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Health and Social Security Scrutiny Panel

Assessment of Mental Health Services

Witnesses: Primary Care Body, L.I.N.C. Mental Health & Wellbeing, Resilience Development Company

Monday, 10th December 2018

Panel:

Deputy M.R. Le Hegarat of St. Helier (Chairman)

Deputy K.G. Pamplin of St. Saviour (Vice-Chairman)

Deputy C.S. Alves of St. Helier

Deputy T. Pointon of St. John

Witnesses:

Dr. David Bailey, Primary Care Body

Lucy Nicolaou, Mental Health Nurse and Manager, L.I.N.C. (Living in a Networked Community) Mental Health & Wellbeing

David Ogilvie, Managing Director, Resilience Development Company

[09:00]

Deputy M.R. Le Hegarat of St. Helier (Chairman):

Good morning. This is being live-streamed and this is a public meeting of the Health and Social Security Scrutiny Panel in relation to agencies who provide some services in relation to mental health because we are currently working on a review of those services. I thank everybody for coming and the panel will introduce themselves and then I will ask the persons who have attended to also

introduce themselves, so that the public are fully aware of who they are and who they represent. My name is Mary Le Hegarat and I am a Deputy for St. Helier and I am the chair of this panel.

Deputy K.G. Pamplin of St. Saviour (Vice-Chairman):

I am Deputy Kevin Pamplin of St. Saviour and I am vice-chairman of this panel.

Deputy C.S. Alves of St. Helier:

I am Deputy Carina Alves of St. Helier District 2 and I am a member of the panel.

Deputy T. Pointon of St. John:

I am Trevor Pointon, I am the Deputy of St. John and I am a member.

Deputy M.R. Le Hegarat:

I will ask you, if you want to …

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Yes, I am Lucy Nicolaou, I am a mental health nurse and I manage L.I.N.C. Mental Health & Wellbeing service.

The Deputy of St. John:

If you could swing the microphone around, thanks.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Okay.

Primary Care Body:

I am Dr. David Bailey, I am a G.P. (General Practitioner) at Indigo Medical practice. I am also a doctor that works with the Alcohol and Drugs Service.

Managing Director, Resilience Development Company:

Morning, my name is David Ogilvie. I am the managing director of Resilience Development Company, which is a commercial company.

Deputy M.R. Le Hegarat:

Thank you. Present also is the Scrutiny Officer and also a member of staff who is working the machine in relation to the transcripts for this meeting. Thank you very much for coming. Just to make you aware that this panel is operating under the parliamentary privileges and we will kick off. Firstly, I would like to ask a question to all of you in general in relation to the demand for your services

over the last 2 years. Would you please be able to advise us if the demand for your services have changed in any way over the last 2 years? If I start with you on my left, that would be good. Thank you.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Yes. We have only been going for about a year, so I can only comment within that period. But when we set up L.I.N.C. initially our focus was on older adults in relation to cognitive impairment. We have changed the direction quite recently because of identifying a different need within the community. I guess, as things do in Jersey, by word of mouth, once it was out there that we were doing something in relation to mental health, we had other people contacting us, adults rather than older adults, looking for support with a range of different mental health problems. It changed when we moved here and sort of redirected our service and all we can offer, accordingly, to meet that need.

Primary Care Body:

In primary care we deal with one in 4 of our patients who have a mental health problem, so there has always been a big demand for mental health service support. I think that has increased over the last 2 years. What we are finding in primary care is that there is increasingly less support from secondary care and the demands are increasing. Demands are increasing for the elderly services, general public and also the adolescent and child health service and causing us increasing concerns with the service delivery that they provide.

Managing Director, Resilience Development Company:

The short answer is, yes, we started off as a very small company 5 years ago and the demand has just grown. If you want to work with us as a company now, we could not work with you until April of next year. To put that into perspective, I would say we start off training very small teams, 20 people. Our current contract is for 700 people in just one organisation, generally off the back of mental health first aid training. We are also working with schools, so there is a much bigger demand from schools. Jersey Childcare Trust, big demand from that sector as well, so it is just the general trend of what we have been seeing in mental health.

Deputy M.R. Le Hegarat:

Thank you. If I could follow up in relation to Dr. Bailey, if I might. Firstly, you mention about across the board that there has been an increase and about the services; would you like to provide us a little bit more information in relation to sort of adult but then also in relation to the children and the services that you find that you are able to tap into, if you could, please?

Primary Care Body:

Before I came here, I asked all general practitioners to give me their opinion. I have also contacted people within Adult Mental Health Services and C.A.M.H.S. (Child and Adolescent Mental Health Services) and discussed also with my colleagues at the Alcohol and Drugs Service. If I can start with C.A.M.H.S., they feel that they are very much understaffed and they are not coping with the current referral rate. I believe there was an open letter to the *Jersey Evening Post* recently to this effect. The U.K. (United Kingdom) service for C.A.M.H.S. would have probably 5 teams; have an inpatient team, an eating disorder team, a more generic team for small general support, crisis intervention, self-harm workers and drug and alcohol workers for young people with substance misuse. They currently only have one team to deal with all of those issues. There are 2 primary care workers in schools, which is insufficient. More complex cases need to be referred off-Island and that has to go via a committee. If someone needs to see somebody outside of the Island the clinicians involved in care of patients are often making telephone calls, so that takes them out of active service. If a young person needs to be admitted there is currently only Orchard House, which is an adult service and it is very unsuitable for an adolescent or a child, so patients are often referred to Robin Ward, which is a general paediatric ward. The transient mental health service demands on C.A.M.H.S. is mirroring the U.K., so there is going to be an increase in self-harm issues relating to social media, self-harm and drug misuse. One of my G.P. colleagues gave me an example that he did an initial referral which did not meet their criteria and the child went on to self-harm. I think that because of the pressures they are under, the threshold at which somebody meets service specifications, if you like, is increasing. As far as the adult services, it is felt by my colleagues that there is no real integration with mental health and the drug and alcohol team. Patients with drug or alcohol misuse with a secondary to mental health issues are often turned away by mental health and directed towards the Alcohol and Drugs Service, which you are really putting a plaster on the problem. It is not really dealing with the underlying cause, it is just dealing with the alcohol and substance misuse. There does not seem to be any clear use of Mind and other services, so there is no visible interaction between secondary care services and a third sector. If we refer somebody for Jersey Talking Therapies there is often a long wait, so people who are in crisis or have ongoing mental health problems have to wait a long time before they get seen. With regards to primary care, I think there is limited access to people who have poor income. People with chronic mental health problems, long-term alcohol problems, who may be out of work or on a low income, are going to struggle to get primary care services. People with chronic relapsing severe mental health problems, likewise, will have poor income and, therefore, not likely to have access to primary care and, therefore, more likely to use the Accident and Emergency Department. It is not appropriate for them to be seen there, they will often get told: “It is a G.P. problem; go and see your G.P.”, so there is no way for them to access mental health services. With regards to the elderly mental health services, again, if someone presents with a memory loss or a mental health problem, there is a long waiting list. Once they get into the service they get good care. But from a primary care perspective, if you have an emergency mental health problem in an elderly patient out of hours or on the weekend,

there is no support for you at all. The same with C.A.M.H.S., there is no out-of-hours provision for service. If you have an acute mental health problem you cannot get treatment that you require until the next day, which if somebody is actively suicidal or has a psychotic illness, it is far from ideal.

Deputy M.R. Le Hegarat:
A question for all of you: why do you think the demand has increased significantly?

Managing Director, Resilience Development Company:
May I just … sorry.

Deputy M.R. Le Hegarat:
Of course you can.

Managing Director, Resilience Development Company:
May I add just a little bit further to your initial question and just listening to you speak? Your first question, sorry, was about rise in demand.

Deputy M.R. Le Hegarat:
Yes.

Managing Director, Resilience Development Company:
I should make a very clear distinction that what we do, as a company, is we are right at the preventative side of things; mental health is a continuum. There is a big rise in demand just in prevention and good practice and avoiding that. But I would also say in the 5 years that we have been operating and building that scale, we have got to listen to a lot of people and there has been a lot of great work around stigma and things like that. As you were speaking, bear in mind we are on the preventative side; anecdotally I would support everything that you have just said. Anecdotally, just as a point of reference, that making the absolute distinction that we are on the preventative side, it is a universal programme delivered in schools, organisations, for people. We are meeting people who are saying the same things that you were saying, have used services and people have problems and challenges and not all are unemployed and then we get to see all of that side of things. Just, as hearing you, I thought I will just make that point that I would absolutely echo what you are saying anecdotally; it is what people tell us.

Primary Care Body:
Likewise, as a G.P., I am screening for physical health problems, looking for people with diabetes, high blood pressure, et cetera; primary prevention of mental health problems is not on our agenda

because the resources are not there. They are only being met outside of the States, which is frustrating.

The Deputy of St. John:

I guess it is fairly obvious that somebody who is not experiencing mental illness but is at risk is unlikely to go to their G.P. and say: "I am at risk, so I would like to pay you £50 for you to intervene."

Managing Director, Resilience Development Company:

Absolutely.

The Deputy of St. John:

But from your point of view you are more likely to have employers who want to employ you because they perceive the possibility that their workforce or their school attendees might be at risk, is that the case?

Managing Director, Resilience Development Company:

Yes, that is, absolutely. Well-being, productive people, happy people is an absolute commercial reality. In terms of what they are seeing, let us bring it right down to the point, what they are seeing is increase in absence risk, increase in sickness and reduction in engagement scores; that is a big generalisation. It is a big generalisation but that is what they are seeing and that is some of the things we reverse. Working with companies we would point you to outcomes where we have seen reduction in sickness levels, reduction in absence and turnover, and increase in engagement.

The Deputy of St. John:

Going back to you, Dr. Bailey, if people have been taking time off sick they will need to come to you or your colleagues to gather the way of it all to be able to remain off sick for a period of time, in other words, a certificate and certainly a diagnosis, if you like. Were you picking up a lot of these people as being in need of or needed support from a mental health point of view or do these people present with a physical malady?

Primary Care Body:

A lot of it is mental health problems; there is a lot of work-related stress, people are having sort of negative life events; separation, divorce, et cetera, that will cause them to have mental health problems. What my colleague is saying here, there are only some employers that are helping to build resilience with people. I think that probably needs to start with the schools, as much as anything.

[09:15]

For example, myself, and some of it is in drug treatment, I mean trying to do talks at schools. Obviously, that is in my own time, so that is very limited and I am very limited to what I can provide. I explored that with the Minister for Education; I sent 2 emails and I got zero response. It is very difficult to engage with people to provide those sorts of services; they just do not exist.

The Deputy of St. John:

Okay, moving over to you, Lucy, and you do not mind me calling you Lucy, I hope.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

No, that is fine.

The Deputy of St. John:

Where is L.I.N.C. in this mix?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

We have sort of developed, I would say quite quickly, over the last 4 to 6 months. So we have started working with some employers and I suppose it is, in a sense, quite similar to the work that sounds as though you are doing in terms of resilience. But bringing it right back and looking at things like developing and well-being policy with employers, looking at different audiences to try and gauge and understand them, what the problems are within certain teams in relation to, not just mental illness but our mental well-being in the sense of good mental health and poor mental health. Those sort of stresses and daily pressures we face at work should not be a barrier to us having good mental health. But, unfortunately, like the Health and Safety Inspectorate Report showed a couple of years ago, it related to figures that 61 per cent of all work-related ill health is stress, which is hugely significant and probably mirrors what you guys are seeing as well. We have been working with a few employers, as I said, working from the ground up, if you like, looking at well-being policy and then looking at early intervention around education but also having a team of counsellors and therapists that can then provide some intervention if it is required for certain people. Perhaps they are not that happy to go to their G.P.s or sitting on a waiting list to access statutory services. That is one area that we have been working on recently. The other kind of areas, I suppose, our main focus at the moment is in terms of recovery-focused services for adults and looking at preventing some of that social isolation that we know is so problematic and seems to be incredibly prevalent. It seems to be, again, one of those gaps, I guess. We talk a lot about recovery-focused practice and it is sort of embedded within policy but how that is being practised, there seems to be a bit of disparity there. We launched in January and recently pooled together a team of peer support workers who are working with us now to co-produce and co-deliver a social group of people who are experiencing problems with their mental health. People who are on a poor or low income or who

are not yet at that stage of returning to work and perhaps are probably with Social Security, they do have somewhere to start accessing some of that support. It is the first step in a journey of recovery but needs to come before those other interventions that are looking at building a C.V. (curriculum vitae) or looking at interview prep, all those kinds of things. This is right from the first step of just building self-confidence, building self-worth, helping people develop new skills and develop that confidence so they can look to the future with hope and return to work or return to meaningful engagement with their peers and their relatives. But often what we see is that ripple effect, is it not, when you are experiencing poor mental health and it affects lots of aspects of your life?

The Deputy of St. John:
You are involved in the aspect of business …

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
Yes, we …

The Deputy of St. John:
… presumably charging fees.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
We do charge fees. We have got a relationship with a couple of charities, so we are able to look at other funding options for people who are struggling to access us otherwise. We are trying to work really hard to make it as accessible as possible. We are not funded in any way by the States currently and we do not sit in the third sectors and we do not receive any public funding. We are in the middle of it at the moment with trying, as I said, to develop those relationships but these things, as you know, take time and we are at the early stages of that.

The Deputy of St. John:
Do you have any relationship with the psychiatric services or mental health services?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
Only in the sense that we have been supporting some individuals who have been accessing Community Mental Health, for example, or coming out of Orchard House, et cetera. Our sort of relationships with them have been in the sense that we are both supporting the same person. But I would say it has been quite challenging at times and, again, of course what you said, trying to work collaboratively with other services, you are not always met with the willingness and the enthusiasm that perhaps you would like and that perhaps would bring about better outcomes for people, which can be frustrating. But, at the same time, I can appreciate if you are feeling understaffed and under-resourced, perhaps that is not top of your agenda and you have got many other things to be

considering. I think, again, those relationships and those kinds of pathways, if you like, of signposting could be improved.

Managing Director, Resilience Development Company:

May I just add something to that because I think it is an important point? We submitted evidence as part of this review with clear outcomes, like reductions in stress. It is important to note that those outcomes, while they are coming from the Resilience Development Company, they are also a combination with Resilience Matters, which is a charity that was formed that receives no funding from the States or anywhere else for that matter. When I am stood in the school at 3.30 p.m. teaching teachers resilience over 9 weeks for 90 minutes a session, there is no charge for that whatsoever. I will just put that across as well. A lot of the work that we have done has been delivered with very little fees; very little fees. I would absolutely agree with what my 2 colleagues are saying here; it has been very difficult to access, yet there are some clear outcomes in that and some clear measures. I will put that point across because it is very easy, I am here representing the company to think it is a commercial operation; in corporate land it absolutely is. But what we kept seeing over that term, over that 5-year term, was people kept saying: "This is not taught in schools, you need to teach us." We set up a charity and we have trained 450 parents and worked with 2 schools so far and most of that has been done on an absolute shoestring for little or no cost. I just wanted to put that out there.

Primary Care Body:

I think the public perceive anyone that is being paid to provide a mental health service or a medical service is somehow in it for themselves.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Yes.

Primary Care Body:

People often sort of say: "The average fee for a G.P. is £40 or £50." But in fact the average charge per patient is about £24 because general practitioners in primary care appreciate when people are hard up and are not in work and are not able to access services from across all businesses here. I think it is only recently that people with mental health problems have had any sort of voice and it just gets shouted out by other areas.

Deputy M.R. Le Hegarat:

Thank you.

Deputy K.G. Pamplin:

Just before I get going and give you a bit of context of why we are here, obviously we are 6 months into our political careers and during the election period we all had our own individual reasons why we were doing it. But it became very clear when we all sat down for the first time, when we talked about the election thing as a Health Scrutiny Panel what we would look at, no surprise; mental health was straight up number one. When we started we wanted to have more into it than just us doing a review about mental health, so that obviously there was the mental health strategy. Our review is hinged on 2 things, look at halfway through the lifespan of this mental health strategy that was launched, how is it coping, how is it doing? Also, we wanted it to be led by everyday folk, which is why we did a survey. We just had over 350 responses, which in a short period of time says, I think, a lot. We wanted this review to be led by what is happening right now, led by real people telling us what is happening right now. Where you guys are really vital to this is to explore what is going on with the mental health strategy, so at the end of our report we have, as you said, David, some tangibles to reflect on. With that in mind, we had already got on the subject of prevention and early intervention and discussing some of the issues, why do you think that some of this has not happened in the mental health strategy? I am probably already hearing your answers about barriers but if we could explore or let us ask this another way: what is working, what is not working, as opposed to the mental health strategy? I will start with anybody who wants to chip in.

Primary Care Body:

It all just boils down to the money. For example, the Alcohol and Drugs Service, it runs out of an old building that is dilapidated; it is not fit for purpose.

Deputy K.G. Pamplin:

Would you say that the mental health strategy was not fit for failure because it is all about money and it is doomed to failure because the number one issue why it has not been successful is money? That is just a starting point and I am just …

Primary Care Body:

Yes, I think it is money. If you look at the Health and Community Services playing our part in the government, which was emailed to us last week, one of the underlying themes is that: "We must work within available budgets", bold. That seems to come through as very much the theme that they are trying to ask for more and more with … there is an increasing demand from C.A.M.H.S., for example, and the budget is not there. The Alcohol and Drugs Service have got half in equivalence of consultant psychiatrists; they need a full-time psychiatrist. Despite trying to get more G.P.s involved in looking after people with substance misuse, there is only me and another part-time G.P. who is about to leave the Island. There is no funding for it. Mental Health are not going to increase the amount of psychiatric support for the Alcohol and Drugs Service anytime soon. If I decided that

I would rather spend my time looking after patients who are going to pay me, then they would not have a prescriber.

Deputy K.G. Pamplin:

Ever since this strategy was launched in 2015, would you say there has been any improvement? If you were to look back in the past 2 years, would you look at that strategy or are you simply saying that it was doomed to fail because they did not address the number one issue?

Primary Care Body:

I think there are positives, there are always going to be positives because I was involved in the initial discussions around the mental health strategy and there were a lot of people who are very passionate about their area, be it the Alzheimer's Society or whatever. There is definitely a willingness to engage, like the Recovery College has started up as a consequence of the …

Deputy K.G. Pamplin:

Another charity though.

Primary Care Body:

Another charity and they provide an awful lot of support. But a quick fix would be … the States cannot get people from the U.K. to come over. The Alcohol and Drugs Service has been down 2 key workers for months because they cannot get people to come over from the U.K. People will come over for an interview and think: "Yes, it is very nice" and then they suddenly realise that Jersey's cost of living is significantly higher than it is in the U.K. and it just does not add up for them. There are those sorts of issues. There have been improvements, there is no doubt. Jersey Talking Therapies was good and its initial sort of start was excellent but, again, I think it is being choked by lack of funding. We used to have a psychologist that used to do a couple of surgeries in the medical practice where I work and suddenly has disappeared because she has left and has not been replaced. Part of the problem has been that the people who come over and are employed by Jersey Talking Therapies are not allowed outside of their working hours to provide a private practice, which people think it is a dirty word but it is not. We are in a financial institution-based industry. There are going to be a lot of wealthy people over here who do have private medical cover. By preventing people to come over to work for the States in Jersey Talking Therapies in their weekend or time off, to be able to set up their own private services, will automatically mean that these people do not exist because they are not going to be recruiting. It is those issues have thwarted any growth.

[09:30]

Deputy K.G. Pamplin:

You mentioned an out-of-hours service, the key part of the strategy was providing services to people accessible …

Primary Care Body:

It says in that, yes.

Deputy K.G. Pamplin:

Yes, but the reality is quite clearly at the moment that there has not been any movement on that because after 5.30 p.m. or even late at night, at 11.30 at night, what does any young person or elderly person do?

Primary Care Body:

I know.

Deputy K.G. Pamplin:

The Comptroller and Auditor General recently did a review on the healthcare strategy in Jersey; he said it was far too complex for an island this size. There are 324 charities and the large majority of those are health-based ones and there seems to be more charities growing all of the time, so that cannot keep continuing. What is the answer? Is the answer, going back to the Island's healthcare strategy, and I am just throwing this out as your opinion as a G.P., about making the Island's healthcare strategy more user-friendly? In fact rip it up, start it again, making G.P.s free access, thinking outside the box. Let us just take the money argument away for a second; how do you change it, as a G.P., to make the strategy work?

Primary Care Body:

I think you are right, maybe simplify it but the problem I would see then is, thinking from me as an individual G.P., with the States yet again reinventing the wheel. It is more money. It is like the hospital, the new hospital project, has spent an awful lot of money and has not really, in the public eye, got very far. As a lot of people think: "Well, you could have bought an off-the-peg hospital that is already predesigned on a bit of land that Health has already got, that would have got a hospital up and running for the cost it has probably spent looking for a place to put the hospital." Those …

Deputy K.G. Pamplin:

Sorry to interrupt.

Primary Care Body:

Yes.

Deputy K.G. Pamplin:

But would you argue that if we had had a health strategy with results that the answer of what a hospital need would be a lot clearer?

Primary Care Body:

Yes.

Managing Director, Resilience Development Company:

Yes, because I am interpreting your question, Kevin, broadly around what progress has Jersey made on employment in its mental health strategy? What further work is required? Point 2 of your terms of reference. Before I say what I am going to say next, I gave up all my time to be part of the mental health review and a lot of my time to be part of the Jersey Recovery College. To answer your question directly, that is a very subjective question to answer if the strategic review has no objectives. It has lots of goals and lots of intent but it does not have any objectives, does it? It says we will do this but it does not say by what and when. Coming from an environment where I come from, which is 22 years in industry, even though I gave up lots of time, that is where I would first start. Because I have read all the evidence, looked through all the evidence coming through here, I have revisited the strategic review, there are no measures. It becomes: have we made significant progress in X or Y? It is down to completely personal opinion, and that will be step one for me, is to make it a strategy rather than a statement of intent. It is like half a job. I am sorry if that is too blunt but I know no other way to describe it. It needs to be: here is what we want to do but by when and how much? The second point that was made quite strongly, perhaps we have done too good a job. Because one of the questions that was raised at the review was: if we are going to get stigma out of the way surely we are going to see increased demand for our services, surely we are; did not really see a lot of focus on that particular question. But it may be that we are doing too well but there are no measures around it. The other thing I would say was part of the challenge is it is a very acute, narrow focus on a budget, the limited budget is at the sharp end where it needs to be. It needs to be at the sharp end but what about all the stuff that was coming before, all that broad. Then I would say in terms of how it could be improved, maybe communication because 2 of us for our company gave up lots of valuable time. We tried to bring in other people from industry. There was very little communication and has been ever since. My broad summary would be change never happens in the centre, does it, real change; it happens right at the fringe? Maybe, and it is my perception and my opinion, that perhaps health, the system, is a little too insular and maybe it needs to look a little bit more outwards and have a larger discussion. Because it goes back to the question that you asked earlier that I do not think we answered: why do we think it is? You have got to look broader, look at the leadership gap that Jersey has. Who has the biggest impact on your day? Your line manager. Look at the level of advice that we give about mental health. I do not mean any disrespect but it is generally very well-meaning in the parts. It is not specific skills-based that you have referred

to. Look at the demand of work, only recently, only last week I think, we are all working probably one more month than we should in overtime. Then I go back to this stuff is not taught in schools; it is a little bit insular. It is all connected, is it not? It is a very difficult question to answer unless you have got the by how much and when and it is a very difficult question to answer if all your focus, which it quite rightly has to be, is on the acute end of things, where people are in absolute dire need and it is a little bit of budget either working with mental health but where would I spend my first £100,000 if I had it? Where it is absolutely needed, at the acute end. Where would I spend the next pound after that? I would be taking a much broader picture. But in all of that, if there was one thing I would say, is perhaps go back to that mental health strategy, start defining some absolute; this is what good looks like. Otherwise we are going to continue to have this conversation. At the end of the day there are people in our community that you see and you see, that I see that need help.

Deputy K.G. Pamplin:

You mentioned communication, so as well as the lack of communication, you implied, between the governing bodies of health and who the people are that are involved in that.

Managing Director, Resilience Development Company:

Yes.

Deputy K.G. Pamplin:

But in the wider stretch of everyday folk, how would you see the communication to the outlet? When the strategy was launched, how was that interpreted, what does that mean and, going forward, what services are available? Because obviously, again, thinking the fact that we wanted this to be led by everyday folk telling us, and it will be probably no surprise for you to hear that a lot of these people did not understand or know what was available or what the strategy was and what service to go to.

Managing Director, Resilience Development Company:

There you go. That is why we should have had some measures in; how are we going to measure the quality of our communication with our key stakeholders? How are we going to measure it and at what frequency? What would we define as quality? All real key measures, that common sense stuff. I have to say as well, because I do not think I have said it, I am not implying that communication was poor; communication was poor, so let me move that from implication to my actual experience of it. That said, there are some very passionate people in that mental … that were in the original mental health review and there is some great work being done, some absolute great work being done. I would pull out singularly Andrew Heaven has taken a great lead on it and looking through some of the evidence I note that that is now not there. Perhaps we are back to leadership and getting some really strong leadership in there and setting some really key measures.

Primary Care Body:

That initial work was excellent for putting people in touch with each other's services. From a primary care point of view, I met a lot of people who I have built links with that will directly improve my patient care. If I had not gone to that I would not have had access to … likewise, I think a lot of third sector because their funds are limited; they put their first £100,000 on to the front end of helping people and do not necessarily communicate with their services to the public. Again, it comes down to a business, providing healthcare is not a dirty word. It is often very nimble and can respond to people's needs because they are a business. They are often looking at the bottom line probably a little bit harder than maybe the government would because it is their profits that is used to provide a service.

Deputy K.G. Pamplin:

Just to be clear before I finish: when was the last time you had communication from the people from your input to the strategy?

Managing Director, Resilience Development Company:

I could not put an exact date on it but 12 or 18 months would be … and, again, I assume this would be with improvement, if you are asking me how I would do it and where do people go? Where are these people that are not in the system? Where is everybody else? They are at school and work, generally speaking. Why are we not communicating with people at school and work and measuring whether those messages are getting through? That is my point around it, being just a little bit insular, as opposed to … you are asking the wrong person, it is about asking people who want to receive this information and receive it. How do they want to receive it? Where do they want to receive it and what would be convenient? Because the rest of the system is dealing with the acute end of it. Bear in mind I am not a professional in that area, it is just my way of describing it.

Deputy C.S. Alves:

Okay, Dr. Bailey, you mentioned there were certain services that you did not know about, following … I just wanted to ask, in general, do you think G.P.s are adequately supported in managing individuals presenting with mental health issues?

Primary Care Body:

Not by secondary care, no. The points I made at the beginning is that if I am in surgery tomorrow morning and someone comes to see me with an anxiety, depression-type problem that may be associated with alcohol, then if I refer them to Jersey Talking Therapies they might have an initial telephone triage, which would assess their severity and, therefore, how quickly you are going to be seen. But in all reality, they are probably not going to be seen within 2 months, 3 months. Then if their drinking escalates to a point that they feel that they are better dealt with by the Alcohol and Drugs Service, the Alcohol and Drugs Service can help them with their drinking but by that stage

they might be in a much more chaotic position through their drinking but they are not going to necessarily engage in the services and you have missed the opportunity at the beginning 3 months ago, and that is a common underlying theme. A teenager comes in with their mum with an eating disorder, they do not get much support. For a while there is no specific eating disorders team, C.A.M.H.S. are dealing with 2 or 3 psychotic individuals on Robin Ward, trying to find them support in the U.K. possibly. They do not have time, they have got the willingness but there are only so many people who can only work for so many hours in a day. Even when they are seen … I saw a young lady with anorexia this summer who I was weighing every week and doing a blood test on every month, which I was happy to do; I am a doctor, I am her doctor and I know her family and we provide the service. But I am not going to charge somebody to see me every week and, okay, putting someone on a set of scales is not exactly ... you need a medical degree. But you have got the responsibility of helping them, you spend a bit of time talking to them and trying to help them through and working with C.A.M.H.S. But part of me thinks: "Why am I weighing somebody once a week?" I am a G.P., I am a doctor; I am supposed to be doing more doctorly things. Why am I taking blood when a healthcare assistant can take blood? Okay, I was adding the value added by being a friendly, professional ear, et cetera. But, to me, that is the sign of C.A.M.H.S. are struggling to support and without primary care. If I was a hard-headed businessman, she would not have seen me.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
I hear that as well. I think that a lot of the people that we are seeing, without exception I would say, bar the younger clients that we have been supporting, every single person that has come in and having been prescribed something by a G.P. are either on medication for depression or anxiety and have more of them that are not being referred to Jersey Talking Therapies. We have people who have been sat on the list for a year and they are still not accessing any therapies. If you look at the best practice step-care model of treating these kind of common mental health problems, when you prescribe a medication there should be something with it. It is not just a case of giving somebody an antidepressant and then off they go.

[09:45]

We were at the G.P. Symposium this year and were able to talk to quite a few G.P.s and it is this dialogue around, we know they are going to wait for a long time to access any kind of meaningful intervention but what else is there? Where else can we assign them to? What else can we offer our patients bar medication?

Primary Care Body:

That is an excellent point. I can prescribe somebody a pill, it will make them feel happier but 6 months later you stop and then they might relapse, so that they have not had an opportunity to build any resilience and, likewise, there are no opportunities provided by the States for them to have sort of preventative-type practices put in as well. You know that there are people out there, through family history or social circumstances, who are at risk of getting mental health problems in the future. I am sure that it is just an unmet need.

Deputy K.G. Pamplin:

Sorry to interrupt, Lucy; you say in your evidence about Jersey Talking Therapies is a welcome addition to the provision on the Island. It has been mentioned now a couple of times, I think it is best to join it up. If somebody is prescribed or referred to Talking Therapies but will have to wait a year it is not working. In your opinion, how would you make it work?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

If we sort of eye up services within the mainland and the models that they rely upon, obviously I understand recruitment right now is a problem for J.T.T. (Jersey Talking Therapies) and I gather that is being addressed with new practitioners due to join the team. But they are a bit more sort of innovative in some of their iApp services. They look at digital-based interventions, which for some people …

Deputy C.S. Alves:

It was the next question, yes.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

There is a particular programme we have just introduced to Jersey called SilverCloud and it is used within 80 per cent of iApp services in the U.K. It has got huge coverage because it has such a broad evidence base. Some of the services, in Berkshire for example, they have been using it for a little while now; they are showing and the data is there that up to 30 per cent of people accessing an iApp service is choosing it as their preference over a face-to-face intervention or attending a group. For those people, which could be a significant number of people in Jersey who are otherwise sat on a waiting list, they get choice over what treatment they are engaging with, they get instant access. Because the intervention itself, the programme, is the intervention, you do not need to sort of really experience clinical expensive therapists to deliver it. The supported element of that programme can be a counsellor. They have even done trials with sort of trained volunteers and are showing the same outcomes. They are maintaining recovery rates for anxiety and depression using standardised assessments that you would use in face-to-face modality. What evidence is there? You think, well, if this is available and it is working well in other iApp services and the evidence is there and it is cost-

effective and slashing waiting times, there are all these massive key drivers behind it, why are we not using it?

Deputy C.S. Alves:

L.I.N.C. provides this online mental health service, is that right?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Yes.

Deputy C.S. Alves:

Yes. What has the uptake been like?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Only recently we were working with SilverCloud last week to redesign the site and it was a little bit clunky, as sometimes new systems are, so we go ... this is one right now, it is tricky. Again, in terms of charging for a service, we know that is a huge barrier for a lot of people. We have been able to offer out with some of the corporate clients that we are working with in terms of the workplace well-being programmes, they purchase some licences to distribute to employees who might benefit from it. I think having that flexibility and convenience with when you engage with it, you do not have to get time off work at 3 o'clock on a Wednesday afternoon to be somewhere every week; you can do it in your own time. It is really favourable for people who are leading busy lives and in corporate settings. In terms of being cost-effective, obviously it will cost a lot less than if you were to engage with somebody in a face-to-face sort of environment. In terms of individuals using it, we have had some update but I do think the cost attached to it is a barrier for people unfortunately. It is one of those things where we are in a catch-22 a little bit. If we could offer out to everyone without any cost, great but we are not in a position to do that currently. Guernsey also recently introduced SilverCloud within their healthcare services with good uptake. It is used, if it is available to people.

Managing Director, Resilience Development Company:

I would add a little bit of flavour to … we are obviously face-to-face but we do deliver all of our stuff online and support it online. I am not here to talk commercially but for all the evidence we have submitted on the parents and students we help, there is certain evidence in commercial. The point is people will take it up if they are motivated to take it up; if it is engaging, all right, and it will get an impact because we use some things in our programmes that come directly out of real good evidence-based practice. People would be more averted to use this; it is our experience of our own product but that is our own product.

Deputy C.S. Alves:

I think you have covered a lot of what I was going to ask at the moment. You mentioned waiting lists as a recognised problem; I think you have all mentioned that and obviously you have just mentioned the online kind of way, is there anything else that you think could help to reduce the waiting lists? Obviously, you have mentioned money but is there anything else you think that …

Primary Care Body:

I think the initiatives that you were saying, you could send out an appointment letter to say: "Look, it is going to be 3 months, why do you not look at this?" Provide them with a link and, okay, some people might not take people up on that. Some people do like their face-to-face counsellor, talking to a human being type thing but some people do not. Some people just want to get the skills to be able to sort of move forward. I think that sort of initiative, I know it costs money but it is going to be cheaper than face-to-face counsellors and time out of work, lost productivity.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

Yes, it also really engages with certain sort of demographics within the community that perhaps otherwise would not come to us and say that they are struggling with a mental health problem. It is sort of showing that targeting men, who we know have a high rate of suicide, et cetera, has been really effective as a socially acceptable way to have therapy, rather than going to see a therapist. It is usually the best one because the programmes in it are all very tailored. You do still have that other clinician, you do still have that kind of knowledge of: "Okay, I am going to make sure this is appropriate for whoever is going to be participating in it", so it has all these kind of facilities within it. I do think we need to start thinking outside of the box a little bit more and rather than just falling back on tradition in what we regard as therapy and what traditionally we regard as mental health service and the roles between those using and delivering services. It is all of these things I think we need to take a look at and …

Deputy K.G. Pamplin:

Is that where, in your evidence, you talk about where G.P.s have little option but to prescribe drugs while individuals wait to access alternative therapies? Do you think there is a problem growing here, that the longer people have access waiting for services, the longer they will just remain on purely just the drugs to keep them going until they meet a therapist? Is that a problem you were alluding to here?

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

It is a trend you tend to see. The rates of prescription drugs in the process have gone up year on year since 2011, I think, where the research goes back to. That is obviously going to have an impact on people. If they are waiting to access the interventions that are going to give them the skills and the strategies to think better, to feel better, it is going to have an impact. I think sometimes we still

have a little bit of this reliance on the medical one, rather than looking at recovery-rotated care, which the Jersey Recovery College is fantastic and they do some amazing work. But recovery-focused care is not one service in isolation of anything else, it needs to be embedded within your mental health system and everybody working on those principles, which, currently, I think perhaps that is not always the case. As my colleague here mentioned, it is not because people do not have the passion or that we do not have fantastic workers within our workforce, it is that they are being restricted in some way or even through staff shortages, lack of resource or lack of funding, whatever it might be, that they are having to sort of rely on that medical model of medication, risk management, sort of almost box-ticking, rather than working with people in a way that is a bit more meaningful and recovery focused.

Deputy M.R. Le Hegarat:

This is a bit of a random question and that this is for you, Dr. Bailey, how much would it cost for you to prescribe an individual one month's medication in relation to anxiety or stress? Do you know that? Because what I am thinking is, is that we say medicate but how much does that cost? I know it does not cost me, as an individual, anything because our prescriptions are free. But it would be very interesting to know how much the actual medication costs, compared to the alternative cost, if that makes some sort of sense.

Primary Care Body:

Yes. A packet of Prozac is cheap as chips.

Deputy M.R. Le Hegarat:

Is it? Okay.

Primary Care Body:

I do not know, the cost price of Prozac, I would be surprised if it is more than £2 a month.

Deputy M.R. Le Hegarat:

Okay. Because I just wondered whether we were … sometimes costing you more than …

Managing Director, Resilience Development Company:

Interesting. What is the cost of having to sit down with your children and tell them that your mum is not dying? Because that is a cost I have put.

Deputy M.R. Le Hegarat:

Yes.

Managing Director, Resilience Development Company:

All right. We can say that £2 is cheap as chips while you wait a very, very long time. But you are comparing medication versus life really.

Deputy M.R. Le Hegarat:

Yes. I just wanted to know that …

Managing Director, Resilience Development Company:

Yes, I understand that and I think, personally, it is a great question. I also think, what is the cost in terms of us as an Island and people? If I had an unlimited wish list is, what is the average amount of time that people stay on medication and for how long? Does it really ever change? Because that would be my reality, my personal experience. But I do not think you can put that £2 for a cost of tablets with a cost just in people's lives. I just go back to your point there, I mean it is not lost to me, you have 2 people sat in the room that offer an alternative service. If we just keep doing what we have always done we get the same results. Perhaps the answer to how do we reduce waiting lists, is to try something different. Not necessarily what I offer or what you offer but just to try something different. In order to do that my suggestion would be we would probably need to create the space for people to do that because it sounds like constantly there is no space from within that system, something has to change. Waiting lists for services, all sorts of different services are reduced all the time all over the world. I am sure there are lots of ways to tackle it, if we have the space to do it. Again, it would need budget and resource and people.

Primary Care Body:

Yes, my hypothetical patient tomorrow morning I am going to start on medication. The usual scenario is that you would see somebody, say, 3 to 6 months; you would see them quite frequently to start off with and then increase the period between appointments and then you would try and wean them off. It is probably not an uncommon scenario for them to stop the medication and go straight back to square one, which, again, it just comes back to. Because you could sort of say, right, okay, someone comes to see me tomorrow and in a month's time you will say, right, how many of them are treated? You would get a good outcome and people would look at that but then they would not necessarily look at the 12-month outcome when they try to get them off medication and they are still on medication; they are going to be on it for years and years and that long-term cost will add up. From a human point of view, it is not just about a sticking plaster.

Deputy M.R. Le Hegarat:

No, I must admit I did not … yes, I would hate you to think that I was asking the question because I think medication is a better option because you are talking to somebody who clearly does not think that it is because I would avoid any type … and I do not think that medication is always the answer,

although sometimes it may be; it depends on what it is. But, let us be honest, we all know that if you have got mental health difficulties, then you need … even if you are on medication, it is not only about medication but it is about supporting all of the other areas as well. But it was just one of those, sometimes the sort of light comes on and you think, in actual fact everybody says it is money, money, money but sometimes what you are doing can cost more, even in the financial terms. I accept totally what you say in relation to …

Managing Director, Resilience Development Company:
Yes, but all we have done there is compared the cost of the drug and the cost to deliver it and all the other associated costs. I would imagine it turns out to be pretty expensive over a 12-month period when you throw everything …

Deputy M.R. Le Hegarat:
Yes.

Primary Care Body:
Looking at another example would be Thursday afternoon for me, my Alcohol and Drugs Service Clinic. The cost of methadone is cheap. An average dose of methadone would probably be pence but then there is the cost to society would be the dispensing and that that is quite expensive. It is something like £4 a day from the pharmacy, and not to decry my pharmacy colleagues because a lot of them are very good and they are very supportive and they go over and above just providing medication.

[10:00]

They will befriend people and help them through on that level as well. But a lot of these people have had a lot of negative events in their lives that have led to them going into drug addiction, which have led to them coming into contact with the criminal justice system, which further means that they cannot get a job. I cannot help but think that … and there is only one psychologist at the Alcohol and Drugs Service for a caseload of 300 people or whatever they have. If you help people get back into work is a big thing, it means that their time is occupied, it gives them self-worth and they get an improved quality of life. They mix with people who are not also using drugs and involved in criminal activity. It is just that one stepping stone that if you invest in them as an individual you get the rewards back.

Deputy K.G. Pamplin:

Just to be clear on that: are you suggesting that the problem with alcohol, from what you are seeing, has not improved, in fact it is getting worse? From what you are telling us because there is only one psychologist, that clearly is not good enough for the demand that you are seeing.

Primary Care Body:

Yes.

Deputy K.G. Pamplin:

But if there is an alcoholic problem that leads to substance abuse, drugs and alcohol.

Primary Care Body:

Jersey Talking Therapies, their remit is to deal with people with low levels of alcohol problems. But Jersey has got the second-highest consumption of alcohol in northern Europe, so we are bound to have an increased prevalence of alcohol-related illness as a consequence to that.

Deputy K.G. Pamplin:

You are not seeing a decline, you are seeing a continual problem with alcohol abuse?

Primary Care Body:

Yes. The reason I hesitated there was that I think it was about 10 or 15 years ago and about 3 years ago there was a study done by an outside university on the drug use sustainable on Jersey. The second survey did not look at alcohol and obviously someone like Andrew Heaven and his department would be able to give you the exact figures but alcohol is still a big problem.

Deputy C.S. Alves:

I just wanted to elaborate a little bit on what I asked you before, you are in quite a unique position, I think, because you work with the Alcohol and Drugs Service as well, so you have got those underlying skills, if you like. In general, G.P.s are just that, they are general practitioners, so they do not necessarily have any specialisms in mental health and what have you. Do you think there is enough support and sort of training out there for them to feel confident enough?

Primary Care Body:

By nature, as a general practitioner, you are a generalist. There are people with special interests and those dealing mental health problems. But because we deal with a lot of mental health problems, G.P.s do provide a lot of mental health support. I think that if you provided more training, then it is never going to go amiss, of course. But I think the most important thing would be to provide … the mental health first aid type things are really good initiatives. If people knew about them and could access them, be it face-to-face or online, would be important. Perhaps empowering people

to treat themselves or help themselves, make themselves more resilient, is just as important as providing training for general practitioners. There is a lot of training out there for G.P.s online as well and a lot of G.P.s go off Island to get training as well. Providing training would be good but it is not essential. You would get more bangs for your buck by providing it at the coalface.

Deputy C.S. Alves:
Okay, thank you.

The Deputy of St. John:
I have got a sort of lurking question, the relationship that you have with the … I will call them psychiatric services; it is an old term. You have observed that they are struggling and they will say that they are struggling and cannot recruit people. They will also say that they have, as a workforce, sufficient training. I spoke to the Mental Health Services manager here the other week and I asked what training did the nurses that provide the service receive. The response was they received their training, they go through their training course and that is the foundation for their ongoing clinical service. It did not seem that there was any additional training or an effort to upskill, so that they become more effective as a body of people. I am just wondering what your observation about it is and your thoughts on the matter.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
I think there is a shortage on Island of certain training, sort of professional training, I guess. I know myself and us at L.I.N.C. and within the LV Group, in fact we will access training on the mainland. Any kind of Master's degrees, additional qualifications, we tend to access on the mainland. I know the training and development on Island there is, I think, a couple of Master's degrees now you can access in terms of advanced nursing practice but there is not a mental health pathway available. It is the clinical practice, which is geared more towards general nursing, so you cannot really access that on Island. A lot of the other sort of training, as a nurse, that we would be expected to engage with, we have to do a certain amount to keep our pin valid, to revalidate it every 3 years and then we keep our registration current. A lot of that, you can do bits online or it is a case of attending conferences; it does not sort of dictate specific training that you have to do that is sort of mandatory, if you like. A lot of it comes down to your area that you are working within and your personal interest. I guess it would fall on individuals perhaps, more than it might in other areas, to seek out and engage with that training, rather than it be something that is expected as part of their role or provided as part of their role really.

The Deputy of St. John:
Is there any generic experience that G.P.s, nurses, O.T.s (Occupational Therapists) and others within mental health might dig into upgrading their response to the client group?

Managing Director, Resilience Development Company:

Do you mean to self or to the client group?

The Deputy of St. John:

To the client group.

Managing Director, Resilience Development Company:

Okay.

The Deputy of St. John:

But certainly I am talking about upgrading yourself in order to improve presentation to the client.

Managing Director, Resilience Development Company:

Yes, so that was a point of clarity. As a company, we have trained prison officers, firefighters, hospice workers; we have trained 100 mental health and social workers in the N.H.S. (National Health Service). We have showed them our brand of resilience training and had the exact same results that you have seen in the evidence base and they are case studies. Right, so there is that itself, our brand of resilience training, it is about self-leadership, it is about understanding how this works and to recognise things like stress and anxiety because if that is not dealt with that leads to a certain place. But to go back to your initial question, I would say, as a supplier of those, and bear in mind most of the time I am sat like this, I am a suit, I have never been a nurse; they are the hardest people to get to engage straightaway. Because they tend to think because they have done a degree in nursing or they have done a degree in teaching or social work that they know it. Then we come along and show them … they do know it but they have never seen it like that, to get a different outcome and you are likely across the board and go: "Yes, okay, yes, perhaps you have showed us something here." Again, if the panel wanted to see the case studies of the commercial work that we have done with nurses and mental health and social workers, we would be happy to provide that. Clearly, we have not but we would be … but that would be my observation, is generally when you are in it and you are in the thick of it and you are dealing with it every single day, you almost feel like there is nothing that you can learn, particularly from somebody from another environment coming along. But my experience over 5 years has shown me that that is not the case.

Primary Care Body:

Because the people on the shop floor are overworked and if you have got people that are overworked they are not going to have much room left, much energy left to take on new skills, so it is a bit of a vicious circle really, is it not?

Managing Director, Resilience Development Company:

It is, yes.

Primary Care Body:

At the end of the day, most people who are in healthcare are more than willing to take on … if someone told me: "There is this new way that you can treat somebody with something else", you would pick up that skill. But if you have been sitting in your surgery from 8.00 a.m. until 6.00 p.m. and said: "Hang on, why do you not just stay another half an hour and learn about resilience?" You are just thinking: "Hang on, I need a cup of tea."

Managing Director, Resilience Development Company:

Yes, the key word is skills-based, so all of our stuff is skills-based. It is not theory, it is not information, things that they have come across before. It is all skills, here is how you do it. To answer your question very specifically, Trevor, yes, there are things out there, our stuff included, so possibly like the thing that you are doing as well. There is lots of stuff but you have got to know that you need it first and then you have got to create the time and spare some budget to be able to do it. But if you are asking specifically, yes, there is; Jersey based, not just U.K. based.

Primary Care Body:

You can never learn enough. I have been prescribing for about 5 or 6 years and went to a motivational interviewing course and the skills that you pick up on that, they are not hard science but they are really useful.

Deputy M.R. Le Hegarat:

I think we have probably established already that you probably do not think that there are adequate resources in Jersey in relation to people in crisis. Recently the government had run a pilot, which saw both police officers and Mental Health Services working together, do you have any observations in relation to that particular pilot scheme?

Primary Care Body:

I am not aware of it, no.

Deputy M.R. Le Hegarat:

You were not aware that the police and … okay, because obviously up until recently because the emergency services, as in the police, find themselves in a position where quite often they are taking on board people who are in crisis, they had linked them together. But due to sort of financial constraints, I think, or at least workload, they were discontinued. Do you think that there is sort of

any - how can I say it - capacity for something of a similar nature to work well? That might be the question better to ask.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

I think the fact that the workload for nursing as a whole was an issue, highlighted there is a need for it. If there are people in the community here who are experiencing crisis with their mental health who are coming into contact with emergency services, I think it is fair to say probably the most appropriate people to react and manage those cases are mental health nurses or people trained within mental health, rather than having that kind of burden in some ways on our emergency services, who obviously have their own things to be dealing with. It is an extra role, it is an extra hat for them to wear, that I would probably suggest there are more appropriate people to wear in those instances. But, like you say, it comes again back down to whether there is funding for that. I do not know.

Primary Care Body:

It is an interesting point, is it not, really? Because it is important to have people who are appropriately trained to deal with mental health problems. But the point that you are making as well is that if you are providing them with some skills that can just deal with people who are in distress, it has got to be a good thing as well. I imagine a lot of the emergency services provide that anyway, having a chat to somebody. There are probably things that are not taught to them that they pick up on the job, the kind word and a bit of friendly support. But if you structure that with some appropriate training you can probably make … they are more effective at helping people.

[10:15]

Managing Director, Resilience Development Company:

Yes. I only have just an observation because that is not my sphere, would be we do a lot of work after people have been trained in mental health first aid. The challenge with training people in mental health first aid is if they are not careful they can carry quite a lot of emotional burden. It is all great stuff but you have got to make sure that you are supporting the people who are supporting the people. But I also sit in the camp that the world would be a lot better off if we just recognised people there and then in the moment, whether that is a policeman dealing with somebody in the community or if it is me shopping at Waitrose and just getting a sense that somebody next to me, who is not quite right. All it took was one or 2 words, which were: “Are you okay?” The answer is clearly not, yet lots of people had passed her in the supermarket. I know that is a bit dreamy but the point is it has got to be a good thing, is it not, that police officers are out there? But we have got to make sure that we are looking after the police officers as well and they are appropriately trained to look after themselves once they are dealing with people in that situation.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

My understanding - I have read a bit around the pilot there - and obviously a lot of us hear the police are going to come into contact with or the ambulance service have some mental health need, but the nurses that were being accessed as part of the pilot work with people who perhaps had a greater need. There was substance misuse involved and there was a diagnosis where there was some sort of clearly psychotic illness. It was one of those more clinical cases, if you like, that perhaps somebody in the mental health first aid training only would struggle to support effectively or, like you say, be left in a situation where they are expected to manage a situation without necessarily the skills or understanding to do that, to bring about the best outcome. I think it is getting the balance, is it not? We do need to make sure that our emergency services and those working in a public place will now have the skills, the sort of strategies that you teach. But I think let us not overlook the fact that there is the clinical aspect to consider as well and that a lot of things come into play within that. Expecting our emergency services to manage those situations that do present more risk or there is a mental illness that has arose to poor mental health and all those economic issues that come with that is quite a large task. The fact that there were liaisons with the nurse on the pilot and workload has been cited as one of the reasons that it has not continued, I would say, is indicative that there is a need.

Deputy M.R. Le Hegarat:

The strategy also refers to the word “place of safety” but this does not, obviously, really exist in Jersey. Do you think that a place of safety is required and how do you think that that should be delivered?

Primary Care Body:

I pointed that out before.

Deputy M.R. Le Hegarat:

Sorry?

Primary Care Body:

I pointed it out before, for example, with C.A.M.H.S., there is no place to admit children; yes, that is shameful.

Deputy M.R. Le Hegarat:

But just quickly following up on that, do you think there were sufficient numbers to have a totally separate facility?

Deputy M.R. Le Hegarat:
Talk to C.A.M.H.S. and you will get the answer, yes.

Deputy M.R. Le Hegarat:
Yes, we will but there is an ongoing process.

Primary Care Body:
Yes.

Deputy M.R. Le Hegarat:
But I just wondered from your perspective.

Primary Care Body:
Orchard House, they do the alcohol detoxes. Okay, a lot of alcohol detoxes are done by the Alcohol Pathway team in the community and that is appropriately done and it is safely done. But if somebody has complicated medical needs or mental health needs, then Orchard House is the place for them and they have got a long waiting list. I had somebody in crisis 2 or 3 weeks ago, needed alcohol detox and you do the referral but you know that they are going to be waiting.

Deputy M.R. Le Hegarat:
Yes.

Primary Care Body:
That sort of place of safety, yes, it is needed.

Deputy M.R. Le Hegarat:
What about in the out-of-hours type scenario? I think I was sort of looking from the point of view that quite often people end up within the cells in the States of Jersey Police and that was sort of the … we do not appear to have any facility for the out of hours and I just wondered whether …

Primary Care Body:
The same goes for elderly mental health problems if you have got someone … okay, that could be difficult because sometimes they have got a medical problem that needs to be addressed beforehand. At the moment the policy seems to be that anybody who is elderly with an acute problem, mental health problem, has to be seen and admitted under the medics first to make sure that they are safe to go into a bed, which is just unofficial policy for saying we do not have beds.

Managing Director, Resilience Development Company:

Can I say the elephant in the room because I feel I must?

Deputy M.R. Le Hegarat:
Yes, certainly.

Managing Director, Resilience Development Company:
Is it not a bit Victorian what we are talking about? Are we not supposed to be civilised? I am sorry to keep playing that card but there are 12 people in this room; let us just take some of the stats that we have been talking about. It means, possibly, 3 of us would find ourselves in a position whereby there is no place of safety. Right, that is Victorian. Just take away everything else, and I do not mind that it is a matter of public record, considering we live in a civilised society, perhaps that is the biggest symptom of the problem that we allow that and we think it is okay. If it was me or if it was you or if it was a member of my family out of hours, we would not be able to put them where ... we would not be able to give them a place of safety. Personally, as a proud Jersey resident, I am quite ashamed of that and quite embarrassed about that as well and I think that should be put on record. We have a system, yet we have no place of safety; that is inherently wrong. It is inherently wrong.

The Deputy of St. John:
I do not think we disagree with you at all on that. We are about to build a new hospital when we get round to seeing about where it should be located. But we have established, and I would really like your opinion on this, that it would probably be appropriate to co-locate the psychiatric services, intervention psychiatric services for adolescents and for adults on the same site as the general hospital. There are plans to currently … and that is changing, we hope, that currently are plans to locate the psychiatric facilities on the Overdale site. But we are looking to try and amalgamate both general and psychiatric services. Do you think that would be a desirable thing to do?

Primary Care Body:
It has got to go somewhere, the Overdale site is there. The other site at St. Saviour as well, that could have been developed.

The Deputy of St. John:
What about the idea that psychiatric services should be co-located in the general physical service?

Managing Director, Resilience Development Company:
There is an argument and we are talking about mental health, which is just exactly the same as physical health, exactly the same. Where we can get to the point where we are able to talk about mental health in exactly the same way as physical health; that is one we would have moved on. That is all I can really offer because it is beyond my area of expertise. But, again, I would hope to

live in a society, when the hospital is built, that mental health is just the same as physical health. Why should it be a separate thing tucked away somewhere or even just think about it from convenience and access to other services? I have heard a story of people needing access to other services. Why should they not be competing for the user? If you just look at it like that; that would be my view, Trevor. If we have no stigma around mental health, then why does it need to be somewhere else?

Primary Care Body:
The adult psychiatric unit got kicked out to make space for the day surgery unit, I believe, is it not? That is where it used to be.

The Deputy of St. John:
Say again?

Primary Care Body:
The adult psychiatric unit used to be where the current day surgery unit is, that block in the hospital.

The Deputy of St. John:
Yes …

Deputy K.G. Pamplin:
To pick on your point, David, about between systems, I do not know if any of you have been to Orchard House.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:
Yes.

Deputy K.G. Pamplin:
How is anybody supposed to get well in an environment in that? Whatever we are talking about here it is the health of all of us, we need to establish what I am picking up from what all of you are saying, is a strategy that does what it says on the tin. But we need to be better. We need to create a place, an environment that everybody is holistically working together; the whole point is we get stronger.

Primary Care Body:
If we think of the potential that is there, there is Queen's Reservoir, a nice, peaceful area for people who could recover and yet it is the current Orchard House. It just feels a bit conveniently out of sight, out of mind.

Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing:

I think that goes for the community services site as well because it is not in the best state of repair. When we are working with people they are very receptive to the environments in which we are supporting them in. If they are getting the message that the furniture is old and things are falling apart and it does not really send a message that they are valued and that we care and that they are important. You would not expect to walk into the General Hospital and see the same kind of issues I think that you would sometimes walking into mental health facilities. There is definitely a difference; it is quite stark. I think it goes back to what you were saying, there should not be any difference in the way that we deliver care, the way we consider mental health care; it should not be any different. It is that parity extreme, is it not, that we are kind of …

Managing Director, Resilience Development Company:

Again, neither myself or you are practitioners, I do not think, Kevin, yet you have just heard: how are you supposed to get well in there? What about the people that are working in there and delivering? I am an expert in engagement and environments and getting people engaged, just thinking about it like that. It is a theme, is it not? The theme is insular, looking in. That question is: how do we get 100,000 people really behind that mental health strategy? Not how do we get the acute services behind that? That is why it is a little bit narrow and not as effective. But I still raise my very first point, it has got to come back to not just what we have got to do but by when, how much? That is what will define the quality of resource.

Deputy M.R. Le Hegarat:

I am conscious of time and how much the 3 of you have provided to us and for that I am exceptionally grateful, the families are exceptionally grateful for you giving your time. Because from our perspective we really do need to speak to a very cross-section of our community to find out where our services are and where we need to be going really. Part of this process, I think as Kevin said, was all 4 of us who come from very different backgrounds, all came up with exactly mental health because we all felt that there are areas that we really need to improve on. But obviously our process has to be to evaluate where we are and where we need to be and how we are going to achieve that. For your time we are really, really grateful. Thank you very much. If there is anything that …

Deputy K.G. Pamplin:

Yes, any questions for us?

Deputy M.R. Le Hegarat:

Yes, that you have, then please feel free. Stunned silence.

Managing Director, Resilience Development Company:

In the absence of any key measures for that review, how are you going to evaluate progress?

Deputy K.G. Pamplin:

Our review, how this scrutiny process works, at the end of our evidence-gathering we will issue a report to Government, the Minister, and in there will be recommendations and we are going to be including and seeking key measurables. Obviously, we will be referring a lot to the evidence that we have gathered and the survey that we have conducted and applying it to the strategy, which is halfway through the process. If that strategy is going to be successful, they are the sort of things we are going to be recommending. Obviously, we will be, as part of this process, doing a public hearing with the help of the Minister towards the end. We will be seeking those sorts of things. Then at the end of that process we do not go: "Well, that was good, that is done." I have a personal commitment, if I achieve nothing else in the next couple of years, to make this happen and I think that is the will of this panel and it is the will of everybody and we want to see it through, so that is …

The Deputy of St. John:

I think the way it is looking is that there is likely to be some very uncomfortable truths put over in the report and we are not going to actively put this report on the shelf and just leave it there. It has got to be a meaningful contribution to Government and the decisions taken by the Government.

Deputy K.G. Pamplin:

It is fair to say the new Government, the new Council of Ministers, have put mental health as one the themes in this. We have got a new benchmark and our position, as Scrutiny, is to hold that new Government to account.

The Deputy of St. John:

I threw my copy in the bin. We amended it, we were so, so great in our speech but it does not bear any relation to the …

[10:30]

Deputy M.R. Le Hegarat:

I think the point that you made at the very start is something that I and, I think, the rest have said is just about you cannot have an overall strategy without clear aims and objectives. This is what we are going to do, specific measurable, smart; we all know what smart means, and so that we have got clear timelines of where we are going to achieve what and how. If you are limited on budget, then you have to look at how you are going to achieve those objectives or if you are not able to achieve them all, which ones are your highest priority? It may be that your 24-hour access crisis

management is your most critical point; that you are going to put more money into that in order that you do not end up further down the line needing more. I do not know but that is the whole point of this review, is to assess where we are but have clear aims and objectives. You are right, that is what it lacks is clear aims and objectives and how we are going to achieve things. Because that has to be, ultimately, what we need to do.

The Deputy of St. John:

I would be interested in looking at some of your evaluation figures and I am sure we all would be interested.

Deputy M.R. Le Hegarat:

Yes, because I think it gives us an insight and that goes for any view …

Managing Director, Resilience Development Company:

One of them is the same screening tool that doctors use in the surgery, if I say "GAD-7" to you, we use it a different way. When you are looking at our results that measure it before and after, you see significant reductions in them. We would be happy to sit and show you anything that you would like to see.

Deputy M.R. Le Hegarat:

Okay, I will …

Managing Director, Resilience Development Company:

Thank you very much.

Deputy M.R. Le Hegarat:

Thank you very much. Thank you.

[10:31]