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Health and Social Security Scrutiny Panel

Assessment of Mental Health Services

Witnesses: Mental health clinicians

Tuesday, 18th 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. M. Garcia, Consultant Psychiatrist, Adult Mental Health

Dr. C. Keep, Consultant Child Management Psychiatrist, C.A.M.H.S.

Dr. L. Posner, Consultant Clinical Psychologist, C.A.M.H.S.

Mr. S. Kashiri, Acting Head, Alcohol and Drugs Service

Mr. M. Swain, Clinical Nurse Practitioner, Adult Mental Health

[9:00]

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

Good morning, everyone, and welcome to this public Health and Social Security Scrutiny Panel. This morning we are speaking to staff in relation to our mental health survey and thank you all for coming. What we will do, if you would not mind, is introduce ourselves. It is being live streamed, so if we all introduce ourselves and give the public an indicator of who we are and what our roles are that would be extremely helpful. I am Deputy Mary Le Hegarat of St. Helier and I am the Chairman of the Health and Social Security Scrutiny Panel.

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

I am Deputy Kevin Pamplin of St. Saviour and I am the 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 a member of the panel.

Community Mental Health Nurse:

I am Mike Swain and I am a clinical nurse practitioner with the Adult Mental Health team.

Consultant Psychiatrist, Adult:

Miguel Garcia, consultant psychiatrist.

Consultant Clinical Psychologist, C.A.M.H.S:

My name is Dr. Laura Posner. I am a consultant clinical psychologist in the C.A.M.H.S.(Child and Adolescent Mental Health Service) team.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

My name is Dr. Catherine Keep. I am a consultant child management psychiatrist working in C.A.M.H.S. I am also the lead clinician for C.A.M.H.S.

Acting Head, Alcohol and Drugs Service:

My name is Simba Kashiri. I am Acting Head of the Alcohol and Drugs Service.

Deputy M.R. Le Hegarat:

Thank you. There are 2 other members of staff here and they are basically here in order that we can record it, that we have a transcript, and obviously Tom is our scrutiny officer. Thank you all for coming. We do at times have a few issues with our recordings, so it would be helpful if you can speak as loud as possible because certainly from the point of view of the way this room works, sometimes the members of the public cannot hear what we are saying. It would be helpful if we can speak as loud as possible. Thank you.

Deputy K.G. Pamplin:

The other thing I would suggest is that we make sure we are positioned by a microphone. It might involve you moving across the table.

Deputy M.R. Le Hegarat:

We decided to do the mental health review following the strategy being released in 2016. That is 2 years ago now, so we based it on that because we wanted a timescale, if you like, and to see whether any of the services have improved or changed. So on that basis, we are pretty much trying to find out information about what has happened in the last 2 years. In general, how has the demand for the services you provide changed over the past 2 years? If I start from my left with you, then it will be helpful if we have that format so we all know.

Community Mental Health Nurse:

In terms of demand on the service, it has definitely increased over the last 2 years. I do not have the figures to hand, but in terms of the referrals that we have in and the amount of assessments that we do in emergency settings it has definitely increased and there is a definite increase on people's individual caseloads that they have individually to care for.

Consultant Psychiatrist, Adult:

It has grown expressly. From the levels of 2011 we had emergency assessments of maybe 50 to 70 whereas in the last 2 years it has gone up to over 200 and we were not really prepared for this happening. It has caused a lot of strain in the police and mental health services and accident and emergency because we did not have enough resources to manage these emergencies together with our ordinary work.

Consultant Clinical Psychologist, C.A.M.H.S.:

Within the C.A.M.H.S. team I have got some figures on that. This year to date we have had 560 referrals. Last year it was 544 and over the last 2 years there has been a sustained increase in the number of referrals compared to the year before: 2016 was 474, 2015 was 481. So there has been an increase in the number of referrals but the more notable factor has been the change in the type of referrals. Over the last 2 years we have got data that shows that almost half of new referrals coming in need to be responded to within a week, so promptly, seen urgently, and that is a real change. We used to have a situation where most of the referrals coming in we would see in order and now because of the risks that are being presented and the crisis at the time of referral, we have had to change the way that we organise ourselves. A few years ago we had a system where every member of the team was on a rota and covered a duty. So I would be on it maybe once a fortnight and we would rotate and manage the duty work. That did not work for us anymore with the increase in referrals, so we have changed the structure of how we work. We started off with one person doing duty work and so that would be any new referral, any to be seen urgently, either through A. and E. (accident and emergency) or through the clinic. But with one worker that was not sustainable either with the increase in demand, so we have now got the situation where we have 2 nurses every day with the support of ... it is always backed up by a doctor as well and they are busy every day.

Deputy K.G. Pamplin:

Can I just dig into the data, because there is a lot of data? The referrals, where do they come from, the majority, if you can split that up?

Consultant Clinical Psychologist, C.A.M.H.S.:

Yes. The referrals come from a range of different professionals. We get a lot of referrals through from accident and emergency. We get a lot through paediatricians, through G.P.s (general practitioners) and through schools.

Deputy K.G. Pamplin:

What would you say is, in the order of majority, where they come from, or what is the most?

Consultant Clinical Psychologist, C.A.M.H.S.:

After today I can send through ... I do have the exact data I can send to you, but off the top of my head I would say G.P.s, paediatricians, A. and E., schools, then social services.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

Can I just say I think the increase in prevalence of mental health disorders in children and young people is probably mirroring that of the U.K. (United Kingdom). There has been recent studies showing that there is an increase of prevalence of conditions in children and young people. The most quoted figure is one in 10. That relates to research that was done some time ago. More recent figures are suggesting one in 8 5 year-olds to 19 year-olds have at least one mental health disorder and particularly in the 17 to 19 age group, which is where we see a lot of our crisis referrals, one in 6 young people have some sort of mental health difficulty. That is the most recent research published in November 2018. It is U.K. figures but I think we are probably following those trends.

The Deputy of St. John:

Are these what one might loosely call neurotic conditions or might they be loosely called psychotic conditions that you see?

Consultant Child Management Psychiatrist, C.A.M.H.S.:

I think we see a combination of difficulties. Certainly rates of illnesses such as psychotic disorders start to increase from age 14. That is well known. I think when young people present with a crisis it is often with a whole combination of factors. Some of it is mental health disorders; sometimes there are other factors in their lives that lead to this crisis.

The Deputy of St. John:

We are aware there are trends in relation to the age that children develop these conditions, but what is the balance that you anecdotally find going through the service?

Consultant Child Management Psychiatrist, C.A.M.H.S.:

Again, it depends on the age. When we are dealing with younger children there are often behavioural problems, what in medical terms is called oppositional defiance disorder or conduct disorder. As children enter their teenage years it is more emotional disorders. Then psychotic disorders are still relatively rare in this age group but the incidence is starting to increase. So it is mainly emotional disorders, which I guess have previously been termed neurotic disorders but we are talking about emotional distress and that is quite a broad category that covers lots of different presentations.

The Deputy of St. John:

So what do you think the factors are in society that have influenced this increase?

Consultant Child Management Psychiatrist, C.A.M.H.S.:

That is a big question and I think for every young person that we deal with is it is always multi-factorial. It is rarely one thing that is causing their presentation. Often it is a whole number of different factors coming together at one point. It might be certain biological factors; they may have a genetic disposition to developing these illnesses. There may be stresses within the education system about expectations. There may be stresses within the family. The impact of social media has often been commented on and that is something that we have to deal with on a daily basis when working with young people because it is so much part of their lives these days.

The Deputy of St. John:

What is the balance? I was thinking yesterday it might be biological causes but the Island has not suddenly become seriously neurologically or chemically imbalanced. In fact, if anything it has got better over the years because the genes have been diluted.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

Yes, but some people have susceptibility, I think, to react into those environmental stresses and societal stresses because of that. But it is very different in every individual, so I do not think I could comment about what proportion all those things add but it is often a combination of all those factors coming together.

Consultant Psychiatrist, Adult:

I think anecdotally I would pinpoint that the financial meltdown years ago has led to a worsening of the working conditions and the chances for young people to get good quality jobs. I would say that

anecdotally, my guess is that social component to the presentation is at least 50 per cent. It is about not appropriate housing and lack of appropriate jobs, especially for the future. If we could have that sorted out, together with a sense of belonging of support for the society, 50 per cent of our workload will really disappear right away.

The Deputy of St. John:

Those are interesting and challenging questions for Government, are they not?

Deputy M.R. Le Hegarat:

I will just ask you to give your view and then I will throw questions so that the others can have an opportunity to drill down a little bit.

Acting Head, Alcohol and Drugs Service:

When we look at at alcohol and drugs services we are looking at 4 competences that we provide, the first of which would be the drug side of things. We have seen an increase in referrals specifically for 3 main types of drugs, for opiates, cannabis and for benzodiazepine. So far we have managed to more or less match our 2017 figures, which was a total of 133 for those main drugs and near enough to 100 will account for all the other minor drugs, MDMA Ecstasy, being used. We provide a community alcohol team and then there is a alcohol liaison service which is based in the hospital. So for both those services we have seen an increase. In the community in 2017 we had 176 new referrals coming into the service. In total it was 461. We are more or less looking at quarter 2 figures for 2018 of about 213, so again we are seeing an increase in that. We have a young person substance misuse worker who works with anyone below the age of 25, and there is 160 referrals in that and again it seems like alcohol, cannabis and ecstasy that they tend to use. Our needle exchange service, which provides sharps, needles, sharps bins and paraphernalia for injecting, we have seen an increase in that. Over 6,000 packs have been discharged from various sites, including the hospital and pharmacies, so there is an upward trend in the need for services. There is a changing landscape in what is being used on the Island.

Deputy M.R. Le Hegarat:

While I am with you, why do you think that that change has happened, that change in demand?

Acting Head, Alcohol and Drugs Service:

I think we are seeing a decrease in our traditional drugs of choice from heroin and cocaine. I think it is to do with supply. Occasionally we will get a peak in heroin or cocaine supply on the Island and that will increase the figures.

[9:15]

What we are tending to see is that people are misusing more prescription drugs, benzodiazepines, strong painkillers, and that is what we are finding our clients present with. They present saying that they are using things like diazepine or that they are using strong painkillers.

Deputy K.G. Pamplin:
Like codeine-based Nurofen and that type of thing?

Acting Head, Alcohol and Drugs Service:
Yes, so those that you can buy over the counter but we are looking more at things like benzamil and very strong painkillers.

Deputy M.R. Le Hegarat:
I am aware that you may not have had an opportunity to answer the same sort of question. Why do you think things have changed?

Community Mental Health Nurse:
We have a couple of different streams of working on mental health. We have got the referrals you are talking about come from different areas like G.P.s and allied health professionals and we have got a large stream that comes through the emergency services, through A. and E. or through wards. Like Simba said, I guess alcohol plays a large part in a lot of the emergencies that we see. I think alcohol and drugs often inhibit people's decision-making and leads them to A. and E. in a crisis. We also have an increased amount of referrals as a knock-on effect of the increase in the referrals C.A.M.H.S. have because when they turn 18 they transition into our service. We have seen quite a large increase coming through from the child and adolescent services. In terms of Miguel's comments, I probably echo that for a lot of referrals that we see. In neurosis, psychosis quite a lot of stuff has a psychosocial base and housing and finance and employment and all those sort of things play a large part in people's mental health and we see an increase in referrals related to psychosocial issues. There has always been a base of people with mood disorders or psychotic disorders, which is probably reasonably stable. It is probably the psychosocial issues that we see an increase in referrals from.

Deputy M.R. Le Hegarat:
In relation to C.A.M.H.S. you have given us an indication of that. How are the rest of you here responding to the changes in the demands that you are getting? How are you responding to those changes?

Community Mental Health Nurse:

I guess similar to the C.A.M.H.S. service, we have streams of work divided during the week. So we have people on call to deal with emergencies on a 24-hourly basis. Unfortunately the economy of scale in Jersey is that when you are working in the services you are all things to all people and so you have your regular work to do as well as your on-call work to do. We do not dedicate nurses and doctors just to doing the emergency stuff. We would do it on a rota and have the rest of our work to do. The reality is it is a struggle. There is no extra people that have come. There has been no increase in the workforce and the workload has increased a lot. So the reality is it is really, really difficult. A lot of the time you are juggling one thing against another to try and get everything done.

Deputy M.R. Le Hegarat:

Does anybody else want to make any comments in relation to how they are responding in relation to the changes in demand?

Consultant Clinical Psychologist, C.A.M.H.S.:

I would just like to echo the similarities to what Mike was saying. We sent through, in our written submission, a paper on the THRIVE model which has been developed in the Anna Freud. I thought that was a really helpful way of understanding the dilemmas in our service at the moment, that on a daily basis we are struggling to manage our time as effectively as we can and to get the balance right between supporting people that are presenting with high levels of risk and high levels of need and also prioritising the other streams of work, the specialist tier 3 mental health work that we need to do. Families may have a child with A.D.H.D. (Attention Deficit Hyperactivity Disorder), they may have a child with autism and associated anxiety, it may be P.T.S.D.(Post Traumatic Stress Disorder) anxiety or depression. That traditional area of work for C.A.M.H.S. is something that we are ... we are the only team on the Island that has the special skills to be working with children who have moderate to severe difficulties in these areas and yet we have a dilemma really about how much time we are able to devote, be creative, improve our provision for this group of need because of the increase in presentation of children who are taking overdoses, who are presenting with risky presentations that need attending to. But as Mike says, it is one team, it is the same team, and we are juggling. But those young people, once we have responded to the crisis, also need our specialist treatment. So it is not just the response to the crisis, it is what comes afterwards in terms of the treatment.

Consultant Psychiatrist, Adult:

Basically we are very much in the reactive mode as opposed to being proactive. It is extremely challenging to try to be proactive because it is not possible even to plan day to day because every day there are things that are coming up that need you to prioritise. I think there is also unfortunately the lack of understanding that mental health is a devolving business. It is not just mental health services and society unfortunately has been pushing what in my opinion, or in our opinion I think,

has been social issues that have been subject to medicalising and suddenly we are overloaded with cases that should be society's responsibility as opposed to our responsibility.

The Deputy of St. John:

What are the mechanisms that you have in place to support yourselves? In such a high tension environment you are going to have problems at times managing the issues for yourselves.

Community Mental Health Nurse:

We have regular supervision. We take supervision. It is not always possible to attend with the workload but there is a weekly opportunity for supervision for the nurses within our team, which is something that is very supportive. We have the nurse consultant who attends that, so we have input at an expert level as well. That is probably what we do to support ourselves. We work very closely as a team. We have good relationships with the doctors and everybody in the team. But, yes, I have to say it is more challenging than it has been. I have been here 21 years. I have worked in child and adolescent services, I have worked in the adult services, I have worked in the inpatient services, and it is much more challenging personally than it ever has been.

The Deputy of St. John:

There is a fluidity of movement between adult and child and adolescent psychiatry, is there?

Consultant Psychiatrist, Adult:

It should but it is not.

Community Mental Health Nurse:

It is not as good as it could be, is it?

Consultant Psychiatrist, Adult:

No. There has not been really proactive planning to manage what was coming. For the last 18 months there has been a series of changes in management with different perceptions of what is the priorities and the ways to tackle them that has led to what we could describe as suffering from fatigue change. It is all the time being made that we are going to be going one direction and then change is happening. At the same time there has been a history of chronic underfunding and a reasonable level of vacancies between 20 per cent of medical staff. So I believe that when the inflow of patients goes up without being prepared that has led to staff gradually becoming more and more tired. There is good staff but everybody is going through, as you would expect, people feeling there is only so much that you have and unless things change quickly it is more difficult to manage these crises.

The Deputy of St. John:

You mentioned that society had medicalised their social problems. Jake Bowley, in his submission, refers to reverting to the medical model in response to problems.

Consultant Psychiatrist, Adult:

People do not know how to manage and probably the easy way is just to push it and make it a health issue and you will have to sort it out. But the reality is that quite often, like I said, if at least 50 per cent of our clients presenting to our services had a good job, good socially supported work and proper accommodation they would not be coming. That is not happening and that results in people then feeling anxious and feeling depressed.

The Deputy of St. John:

The question I just put was are in fact services dealing with those social issues utilising the medical model, that is treating people with drugs rather than ...

Consultant Psychiatrist, Adult:

What is happening is that as a result of these 3 issues I have mentioned not being addressed then people will get anxious and depressed and they will have to treat that anxiety and depression and we have to use a combination of talking therapies and sometimes medication. However, the moment that we can lift that we are left with issues that have not been resolved so we are stuck.

Acting Head, Alcohol and Drugs Service:

I will just add that I think the difference with Jersey is if you pay initially you go to primary services, you see your G.P. The fact that you have paid, most people come back with a prescription from a G.P. Maybe normalising those things we have moved away from if there is a reaction that we know ... so where there is an action we know that there is a specific reaction in terms of sometimes it is okay to feel stress, sometimes it is okay to feel a natural reaction, but what people will tend to do is go to a G.P.'s surgery and you might end up with a prescription and by the time they come to our services they have already been prescribed drugs which they expect us to continue.

The Deputy of St. John:

So this is an interaction between your services and the G.P.s in terms of an understanding of how it would be best to address the problems of society. Is that what you are saying?

Acting Head, Alcohol and Drugs Service:

It is a continuous dialogue.

Consultant Psychiatrist, Adult:

That is one angle.

Consultant Clinical Psychologist, C.A.M.H.S.:

Can I just say that it is different for children in that G.P.s do not prescribe psychiatric medication if you are 18. They will always refer to us. If they think it is indicated they always refer on to a specialist.

Community Mental Health Nurse:

I do some work with the Recovery College in working alongside the third sector in psychosocial intervention to try and turn people away before they come to our door and give people coping strategies. But in the same scenario, if I take a couple of hours twice a week to do that, then it is a couple of hours out of my caseload for everything else. Nothing else changes in terms of your caseload. There is other streams of work that we engage in the best that we can but it is just the difficulty of logistics really.

Acting Head, Alcohol and Drugs Service:

Just to add in terms of how we are dealing with changing demands as well, it is understanding that there is work that needs to be done outside of the States provision in terms of the recovery agenda, so working specifically with charities and churches out there who would offer something that we cannot: a drop-in service, for example, just to have a cup of tea versus coming in and having a discussion specific to your problems that you are presenting with, that psychosocial workaround. It is more or less looking at working with other services not, if you like, providing, being the one-stop shop for everything.

Deputy K.G. Pamplin:

Picking up on that point, I am going to talk a bit about communication. It is not surprising from my background, but picking up on your charity point, in my previous background I was business manager of the Jersey Brain Tumour Charity and Headway Jersey. So our very basic rule of thumb was we were there to provide practical, financial but emotional support from the absolute moment of crisis whenever that diagnosis is made or after the head injury or whatever. That is just to give you some context of where I am coming from and the communication between the third sector who are very much fundamental to people's lives. Communication is key and one thing we discovered very quickly is to have that constant communication when you are being passed around a complex health system and social security and housing and when you are dealing with things differently. So how important is that good communication when dealing with people who are suffering, who are struggling or dealing with any form at any level of mental health problems?

Community Mental Health Nurse:

Communication with the third sector or with the ...

Deputy K.G. Pamplin:
With people themselves, the patients.

Community Mental Health Nurse:
It is paramount, is it not, and we work on a co-constructed model where, you know, nothing about me without me basically ... that we would ask people to be involved in every stage of their care plan and their treatment. Outside of somebody under an article of the mental health law where sometimes, for reasons of health and safety we do have to take control of the situation, we would communicate fully with people. We work a lot with Mind and with the carers support group as well, as a triangle of care and involving relatives and carers at every stage that we can. We always run up against the confidentiality issue that can always be quite challenging and we just have to abide by that. There is not a way round that unless you can override it for reasons of safety.

[9:30]

But we would look to co-construct every sort of element of care that we can and involve carers and whatever third-sector charities are involved as well if it is appropriate. Like I say, we work a lot with Mind, with peer support, with carers. We work with the Recovery College with the courses that they run.

Deputy K.G. Pamplin:
To flesh it out some more as we go round, what mechanisms would you do? If I am your patient, how would you keep in contact with me? Is it email, is it texting, is it phone, and how does that develop over time? I guess it is based on the individual but just to paint a picture.

Community Mental Health Nurse:
Everything is individualised. I guess most of it is face-to-face contact. We love to have face-to-face contact with people in terms of psychiatric assessment. There is certainly a lot that you lose in texts. Texts can be misinterpreted when there is no mental health issue involved, to get the congruity between what somebody is saying and how they are presenting. Most stuff is face to face but we certainly would email people, write to people, text people, phone people. I do not think there is any limit or exclusion really. It is whatever is most appropriate at the time, but in terms of assessment we would favour face to face wherever possible.

Consultant Psychiatrist, Adult:
As I was listening to my colleague I was just writing a few points. I wrote corporate action, collaborative work, involve plenty of carers, moving away from the paternalistic approach in which

we are health professionals: "We know best, therefore we tell you what you have to do." It is a joined-up way of working. We have to bear in mind that it is very difficult to have a blanket role. I think we should be looking, as my colleague said, at individualised care packages. It might be the case that we are dealing with young people who are very much with social media and they would rather use that as opposed to the face to face. I think we have to be creative. It is often the case that patients need to feel safe and the place where they feel the most safe is their own home. So this thing about getting them out of the house to go to accident and emergency or to come to see us in the community I do not think is necessarily the way forward. So I think that needs to be explored and communication is the key to success and that it is clear and is consistent. I think that is why it is essential that in the reconciling of our services that patients and carers have a very relevant input otherwise it will be ourselves figuring it out for them, which is not right.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

I think from a C.A.M.H.S. perspective it is integral to our way of thinking about how to approach a problem. We always work with the systems around a young person and that, firstly, involves working very closely with their family, their parents and carers as a part of their treatment and that is core to our way of working. In terms of communication with other agencies, we often liaise very closely with the school, with Children's Services where necessary and a number of third-sector agencies. We have joint parenting programmes with Autism Jersey in terms of support for parents of children with autism and then a parenting programme in collaboration with The Bridge. We work very closely with our colleagues on Robin Ward to support young people admitted there. We try to invite people from other organisations to our team meeting on a regular basis so we can develop links and just so we know we can work together, share our skills. I think it just facilitates a conversation if you know who you are talking to within those services. Again, it is a small place. It is often one or 2 people who may be working in the services that we need to make links with, and they are invaluable really. I think some of the links we have there are very helpful in supporting children and young people. But I think there is always room for that developing further. In terms of communication with the families, every time we see someone if we write a letter we will always copy the young person and their family into that letter so that it is transparent what our thinking is, what the assessment is. Again, I guess we do not use terminology like co-production quite so much but it is that theme that we are working together to come up with a care plan that is going to work for the child and family together. But you are right, communication is absolutely key to what we are doing all the time and it is often what we are working with in order to try and make things better.

Acting Head, Alcohol and Drugs Service:

I agree with what has been mentioned already. For us communication is key specifically when we are dealing with families involved. We have to be clear whose agenda is driving the presentation. Sometimes at home it might be someone, for example, with alcohol problems, that they have an

alcohol problem, it is a clear alcohol problem but the individual concerned is not ready to engage yet and yet it is the family or friends that are driving the presentation. So communication is key in that respect. Also when it comes to having a difficult conversation in our opiate replacement prescribing, oftentimes people might want more medication where it is a negotiation in terms of looking at either psychosocial interventions besides just increasing methadone, for example, or things like that. I agree with what has been mentioned. Without communicating with multidisciplinary teams and other agencies and families, we are on a losing streak if we do not do it.

Deputy K.G. Pamplin:

Thank you all for your answers. I want to dig into some of the comments you have been making this morning. I am hearing, just to quote you: dilemma in the service, prioritising specialist work, juggling one team, pressure, crucial underfunding. If that is going on, would it be a fair summary to say that the communication part of things is not as good as it should be because of these issues and also part of the submissions and part of what people are telling us, inadequate I.T. (information technology), systems of how you communicate with patients, the struggle with G.D.P.R. (General Data Protection Regulation) this year and data protection? Is it fair to say from what you are describing to us this morning that there is a problem with communication because it cannot be consistent otherwise what you are telling me there is a ...

Community Mental Health Nurse:

But out of all those things that you mentioned there, it would be the time of the issue. I would regularly get an email when I am in one appointment to say somebody has phoned up and could I give them a ring back. It could quite often be the next day before I have any time at all to do that. I would like to phone them back straightaway but there is just a reality that it is impossible.

Consultant Psychiatrist, Adult:

Yes, I agree entirely with what you just said. I will just give an example. Within Health, for example, Jersey Talking Therapies has their own system of communication which does not talk to our system of communication in adult mental health which does not talk to the system of communication which is in accident and emergency which does not talk to the main part of the hospital. How can you expect ... it is often the case that you have to spend your time really making sure that in order for the information to be conveyed appropriately you have to talk to 3 or 4 different people because otherwise you cannot trust that the information is going to be disseminated. Can you imagine when there is a change of shift and people and handover and at the same time you are working in an extremely reactive environment with crises coming up?

Deputy K.G. Pamplin:

To pick on that point, to give you a scenario, it is 1 o'clock in the morning and a young person is in crisis, with that scenario you just described; that is not good, is it?

Consultant Psychiatrist, Adult:
It is a very good one because to start with a young person presenting at 1 o'clock in the morning will not have access to the same service that they would be having access to if they were presenting during working hours. Unfortunately there is no provision for young people after hours. It comes to the adult mental health bit and that is unfortunately how it is because the C.A.M.H.S. service is already overstretched and the C.A.M.H.S. staff that already do shift work completely feel miserable because it is not humanly possible.

Consultant Child Management Psychiatrist, C.A.M.H.S.:
Can I just clarify that? I agree there is no dedicated response to young people out of hours but our colleagues in adult mental health do provide a response. They do get a response. It is just not a dedicated C.A.M.H.S. response to that.

Deputy K.G. Pamplin:
From what is being described by yourselves about the lack of I.T. systems, communications, if a police officer is called and does not have the information available or the social worker is not available, someone else gets involves. That is what we are talking about; it is what you are describing this morning.

Community Mental Health Nurse:
The nurses at A. and E. cannot see our notes. Our system does not talk to A. and E. It is only the consultants at A. and E. who have got our notes.

Consultant Psychiatrist, Adult:
No, not even.

Community Mental Health Nurse:
Not even the consultants, yes.

Deputy K.G. Pamplin:
From a professional point of view, what would that do to somebody in a moment of crisis if they had to re-explain their situation to a new person?

Community Mental Health Nurse:

It is negative, but it is also about the treating clinicians in A. and E. being able to have the background and the context about that person's story so far, which is vitally important in their assessment.

Consultant Psychiatrist, Adult:

But something is not working because that should be the very, very last resort of somebody landing in accident and emergency, whether it is a young or an older person with police attendance. That should be rare and unfortunately it is often becoming the norm. For that to become the norm, that is indicating that something is not really working how it should be. When you look back at how these individuals are presenting at this moment in time and you get the history, you can really pinpoint where everything has started, that if something could have been done at that moment in time it would have made it less likely that they were presenting in these crises. When they present in crisis, obviously there is an amount of suffering that the person would have been experiencing that is compounded by this lack of appropriate communication and lack of adequate services happening. As it is compounded, the person becomes more distressed and more agitated and then is more difficult to manage.

Consultant Clinical Psychologist, C.A.M.H.S.:

What we do for young people who have had quite a lot of problems outside of hours and maybe their families are calling the police, we have a way of communicating with the police. With consent from the family, we share information with the police so that a summary of the situation is shared with the police database, so if they are called out of hours they have a bit of a context, a bit of an understanding of what is happening within that family. They are very helpful to deal with directly.

The Deputy of St. John:

Do you have a home visiting service?

Community Mental Health Nurse:

Yes. There is a number of clients that just do not want to come to La Chasse to be seen and there are people with issues that restrict them from getting out, but we do not have a separate service for it. Again, it is just all the same team doing it and obviously there is the logistics of doing a home visit where you might get one appointment in 1½ hours and you might have got 2 or 3 in if people came to see you at the clinic. We do do it but it is the same people and it is time from one part of the service to another.

The Deputy of St. John:

We have heard from various witnesses that psychiatric nurses do not do home visits.

Community Mental Health Nurse:

That is not true from our service.

Consultant Psychiatrist, Adult:
But there is not a dedicated home treatment, only that, and it comes down to the same, that we only have one team and we have to be really prioritising on a daily basis where it is required. Unfortunately the crisis is such that the only way to manage the situation is what you told us what you would be doing, which is far from what we would like. We would like not to have to go to people's home because they are in crisis. We would like to be able to have the resources to go well before there is a crisis because that is the best environment for the person and what should happen, but the reality is that there is not a dedicated team, not because of a lack of willingness. It is because of lack of resources.

Deputy C.S. Alves:
Just following on from Trevor and Kevin, I understand that in C.A.M.H.S. this might be slightly different because you are dealing with minors essentially, so communicating with families and friends obviously is a different procedure. You have mentioned G.D.P.R. and other issues. Are there any other mechanisms that you have to communicate with friends and family? We have heard from some witnesses who were being cared for by friends but they were not always involved or aware of what was available to them. Are there mechanisms, are there things where you point people in the right direction, and at what point do you do that?

Consultant Clinical Psychologist, C.A.M.H.S.:
Within C.A.M.H.S. it has to be led by the wishes of the young person, so obviously it varies depending on their age but say, for example, if it was a teenager that I was working with, I always try and encourage them to involve anybody that can be helpful and I am always trying to encourage young people to involve their friends in conversations. I normally get a "no" first time; I wear them down eventually. But that communication is difficult and I understand that because a lot of the young people coming to talk to us are talking about being very worried about their friends who have got mental health difficulties.

[9:45]

So we have been doing some work with the pastoral support teams in different schools and the pastoral support staff have been running assemblies and little groups and really trying to encourage young people, if they are worried about a friend, to take that to an adult rather than holding it, because it is too much. Young people who are trying to support a friend who is feeling suicidal is stressful. It is my job and it is stressful for me doing it. If you are 15, it is not okay. So we are really trying to change that culture, but obviously children are loyal to their friends. They do not want them

to think that they are talking behind their backs. So that is some cultural change that is needed. Also, although their friendships are invaluable, it is very core to the way adolescents function, again it is that thing about a responsible adult being involved in the conversation. There are limitations to what support friends ... they provide great support but there are limitation. Particularly when there are risk issues we need to be involving the responsible adults in their lives in keeping them safe, but we will involve friends as well where necessary.

Consultant Psychiatrist, Adult:
Information is key for us and I cannot imagine having the opportunity to see reliable informants willing to be part of the process with the consent of the client that we will not embrace. We do embrace that and in fact whenever a patient comes to see me and they come with a relative it is up to them. If it was up to me of course I would want them in because I will gather the 2 sides of what is happening. So there is a very clear understanding for mental health services that carers are to have a role. However, it comes down to the individual and I think that is not always conveyed clearly by the individual themselves.

Acting Head, Alcohol and Drugs Service:
At the start of any treatment, we get our clients to sign consent forms that stipulate which services to include in their treatment and care. In care plan reviews and treatment reviews we also look at the issue of consent and we are guided by principles of sharing, principles as to what to share, when and to whom.

Community Mental Health Nurse:
I probably get as much contact with relatives and carers and friends as I do from clients themselves throughout a working week. Somebody will be concerned about somebody or calling up to say that they cannot make it at a certain time. But I was just thinking about your question about when they are involved and I was thinking about the large stream of our work, which is the risk assessment in A. and E. Generally part of every safety plan that we make would be, if somebody was going to go home with a care plan and follow up on that, generally that they go home with somebody or that they have got somebody with them. We know in terms of risk it is vastly reduced if people are with somebody else. So generally the first point where people are involved is probably during that initial assessment in E.D. (emergency department) that we are looking to. If we can construct a safety plan to keep somebody safe overnight then we would be looking at involving carers, friends and relatives at that point right at the beginning, probably about an hour in from meeting the person.

Deputy C.S. Alves:
You have kind of mentioned it a couple of times in different scenarios, but if someone is experiencing a mental health crisis, how do they come into your care specifically?

Community Mental Health Nurse:

If it is a crisis we have got an emergency pathway that goes to A. and E. out of hours and sometime comes through G.P.s during hours, but depending on what the crisis is we still might want that medical screening. In terms of crisis it is largely through G.P.s and A. and E. It might be a medical ward if somebody has, for instance, taken an overdose or something and they have been treated and then medically cleared to get a referral from there. We will get faxes and calls from G.P.s from their surgeries with people in front of them. That would be a lesser stream than the medical wards and E.D. but we do get that as well when the G.P. can be confident that they are medically okay and they might organise an urgent appointment that day, either at La Chasse or down at the A. and E.

Consultant Psychiatrist, Adult:

The police also.

Community Mental Health Nurse:

Yes. The police and also the prison. The prison has access to our on-call service as well. They have access to that and the police is an increasing stream of work where people are detained in the police cells and there is concern from the forensic medical examiner about somebody's state of mental health and wants an assessment.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

It is all of those things as well for us and also schools with young people in crisis and academies may contact us about their young people.

Deputy M.R. Le Hegarat:

I would like to get your views in relation to the mental health estate. We know that the mental health estate has had lack of investment in recent years. What do you think are the main problems in relation to the mental health estate at this present time?

Community Mental Health Nurse:

That is a big question: underfunding, is it not? The estate in terms of the inpatient unit really needs rebuilding. Orchard House itself I would say is an inadequate provision for the Island. In terms of the community, it is about attracting people. I think there has been investment. We have got jobs waiting to be filled but we cannot get anybody into them, so it is not that there is not money for jobs. There is jobs but there is not people applying for them. I think it is all about the funding to the service.

Deputy M.R. Le Hegarat:

Before I move on, you just mentioned about nobody applying for those jobs. Why do you think that is? You have been here 21 years so maybe you can see ...

Community Mental Health Nurse:

Yes, I have been here 21 years. I do not know. I do not know if the way that it is advertised needs looking at, the way that they advertised in gov.je, whether they need to go out to different sort of formats of Facebook, LinkedIn and those sort of things, which may have more success than we are having in recruiting. It is not as attractive to come here in terms of wages as it used to be. The cost of living is really, really high. We have had people come and then they realise just how much rent is and go back. We have had people that on paper have felt an attractive prospect. So you are really selling the idea of the Island as much as you are the job, but it comes down to economy for a lot of people, does it not?

Acting Head, Alcohol and Drugs Service:

I think we need to be a bit more creative in how we market the Island. In terms of health, we are not as good as some sectors like finance, for example. We need to step up, go to the mainland, go and sell the Island, because I think our unique selling point is lifestyle on the Island and I do not think we do much of that. All they see would be an advert that says: "We are looking for a nurse in a ward and we will pay this much." They can see that in Northampton, they can see that in London, so we need to be more creative in that. Also once they are here I think there is a lot of work that needs to be done in making people feel assimilated and part of the culture.

Consultant Clinical Psychologist, C.A.M.H.S.:

We have done quite a bit of work in C.A.M.H.S. We have been over and presented at conferences and taken out advertising. People do apply to come and work in our team. We do a lot of work to support people in coming over and that is another thing compared to finance where my understanding is that H.R. (human resources) are a little bit more proactive in supporting people relocating to the Island. That is work we are doing ourselves as goodwill really in the evenings. We have currently got a couple of nurses who are moving over to the Island and we have been emailing them, helping them out with looking for places, just in our own free time really to support that. People will come. They like the nature of the team, they like the people. It is quite difficult to transition and there are recruitment difficulties. At C.A.M.H.S. in the U.K. there has been quite a lot of investment. The U.K. Government have recognised the increasing demand and the lack of provision for children with mental health difficulties, so their services have grown in the U.K. and that has had some impact in terms of there is a finite number of people coming through the training programmes. But there has been some investment here. There is a local nursing programme, so there is a cohort of locally trained nurses. That has started but I think we have not seen the results of that. It is fairly new.

Consultant Psychiatrist, Adult:

When I see a client that is in the finance industry and they have relocated to Jersey and I ask them: "Why did you come to Jersey?" the first thing they say is: "Because they offered me a good package." We are unable to offer a good package, that is one thing. There is the happiness of your workforce. We are an unhappy workforce; we are tired. So how will that translate into making it appealing? That is the reality. You have a very well prepared, hardworking workforce which has been put under a ridiculous amount of pressure over a protracted period of time and realistically there is not going to be a quick fix. So until we change the habits, we still have a long way and we are really running low. We regret so but it is very challenging. I think this too is essential. Going back to the estate, I have to bite my tongue but when I first came here and they told me what I have the first day I was told ... I came from a unit that was gold standard in Australia. I had worked there for the previous 8 years and I was looking what does this ... do not worry, it is not fit for purpose and it is going to change. That was 9 years ago and for the last 9 years my colleagues and myself we all have had to work in a unit that is not fit for purpose. We are in the community. We work in a building that they really have to be very aware of how to moderate their voices because otherwise next door they can hear what you are talking about and we have been working in these conditions for years. The admin staff have a very narrow area to work in. It is a waiting area and already the first impression is not going to be ideal and again you have to be very mindful of how you talk because it could be heard.

Deputy K.G. Pamplin:

It begs the question, does it not: why did you stay?

Consultant Psychiatrist, Adult:

Why did I stay? Because I am a dreamer. I am an idealist and I am naive. So be it, but I am here because I believe things are going to change really now more than ever. I think for me, this is it, get it right now or I see no point in staying. I really believe it is going to change. Everybody is talking about it. Everybody I think finally gets it, so I believe this is going to happen but it is not going to be an easy ride.

Deputy M.R. Le Hegarat:

We need to make sure we change it so that you stay then?

Consultant Psychiatrist, Adult:

I hope so.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

Can I just make a point about this? I think it comes down to one of the things again about parity of esteem for mental health problems as well, the buildings that we see our patients in being of equal

quality to the buildings where we would see people with physical health problems. Also I think this is a great opportunity to build those links between mental health and physical health with all the discussions that are going on about the health estate at the moment. But I think it is just something about recognising that mental health problems are as important as physical health problems.

Acting Head, Alcohol and Drugs Service:

I just wanted to pick up on that point. Some of the buildings that we work from I do not think make our clients feel valued. Ours at Gloucester Lodge, the same as La Chasse, we were told is not fit for purpose and we will be moving. I am told by my colleagues who have been in the team for longer than I have that this has been an issue that we have come back to. We have got a running joke that even the rats have moved out, that is how bad the building is. Again, maybe I am just naive but our directors have been and given assurances that this is priority number one and that we will be moved somewhere. So we are hoping that things change, but the key is it is how it makes our clients feel. Coming over to old buildings that are full of mould is not as welcoming.

The Deputy of St. John:

Not very at all. Recent moves have put C.A.M.H.S. and Social Services together. Is it being a success?

Consultant Child Management Psychiatrist, C.A.M.H.S.:

Well, at this point in time we have not actually transitioned to the Children's Services. We are still in a state of ... we still remain under Health and Community Services.

The Deputy of St. John:

But they have physically relocated you?

Consultant Child Management Psychiatrist, C.A.M.H.S.:

The building, yes. We are in the same building, yes. It is a newer, brighter building, which is in the centre of town, so it is a lot more accessible for families.

[10:00]

I think that has its downside for some young people because it is very visible when they are coming into the C.A.M.H.S. building and we have had some comments in our book on the desk saying that that is a difficulty for some families.

Consultant Clinical Psychologist, C.A.M.H.S.:

On your comment about how it makes people feel coming into the building, to my mind it was not at the heart of the spec in the many conversations we had about moving. To me, it felt as if the move was about an idea of corporatising a one-stop shop, a one.gov children's service all together. I think if you had asked our clients - and we do ask and talk to our clients regularly - about their ideal provision for a child mental health service, they would have come up with a different concept, something with more privacy, something a little bit more discreet that they could go to without ... it is difficult. Jersey is such a small Island and people come to our service and, okay, we want to reduce the stigma but people are coming and they bump into people they know all the time and it is difficult. We are trying to encourage people to come to us rather than us go on home visits, for that practical reason of our time management, so we really need to provide an environment that is warm and welcoming.

Deputy K.G. Pamplin:

Did anybody at any level of C.A.M.H.S. have any say in saying: "Hang on a minute, we have doubts about this move" or was it literally, and I know it is probably out of your powers and remits but: "You are going here"? You have just instinctively said all the things that we are starting to hear from young people and other people, that it looks like a bank, there is no privacy, it just does not look like a place to go and get well and get support. At any level did anybody at C.A.M.H.S. have a say?

Consultant Clinical Psychologist, C.A.M.H.S.:

To be fair we have had really mixed feedback. Some people come in and they are like: "Oh, it is beautiful." They like the architecture, they think it is quite ... and then other people ... there is a range of feedback. Yes, we had a lot of conversations over the last ... we have been talking about leaving Royde House for 9 years. Over that time there were a lot of conversations about our hopes, our wishes. We canvassed, we have done surveys, had posters up in the waiting room, we have had dialogues with families. The information was all there about our ideal, our hope, but then there was ...

Deputy K.G. Pamplin:

Just to be clear it was a case of: "You are moving here. We have got this on your aspirations. We do not have that available. You are going here"?

Consultant Clinical Psychologist, C.A.M.H.S.:

It has met some of the requirements and not others.

Deputy K.G. Pamplin:

But that is what you are describing, after 9 years: "You are moving here"?

Consultant Clinical Psychologist, C.A.M.H.S.:
Yes.

Deputy M.R. Le Hegarat:
Should mental health services be all brought together in one location?

Acting Head, Alcohol and Drugs Service:
It is a difficult one. If we are talking about maybe bringing drug and alcohol services in with maybe some service provision where we have got client groups that are quite vulnerable that might cause problems in itself. Without doing a disservice to my client group, some of them are quite creative in how they try and either make money or access drugs, prescription drugs, and we know that there are some prescription drugs being prescribed by other services that would be very, very attractive. So, for me it would be with caution.

Consultant Psychiatrist, Adult:
I think integration is the key word but integration of mental, physical and social. The idea of a campus that facilitates and promotes integration is very much the way forward as opposed to one building holding everything. I think we have in this Island a big issue with stigma that needs to be recognised and addressed. I have to say that a bit of what you were describing before, for me it is only recently, the last 12 to 18 months, that I have been asked for my opinion and that has been consistently more and more listened to. That is also helping me to believe that things are going to change because we have something that people are interested in listening to, which in the past did not seem to be the case. So I think as long as there is integration and as long as there is a sort of campus it would be okay. Now the new hospital is very interesting. Where I used to go to the consultants meeting and they were talking to us about the new hospital and I remember on at least 3 occasions raising my hand: "What about mental health?" and the answer I got consistently was: "We will come and talk to you" whereas now I have been able to say: "What about mental health?" and they said: "We need to make sure that the hospital is going to capture mental health to help address the issue of the stigma. We really need to find a way for joint shared care for patients with cancer, mental health and with physical health. We do need to look at how we do that." That was unheard of not that long ago.

The Deputy of St. John:
Hopefully in January the States Assembly will be voting upon whether to stop things as they are and find a site that is large enough to accommodate mental health and general facilities and also expand into other things like radiotherapy and so on.

Consultant Psychiatrist, Adult:

Like I said before, the important thing is that whatever the building that it really captures the needs of proper integration and there has to be a shared care approach to patients in general. It is now widely recognised that anybody who is in the hospital with any sort of physical health issues with a comorbidity with mental health issues that is in different addresses, different places is going to be much less appealing. For me it is not so much about the building as much as it is that it really promotes and ensures that integration is happening.

Deputy C.S. Alves:

Going back to C.A.M.H.S., when a child or young person who is in C.A.M.H.S. reaches 18 years of age, what happens to them? Do they transition to adult mental health services? If so, how does that happen?

Consultant Clinical Psychologist, C.A.M.H.S.:

I think that would depend on their needs at the time. I do not know the actual figures but a small proportion will have ongoing mental health needs of a serious nature that will need ongoing care from adult mental health services. At that point we would help them make the transition to adult mental health services. I think there is a need to develop more robust procedures for that happening. As I mentioned in my figures at the start, that there is a high proportion of difficulties in that 17 to 19 age group, so there is quite a lot of need there. I think thresholds are different between C.A.M.H.S. and adult mental health services. We talked about one example about the young people prescribed psychotropic medication that would all be done by C.A.M.H.S. whereas when people turn 18 and become adults, G.P.s are more prepared to take on some of the responsibility for prescribing in that age group, so that is one of the differences. But we would also look to other services that may be able to support young people, such as Jersey Talking Therapies and maybe primary care could go on to support them and some of the other psychosocial supports that we have talked about. The Social Security Department have developed quite a lot of support through a different team for people who need support into the workplace. It is really a negotiation; from around the age of 17½ we will start to talk to young people about what would they like to be doing in terms of support. Do they want to have a break and see how they get on without mental health services involved? There are some different options just talking about it around the mental health team.

Consultant Psychiatrist, Adult:

In the ideal world, I would personally like that it is not as it is now. You get to 18 or just close to 18 and then you go to adult. For me that does not make much sense. I think it would make more sense to have like a dedicated service that is just looking after aged 16 to 25, 27, and that is really going to ensure that there is going to be consistency and clarity at this crucial part of their development and their adapting into society. This current system is not working, in my opinion, as well as this other one would. It is again going to come down to are we really going to be able to have the

resources in place to implement it, because at the moment we are constantly in the reactive mode. As we finish here, we will go to work and we will suddenly be landed with so many demands that we will have to prioritise let alone plan forward to develop.

Consultant Child Management Psychiatrist, C.A.M.H.S.:

That is what I was going on to say, that that is the situation at the moment but I think we would like to look at maybe a older adolescent, young adult service to try and bridge that gap rather than it being a distinct change between the 2. It is the time when there are lots of transitions in young people's lives, if we could have a service that provided more continuity across that. Also from a neuroscience point of view, adolescence actually continues until mid-20s in terms of brain development. So recognising that in terms of the services that we provide is important.

Deputy C.S. Alves:

My next question was going to be if somebody does come into your service where they are just under 18 years old, do they go to C.A.M.H.S. or do they go straight to ... how does it work? What you mentioned there would refer to somebody who has probably been in your care for some time by the time they reach 18, but if somebody comes in, has a referral and they are 17½ or something like that, how would that work? Would they still go to C.A.M.H.S. or do they go to ...

Community Mental Health Nurse:

It would go to C.A.M.H.S. in the first instance if they were under 18 and it really would depend on what was in the referral. So if it looked like a discrete piece of work that might be a couple of months or something at 17½ then it would make sense that it stayed with C.A.M.H.S. but if the referral was for somebody who was close to 18 and it looked like they were going to be have an enduring mental illness then it would make a lot of sense to form a relationship with one service and they would come straight to us. But it would just depend on the nature and I guess a little bit about your prediction of what course that care might take. But just on your previous question about the referrals in from C.A.M.H.S. across to our service, we would get much less in terms of referrals as Laura said. They would have a discussion with people and say: "Do you want a referral?" and quite a lot at that point will say: "No, look, I will go to J.T.T. (Jersey Talking Therapies), I am going to do other stuff." But we would get an awful lot of people that we see that would have been in C.A.M.H.S. and have had a few months, they have had 6 months or something, or they have gone to J.T.T. and they have mentioned some elements of risk and J.T.T. will not work with them. That is the other thing with J.T.T., if there is any element of risk of suicidality then they refer everything back to us. So the majority of people who come to us from C.A.M.H.S. would come in as a new referral, having left C.A.M.H.S. and decided not to continue with the mental health services at that point and have a referral but then within a number of months being re-referred either in crisis or because they have gone to their G.P.

Consultant Psychiatrist, Adult:

Linking in with what has been said, as you are well aware, J.T.T. is overstretched with an unrealistic waiting list which then by default lands with clients coming our way, which is not what we are meant to be accounted for but it is what is happening. It is putting a huge amount of pressure on our services. For example, there is an A.D.H.D. list but now they are coming straight to us also because they are overstretched and we were not prepared for it. So these cases have now become ... then suddenly with A.D.H.D. we have had to find a way to look after them and also their awareness of other attention deficit orders that have big numbers coming our way on top of what we have is really putting our services under a lot of pressure.

Deputy K.G. Pamplin:

I just want to pick up on a couple of points you have been saying about how one of the main entry points for people is their G.P. and it is the G.P. that starts the referral process. I just want your thoughts and comments here. For most people they have to pay to see their G.P. and we have a unique system in Jersey where we have a general public hospital, a number of health-based charities but the entry level is to see your G.P. and you pay to see your G.P. over here. Various practices have pay models but generally speaking you have to pay, with the caveat that in the U.K. there is long waiting lists to see G.P.s, I get that. I just want to keep the focus on the Jersey. If somebody is in crisis or somebody needs that referral, how impactful are you seeing it, with the rise in demands that people are getting to the worst case scenarios because they are making a decision because of what you described earlier, the social scenarios, they are making a choice not to pay to go and see their G.P.? I just would like your thoughts on that as experts in your field.

[10:15]

Acting Head, Alcohol and Drugs Service:

I am currently involved in a work scheme that is looking at emergency department attendees and the figures that are coming back is there is quite a large number of individuals who present to E.D. specifically because they do not wish to pay to see their G.P. to kick start a referral. Also oftentimes if you end up in E.D., you end up with an admission and you get quick access to treatment. There is no waiting list, so there is no referral that you have to wait to be processed to get into the system. Speaking specifically for the Alcohol and Drugs Service, a large number of final referrals are coming through self-referral, so we do allow self-referrals. We have taken that element of needing to see your G.P. first to access services. But what it means is that we have to do a lot of screening first to make sure that we get the right kind of client, good client.

Consultant Clinical Psychologist, C.A.M.H.S.:

Within C.A.M.H.S. there is the opportunity for parents to go into school and talk to their pastoral support team in the school. We have everything, we have lower rates of G.P. referrals then within the adult service and it gives us that extra option. However, obviously that does not suit all families and, depending on the nature of the problems, people would like it to be a little bit more private. It is not something that people talk to us very much about, I have to say. There is some diversity within G.P.s now; some G.P.s are not charging so much for children, for appointments for children. It comes across as a burning issue from the families that I talk to.

Consultant Psychiatrist, Adult:

It is a very good point. Again, when I first came I was surprised, there was a daily mental health called the adult recovery team, of which I was the lead. This team was meant to look after patients who were suffering through mental illness anything above 2 years, so it was a huge caseload. I suddenly found out that we had in our books 300 or 400 patients, which was completely unmanageable and then the natural instinct was to resort to G.P.s. However, I found that the G.P.s were looking to be paid. We were dealing with a group of patients whose main symptom often was the lack of insight, lack of awareness of being unwell, therefore they would not want to take medication. We were telling them that they had go to the G.P. to really pay to get something they did not want in the first place, so that is, again, something for me. I like to think of me as very, very pragmatic, so I thought this needs to change, we really have to have a way that at least this cluster of individuals can have direct access to G.P.s to get medication and it is going to be free of charge. Nine years after it is still not sorted, despite of what has been told. I know patients that will rather have money to be spent on coffee or cigarettes or you name it, as opposed to going to the G.P. I think, again, the risk of really resorting to the G.P.s as the first point of contact, it is really, again, the medicalising. People come in crisis because they broke up with their partner, because they are having problems with colleagues at work, you name it. I think it would be good, which has already been developed, if it is called like the visiting lounge or a place where people can go to and they really can get staff that are trained and really being able to listen and to counsel them. From then onwards if it is perceived that they need to de-escalate it then it would go to the G.P.s. What is happening now, when people are in crisis the financial issue can act as a deterrent. They understand that they can go to accident and emergency and it is going to be free of charge. Related to people presenting in accident and emergency, that relates to accident and emergency not being used for what it is meant to, again with the department becoming even busier for something which they are not meant to be dealing with.

Acting Head, Alcohol and Drugs Service:

I think also just to add on to in G.P. surgeries, the alcohol pathway team came from the P.82, mainly the White Paper 2012, and one of the key things there was that we need to move away from providing services just from one location, say drug and alcohol, to maybe G.P. surgeries and other

community venues. Following from that, we have been able to get into a few G.P. surgeries: Health Plus, Castle Quay, Indigo and Cleveland Clinic. In those G.P. surgeries the individual does not necessarily need to see the G.P. They can be signposted to us and we can see them free of charge. We have a budget to pay rent for a room within the G.P. surgeries. Some G.P.s have not welcomed that idea. We have approached and they have not accepted an invitation to come in and provide services from their locations.

Deputy K.G. Pamplin:

What is the ratio of that, because obviously there are quite a few surgeries? If you were going to put a figure on it, the ones who have been welcoming and the ones who have not, if you just put a number …

Acting Head, Alcohol and Drugs Service:

No, but from the ones I have approached I would say probably 80 per cent said yes. We looked at where we get most of our referrals from and we targeted those. From that I would say, anecdotally, probably 80 per cent, I think, said yes.

Deputy K.G. Pamplin:

Just to be clear, you have to pay rent for that to work?

Acting Head, Alcohol and Drugs Service:

We pay for the room.

Consultant Psychiatrist, Adult:

There is a case for, again, what is happening is that G.P.s, who are often well aware of mental health issues and how to relieve back home, they are nowhere great, they see somebody who is suffering from an anxiety disorder or a depressive illness and they are aware that they should be arranging some sort of psychological input. However, they are told that what is provided by the Government, Jersey Talking Therapies, there is a waiting list of 6 to 12 months, which lands with them having a patient that they do not think that they are able to do what they are meant to do, that will make them maybe prescribe more than what they should and maybe they end up referring more to us than they would have otherwise, which, in turn, leads to everybody being more overworked and not being able to do what we are meant to do in the first place.

Deputy K.G. Pamplin:

It is interesting you mentioned talking therapies because it has come up a lot; I am not surprised that it has come up again this morning. You mentioned the I.T. system but the approach, the idea of talking therapies is sound.

Consultant Psychiatrist, Adult:

Yes.

Deputy K.G. Pamplin:

I do not think anybody is disputing that. In your opinion, how can we fix this? It just seems it is a very holistic … the answers are right there, just simply is it funding or is it just a different way of thinking that there are alternatives out there? There are charities who are ready to refer. It is just a linked-up pathway that is required here and funding, I am guessing, is what I am hearing.

Consultant Psychiatrist, Adult:

I think you are completely right; it is exactly this. We are relying more and more on the third sector and that is key, which instead of separate silos, we are working together. That would really help to really get Jersey Talking Therapies doing what they are meant to do. I think that when the doors were opened in Jersey Talking Therapies there was a lack of being proactive in making sure that what is gathered is only what is meant to be. It was the widening of the access to the services that has landed with them now having a limited resource and too many clients and their inability of having access, which is really compounding the problem. I think just the case of having more binding from the third sector, there is more investment that needs to happen. There is a current backlog that needs to be sorted and until it is sorted I cannot see how this is going to change. There is a counter from other mental health that there is a lack of psychologists; we do not have enough. We do not have the staff that have some degree of training in C.P.D. (continuing professional development) but really the psychologists per se, compared to where I have worked before, we have much less, which is not really helping. The third sector, there has to be more services and there has to be more psychologists in secondary care.

Deputy K.G. Pamplin:

A crucial part of that, to go back to my first point today, is communication, from somebody who managed a charity. Our biggest problem was being taken seriously, even though we had experts, we had family liaison officers and we had all the knowledge and the information about brain tumours. But we had to go and bang on doors and say to people: "We are here." We would find people months down the line stumbling across us on Facebook only saying: "Why were you not referred to?" That is just one charity. There are many out there - children's charities, mental health charities, Silkworth - all these charities who are saying: "We are here." Is there a breakdown in the referral process? The health system is complex: private doctors, general hospital, health charities. Is it what you are seeing, because you live and breathe it; it is the referral, it is people talking to each other on an island that is 9 by 5? I struggle to get my head around it.

Consultant Psychiatrist, Adult:

Partnership is the way forward. If we do not establish partnership it is not going to work. I think there was a very much silo mentality with health and around the view of how the issues have to be tackled. I think if was we believe that it could be sorted just alone, ourselves. I think that is a big understanding, that there is no chance that this is going to be sorted by Health, including its partners and with the other agencies. I think more and more we are relying on Silkworth or relying on Mind Jersey or relying on The Shelter, but I think there has to be much more open dialogue, clear pathways with a view to our support. Those are the only ways forward.

Acting Head, Alcohol and Drugs Service:

I just wanted to say in answer to that that we need to be deliberate in that approach. My experience working in the mainland is that they had specific tiers. Tier 1 would be G.P.s; tier 2 would be the third sector; tier 3 would be specialist services; tier 4 is the residential element of treatment. With that clarity came an easier way to start signposting. You knew if someone presented with this particular issue they are easily signposted to a tier 2 service because what they needed was practical stuff in terms of what maybe that sector could provide. In addition to that, the way that we started working is just realising our limitations and our strengths. We have regular meetings, we meet regularly with Silkworth, so a planned meeting once a month with Silkworth. We have a link worker working within The Shelter itself who goes there every Tuesday to cover The Shelter. We are doing a lot of in-reach now but not outreach in The Shelter. We are going out basically to each of these services and saying: "We are here, how can we work together?" They feed back to us and we feed back to them.

Deputy M.R. Le Hegarat:

I am conscious that you are all exceptionally busy people and it is 10.30 a.m. and we have been going for 1½ hours. Rather than us firing more questions at you, is there anything from your perspective, information you would like to provide us with today, so that we can then move forward, or if there is anything we have not covered, of course, or you feel we have not covered?

Acting Head, Alcohol and Drugs Service:

Mine is a question to you.

Deputy M.R. Le Hegarat:

Yes, that is fine.

Acting Head, Alcohol and Drugs Service:

It is around cannabis and the prescription of cannabis on the Island.

Deputy K.G. Pamplin:

I wondered whether you were going to ask me that. **[Laughter]**

Acting Head, Alcohol and Drugs Service:

Have we given thought to what kind of cannabis we are going to be prescribing and also the controls in terms of who is going to be prescribing it and how we are going to manage diversion?

Deputy K.G. Pamplin:

That is a really good question and we have been asking you and get 4 different opinions. I think my opinion on this is that we have got to change on how we treat people. Those people who go into crisis and turn to alcohol or drugs or whatever are doing that because they are not getting the help provided. They are not criminals; they are entering a society which is perpetuated by criminals who feed on the vulnerable. We have to change that and have to change how we help and perceive the mental health of people who have entered, not treat them like criminals. It is how I treat my children. If my daughter does something bad I tell her off and I explain it is the behaviour I am not happy with: "I still love you but I am not happy with the behaviour." I think there is a shift and change there, if we can help people and change the focus. That is my viewpoint on cannabis in terms of people because it is an accessible drug for a lot of people, right or wrong. On medical cannabis I am open minded but we have to find the right approach that works for Jersey because we are an island and we are not part of the mainland.

[10:30]

We have to find what works for us that helps people who have got addiction but also helps people who need the support to get them off, as you described earlier, codeine-based paracetamol drugs; all these drugs that are addictive and can do lots of damage combined with other medications. I want us to hear from the experts so we can all work together. That surely is the only way forward. That is my opinion.

The Deputy of St. John:

Are you fearful that you will be involved in prescribing efficacy rather than a preventative efficacy?

Acting Head, Alcohol and Drugs Service:

Not necessarily. My fear is in terms of diversion from whatever is being prescribed for them. If a G.P. is prescribing it, it would have a value on the Island that it does not have in the mainland, for example, due to issues of access.

The Deputy of St. John:

We are at the first hurdle; that is persuading G.P.s that they can prescribe it.

Deputy C.S. Alves:

I think that side of things is currently being looked at by the Minister for Health with the Law Draftsman. They are looking into the rules of the nitty-gritty that you have just mentioned there and how it is going to work. I think there is still some time before that will probably come back to the Assembly, I suspect, and be finalised.

Consultant Psychiatrist, Adult:

I would like to say just a couple of things. One is that I would like that out of these, hopefully, it will help to raise the awareness, as I said before, of society as a whole that mental health is everybody's business, it is not just mental health services. I think the recognition is like … there is like, for example, The Shelter, which is doing a huge amount of work that really needs more resources and more support allocated. Then to acknowledge that there are gaps that need to be addressed as soon as possible, like the transgender issues, I think that, hopefully …

Deputy K.G. Pamplin:

Yes, we are meeting with Liberate next week.

Consultant Psychiatrist, Adult:

Great.

Deputy K.G. Pamplin:

Just to highlight what we have done, ever since we constituted, to give you some idea - we are brand new politicians sat here, newly elected - we all sat round the table. We are scrutinising what the Government do. We are not Government. Very quickly, the first thing we talked about was mental health, based on our own experience and different backgrounds and the election. As Mary started off with, we hinged on the strategy; it is 2 and a bit years and how is it working? But also we wanted it to be led by everyday folk. We did a survey that has gone out and in less than 8 weeks we had over 350 people respond. It is not just a tick-boxing, because there have been some terrible surveys released, but this one was wrapped around people. I can tell you honestly right now, people have sat down and really opened up. People have come forward and personally told us their stories. We are creating a report, not just based on … and we will because we have heard from you, we have heard from doctors but it is going to be a real snapshot of what we hear and real people feeling they could come forward. As you know, as professionals, is that not the most crucial first step? We have got that and when we release this report we are looking for good things. We have identified some good things but our report is not going to be holding back. But it is wrapped around what people are telling us and, hopefully, it peaks into what you are saying, that the culture … because everything

you described today, I can tell you, is what we are hearing, what we are seeing and why we are sat here today. But if we are going to achieve what you have just said, then we need everybody to change their mind and thinking and listen to what people are saying, invest in it, and we are going to be saying Orchard House is a disgrace. I have said that and I think you have been alluding to it and we need to work together. I am curious what you said earlier about marketing coming to Jersey, because you have all described a complex, underfunded, decrepit looking service. If we had a service that looked incredible, that was really helping people, as professionals would you not want to go there, regardless of where it is, I would suggest? Have you got any more questions for us about our process, what we are doing, because I think we are …

Deputy M.R. Le Hegarat:

Thank you very much. It has been very, very helpful and I think it was very open as well. I think sometimes people are a little bit cautious about being that open but I thank you for that openness. It is only by the practitioners, like yourselves, telling us how it is that we will get to know how it is, if that makes sense. People have come to us, they have provided us with written evidence and they have provided us with oral evidence. But sometimes, you are right, if somebody, say, had a positive experience they are not going to come to us. It is very good to get and understand some of the reasons why there might be sort of hiccups along the way, because I think we picked up very distinctly that there is a resource problem. But it is not just this morning that we have realised that, I think it is across the board. Thank you very much because it is very, very helpful to us. Thank you.

[10:35]