaching or research. We would advise senior management within the Directorate to review the consultant job plan as a matter of urgency.

7.21 Training

7.21.1 It seems to us self-evident that an isolated service should invest more than most in training and development of staff. Jersey does not have an abundance of available staff to fill posts in children's services and an additional commitment to training is necessary if high public expectations are to be met. Bearing in mind these factors particular to Jersey, we were disappointed at the apparent lack of priority for training and knowledge of the available budget. The additional competence and confidence which would follow from further post-qualification training would allow a more equitable division of responsibilities within the specialist team.

7.21.2 The Training Policy (dated 20 June 2002) and the 'annual training plan' should be updated as soon as possible and be the basis for a realistic training bid in next year's budget. The possibilities for re-allocating money this year into the training budget should be investigated. We would suggest that the policy is revised to give fuller recognition to the importance of training for an island community. The sort of change we suggest is needed is illustrated in the following revision of paragraph 1 (suggested new text in bold type):

'In order to provide a high quality efficient service, team members ~~would be expected~~ ***are required*** *to continue with their professional development, and will ~~be expected~~ be involved*

in training and attend conferences to enhance the service. ***Training is an essential activity to offset the dangers of isolation inherent in working in an island community'.***

7.22 Role of voluntary sector

7.22.1 Autism Jersey is good example of the voluntary sector developing services to promote children's mental health. Voluntary organisations can attract resources, both human and financial, which are not available to statutory services. This might offer a more rapid route for developing the range of services available to children than a total reliance on States funding. The importance of the sector in advocating on behalf of children should be recognised, given the lack of a children's commissioner, a post that we do not think could be justified in a community the size of Jersey.

We recommend that CAMHS recognises the role and strengthens the contribution of the voluntary sector by:

- ***Supporting existing voluntary organisations (the ADHD group is a good example) and recognising the contribution made by the Brook counselling service, Minden Base and the NSPCC Pathways project.***
- ***Considering which other voluntary bodies could be encouraged to make a positive contribution to the mental health of the children of Jersey, for example school-based programmes like Pyramid and Place to Be, and organisations which offer cognitive-behavioural therapy.***
- ***Appreciating and strengthening where possible the sector's advocacy role.***

APPENDIX A: MODEL OF TIERS

Taken from Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services, the Mental Health and Psychological Well-being of Children and Young People, pgs 46-47.*

The Four Tier Strategic Framework

Tier	Professionals Providing the Service Include	Function/Service
Tier 1 A primary level of care	GPs Health visitors School nurses Social workers Teachers Juvenile justice workers Voluntary agencies Social Services	CAMHS at this level are provided by professionals working in universal services who are in a position to: Identify mental health problems early in their development Offer general advice Pursue opportunities for mental health promotion and prevention
Tier 2 A level of service provided by uni-professional groups which relate to each other through a network rather than a team	Clinical child psychologists Paediatricians (especially community) Educational psychologists Child & adolescent psychiatrists Community nurses/nurse specialists	CAMHS professionals should be able to offer: Training and consultation to other professionals (who might be within Tier 1) Consultation to professionals and families Outreach Assessment
Tier 3 A specialised service for more severe, complex or persistent disorders	Child & adolescent psychiatrists Clinical child psychologists Nurses (community or inpatient) Child psychotherapists Occupational therapists Speech and language therapists Art, music and drama therapists	Services offer: Assessment and treatment Assessment for referrals to Tier 4 Contributions to the services, consultation and training at Tiers 1 and 2.
Tier 4 Essential tiertiary level services such as day units, highly specialised outpatient teams and inpatient units		Child and adolescent inpatient units Secure forensic units Eating disorders units Specialist teams (e.g. for sexual abuse) Specialist teams for neuro-psychiatric problems

APPENDIX B: MATRIX OF PEOPLE SEEN

Sector	Frontline	Managers/ Directors/ Heads
Health	13	5
Education	4	15
Social Services	2	7
Users, Carers, Voluntary	15 +2	
Others	1	1

Total number of people seen = 65.

APPENDIX C: COMPREHENSIVE CAMHS

Taken from Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services, the Mental Health and Psychological Well-being of Children and Young People, pgs 48-52.*

Appendix 2: A Comprehensive CAMHS

Improvement, Expansion and Reform has set the expectation that a comprehensive child and adolescent mental health service (CAMHS) will be available in all areas by 2006. This means that in any locality, there is clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting to hospital a young person with serious mental illness. This is reiterated in *National Standards, Local Action*, which sets out the priorities for 2005/06-2007/08 for the NHS, and emphasises the need to maintain the levels of service achieved through the 2003-06 planning round.

Clear pathways should be set out to show how the range of mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function. This will not necessarily mean that all services will be in their final configuration or available in every locality by 2006. Where local provision is not appropriate or possible, commissioners will need to set out the collaborative arrangements that will ensure that there is an agreed care pathway to meet the specific needs from an alternative service. Further improvements and developments will be required throughout the lifetime of the National Service Framework implementation to extend the range of services provided and ensure the highest standards of care. The aspiration should be to continually improve and develop the services in the context of multi-agency partnerships across the spectrum of need, and informed by the best available evidence.

A comprehensive service in practice

Commissioners will require a clear definition and description of a comprehensive CAMHS. This can be set out under a number of separate headings:

Underpinning Principles:

>Access to CAMHS should be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality.

>Effective CAMHS commissioning is a multi-agency activity and requires that the commissioners have the requisite skills, knowledge, time and executive authority to undertake the task.

>Both the commissioning and delivery of services should be informed by a multi- agency assessment of need that is updated regularly. This needs to incorporate:

- Locally adjusted epidemiological information on the prevalence of children's mental health problems to reflect the diversity of the population and other local demographic circumstances.
- An assessment of the needs of particular groups of children and young people in the locality who are vulnerable or at risk
- An audit of services currently provided by all agencies that address both directly and indirectly the mental health needs of children and young people.
- An analysis of current service usage.
- The views of all stakeholders including those of the children, young people and families.
- The available evidence of the efficacy and effectiveness of interventions and service models.

- Current national and local policy priorities.

>Services should be commissioned to ensure that the workforce is of sufficient critical mass to have the capability to meet the range of defined needs safely, effectively and efficiently.

Range of Services:

>The range of services and their settings should reflect the specific needs:

- Related to the age of children and young people using the service
- Related to the circumstances of the child, particularly if they may affect access to services
- Associated with the presence of a learning disability.

>Arrangements should be in place to ensure that 24 hour cover is provided to meet urgent needs and a specialist mental health assessment should be undertaken within 24 hours or during the next working day.

>There needs to be a balance of service provision in order that all levels of need can be met as required:

- Within primary level services (Tier 1), those in contact with children need to be able to have sufficient knowledge of children's mental health to be able to: identify those who need help; offer advice and support to those with mild or minor problems; and have sufficient knowledge of specialist services to be able to refer on appropriately when necessary.
- Child mental health workers (Tier 2) need to be available to support, train, liaise with, consult to and provide direct work with other agencies providing services for children.
- Specialist multidisciplinary teams in all localities should be able to provide:
    - Specialist assessment and treatment services
    - Services for the full range of mental disorders in conjunction with other agencies as appropriate.
    - A mix of short term and long term interventions and care according to levels of complexity, co-morbidity and chronicity.
    - A full range of evidence-based treatments;
    - Specialist services that are commissioned on a regional or multi-district basis, including in-patient care.

Workforce and Skills:

>The professional mix within specialist services and teams should be balanced to ensure the availability of an appropriate representation of skills, in particular, professional and team isolation should be avoided in all services.

>Staff have the skills, competencies and capabilities that are necessary. All services should ensure they can:

- Work across agency boundaries and within a variety of settings;
- Engage children, young people and their families who have difficulty accessing services.
- Deliver interventions based on the best available evidence.

>Services require management expertise with sufficient knowledge, understanding and executive authority to be able to support the effective and efficient multi- agency delivery of CAMHS.

>The administrative workforce should be sufficient to ensure that all necessary administrative functions, including data collection, can be fulfilled.

>Commissioners in conjunction with specialist providers should support the development of CAMH expertise within all children's agencies.

Training and development:

>Clear supervisory arrangements and structures should be in place to ensure accountable and safe service delivery.

>Multi-professional training and consultative work, undertaken both within and across agencies, is essential.

>The necessary resources to support the training and development requirements of the CAMHS workforce should be available.

Organisational arrangements:

>Agreed protocols should be in place to manage waiting lists and times according to need.

>Services should be accommodated in buildings fit for supporting all the expected functions.

>Where services are located in non-CAMHS dedicated community settings (e.g. schools), arrangements should be made to provide suitable accommodation for supporting service delivery.

>The equipment and accommodation used for direct work with children should ensure that children's safety is of paramount concern.

>IT resources and equipment to support high quality care and the monitoring and evaluation of services should be available in all appropriate settings.

>Where interfaces exist between services, as between adult and children's mental health services, arrangements should be negotiated to ensure clarity and effectiveness of separate and joint service responsibilities and smooth transitions of care.

>Where service delivery demands effective partnerships between agencies (e.g. children and young people with complex, persistent and severe behavioural disorders) joint protocols should be agreed at senior officer level between the NHS, social services and education.

>Clinical governance arrangements should ensure that all staff are trained, supported and able to deliver sound, ethical and safe services.

APPENDIX D: CONTRIBUTORS

First Name	Surname	Area/Title
Philip	Anderson	Deputy Head, Hautlieu School
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John	Birtwhistle	Prinicpal Educational Psychologist (retired)
Grant	Blackwell	Manager, Youth Action Team
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Margaret	Brown	Educational Psychologist
Ann	Campion	CAMHS Nurse
Janet	Clark	CAMHS Nurse
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Shirley	Costigan	Youth Service
Janet	Coutts	CAMHS Nurse
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Phil	Dennett	Service Coordinator, Children's Executive
Laura	Dicker	NSPCC
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Linda	Dodds	Manager: Assessment & Child Protection Team
Chris	Dunne	Manager: H&SS, Special Needs Service
Ian	Dyer	Directorate Manager, Mental Health
Sharon	Eddie	Head Teacher, Mont à L'Abbé School
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Michael	Gafoor	Alcohol & Drug Service
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Annette	Urry	Occupational Therapy
Dr Tracy	Wade	Consultant Clinical Psychologist
Jim	Ward	Community & Day Services Manager
Mark	Warren	Forensic & Challenging Behaviour Team
Lorraine	Wells	Eating Disorders Team
Danny	Wherry	Manager: Placement & Support

NB We have not named the 15 service users who contributed to the review.

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