STATES OF JERSEY

Health, Social Security and Housing Scrutiny Panel
Child and Adolescent Mental Health Service Review

MONDAY, 24th MARCH 2014

Panel:

Deputy J.A. Hilton of St. Helier (Chairman)

Deputy J.G. Reed of St. Ouen

Witness:

Consultant - Paediatrics, Health and Social Services

[10:28]

Deputy J.A. Hilton of St. Helier (Chairman):

Good morning and welcome. I am Deputy Jackie Hilton, Vice Chairman of this panel.

Deputy J.G. Reed of St. Ouen:

Deputy James Reed, panel member.

Scrutiny Officer:

Janice Hales, Scrutiny Officer.

Consultant - Paediatrics, Health and Social Services:

I am Mark Jones, consultant paediatrician.

Deputy J.A. Hilton:

Welcome. Before we start, I would like to offer the apologies of the Deputy of St. Peter who is unwell at the present time. For the benefit of members of the public, there is a notice on the wall for you to read through. I would like to start by asking you if you could give us the number of the children that were admitted to Robin Ward last year with mental health problems?

Consultant - Paediatrics, Health and Social Services:

No, I am not able to give you that figure, I am sorry. That would be data that I do not have in my hand.

The Deputy of St. Ouen:

Is it possible to provide it to the panel?

Consultant - Paediatrics, Health and Social Services:

It would be. We do not retain and collect that data but C.A.M.H.S. (Child and Adolescent Mental Health Service) would have access to that so I could certainly call on my colleagues to do so.

[10:30]

The Deputy of St. Ouen:

Just to give us a sense of the numbers, have you got any rough idea?

Consultant - Paediatrics, Health and Social Services:

We have approximately 100 a year.

The Deputy of St. Ouen:

A hundred a year?

Consultant - Paediatrics, Health and Social Services:

Yes.

Deputy J.A. Hilton:

One hundred different individuals or 100 occasions when young people are admitted?

Consultant - Paediatrics, Health and Social Services:

One hundred occasions of admission.

Deputy J.A. Hilton:

It could be that may be repeat visits by the same young person?

Consultant - Paediatrics, Health and Social Services:

Yes.

The Deputy of St. Ouen:

Just following up on that - and again perhaps you could provide it to us at a later date - what is the number of children who are admitted to Robin Ward who were known to C.A.M.H.S.?

Consultant - Paediatrics, Health and Social Services:

I could not give you that data at the moment but the numbers are approximately half, so half would be known and half would not be, so of that order.

The Deputy of St. Ouen:

With regard to the half that are not known, what process is followed when you are presented with a youngster with mental health issues?

Consultant - Paediatrics, Health and Social Services:

The majority of children who are admitted to Robin Ward are admitted after hours, so many of them who are admitted are as the result of self-harm of some form or of drugs or alcohol use. So, because they are admitted after hours, we have a limited C.A.M.H.S. service, they are admitted under us as paediatricians and then they would be referred to C.A.M.H.S. in the morning. On a weekend there is a service of a psychologist or a mental health nurse who will come between 10.00 a.m. and 12.00 noon to see and assess, but largely they are admitted under us.

The Deputy of St. Ouen:

Just talk us through an example of a youngster arriving at accident and emergency with a significant problem.

Consultant - Paediatrics, Health and Social Services:

As you say, they would probably go through the emergency room, be assessed by a doctor there. We would be referred to say: “This is a problem which we think requires admission.” We would then assess. It would be one of our staff grades mostly likely, junior doctors, who would see that child. If there was an urgent need for review then I or one of my consultant colleagues would come to attend that child and we would admit the child to Robin Ward. The process on the ward would be similar to any other child in terms of admission. It would be assessment by both medical and nursing staff and then a decision made as to what that young person might require. Obviously

this is a slightly different arena in terms of what we are trained to provide and so this extends our remit really to try to understand what the immediate needs of that child might be.

The Deputy of St. Ouen:
If the doctor that sees the child believes that there is an underlying mental health problem, is the doctor at that point able to contact a psychologist or psychiatrist?

Consultant - Paediatrics, Health and Social Services:
If it is during the daytime, that would be true. So if that was the case in the emergency room and the junior doctor there or the consultant saw the child and it was between 9.00 a.m. and 5.00 p.m., or close to 5.00 p.m., then we would be able to access the C.A.M.H.S. service.

The Deputy of St. Ouen:
But after hours, because you say they are predominantly admitted after hours?

Consultant - Paediatrics, Health and Social Services:
Yes.

The Deputy of St. Ouen:
What happens then?

Consultant - Paediatrics, Health and Social Services:
After that they would contact the paediatric team, the medical team.

The Deputy of St. Ouen:
Would they come straight away?

Consultant - Paediatrics, Health and Social Services:
We would come straight away.

The Deputy of St. Ouen:
So, just because it is out of hours it does not mean that access is limited then?

Consultant - Paediatrics, Health and Social Services:
Access is limited to specialist help, so C.A.M.H.S. help, but access to the hospital is not in that we would bring them up on to Robin Ward under ourselves as medical paediatricians.

The Deputy of St. Ouen:
Obviously your aim is to provide for their immediate needs.

Consultant - Paediatrics, Health and Social Services:
Yes.

The Deputy of St. Ouen:
What challenges does it present?

Consultant - Paediatrics, Health and Social Services:
It depends, of course, on the nature of the problem. As I say, much of what we see after hours is either self-harm or is drugs and alcohol use. If there is a physical consequence to those events, in terms of self-harm if it is physical harm and it requires some form of medical or surgical attention, we would obviously attend to that urgently. We have access to all the services of the hospital, of course. If it were about intoxication then we would treat that child according to the standard best practice protocols of young people who are intoxicated, so that is again a medical approach. If it were drugs, obviously often it is obscure as to what drugs have been taken. There would be the kinds of screens that you would look for for typical consumption of either paracetamol or other drugs, but if it were a variety of psychoactive drugs then often it is obscure. We have to look at the symptoms of the child and decide what kinds of needs there might be, whether that be cardiac needs or neurological problems, and if we can make a best guess as to what may have been consumed we would do so. We are often in touch with services in the U.K. (United Kingdom), toxicology services, to give us some advice about what kinds of protocols we need to follow for unknown substances that have been consumed.

The Deputy of St. Ouen:
Basically you are aiming to deal with the issues that may be related to the mental health problem rather than the mental health problem per se?

Consultant - Paediatrics, Health and Social Services:
Exactly, yes.

The Deputy of St. Ouen:
What if the child was displaying serious behavioural problems?

Consultant - Paediatrics, Health and Social Services:
I suppose that is then about the risk of harm to themselves or harm to others in the hospital, so that is an assessment that we would undertake to try to gain some understanding of what those

relative risks are. Of course, we are not experts in areas of psychosis but sometimes these things do happen and can happen quite urgently and require some form of intervention. We do not have access to C.A.M.H.S. but we would have access to adult psychiatry, so we might well consult with our adult colleagues to say: "Although this is a young person, what might be an appropriate approach to manage this?" At times we may gain access to C.A.M.H.S. consultant support but that would be in extremis. Much of the time we are managing these things ourselves.

Deputy J.A. Hilton:

With regard to adult mental health, you are saying there is 24/7 call on a psychiatrist?

Consultant - Paediatrics, Health and Social Services:

There is. As I say, in conditions of extreme, for instance suicidal behaviour we would call upon an adult psychiatrist's expertise to try to assist us in managing that risk. There are not facilities for managing that risk other than Robin Ward, and Robin Ward is not a secure facility for that kind of problem but we would manage as best as we could.

The Deputy of St. Ouen:

Why has it been determined that Robin Ward is the best place?

Consultant - Paediatrics, Health and Social Services:

I think because it has 24/7 cover, so it has expert nurses and doctors who are very familiar with children and very used to dealing with typical problems of childhood. I think because it is an in-house facility, it is in the hospital, other people can be called upon to assist particularly in afterhours care where often there is an element of other perhaps physical needs that are simultaneously either happening or potentially could happen, so the hospital makes sense. On the other hand, there are, nevertheless, a few pure mental health difficulties that can present that present afterhours, either acute psychosis or acute depressive illness, which are not really about that kind of multidisciplinary approach but are primarily about a mental health practitioner.

Deputy J.A. Hilton:

How often are you faced with a young person who has attempted suicide or has a significant psychosis on the weekend? Can you tell us how many times that has happened to you, say in the past year, that you are aware of?

Consultant - Paediatrics, Health and Social Services:

I would say we have had, in the last year, occasions to manage that kind of problem. We are not talking large numbers but we are talking occasional children, so it is probably less than 10. In

terms of severe risks of suicide I would say it is one or 2 annually. It is not large numbers but nevertheless they are obviously very challenging children when they do arise.

Deputy J.A. Hilton:

Yes, of course. You mentioned an adult psychiatrist who is used during out of hours if necessary. Would an adult psychiatrist have access to the records of a young person who was already in the system with C.A.M.H.S. to assist them?

Consultant - Paediatrics, Health and Social Services:

They would do, as I understand it. We do. As the consultant paediatricians, we have access to that. It is a system called Face. It is not the same system as the hospital uses but we do have access to it. I must say, because we do not use it often, we are not as familiar with it and therefore may not be quite as adept at accessing the relevant and important information that we might like to, but we have an ability to access it.

Deputy J.A. Hilton:

Where you have a young person who has attempted suicide and gets admitted, say on a Friday evening or in the early hours of Saturday morning, have there been many occasions when that young person has remained in Robin Ward until, say, the Monday?

Consultant - Paediatrics, Health and Social Services:

Certainly. That is a fairly regular occurrence where that might take place, yes.

Deputy J.A. Hilton:

So they do remain in Robin Ward, basically?

Consultant - Paediatrics, Health and Social Services:

Yes. Say, for instance, we have a child who has taken an overdose of a substance who requires medical treatment for that, on the Saturday morning we would hope to be able to access C.A.M.H.S. and have them see and assess and make a judgment about the mental health issue, but it may be that the mental issue is unstable and requires continuing care on Robin Ward. We might get a plan from C.A.M.H.S. to say: “These are the things that I would do with that child up until the point at which we are in full service” or it might be that there is an ongoing physical complication as a result of that overdose when we would then say: “You need to stay because this is ongoing and we need to treat it through until Monday.”

Deputy J.A. Hilton:

With regard to your staff, do they have any particular mental health training?

Consultant - Paediatrics, Health and Social Services:

C.A.M.H.S. in recent years has tried to support that. We have had a series of sessions from a clinical psychologist and psychiatrist to provide some knowledge as to the presentations of different conditions, as to the typical management of those problems. At the present time that is not rolling out but we did certainly have some of that last year and the year before. I would say that an established, ongoing support mechanism for advancing the skill set and understanding of our nursing staff and our medical staff has yet to be established.

Deputy J.A. Hilton:

I am curious to know where you practised as a paediatrician prior to coming to Jersey and what the process was at your previous hospital with regard to this issue.

Consultant - Paediatrics, Health and Social Services:

I previously worked in Cheshire at the Countess of Chester Hospital. I was a consultant community paediatrician there so, although I was based within a hospital trust, I nevertheless did community work in terms of paediatrics. My primary roles were child protection, looked-after children and behavioural problems of children, so I obviously had quite an overlap with C.A.M.H.S. The C.A.M.H.S. services were, in the U.K. generally at that time, divided into hospital-based services, so for C.A.M.H.S. that would be specialist C.A.M.H.S., dealing with psychiatric illness, and then community trusts who manage what are commonly termed tier 1 and tier 2 approaches, so universal or to some degree targeted services for children. That same model is not quite what Jersey has. Jersey has a specialist C.A.M.H.S. provision. It does not really have a primary care establishment and therefore primary care arrangement for tier 1 universal services.

[10:45]

Deputy J.A. Hilton:

C.A.M.H.S. here in Jersey is still at tier 3. Do you think the system that you worked under previously worked better there than the system we have here, the fact that C.A.M.H.S. there, the community side, dealt with tier 1 and 2 as well?

Consultant - Paediatrics, Health and Social Services:

I think there is a growing expectation that that form of access to mental health services is available, and certainly there was a growing arrangement for that provision in the U.K. I suspect that in Jersey there is a growing expectation that that should be available to them here. For the kinds of behaviour problems that I might encounter, there is really myself and at times, if problems become more significant, I can access either social care, because often behaviour issues have

some social element to them, or alternatively a psychologist if the threshold is met whereby that need is significant.

Deputy J.A. Hilton:

Have you ever been faced with a situation where you have had a young person admitted into Robin Ward, especially out of hours, with say behavioural difficulties that has caused real challenges for you and your staff in managing that young person?

Consultant - Paediatrics, Health and Social Services:

Yes, I guess so. Conduct disorder, which is children who have not been formally diagnosed with oppositional behaviour, so reluctance, difficult relationships, unwillingness to either communicate or to co-operate; those kinds of children may arise spontaneously without a formal diagnosis but come to us on Robin Ward. That can happen at times. Other children might well be children with specific communication difficulties such as autistic children for whom, as I am sure you know, there is team called TAASC who make diagnostic assessments, but of course the ongoing support for that child's needs does not come in large part from that team. It comes from other voluntary services such as Autism Jersey or from time to time from other arrangements. So we do encounter children on a regular basis who either have autism or learning difficulties whom our nursing staff are not necessarily trained to manage. They do their very best but they do not have necessarily the skills to manage them as well as perhaps ...

Deputy J.A. Hilton:

Have you ever been in a position where you have had to call the police to assist you with a young person whose behaviour has been difficult to manage?

Consultant - Paediatrics, Health and Social Services:

We have very rarely had to call upon the police. In large part, that has been a mix of the use of substances and alcohol at the same time as a child who has perhaps a mental health problem such as a conduct disorder or at least an undiagnosed behavioural problem.

The Deputy of St. Ouen:

Just coming back to the issue of training, you mentioned a couple of times that, as I understand it, there is insufficient training currently provided to improve the skills available to frontline staff. Is that something that you believe to be key in improving the service that the hospital can provide?

Consultant - Paediatrics, Health and Social Services:

Mental health problems can arise within any discipline in health and so it would be unrealistic to think that you could access a psychologist or a psychiatrist at all times all the time for all the

problems. As I understand it, the kind of numbers of children that C.A.M.H.S. see each year is approximately 500 and the need, based upon average U.K. figures of mental health problems, is about 10 per cent of children will have mental health difficulties at some point or another during their childhood. So if you put those figures into the numbers of children in the Island, that would work out to be approximately 1,500. So there are about 1,000 children who do not receive C.A.M.H.S. input. Could you realistically expand C.A.M.H.S. services to deliver for all those children? Probably not, so there is most definitely a need for those who are not a specialist C.A.M.H.S. provider to have some knowledge in looking after children with behavioural or mental health difficulties. But of course we are at the sharp edge of that on Robin Ward because we see the children are who presenting very spontaneously with the more severe or at least more significant end of the spectrum of problems in often a very crisis-led event. The night-time, the issues that occur at night, the anxiety that arises at night and the whole process of admission leads to quite a degree of anxiety and a sense of uncertainty for those children and the families who might encounter that. So there is no doubt that we need to have nursing staff and medical staff who are equipped to be able to provide in that sense.

The Deputy of St. Ouen:

You mentioned Robin Ward and improving the skills of the staff that are caring for the youngsters within that ward. Is the same situation faced with regards to accident and emergency staff? Are they better equipped or could they also benefit from additional training?

Consultant - Paediatrics, Health and Social Services:

I think they would benefit as well. Obviously emergency room staff will have some experience and exposure to adults who have mental health difficulties. No doubt that is a regular experience for them. How confident they feel in the assessment of young people who present with the same, again I cannot speak for them but no doubt they would benefit from both training and support.

The Deputy of St. Ouen:

Apart from training, do you believe, given the figures that you have spoken about, that the Island would benefit from having more specialist individuals within the hospital setting that could provide for these youngsters?

Consultant - Paediatrics, Health and Social Services:

I suppose there are probably 2 ways that this could go if you were to say that the current provision of services needs additional support. One would be that idea whereby you have a lead within the hospital for child mental health conditions who could then diffuse some of that knowledge and experience and be perhaps available at times out of hours and through the week to augment that kind of understanding and learning. Another way would be to say that you have within C.A.M.H.S.

either an individual or a rota of individuals who could support that training and education as well as some on-call out of hours support. At the moment, as I say, we have some support on weekend days for a limited period of time. Is that sufficient? My view is that is not sufficient for our current needs. We have certainly seen an expansion of the numbers of children attending Robin Ward with really quite complex mental health requirements and we would say that at the moment we are still rather vulnerable to that lack of specialist input.

The Deputy of St. Ouen:

Just one last question around Robin Ward: can you very briefly describe the sort of facilities offered to teenagers and young children on Robin Ward?

Consultant - Paediatrics, Health and Social Services:

Robin Ward was designed some years ago to provide a service that deals with a large number of issues related to childhood. It has been divided into areas for isolation; children who come in with infectious illness have cubicles, as many as we can accommodate, to isolate them from other children. These are relatively small cubicles and they are designed largely for the physical needs of a child with an infectious illness. We have one room that is ideally dedicated to the management of children with cancer who might require isolation from other patients. That is a somewhat larger room that has an en suite facility because in many instances those children cannot mingle with other patients on the ward. We have then an open bay area that services a variety of different needs from medical problems of children to surgical patients or patients who are either pre- or post-surgery. In large part that is the area where we would look after children and young people with mental health problems. From time to time where there is a serious risk, either to themselves or to others who are on the ward, we would place them in our highest dependency isolation room, which is quite a small little room right beside the nursing station, so that we can keep an close eye on them and at the same time those patients can be isolated from the rest of the ward. But it is not a secure facility. It simply is a cubicle with a door that is opened by being pushed.

Deputy J.A. Hilton:

Do you think these facilities are adequate?

Consultant - Paediatrics, Health and Social Services:

No, they are not in current modern day standards adequate for the variety of different conditions of children with mental health problems.

The Deputy of St. Ouen:

What would need to change?

Consultant - Paediatrics, Health and Social Services:

I think we need to secure a room, at least one, that is designed around the current modern day practice of children with either serious psychosis or suicidal intent. I think that would be a basic standard to provide at the hospital.

Deputy J.A. Hilton:

Would that be possible within the physical envelope of Robin Ward at the present time?

Consultant - Paediatrics, Health and Social Services:

I think it would be challenging but I think it would still be possible. We have a relatively large playroom which I think could accommodate that or, alternatively, we could look to the open bay area and try to make an isolation area within that. It would restrict the way that we could flexibly use the ward but nevertheless I think, given that the admissions of mental health illness are now quite regular, it is pretty clear that we need a facility and we need it before the build of a new hospital.

Deputy J.A. Hilton:

Would you support that move?

Consultant - Paediatrics, Health and Social Services:

Sorry, support ...?

Deputy J.A. Hilton:

Has there been any discussions around delivering that? Have you spoken to hospital management about your concerns around what is happening at present?

Consultant - Paediatrics, Health and Social Services:

That has been broached in the past when we have had other examples of children presenting with challenging behaviours. I certainly would support that. I think that although there is a compromise in any alteration of a facility that has got limited space, nevertheless that is among the kinds of priorities that I think the ward requires.

The Deputy of St. Ouen:

Given that within the hospital there are single rooms available, or beds in a mainly private wing, has any consideration been given to making use of those facilities for some of the perhaps older children that require your care?

Consultant - Paediatrics, Health and Social Services:

I think that has been considered. I do not think it has been given deep thought. The challenge of doing so is isolation of the patient from the kinds of staff and the environment that might be suitable. All things are possible but it depends upon the mix of specialist support.

The Deputy of St. Ouen:

Within the same area is much better than utilising some other facility elsewhere in the hospital?

Consultant - Paediatrics, Health and Social Services:

Yes, much more efficient and normalising. In many ways, as much as we might require a room or specialist input, as best as possible we try to treat children with mental health conditions no differently than those with physical conditions.

Deputy J.A. Hilton:

Can I just ask you a question? Before we talked about facilities, you mentioned about the lack of specialist help, especially out of hours, for young people in Robin Ward. Have you expressed that opinion to anyone at C.A.M.H.S.? Are they aware of your concerns?

[11:00]

Consultant - Paediatrics, Health and Social Services:

I think that has been a long-term discussion. We have certainly tried to address this in terms of making pathways, if you like, for care of children. Dr. Coverley and our former head nurse, Anne Kelly, wrote a draft document in 2011 to try to address some of these issues as best as was possible, given the resources at hand. That is largely about what kinds of things might a child who has self-harmed require, what kind of initial assessment might you undertake and so on. I think that document has been quite helpful but it still, in my opinion, does not relieve the pressure upon staff to continuously provide for such a variety of different what I would consider quite specialist and quite urgent needs on the ward.

The Deputy of St. Ouen:

Are parents or guardians able to stay overnight and remain with their particular child in Robin Ward?

Consultant - Paediatrics, Health and Social Services:

Yes, we try to accommodate as best as possible. Obviously it is seasonally dependent. When we have large numbers of children on the ward in the winter months that can be much more of a challenge. The isolation rooms are quite small so there is really only room for a very slim bed

beside a cot or, if it is an older child, beside a bed, so they are really quite limited in terms of available space. There is a kitchen and there is a small bathroom for parents at the end of the ward. We have been challenged by some of the somewhat decaying facilities that we have around us, so the ward itself really requires renovating as a matter of some urgency.

The Deputy of St. Ouen:

You would not necessarily encourage parents to remain with their teenager overnight?

Consultant - Paediatrics, Health and Social Services:

I think we would encourage it but I am not sure that necessarily parents would feel encouraged by the facilities on offer.

The Deputy of St. Ouen:

Out of interest, what vetting, if any, is undertaken with regard to allowing parents or guardians to stay overnight, given that it is within an open ward sort of environment?

Consultant - Paediatrics, Health and Social Services:

I would say formally there is no vetting procedure. I would say that we have a good feel for parents and issues that might arise but in terms of undertaking that on a routine basis with each parent who might choose to stay overnight, I do not think that that is a formalised process.

The Deputy of St. Ouen:

Given that and the fact that some of these youngsters have special needs, it is even more important that the appropriate environment is provided within the hospital setting, albeit that within the general area of the children's section.

Consultant - Paediatrics, Health and Social Services:

I think for both physical and mental health conditions there can be a need for more than one member of a family to be available in an overnight setting because sometimes physical conditions can be very challenging and potentially life threatening at times, whereby it is really inadequate to only have facilities for one parent. But equally, as you can appreciate, a child who comes in either intoxicated or under the influence of drugs is a very scary situation for many parents and to not be able to accommodate both parents or carers is a compromise and one where I think, if I were in that situation myself, I would feel compromised.

The Deputy of St. Ouen:

Given that discussions have been taking place regarding the provision of a new hospital, have you had any involvement, has any discussion taken place around the requirements that the children's facility, ward, may require in the future?

Consultant - Paediatrics, Health and Social Services:

Yes, preliminary. We certainly have recognised these issues related to C.A.M.H.S. but other things that are arising in the course of the changing demographic and the changes of skills that we can deliver to the children. The whole way that you would design a ward now and the kinds of expectations of good practice in modern medical facilities have changed considerably since Robin Ward was designed. So that would certainly be part of the picture, although I think at the moment the discussions have been largely around services rather than facilities. What services would we want to deliver in a new hospital and how would they look has been largely the discussion that has taken place to date.

The Deputy of St. Ouen:

It would be too early to believe that appropriate consideration has been given to providing for youngsters in a new hospital facility?

Consultant - Paediatrics, Health and Social Services:

I think there is no certainty about that at present.

The Deputy of St. Ouen:

Thank you.

Deputy J.A. Hilton:

Do you have any direct involvement with any other agencies that deal with young people with mental health issues or behavioural problems?

Consultant - Paediatrics, Health and Social Services:

Probably the closest alternative agency that I deal with ... one of my roles in the Island is as the medical lead for child protection, so perhaps the other area that I would encounter with children who have both social and mental health conditions would be Children's Services.

The Deputy of St. Ouen:

How is that relationship?

Consultant - Paediatrics, Health and Social Services:

I think it is a growing and developing area. It is well supported and I think we are gaining in sophistication as to our approach to children with those combined needs. I have some sense that the support that C.A.M.H.S. is able to deliver to Children's Services by definition is limited because of all the other needs that are the demands upon C.A.M.H.S. So I think there is support but the hours and the numbers of individuals involved is relatively limited.

The Deputy of St. Ouen:

Is there currently a greater emphasis on early intervention programmes with regard to Children's Services and the work that you are undertaking?

Consultant - Paediatrics, Health and Social Services:

Yes. Out of the White Paper there has been some movement towards preventative mental health approaches and I think that is a great step forward. If we can identify children and families who may be vulnerable to longer-term mental health illness, then that is to be applauded. To provide the kinds of services that may be helpful to reducing or even eliminating some of the problems that we see currently with mental health among young people would be ideal.

The Deputy of St. Ouen:

If we wanted to see greater improvements in that sort of area, what specifically should we be focusing on?

Consultant - Paediatrics, Health and Social Services:

That is a very complex question; no simple answer. I suppose it is about supporting primarily the international ideas, particularly through the World Health Organisation, to support women to be supported in caring for very young children, to receive sufficient support in terms of psychological and day-to-day support, mental health support, but also financial support to enable them to be able to care for their children in an appropriate fashion.

The Deputy of St. Ouen:

We hear a lot of about the multiagency approach. It is a word that keeps cropping up in the various discussions that we have with the Health Department. In particular, are there any areas where again improvements could be made in that regard to ensure that there is a greater accountability for the individual within that sort of approach, individual professionalism?

Consultant - Paediatrics, Health and Social Services:

I think that is about reorganising services to deliver prevention and that would almost certainly then impact upon what we have been currently talking about, which is about reactive intervention. So I

think the movement towards preventative activity is the correct direction but I think it would be remiss to ignore the issues that are at hand, which are growing problems of young persons' interest in taking psychoactive substances, of still ongoing, perhaps not for the population of young people as a whole but for very vulnerable groups of children, experimenting with alcohol in ways that are almost certainly unknown to them in terms of the long-term, even the medium-term risks. Specialists have presented in the hospital informing us that in the U.K. now - and, given our figures in terms of alcohol intake among young people, here - the numbers of children who are at risk or are actually undergoing liver failure as a consequence of alcohol bingeing has quadrupled in the last 15 years, such that we are seeing people as young as 20, 21 undergoing liver transplantation for experimental binge drinking.

Deputy J.A. Hilton:
Is this in the U.K.?

Consultant - Paediatrics, Health and Social Services:
This is in the U.K., but almost certainly that kind of pattern of excess alcohol consumption and the consequences of it are really poorly understood by young people or the adults who supervise them.

The Deputy of St. Ouen:
It is a difficult issue, but how do we deal with the problems? One is aware that, with regard to education, efforts are being made to highlight abuse of alcohol and drugs and so on. What else do you believe could be done to try to help these youngsters from getting to the position as you describe?

Consultant - Paediatrics, Health and Social Services:
I think a lot is being done, particularly through education, to try to educate young people as to the risks of experimenting with either alcohol or drugs, but I think in the end it is about modelling of behaviour. It is about when alcohol and drugs are accepted in broader society as activities that are acceptable, or at least are condoned to some degree, that kind of experimentation among young people is to be expected.

The Deputy of St. Ouen:
So you are saying it is a cultural issue rather than an education issue?

Consultant - Paediatrics, Health and Social Services:
I think Jersey is not unique in this endeavour.

Deputy J.A. Hilton:

I think you said that you are responsible for safeguarding. In your experience, do you think that if we had had better earlier intervention services historically that maybe we would not be in the situation that we are in, that that would have had a very positive effect on the parents and children? Is there any evidence to support that?

Consultant - Paediatrics, Health and Social Services:

In specific terms it is speculative, but I guess if you were looking at populations and looking at some of the evidence of the cyclical generation-after-generation effects upon young people and their sense of deprivation and alienation from the society in which they live, you could make a reasonably robust argument to say that you have to break that chain by intervening as early as possible. There is some biological plausibility now to those arguments whereby the brain development of very young children can be seen to be altered by the effects of deprivation, whether that be of caring and nurturing or whether that be a biological deprivation. There is no doubt there is fairly robust and growing evidence that the long-term consequence is not just a psychological one but is a biological one.

The Deputy of St. Ouen:

Are you aware that C.A.M.H.S. has been advising parents to phone the hospital if they have a problem out of hours?

Consultant - Paediatrics, Health and Social Services:

No, I am not aware of that.

The Deputy of St. Ouen:

Do you think that is appropriate advice to give or would you believe that there are other ways of dealing with the issue?

Consultant - Paediatrics, Health and Social Services:

I would say that that would not be an appropriate arrangement because we have no agreement for that arrangement so it would be an unexpected call upon our service. In general, in terms of trying to be supportive to families, we will take phone calls on Robin Ward and elsewhere in the hospital to try to be understanding of the dilemmas that they may be facing but in general we would also encourage them to seek the support of their general practitioners rather than come directly to us.

[11:15]

The Deputy of St. Ouen:

So basically you would look to the G.P.s (general practitioners) and C.A.M.H.S. and those who work within it to provide that initial point of contact?

Consultant - Paediatrics, Health and Social Services:

Yes. I think ourselves and C.A.M.H.S. are both specialist services and so we would not seek to provide services in a primary care fashion, in other words a direct patient-to-consultant or staff grade response.

The Deputy of St. Ouen:

Just to give us an idea, how many staff normally work on Robin Ward at one time?

Consultant - Paediatrics, Health and Social Services:

From the nursing staff point of view, during the day there would be approximately 3 nurses on at any one time and at night 2 nursing staff. During the day from the medical point of view, there would be obviously a consultant who would be available, not necessarily always on the ward but would be available, and there would be 2 doctors, 2 staff grade doctors, so trainee paediatricians, who would be available during the day. Then at night there would be one staff grade and one consultant available.

The Deputy of St. Ouen:

If the ward was faced with a particularly high demand from an individual for care, whatever shape or form it would take, what happens? Are they able to call on additional staff to come and help?

Consultant - Paediatrics, Health and Social Services:

If there was a high demand or a high need patient, from the nursing point of view they would have the possibility of calling upon bank staff, so that is staff who have offered themselves to provide urgent services for the hospital as required. The complement of staff available to do so can be stretched at times. You can foresee the kinds of times where that might be more challenging. Over Christmas periods or Easter or holiday months in the summer we may not necessarily be able to fulfil that requirement. If that is true then, if there was an immediate need, we would call upon the charge nurse who is available to the hospital, so out of Robin Ward, the person looking after the whole of the hospital's nursing provision, to see if there was other staff available who could simply support our nurses.

The Deputy of St. Ouen:

Given that in recent times we have seen an increase in births, how confident are you that the children's ward is appropriately staffed?

Consultant - Paediatrics, Health and Social Services:

I think it has improved. In fact, recently I think we have had greater numbers of nursing staff available both in terms of provision on the ward but also available to us. So I think that has got better lately. In terms of our on-call complement, we have a number of staff grades that has recently been expanded but they are doing prospective cover, which simply means that when either ill or away for annual leave or on conference leave, so educational leave, they cover each other. I think we are fairly much status quo in terms of the complement of our staff grade numbers. I think if we were to compare ourselves with the U.K. we would say that we are rather down on numbers relative to our colleagues across the water. From the consultant point of view, we are most definitely down by comparison to the U.K. in terms of numbers. We have 3 consultants here. For an equivalent-sized unit in the U.K. it is difficult to say because they are mostly somewhat larger, but I would say that we are seeking and have in our plans to expand our consultant numbers.

The Deputy of St. Ouen:

Increase the number of consultants by one?

Consultant - Paediatrics, Health and Social Services:

Yes, that is our first foray.

The Deputy of St. Ouen:

With regard to doctors, again, do you have access to doctors that have improved knowledge or specialist knowledge of children and children's ailments and problems?

Consultant - Paediatrics, Health and Social Services:

For sub-speciality care, we have arrangements largely with Southampton for physical conditions. We have a number of consultants who visit us, come to run clinics here in the Island, from cardiology to endocrinology to neurology, lots of different specialist services. For particular areas of sub-speciality, we call upon some other hospitals simply because the services are very high level, so nationally-based services. Great Ormond Street is our other typical port of call for very specialist services.

The Deputy of St. Ouen:

The information that we have been provided with, or evidence we have been provided with when speaking to various parents of children with mental health and behavioural issues, is that some parents are seeking to get some form of diagnosis to better understand the condition and the problems that their child is facing. We are also aware that C.A.M.H.S. only tends to focus on

those that are diagnosed rather than those that are perhaps waiting for a diagnosis. Is that your experience?

Consultant - Paediatrics, Health and Social Services:

No. I would think that is not my experience and I would say if anything it is somewhat the other way round. I would say that establishing a diagnosis is really critical for the child, for the parents and for the doctors involved. That really is the central point of enlightenment as well as management. The drive to establish that is really very strong among the medical fraternity, I suppose. So I do not think that is right, although within the area of mental health it is sometimes quite difficult to define exactly what that underlying diagnosis is. Sometimes it is more than one diagnosis, sometimes it is simply the case that we have yet to establish ... I will give you an example. In the field of communication difficulties there is a team called the TAASC team. They are established as a multidisciplinary team to try to identify children who have a diagnosis of autistic spectrum disorders, but there remain a significant number of children who cannot be diagnosed with that condition and yet it is clear that they are challenged by communication difficulties, not defined in diagnostic terms but clear to ourselves as professionals and to their parents. Those are a very challenging group because they are undefined and therefore, in terms of trying to be clear with others who may not be as familiar with that area, what kinds of support they require and perhaps also what might be, for instance, the kinds of available financial support or support outside of the typical arena of health. I would say they are by no means ignored but are more challenging because a label is a very helpful thing, in many ways, to establish a recognition of what needs are.

The Deputy of St. Ouen:

One of the messages that came across, and I thought it was explained quite well, from one parent was if their child broke an arm, let us say, there is a process that you follow: you go to see the G.P; the G.P. sends you to hospital; you see the specialist; work is undertaken; rehabilitation happens; and ultimately the child's arm is fixed. However, when it comes to mental health problems, it is less clear as to exactly what care and process is followed once a child demonstrates certain mental health issues. What care pathways, what signposting do you as a consultant give, and perhaps the staff on Robin Ward give, to the respective parents regarding a problem that you are faced with through admission?

Consultant - Paediatrics, Health and Social Services:

I guess that is one of the reasons that I set up a behaviour clinic, because often behaviours are not psychiatric. They are simply behaviours but they might speak to an underlying psychological or other area of challenge, social challenge, which nevertheless is in need of a formal diagnosis. I would certainly signpost parents who have those kinds of challenging issues to C.A.M.H.S. if it

was clear to myself as a consultant paediatrician that that kind of support would be appropriate and could deliver the kind of help that that child or parent might require. Perhaps going back to the point that a parent made with you about a lack of clarity, I think that is absolutely true. At a primary level, recognising that challenging behaviour, because all children at times can be challenging, perhaps like all adults, and acknowledging when a behaviour becomes an entity that requires support outside of the family, in other words that professionals may be able to deliver more than the parent can currently provide, is something that is a judgment, in large part, made by a variety of people who may not have quite the level of experience that others do in making that judgment. You will find from the point of view of all the different professionals that a parent might become involved with, from schools to general practitioners to health visitors to people in charitable groups, lots of different points of potential access to say: "I need some help" but maybe not a consistent response from those who might be available to signpost.

The Deputy of St. Ouen:

Are you concerned that medication seems to be the primary treatment offered to youngsters with mental health problems?

Consultant - Paediatrics, Health and Social Services:

I do not think that is true. I think that the primary support for children with mental health problems is one of counselling and support, either through programmes such as cognitive behaviour therapy, so specific programmes, or behaviour modification treatments. I think the majority of children who might encounter C.A.M.H.S. are not treated with medications, although there are some situations where medications really can make a substantial difference. You may be aware that in the past, some 7 or 8 years ago, there was a review of the use of medications in treating psychosis, so psychotic depression and depressive illness as a whole, and the concern that perhaps that was leading to increased suicidality. Out of that came quite a significant reduction in the use of agents to treat acute depressive illness, very much a narrowing of the available agents to be used and the reasons for using them, and that did have a profound impact on C.A.M.H.S. Nevertheless, those medicines still can be fundamentally important for specific children. I would say medicine is not in large part the answer for mental health conditions for children.

The Deputy of St. Ouen:

Would staff on Robin Ward be aware that a young person that is admitted may be on medication or would be taking medication for a particular mental health problem?

Consultant - Paediatrics, Health and Social Services:

For an admission, all children and parents will be asked about medications that they are taking. They may not be aware that a medication has been prescribed because we would not routinely

have access to C.A.M.H.S. information other than, as I say, if we, as consultants, searched for it ourselves to see that this is a patient who we now know is being cared for by professionals at C.A.M.H.S. and therefore it may well be the case that they are on medication. That would require us to be actively searching rather than us necessarily know simply by meeting with the patient.

Deputy J.A. Hilton:
Can I ask you a question about the behaviours clinic that you mentioned just previously? Was it something you set up?

Consultant - Paediatrics, Health and Social Services:
Yes, it was because of my previous experience and training and because there was a recognition that a number of patients coming to a general paediatric clinic that I was running actually had primarily behaviour issues rather than medical ones. The kinds of approaches and time that you require to assess and manage behaviour problems is often very different from medical ones.

[11:30]

Deputy J.A. Hilton:
Were C.A.M.H.S. aware that you had set up a behaviours clinic? Were they involved in that in any way?

Consultant - Paediatrics, Health and Social Services:
They were not involved in that. That was something that I did myself. They are aware that I run this clinic and it is a mixed clinic of different needs. For instance, one of the areas that I assess in that clinic is children with communication problems, autism and the like, and many of the patients that I might refer to the team Task come from that clinic.

Deputy J.A. Hilton:
So these young people would present themselves to you in the department for something else and through that you become aware that there is another issue, so then you refer them on to TAASC?

Consultant - Paediatrics, Health and Social Services:
Yes, that is the way it started. I would say largely now the general practitioner population are aware of the clinic that I run, or my secretary and others might direct patients who have been referred in for a variety of different problems to my behaviour clinic.

Deputy J.A. Hilton:

Were you aware that there was a horrendous waiting list for the TAASC team diagnosis? In fact, I believe they closed their waiting list last year for a period of time.

Consultant - Paediatrics, Health and Social Services:

Yes. I was involved in that because I was concerned that the general public were not aware that our resources, our capacity for delivering a service was compromised by the large numbers that we were receiving. So, in order to manage the backlog of patients who were currently on our books, it would be unfair on new referrals to say we were going to see them in a timely manner, because that was not the case.

Deputy J.A. Hilton:

That must have had quite a big impact on some of those parents who were told that the list was actually closed. What happened to them consequently?

Consultant - Paediatrics, Health and Social Services:

There was no specific pathway, although there are others that we can call upon to provide service, but that is not formalised and was not a formalised arrangement. One or 2 of the patients that I saw received services off-Island because of that issue, but nevertheless it was important that we had some recognition that the numbers that we were attempting to see in arrangements that were not dedicated arrangements, which were largely additions to our daily workload, could not be achieved in a manner that would be representing a fair and timely approach for new referrals.

Deputy J.A. Hilton:

What response did you get from the management in the hospital when you closed the TAASC waiting list because you were just being overwhelmed by the sheer numbers coming forward?

Consultant - Paediatrics, Health and Social Services:

I think there was an understanding of the dilemma that we were in. I think there was an attempt to provide further administrative support to try to manage some clarity about this issue, to provide some information to parents to at least give them some indication as to how long they were likely to wait, because up until that point there was no letter that gave any specific dates as to when patients were likely to be seen. So we have now achieved that. At least we have got a temporary arrangement to deliver that kind of administrative support that was needed. I think we have tried as best we can to make efficiencies in terms of the assessment process, trying to do more joint assessments so that we are not delaying the conclusion of assessments by having multiple assessments over long periods of time, although I would say that there is still some work to be

done. For instance, I am not yet able to participate in joint assessments simply because of the other demands upon myself in terms of acute clinical work.

Deputy J.A. Hilton:

There must still be a waiting list.

Consultant - Paediatrics, Health and Social Services:

There is still a waiting list, yes.

Deputy J.A. Hilton:

Have you any idea how long the waiting list is for a family who are referred to the TAASC team?

Consultant - Paediatrics, Health and Social Services:

What the team has done is to try to prioritise needs. We have created 3 tiers of priority. In the priority 1, whereby there are major behavioural issues and/or learning failure and/or an imminent decision about schooling and so on, we would try to prioritise those children. When a child is quite young and there is some doubt about diagnosis or there are significant other issues that need to be tackled in the interim while assessments are going on, that child might be a priority 3. For priority 3 patients, we are looking at something in the order of 9 months to a year.

The Deputy of St. Ouen:

You are saying the capacity problem still has not disappeared?

Consultant - Paediatrics, Health and Social Services:

No.

The Deputy of St. Ouen:

What is the answer? The answer, as you said ...

Consultant - Paediatrics, Health and Social Services:

The answer is probably a combination of joint clinical arrangements whereby when a child is seen the majority of the assessment is undertaken in one afternoon or in one day, so it is not spanned out over several months. Realistically that is not possible for all patients because there may be a requirement to assess a child, for instance, in a school environment or in a home environment or to gain further information from other services such as Social Services as to their thinking, but I think there can be efficiencies made. But the other element is resource, having sufficient professionals involved in this team; for instance, when somebody is on leave or somebody is

unwell, the service does not fall down as a consequence of one individual being absent from assessment.

Deputy J.A. Hilton:

At the current time, with regard to assessment, if somebody is off sick there is nobody there to replace them?

Consultant - Paediatrics, Health and Social Services:

At the current time, each different specialist area is represented by one individual.

Deputy J.A. Hilton:

So it is obvious that there are tremendous problems if somebody goes on holiday or becomes unwell. Have the hospital management been made aware of these problems?

Consultant - Paediatrics, Health and Social Services:

Yes, I think they know well what the team comprises. I think there is some lack of certainty about the dedicated time that is required to assess children in this manner and the requirement to come together as a group to discuss children. As I say, up until now this group has been a voluntary arrangement. It has not been a designed programme that is accounted for in large part through job planning.

The Deputy of St. Ouen:

How would you make it that, move it forward?

Consultant - Paediatrics, Health and Social Services:

I think it is further dialogue with our managers to have recognition that the service is essential, that it is more efficient than an off-Island service, that we do have to account for individuals who may be indisposed when assessments are taking place, that that should not hold up service provision, that we need better communication with our referral groups in terms of the professionals referring to us but also the parents who are waiting to hear from us.

Deputy J.A. Hilton:

Just remind me, the TAASC team is purely to do with the autistic spectrum?

Consultant - Paediatrics, Health and Social Services:

It is largely to establish that diagnosis or an alternative to social communication difficulties.

Deputy J.A. Hilton:

Before we finish, I just wanted to ask you, at this present moment in time what would you most like to see changing in order to help young people and children with either behavioural difficulties or mental health issues? Is there any one thing?

Consultant - Paediatrics, Health and Social Services:

I perhaps need to speak to gaps in services that I encounter on a regular basis. We have talked about the provision for the hospital in dealing with acute mental illness and the kind of specialist need as well as the environment that we require to deliver a professional and modern day service. The other area that I think is challenging to us is children who have other needs in addition to their mental health needs. We have many children who have chronic medical conditions or learning difficulties or even life-limiting conditions for whom the provision of psychology services is quite limited. Routinely a newly diagnosed diabetic or a newly diagnosed cystic fibrosis patient or a newly diagnosed child with cerebral palsy will not gain access to psychological services. I think that really is a gap in service provision that could avoid a number of the difficulties that we encounter regularly for children who have those kinds of long-lived conditions. I think that could be designed quite straightforwardly, but it will require an increase of resource to be able to deliver it.

Deputy J.A. Hilton:

Thank you very much indeed for coming along to speak to us this morning. We really appreciate it.

The Deputy of St. Ouen:

Thank you.

Consultant - Paediatrics, Health and Social Services:

You are very welcome.

Deputy J.A. Hilton:

I close the meeting.

[11:41]