STATES OF JERSEY

Health, Social Services and Housing Scrutiny Panel

Child and Adolescent Mental Health Services (C.A.M.H.S.) Review

MONDAY, 3rd FEBRUARY 2014

Panel:

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

Deputy J.G. Reed of St. Ouen

Witnesses:

Deputy A.E. Pryke (The Minister for Health and Social Services)

Managing Director, Community and Social Services

Psychiatrist, C.A.M.H.S.

Service Director, Children's Service

[10:30]

Deputy J.A. Hilton (Vice Chairman):

Welcome to the Health, Social Security and Housing Scrutiny Panel for this hearing on the Child and Adolescent Mental Health Service. I am Deputy Jackie Hilton, the Vice Chair of the panel.

Deputy J.G. Reed of St. Ouen:

Deputy James Reed, panel member.

Managing Director, Community and Social Services:

Richard Jouault, Managing Director of Community and Social Services.

The Minister for Health and Social Services:

Deputy Anne Pryke, Minister for Health and Social Services.

Child Psychiatrist:

Carolyn Coverley, Child Psychiatrist and Deputy Local Director of Community and Social Services.

Service Director, Children's Services:

Phil Dennett, Director of Children's Services.

Deputy J.A. Hilton:

Thank you very much indeed.

The Deputy of St. Ouen:

Yes, first of all, we would like to know how many children and young adults on the Island are suffering mental health and behavioural problems?

The Minister for Health and Social Services:

That is a very broad question and I think you need to start by putting a little bit of context around this. There is a comprehensive C.A.M.H.S. (Child and Adolescent Mental Health Service) service which ranges to include agencies like education, health visitors, Bridge, et cetera, and then there is a specialist C.A.M.H.S. service of which Carolyn leads. So that is more for the higher range children with mental health issues.

The Deputy of St. Ouen:

Right, okay, but are you able to ...

The Minister for Health and Social Services:

But it is important to put that across because mental health is not just the business of C.A.M.H.S., it is really everybody's business.

The Deputy of St. Ouen:
Absolutely, but obviously C.A.M.H.S. specifically, as I understand it, focus on the issues around mental health to do with children and adolescents. We would hope that you would be able to provide us with some figure around how many children and young adolescents need help. Maybe you can give us that figure.

The Minister for Health and Social Services:
We can do that but also it is important that we set the scene that there is a comprehensive child and adolescent service ...

The Deputy of St. Ouen:
We can explore that later.

The Minister for Health and Social Services:
... which incorporates lots of it but the specialist one comes under Carolyn and I am sure Carolyn will talk about this caseload.

The Deputy of St. Ouen:
Okay, so how many young people suffer with mental health issues that you are aware of?

Child Psychiatrist:
Well, the specialist C.A.M.H.S. has 600 open cases at the moment. That will be young people who have significant mental health problems.

The Deputy of St. Ouen:
That covers from what age to what age?

Child Psychiatrist:
Well, we go from 0 to 18. We have some young people who may be over 18 who remain in services for a period of time to complete their treatment. Most will be 5 plus, but we do have a few that are under 5.

Deputy J.A. Hilton:
Can you explain what open cases means?

Child Psychiatrist:
Well, they will be ones that are being seen by our service at this point in time.

Deputy J.A. Hilton:
May it be that you have not seen them for a long period of time?

Child Psychiatrist:
We should be seeing them all at least every 6 months. So if they are not needing any follow up, they should not be open to our service.

The Deputy of St. Ouen:
Apart from the open cases that you have, are you aware of any other individuals that might sit outside of that that still have mental health or serious behavioural issues?

Child Psychiatrist:
I think there is a difference between them, when you talk about mental health and behaviour. So there will be some young people who may be using substances, getting into other problems, that would not be part of the specialist C.A.M.H.S. service so there will be other young people being managed in other services.

The Deputy of St. Ouen:
Okay, so you are open ... just help us here, when you talk about an open case, does it relate to an individual that has actually received a diagnosis and is obtaining frequent ...

Child Psychiatrist:
I think quite a lot of our young people might not have a diagnosis. A diagnosis can be really important but a number of young people present with a range of problems which might be more descriptive to them because early on in the presentation it is not always clear what a diagnosis might be. The ones that are open would be from the point we receive the referral to the point we then say we do not need to see them any more and we would send a letter and close the case.

The Deputy of St. Ouen:
Okay, that is great. Out of the 600, how many of those would have been diagnosed with a particular problem.

Child Psychiatrist:
When we last looked - and it was a couple of years ago - at the sort of groupings of our young people, 39 per cent had developmental disorders, so the A.D.H.D. (Attention deficit hyperactivity

disorder), autism, tourette's, I think it was about 34 per cent had emotional problems - that is depression, anxiety type presentations - and about 24-25 per cent were more complex situations with behaviour problems.

The Deputy of St. Ouen:
That does not necessarily answer the question, though. I understand the spread of the symptoms or issues that are covered, the question was: how many of the 600 open cases are still to obtain or receive any diagnosis?

Child Psychiatrist:
I could not give a figure and we will not always be looking at diagnosis. Diagnosis, as I said, is important for some young people, but what we feel is the most important issue is defining the problem. That might not be a medical diagnosis, it could be a description of a range of problems.

The Deputy of St. Ouen:
So do you believe that you are covering all of the individuals that currently have mental health problems that would generally fit under your remit?

Child Psychiatrist:
I think if we look at the remit for tier 3 service, or specialist service in the U.K. (United Kingdom), we would be meeting those requirements.

The Deputy of St. Ouen:
Forget about the U.K., it is Jersey. Obviously we have a small population and we would hope we would do far better than the U.K. So can you just tell us what you believe to be the situation here currently?

Child Psychiatrist:
I think if we looked at development disorders, which I said is a third of our service, we feel we would be recognising those general people with a developmental disorder and they are being picked up. Some will be managed in education, so they do not need to come up to specialist C.A.M.H.S. but are being managed within a school environment. We feel again across the different layers that a lot of young people with emotional problems will be having their difficulties recognised. Often it might be school counsellors. The Yes Project and others that will be working with them and those that are needing more specialist interventions will be coming up to our service.

The Deputy of St. Ouen:

I am pleased you have mentioned education, is there an expectation that the Education Department or the school notifies C.A.M.H.S. of any concerns that they might have around an individual within their care?

Child Psychiatrist:

Again, it depends on what level that is. We know from again using the U.K. statistics there are likely to be about 1,500 children, young people, at any one time with some form of mental health issues. We would again expect education to be working with those and we would not expect to be notified about them all. However, all the secondary schools have got school counsellors and our service provides supervision to all the school counsellors which brings a good link between the 2 services.

The Deputy of St. Ouen:

Thank you for your response, but again the question was: is it expected that education raise their concerns directly with C.A.M.H.S. around an individual? Are you saying not necessarily?

Child Psychiatrist:

If the level of concern was such that it would meet the threshold for specialist C.A.M.H.S.

The Deputy of St. Ouen:

But they are not the specialists in mental health issues.

Child Psychiatrist:

But they have school ... so all secondary schools have school counsellors. The school counsellors are the ones that usually refer to our service, have regular meetings with our service and that is the sort of linking ... if there are any issues about whether there might be mental health issues, through supervision that would be identified.

The Deputy of St. Ouen:

One last question on that. We are aware that you have school counsellors for the States secondary schools, but obviously that is 11 to 18. How are the younger individuals up to the age of 11 identified and provided for?

Child Psychiatrist:

I guess within education ... because you also have the educational psychologists so often the education psychologists would be advising schools. So if they had any concerns it could go

through educational psychology. They also, I know within education, provide the well-being workers who again help to support young people or children within schools.

The Deputy of St. Ouen:
Okay, thank you.

The Minister for Health and Social Services:
It would also be fair to say there that it is not just education, it is the G.P.s (general practitioner) and health visitors, so it is quite a range across the board that provide the necessary professionals.

The Deputy of St. Ouen:
We are all well aware that all children are required to be compulsorily educated on the Island and therefore you will capture everybody.

Service Director, Children's Services:
Can I add one point to that? Just on the Mast(?) set up, as you rightly said, Deputy Reed, that has been an initiative across the secondary schools, it has now been running for a number of years and it was felt opportune to review that process at the moment and over the next couple of weeks there is going to be somebody coming over from the U.K. with relevant experience in that kind of set up to look at a review of the Mast service. One of the questions is going to be around the primary school bit, as to whether that needs extension or how it is working on the links with the primary schools.

Child Psychiatrist:
School counsellors sit within Mast so ...

Deputy J.A. Hilton:
I just wanted to take you back a little bit to the start, you said we have got 600 open cases and you said that those cases would have significant mental health problems. Zero to 18 years and I believe you said that they would be seen every 6 months?

Child Psychiatrist:
No, I guess the question had been whether there might be cases who are not seen for years. What we would be saying is we do have some young people, particularly say within our A.D.H.D. clinic who are well managed, well stabilised but if they are on medication we would review them every 6 months.

Deputy J.A. Hilton:
Every 6 months.

Child Psychiatrist:
If anybody needed to be seen less frequently we would not be having them ...

Deputy J.A. Hilton:
So any young person with a diagnosis of A.D.H.D. would be, if they were on your books, being seen every 6 months?

Child Psychiatrist:
Yes, as a minimum, some will be seen more frequently.

Deputy J.A. Hilton:
As a minimum, okay.

Child Psychiatrist:
I think when I say that 6 months, the other end would be there are some young people that might be having quite a few hours a week in the team or when we do locational special packages there might be one or 2 staff who are dedicated to one young person.

Deputy J.A. Hilton:
Is the service meeting that demand at the moment?

Child Psychiatrist:
Which?

Deputy J.A. Hilton:
The demand of the cases being reviewed every 6 months. Those live cases that should be, is the service meeting that demand to see them and review them every 6 months?

Child Psychiatrist:
It is mainly the ones with A.D.H.D. and they would be generally ... we are just changing data systems so there has been a slight delay but generally within 6 to 7 months they would be seen.

Deputy J.A. Hilton:

Okay, all right, thank you. Can I just go back to the last question we asked about children in primary school? My understanding is that there are no counsellors at the moment at primary school level and you said that you are bringing somebody in very short to co-ordinate the Mast ...

Service Director, Children's Services:

It is to review.

Deputy J.A. Hilton:

To review what services are provided at the current time at primary school level. I wanted to ask you, if a parent had concerns about behaviour of their child at primary school level, would you expect the head of whatever school they attended to address that issue and refer them on and be proactive in that way?

Child Psychiatrist:

Yes, in the end we take referrals from any professional. The majority come from G.P.s, but school and education is second to that. So sometimes parents will go and talk to the head or the education needs co-ordinator and they will put the referral through to C.A.M.H.S.

Deputy J.A. Hilton:

If you could explain to us the procedure of how a child would find themselves at C.A.M.H.S. So it would either be through the G.P. or possibly through school. Are people allowed to self-refer?

Child Psychiatrist:

No, that is one thing we do not do but any professional ... again because we are a specialist service, we would want to look, as with many services, that their needs could be met by the universal services or the targeted service that has happened. So there would be a professional looking to see a specialist counsellor is the right service or are there other services that could meet this child and family's needs.

Deputy J.A. Hilton:

Okay, so could you explain to us what happens from the time that a child is presented to C.A.M.H.S. until they receive treatment or diagnosis? I am interested in timeframes and exactly what happens.

Child Psychiatrist:
So we have written referrals. If it is urgent or an emergency, that is different and we take telephone referrals. We do have a system where anybody that is referred as an emergency will be seen within 24 hours. If it is an urgent referral, within the week and then we have our routine ones.

Deputy J.A. Hilton:
Can I stop you there? Who decides what is an emergency? Who makes that initial decision?

Child Psychiatrist:
Every day it comes through ... we have a duty worker who will look at the referral. We then have one of the senior clinicians who is also available to discuss any ones that come through that are concerning. So it is made at that level. Referrals then go to a referral meeting. So once a week all referrals are looked at and, again, just looking at priorities and if there are risk factors there. If it is decided it is an appropriate referral for C.A.M.H.S., questionnaires will get sent out to help us then look at how best to manage that case, with an appointment.

[10:45]

Deputy J.A. Hilton:
So level 1, which is the most serious concern, I think you just said that an individual would be seen within 24 hours. What happens if a crisis occurs over the weekend or over a bank holiday for a level 1 case?

Child Psychiatrist:
There is cover for C.A.M.H.S. 24/7 but that is provided by paediatrics and adult mental health. So for somebody under 17 it would be the consultant paediatrician in the first instance. So any young person would be taken to A. and E. (Accident and Emergency), the consultant paediatrician would be involved, if necessary they can then access the adult mental health service and jointly manage that young person. A 17 year-old would be seen by the adult mental health service. The C.A.M.H.S. service provides every day 2 hours on bank holidays and weekends, so we are available for 2 hours a day to see anyone that has been admitted and provided specialist advice.

Deputy J.A. Hilton:
With regard to young people who are admitted to A. and E., if they need to be hospitalised, where would that normally happen?

Child Psychiatrist:

For under 17 year-olds it would generally be the paediatric ward. Very occasionally if there are risk issues that cannot be managed by paediatrics it might need to be a specialist package of care on the adult mental health ward as with 17 year-olds. Sometimes, depending on the issues, it might be a package of care with social workers and the residential care. So sometimes that might be provided elsewhere.

Deputy J.A. Hilton:

Is it a matter of concern that sometimes you may get teenagers, with significant mental health issues, on the children's ward alongside babies and young children? If it is a matter of concern, what do you intend to do about it? How is that going to be addressed in the future?

Child Psychiatrist:

I suppose it is something that we are looking at discussing about provision. I guess in an Island the size of Jersey we do not have the need to have an actual inpatient unit for young people and children, where in the U.K. normally inpatients units would be for a population of about 1 million or so. So we have to have a flexible response looking at the needs of the young person when they present. The needs are so different it is very difficult to have a one-stop shop always with the response, we find the needs are so different.

Managing Director, Community and Social Services:

Could I just add something there? There is a protocol pathway which we can we provide you, which will give you all the detail about when a child stays in Robin ward and when they move.

Deputy J.A. Hilton:

That would be lovely, thank you.

The Deputy of St. Ouen:

Just sticking with the use of Robin ward, have any other options of facilities been considered as being more appropriate within the hospital rather than necessarily just using Robin ward as the sort of holding area for teenage youngsters with issues?

Child Psychiatrist:

I guess in the end Robin ward is the only child friendly ward there. For many young people that is the appropriate environment, they have staff that are skilled, we now have a nurse on the ward who is spending time within C.A.M.H.S. to get more mental health experience.

The Deputy of St. Ouen:

Are you saying that putting teenagers with very young children is the best option?

Child Psychiatrist:

For Jersey. When you say young children, I guess Robin ward is for adolescents as well. So they will have adolescents with physical problems there and quite often they do need medical treatment anyway. So most adolescents go into Robin ward, often those that might have self-harmed or taken an overdose. Again, U.K. guidance from the Royal College of Psychiatrists, a N.I.C.E. (National Institute for Health and Clinical Excellence), is a young person under 17 who takes an overdose should be admitted to a paediatric ward under the care of paediatricians. The majority would then be discharged anyway next day. There are very few that would remain on Robin ward.

The Deputy of St. Ouen:

Can I ask, Minister, is anything stopping you or your department from using some of the single private rooms in the private wing to provide short-term accommodation for these young people, instead of Robin ward?

The Minister for Health and Social Services:

Not that I can think of off the top of my head. I would have to go and ask Helen that question but then it goes down to risk assessment and it is the clinician decision at that time when they are admitted to A. and E., that is the most overriding thing to make sure that wherever they go they have been risk-assessed, and wherever they go to make sure that they have staff who are fully trained to be able to cope with their particular problems at that particular time. That is important. Rather than where they go, it is making sure that there are the staff and that they are properly assessed.

The Deputy of St. Ouen:

Thank you. Can I just rewind a little bit? We talk about the procedure as to how a child finds itself at C.A.M.H.S. Am I understanding that you said that all children have to be referred to C.A.M.H.S. by a professional?

Child Psychiatrist:

Yes.

The Deputy of St. Ouen:

Yet you then went on to say that C.A.M.H.S. itself does further assessments to identify a particular need. One would have thought that the professional has already been able to identify the fact that the child had a need, which is why they referred them to you in the first place.

Child Psychiatrist:

Just to clarify, when we send the questionnaires out we usually send it out with the appointment so it just aids us when we do the initial assessment to look at who would be the right staff to meet with them and to assess risk any further. So we use the questionnaires ... when we get them back we screen them to make sure we have not missed any risk that has not been identified by the professional.

The Deputy of St. Ouen:

The questionnaire is filled in by who?

Child Psychiatrist:

We have 2 questionnaires. One is one that just gets more information about what the family see as the problem, who is in the family and getting consent, if necessary, to contact school and finding out what school it is. The other questionnaire is what is called a child behaviour checklist, which is a series of questions which is filled in by the parent for younger children and for teenagers it is filled in by the individual themselves and their parents, and that shows us areas that might be of concern.

The Deputy of St. Ouen:

All right, so apart from the initial referral by the professional, there is no further input required from the professional to help C.A.M.H.S. determine how to proceed with the youngster? What treatment.

Child Psychiatrist:

It depends, because sometimes we go back to the referrer to get more information or to have some of those discussions and if it looks like there might be an issue about engagement we might discuss with the referrer about how best to do that. Also sometimes are not sure we need to see the family individually and sometime we offer consultations, so we go back to the referrer and meet up with them to talk in more detail about what they are doing and whether we need to be seen or we need to give advice.

Deputy J.A. Hilton:

Talking about referrals, I think there are 3 levels. Levels 1, 2 and 3. Level 1, an individual would be seen within 24 hours. Am I correct in thinking that level 2 and 3, the questionnaire would go out ...

Child Psychiatrist:
Not necessarily for level 2.

Deputy J.A. Hilton:
But for level 3?

Child Psychiatrist:
Yes.

Deputy J.A. Hilton:
So for level 3 the usual process is for a young person to be referred. The questionnaire would go out for the young person to complete and/or their family. What sort of timescales are we talking around the questionnaire going out in the first instance, it coming back, to it being seen by somebody in C.A.M.H.S.

Child Psychiatrist:
As I said, normally we send the questionnaire out with the appointment so we are not waiting but we ask for the questionnaire as confirmation of the appointment. There are few families who we are not sure if we are the right agency and we wait to get the questionnaire back to see who might be most appropriate. We also work to 6 weeks for level 3. To be seen within 6 weeks. Unfortunately our referral rates have gone up rapidly this year and we are now at 11 weeks. But, again, and Jersey is different, within the U.K. that would be within the normal.

Deputy J.A. Hilton:
What do you think is the reason for the big ... okay, it has almost doubled the waiting list and I think you said that is because of the amount of referrals, why do you think that is? What is happening?

Child Psychiatrist:
We know just from a duty point of view that in each of the last 3 quarters we have had 3 times as many urgent referrals, or many emergencies ones, for each quarter than we did previously, so we are having a rapid rise in young people who are self-harm or have suicidal thoughts.

Deputy J.A. Hilton:
So what is being done to address the issue of the long ... you said 3 times more young people in each of the first 3 quarters of 2013 being referred to your service either for suicidal thoughts or self-harming. What is the service doing to address that issue?

Child Psychiatrist:
We are prioritising our caseload; we are also looking at getting some additional staffing in. Unfortunately finding specialist staff to come and support us has been very difficult so we have looked to bring in some specialist staff to help.

Deputy J.A. Hilton:
I believe that you had 2 additional nurses during November and December 2013, was that to assist you specifically with that work load?

Child Psychiatrist:
Yes.

Deputy J.A. Hilton:
Then they left. Why did they leave? Why was their contract not extended because you know the problem is still presenting itself?

Child Psychiatrist:
They were agency staff and they were not able to stay at that point. Again, with one particular one, there were issues about their background training and how much they could do of the specialist work that we needed.

Deputy J.A. Hilton:
So in light of recent events that obviously put your department under even greater pressure so how much effort is being put into addressing those waiting issues and addressing the issues that are facing our young people, with regard to staffing.

Managing Director, Community and Social Services:
The expectation that this increased demand will continue so our plan is to bring forward increased capacity within the service and do that within 2014. As Carolyn has alluded to, having more resources to recruit more staff does not mean you will get more staff because it is a particularly difficult area to recruit to at the moment. That is our intention. Coming back to the point the Minister made earlier about specialist versus comprehensive C.A.M.H.S. service, it is important that also we look that there is an increased demand for this comprehensive service. So the Yes project, for example, has also seen significant increase in demand for their services. So we have to look at improving and increasing the capacity within specialist C.A.M.H.S. and across the more comprehensive C.A.M.H.S. services. So the kind of things that we do in prevention, early intervention need to be part of this. There is some work that is underway with regard to that as well.

Deputy J.A. Hilton:

You just mentioned the Yes service, and my understanding is it is a brilliant service, it gets out there and it reaches the young people it intends to reach. So how much is C.A.M.H.S. or the Children's Service working with the Education Department to increase that service at that level at the present time?

Managing Director, Community and Social Services:

We are certainly working very closely - and I work closely on a weekly basis with a co-ordinating group across the piece to ensure that we are all recognising where all the pinch points are within the services. I can only speak for our own service in terms of business cases being brought forward to consider increased capacity, I cannot speak for Education, Sports and Culture in relation to how they are going to do that. So it is certainly our intention in the next couple of months to bring forward a case to increase our supply of services within our specialist C.A.M.H.S., but I have to say, in doing so I will be competing against other services with long waiting lists, orthopaedics and such like. But it is my intention to bring forward that case and gain additional resources.

Deputy J.A. Hilton:

How much support do you think you have, Minister, on the Council of Ministers to obtain additional funding to address an issue which is of great importance to all, the future is in our young people?

The Minister for Health and Social Services:

Absolutely, and it is going to be difficult as we move forward into the next M.T.F.P. (Medium Term Financial Plan) too. So it is a case of making sure that they fully understand the issues.

Deputy J.A. Hilton:

So how are you going to make them understand what appears to be almost a crisis involving the department and us trying to address the issues that our young people are facing?

The Minister for Health and Social Services:

It is the wider issue of healthcare per se, as Richard alluded to, the waiting lists and whatever. But you are quite right, it is important and everything needs to be done to raise the awareness within the Council of Ministers as to how important this area is. But also, in saying that, with the White Paper there has been some investment this year in early intervention, et cetera, as well you know. Is that enough? Probably not, but we need to understand the issues there and having that business case is important as we go forward into the next Medium Term Financial Plan.

The Deputy of St. Ouen:
Can we just be clear, are you saying that access to appropriate funds is limiting the service that you can provide rather than identifying the need and making sure that the resources are available to deal with the problem?

Service Director, Children's Services:
Can I just come in? We have identified the need, as Carolyn rightly said, I think we have seen demand increase significantly in the last 9 to 12 months, equally in the social care field on the social work basis, we have a significant increase in referrals.

[11:00]

I think this jurisdiction, like most other jurisdictions across the western world are getting their heads around that because the issues of increased self-harm are being seen in other jurisdictions while youth offending, for instance, is disappearing off the bottom of the graph. So I have done some work with the management within C.A.M.H.S. and management within social work fields to look at how we will respond to that. At the moment I am putting together business cases to identify what that increase is about and what we may need to take that forward. So that is that initial bid that I will be presenting to the Minister in the coming weeks.

The Deputy of St. Ouen:
Did the increase in referrals come as a surprise to you?

Service Director, Children's Services:
I think the rate of increase I would say has come as a real surprise, not just to us, as I say, if you look at any jurisdiction at the moment across the western world there is a significant increase in self-harm and it is increasing at an alarming rate. I think that is the surprise in it.

Managing Director, Community and Social Services:
I think the additional surprise, and Carolyn might confirm this, is also not just the increase in demand but the sustained increase in demand. You can have peaks and troughs in a small community, that is not unusual ... would that be right, Carolyn?

Child Psychiatrist:
Yes, I think when we saw it for the first few months we thought it was just a normal sort of peak, by the time it got to 6 and 9 months realising it was much more sustained.

Deputy J.A. Hilton:

What are your indications for the last quarter of last year? The same?

Child Psychiatrist:

Yes. So it was the last 3 quarters. So the first quarter last year we had lower figures and it was the next 3 quarters that were higher.

The Deputy of St. Ouen:

What, in your opinion, are the reasons for the increase?

The Minister for Health and Social Services:

I was just about to say, at C.P.G. (Children's Policy Group) we looked at youth offenders and the number of youth offending has dropped, as Phil said, significantly, which is a good thing but then I would say young people have to vent their anxiety through something, and better diagnosis of autism too I think has reduced that youth offending. Some work done not only in Jersey but in the U.K. and Europe is understanding what the real issues are, whether it is social media, children sitting in their rooms on the internet, under pressures that that brings. I do not know.

Managing Director, Community and Social Services:

I think it is a really important question and one that we need to spend a lot of time closely analysing. We have identified over the Christmas period about new psychoactive substances and we have always been aware of the dangers of alcohol and illegal drugs for young people, recognising that in the general backdrop the consumption is falling for the general population of young people but there are a small cohort of young people for whom alcohol and drugs is a significant issue. I think we need to look very closely at those young people who are no longer in education, not accessing education formally, who are not in training, do not have education and are engaged in activities of high risk involving alcohol and drugs at a young age and we have really have to ask ourselves, as a society, what are we doing about that and how are young people as young as 12, 13, 14 getting hold of illegal drugs and drink.

The Deputy of St. Ouen:

I understand that and I am as concerned as you are with regards to youngsters accessing drugs and alcohol, some would suggest that they are doing that because of an underlying issue that they face within their own lives. But I am more interested in the point you raise about self-harming because that is not necessarily directly related to alcohol or drug abuse, that is another issue. So just help me here, why are we seeing an increase in self-harming?

Child Psychiatrist:

I think we are all alluding that we do not know. It is not just happening in Jersey, it is happening in the U.K. I think alcohol and substance misuse does have a role in self-harm as does social media. We are aware that a number of young people are really traumatised by what is happening there but we still do not fully understand the picture. That is not just in Jersey, it is in the U.K. and I think in other areas.

Deputy J.A. Hilton:

Does self-harming come about because of more emotional difficulties?

Child Psychiatrist:

Again, we use that term "self-harm" and it encompasses a whole range of different presentations from one end where it might be a young person who has suicidal thoughts, attempting to kill themselves, a lot of young people might use it as a form of relieving stress and distress. They might say they have not thought to the future but at that moment in time it is just a way of getting out of that stress in that point in time. Again, people use self-harm as a way of reducing stress. They have no intention of killing themselves but it is a way of addressing acute stress and distress.

Deputy J.A. Hilton:

So is there evidence to suggest that it is linked to internet usage and internet bullying?

Child Psychiatrist:

There are reports and I do not think at the moment there is any major research studies, but again within the U.K. there are a lot of reports about there seeming to be an increased rate of young people complaining about internet bullying and other issues, which has led to some of them self-harming.

Managing Director, Community and Social Services:

Self-harm is certainly more common than we hear about. I cannot remember what the figure is in terms of university graduates who have reported self-harm at some point. Something like 40 per cent.

Child Psychiatrist:

Community studies vary a lot but I know for young people they talk at probably one in 4 will have self-harmed at some point. It is very difficult because definitions go from picking a spot or pulling a hair out to serious suicide intent, but a large number will at some point have self-harmed.

The Deputy of St. Ouen:
With regards to your 600 open cases, what types of treatment are available to those youngsters that are in your care?

Child Psychiatrist:
I guess it is a whole range of different treatments that we offer. There can be individual work with a child or a teenager which might be like different forms of therapy. Could be cognitive behaviour therapy, which would be something that all the team could offer ...

The Deputy of St. Ouen:
Counselling?

Child Psychiatrist:
Yes, it is different forms of counselling. Yes, I was thinking about your lines of recommendation, it was about a range of them. So it is a range of different therapeutic modalities plus art therapies, the non-verbal type therapies. There would be work with parents about behavioural advice and behavioural management. We offer work with families, so with the whole family together, addressing issues and talking about those issues. We might work within schools, advising schools, and we also then use medication. So there are some people who will be taking medication.

The Deputy of St. Ouen:
Out of the 600 individuals, roughly how many would be on medication?

Child Psychiatrist:
For A.D.H.D, we have recently looked at it, there was 65 on medication for A.D.H.D. at that point in time.

The Deputy of St. Ouen:
How many?

Child Psychiatrist:
Sixty-five. That is for A.D.H.D. It is that we just looked at that programme. I would say probably there be another - this only a rough estimate - 35, 40 young people that would be taking medication on top of that.

The Deputy of St. Ouen:

Are you able to provide us with accurate figures on each individual who is receiving medication within your care?

Child Psychiatrist:

Yes. I guess not on an individual basis ...

The Deputy of St. Ouen:

Not individual but I mean ...

The Minister for Health and Social Services:

Yes, I am sure that the number will change because you only have ...

Managing Director, Community and Social Services:

Roughly 20 per cent of the cases are medicated.

The Deputy of St. Ouen:

Obviously it is a concern to me as an outsider to hear that you do not know necessarily the number of people that are on medication, because one would have thought medication is used in a number of different ways, some for a short-term solution and others for much longer term use. Again, one would hope that the information is available that you can identify exactly how many people are on medication, the type of medication and the period of time. Is that possible?

Child Psychiatrist:

Yes. Period of time, because it is so variable is more difficult because some young people might be on medication, they might stop it and they might restart it. But, yes, we will know every young person that we are prescribing for.

Managing Director, Community and Social Services:

I was just thinking whether your medication budget might help, but of course it will not. We know how much money is spent on medication in C.A.M.H.S. but of course that will vary enormously depending on which drugs have been brought in and which costs are ... I am not sure that is going to help. But from the active caseload on this data we ought to be able to give you a point in time.

The Minister for Health and Social Services:

That does not mean to say they taking it.

Deputy J.A. Hilton:

We have conducted a number of private hearings and one of the themes that have come out through these private hearings is taking an holistic approach to caring for the family rather than just the individual. What services does C.A.M.H.S. provide to help families who are finding themselves in a situation of dealing with maybe an extremely disturbed young person?

Child Psychiatrist:

We offer family work and we will meet with the family as a whole. We will also meet with parents. Quite often what we would do is have 2 therapists involved so somebody might be working with the young person and somebody with the parents and then bringing them together. We would also then be working with some of our partners so it might be with social workers, it might be with people in education, sometimes we talk to G.P.s who might be supporting the parents. One of the issues that I am aware of for parents is as a young person gets capacity we do have to accept that capacity in their decisions. So we are aware that sometimes it becomes difficult because the young person wants to access support and health but does not always want their parents to be aware of what those issues are. Of course when you get to 18 that is a clear right. As you are getting up to 18, they do have the rights of confidentiality.

Deputy J.A. Hilton:

So at what age do young people have the right of confidentiality? At what point would your service turn around to the parents and say: "I am sorry, but we are going to respect the rights of the child with regard the treatment?"

Child Psychiatrist:

What we generally say as soon as a young person has recognised their high incapacity, so that could be mid teens, but it depends on the individual child and young person. We always work very hard to say: "It would be really important to share this with your parents." We would still offer support to parents, we may not be able to disclose all the information however what we always say is if a child is of significant risk, so if they are making threats to maybe kill themselves, we would be very clear with the young person that we would be talking to their parents or a carer.

Deputy J.A. Hilton:

So you said mid teens, so is there a possibility that a child of maybe 15 years old could turn around to you and say: "I do not want you to discuss this with my parents" and you would go along with that?

Child Psychiatrist:

Depending what "this" is.

Deputy J.A. Hilton:

Well, their treatment, their mental health issues, I am just a little bit surprised at that because I just assumed that at least until age 16 ... and we have heard this through our hearings that that is a concern for parents, that they feel as though they are playing no part in their child's treatment and how best to deal with them, because more often than not they are the ones who are providing 24-hour care for their child but are not fully aware of what is going on.

Child Psychiatrist:

Yes, I think any parent would be concerned but there is that balance between respecting the right of confidentiality and young people saying: "Actually if you talk to my parents about this issue I am not coming back to the service." Then they lose access to any help and support. However, having said that, we work very closely and carefully so we do ... it might not be everything can be discussed but we would meet the parents, we would be offering support. So if the 15 year-old ... even if they say: "I do not want you to talk to my parents" we would still talk to parents, it is just that some of the content we would not disclose.

Deputy J.A. Hilton:

All right, and what does the law state?

Child Psychiatrist:

That is one of things I guess is happening at the moment, the Mental Capacity Law is being written because one of the issues we have got is in the UK we have the Mental Capacity Law, at the moment do not in Jersey so it is slightly confusing. But for the medical practitioner and clinicians we have very clear guidance from our medical bodies about confidentiality and right confidentiality.

The Minister for Health and Social Services:

It is about being competent ...

Child Psychiatrist:

Yes.

The Minister for Health and Social Services:

I do not know whether you can explain that because you will probably explain it or Richard will explain it better than me, Gillick ...

Child Psychiatrist:

Yes, Gillick was around family planning rather than mental health.

Deputy J.A. Hilton:
Yes, I remember that case.

The Deputy of St. Ouen:
Just widening the view a little bit from just simply focusing on C.A.M.H.S., you said C.A.M.H.S. provide some assistance to parents. Minister, do you think that at the moment sufficient assistance and support is provided to the parents in particular of those individuals who have youngsters that have mental health issues?

The Minister for Health and Social Services:
I would like to think so because C.A.M.H.S. is a very good specialist service and I suppose one way you could judge it is about ... I do get some emails from concerned parents, and I can understand their concerns, regarding ... one way was the formal complaints, very few formal complaints have come through.

[11:15]
I am very much aware this is a very complex area and when you are talking about young people and parents come from - I would have thought, being a parent myself - a different angle to what their children are. Are the on the same road together? I would like to think so but they all will come with their own very concerned agenda.

The Deputy of St. Ouen:
Can I ask the Director of Children's Services what role does the social work play in supporting C.A.M.H.S. in the wraparound care that we hope exists for both parents and the individual?

Service Director, Children's Services:
It is vital. Carolyn has mentioned a number of times about the multi-agency aspect to this and as you know from my service I manage C.A.M.H.S., I also manage the social work service, I manage the residential and the secure service. At any one time those will be working together. Carolyn was mentioning the response to somebody going to A. and E. and said we put packages of care together. We have put some very creative packages of care together that have maybe focused on a residential unit or we have set up a residential unit or we have used the secure unit at times and that involves C.A.M.H.S. service with their mental health nurses, our residential workers, the social worker, they are all involved in that focused process.

The Deputy of St. Ouen:

On a range of one to 10, how would you rate the multi-agency approach around the mental health issues to do with young people?

Service Director, Children's Services:

I would rate it very highly. Very highly indeed. If you want a number I would say 7 or 8. I think there is still some way to go and I think that is about the current demand that we have. But again as Carolyn said, it is complex when we are dealing with a range of issues. People tend to put it under one umbrella but it is a range of issues and at that point in a small jurisdiction like Jersey, you have to put together very specific services around some young people. I believe that we do that extremely well.

The Deputy of St. Ouen:

On what evidence do you base that comment?

Service Director, Children's Services:

I can base that on looking back ... if we are talking at the high end where we have had to put together those packets of care, I can think back over a number of cases in recent years when we have put together some very creative packages of care. But just on the general day-to-day basis for the 600 that Carolyn has talked about in her service and the probably 500-600 we have got in children's social work services, and a number of young people looked after, those services work creatively together on a daily basis. In response to recent incidents that Richard has alluded to, we put together an operational group which is meeting on a weekly basis and a strategic group from across all the services meeting together on a 2-weekly basis, which is looking at all of these issues and focusing in very specifically on the needs of young people. I believe we are doing that extremely well.

Managing Director, Community and Social Services:

I would just add to that, in terms of the multi-agency response it is not just Health and Social Services, but the youth service from the Education Department, the Education Department itself under the guidance of one of the directors and also the principal educational psychologist, the police with their response to minimising harm has been quite exceptional with very bespoke care and without doubt have intervened to reduce harm more recently.

The Minister for Health and Social Services:

Can I just add that, sorry, Deputy. I would like to put on record to congratulate all the professionals for the work they have done over Christmas and New Year. It was really good multi-agency working because in a small Island we need to flexible, because it is the same young

people that will turn out the police, us and Education. So it is all the same children and it is very important to work together. To talk about the work that has been done now but also there is some work to be done with the Medical Officer of Health on the self-harm and suicide strategy and it might be worth at some time having a briefing from her.

Deputy J.A. Hilton:
Thank you.

The Deputy of St. Ouen:
You say there is 600 open cases and obviously you know each one, have you ever surveyed all of those individuals and families involved to see what their view is of this multi-agency approach that you believe to be at a high level?

Child Psychiatrist:
I guess within the specialist C.A.M.H.S. bit, so those 600 cases, we have done ... we usually take maybe a few months and send out questionnaires. So we have done surveys, it has not been so much about the multi-agency response it has just been about quality of C.A.M.H.S.

The Deputy of St. Ouen:
Would you consider undertaking that exercise?

Service Director, Children's Services:
I think it is 2 external pieces of work that have happened with the care inspectorate who came in and looked at the social work side and Young Mind who came in 2006 and made very specific comments about services and the way services worked together.

The Deputy of St. Ouen:
My other question is why wait for an external organisation to come in and have a look. You obviously want to care for the individuals that present themselves to you. Why not go and look ... seek their views in the same way that obviously we have ended up being approached by quite a large number of parents who have significant concerns that they have raised with us. I would have hoped that you would be the better ... in fact, that is what we are intending to do, the better place to discuss their matters, their concerns.

Child Psychiatrist:
Sorry, just the other bit, we are now doing within C.A.M.H.S., but we do not have data yet because it is something we have only introduced in the last 8, 10 months, is that every time we finish the

care we send out a questionnaire. So every single person should be getting a questionnaire when the care finishes. Again it is specifically about C.A.M.H.S. rather than multi-agency but it is a U.K. recognised questionnaire that we send out, which we can then compare with U.K. data, so there is a U.K. based data collection service now and we will be able to compare our outcomes with ...

Service Director, Children's Services:

Maybe just adding to those, just pointing out the efforts that we have put into helping create external bodies but within Jersey to be able to feedback. We have the independent reviewing officer process now, there is the Board of Visitors for Looked after Children, N.S.P.C.C. (National Society for the Prevention of Cruelty to Children) advocacy service and there are guardians appointed through the court, all of these things are there to give an extra voice to families and young people in that situation.

Deputy J.A. Hilton:

Just going back to families and young people, could you explain to us in what circumstances, if you received a questionnaire from a young person who had been referred to your service, if it came back that they were experiencing feelings of self-harm and suicidal thoughts but C.A.M.H.S. believed that their home life, their family life should change in some way, can you explain what action you would take to address that?

Child Psychiatrist:

I guess if the questionnaires are coming back ... if there are issues around self-harm or suicidal thoughts they would always be offered initial assessment and then recommendations would be based on that initial assessment.

Deputy J.A. Hilton:

All right, and if C.A.M.H.S. believed that a young person's home life was having some impact on their mental health, how would you address that issue?

Child Psychiatrist:

I suppose the assessments are quite detailed so we look at school development, we look at relationships, we look at the mental state of the young person at that point in time, so it would then be looking at what might need to change, again, about recognition in the family, because what we decide has to be in agreement with the family, so hopefully have a common understanding of what those difficulties are. Then addressing it will depend on which agency would be in the best place to do that.

Deputy J.A. Hilton:

So what would you do in the circumstances that you had a family with a young person with mental health issues and the family were reluctant for whatever reason to engage with you? How would you help the young person concerned who you had already recognised had significant issues?

Child Psychiatrist:

Again, it would be looking ... sometimes going back to referrers and working with referrers, sometimes it would be working with other agencies, so there might be other people that will engage with the school counsellor, engage well with the social worker. There are a number of other people who work through the social worker so we might be supporting the social worker. I can think of some in particular who will be doing some of that sort of therapeutic in support of our service.

Deputy J.A. Hilton:

So you would always offer support in some way to address ... I am just trying to understand where you have somebody who is obviously not well is abandoned, can you imagine any circumstances where that might happen?

Child Psychiatrist:

Again, it depends on the level. The difficulty is there are some young people who might not be engaged in any service and in not education - Richard referred to that sort of not in education training group - who might be presenting with a number of issues but who are not ready to engage in not just our service but any service. All we can do is keep offering. Not just C.A.M.H.S. but a whole range of services as and when they present. They might be sent to A. and E., they might be sent to the police, they might be sent to a number of agencies and that is a constant offering of services.

Deputy J.A. Hilton:

Thank you.

The Deputy of St. Ouen:

Just to clarify a point, we have just spoken about the questionnaire approach, if a young person was referred to you who was experiencing some thoughts of self-harming and wanted to do something worse, would you wait until the questionnaire has been filled in or would you act far more quickly?

Child Psychiatrist:

If the information in the referral makes us concerned, that would be a level 2 and we would not be sending the questionnaire or waiting for the questionnaire, we would be seeing them within 2 weeks. However, we referenced before, we know that maybe something up to one in 4 young people might self-harm at any point so the self-harm might be something that is quite superficial not related to any thoughts of low mood or wanting to die, we would then send questionnaires and wait for it. But any young person that the referrer is concerned about significant self-harm would be seen within a short time scale.

Deputy J.A. Hilton:

Can I just ask you a question around ... again it is waiting lists for the diagnosis of autistic spectrum disorder. We were sent some information which was telling us that there were 14 children in the process of assessment by the team and noticed that there were children, one in June 2013, 2 in September 2013, 6 in October 2013 and 5 in November 2013, and we seem to have a significant waiting list. I know there was a significant waiting list last year, something like 7 months.

Child Psychiatrist:

It was longer. First of all, can we just say that the diagnostic process for autism is not C.A.M.H.S. Some of our service are involved in that process. We have a team that is called the team for assessment of autism and social communication.

Deputy J.A. Hilton:

So it does not fall under C.A.M.H.S.?

Child Psychiatrist:

It does not fall under C.A.M.H.S. There is often confusion around that. C.A.M.H.S. in the past has provided some admin type support but it is multi-agency so it is Education and part of Social Services.

Deputy J.A. Hilton:

Where does it fall on that ...

Child Psychiatrist:

It is a virtual team, a multi-agency team.

Service Director, Children's Services:

It is a multi-agency part of it.

Managing Director, Community and Social Services:
It is Education and psychologists from Education, Sport and Culture, and it could be a number of different professionals from a variety of different ...

The Deputy of St. Ouen:
Can you send us that information? That details of it.

Deputy J.A. Hilton:
Are you aware of the waiting times as far as this team is concerned?

Child Psychiatrist:
From referral to diagnosis at the moment we are still looking at about 9 months, which sounds long but I have to say, again, compared to many specialist services in the U.K. where you could wait 18 months to 2 years for a diagnosis. It is still better than U.K. services.

Managing Director, Community and Social Services:
It does depend at what time a child is referred and also the severity or how clear cut the diagnosis is.

Child Psychiatrist:
Yes. Some will have a quicker process if there is no particular issue.

Deputy J.A. Hilton:
But we are saying at the moment basically a 9 month waiting list for an autistic spectrum assessment diagnosis?

Child Psychiatrist:
Yes, to the end, so not to be seen. So sorry the wait between referral to be seen and being seen is ... but again, because it is multi-agency there will be different points at different times. So usually there will already be some of these assessors involved with the child, so when they come in they are part of a service ... they should be getting services. So it does not stop them getting a service response. So they will be getting service, it is purely the full diagnosis that takes longer.

Deputy J.A. Hilton:
Was that list closed last year through sheer weight of numbers?

Child Psychiatrist:

I think there was a discussion about calling it closed, in fact there was about a 3 month period where we were not allocating any cases while we were catching up because the referral rate had gone up from an average of about 15 a year to over 30 a year. Again it is another one that had doubled. We thought that was going to be a blip, we have had blips before, but it has continued now.

Deputy J.A. Hilton:

What extra resources are being put into that service so that these people are actually being assessed in what could be classed as a reasonable period of time?

[11:30]

Child Psychiatrist:

One of the important things that has happened again through the White Paper is that we have now got a family co-ordinator and admin support to make the whole process more efficient, to co-ordinate it, to support families through that whole process.

Managing Director, Community and Social Services:

I think another feature that is important to remember is that in the U.K. that diagnosis may attach itself to resource allocation. I think we have said this before in the past. That is not the case here in Jersey. Irrespective of the diagnosis, we would attempt the needs as soon as we were aware of them.

Deputy J.A. Hilton:

But I think it is the case, is it not, that without a diagnosis children on the autistic spectrum will not get the support they require in schools?

Child Psychiatrist:

Again, in some ways you would need to ask Education about this, but I am aware there are children who have such communication difficulties who are already getting clinician support and come through ... and we might or might not get a diagnosis. The clinician support is based on their needs rather than purely a diagnosis. Across services we all say it is about need rather than a formal diagnosis.

Deputy J.A. Hilton:

Obviously we will speak to Education about that because it is a really important point, because I think what is coming across to us is without the diagnosis, these children simply do not get the

support in schools. Some schools may be slightly different, where there is specific communications disorder provision within the school and it may well be that they do get support, but where children are in mainstream primary school, for instance, where there is no additional support, they are just, it would seem to me, left floundering without that diagnosis. A waiting list, referral to diagnosis hopefully, of 9 months is just unacceptable.

The Deputy of St. Ouen:

The final question is around what emphasis does the department place on raising awareness of mental health issues with children and young people?

The Minister for Health and Social Services:

You mean a person's framework within ... sorry, I did not quite hear.

The Deputy of St. Ouen:

No, I will repeat the question. What emphasis does the department place on raising awareness of mental health issues with children and young people?

The Minister for Health and Social Services:

I think that is done across the board. I am sure you ...

The Deputy of St. Ouen:

Generally.

Managing Director, Community and Social Services:

Yes, I think we spoke about this on Friday. Again, it comes right back to where we started at the beginning when we talk about comprehensive and specialist C.A.M.H.S. services. It is important that the issues of mental health and well-being are addressed universally across the board. That is by all the services that work universally with children and young people. So we work with our colleagues in Education, Sport and Culture to ensure that the right piece of work goes into schools and at the same time, within our specialist service, whether that be in A. and E. or in C.A.M.H.S. services, when we are coming across children presenting with those difficulties we are providing a different level of input, a specialist C.A.M.H.S. service for those young people.

The Deputy of St. Ouen:

What have you done to address the stigma of children with mental health issues?

The Minister for Health and Social Services:

I think the more you talk about it and raise those issues, the understanding by society in general ... because it is all our problems, it is not just the Health service and Social Services problems, or Education, it is everybody's problem. I think I am beginning to understand the issue that our young people have, whether it be drugs, alcohol or whatever, or the peer pressure that they get, it is raising the awareness, understanding what is behind it and trying to do something about it.

The Deputy of St. Ouen:

Obviously as the Minister for Health and Social Services, what part are you yourself and your department playing in dealing with the stigma that is attached?

Managing Director, Community and Social Services:

Part of it is the direct input with children and also the indirect input. For example, if we are talking about young people in substance abuse it is not just about directly working with young people, it is not just about directly working with Education so they can work with young people, it is about working with the parents, providing the parents a guide to drugs so that they can have a conversation with children. As the Minister says, it is about people openly talking about things and the best way to talk about things is to be well informed.

Deputy J.A. Hilton:

I will call the meeting to a close. I forgot to give the apologies on behalf of our chair, the Deputy of St. Peter at the beginning of the meeting so I would like to pass on her apologies.

The Minister for Health and Social Services:

Julie Garbutt sent her apologies too.

Deputy J.A. Hilton:

Thank you very much, I close the meeting.

[11:34]