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Education and Home Affairs Scrutiny Panel Prison Services Review Hearing with the Assistant Minister for Health and Social Services

MONDAY, 4th MARCH 2013

Panel:
Deputy J.M. Maçon of St. Saviour (Chairman)
Deputy M. Tadier of St. Brelade
Connétable M.P.S. Le Troquer of St. Martin

Witnesses:
Connétable J.M. Refault of St. Peter (Associate Minister for Health and Social Services)
Mr. C. Dunne (Director, Adult Services)
Mr. I. Dyer (Director, Older Adult Services)
Ms. M. Leeming (Service Manager, Adult Mental Health)
Dr. D. Harrison (Clinical Director, Mental Health)

Key issues:

Deputy J.M. Maçon of St. Saviour (Chairman):

Hello, good morning to all of you. First of all, thank you very much for your letter that we received, although I appreciate we will not be delving into the precise wording of that to begin with; you can breathe. But I do want to point out that you have requested to see the panel this morning in response to the public hearing that we held with Advocate Fogarty. I believe there are a few points that you would like to put your side of the story, of course. I should make the point, however, to everyone that just because something is said in a scrutiny hearing it does not automatically mean that we take whatever is said as absolute fact. Of course, we drill down and look for the information regardless of the witnesses. So I just wanted to clarify that point before we begin. Assistant Minister for Health and Social Services, are there any opening statements that you would like to begin with?

Assistant Minister for Health and Social Services:

No, not from me. I am going to ask [Director, Adult Services], who has been orchestrating all the information behind the scenes and getting all the relative information put together from that briefing we have had already. I would like to hand over to [Director, Adult Services] to encompass why we are here this morning.

Director, Adult Services:

First of all, can I just say thank you for the opportunity of coming back. I do appreciate your opening comments in terms of taking a balance across everything that you do here. There were several reasons why we just thought it might be helpful for us to come back and just share our own responses and thoughts and perhaps share a little bit more detail with you around some of the work that we are doing, partly because we recognise that the makeup of the panel had changed with Deputy Tadier joining the panel, and obviously when we first came to talk to you about the work that we are doing Deputy Tadier was not here. So we just thought it might be helpful to reiterate some of the points that we made.

Deputy M. Tadier:

I think I was in the audience at that time; I was following it anyway.

Director, Adult Services:

Oh, right. My apologies.

Deputy M. Tadier:

No, but that is fine. Reiteration is always good.

Director, Adult Services:

I was concerned that some of the information that was shared perhaps there was a misunderstanding that could have been misleading for the panel and we just felt it important to come back and try and redress some of the statements that were made in order for you to take a more balanced view around some of those points. Equally, we had requested - and I appreciate the support from Mike in setting this up - that we could actually perhaps run today in 2 halves so that we could have some open discussion and then maybe take the opportunity ...

Deputy J.M. Maçon:

If I could intervene, I do apologise. Yes, just to make it absolutely clear, this will be held in 2 sections. There will be a public hearing and I believe a few minor points will be held in a private hearing afterwards.

Director, Adult Services:

Yes, so thank you for that.

Assistant Minister for Health and Social Services:

I think maybe just for the sake of the audience, actually, we are going to talk about particular cases in the private hearing which are not appropriate to be held in public, just so they understand why we are doing a separate part. Thank you, Chairman.

Deputy J.M. Maçon:

Yes, indeed.

Director, Adult Services:

We thought that might be helpful for you to understand as a panel a little bit more detail around the complexity of those cases.

Availability of Psychiatric Services at Police station

Deputy J.M. Maçon:

If I can jump in then with a few questions, we heard in our previous hearing that there was a concern expressed around ... well, slightly outside the scope of our review as it tends to be morphing, but to do with police H.Q. (headquarters) and individuals that attend at the police station. There was a concern about the availability of the police being able to contact and

have down certain healthcare professionals. I am sure you are aware of what was said. Would you like to respond to that?

Director, Adult Services:

Yes, certainly. That was one of the issues that we just wanted to put right for you because our understanding ... and we did take the opportunity to talk to some of our colleagues who work with us within the Police Department just to clarify. I will invite [Clinical Director, Mental Health] maybe just to share with you a little bit about how the process works. But we absolutely refute that there is any difficulty in accessing a psychiatrist when that is requested at the police station. We have no evidence of that being a difficulty and our colleagues in the police assured us that that is not the case as well. We actually have in place an on-call duty system that is run by the consultant psychiatrists in order to be able to respond appropriately and as quickly as possible when that request comes through. That was certainly one matter that we just wished to state that we have no evidence of that being a problem.

The Connétable of St. Martin:

Is that psychiatrist ...?

Clinical Director, Mental Health:

Do you want me to explain what the system is?

The Connétable of St. Martin:

Please, yes.

Clinical Director, Mental Health:

Contrary to what Advocate Fogarty was saying to the Scrutiny Panel - and I do appreciate you saying that you do not take everything that is said here as fact - we do not just work 9.00 a.m. to 5.00 p.m. We do an on-call system 24 hours a day. At the present time, each consultant psychiatrist is working one in 3 on call. So every third night and every third weekend we will be on call for 24 hours a day. Part of our on-call commitment is to respond to people outside the Mental Health Service; for example, the Police Service. If someone is taken into custody and the police have concern about their mental health they will alert the police forensic medical examiner, who is a G.P. (general practitioner); the G.P. will come in and assess the prisoner. If the G.P. then has further concern about that person's mental health, they will contact the Mental Health Service and they will be put through to the consultant psychiatrist on call. We will respond to the police F.M.E. (forensic medical examiner) in a timely fashion. Generally speaking, I would say that we discuss with the

F.M.E. when they want us there. Sometimes we have to co-ordinate to be there with an approved social worker and a G.P., depending on whether a mental health board assessment needs to be made. But we will be there within half an hour if we are needed, any time of day or night. We have been there in the early hours of the morning, in the afternoon. It is not an area that I have been aware there has been a problem.

Deputy M. Tadier:

There is an "if" there which you mentioned, because you say in your submission that lay people cannot be expected to diagnose and treat mental health conditions. So it is "if" the police have concerns, but police obviously will be under their own duress, and they may be able to pick up very obvious tell-tale signs of psychiatric ill health but they are not experts in mental health either. I could interpret potentially Advocate Fogarty's comments of: "If they are lucky enough to be scrutinised by a psychiatrist" it depends on that process being fulfilled. If you get somebody who comes in perhaps who is drunk or potentially shows signs of drug usage, it will not necessarily be easy to discern especially without access to their medical records whether they have any psychiatric illness, and it seems to me is that an area which is one of the weak links potentially?

Assistant Minister for Health and Social Services:

I think if I may, if I can help you, Deputy Tadier, what I take from your comments there is that there is a suspicion that everybody would need some form of screening. That is physically not possible for us to do a screening of every sort of person that comes into police headquarters. So we are relying on other ... the police are fairly well tuned from experience when they are seeing somebody who is disturbed and will refer that to the G.P. who then will confirm that and on the basis of that confirmation our service will be called out. [Clinical Director, Mental Health], are you happy with my explanation there or do you want to add to that?

Clinical Director, Mental Health:

Yes, we are reliant on, I suppose in the first instance, members of the police force having a concern about the person's behaviour for them to alert the G.P., the police F.M.E. It is difficult to conduct an appropriate mental health examination when that person is intoxicated by drugs or alcohol. It is very difficult to get an accurate picture of what their underlying mental state is. For such people, what we advise is that they are kept in a place of safety until they have sobered up, until they are less intoxicated, and that mental health assessment can then take place.

The Connétable of St. Martin:

So you have the police officer first of all; then the custody officer possibly as a second stage; then the police medical examiner. Is that the same in other jurisdictions or is there any other way of doing it? You have explained. It is difficult, is it not?

Director, Older Adult Services:

In other jurisdictions it is not dissimilar. It does depend on the size of the services being provided. So, in the area that I came from, forensic psychiatry in Kent, what they now have is a liaison service to the police stations in Kent from an experienced mental health nurse. But that covers the police stations throughout Kent. To try to do that in a jurisdiction the size of Jersey, there would not be the work or the demand for such a role. On top of which, the ease of access to psychiatric response when someone identifies a potential concern is really quite straightforward. As soon as someone identifies that there may be a behaviour that would indicate a mental health condition, then the local police G.P. can contact a psychiatrist. It is not a difficult process. If of course it is a hidden concern, if people's behaviours are not as such overt, then it might take a little bit longer before they are noticed in the police cell or somewhere else.

Clinical Director, Mental Health:

The other avenue that maybe we should mention is if the police chose they can take the person to A. and E. (Accident and Emergency) rather than to the police station and at A. and E. they would receive the assessment.

The Connétable of St. Martin:

The assessment at A. and E. is carried out by the A. and E. doctor or psychiatric consultant?

Clinical Director, Mental Health:

It is conducted by the liaison mental health service, which includes community psychiatric nurses and psychiatric doctors.

The Connétable of St. Martin:

Just going back slightly on what we were talking about before, is it the consultant that is contacted to come down to the police station or is a psychiatric nurse sent in his/her place?

Clinical Director, Mental Health:

It is a consultant psychiatrist that goes.

[10:45]

Assistant Minister for Health and Social Services:

I think it is fair to say from the piece of work I was doing this morning with regard to mental health that there is quite strong evidence to show that somebody coming into the penal system, whichever door they come through, probably has a much quicker and faster access to mental health consultants than they would in a normal run of events. Because at the moment there is a trigger: it is reported to us; the consultants react to it immediately. Whereas if you are going through your G.P. it will take time for the referral process to get you to see a consultant psychiatrist. In this case it is immediate.

Expert Diagnosis requirement

Deputy M. Tadier:

Can I ask, it is slightly related but it is a thing that has come up in previous hearings about the distinction between what is termed as behavioural problems versus psychiatric problems. Despite what I said about the police not necessarily being able to pick up issues, I am aware of cases in the past where they believe that somebody has a mental illness or they display symptoms of it only to go to A. and E. and be told that they do not have that; it is a behavioural problem. Perhaps also the same when trying to access Orchard House or somewhere like that. There seems to be a catch-22 because the police think an individual has a mental illness and then there is not necessarily the immediate access for somebody who might need C.B.T. (Cognitive Behaviour Therapy), for example, and not necessarily to be institutionalised.

Clinical Director, Mental Health:

Part of our job when we are assessing is to diagnose what problem that person has. They may have a mental illness or they may have a personality disorder, a mental disorder, or they may be just choosing to behave the way they are behaving. That is part of my training is to assess what the diagnosis is for that person. Sometimes it is not straightforward and people can choose to behave in a way that you might think that they are mentally ill when really it is just their choice to behave that way for whatever reason. So we do get occasions where a lay person or a non-trained person might think: “That person is clearly mentally ill; look at the way he is behaving” and when we get behind that the pattern of behaviour reflects their personality rather than a major mental illness like schizophrenia or like manic depression, bipolar affective disorder or depression. Part of our job is to get in there and work out exactly

what is the problem for that person. You are very right; the treatment will depend on what the diagnosis is, so the treatment for a personality disorder often will be different from the treatment for a mental illness. It might not require admission; it might require the kind of psychological therapy you are talking about. That is part of our job. Sometimes it is a little frustrating when we see other people that are not trained making judgments that are not in agreement with our judgment and we have that sort of disagreement.

Deputy M. Tadier:

Just to follow up very quickly, if somebody is found to have psychiatric problems you will send a psychiatrist down to the police station or they will be sent down, but if someone is found to have behavioural problems you will not send a behavioural therapist down there and then to sort out the problem. So they will simply end up in the system, I would have thought, potentially in the prison system.

Clinical Director, Mental Health:

They will require the assessment to begin with to make the informed decision as to what the diagnosis is.

Director, Older Adult Services:

I think as well, trying to look at the evidence-based approach depending on the presentation of the individual, the most important thing is that an expert in mental health carries out that assessment. If someone identifies a concern, be it the police or a member of the public, either at the police station or at the accident and emergency department, an expert in mental health carries out the assessment. From that assessment, as [Clinical Director, Mental Health] said, it could be a diagnosis that could link to schizophrenia or bipolar disorder or a depression, which would be an illness, or it could be a disorder which could be, for example, an anxiety disorder, obsessive compulsive disorders, posttraumatic stress disorder, personality disorder. Obviously, the treatment for each of those conditions is significantly different. I think the most important thing to be aware of when we talk about disorder is that with any disorder, yes, there are good treatments, but they are not treatments we can insist that people take because those treatments, as you mentioned ... for example, cognitive behaviour therapy, which is very good for people with anxiety disorders or posttraumatic stress disorder, for example, but will not work unless someone wants to engage with that approach. What you would not do with someone with that type of disorder is send them to hospital because that is counterproductive. That is most often the case with people with personality disorders. The treatment for the personality disorder you are most likely to see, such as borderline personality disorder, would be what we call dialectical behaviour therapy,

which is an outpatient treatment. To try to insist someone receive treatment in hospital would be counterproductive, and I think that is often the concern that lay people will see. They will see someone behaving in a particular way and they will make the statement: "Well, it is obvious they are made" and when you get under it and you do the proper assessment and the experts do the assessment, what might be obvious distressed behaviour is not obvious that it is going to benefit from an inpatient stay. That is a longwinded way of saying that the complications that the experts ...

Deputy M. Tadier:

I understand that, but I also imagine that while they just think that, somebody who has behavioural therapy probably will not flourish in a custodial atmosphere either.

Diversion approaches

Director, Older Adult Services:

If you are happy for me to continue, I think probably what you are describing and what Advocate Fogarty I think was describing was what happened during the 1990s and into the early 2000s with mental health within the criminal justice system, which is what we call diversion approaches where basically if someone had a mental health condition the system then was geared to divert them from the criminal justice system. That is something that we have tried to move away from because there are inherent problems with that. One of the difficulties is if I break the law it is not for a nurse or a psychiatrist to decide whether or not I should go through the judicial process; it is for the criminal justice process to do so. If I can give a high profile case where that did not happen, which is that of Christopher Clunis who regularly broke the law by threatening people with knives or attacking people and he was mentally unwell, but because he was mentally unwell he was diverted from the criminal justice system until eventually he killed someone. When he had killed Jonathan Zito, then he ended up in Broadmoor Hospital and he then ended up suing the local trust and the local authorities for not prosecuting him sooner; because had they done so he would not have been in the position to kill someone. So I think you need to be clear that my understanding of what Advocate Fogarty was describing is that we should divert people from the criminal justice system. Obviously, if it is a minor offence - and who are we, perhaps, to assess what is a minor offence - we might well do that, but more often than not I think it needs to be the criminal justice system that makes the decision when hearing all the facts, including the facts of the medical opinion.

The Connétable of St. Martin:

There are 2 things. Did you say in the 1990s? How has Jersey changed or are we doing a different system now? We are trying to get people into it so they get the help?

Director, Older Adult Services:

I think we have tried to work with people since ... I arrived in Jersey in 1998 and my role at that time was as a forensic nurse specialist. So I was specifically appointed to work with people in the criminal justice system and between the mental health services. I would say since that time we have tried to work very much hand in hand with our colleagues in probation and the police and the prison so those people who have mental health conditions that are in the criminal justice system get the appropriate support at the appropriate time. What we have tried not to do is to get to the situation where people are diverted from the criminal justice system because they have a mental health problem. The courts need to make that decision.

The Connétable of St. Martin:

Do you think Advocate Fogarty was going in the other direction?

Director, Older Adult Services:

I think Advocate Fogarty was describing a court diversion service that would have been used in the 1990s into 2000; some services in England were still using it in 2000. But it has been moved away because of some of the outcomes of having diversion.

The Connétable of St. Martin:

While we are on that subject at the moment, because that was in open interview with scrutiny, the comments that Advocate Fogarty made at the time: “Almost impossible to get a psychiatrist to attend the police station headquarters“ and then goes on: “You'll be lucky if you can get them - the consultant psychiatrists - to stay half an hour.“ We give you the opportunity now to answer to those 2, because you have it in writing but, of course, it has not been made public.

Clinical Director, Mental Health:

I was very surprised to read those comments. I do not know whether Advocate Fogarty is monitoring our response to the police requests. We will not go to the police station unless the police or the police G.P., the F.M.E., request us to. When they request us to we go down as rapidly as we can and we will stay as long as is required for that assessment.

Deputy M. Tadier:

How many of you are there that would go down in the team?

Clinical Director, Mental Health:

At the moment there are 3 of us on that on call.

Deputy M. Tadier:

Is one of you on call at one time?

Clinical Director, Mental Health:

Oh, yes, one. It depends on the case, but often we will be looking at whether that patient needs admission to hospital, if the prisoner needs admission to hospital, and whether that needs to be under the Mental Health Law, and if we think that might be the case then we need to bring down a specialised social worker and there needs to be 2 medical practitioners there. Usually, that would be the consultant and the police doctor along with the social worker.

Deputy J.M. Maçon:

I wonder if we could get a few facts and figures, please. You commented about the process. I wonder if you can tell us the number of calls received on an annual basis that they receive from the police station.

Clinical Director, Mental Health:

I do not have those statistics at hand.

Deputy J.M. Maçon:

Could you make that available to us?

Director, Adult Services:

Yes, we can. We can get the accurate figures and I will make sure that you have the accurate figure.

Deputy J.M. Maçon:

From what you said, a question that arises from that then would be: from then what is referred to you, is there an issue or have you identified a potential issue or are you happy with the situation about training? For example, because I do not have the figures here, the amount of calls you receive and when you go down whether you say: "Yes, that was a

correct referral to us“ or: “No, that was not a correct referral to us.“ Let us start there: is there a ratio? Is there ...?

Clinical Director, Mental Health:
Again, it is just anecdotal information I can give you, Deputy, but being involved in that rota I can say that the police F.M.E.s, the doctors who work for the police, are all experienced G.P.s and have experience in mental health. Generally speaking, their referrals to us are appropriate. Whether that prisoner has a mental health problem or not, the assessment is appropriate. I do not think we are being called down to the police stations very often when it is not appropriate.

Deputy M. Tadier:
Obviously, the cases where you are not called down which may be appropriate, you have no way of knowing how often that happens.

Clinical Director, Mental Health:
I cannot comment.

Deputy M. Tadier:
We would probably need to talk to the police about that.

The Connétable of St. Martin:
If you get more people into the system, into the criminal system then that need assistance - they are referred to you then properly through the courts - do you have sufficient resources to deal with it? Are they putting a drain on ...?

Clinical Director, Mental Health:
I think it is important to say what [Director, Older Adult Services] has been describing, a move away from court diversion, that does not mean to say that mental health services will not be involved with those people going through the criminal justice system. We are there to provide the assessment so as we can help the people in the criminal justice system, the magistrates or whatever, to make the appropriate decisions. We are also there hopefully to provide the appropriate treatment for that patient, whether it is outpatient treatment or inpatient. We can discuss whether we have the appropriate services and appropriate facilities for that.

The Connétable of St. Martin: Do you have the resources to deal with that?

Deputy M. Tadier:

Shall we put it a different way? Because I think there is a quote where you do agree with something that Advocate Fogarty said. She said: "Jersey does not have adequate facilities for people with psychiatric conditions that make them dangerous or particularly difficult to care for." You agree with that statement. What are the issues?

Secure Care Services

Clinical Director, Mental Health:

We do not have any secure care services available in Jersey. I think this is an issue that Advocate Fogarty quite rightly brings up. We can treat people in the community that community treatment is appropriate for, outpatient treatment is appropriate for, and support them with community psychiatric nurses, et cetera. When it comes to more intense treatment, admission to hospital, all we have in Jersey is one open psychiatric ward for adults. I am not talking about children or older adults but working age. We have one inpatient facility which is not secure; it is an open ward up at St. Saviour's Hospital. So if that personal assessment has a level of risk to other people that they require secure care services, they are dangerous, they are risky and could be violent, then we do not have facilities for them. That is where we have to look off-Island to a secure care facility.

Assistant Minister for Health and Social Services:

It might be useful for you to come in, [Director, Adult Services], and describe that, please. What happens if they go off-Island now?

[11:00]

Deputy J.M. Maçon:

That is very kind but we already have that information; we are aware.

Assistant Minister for Health and Social Services:

Oh, you have? Right, okay.

Deputy J.M. Maçon:

If I can just probe, you spoke about the process about if a clinician does go down. I wonder if you can tell us, because there was an assertion about the amount of time that was devoted.

I wonder if you have that information where you can say: "We have had this many calls out. This amount of time was spent with an individual," et cetera. Do you have that information?

Director, Adult Services:
Again, we can provide you that information because there is a record with the police in terms of the time spent on individual callouts.

Clinical Director, Mental Health:
Every time we go to the police station there is a log of when we arrive and a log of when we finish, so that information should be available.

Director, Adult Services:
I think our concern was that there was an assertion that said that we would minimise the time required, and I think we just wanted to make the point that that is absolutely not the case. Any consultant that gets called out will spend whatever is the required amount of time. I think the issue there is that sometimes that might be half an hour but actually it varies. It can be significantly longer, depending on the complexity and the needs of the individual and, in particular, if somebody would require transferring under Article through to Orchard House.

Clinical Director, Mental Health:
Personally, I have been there for probably just under an hour on some occasions and 3 hours on other occasions. It all depends on the complexity of the case.

Deputy M. Tadier:
The interesting thing about this review is that it is obviously healthcare meets the provision of justice. One of those areas is rehabilitation, and I think that is obviously what we are all concerned about. Part of the prison service is to rehabilitate as well as to punish for bad behaviour. How do we rehabilitate best if the reason people are offending is primarily due to mental illness and not due to social, societal or behavioural considerations? Are we doing that to the optimum point at the moment?

Director, Older Adult Services:
I am wondering whether I need to come back a little bit about diversion because I want to just clarify what diversion does not mean. Because we touched on it, that mental health services are not involved with the people who go through the criminal justice. What it means is it is just that people do not not go before the court if appropriate to do so. So someone will not be diverted from the criminal justice system, but they may well be in Orchard House while

going through the process before the Magistrates Court or another court within Jersey. Similarly, if someone's needs cannot be met locally and the offending is such that they could pose a risk to themselves or others, there will be a number of people receiving treatment off-Island in specialist services there. One of the challenges we have at the moment is we do not have a secure facility on Jersey to provide the treatment and the rehabilitation for those whose level of risk is above an acceptable sort of plimsoll line. That is being ... a paper will be taken to the Council of Ministers to look at a Criminal Justice (Mental Disorder Offenders) Law and with that the option of looking at a local secure provision for this client group. They are small numbers but they require a high level of support and treatment.

Court Direction for Treatment

Deputy J.M. Maçon:

If I can move us on slightly as well, there was discussion around the assertion that Health and Social Services declined or possibly refused treatment of an individual when directed - I do not know exactly what the legalese term is - by the Royal Court. I wonder if you would just like to begin by commenting on that.

Director, Adult Services:

Yes, I think obviously that was one of 2 cases where there was information disclosed at the last hearing and with respect to the private session we would appreciate the opportunity maybe of talking about those cases to give you a little bit more understanding around the complexity. What I would say is that wherever an assessment has clearly identified the requirement for specialist treatment that cannot be provided on-Island, that has gone ahead and we have made those placements. I say that openly from the point of view as the person responsible for managing the finances associated with that and the pressures that we are under. We have significant cost pressures today because we have had to make essential placements off-Island and we work very closely with our finance department and with the Treasury when we are under such pressure. Today we have a number of placements off-Island. We have another placement recently that we know we have to make an essential placement for assessment and treatment. I would absolutely refute any notion that we would not make the appropriate placements off-Island when that is the right thing to do.

Deputy M. Tadier:

Can I just ask 2 questions? You said when it is clearly identified. How clearly does it have to be identified before you would send someone away?

Director, Adult Services:

It has to be absolutely clear because there are several issues here. First and foremost, in any of our service areas, not just within mental health, we would clearly not want any individual to have to go off-Island unnecessarily because that in itself can be quite distressing for individuals and for families. The second is we need to be clear that we cannot provide on-Island a particular area of service, and actually there are some specialisms that we have. There is expertise that we have as a part of our services that means we can provide some very important and critical services. Clearly as a small Island community we are never in the position to be able to provide the full breadth around this very complex area, in particular within mental health, the unique needs that if we were in the U.K. (United Kingdom) and bordering a number of other authorities where each authority will take on the lead to provide a specialism and you engage cross borders for placements, we are never in a position to be able to do that. If we are going to make a placement off-Island, we must absolutely understand what the need is. We must understand where there are situations that we need more detailed specialist assessment to understand what the diagnosis, and therefore treatment, might be. It is our consultant psychiatrists again who will lead on the shared decision making around those processes, because we will always lead and facilitate those off-Island placements. They are not done separately. It is not that the police or the prison will arbitrarily make placements. It will always come through with the assessment. If I use the word "control", it is that bit about taking all the information we have and making what we believe to be the right decision at that time. As I say, it is so important to understand that we would never not make a placement if it was deemed to be the right thing for that person at that time.

Deputy M. Tadier:

In terms of cost, we do not necessarily need the breakdown of costs, although that would be useful at some point, I am sure - we will ask for that - is there a fixed budget with regard to where you will get your money from or do you have to apply on an *ad hoc* basis every time a case comes up?

Director, Adult Services:

I have a budget for both on-Island and off-Island care packages and placements. So we have a number of people on-Island where we will wrap services around the person to try and ensure that they are safe and well and accessing the right treatment and support to enable people to continue to live independently in the community. Part of that budget we also have for our off-Island placements. There is a budget for that. I am overspent on the off-Island

placements. We continue to be overspent because that is indicative of the pressures that we have and the fact that we do respond to individuals rather than restrict the opportunity for those placements. The route that we take is that within Health and Social Services we have a panel that is chaired by the Director of Finance that we refer to as our high-cost placement panel. We meet on a monthly basis to review all those placements. When we are under pressure, what we are doing is putting together the business case around individual requirements and accessing through contingency monies and sometimes in partnership with the Treasury when that is significant.

The Connétable of St. Martin:
Not in partnership with Home Affairs?

Director, Adult Services:
No. The financial responsibility for health placement sits entirely with Health and Social Services.

Deputy M. Tadier:
So in a situation where a prisoner, for example, needs to go to a secure unit which provides mental care in the U.K. that is put by yourself?

Director, Adult Services:
Yes. The cost is picked up entirely by Health and Social Services.

Deputy M. Tadier:
Are you happy with that arrangement or do you think there should be some share because it clearly covers 2 areas, does it not?

Assistant Minister for Health and Social Services:
Absolutely. This is one of the big issues we had with a certain high profile case a year or so ago where the person waiting for trial was sent to a mental institution in the U.K., a secure mental institution. That was costing the Health budget around about £300,000 a year. These are the issues that, while there may have been an underlying health reason, it was an issue, in my view, from a budgeting point of view, which should have been first of all dealt with through the Home Affairs budget. But this is another area where we are well aware within Health that we need to discuss and try and refine who pays in those types of circumstances. But that is not for these guys. They just get on with the work and we have to find the money.

Clinical Director, Mental Health:

The suggestion was made that the clinicians on the ground who are doing the assessing would not diagnose someone or not go into treatment for someone - not get treatment for someone - because we do not have the facilities. That just is not happening. We will diagnose that person as best we can and then we will look to see whether we have the facilities to treat that person, and if have not then we will instigate the referral off-Island and then off-Island clinicians will usually come to see the patient in Jersey to make the assessment to see whether they agree with us and to see whether they have the facilities that are correct for that patient. That is the process we go through.

The Connétable of St. Martin:

So if you suddenly had 5 or 6 in one go, the worst scenario, you do not have the money?

Clinical Director, Mental Health:

I would still make the diagnoses.

The Connétable of St. Martin:

Oh, certainly, yes.

Director, Adult Services:

Can I share with you an experience we had at the end of 2011 because that was a similar scenario? Within a fairly short period of time within the final quarter of that year there was the need for 4 additional off-Island placements; budgeting wise we had actually committed the budget that we have. That created a real difficulty for us. We had 4 outstanding situations that we at that time as a service did not have the money to address. The process that I talked about, which is putting together the business case around each placement requirement, negotiated with our own finance department, in terms of the contingencies we solved the problem and made the placements. What that did do was put us under significant pressure going into the following year. We continue with that level of pressure today and it has not stopped us making new placements when that is required. The bottom line is that the placements that we are talking about - and this is why we wanted to talk to you in private around the 2 cases so you could understand both extremes of those cases that were named - it is not short-term work. Once we have made a commitment, we recognise that most times this is not a couple of weeks or a couple of months. This will roll on in terms of the treatment

that is required, which is so specialist and invariably can be a couple of years in order to enable somebody to reach the point where they become well again, ready to return to living back in the community.

Deputy J.M. Maçon:
Can I just move on then slightly? In that you were talking about the need to go off-Island or not off-Island. We know that certainly there is a view from the Minister for Home Affairs, there is a view from the Prison Board of Visitors and also slightly echoed in Advocate Fogarty's submission to us, which is in a very small, limited number of cases that when the assessment of an individual has received off-Island assessment it has been substantially different from what has come back from the independent ... from the external diagnosis than what has been given and deemed in Jersey. Would you like to respond to that?

Director, Adult Services:
Yes, certainly. If I just take us back to what we were saying before about process, the vast majority of those assessments and placements have been facilitated by us as Health and Social Services.

[11:15]

It is not that there are a range of assessments completed and then arbitrarily somebody comes along from the U.K. and assesses and makes a different diagnosis. It is often as an outcome of individuals like [Clinical Director, Mental Health] reaching a point where the complexity is so great we need additional support, advice from certain specialists, and it is [Clinical Director, Mental Health] who would facilitate those off-Island assessments every time.

Deputy J.M. Maçon:
Are you telling me then that that decision is made internally from the Health Department and is not perhaps court ordered?

Director, Adult Services:
Yes. In terms of the individuals associated in prison that is the process, that that would come through [Clinical Director, Mental Health] in terms of the ongoing work that we are doing in partnership with the prison health service as well. There may well be individuals where there could be an assessment commissioned through the courts. That is separate. An assessment may well be commissioned in order for them to take a decision around an

individual and sometimes that can be requested off-Island. There may well be certain circumstances where the outcome of that assessment could be different to what we are saying on-Island. Again, there is something about understanding the complexity of this work that it is not as simple as: “I have broken my leg." The whole process of this assessment diagnosis is sometimes very much more complex. Certainly, prisoners whose health deteriorates to such a degree that it requires further assessment and treatment will be managed and co-ordinated through our service and it would be [Clinical Director, Mental Health] that would lead with that.

Deputy M. Tadier:

Can I just go back to the budget and the idea of sending people away for treatment where they cannot be looked after or it is not best for them to be looked after on-Island? Are you saying that if you had twice the budget that you have now you would not send any more people away than you currently do?

Director, Adult Services:

No, no, no.

Deputy M. Tadier:

You would not need to because you are not limited by your financial constraints at all?

Director, Adult Services:

It is such a difficult one this, because our budgets are planned over the trends that might happen in terms of the activity that particular services are doing. So, for example, in terms of off-Island places in mental health, it would be estimated that there might be x number of placements that are required within a given year. The same happens within our learning disability services. They are much less in numbers than our mental health service but there are particular assessments and treatments that might be required in a given year. What we had was a unique period in 2011 where that peak exceeded all of our expectations. However, we responded to that. It was not easy because we do have fixed budgets across the whole of our States departments and we are all working hard to try and manage within our means at a difficult time economically. But if I heard you correctly, whether the budget was doubled or not, it does not stop us responding appropriately to prioritising those people that require it.

Clinical Director, Mental Health:
I think it is fair to say that the majority of the off-Island placements tend to be for secure care services.

Director, Adult Services: Yes, it is.

Clinical Director, Mental Health:
Because it is something we do not have here. We do have a comprehensive set of mental health services and so we can cater for the vast majority of mental health problems on the Island. There are some unusual disorders that we cannot cater for and they will go off-Island. But the majority of the secured care services ... if you were, for example, to double the budget, we are not going to get any increased number of people requiring the secure care services, if that is an answer to your question.

Review of off-island placements

The Connétable of St. Martin:
Right. If you go off-Island then, is it like universities? Have you got certain fees at different hospitals? Do you search around for them? You obviously want the best treatment for the person but are there facilities that are cheaper?

Director, Adult Services:
Yes. There are 2 things happening at the moment. That is a very good question because obviously we would want to ensure that we are getting good value for money but also effective outcomes in terms of the assessment and treatment for individuals. We believe that we have effective placements. The services that we contract with are reputable services that do deliver good outcomes. There are 2 things that are happening at the moment that are hopefully going to evidence that we are doing so. One is that we have commissioned with an organisation called Value in Care to review a number of our off-Island placements. They do this nationally for authorities to tell us whether we are getting value for money, and then if for any reason we are not they will support us in the negotiation around that. The second thing that is now in place, which is certainly assisting us in the latest placement that we have made, is with the establishment of a commissioning service within Health and Social Services now. We have access to experts in contracting and commissioning to ensure that when we do negotiate with U.K. authorities that we are getting best value. What is always very difficult is the power we have to negotiate when we are often only ever placing one

person in one specialist unit. The bit we try to ensure is that we are least not paying any more than other local authorities would in those specialist units. The reality check is that all of these specialist units are expensive.

Deputy J.M. Maçon:
Do you find that Jersey is singled out and they would try to charge Jersey more?

The Connétable of St. Martin: Tax haven and all that.

Director, Adult Services:
Yes, I do not think we have evidence that that is the case. I think there has always been a concern that people would view us as a wealthy Island and, therefore, they can add a few per cent on. This is where we have worked hard to always try and negotiate well. We start from the point that we are providers of services and as a small island we have tended to wear several hats at once. That is why I am saying as for the introduction of a bespoke commissioning arm of the service that brings in people with that expertise to negotiate better and understand the value we expect is going to assist us from here on. We have our first placement that they have come alongside us to just start to look at whether we are negotiating appropriately. We have had concern in the past that because we are a small jurisdiction making individual placements that that could be abused but we work really hard to try and ensure that is not the case.

Assistant Minister for Health and Social Services:
I think it would be worth saying, Mr Chairman, that when we look at medical placements in the U.K. it is very analogous to putting medical placements in the U.K. It is the same process, effectively. Where we do not have a facility here to treat a particular type of cancer, we would send it to a specialist who would deliver the best care in the U.K. So what we are doing in mental health in referring to the U.K. is exactly the same as we are doing in medical health as well. Where we need a specialism which is not here, we automatically refer to the U.K. No matter what the cost is, the patient's interest is our interest. While it is not in our interests to pay over the odds, it is also not in our interests to go for a budget option because it may well mean the patient stays in there a lot longer than they would have done had the right factors been put in place the first time. This is why [Director, Adult Services] particularly manages the budget. He ignores his bottom line. We have to worry about that in the ministerial team where the money is going to come from but his role is to make sure of the right placements at the right time to get the best outcome for the patients.

Deputy J.M. Maçon:

Sorry, can I just carry on with that? You commented that essentially you would not want to pay more than comparatively the local authority, if I have understood what you have said. Can you explain to me, please, how do you determine that?

Director, Adult Services:

This is where, I think, having the expertise of a commissioning service in place now will improve this. The reality is that what we tend to do is talk to colleagues and peers that we know in other authorities to establish what is happening elsewhere. So, for example, the authority I worked for before I moved to Jersey was Cheshire and I have ex-colleagues and peers who are in services there. We engage and we chat and you tend to use the contacts to try and establish ... that is why we have recently moved to commissioning with Value in Care as an independent service that will look nationally at the fees that are charged and the outcomes that people get from within services. I am reassured that we now have on-Island experts sitting alongside us who have that national perspective in terms of placements and contracts.

Director, Older Adult Services:

Traditionally, when we did not have the commissioner, the bottom line is that [Director, Adult Services] or myself, working with our clinical colleagues, did the commissioning and one of the drivers in the past used to be where we could find a bed. It was often the case that the courts would be wanting someone who has a problem to be identified to the appropriate environment as soon as possible and there was many a time when I phoned round to a whole host of secure services to see whether or not they have a bed and, if they have a bed, whether or not they could come over and do an assessment to see whether or not someone was suitable for that. So there were those difficulties. That said, the N.H.S. (National Health Service) at one time did have tariffs. Now, that has changed somewhat since they have moved towards our foundation trusts, where the trusts are there to provide some money for their own services. They are looking to provide an income, all trusts to some degree have done, so the tariff within the N.H.S. has changed somewhat. But that is why I think it is beneficial now having the commissioners who understand how the N.H.S. worked when we needed to go off Island better than we do.

Deputy J.M. Maçon:

Just a final question from me on this section, just to double check then, there was no scope or ability for Jersey to ring up other local authorities in other areas to ask them how much is

being charged if a person has x, how much they are being charged here, here, here? Is that correct?

Director, Adult Services:
There has always been a scope to do that. Invariably, the way that would be done was you would start with the contacts that you know in order to ask that, but there is always a scope to phone up other authorities and check. Often providers of services will give you other authorities that are using their service so you can check.

Clinical Director, Mental Health:
Each service has a tariff. They will tell you what their daily rate is for whatever condition you are talking about.

Deputy M. Tadier:
When you worked in Cheshire, which government was in power at the time?

Director, Adult Services:
Well, I worked there for 18 years, so it was Conservative most of the time.
Deputy M. Tadier:
Was it funded locally or did you have a centralised budget for that?

Director, Adult Services: For ...?

Deputy M. Tadier: For where you worked.

Director, Adult Services: It was local government.

Deputy M. Tadier:
Okay. I just wanted to ask, though, it seems to me that you are saying you are not limited in terms of your budget and in terms of money about putting people in a placement when they need it and when you think it is the best thing. But it seems that there are other constraints; for example, if you phone up a specialist unit, they do not have a bed available ...

Director, Adult Services: Yes, that is right.

Deputy M. Tadier: ... there is no point in getting a specialist over to do the analysis because there is nowhere for him or her to go. So there are possible constraints. What do you in the meantime when somebody is waiting for that placement? How are they treated in Jersey?

Director, Adult Services:
We have to work in partnership with the prison. We have to use what we have to best effect. What we recognise is we have 2 environments that sometimes are not the right environment. We either have Orchard House and we will either work in partnership with the prison, so the prison will provide the security while we provide the healthcare. Or the person will remain in prison and we will continue to provide the healthcare in prison. We acknowledge that neither of those options is the right outcome for the person, but while we are in that interim period looking for the right placement and that placement being available ... because you are absolutely right, one of the frustrations that [Clinical Director, Mental Health] will have on a number of occasions is the engagement with what we believe to be the right service. They will come and do their assessment, make their recommendation, but that recommendation has to go back to their own board. Their own board could say no and we end up having to start again or they may recommend a different service. Those are factors that are beyond our control that we work really hard to try and minimise but can cause delay and that adds the weight to the difficulty of the joint work we do of ensuring that somebody remains safe because of being a prisoner but also receiving what we hope is appropriate healthcare through that period.

Deputy M. Tadier:
Is it ever the case that the length of delay may exceed in some occasions the length of the sentence that that person has received?

Director, Adult Services: That is a good question.

Clinical Director, Mental Health: I suppose in theory that could happen.

Deputy M. Tadier:
Especially as a short term ... I do not know but I suppose that is the issue if there are ...

Director, Adult Services:
I am not aware of an individual case that that has happened but we can certainly go and ask the question if that is helpful.

Deputy M. Tadier:

Yes, but what are typical lengths of time you may have to wait for a specialist?

Clinical Director, Mental Health:

Quite often if someone is being treated in a secure care setting, the length of treatment that they require will exceed the sentence that they are serving. What happens then is an administrative thing in that an assessment is made at the end of their sentence to see if they continue to need treatment and they would go on to a different Article of the Mental Health Law, section of the Mental Health Act.

Deputy M. Tadier:

Yes, but if that happens in Jersey then, because if they were already in a secure unit in the U.K. their sentence ends and then they would get referred somewhere if they need it. But does that happen locally when the sentence is over or do they simply get released and then they may not be in the system anymore?

Clinical Director, Mental Health:

I am not aware of any case like that but I suppose what would happen is that they would get released. The mental health services would do an immediate assessment and see whether they met the criteria for ...

Deputy M. Tadier:

But if you did not have anywhere to put them when they were in prison, presumably where would you put them when they came out of prison?

Director, Adult Services:

In theory, if they were released from prison then that would be on the same basis as anybody else living in the community, but if they required, under Mental Health Law, an article to be treated, then they would be articled to come into Orchard House and we would manage it from there.

Clinical Director, Mental Health:

We have had patients in Orchard House that we feel are not appropriate for Orchard House in that their level of risk is too high. They are not in prison because they have not committed an offence; they are in Orchard House. So we are treating patients that are, in our view, too high a risk for an open unit. In those cases, we again refer to the off-Island facilities and try

and expedite the process as much as we can. But for that period of time, you are left with someone that would be better treated in the secure care environment.

Service Manager, Adult Mental Health:

Practically, if they are in our care then we just have to step up that area in order to meet their needs, to keep it safe for that individual and for others. It is challenging because the environment does not lend itself to have that level of security. So if we have assessed someone as needing an off-Island placement, then we expedite that as quickly as we can in order to maintain everybody's safety and for the health and wellbeing of that individual. If I could just confirm that when somebody goes off-Island, we have a team of specialist staff, so social worker, nurse and [Clinical Director, Mental Health] as a consultant psychiatrist, who continuously monitors the off-Island placement and just ensures that the treatment options that we sent you off-Island for, that you are receiving those. That is very regular. They do go over for what they call C.P.A. (care programme approach) reviews and for tribunals just to make sure that we are getting the types of specialist service that we sent you for.

Director, Older Adult Services:

Can I just say as well, I would not like the panel to think that in England someone who is assessed as needing a secure service gets it the following day. It is not unusual for there to be time delays in services there, whether it be a transfer of a sentenced prisoner or a referral for remand assessment.

Clinical Director, Mental Health:

Like [Director, Older Adult Services] , I have experience in working in secure care services in Britain. I used to work in the State Hospital Carstairs, a high secure hospital in Scotland. Every week we would have a referrals meeting where new cases were brought and it had been identified that this patient or that patient needed to come into the hospital and the hospital was always full and it was always a case of how long it was going to be until we would get a spare place for the next patient to come in.

Director, Older Adult Services:

So it is not unique to Jersey for someone to possibly stay in a prison environment for longer than would be appropriate or we would wish.

Deputy M. Tadier:

Just one last point and then I will let someone else jump in if they need to. There was a high-profile case and a tragic case in Jersey which we will all be familiar with where the Bailiff was

presiding and he said that this individual should have gone to a secure unit somewhere to receive mental health treatment but he was not able to do that for whatever reason. I think that individual obviously ended up in regular ... I do not know if he stayed in Jersey, but is that a problem for you to have to deal with those very difficult cases or is it a legal technicality which perhaps needs to be addressed?

Director, Adult Services:

It is. It is legal issues. It is linked to the law that we presently have in place, which is certainly the work that [Director, Older Adult Services] is leading on in terms of updating present law that underpins our mental health services and the link to the judiciary. So we are expecting that that will improve.

Deputy M. Tadier: Right.

Mental Health Services in HM La Moye Prison

Deputy J.M. Maçon:

Okay, if I can just ask, there was some discussion about the level of staffing available at the prison, that potentially there was a lack of full-time psychiatric nurses based at La Moye. I wonder if, firstly, you could tell us has there ever been any external review of the mental health services that are provided to prisoners.

Director, Older Adult Services:

There have been 2 reviews, one in 1996, which at that time led to my appointment and one or 2 other changes in healthcare provision for people with mental health problems in the criminal justice system, and then there was a review in 2004 from Rosemary Wool who was the ... I am trying to think what was her title. She was the recently retired Senior Medical Officer for Prisons in England. She came over and looked at the mental health services ... well, health services across the board into the prison and a number of recommendations came from there. It would be fair to say that a business case was put forward at that time to Health and Social Services to improve and increase input into the prison from nursing, our common drug workers, psychologists and social workers, to have more input into the prison. Initially, funding was found for that but unfortunately, due to cost pressures elsewhere within Health and Social Services at that time, that money was absorbed elsewhere. So those extra posts were not put into the prison as such. So I believe within the services that we now have within Health and Social Services, and particularly within the adult mental health

service, which is [Director, Adult Services]' responsibility now, effectively the cake has been cut in such a way to ensure that support is provided to the prison as regularly as possible. But it is not to the level or the degree that would have been the case had the business case been able to stand.

Deputy J.M. Maçon:

So would it be fair to say the department has found a best way to fit the circumstances given the financial pressures but it still would prefer to have a different scenario?

Assistant Minister for Health and Social Services:

[Clinical Director, Mental Health], you were commenting earlier on this morning on a different matter about the in-reach service we do within the prison. Would that be helpful, do you think?

Clinical Director, Mental Health:

I can say what we have. I think Advocate Fogarty is a little misinformed. There are 2 nurses with mental health training employed by the prison in the healthcare centre there. So there are nurses in the healthcare centre. A G.P. will visit daily through the week and do a clinic, and then the mental health service has an in-reach service so a community nurse forensic specialist will visit each week and see patients that are identified from the healthcare staff or from the G.P. and then myself as the visiting psychiatrist, I go in once a week for a clinic also. So prisoners are identified. They can either go themselves to the healthcare staff or they are identified by prison officers or healthcare staff or by the G.P. and they will be put on to our clinic. It mirrors in some way an outpatient clinic or a community mental health service.

Deputy J.M. Maçon:

If I can ask you then, how should it be in your professional opinion?

Clinical Director, Mental Health:

Of course, you can always do with more input, but I think that the service they get as a community service is not bad. I think they get to see a mental health professional quite quickly, probably quicker than they would see a mental health professional if they were not in prison and the treatment they get is the appropriate treatment. I would like to see more clinical psychology input. That is one area that we are lacking in the prison at the moment. They have a forensic psychologist but they do not have a clinical psychologist. They do have a drug and alcohol worker; they do have the community psychiatric nurse. There is the issue

of people that require more input than community input. Those are the people that would be normally admitted to hospital. That is when we look at the secure care facility or lack of it.

Deputy M. Tadier:
Sorry to interrupt, so it is quicker to get access to mental healthcare when you are in prison than when you are not? So that is a --

Clinical Director, Mental Health:
Again, that is anecdotal but I go each week, so the waiting list to see the consultant psychiatrist in the prison is less than a week. In the community mental health services, again the waiting list is not very long ...

Service Manager, Adult Mental Health No.

Deputy M. Tadier:
Is it the case, though ... that was obviously slightly tongue in cheek, but it is an interesting point to note. At one point, [Director, Older Adult Services] told us that there was provision for a nurse to be at the prison, to work there. Is that correct?

Deputy J.M. Maçon: What provision was it exactly?

Director, Older Adult Services:
Right, the provision that was recommended within the Wool report and that was put forward in a business case was for 0.5 psychology services, clinical psychology, so it would be half time clinical psychologist. They would not necessarily be working in the prison, but they would be inputting into the prison and doing therapeutic work with prisoners. The nurse would be a liaison nurse and that nurse would then work as part of the community mental health team, not dissimilar to what the nurse is doing now, just more of them. So you could have input in and also there is the time when people come out of prison, making sure that you have that transition between being a prison inmate and ...

Deputy M. Tadier: Do you think it would be beneficial to have a resident psychiatric nurse there because presumably there are other medical staff at the hospital?

Director, Older Adult Services:
We do have 2 psychiatric nurses who are employed by the prison, who are in the healthcare team of the prison. My concern there - and I have discussed this in the past with the Prison

Governor - is that they are first and foremost prison officers and, secondly, nurses. What has happened in England is that the New Ways of Working has identified that the healthcare within most prisons now is provided by the local health authority or trust. So they employ the people who provide healthcare and the prison employs the people who provide the security care. We were looking at that.

Deputy J.M. Maçon: Yes, Assistant Minister?

Assistant Minister for Health and Social Services:
Yes, can I just clarify a point that Deputy Tadier raised earlier, a few moments ago? I would not like the panel to think that people in prison get far better mental health services than they do in the community. The difference being within a closed community like the prison, they are being constantly monitored and any behavioural changes are spotted immediately and, therefore, referred through much quicker than somebody with those same slight behavioural changes would be in the community. It is not that there is a better service, it is just because of the monitoring there they are identified much more quickly because of the closed environment which they are in. I would not like the story to go out, go to prison if you want quick mental health service. That is not the case at all.

Deputy M. Tadier:
So there is no *J.E.P. (Jersey Evening Post)* reporter who is going to put that on the ... **[Laughter]**

Service Manager, Adult Mental Health
Equally, I would also think that being in prison means you are probably willing to engage more with health staff. So the service may be available to you in the community but you may choose not to accept appointments or otherwise, whereas generally in the prison people have, by the very nature of where they are, a willingness to engage.

Deputy M. Tadier:
Sure. So is there any plan to implement that recommendation, which seems to be best practice elsewhere, that there be a demarcation between the prison officers and psychiatric nurses?

Director, Adult Services:
I think this is where we need to pick up our dialogue with our colleagues at the prison and, on the back of where your investigation started, we are really interested in getting around the

table with the Prison Governor to look at how can we further improve the work we do together. We have a view from a mental health service perspective about how we might be able to improve that and we need to sit down with them. For this quarter of the year, because we have been trying to engage with the relevant Ministers and panel members as well, we have just struggled to get everybody around the table at the same time in order for us to pursue that dialogue. But it is on the cards and I am certain that it is in March that we now have a date for that process to start that will allow us to come together. Because, historically, the one thing we can say is that we have always had a very good working relationship both with the police and with the prison in terms of the work we need to do collaboratively.

[11:45]

Deputy J.M. Maçon:
It sounds like this issue has been going on a little while. I wonder if you could tell us what barriers or problems you have identified. Perhaps you will say you have already done that, but if you could flesh that out again so that we have a better understanding.

Director, Adult Services: In the joint working?

Deputy J.M. Maçon: Well, in the nature between prison officers first, nurses second, that type of thing.

Director, Adult Services:
Well, I think what we would want to look at is clearly having a system where we have a service going into the prison that has the primary focus on the health needs of the individual. [Director, Older Adult Services] rightly pointed out that in the U.K. they have taken a stance to separate where people's primary reason for working with individuals is their healthcare as opposed to their security issues as a warden. I would just be very interested to have that dialogue and discussion and for us to share our view, which is as a Health and Social Services Department we would want to be providing an input to and managing the delivery of healthcare with them. There are clearly matters to be discussed and there will be views on both sides as to the most appropriate way for us to deliver that together.

Service Manager, Adult Mental Health:
On a practical level, when a prisoner comes to our in-patient services, I have signed a protocol, co-signed it with Bill Millar, the Governor, so that we have some clarity about roles

and remits and responsibilities, so that we can work more effectively and more collaboratively. At the moment with the police, I am working with Inspector Henderson to draw up a pathway for people that come into police contact where there is some consideration for their health needs. We are also working with our G.N.A. colleagues. We are just putting together a draft paper that will go out for circulation that will help everybody to do the right thing at the right time or in the best interests of anybody that they pick up where there is a healthcare need.

Deputy J.M. Maçon:
I am just conscious of time and I am still aware we need to go to our private session. Are there any final questions that you would like to put?

The Connétable of St. Martin:
Thank you, yes, Chairman. Getting back to the reason that we are here today, obviously the advocate has been in public scrutiny and you have done your response but your response is in writing. Are there any other things you wish to get across while we are still in public to answer some of those comments? I do not know if the advocate has been in contact with you since that scrutiny in private consultation or if there is anything you want to counter on her ...

Director, Adult Services:
No, my concern was that there was information shared that I believed was misinformed and I believed was inappropriate in terms of the view that was expressed around what was happening. I appreciate the opportunity for us to come back and just clarify some of those points. It is my intention post-Scrutiny Panel that I would want to arrange to meet with Advocate Fogarty to equally go through and I would be very happy to go through my response to you with her so that we can find where there is any misunderstanding. Equally, if there are any issues of concern that she raises which have a legitimacy there, I would be very happy to look into that. Because whatever the rights or wrongs of what we believe, the only thing we want to be able to do is to provide effective mental health services to those people who are in sometimes the most vulnerable place when they are either at the police station or in the prison.

Deputy J.M. Maçon: Deputy Tadier, final question from you?

Deputy M. Tadier: This is to the Assistant Minister. I know you have some oversight of the financial responsibility, I think, of the department.

Assistant Minister for Health and Social Services:

We have a regular briefing once a month with the financial lead in the department and the Chief Executive Officer looking at where the pressures are within the budget and how we may find ways of trying to ameliorate the pressure by supporting the budget wherever necessary.

Deputy M. Tadier:

I think we understand that Jersey, being a small jurisdiction, is always going to be in the scenario where certain people do not fit the service and, therefore, we have to try and tailor the service elsewhere to fit them. But do you think there is any way to optimise this provision at the prison so that perhaps with a bit more mental health specific care there, possibly even if it means building a new block where that can take place, would that optimise and save money going forward so that there is perhaps more mental provision that can take place on site?

Assistant Minister for Health and Social Services:

One of the problems is not providing the facility in which to put them, it is also providing the staff, because there are several patients that we are aware of that need 3 to one, 24-hour sort of cover. Now, if you have 3 to one then you are looking over a shift and then ... you are looking at an enormous amount of staff to just service one individual. The problem with Jersey is that we may have a very small number but we may have to have a very big staff on standby in case that number suddenly grows overnight. For example, if we only have one at a time and suddenly we get 2, we need to carry double the staff just in case a second person comes in. So in a small jurisdiction it is not really cost effective. The same as like, for example, if we wanted specialist heart surgery, we would not do it over here because there is not enough people coming through to keep that team here. So that is why the best treatment is where the expertise is, is to actually get them where the expertise is ...

Deputy M. Tadier:

If I put it this way, people end up in prison for various different reasons and they have a gym at the prison. It is on site so people can keep fit. They have a library. They teach literacy and numeracy up there, on site, so people can resolve those issues. We have also been told by Mind that prisoners have a higher proportion of psychiatric need, partly due to the fact that they are in prison but also perhaps ... but we do not seem to have a designated psychiatric care unit down there which could provide perhaps very basic but very effective provision for them. Do you think that could be cost effective in the long run?

Assistant Minister for Health and Social Services:

That is a difficult one for me because I am not a clinician to understand the actual needs. While the instinct would be to say that would be an ideal situation, it may not be deliverable from a clinician point of view. It may not be the best fix in a small jurisdiction. Really, I would have to give way to my colleagues here that are more experienced at the delivery end.

Deputy J.M. Maçon:

I see a hand waving.

Director, Older Adult Services:

It is just really for information. The prison used to have a number of beds that were classed as prison hospital beds and they closed those around about the time that I arrived on the Island. It was a decision made by the Home Affairs Department or the prison at that time, the Prison Board at that time. It is not unusual for prisons to have small units where people with mental health problems or perhaps people convalescing from physical health problems can recover where they have specialist staff. I do not know the rationale for the closure or any plans for any future development of a healthcare suite, but at the moment I am not aware of any plans ahead to do that.

Director, Adult Services:

I think in response to the issue around a bespoke service, I do just want to emphasise the quality of the in-reach service that goes in. We are very fortunate to have [Clinical Director, Mental Health] and the expertise he brings from a forensic perspective as a consultant psychiatrist. We have an excellent forensic specialist nurse in the team and actually within the service, as a mental health service overall, there are pockets of expertise that we will drop in and out. Somebody referenced the eating disorder service, which again, by nature of it being a small service, it is not a separate discrete team but it is a virtual team made up of the expertise we have available to us within the broader service. I probably would say that I do believe that the in-reach service is an excellent service that is going in. There are a small number of highly complex individuals that we have touched on that will always generate the debate. The majority of people experiencing some degree of poor mental health within the prison get quick access to a very high quality support within that. That does not mean to say that at any time, as [Clinical Director, Mental Health] said earlier, given additional resources, of course we would do more, but we recognise the place we are in today, which is constraints on the finances that are available. We want to try and evidence that we make

absolutely the best out of what we have. I personally feel that the quality of the in-reach service that we are putting in is very good.

Clinical Director, Mental Health:

If we are talking about more in-depth input than that, if you are talking about residential facilities locally, certainly you would minimise any delay that that prison is experiencing to get the help if you had a local facility. Certainly, they would not be separated from their family by having to go off-Island and that is another advantage. So if you had a secure care facility, it would have those advantages. You would also need to have a change in the Mental Health Law to facilitate hospital orders to facilitate that patient getting that treatment as well. One complicating factor, which is a big factor, is that you are talking about a generic facility for all secure care. At present, they are all in specialties. Off-Island now we are using a women's unit, a male unit, low secure unit, a medium secure unit, a high secure unit, a unit for personality disorder, so all of the separate kinds of facilities that we are utilising at the moment, you would lose some of that sub-speciality if you just had one generic unit. So there are advantages and there are challenges as well, but it is something I would welcome exploring.

Deputy J.M. Maçon:

Well, thank you very much for that. I will bring this public section of the hearing to a close. Thank you very much and I shall ask that the members of the public, who are no longer here, and the media leave the room.

[11:56]