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Assemblée des États

Health and Social Security Scrutiny Panel

Assessment of Mental Health Services

Witness: Contact Consulting

Friday, 13th 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

Witness:

Mr. S. Appleton (Managing Director, Contact Consulting)

[11:59]

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

Good morning. Thank you very much for coming in. As you're probably aware, as a panel we decided to review the Mental Health Law in July. Before we start and we go through the whole process, we will introduce ourselves and we would like you to do the same. This is obviously being live-streamed so the public can hear what is going on and I will just make you aware that it is covered by Parliamentary privilege. I am Deputy Mary Le Hegarat of St. Helier and I'm the Chairman of the Health and Social Services Scrutiny Panel.

[12:00]

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

I am Deputy Kevin Pamplin of St. Saviour and I am the Vice-Chairman of the 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 M.R. Le Hegarat:

We have another member who is Deputy Trevor Pointon from St. John but he is unable to be with us today. Obviously you have met our Scrutiny Officer and also there is someone who is doing the transcript and the streaming. If you would like to introduce yourself?

Managing Director, Contact Consulting:

My name is Steve Appleton; I am the managing director of Contact Consulting, which is a research consultancy organisation based in Oxfordshire in England. We work across the U.K. (United Kingdom) and internationally, principally in the field of mental health, but also we work in the field of older people and housing and also in substance misuse as well. The organisation has been in operation overall for about 20 or so years. I have been a part of our organisation for about 11 years. Prior to that I was a senior manager in an English Strategic Health Authority with responsibility for mental health, learning disability and substance misuse issues and originally I trained as a social worker and worked in mental health services in various parts of England.

Deputy M.R. Le Hegarat:

Firstly, just to give you a background, we are all new to politics, all 4 of us, we all come from very different backgrounds, some of us have had some experience in relation to mental health. Once we got together as a scrutiny panel this was basically the thing that we decided that we were going to review first. It was something that came up during the election process and so we decided that we were going to do this as our first piece of work and we launched it at the end of July. We are speaking to a number of individuals who are providing us with personal testimonies, both orally and in writing, and we are speaking to a number of private third-party organisations as well as States departments. We have run a survey and that survey has received over 300 responses. What we will then do with our Scrutiny Officer is look at all of the evidence and the data that we have received and then a report will be compiled and that hopefully will be end of January, middle of February. We have had a little bit of slippage because we kept the survey open longer than first anticipated because we had a particular group that said that they wanted to contribute towards that and we thought that was a benefit. So once that is completed obviously we will then be in a position to provide some recommendations. That will be provided to the Minister for Health and Social Services and then obviously the department will come back to us either agreeing/accepting or not, however that may be. Thereafter, we will obviously see where we have made recommendations, if they have been accepted; we will then obviously keep abreast of how it progresses and moves forward. We decided that we would look more on the previous 2 years because there was, as you are aware, a Mental Health Strategy in 2015/16, so it makes sense to us to look at what has changed in that period of time. Obviously some of the information that we have gathered is slightly previously to

that, however that was the basis because we felt that was probably the best course of action, we wanted to keep it on to a timeline. We will ask various questions along the way and obviously if there is anything you wish to ask us please feel free to do so. In your evidence you state that trends set out in the Strategy are still relevant today. How were the trends set out in the Strategy developed?

Managing Director, Contact Consulting:

We felt that it was important at the start of developing the Strategy to have an as up-to-date as possible view of 2 things essentially, a broad view of the population of Jersey, so trying to think about how that segments in terms of the general population, but then breaking that down into different age groups to get a bit of a sense of what is the proportion between children and young people, adults of working age, and older people. Then to start to think about what are the likely levels of prevalence of certainly mild to moderate mental health problems that one might see generally presenting in general practice and at the kind of earlier end of the spectrum in terms of more public mental health prevention awareness; those sorts of issues. Then thinking about levels of prevalence for more serious mental illness and making very clear that distinction between severe mental illness and broader mental health; I think it is an important distinction to make. We did a number of things, we looked at population prevalence data that was made available through colleagues here in the States of Jersey, partly from Public Health but also from the census documentation here. We also ran some comparisons with data from Oxford Brookes University's Institute of Public Care online system, which is available to anybody to look at for a fee. What that does is it makes some pretty accurate predictions about population growth over various intervals going up to about 30 years beyond the point at which you start. So you can get a bit of a sense of how the population may change, both in terms of numbers and ratios. Some of the other information about levels of prevalence came from work that had already been done here by colleagues in Public Health and so what we tried to do was to look at that and match the 2 by making some calculations. What you see is that Jersey as an Island, in terms of its population and prevalence of mental health, is not especially different certainly to the United Kingdom and certainly to England in terms of about one in 3 people are likely to experience some form of mental health issue at some point in their lives. That does not mean necessarily they will have a serious mental illness but they may experience a mental health problem for which they may well require some form of support, whether that be through general practice of through voluntary and community sector organisations, what have you. The rates of psychosis, for example, is a serious mental illness, in Jersey are about the same as they are in England, they are just under one per cent of the entire population that is across all ages. So that is broadly consistent. So we looked at a range of information and data. As part of our work, when we were originally appointed, our submission to undertake the work, the proposal, was done jointly with colleagues from the Health Services Management Centre at the University of Birmingham with whom I have worked on a number of occasions. So we were able to bring some academic

input into that process and also utilise their library in terms of being able to gather evidence and information and you will be aware that there was a broader literature review that was done as part of the process. So that is how all that information was gathered, so it was publicly available data, it was just bringing it together in one place. The trends in terms of what we were setting out in the Strategy would broadly be expected to be about the same as they were then. That is not to say that they would not benefit from a refresh because things change. But I think they are broadly consistent and certainly from having read the Government's submission to you many of the tables and the data that are contained in their submission are from the Strategy, so one assumes that they believe those to be still consistent and accurate.

Deputy M.R. Le Hegarat:

There appears to be a steep rise in C.A.M.H.S. (Child and Adolescent Mental Health Service) admissions since the Strategy was published. To what extent is this consistent with other jurisdictions?

Managing Director, Contact Consulting:

I think we are seeing, across a number of jurisdictions and not just in the United Kingdom but in other countries too, a rising level of demand for Child and Adolescent Mental Health Services. What do we attribute that to? There are probably a number of potential answers to that. It was interesting, I was watching evidence given by the Resilience Company the other day and they made an interesting point, which was have we been very successful in reducing stigma and discrimination? Yes, we probably have been quite successful at that. What has been the knock-on effect of that? The knock-on effect of that is that people are much more aware that they may have an issue and therefore they want to ask for some help and they are more likely to ask for help with it. What is the knock-on effect of that? It is a rising demand for services. So if you are going to engage in work that is about reducing stigma and discrimination and encouraging people to seek help, you have to match that with adequate capacity in your service to deal with that increasing demand. There are a number of other factors particularly for children and young people, there is a huge focus at the moment around the role and impact of social media and the impact that it has on children and young people's mental health, whether that is about body image, whether it is about online bullying, I am still reasonably young enough to remember being at school and if you were bullied at school when I was a lad you went home you largely escaped from it. There is not that escape in the same way now for children and young people. There are different sorts of pressures around examinations and targets and all those sorts of things. So I think it is a combination of societal and cultural impact as well as the reduction of stigma and discrimination, which has made children and young people feel more able to ask for help or indeed their parents to feel more able to ask for help from the services. I also think the recognition of some of these issues is probably greater than it was before; there is more of an acceptance that some of the experiences of children and young people are about their

mental health. Of course mental health and physical health are closely linked and those sorts of things, so there are a number of drivers, but again I do not think Jersey as a place is unique in experiencing that. We see that particularly in England, at the moment there has been a huge drive around trying to improve access and provision around Child and Adolescent Mental Health Services. Some would say there is still a long way to go and there probably is, but there is investment being focused in that particular area and there is also investment and focus being given particularly around mothers in the postnatal period and equally announcements just in the last week about screening new fathers for postnatal mental health problems. Those are all wrapped up in terms of how families with children cope and react to those sorts of things. Will that demand continue to rise? I suspect it may do. We will have to look at how those trends develop over the next few years because a couple of years is a relatively short space of time. But I do think that raised awareness, that reduction in stigma, greater recognition, is driving some degree of demand. If a service exists, to some extent people will use it as well.

Deputy K.G. Pamplin:

Just before we go into more detail about the Mental Health Strategy, picking up on your point there, would you think it is fair to say that there has been an underestimation then of the level, when you raise the level of stigma, you release the strategy, you commit to that, it opens up the pathways; that people have underestimated the problem?

Managing Director, Contact Consulting:

I think that is a fair analysis. It is a bit like the Field of Dreams theory, if you remember the film, if you build it they will come. I think there is some truth in that as a hypothesis. There probably has been an underestimation. What I would say, in my experience of working here on and off over the last 4 years or so, there is a palpable change in attitude and willingness to discuss and shine a light on the issue of mental health and also on serious mental illness in a way that perhaps was not the case in the past and that some of those issues were not talked about, were not discussed openly, were not a matter of public debate, and that services were not well developed and had not been well developed in the past. Therefore there has been an underestimation of the need to increase the availability of those services to keep pace with that demand. That takes time to do. You cannot click your fingers and create a new workforce overnight, particularly with the challenges of workforce recruitment and retention in an Island setting.

Deputy K.G. Pamplin:

Turning back to the Mental Health Strategy, can you provide us with an overview of how the Strategy was developed and your role in the process?

Managing Director, Contact Consulting:

Sure. We responded to an open tendering process and we thought this looks like a really interesting piece of work and one of the things that really interested us about it was in fact the brief that was provided by the then Health and Social Services Department, as it was then called, in terms of the approach that they wished to take in developing a Strategy because you will all know, I am sure, that if you want to write a Strategy you can very easily go into a dark room and sit down and hunker over a keyboard and write it and it will appear reasonably quickly. But it is very unlikely that anybody is going to buy into that and your chances of success of delivering it are probably quite limited because it will largely be your view about what you think ought to happen.

[12:15]

What interested and excited us about it was that it was very clear within the brief that there would be a need to engage with the citizens of Jersey as part of this process and we thought that struck a really interesting tone in terms of involvement and engagement. The other thing that interested us, and a point I want to be really clear about, is that this Mental Health Strategy was not simply about services, not simply about clinical services, it was about the mental health and wellbeing of the population of Jersey, so it is about trying to take an Island-wide population-based approach to the improvement of the mental health and wellbeing. It is not simply about setting out a set of answers in terms of service specification about: "You need this many teams and this many people." It is slightly higher level and a different approach to that. Our role was multi-faceted really. The first bit was to draw together the information and the data around the trends and trying to look at what the levels of need were and to take a bit of a view about what is the balance of investment, does it feel about right, does it not? What does the quality of the services look like currently? We are talking 2014/15. To look at some of the evidence about what works and what does not work in other places to try to make some comparisons with places that were broadly similar types of jurisdiction, whether they be island communities or similar types of populations. Then to do 2 other things, which I think were really key, one was what we described as a customer voice exercise, which was to engage with ordinary members of the public through a range of processes, through open space type meetings, which is a methodology for engagement with the public where the people that attend that meeting set the agenda rather than the facilitator and you come up with a range of outcomes, it is slightly organised chaos, but you generally get a good outcome from that. But also some one-to-one interviews with people who were interested and we did those in different places, so we did them in the Job Centre, we did them in the library, we did them in G.P. (general practitioner) practices, so we did them in places that people were going to go to rather than saying: "We want you to turn up at 3.00 p.m. in the afternoon in St. Helier Parish Hall." Some would say: "I cannot do that because I am at work." So we did it at weekends, we did it evenings, we did it at times when people were going to be available. The other thing that we did was develop a Citizens' Jury, we describe it as a Citizens' Panel rather than a jury because there are some potentially negative connotations about a

jury. This is a well-established methodology around community-based engagement and what we were keen to do was to compose that Citizens' Panel of people with lived experience. So pretty much all, if not all a very high proportion, of the people who were part of that Citizens' Panel were people who either had current or previous experience of mental health problems or who were caring for somebody who had a mental health problem. What we asked them to do was to help us to think about: "What would a good set of services in Jersey look like, what would that mean for you as somebody that has experienced these sorts of issues? Can you help us to shape the sorts of things that we ought to be focusing on within the Strategy? Give us your thoughts and views about that." From my recollection, and I have the report with me, is about 14 or 15 people were part of that panel. We did a big selection process; we wrote out to over 1,000 people, Jersey Post sent the letters out for us. We got a big response; I think we got over 150 responses, which for that sort of mail out is a pretty high return rate. Then the people that were selected to come on to the panel were selected to ensure that we had a good representation of age, gender, ethnicity, employment status, those sorts of things, so it could be described as being, as much as these things can be, as broadly representative, rather than simply being the same people that might turn up to public meetings or come and sit and watch scrutiny panels. We had about 7 or 8 meetings with that Citizens' Panel altogether, it was facilitated by one of my colleagues, Peter Bryant, who continued to do some work here in Jersey on other matters. They set out for us what they thought the building blocks ought to be and what "good" would look like from their perspective and we synthesised that with some of the evidence that we had been collecting and that helped us to shape up what we thought the overall headings ought to be, what were the key issues that we ought to be thinking about within the Strategy. From there, we moved into an action learning set approach, so we gathered a range of stakeholders from across different departments, not just Health, but people from Education, from the Prison, people from Criminal Justice Department, people from the voluntary and community sector, a whole range of different people into these action learning sets and that was an opportunity for them to think about what are the practice and operational challenges that we face and how would these building blocks map across to help us think about how we could tackle those in different ways and improve the mental health and wellbeing of our population, but also where that might have a direct impact on service? Some of that of course is tied to existing policy and legislation requirements as well. From all of that fairly lengthy process, it was not a short process at all, we then produced a draft outline document. That was then shared with all the various stakeholders to comment on and give us feedback on. We then finalised that document and it was then presented and launched at what was described as an engagement day event, which was a day-long session, and that was an opportunity for everybody to have a final say on what the document looked like and to almost in a sense sign up to it and say: "These are the things that we think we ought to try to be doing as a group and we will commit to gather again in 12 months' time to see what progress we have made." There was a subsequent day. It was made very clear to us that this was an overarching document and that within it there should be a range of recommendations for action and that there

was an imperative, if you will, for those to be delivered. This was on the back of the P.82 that has been identified for improvement in mental health in particular because what is really important to say is there was a recognition at that point that the services and the system was not in the place that stakeholders wished it to be. The Strategy was seen as a way in which we could bring colleagues together to think about that jointly. One of the other things to say is that this approach that was set out in the brief and which we delivered has had some international recognition in terms of its effectiveness, both in academic literature, but also it has been cited at various conferences and people have looked at the way in which Jersey operated this piece of work and have attempted to replicate it and certainly I have seen evidence of that in parts of London and also some work that I have been involved in, in London and in the West Midlands, where similar approaches have been taken to think about population-based mental health and some of those are also based on other international examples. But the lessons learned here have been drawn upon by other systems as a model of good practice for how you engage citizens and communities in thinking about the development of the way in which you think mental health and wellbeing ought to be addressed within a particular jurisdiction.

Deputy K.G. Pamplin:

Just to go back to pick up on your point about your statement where you say that the Strategy was about people, the wellbeing of Islanders and mental health in this approach, but you also effectively say that maybe that has been lost in translation in terms of the Strategy as a whole. I know we are jumping ahead, we have other questions, but we are here reviewing the Strategy and where we have progressed, but how you have described it I totally understand, I think we all would, so when you hand over your work and project, the reason we are here, I think it has been lost in translation somewhere.

Managing Director, Contact Consulting:

Yes, is the honest answer to your question, I think there has been something lost along the way. Working as an independent consultancy organisation, it is not unusual to do a piece of work and to hand it over and to leave and never know what happens next. We have been very fortunate to have been able to continue to do work in Jersey over the last 3 or 4 years, some of it has been about the delivery of the Strategy, but the vast majority of it has been other types of work, some of which had some connection to it, but not in terms of overall delivery. However, if you spend any amount of time here, because it is a relatively small place and there are a relatively small number of senior officers, you tend to bump into people at the same meetings or different meetings at various times, so you get to hear a little bit about what is going on. My sense is that initially there was a very strong drive around implementation and a very clear plan about how that would be taken forward and certainly, as I think I mentioned in my submission, around older people's mental health services. That is a very clear example of translation of strategic intent into operational delivery. What has

been lost, certainly over the last year or 18 months, has been that connection between the Strategy and operational development and that is not just about services; that is just about the broad thrust of saying this is about mental health and wellbeing of Islanders, of Jersey as a whole. That is what is missing. I would say inevitably when you do a piece of work you hope that particular people, who have signed up to it and agreed with it, will be able to take it forward and I think that there have been a number of obstacles, and no doubt we will come on to those, that have got in the way of making that direct translation so that if you asked your average person walking through the Christmas Market in the Royal Square today: "What tangible difference can you see?" it would not surprise me if they said: "I am not really sure."

Deputy C.S. Alves:

So we know that some things set out in the Strategy have already been delivered, such as the Recovery College. Are there any initiatives in the Strategy, which are yet to be delivered?

Managing Director, Contact Consulting:

There are potentially a number but I guess my sense is that the response for people in crisis remains work in progress and that is regrettable because when people are in crisis that is when people most need help and they need it quickly and they need it as close to home as possible. My sense is that is not happening with any degree of consistency. It may be happening for some but it is not the experience of everybody, from what I hear and what I read. You will appreciate that obviously I am not here every week, indeed I have not been here for a little while directly. Allied to that, the development of the provision of mental health expertise and support in primary care is significantly lacking in Jersey. We could debate the merits of the general practitioner and the primary care funding system on the Island but, whichever way you cut it, people are not getting mental health support in primary care in the way that you would hope that they would. As an aside, there are still gaps around drug and alcohol treatment, significant gaps there, and the comorbidities between mental health and substance misuse are very well evidenced so that is a big gap. We know that there are broader issues around substance misuse on the Island anyway, particularly in relation to alcohol, much more so than illicit drugs, although prescription drug addiction seems to me, from what I read, to be an area of concern. Great play has been made around street triage and place of safety development in Jersey. There has been a relatively successful street triage pilot but I am not clear that it is leading to any longer-term delivery. It depends who you talk to about the effectiveness of street triage, some people say it is excellent; other people will say some of the studies are a bit short and they do not really give us a true picture. With any new service it takes a while to work that out and I suppose I am not an academic but I tend to take the view that for something to become evidence-based somebody has to have a good idea and try it out. There is every reason to think that it would be worth trying that further. There are challenges here in delivering any form of street triage because of the dispersed nature of where people live. It is a relatively rural place but the

hotspots in St. Helier will probably be well known, both to the police and to Mental Health Services. The provision of a place of safety, I think you will be aware of the position in England, we have made some advances in that area, there are still a few places that do not have them non-police stations, but I stand to be corrected, but there should be no reason why that is not already in place here in Jersey. It is not beyond the wit of man to have come to an agreement to staff it, to find an adequate place for it to be, whether that be at the acute hospital or indeed at the Mental Health Unit. But that could have been done if there was the will to have done it. If that is going to happen, I would not be banging any drums and celebrating very loudly when it is achieved, it should have been achieved some time ago. So I think those feel for me to be significant gaps. The other bit is around estate, the provision of the inpatient unit, certainly the last time I was there, it is not somewhere I particularly want to spend very much time, particularly if I was severely unwell.

[12:30]

Deputy K.G. Pamplin:
Just for clarification, you are talking Orchard House?

Managing Director, Contact Consulting:
Yes, Orchard House. I do not think it is fit for purpose. I do not think anybody that lives and works there thinks it is fit for purpose. It requires reprovision in my view, capital investment in renovating it and changing it is a false economy in my judgment. It needs to be reprovided. You could take the view that there was an opportunity to think about that as part of the development of the Future Hospital Programme and if you think about the connections between physical and mental health there are all sorts of reasons why you could have tied those together, particularly given the potential diseconomies of scale that exist in Jersey around providing a large General Hospital for a relatively small population and all the challenges financially and otherwise that brings for the Island. So the inpatient service is not anywhere near where anybody thinks it ought to be and from a workforce point of view it remains hard to recruit and retain certain members of staff. There are all sorts of reasons for that and you will know them much better than me and experience them on a day-to-day basis I am sure, but we need to make the service an attractive one for people to want to come and work in, whether they already live here or whether they live somewhere else currently. Rather than people seeing it as an opportunity to come and finish their career, we need progressive professionals to come and work here who are either very experienced or want to build their experience and do innovative things because there are opportunities to do that here. The broader public health and population-based approach has not yet been delivered, trying to think about how you bring different departments within the States together with business, with schools, colleges, and other third-sector organisations, as well as some commercial organisations I suspect, to think about ways in which you can improve the mental health and wellbeing of the broader population. So what is the role of

large businesses working and sited in Jersey, certainly large financial institutions, we know that the mental health and wellbeing of people working in large financial institutions can be quite challenged. There are examples of work by colleagues of mine in City Mental Health Alliance in London working with City organisations have done some tremendous work around improving mental health and wellbeing, making themselves mentally healthy workplaces. There is a great opportunity to do that here in Jersey and I am not sure that they are being grasped. So how you bring organisations and communities together to see this as a population-based issue, I think the stigma discrimination stuff has had an impact and I do think that some of the work around suicide reduction has seen some traction because the suicide rate has generally been seen to drop in Jersey. It is not proportionately high. I am sure there is more to do but it is on a certainly either static or downward trend from recollection. So there remain a number of gaps that are partly about the broader philosophical translation of what is in the Strategy as well as the quality of crisis care in adult services broadly is not where we want it to be, our inpatient service is not as good as we would like it to be and the estate is poor. We do not have a place of safety. The thing that is frustrating for many people is how is it that in a small place, with a relatively small number of people, that where services should be really straightforward for them to work together in an integrated partnership-based way, but there exists very few frameworks for that to happen in Jersey. When you look at the issues, you might be aware, we did a review of the Jersey Safeguarding Boards, which was published earlier this year, and although safeguarding is not in the legislation there is a memorandum of understanding, but there is no framework for how organisations and individuals work together, it is based on relationships. All joint working is based on relationships and that is fine when everybody gets on with each other and there are no problems. I think what you see across the piece is that, without those frameworks, those relationships can become fractured and at the moment I certainly have the sense, albeit at a distance, that some of those relationships are fractured and that mental health remains slightly to one side of the broader health agenda rather than being integrated into it more broadly with physical health development and certainly in relation to the way in which other organisations and individuals work with them. Sorry, that is a very long answer to what was really a very short question.

Deputy C.S. Alves:

To follow on from it, why do you think these initiatives have not been delivered? You gave us a couple of reasons in regards to Orchard House and the lack of investment and making it attractive.

Managing Director, Contact Consulting:

There are a myriad of reasons I guess and I should preface it by saying these are my personal opinions based on my experience with working here and obviously I am not here all the time, as I said earlier on, so I just preface it with that these are my professional and personal observations from working here. The environment and the climate to deliver the Mental Health Strategy was

perfect at the point at which it was written and published. The money was available, the political will was there, the senior people in Health and Social Services were signed up to it as a programme, there was a good leadership within the department at a senior level in terms of having developed the brief, worked with us, and I would say just as an aside the relationship between ourselves as a contractor and the department and the people in the department, it was a truly collaborative piece of work, it was not us doing it on their behalf, we worked really closely with them and we could not have done it in the way that we did without their support. But things began to change in terms of the financial position within the States changing a bit and some reductions in spend having to be made and some of the priorities that had been identified, certainly under the P.82 money, can we still deliver those, can we not? In more recent times, what we have seen is changes in personnel, certainly previous Deputy Director of Commissioning moving to a different department, to another job, has had a direct impact on delivery. So I saw a colleague the other day pay tribute to Andrew Haddon's work and I would like to do that too because I think he oversaw this project with a huge degree of expertise, "passion" is a much overused word in our lexicon these days and sometimes does not mean very much unless it is allied to some degree of expertise and Andrew possesses both in equal measure and worked really hard on this programme. His departure and the inadequacy of what was put in place afterwards, and that is not a comment on the individuals, it is just about the structure, did not imbue the delivery of this strategy with the degree of priority that had previously been the case. Where we are now is a realisation certainly from people working in the system that there needs to be some reinvigoration of that delivery. Some of the obstacles have been about people in terms of posts, have been about money, they have been about interagency relationships, but also it is about ultimately who is responsible for the delivery of this programme. At the moment that remains unclear. As I understand it, there is a newly-shaped mental health implementation group. That newly-shaped mental health implementation group is chaired by the Director General of Criminal Justice and Home Affairs and that leads me to ask the question of our colleagues in Health: "Why are you not chairing that group? It is your responsibility." Yes, of course mental health is a cross-sectorial endeavour, but it is not ultimately the responsibility of Home Affairs and Criminal Justice. It feels hugely inappropriate to me. I do not think it sends a very positive message about mental health that it is seen to be part of a criminal justice process. Yes, criminal justice is a key element in terms of service provision and dealing with people who offend in the context of their mental health problems is important but mental health is a health and social care responsibility. I think they should be stepping up and leading very, very clearly. Yes, of course working with colleagues in other departments extremely closely, but I think it sends entirely the wrong message and that has happened because of a gap in that department that someone else has felt it necessary to fill. That sends its own message about where Health and Social Services have been in terms of trying to deliver this over the last 12 or 18 months.

Deputy K.G. Pamplin:

I just want to carry on this theme because what you are saying here is very interesting, I do not know how aware you were of the recent Auditor General's report into the delivery of the Future Hospital and healthcare governance. In her latest report she talked about this sort of thing where it was overly complex for an Island this size. Interestingly, she said the Future Hospital project should have been led by the client, which was Health. What you are saying here is echoing that report saying that the key deliverer of this Mental Health Strategy should be Health, but what you are saying is it is being led elsewhere. So what would you say, with your expertise, could be the outcome of that?

Managing Director, Contact Consulting:

I think there is a danger if Health do not take a lead responsibility for an area of service, which falls within their span of responsibility, which is that people will feel that they have abdicated that responsibility and you then do not get the degree of buy-in from clinical and managerial colleagues and then it becomes a fracture and it is seen that it is somebody else's responsibility so we do not need to do it. Ultimately what it does is it increases the risks of not being able to deliver what is set out in the Strategy. What I would say to you is that it is entirely appropriate to review a Strategy partway through and I very much welcome the fact you are doing it, but what I would say is what is in that document remains as valid as it was when it was published in 2015/16, the messages in it have not changed in terms of how important they are, the priorities are still broadly the same, what I would like to see is a system whereby departments can work together much more effectively to say: "Mental health is everybody's business." Somebody has to lead it, it naturally makes sense for Health and Social Care to lead it, but of course with input from colleagues from Education and Children's Services and of course with input from colleagues from Home Affairs and Criminal Justice, but also with input from colleagues who you had around the table earlier in the week from voluntary sector organisations like Mind, like the brilliant Recovery College and people like Beth who are just fantastic, need to be engaged in that delivery and you need somebody senior within that organisation overseeing this as a project on a daily basis. That is why organisations like ours were not involved in delivery of implementation on a day-to-day basis because we could not be here on a day-to-day basis, we would have loved to have done it in lots of respects and the boot might be on the other foot if that was the case I guess. But it requires people to think about whose money are we spending and sort of artificial boundaries between that is Health money; that is somebody else, Education, does it matter? Are we, as you were hearing the other day, investing properly in getting mental health support into our schools and colleges? You can say is that a Health responsibility or is it an Education responsibility? I would say it is a population and it is a States of Jersey responsibility. Let us think about how we get out of these traditional silos of budgeting and policy making and legislation. Let us try to break that down a bit. Now I know that is easier said than done but I would agree that one of the things that struck me the first time I came here, and when I came here to be interviewed for the piece of work was the first time I had ever been to Jersey, so I had no

preconceived experience of being here, but what I rapidly discovered was that, for a very small place, it is an extremely bureaucratic system and it is extremely hierarchical in that regard and there is not a lot of flex. When you have groups of people who work together very, very closely --

[12:43]

That, again, as I said earlier on, is fine when everybody gets on. If there is a problem, that becomes quite difficult to get through. There has not, as we have said in other work that we have done, particularly in the Safeguarding Board Review there has not been a culture of constructive criticism or professional challenge on this Island in the way that you would see in other places. That leads to great difficulty in people feeling able to say: "I am not sure I agree and this is why," or to challenge an issue of practice and feel safe to do that, because it is a small place and everybody knows each other. There are all sorts of cultural issues wrapped up in that, which nobody is going to be able to solve overnight. But to come back to the thrust of your question, sorry, I think that mental health is, in effect, a joint endeavour, but somebody has to lead it. It seems to me that Health and Social Care are the natural part of the organisation locally to do that, working jointly with colleagues. I think it sends a poor message of your governance and structures if they do not do that.

Deputy M.R. Le Hegarat:
That is pretty much all the questions I was going to ask. We will move on from those. It is quite clear that, from your perspective, the Mental Health Improvement Board should be led by Health?

[12:45]

Contact Consulting:
Yes, it should. It is the very name. If it is a Health Improvement Board, why would anyone else need it?

Deputy M.R. Le Hegarat:
Exactly.

Deputy K.G. Pamplin:
You talked about the framework, which leads on to the people in crisis, pathways and referrals and the process and the connectivity, which you alluded to between charities and community providers. What are the problems from, again, your experience if those care, pathways and referrals are not in place for people in crisis? What could potentially be the implication if they are not in place?

Contact Consulting:

It is a spectrum, is it not? You can start anywhere on that spectrum, but if you go right to the end of it, the most serious consequence of not having decent pathways and decent services is that people die. It is as simple as that; people will take their own lives, very sadly, or people will end up in prolonged distress that will have an impact on their later wellbeing and it will have an impact on their friends and families. Having a system that works and that can respond to people at the moment of most acute crisis, seems to me to be really crucial. There is a risk that people can harm themselves. There is equally a risk, however small that might be, that they may harm other people if they are not properly supported and looked after at the point of crisis. Then supported through a process of treatment and recovery that helps them to build independence and be well. That is about 2 things really. It is about intervening early with young people and having those services well set up and structured. It is also about having a proper crisis response that brings together a range of professionals, whether that be nurses, psychologists, social workers, as well as medical staff, to be able to support people in that moment of highest need and highest acuity. There are 2 elements of that. There will be some people who experience that crisis who are already known to services. There will also be a cohort of people who have not been previously known to services. They may be people who are visiting the Island on holiday or on business or they may have just come to live here and never experienced a mental health problem before. So you kind of have to be able to respond to potential sets of circumstances. You need to be able to rapidly assess them, rapidly determine what treatment you are going to be able to give them, how that is going to be delivered and where. That also has to be something that is not simply about: "Well, we assess people under your new Mental Health Law and we detain people for a period of time in hospital and we treat them for a bit and then we let them leave." What is the follow-up from that? The pathway is a continuum. There will be an element of self-referral for some people at moments of crisis and there will be an element of referral to crisis services for people who are already in contact with the specialist community-based services or indeed other forms of service across the Island. What it shines a light on is the way in which community services are not as well developed or that there is an imbalance between the provision of community-based services and inpatient services.

Deputy K.G. Pamplin:

Or as you described earlier, disconnect.

Contact Consulting:

There is certainly a disconnect between the 2. There is not a continuum, it seems to me. Colleagues in primary care are well able to refer. That is not the problem. The problem is what happens when the referral lands in the community team and their ability to respond to that; whether it is a crisis referral or whether it is a non-crisis referral. For example, someone has come in with a presentation and the G.P. (general practitioner) feels that they need a specialist assessment. How long have they got to wait for that? Waiting times in Jersey have traditionally not been too bad, but what we

hear anecdotally is there are plenty of experiences of people where it is poor. There are some examples of where national targets have been set in England and it has been difficult sometimes to achieve those. Certainly there is going to be, in the new N.H.S. (National Health System), which depending on other things that are happening in Parliament at the moment, may well be launched next week around the long-term plan. We think that there will be something in there about a 4-hour target waiting time for people in crisis. Which will be really interesting, in terms of how you deliver that, given levels of demand in capacity. Here, part of the issue is about capacity. It is about how much investment is made in community-based services. Do you believe in community mental health services? If you do then you invest the money that it costs. It is not a cheaper alternative. It probably costs more. But if you are really unwell, where would you prefer to be treated? You would prefer to be treated as close to your home, if not in your home, if that is possible. You only really should be in hospital if there is no other alternative, so creating a range of services that allow for alternative to admissions. One of the other gaps, I would say, there is very limited provision in terms of supported housing in Jersey. There is no crisis house provision. Again, you can look at the evidence and some says it is good and some says the jury is out. My own view is that crisis housing of various types. There are various models; there are good models in London, good models in places like Leeds, for example, which are non-residential crisis housing. There is not that sort of provision here, so you kind of end up having to put a lot of supports up in the community or you are going to have to admit them. That is why the beds are well occupied, given the population. They are not over occupied on a percentage basis, certainly numbers last time were looking about 75 - 80 per cent occupancy rate, compared with a 93 - 95 per cent occupancy rate in English inpatient wards. It is not high, but there is certainly a reliance on that provision when things get difficult or people end up staying in the police station for a really long time. That is wholly inappropriate.

Deputy K.G. Pamplin:

So digging into it a bit more, earlier with your reference to Orchard House, you have it in your evidence that you say: "Jersey does not have a psychiatric intensive care unit and that could be a problem." Given what you said earlier about the future hospital, where we are at with that situation, I just want to go more into that. Are you saying there is an opportunity missed and that what this strategy was saying and what you are saying today about the delivery of a future hospital … are you seeing an opportunity missed in terms of what you are suggesting here, and going to my next point, about a place of safety with the future hospital? Do you think we have missed an opportunity here?

Contact Consulting:

I think missed a trick to combine the planning of the redevelopment of both sets of services. I am not saying, and I want to be really clear, that a mental health inpatient ward should be necessarily sited in a general hospital, because that is not the general experience in other places. So I am not advocating that. What I am advocating is a degree of joint planning. If we knew in 2014 that Orchard

House was not a suitable environment, and that has not changed, but we knew we were going to be doing some work and we had already started doing some work on a future hospital, re provision, why would we not have combined the resources and the thinking and the expertise that has gone into thinking about what do we need in terms of a new general hospital in Jersey with what do we need for the future in terms of inpatient care? Inpatient care for both for adults and also what sort of provision might we need for children and young people? What provision might we need for older people, who require inpatient care, particularly people with functional mental illness? That is an opportunity missed. There is a capital planning missed opportunity, is there not, because you would spend that money in terms of that planning just the once? I do not think there was a sufficient audit of what the actual level of need in Jersey is for beds. I think some of that work has been done since. I have not seen it, so I cannot comment on it, but I can see the methodology. The thought about: how many beds do we need and of what type? Certainly the fact that there is not a psychiatric intensive care unit brings its own challenges for the staff working in Orchard House. How do they manage and deal with people who require those conditions of intensive care? Some of that intensive care may be where people are unable to leave, because the door is locked. That is not there. I have talked in the evidence about medium secure services and think we all accept that you cannot make an economic or otherwise case for having a medium secure service of your own in Jersey. It just does not stack up; there is not a demand and it would be way too expensive. What does stack up is having a much more structured agreement with a provider or other providers in England or wherever that you establish a good contractual, working relationship. They get to know your patients. You get to know them as professionals. There is good liaison. There is a good review. People do not stay there longer than they should do. They are repatriated back to Jersey as soon as possible. That seems to me to be perfectly reasonable. However, if you go and talk to the people running the Health Care Department at the prison, what they will tell you is that when people become mentally unwell when they are in the prison and they are unable to cope with that because they are not trained mental health professionals. Those individuals have to be taken to Orchard House. However, because the conditions there are not secure, 2 prison officers have to sit with that patient for the entire time that that patient is in hospital. That has issues for me, not just about resource management for the prison, which is an issue for them. It is a resource management issue for the system, for the States and it is also an issue about the dignity of that person, who is effectively being guarded. They are not being nursed by those individuals, they are being guarded. It is harder for them to be nursed in those circumstances. It is not an appropriate place for them to be, but no other appropriate place exists. Indeed, if somebody is being admitted and they are being admitted, because they have been detained under your Mental Health Law and they require those conditions, where do they go? Well, they end up staying at the police station for longer than they ought. That is certainly anecdotally what I hear. Forgive me, I have not read the new Mental Health Law in the fullest of detail. I pay tribute to Ian Dyer for the work he has done on that, because it is a complex process to reshape and recast that law and bring it into the 21st Century. We know that in England

at the moment that there has been an independent review of mental health legislation which was published last week. There are challenges to doing that work, so to get that law in place and enacted is a significant achievement. However, if you are going to accept that at times you will have to compulsorily detain people, you need to have the facilities in which you can do that safely and appropriately. That is not just people who are members of the ordinary community. They are people who are in prison too. They are part of the community. The previous Governor, when we did work with him looking at the gap analysis around prison health care, in particular prison mental health care, would say to me: "The prison is just another address. Why can we not just treat it like another address?" He, of course, was entirely right. That kind of continuum, to come back to your original point, sorry, putting the referral in from primary care or wherever is not really the challenge. The challenge is how you create the pathway through which that referral goes and how that individual who has been referred is appropriately assessed in a timely manner; receives the treatment and support that they require in a timely manner and in the most professional way; and when they are well enough that they are discharged from those services. It is not just the entry point it is the exit point from the service as well. Ultimately that is about demand management. It is about the right capacity, in terms of how your services are staffed, where they are, how they work and the interaction between community services and inpatient services as well as with ambulance and police. We are talking about that end of the spectrum, rather than the more public health type initiatives. There is a need to really think about how that works. It feels to me that for a lot of people it does not work as well as it should.

Deputy K.G. Pamplin:

To wrap this up on the estate issue, because the culture of how the prison is all the way over there, Orchard House is all the way over there and the hospital remains in town, you are almost suggesting that it could be visibly as well as mentally more connected up. That if a mental health facility or psychiatric hospital should be more visibly closely linked up with whatever …

Contact Consulting:

I certainly think that there can be a greater connection in terms of where things are sited. If you look at where Orchard House is, it is not in town, is it? Just in practical terms of visiting people, if you do not have a car and you are on a low income, how do you go and visit your relative? It is not easy to do. That is not great. Let alone, what were are the experiences like when you get there, in terms of what it looks like and how fit for purpose it is? Bringing it closer to physical health care services, both from the system point of view as well as an estate point of view, may have some benefit. I also think it is also the message we send about your acceptance of mental health as an issue and your acceptance of the fact that people can experience serious mental illness and how you respond to that.

[13:00]

Interestingly, I was in Amsterdam a couple of weeks ago. I went to visit a mental health hospital. They do not describe it as a hospital; they describe it as a mental health clinic. It is slap-bang in the middle of a residential area. There are houses and shops all around it. When you walk past it, you would never know that it was a mental health hospital. In fact, the C.E.O. (Chief Executive Officer) of the organisation that runs it was saying to me that a large organisation opened a hotel next door and very often people come into the wrong building, because they think we are the hotel." It looks like a hotel and the provision inside is like a hotel. If you had that provision in St. Helier … well it would not necessarily be any more accessible for people that lived in the north of the Island than where it is now. There are those sorts of challenges. However, in terms of: what does that do for our culture sense of how we treat people with mental health problems, in terms of our attitudes and how we accept that it is just the same as having an ordinary hospital where it is?

Deputy K.G. Pamplin:

Just to be clear, final point, you are saying it should not be in the general hospital, that should be kept separately. There are 2 suggestions; that it should be in the immediate area and it was suggested after the Strategy, when the former Minister for Health and Social Services stood at the Overdale site and said: "Hey, mental health site here." It obviously went to election and it has kind of gone away. So keep the hospital separate, but create a separate place, or alternatively create a campus, fairly similar to Guernsey and other parts of the U.K. (United Kingdom) where the general hospital and the psychiatric hospital are all in one place.

Contact Consulting:

Yes.

Deputy K.G. Pamplin:

I am just curious.

Contact Consulting:

Yes, I think you could do that. I certainly think bringing all mental health inpatient services together in one place seems to me to make sense. The estate management and the transitions between services may have an impact on that. Where they are physically in terms of how people get to them and those sorts of things are, of course, considerations that need to be thought about.

Deputy K.G. Pamplin:

The example of Amsterdam is really curious, because it sounds like a hotel and is not viewed as part of a campus where people go to get well.

Contact Consulting:

No.

Deputy K.G. Pamplin:

The argument strengthens there: have a good modern-day hospital, but have a wellbeing place that is …

Contact Consulting:

Yes and you have to see the inpatient provision as simply part of the range of services that are available.

Deputy K.G. Pamplin:

Yes.

Contact Consulting:

Thinking about: how many beds do we need? How many staff do we need? How often is that service being used? The hospital should be a place where people go when they are in the most serious degree of need and they cannot be looked after in the community. Most people would be preferred to be looked after at home. In some circumstances that is not possible, but let us have them in hospital for a shorter period of time, as is necessary, get them well enough to return to home. If they cannot return to home immediately, let us have a range of supported provision that will enable them to make those steps. Let us make sure that around that, we also start thinking about how we get people into work or back into work. How do we make sure they maintain their networks with their family and friends? How do they fit into their community? How do we make sure they are financially stable? Have they got good access to primary care when they need it? See it as part of the continuum, not as a separate part of the service. See it as a mental health system, rather than a set of defined structure, buildings or services. You can build whatever you want, but if you define the services by the buildings, that is kind of the wrong way round. It is like when you go to close things; as in my experience in the past as somebody that was involved in closing services, one of the challenges in communicating that closure to the public is that the public rightly, to some degree at any rate, regard the building as the service, rather than the people that work in that building. When we would relocate a new patient service or something and we would be thinking we are going to deliver this is a different way from a different place; it is not about the building as a whole. Do not get too focused on what it is called. Think about it as a mental health system, within which a range of elements of service needs to be delivered. Some of them can be delivered from the same place, some from different places. Keep a focus around community versus inpatient care. Get that balance right. Also, get the balance between public mental health, wellbeing, education, awareness and

mental health literacy and engaging employers, making sure we can get jobs, reducing suicides, creating the conditions for mental wellness on the Island, et cetera. Then you will reduce the demand for your high-end services and save money in the long run.

Deputy C.S. Alves:

You have mentioned, quite a few times, but you mentioned it in your submission as well, about how partnerships are based on individual relationships. What could we put in place to encourage greater partnership working, as opposed to it being based on relationships?

Contact Consulting:

Yes. Nothing works without people working together. It is really about culture and the way in which people have traditionally worked, not just here in Jersey, but in other places as well. How do you break down some of those professional boundaries while respecting the fact that, for example, nursing staff have a very particular set of regulations and responsibilities that are defined as part of their profession, in the same way that social workers do or occupational therapists do or psychiatrists do. What are the common threats that are in between their endeavour? Try to focus on those and think about that in terms of organisation development. Creating multidisciplinary teams is not simply co-locating them in one office. You can put any group of professionals together in one room, that is pretty straight forward, but what is the culture of the service? What are we striving to achieve? It sounds a little bit like a really bad American organisational development conference, if you are not careful. But how do you create a sense of a shared vision and a shared ambition, as a service, as a team? How do you create that vision of a system of which you are all part? You might work in one part for a bit and you might work in another part for a different period of time. The frameworks, in a sense, it seems to me, are about what are the written undertakings that we make, in terms of the way in which we will deliver services? I am aware that there are some memoranda of understanding, for example, between the police and Health around working with people who have ended up in the police station. That is a really good example of how good personal relationships have brought together development of an underpinning framework. People understand what their responsibilities are, where they overlap, where they do not, where they stop and where they start. Therefore, that bit of the system works pretty well. That is not to say you need to be overly focused around a contractual relationship. It needs to be more than that. Some underpinning written documentation: this is what we do, this is what you do, this is where our shared endeavour is, this is where we stop and you start or vice-versa. It is important to have that really clear. I do not think that exists at the moment. It goes back to my point about seeing it as a system rather than a set of individuals. That takes me back, I guess, to my point about cross-sectorial work requires you to understand where responsibilities start and stop. I do not think that that is well understood. That, for me, currently goes both operationally and strategically. I do not think that is well understood.

Deputy C.S. Alves:

Mind Jersey have highlighted the Triangle of Care model. Do you think this model has merits and will it work in Jersey?

Contact Consulting:

It is a well-established model. The evidence is there to support it. I would have no reason to question the proposition that it could work here. You will see in the Strategy that what we tried to do was to look at the triangle of need, to some extent. You can see that most of the money is spent at the top of the triangle. If you think about what Mind are suggesting, it is probably the same thing, in terms of: how do you rebalance the approach that we take that means that you still invest appropriately at the top, but you do not forget that wider bit of the population at the bottom of that triangle. There are merits. You would want to do some further work to test that out and see if it aligns with some of the principles in the Strategy. I see no reason why it should not be explored. There are all sorts of things that could be trialled. A place like Jersey is a good place to try things out. There is a very vibrant voluntary sector community here. The only caveat I would add to that, just to say, is that you do need to be careful that the statutory responsibilities that Welfare and other organisations need to deliver should not be shuffled on to. Very good although they are, community voluntary sector organisations, they are there to support with different types of services. I am a trustee of the Association of Mental Health Providers in England, who are the U.K. representative body for voluntary sector organisations working in mental health. Somewhere between 8 and 10 million people with mental health problems in the U.K. are supported by a voluntary sector organisation in some way shape or form. They are an absolutely bedrock in filling those gaps that the statutory sector either cannot or should not be providing. That is an interesting balance between the 2 of those things. I would encourage the system locally to work with Mind and some of the other organisations as well as groups of people with lived-experience to think about what models could work. Let us look at what the Strategy says in terms of the way in which services should be shaped. Forgive me for repeating it, but there should be a focus around community, in terms of provision. There should be improvements in estate. There should be a multidisciplinary approach. There should be more in terms of population mental health and wellbeing. How can we make that happen? We have said we are going to do it and we have made some progress, but we have not achieved it yet. It is a 5-year Strategy. We still have 2½ years to go. Let us not be pessimistic about it. We still have time to do it. We may need to go back and say: are these things still relevant? Can we still afford them? Is there still the will to do them? Should we reprioritise them? They are all entirely valid. The underpinning principles remain as strong as they were. One of the things that came out of that Citizens Panel was a desire for those people to remain involved in thinking about the planning implementation. That did happen for a bit. I could not tell you whether those individuals continued to meet, I am afraid. If you want to reinvigorate this, you revisit that model and, even if you cannot bring those individuals back together, you bring together a group of people who are representative,

at least as far as they can be, people that live and work on this Island, to tell you what is working well and what is not working well and what it is that they both need and want. I do recognise the 2 things are not the same and there is a limited amount of money to spend. If you engage them … they are the people who are closest to the experience of what it is like to be mentally unwell on this Island, they know exactly what it feels like and what the responses are. You support that with a range of expertise and knowledge from professionals from across the system. Jersey has set a standard around that community engagement and it could, if it wished, continue to do that. The model that you are describing would fit well, I think, into that sort of approach and it would be an opportunity to test out and say: "Look, we have a bit of time here with delivery, let us just have a think about what are the things we really want to do and what can we achieve? Let us also pat ourselves on the back for the things we have done." The government submission talks a lot about things that have been done. You could probably ask them some more detail about that and they would be better informed than I about what is really there. That does not mean that you cannot take a fork in the road and take a slightly different route. As long as the end point is the same, the route by which you get there can change.

Deputy M.R. Le Hegarat:

As part of the One Government changes which are probably taken back from the Civil Service, child and adolescent mental health services are being separated from adult mental health services. Do you have any views on this change?

[13:15]

Contact Consulting:

You will have gathered that I have a view about most things **[Laughter]** and I do have a view about that. I have sort of alluded to it in … well, I do not allude to it, I am reasonably explicit in my submission, but I have sort of alluded to my approach in the things that I have said earlier. I am not a zealot for particular structures. You have to develop and put in place what you think is going to best meet the needs of any element of the population, but for children and young people it is crucial you get that right. There are certainly benefits to placing the mental health of children and young people away from the mental health service for adults and old people. I can see that there are benefits and they have been articulated to you by people who have put in other submissions and who have spoken to you already, so I will not re-rehearse that, I guess. There are some benefits. However, what I would say is that by doing that you break the system that we were just talking about; you effectively fracture it. You take away the opportunity to build a life-course approach in the way that your mental health services work. What you do is you create a larger gap for transition. You will be aware from some of the evidence you heard from the Children's Commissioner earlier this week that one of the real challenges is around that transition from being a child or young person into

adulthood, particularly if you continue to need to use secondary care mental health services. Where is the age cut off? What is the period of planning for transition? Are there even any transition services in place that will help you to bridge that gap? Also, what is the transition out of those services if you are not going to require them in early adulthood? The risk inherent in placing child and adolescent mental health services away from the mental health system is that you widen that gap and make it harder to bridge it for transition. That is my principle reservation about it. I can see that there is sense, particularly thinking about how we improve health and wellbeing in schools and in colleges. Why would we not site children and young people's mental health within the education of children's department? You can kind of see the logic. It breaks the connection with the rest of the system, in terms of mental health. It gets in the way of that continuum and, for me, it increases that risk around transition. I am not a child and adolescent mental health expert, in that sense, from a clinical point of view. But from a service provision point of view … and I am about to review some services in a part of England that are about: what do those services look like in terms of a pathway? How do they work? How do they connect? I guess the challenge in creating this change, which I think has already been made, is: what are those pathways? To come back to your point about: how do people navigate their way through the system? What does that navigation look like? Who has designed the map? Is it interpretable? When you get to the point of saying: "I need to flip the map over, because I am moving into adulthood, how do I find where the right crossings are and the destinations that I want to go to?" Sorry to labour the analogy. That is the inherent risk of separating the 2. In terms of the clinical support, they are still the same services, but they are reporting into a different place. You could take a philosophical judgment about that, depending on which side of the fence you would want to sit. For me, it is that transition bit that feels to me to be the most fragile.

Deputy M.R. Le Hegarat:

How would you mitigate that then?

Contact Consulting:

You need a good child and adolescent mental health transition service, says the man who wrote a piece of guidance about this some years ago. It is probably a bit out of date now, but it might still stand the test. There are experts in this field, who I think can help you to think that through. I am not a transition expert, as such. I would say that I think what you need is proper support and planning. The evidence is clear about that; you need to prepare children and young people for that transition. You cannot just say, "Right. You are 17 and 364 days and tomorrow I am not going to be your support worker any more it is going to be this person and they are based up at wherever it is." You need to invest time over a good year-long period probably to help to develop that transition and make sure the support is there. They need to begin to change. The other challenge, it seems to me, sorry to bring up challenges rather than answers at this point, around the early intervention piece is early intervention is best delivered between the ages of 14 and 25. So are you a young

person when you are 24 or 25 or are you an adult? It is an interesting debate. If that service is part of Children's and you were 18 or 19, where would you go? Would you go into this bit of the service or would you go into this bit of the service? So, for me, that is that bit about it being a system and should not be defined by where an artificial age limit is. I would think about transitioning when you are ready to transition between service, not when you hit an artificial date that says, you are 17 and 364 days …

Deputy M.R. Le Hegarat:

Effectively what you are saying is that somewhere between sort of 14 and 25 is where you would transition into the different service?

Contact Consulting:

Yes. I would probably raise that lower number a bit higher. I would probably say anywhere between 16 and onwards is when you would begin to transition. It is a bit like when you think about older people with dementia when they need to go into hospital or they need nursing home care. If somebody has early onset dementia, is it appropriate for a 55 year-old person to be residing largely with people in their 80s, just because they all happen to have dementia? Probably not. So, therefore, somebody who is 18 or 19 might be better supported by C.A.M.H.S. (Child and Adolescent Mental Health Service) that by Adult or vice-versa. These sort of artificial constructs … the services in the system need to be based on the needs. I am almost arguing against my own point in a way, saying it does not really matter where you site them, because it is about needs. Of course, it matters to some extent. If you have that clearly set out and you have a transition service, settled individual professionals who are able to support people in transition, that, to answer your original question around mitigation, seems to me to be really important. If you do not have that then you are going to run a real risk people are going to fall through that gap and we have talked about what the consequences are.

Deputy K.G. Pamplin:

We are coming to the end. I think it is a fair point to say, and you said it yourself, that a review of strategy is a good thing. We are doing it in a public forum, hence of Scrutiny profile. The key part, I believe with Strategy and I think we would all agree, is that the performance, achievements and measurement of delivery have to be marked. For a Strategy to be successful, it has got to have those key things. So, to sum and wrap this all up, where are we in 2½ years and how do we see it through, bearing those things in mind?

Contact Consulting:

I think the first thing to say is that I listened carefully to some of the evidence that was given to you earlier in the week and I noted the point that was made about there being no outcomes here in this

Strategy. That is because it is a strategy. It is not an outcomes plan. But it does say that one of the things that should be developed is a set of outcome measures. I am sure that you are aware that a lot of work was done by colleagues on the development of an outcomes measurement document. That has been published. There are a number of clear outcome measures in terms of improvement delivery. I am not sure where they are in terms of publishing it for a second year, but it was intended to be an annualised publication. That set of outcomes measures were developed with another organisation, who I know of, who are experts in that area. I think it is a good document and they are good outcome measures. So that is the place I would look in terms of: where are we and how are we doing? How do we hold departments and senior officers to account for delivery? That is where you start. You also come back to: these are the commitments that we gave. I know that the politicians have changed and the officers have changed and the financial situation has changed, but we signed up to this as a community, as an Island, to say: "This is important to us." The positive thing is you are reinforcing that, as a set of new politicians, saying: "This is important to us. People have told us through the campaign and in our time coming into office that this remains a really important issue." I think it does remain a really important issue. There are a number of other important issues in Jersey, as there are in other jurisdictions, there is no escaping that. Ultimately, this is something that you are going to do something about. I would both look at those outcome measures and also go back to the original document and say: "Where is the tangible evidence of the things that we have done in terms of improving services and putting things in place?" In my submission I said to you … you have mentioned recovery colleges, which is a very tangible example of something that has come from the Strategy. The development and changes in older people's mental health services are a tangible change. Jersey Talking Therapies was already in place before the Strategy was developed, but subsequent work that we have done with them has helped to think about: how accessible is that service? It is quite difficult to get into, so if we change the way in which you access it, by making it an open access service, that would be a good way of seeing how we can have an impact and equally how we might lower the levels of polypharmacy use for mild to moderate mental health problems. So there are a number of things you can do. It would be helpful to just take … as you are doing in this sense, but with officers, to say: so are you really clear about what we have done? What is left to do? What are the most important things that we need to do? How are we going to balance those with the financial constraints that we have? Ultimately, I am bound to say that from my perspective, and I see this everywhere I go, whether it is in other parts of the United Kingdom or in other countries, successful delivery of Strategy relies on a number of key things being in place. It relies on there being a strategy in the first place, with a clear and shared vision. It requires political will, at all levels, for it to happen, because that is the way you get the money. It also requires leadership within departments to get on and deliver it. It requires focus to do that. It also requires engagement with citizens, because they will tell you what is working and what is not. If you engage with them you are much more likely to be able to delivery it. As far as mental health is concerned, it requires, here in Jersey, a rebalancing of approach, which

is to say if we invest effectively in public mental health and wellbeing across our population, we can have a direct impact, not only on improving their mental health and wellbeing, but on the way in which our services operate and need to be structured. So it is not about making efficiencies. It is just saying: we can reduce the amount and we can spend that money, therefore, more effectively and in different ways and we can really focus on getting a really high quality service in the secondary care element for the people that really need it, because they are the top of the triangle. If they are in the highest level of need, those services need to be able to respond swiftly, with high quality and get people well and back out, so they are at the bottom of that triangle in the long run. It requires those elements that I described for that to happen. To come back to the point, it requires leadership from the Health and Social Services Department. It requires engagement and joint working with other departments to take a partnership approach. It is about mutual interest and shared endeavour to deliver this strategy. To come back to your earlier point, to not do that would be a significantly missed opportunity for this Island. The amount of time and energy, let alone resources, that was invested in the development of this Strategy will be for nought if you are unable to demonstrate that services have changed and improved and the mental health and wellbeing of your population has improved. What you will risk doing is coming back in another 2½ years and saying: "Didn't we have a strategy on that? I think we might need to do a new one." Maybe you will need to do a new one in 2½ years, but it should build on the one that you have, not start again from where we started in 2015.

Deputy M.R. Le Hegarat:

Thank you. That is pretty much us all done, unless you have any questions for us.

Contact Consulting:

I do not think so, just that hopefully I have covered the things that you wanted to cover. I am more than happy to follow up if there is anything else that crops up.

Deputy M.R. Le Hegarat:

Likewise if there is anything that you feel has been missed. Thank you very much for your time. It has obviously been very beneficial for us to be able to go through and get a real perspective of the thinking, I suppose, behind the Strategy in the first place. Thank you very much indeed.

Contact Consulting:

Thank you very much for inviting me to speak to you. It has been a pleasure to meet you.

Deputy K.G. Pamplin:

Thank you.

[13:29]