

# Assessment of Mental Health Services

Health and Social Security Panel

6th March 2019

S.R.4/2019



States of Jersey  
States Assembly



États de Jersey  
Assemblée des États

## Assessment of Mental Health Services

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## Chairman's Foreword

Mental health doesn't discriminate. It can affect anyone in any walk of life. In fact, it has been estimated that an astonishing one in four of us will experience a mental health problem each year.

Our island has a range of services available to people with mental health problems. They include peer-to-peer support, training courses, psychological therapies and inpatient facilities. These services are provided by public, private, voluntary and community organisations.



But what do we know about these services? How easy are they to access and use? And what is the experience of those who use them, as well as their family and friends?

Furthermore, what progress has the Government made on implementing its Mental Health Strategy that was published in 2015 and aimed to improve services between 2016 and 2020.

Our review aimed to answer these questions.

To do this, we collected a huge amount of evidence from service users via our survey and personal testimony, from visits to mental health services and by speaking to expert witnesses in the public, private and community and voluntary services. We are extremely grateful to everyone who contributed to our review.

What do the results show us? Are Jersey's mental health services good as they could be? The honest answer is no. Has the Government done enough to improve mental health services? Unfortunately, the answer is, again, no.

It was clear during our review that the staff working in mental health services are dedicated and hardworking. They deserve recognition for maintaining services whilst operating in less than ideal circumstances.

The real problem has been a lack of political and executive leadership and a lack of investment in staff and the mental health estate. It is clear that this has had a negative impact on mental health services. If services are to be improved both these issues – leadership and investment – must be addressed as a priority.

We recognize that there is only one set of services available to people in Jersey and we emphasize that the findings in our report should not put anyone off seeking help with their mental health if they feel they need it.

We are reporting on these issues as a critical friend to Government offering insight into the quality of the service today and setting out areas for improvement. We hope that our key findings and recommendations will be viewed in this light.

I would like to thank my colleagues on the Panel – Deputy Carina Alves, Deputy Kevin Pamplin and Deputy Trevor Pointon – for their contribution to this review.

A handwritten signature in black ink that reads "M. Le Hegarat".

Mary Le Hegarat

Chairman, Health and Social Security Panel

## Executive Summary

In December 2015, the Government launched a Mental Health Strategy, which aimed to improve services between 2016 and 2020. In July 2018, halfway through the Strategy, we launched our mental health review to see what progress the Government had made.

As part of our review, we conducted a survey to hear the views and opinions of people who had used Jersey's mental health services in the past 2 years. The results of our survey are set out in Chapter 3. They showed that most people had to wait to access services, most people found the wait unacceptable, and most people said that their mental health got worse while they were waiting. The results also showed that most people had a positive experience when using mental health services, especially with the staff in those services. However, over a third of respondents said that their mental health had not changed or got worse since using mental health services. There were also a number of other issues including unwelcoming services, a lack of out of hour's services, a lack of flexibility, poor communication with families and carers, and failing to meet service users' needs.

It was clear that Jersey's mental health services were not as good as they could be and that improvements to the services had stalled. We identified several issues that needed to be addressed as a priority. These are set out in Chapter 4.

We found that there had been a lack of political and executive leadership focused on improving mental health services. This has had a detrimental impact on efforts to implement the Mental Health Strategy and improve services. We recommend that responsibility for mental health services is made clearer and more visible to the general public. We also recommend that the Mental Health Improvement Board, which has been set up to drive forward improvements, be reformed to improve its governance and accountability.

We found that there had been a lack of investment over a sustained period of time. Any significant improvements to mental health services were contingent on increased financial investment. Some of these improvements were essential to ensure that the services are able to function properly.

We found that mental health services are understaffed and struggle to fill vacant posts. We recommend that the Government needs to do more to grow talent at home and to make it easier for people to move to the Island.

We also found that the quality of the mental health estate is completely unacceptable. Many of the buildings are dilapidated, uninviting and not fit for purpose. This is having a detrimental effect on staff and service users. We highlight that the Government's plans to build a new general hospital provide an ideal opportunity to create a world class mental health facility – including a new place of safety – and co-locate it with the new general hospital.

We identify that some of these problems stem from mental and physical health not being treated equally. We call on the Government to adopt the “parity of esteem” concept where by mental and physical health are put on an equal footing.

In Chapter 5 we identify a number of other areas where services could be improved. We recommend that the Government adopt a “co-production” approach to working with service users to design and deliver mental health services. We also recommend that Government should provide adequate support to community and voluntary organisations who provide what are essentially frontline services and fill gaps in statutory services. We make

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recommendations to ensure that General Practitioners (GPs) can play a full role in supporting patients with mental health problems.

We also highlight issues with how service users move from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services as well as issues with where CAMHS sits in relation to other mental health services.

Finally, we heard that the current pathway for transgender people to transition is long and complex which can have a detrimental impact on their mental health. We recommended that the Government explore how this process of transitioning could be improved for transgender people.

## Findings and Recommendations

1. **KEY FINDING 1:** The Government's Mental Health Strategy represented a positive and welcome step toward improving mental health services. However, progress on implementing the Strategy has been piecemeal and it is not clear why some things have been done while others have not. It is difficult to measure progress against the strategy as it did not include any objectives.
2. **RECOMMENDATION 1:** A part of its refresh of the Mental Health Strategy, the Government should develop some clear objectives from which progress can be measured. These should be published on the Government's website.
3. **KEY FINDING 2:** We are concerned that the appropriate outcome-based indicators for measuring the performance Jersey's mental health services are lacking.
4. **RECOMMENDATION 2:** The Government should publish a list of the outcome-based measures and indicators it will use to monitor its performance in relation to mental health by the end of 2019. The information it collects in relation to these measures and indicators should be published on a yearly basis thereafter.
5. **KEY FINDING 3:** We surveyed 340 mental health service users and found that while the majority of respondents found it easy to be referred, most people had to wait to access services, most people found the wait unacceptable and most people said that their mental health got worse while they were waiting.
6. **KEY FINDING 4:** In general, mental health service users had a positive experience when using mental health services. However, we note that over a third of respondents said that their mental health had not changed or got worse since using mental health services. Staff in mental health services were considered to be respectful, compassionate and knowledgeable. However, there were a number of issues including unwelcoming services, a lack of out of hour's services, a lack of flexibility, poor communication with families and carers and failing to meet service users' needs.
7. **KEY FINDING 5:** We believe that our survey has provided a valuable insight into the current state of mental health services. It has highlighted the importance of asking service users their views and opinions about the quality of mental health services.
8. **RECOMMENDATION 3:** The Government should regularly ask service users for their views and opinions on the quality of the mental health services it provides. In light of our survey, the Government should start this regular engagement in Q1 2020. Regardless of the tools that the Government uses to collect user feedback, the results should always be published.
9. **KEY FINDING 6:** There has been a lack of political and executive leadership focused on improving mental health services in Jersey. This has had a detrimental impact on efforts to implement the Mental Health Strategy and improve services.
10. **RECOMMENDATION 4:** The Government should consider the merits of having a designated Minister for Mental Health to provide sufficient leadership for mental health in Jersey. Alternatively, the Government should transfer official responsibility

**for mental health to a designated person. The Government should demonstrate that it has considered this matter and set out its decision in response to this report.**

11. **KEY FINDING 7:** We are seriously concerned about the structure of the Mental Health Improvement Board. We are concerned that it is chaired by the Director General of the Department of Justice and Home Affairs and we are concerned that it does not have anyone with lived experience of mental health services on the Board.
12. **RECOMMENDATION 5:** **The terms of reference, membership and reporting lines of the Mental Health Improvement Board should also be made public. The Board should be chaired by a senior officer in Health and Community Services. Membership of the Board should include operational representatives from all frontline services that interact with mental health as well as appropriate third sector organisations. Its membership should also include at least two people with lived experience of mental health problems.**
13. **KEY FINDING 8:** Mental health services have suffered from a lack of investment over a sustained period of time. The improvements required in mental health services are dependent on increased financial investment. Some of these improvements are essential to ensure that the service is able to function properly and include recruiting and retaining staff and enhancing the mental health estate.
14. **KEY FINDING 9:** Prospective candidates applying for mental health roles often reject offers when they understand the implications of Jersey's high cost of living. These recruitment problems have led to a lack of staff in mental health services.
15. **KEY FINDING 10:** Programmes to increase the pool of home grown mental health staff in Jersey is very positive. However, it is unlikely to solve the immediate staff shortage problem.
16. **RECOMMENDATION 6:** **If prospective candidates applying for mental health roles cannot afford to live in the Island then either salaries need to increase or a way of mitigating the high cost of living need to be found. The salaries of key mental health staff should be reviewed and adjusted so that they are competitive with the UK when Jersey's cost of living is taken into account.**
17. **RECOMMENDATION 7:** **In addition to assisting with pay and cost of living, the Government should do more to help successful applicants with moving and settling in the Island. The Government could provide for example, resettlement loans/grants, assistance with the cost of importing a vehicle, registering for a driving licence, obtaining a registration card and childcare.**
18. **RECOMMENDATION 8:** **Recruitment and retention problems in Jersey's mental health services should not prevent the Government from making progress on improving these services. Regardless of whether the number of staff increases, the Government should focus on improving ways of working within current resource constraints and focusing on investing in existing staff by giving them access to, for example, appropriate training.**
19. **KEY FINDING 11:** The quality of the mental health estate is completely unacceptable. Many of the buildings are dilapidated, uninviting and not fit for purpose. This is having a detrimental effect on staff and service users. In some cases the poor quality of the estate

is failing to keep both service users and staff safe. It is highly likely that this is having a negative impact on recruitment of mental health staff.

20. **KEY FINDING 12:** Orchard House (the Islands adult in-patient mental health service) is particularly bad. It recently failed a health and safety inspection. We received a significant number complaints about Orchard House via our survey, when collecting personal testimony and from our expert witnesses. In particular we note that there appeared to be little therapeutic activity for patients to do while they are there.
21. **RECOMMENDATION 9:** The government should prioritise finding a replacement for Orchard House in the short to medium term. The Government should also improve governance within Orchard House including setting appropriate standards and performance processes to ensure that staff but especially service users remain safe. These should be developed and implemented by the end of 2019.
22. **KEY FINDING 13:** The Government has the potential to create a world class mental health facility. In order to achieve this, we believe that as far as possible, mental and physical health services should be co-located. The redevelopment of Jersey's general hospital means that this is an ideal time to incorporate mental health it into the planning for the future hospital.
23. **RECOMMENDATION 10:** As part of its work to develop a new General Hospital, the Government should conduct an assessment of what mental health services could be co-located with the future hospital.
24. **KEY FINDING 14:** Jersey does not have an appropriate place of safety for children or adults in a mental health crisis. People in crisis are often detained in inappropriate environments such as police cells. It is inappropriate for young people to be detained on Robin Ward (the children's ward in the General Hospital) or Orchard House (the Islands adult in-patient mental health service).
25. **RECOMMENDATION 11:** An appropriate place of safety should be created within the existing hospital until an alternative arrangement can be found. Children and adults in mental health crisis should be separated.
26. **RECOMMENDATION 12:** The Government should explore alternative options for dealing with people in crisis. This could include, for example, "crisis intervention teams" which provide a more patient centred approach.
27. **KEY FINDING 15:** Parity of esteem, treating physical and mental health equally, has benefits for patients and staff. It allows health and social care services to take a "whole person" approach to people's care.
28. **RECOMMENDATION 13:** The Government should adopt the parity of esteem concept and develop a plan for how it will be integrated into health and social care services. This concept should be reflected in the Mental Health Improvement Board's terms of reference.
29. **KEY FINDING 16:** Co-production means delivering mental health services in partnership with service users and mental health professionals. There is evidence to suggest that empowering service users is a good way to deliver services. The Government has said that it uses co-production but we have seen little evidence that this is the case – especially

in relation to refreshing the Strategy and improving services through the Mental Health Improvement Board.

30. **RECOMMENDATION 14: The Government should adopt a genuine co-production approach to the design and ongoing delivery of Jersey's mental health services. People with lived experience should be empowered and involved in all aspects of mental health strategic and operation development including having a voice at corporate management level. These people should also be remunerated for their contribution.**
31. **KEY FINDING 17:** Jersey's community and voluntary organisations provide a range of valuable services which support people with mental health problems. It is clear that the Government wants these organisations to fill the gaps which are not covered by statutory services. The gaps are so large, however, we are not sure that they can be filled by the community and voluntary sector.
32. **KEY FINDING 18:** It is clear that responsibility for promoting good mental health extends beyond the Government and community and voluntary organisations. Mental health is everyone's business. We note that some private sector organisations are starting to promote good mental health in the workplace and supporting staff who are experiencing mental health problems.
33. **RECOMMENDATION 15: If the Government wants the community and voluntary sector to provide what are essentially frontline mental health services then it needs to provide realistic support to these organisations. The Government should provide adequate funding to, at the very least, cover the cost of delivering services, as well as longer-term contracts to these organisations (which could still be reviewed intermittently) in order to ensure that these services can provide the services required.**
34. **KEY FINDING 19: General Practitioners (GPs)** play an important role in supporting people with mental health issues and referring people into mental health services. However, people's experience of GPs in relation to mental health has been mixed suggesting inconsistency across the profession. This has potentially negative implications for those people who are under the care of GPs who do not know much about mental health or the services on offer in the Island.
35. **RECOMMENDATION 16: The Government should offer to all Jersey's General Practitioner (GP) practices, training on mental health and information about Jersey's mental health services.**
36. **KEY FINDING 20:** Jersey's General Practitioner (GP) practices are private businesses who charge a range of prices for a consultation with a GP. The up-front surgery costs associated with visiting GPs had an impact on how involved GPs were with a person's ongoing mental health. We have heard that people may avoid seeing their GP to discuss their mental health because of the cost involved.
37. **RECOMMENDATION 17: The Government should review the fees charged by General Practitioners GPs in relation to mental health. It should explore, in close consultation with GPs, whether a different funding method could be used if a patient presents to a GP with mental health problems rather than physical problems.**

38. **KEY FINDING 21:** Currently, children and young people with mental health problems are cared for by the Child and Adolescent Mental Health Service until they are 18 at which point they transition to being cared for by Adult Mental Health Services. The appropriateness of this cut-off was challenged by several stakeholders including CAMHS clinicians. It was generally agreed that people should transition between services when it is right for them or up to their mid-twenties. However, the ability for CAMHS to support this is dependent on adequate resources which it does not have at present.
39. **RECOMMENDATION 18:** **Until mental health services are better staffed it will be challenging for them to provide appropriate transition arrangements between CAMHS and adult mental health services. However, we believe that CAMHS should start sharing a person's file with adult services once they have reached a certain age – even if that person isn't referred to adult services when they leave CAMHS.**
40. **KEY FINDING 22:** While we can understand the theory behind moving CAMHS from health to education, we do not think that this will work in practise. There are a number of risks associated with this change. We do not believe that the Government has sufficiently justified this change or demonstrated how the risks will be mitigated. It is also not clear who CAMHS staff will be reporting to and how clinicians will maintain links to other clinical organisations.
41. **RECOMMENDATION 19:** **CAMHS should remain part of the Department for Health and Community Services.**
42. **KEY FINDING 23:** We heard some suggestions that mental health services were focused on a “medical model” for treating people with mental health problems rather than alternative non-medical therapies. Although the Government has made efforts to improve therapeutic services with the establishment of Jersey Talking therapies, the service is so oversubscribed and the waiting lists so long that this service isn't filling the gap. We heard about an alternative form of therapy called Open Dialogue but it was not clear that mental health services used this or other alternative therapies when caring for people with mental health problems.
43. **RECOMMENDATION 20:** **The Government should review the model of care that is used in Jersey's mental health services. As part of this, the Government should define the model of care that it uses. This definition should include elements used in Open Dialogue including collaborative and joined up approaches to care. This should be published in Q2 2020.**
44. **KEY FINDING 24:** The current pathway for transgender people to transition is long and complex which can have a detrimental impact on their mental health. We did not have the opportunity to look into this issue in more detail. However, we think that the arguments presented by Liberate Jersey have merit and should be explored further.
45. **RECOMMENDATION 21:** **The Government should commit to meet with Liberate Jersey to discuss their concerns and proposals in relation to pathways for transgender people. It should also review the current pathway for transgender people and consider if it would be possible to improve the process. This work should be made public.**

## 1. Introduction

46. Mental health encompasses our emotional, psychological, and social well-being. It affects how people think, feel and act. The prevalence of reported mental health problems have been rising steadily overtime and at some point in our lives most of us will encounter some kind of mental health problem.

47. We know that mental health issues can present in a variety of ways. Common mental health problems include issues associated with depression, anxiety, bipolar disorder, schizophrenia, neurological disability and organic brain disease e.g. dementia.

48. There are many factors which contribute to good or poor mental health (see below).

Levels	Adverse Factors	Protective Factors
Individual Attributes	Low Self Esteem Cognitive/emotional immaturity Difficulties in communicating Medical Illnesses Substance misuse	Self Esteem/ confidence Ability to solve problems and manage stress or adversity Communication skills Physical health/Fitness
Social Circumstances	Loneliness, Bereavement Neglect, Family conflict Exposure to violence/abuse Low income and poverty Difficulties or failure at school Work stress, unemployment	Social Support of family & friends Good Parenting/family interaction Physical security and safety Economic security Scholastic achievement Satisfaction and success at work
Environmental Factors	Poor access to basic services Injustice and discrimination Social and gender inequalities Exposure to war or disaster	Equality of access to basic services Social Justice, tolerance, integration Social and gender equality Physical security and safety

Source: World Health Organisation, [Risks to mental health: an overview of vulnerabilities and risk factors](#), August 2012

49. Jersey has a range of mental health services available spanning primary care, secondary care services operated by the States of Jersey and within the large charitable/not for profit/independent sector on the island. Services include: peer-to-peer support, training courses, psychological therapies for mild to moderate mental health problems, and medical treatments and inpatient facilities for moderate to severe mental health problems.

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The former are provided by public, private, voluntary and community organisations. The latter are provided by public and statutory services.

50. Our review sought to find out what we know about these services, how easy they are to access and use, and what is the experience of those who use them, including their family and friends. We also wanted to assess what progress the Government has made on delivering its 2015 Mental Health Strategy which aimed to improve services from 2016 to 2020.
51. In Chapter 2 we explore what has happened since the mental health strategy was published and in Chapter 3 we set out the results from our survey which asked service users about their experience of assessing and using mental health services. Chapter 4 sets out some overarching and cross cutting issues which we believe the Government needs to address as a priority. Chapter 5 sets out further areas which should be considered once the overarching issues have been addressed.
52. From the beginning, we wanted to make sure that the people who used mental health services were at the heart of our review. We collected a large body of evidence directly from them including 340 responses to our survey, personal private testimonies from 15 people who shared their experience of Jersey's mental health services, and a meeting with a group of young people at the Youth Enquiry Service. In addition to this we visited Orchard House (adult in-patient services) La Chasse (adult out-patient services), CAMHS (child and adolescent services), Jersey Talking Therapies (a service offering psychological therapies for people over 18 years old), the Police Headquarters and the Prison to see these buildings and services for ourselves and speak directly to the staff who ran them. We also received 16 pieces of written evidence and held 9 public and 1 private hearing with 15 different charities, businesses, clinical groups, government officials and the Minister for Health and Social Services. We are grateful to everyone who contributed to our review, especially the people who shared their personal experiences via the survey or in person.
53. We would like to state at the outset that we recognise that there is only one set of services available to people who live in Jersey. Nothing you read in this report should prevent you from seeking help with your mental health, if you think that you need it. We are reporting on this issue as a critical friend to Government offering insight into the quality of the service today and setting out areas for improvement. We hope that our key findings and recommendations will be viewed in this light.

## 2. Mental Health Strategy

54. In 2012 the States Assembly adopted proposition P.82, *Health and Social Services: A New Way Forward*.<sup>1</sup> This proposition approved a redesign of Jersey's health and social care services. In 2015, as part of this, the Government undertook a "system-wide review" of mental health services. The review was informed by "innovative participatory approaches" designed to involve different stakeholders including people with lived experience of poor mental health. These techniques allowed the Government to "fully understand the potential options for providing high quality mental health services in the future".<sup>2</sup>
55. Stephen Appleton, Managing Director of Contact Consulting, a consultancy who was involved in the review, said that this approach was used to secure buy-in from a wide range of people and that the approach had been internationally recognised as a model of good practice.<sup>3</sup>
56. The result of this review was the Mental Health Strategy for Jersey (the Strategy) that was published in November 2015 and which would improve services between 2016 and 2020.<sup>4</sup> The Strategy set out five priority areas which offered a "comprehensive strategic direction for future whole system development". The priority areas included:
- Social Inclusion and Recovery
  - Prevention and Early Intervention
  - Service Access, Care Coordination and Continuity of Care
  - Quality Improvement and Innovation
  - Leadership and Accountability
57. For each priority area the Strategy set out "what we will do" and listed between 5 and 18 actions (and 45 actions in total). The actions were wide ranging. Examples include, supporting "cultural and philosophical shifts" in mental health service delivery, providing more support to charities, General Practitioners and mental health clinicians to deliver mental health services, improving processes in how patients are treated and finding new buildings to house Government-provided services such as adult in-patient services.<sup>5</sup>
58. When we launched our review in July 2018 – halfway through the Strategy – we asked the Government to tell us what progress it had made on implementing the Strategy and how mental health services had changed since its launch.<sup>6</sup>
59. In its response the Government highlighted a range of initiatives that it had delivered. It included developing new promotion and engagement initiatives, such as "Jersey Wellfest", to help people find out about the services available on the Island. It included supporting

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<sup>1</sup> States of Jersey, [Health and Social Services: A New Way Forward](#), P.82/2012, 11 September 2012

<sup>2</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p47

<sup>3</sup> [Contact Consulting](#), p1

<sup>4</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015

<sup>5</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p59-75

<sup>6</sup> Letter from the Chairman of the Health and Social Security Panel to the Minister for Health and Social Services, 11 July 2018

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the implementation of new mental health laws and the Suicide Prevention Programme. It included the establishment of new services such as the Recovery College, more mental health provision in schools, training for staff in the prison, probation and the police service.<sup>7</sup>

60. The Government also highlighted a number of areas where further work was required. For example, it wanted to see more community-based services, a 'place of safety' for people experiencing a mental health crisis and an improved mental health estate. The Government stated that these things would be incorporated into a Mental Health Improvement Plan "which will set out the next phase of development and improvement".<sup>8</sup> This would also include a "refresh" of the Strategy.<sup>9</sup>
61. We sought to test the Government's assessment of progress by asking others what progress they thought the Government had made. The majority of people we spoke to agreed that the Strategy and the way in which it was developed was very positive. However, there were concerns about how the Strategy was being implemented.
62. Stephen Appleton from Contact Consulting indicated that progress on delivering the Strategy had slowed. He suggested that a connection had been lost between the Strategy and "operational development" of mental health services.<sup>10</sup> Issues highlighted in the evidence ranged from a lack of leadership, shortages in clinical staff, a lack of funding, and problems with the mental health estate, to name a few.
63. David Ogilvie, Managing Director of Resilience Development Company, however, argued that questions around progress on delivering the Strategy were subjective as the Strategy didn't have any objectives. He said:

*To answer your question directly, that is a very subjective question to answer if the strategic review has no objectives. It has lots of goals and lots of intent but it does not have any objectives, does it? It says we will do this but it does not say by what and when. [...] It becomes: have we made significant progress in X or Y? It is down to completely personal opinion, and that will be step one for me, is to make it a strategy rather than a statement of intent. It is like half a job.<sup>11</sup>*

64. Stephen Appleton challenged David Ogilvie's argument:

*[...] 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. [...] 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. [...] I think it is a good document and they are good outcome measures.<sup>12</sup>*

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<sup>7</sup> States of Jersey, [Health & Community Services Response](#), 9 October 2018, p9-18

<sup>8</sup> States of Jersey, [Health & Community Services Response](#), 9 October 2018, p19

<sup>9</sup> States of Jersey, [Health & Community Services Response](#), 9 October 2018, p18

<sup>10</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p8-9

<sup>11</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p13

<sup>12</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p25-26

65. We were aware that the Government had already developed some indicators and measures in relation to mental health.<sup>13</sup> However, when we asked the Government about how it measures its performance in this area, Karen Wilson, Interim Director of Quality, Governance and Nursing (Community) said that there were “gaps” in the information the Government was collecting. She said that the information it was collecting was “activity-based” indicators and that the Government would like to shift to “outcome-based information”. Ms Wilson explained:

*The areas that we look at are things like waiting times, referral to treatment times, we look at some of the public health data in terms of prevalence, we look at incidents, complaints. We also have in some areas feedback from service users and carers themselves about their experience of care and support. The key things I think for us are about focusing on measuring how accessible we are, how responsive we are, and also how financially and clinically effective we are. So some of our indicators also relate to some of the clinical performance measures around the effectiveness of some of our care, so how people recover and how soon people can get out of hospital to lead their usual life. So things like how long they stay in hospital, bed occupancy, length of stay, those sorts of things will drive a review of how we understand performance of the service as it stands.<sup>14</sup>*

**KEY FINDING 1:** The Government’s Mental Health Strategy represented a positive and welcome step toward improving mental health services. However, progress on implementing the Strategy has been piecemeal and it is not clear why some things have been done while others have not. It is difficult to measure progress against the strategy as it did not include any objectives.

**RECOMMENDATION 1:** A part of its refresh of the Mental Health Strategy, the Government should develop some clear objectives from which progress can be measured. These should be published on the Government’s website.

**KEY FINDING 2:** We are concerned that the appropriate outcome-based indicators for measuring the performance Jersey’s mental health services are lacking.

**RECOMMENDATION 2:** The Government should publish a list of the outcome-based measures and indicators it will use to monitor its performance in relation to mental health by the end of 2019. The information it collects in relation to these measures and indicators should be published on a yearly basis thereafter.

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<sup>13</sup> States of Jersey, [Mental Health Quality Report](#), 15 May 2017

<sup>14</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p13-15

## 3. User Experience of Mental Health Services

### Mental Health Survey

66. We wanted to collect the views and opinions of as many people who had used Jersey's mental health services in the past 2 years as possible. As a result, we developed a survey in the summer of 2018 with help from Statistics Jersey, Officers in the Department for Health and Community Services, staff at Mind Jersey, and an individual with lived experience of mental health problems.
67. The survey was open for 8 weeks from the 10 October to 3 December 2018. It was available online, in hardcopy and in English, Portuguese and Polish. The online version was promoted in the news, on our website and via social media. Hardcopies were offered to people waiting for appointments at some mental health services. When promoting the survey we encouraged people to share positive and negative experiences.
68. In total 340 people responded to the survey. All the responses to the survey were treated anonymously. We are very grateful to everyone who contributed.
69. It is important to note that there are some limitations to our survey. The survey represents a "snap shot" in time and only reflects the views and opinions of the people who choose to complete the survey. The survey is not therefore, statistically representative of the population of the Island as a whole or the total population of people who have used mental health services. Inevitably there will be people that we did not reach. Despite these limitations we believe that the results from our survey provide a valuable indication of views on the current state of mental health services in the Island.
70. In the rest of this chapter we set out a summary of the results of this survey.

### Who Responded?

71. The majority (69%) of people who responded to our survey were referring to their own experience of mental health problems. 22% were responding as carers for someone experiencing mental health problems. 8% were responding on behalf of someone else with mental health problems.
72. Respondents to the survey had used a range of services. We had representation from all types of services but most of the respondents had used Jersey Talking Therapies (23%), hospital-based (18%) or community-based (19%) adult mental health services (people between the ages of 18-65). We also had good representation from people who had used hospital-based (4%) and community-based (9%) child and adolescent mental health services (people under 18 years old) (CAMHS) and people who had used charitable, voluntary and community (7%) and private (7%) mental health services. We had comparatively few people respond from hospital-based (2%) or community-based (1%) older adult mental health services (people over 65 years old). A small number of people told us that they were accessing mental health services from school, the youth service and the prison.
73. We have divided the services between "hospital-based" and "community-based" services so that we can understand if there are differences between service user experiences of in-patient and out-patient services. It is worth noting, however, that most of the staff

## Assessment of Mental Health Services

supporting these services are the same. For example, clinicians in CAMHS support service users in both in-patient and out-patient services.

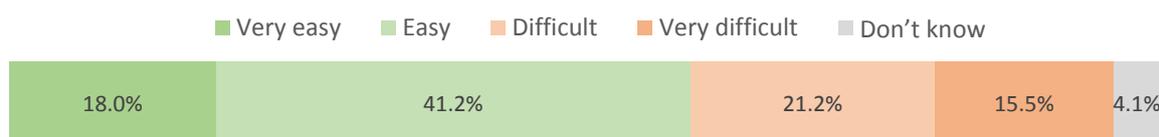
74. The results that follow are combined results for all the services as a whole except for when we say otherwise.

## Accessing Mental Health Services

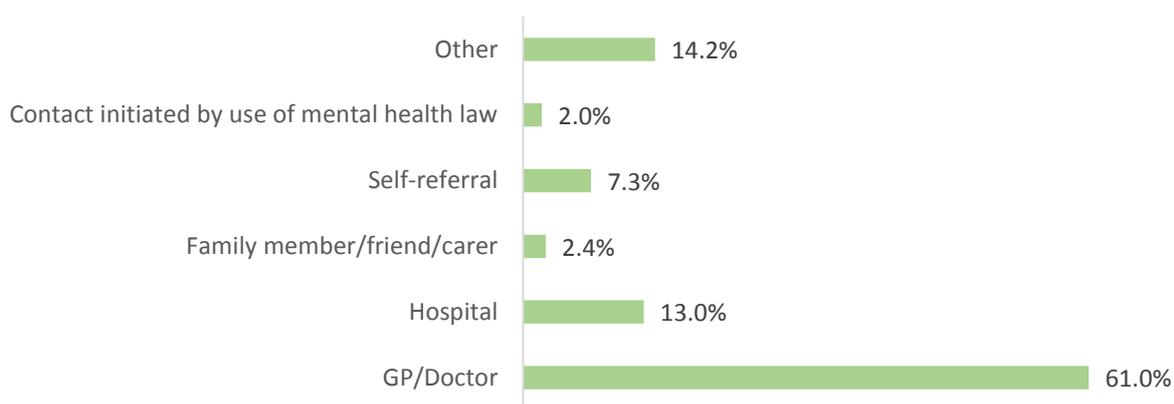
75. Overall, the majority (59%) of respondents found it easy or very easy to be referred to the mental health service that they used. 37% of respondents found it difficult or very difficult to be referred (Figure 3.1). Respondents found it particularly easy to be referred to Jersey Talking Therapies with 69% agreeing compared to 30% who did not.

76. The majority (61%) of respondents were referred into mental health services via their GP (Figure 3.2). 13% were referred by the hospital, 7% were self-referral, 2% by a family member, friend or carer and 2% by the use of the mental health law. Of the 14% who selected other, they were referred through a number of different routes including, for example, schools, social workers, the police and the prison service.

**Figure 3.1 How easy was it to be referred to the mental health service you used?**



**Figure 3.2 Who referred you to the mental health service that you used?**



77. Most respondents (74%) who were referred into mental services had to wait to access those services (Figure 3.3). For those people who had to wait, the wait ranged from hours to over a year or more. 77% of respondents described that wait as not very or not at all acceptable compared with 21% of respondents who described that wait as fairly or very acceptable (Figure 3.4).

78. 97% of respondents who were referred to Jersey Talking Therapies had to wait and 24% described the wait as not very acceptable and 62% as not at all acceptable. Respondents

## Assessment of Mental Health Services

were also dissatisfied with the wait for hospital-based and community-based adult mental health services. 79% and 67% respectively found the wait unacceptable.

79. Similarly, respondents were dissatisfied with the wait for hospital-based and community-based CAMHS services. 70% and 72% respectively found the wait unacceptable. This point was also made during our meeting with young people at the Youth Enquiry Service.

80. We asked respondents if they had any comments about waiting times for mental health services. There was a strong feeling that waiting times needed to be reduced. Many people commented on the long waiting times describing them as “appalling” “disgusting”, “diabolical” and “horrendous”. One respondent stated:

*Waiting times generally are unacceptable. There is a wait first for assessment followed by another before treatment commences. Staff are naturally unwilling to commit to a waiting time as they have no control and cannot guarantee how long it will be. Most mental health patients are experiencing some kind of distress. The longer they wait for treatment, the greater the distress and the more problems can be arise, not just for them but for their, family, friends, partners and work colleagues.*

**Figure 3.3 Did you have to wait to access the mental health service you used?**



**Figure 3.4 How would you describe the amount of time you had to wait?**



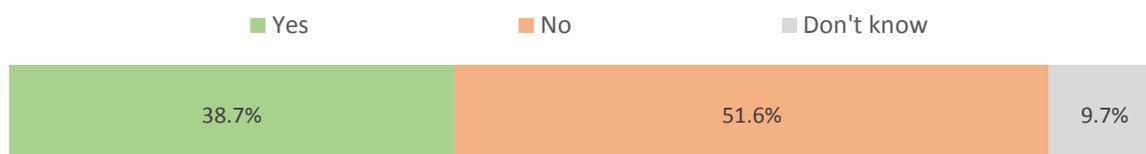
81. Just over half (52%) of the respondents, who said that they had to wait to access the mental health service that they used, said that they were not made aware of how long the wait would be (Figure 3.5). 39%, however, said that they were made aware of how long they would have to wait. The results for most of the services were fairly evenly split between being told and not told how long the wait would be. This suggests that there may be inconsistent approaches to this issue within services. The main reasons respondents were told there was a wait, was the “high demand” for the service and a “lack of staff”. Some people highlighted how the lack of communication about their wait had a negative impact on their mental health. One respondent stated:

*If told the likely waiting time between referrals, further contact, receiving treatment, etc., these are rarely accurate. This is unacceptable and leads to an unrealistic expectation that I will be seen sooner rather than later. By not*

## Assessment of Mental Health Services

*communicating accurate waiting times, I feel that my mental health and trust in the mental health services in Jersey suffered.*

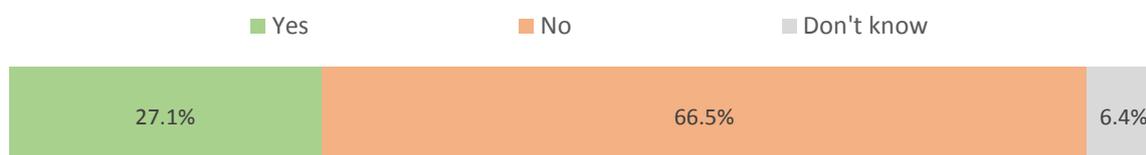
**Figure 3.5 Were you made aware of how long the wait would be?**



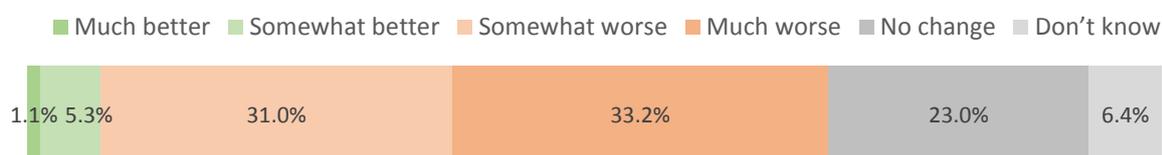
82. Overall, 67% of respondents said that they were not given any information about other services, such as the Samaritans, while they were waiting (Figure 3.6). Substantial numbers of respondents from hospital-based CAMHS services (60%), community-based CAMHS (58%), hospital-based adult services (65%), community-based adult services (64%) and Jersey Talking Therapies (71%) said that they did not receive information about other services. This is pertinent because 64% of people who had to wait said that their mental health became somewhat or much worse during the wait (Figure 3.7).

83. Of the 27% who said that they were given information about other services, the specific organisations included the Samaritans, Mind Jersey, Jersey Recovery College, the YES project, Brighter Futures, Headway, the Hospice (for bereavement counselling), the Drug and Alcohol Service and the Hospital “in case of an emergency”.

**Figure 3.6 Were you given any information about other services while you were waiting (e.g. Mind Jersey, Samaritans etc.)?**



**Figure 3.7 Did you notice a change in your mental health while you were waiting to access the service?**



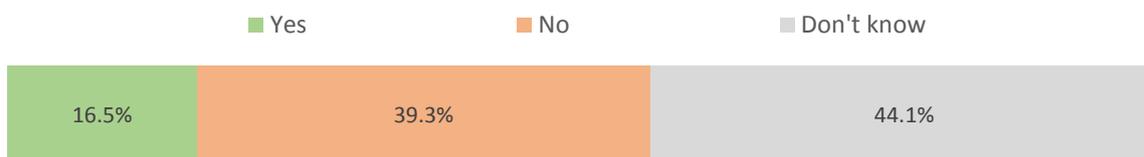
84. Only 17% of respondents said that they knew of other organisations in Jersey that provide a similar service to the one they were using. 39% said that they did not know and 44% said that they were not sure (Figure 3.8). Similarly, 29% of respondents said that they knew of alternative treatments, services or forms of support for their mental health

## Assessment of Mental Health Services

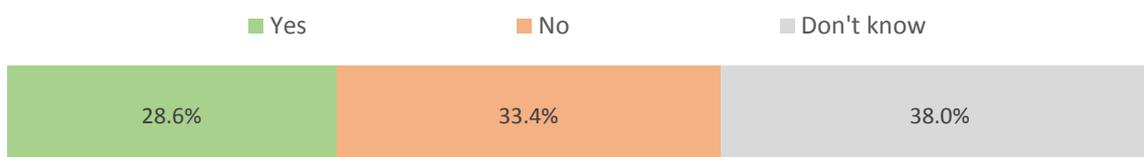
problems. 33% said they did not know and 38% said that they were not sure (Figure 3.9). when we were collecting personal testimony, one person said:

*It seems to be, from my experience in this situation, that it was very much a situation whereby the services are there if you come looking for them.*

**Figure 3.8 Do you know if there are any other organisations in Jersey that provide the service you were using?**



**Figure 3.9 Do you know if there are any alternative treatments, services or forms of support for your mental health problem?**



**KEY FINDING 3:** We surveyed 340 mental health service users and found that while the majority of respondents found it easy to be referred, most people had to wait to access services, most people found the wait unacceptable and most people said that their mental health got worse while they were waiting.

## Using Mental Health Services

85. In addition to asking people about their experience of accessing services we asked them about their experience on a range of topics when using the service.

86. Overall, 62% of respondents thought that mental health services were in a convenient place compared to 11% who did not (Figure 3.10). Jersey Talking Therapies (72%), community-based CAMHS services (65%), hospital-based CAMHS services (64%), and community-based adult services (65%) were all considered to be in a convenient place. Hospital-based adult services performed slightly less well (56%). Charitable, voluntary and community as well as private services were also considered to be in convenient places.

87. 53% of respondents thought that mental health services were easy to contact compared to 37% who did not. Jersey Talking Therapies performed well with 65% of respondents agreeing that it was easy to contact compared to 26%. Similarly, Community-based CAHMS performed well with 65% of respondents agreeing that it was easy to contact compared to 26% who did not. Hospital-based adult mental health services performed less well with 53% suggesting it was not easy to contact compared to 35% who did.

## Assessment of Mental Health Services

88. Despite most services being in convenient places and easy to contact, only 46.2% of respondents thought that mental health services could be accessed at convenient times compared to 43.6% who did not. The results in relation to specific services were mixed. Community-based CAMHS services and community-based adult services performed better by comparison to hospital-based CAMHS and hospital-based adult services.

89. Those people who did not think that the service was easy to access highlighted problems with accessing services “out of hours” in the evenings, at night and on the weekends. One respondent stated:

*During normal hours yes.....weekends no, Christmas no, bank holidays no, Mental health does not have the luxury to work 8 hours a day 5 days per week, it is with you 24 hours per day 7 days per week.*

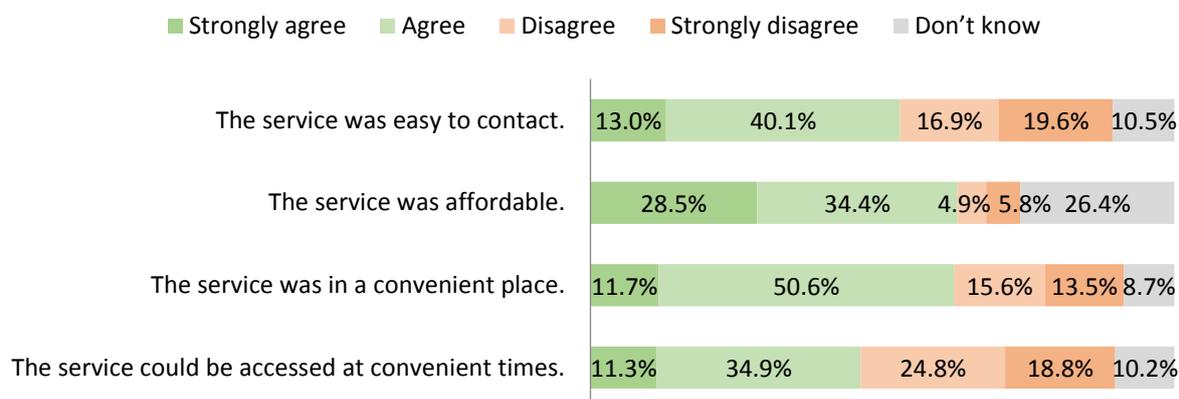
90. Another respondent highlighted that, outside of normal hours, people were encouraged to go to A&E which was not ideal:

*If problems occur outside normal hours, people are directed to A&E. This is a busy department not ideally suited for people undergoing mental distress, including suicidal ideation. Mental Health staff are not always immediately available.*

91. Several respondents highlighted that only being able to access appointments during normal working hours was sometimes problematic in a work context. One respondent stated:

*Appointments are usually during work time so you either take it as your lunch or tell your employer and not all employers are supportive.*

**Figure 3.10 Overall satisfaction with mental health services**



92. Overall, most respondents thought that mental health services were clean (75%). Just over half thought that they were well-maintained (53%) and comfortable (52%) (Figure 3.11). Just under half (48%) thought that mental health facilities including charitable, voluntary and community as well as private services were welcoming.

93. 59% of people thought that Jersey Talking Therapies were welcoming compared to 21% who did not.

## Assessment of Mental Health Services

94. Hospital-based adult mental health services performed less well with 53% of respondents saying that they were not welcoming compared to 36% who thought that they were. 52% of respondents thought that community-based adult mental health services were not welcoming compared to 40% who thought they were. Similarly, 55% of respondents thought that community-based CAMHS services were not welcoming compared to 35% who thought that they were.

95. Of the respondents who were not satisfied with Jersey's mental health facilities, we heard a number of comments about specific facilities. Orchard house (the adult in-patient service) was described as "horrible", "shabby", "out dated", "not fit for purpose" and "going back in time". One respondent said that there was little for patients to do:

*Orchard House is not fit for purpose. Since the regrettable closure of Maison du Lac there is nothing to do. During my recent stay there were no structured activities, patients being generally left to their own devices. The environment was bland, boring and stultifying. Patients were sometimes confined inside during hot weather, apparently due to staff shortages, and there was one fan in the whole building available to patients, and no air conditioning. The food, which becomes important when there is so little to do, was uninspiring.*

96. La Chasse (the adult out-patient service) was described as "tired and pokey", "dated" and the waiting room in particular was described as "very small and daunting". One respondent stated:

*La Chasse is very tired and pokey. The waiting room is really terrible with people actually choosing to sometimes stand outside instead of waiting in it. It is tiny with chairs facing directly opposite each other. Sometimes when the radio is on news stories can come on that might be triggering. There is no water machine (though the receptionist does try to offer it to people on arrival). The rooms are tiny! You struggle when there is more than two people in them. They are very basic and not nicely decorated - it isn't a nice place to go and get treatment. The chairs are old and uncomfortable though one room does have Sofas / comfortable chairs. In the summer the building gets very hot due to no air conditioning and the waiting room is like a greenhouse. It isn't a very uplifting and cared for building - it seems itself quite sad.*

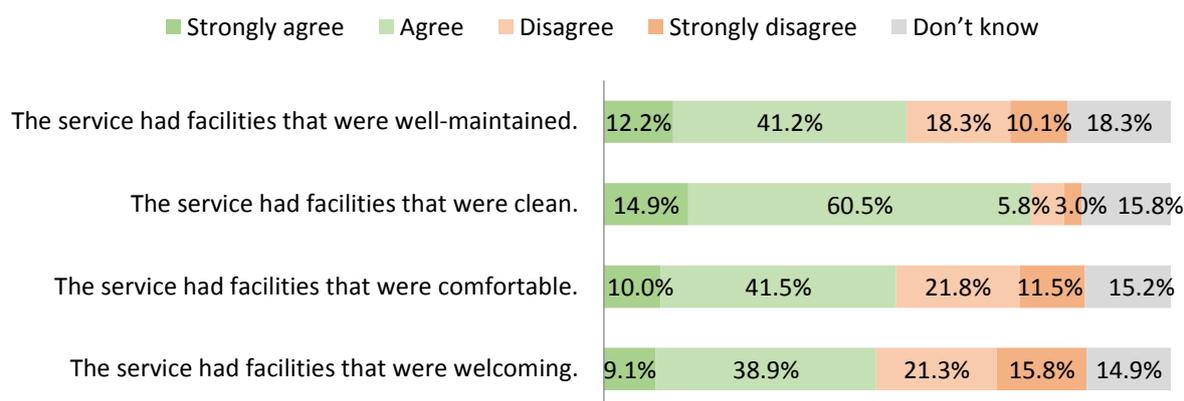
97. The entrance to mental health services was picked up by other respondents. In relation to Jersey Talking Therapies, one respondent stated:

*The office that I went to was above Liberation Station. It was used for other businesses. I felt awkward walking in and asking for my therapist where there were people who could see me. It was sterile and business like. It made me feel uncomfortable.*

98. In relation to CAMHS, one respondent stated:

*The reception is not private and so you have to identify your child's name in front of other clients. There is no privacy to discuss medication requests etc. Jersey is too small so young people bump into other young people and they don't like it. Also, they don't like that it is next door to their social workers. One toilet doesn't flush and it has been broken for a few weeks now.*

**Figure 3.11 Satisfaction with mental health facilities**



99. The majority of respondents were happy with the way they were treated by staff working across mental health services (Figure 3.12). 74% agreed that staff treated them with respect and 69% agreed that staff treated them with compassion. Similarly, 63% of respondents thought that staff were knowledgeable.

100. 57% of respondents thought that mental health staff were good at communicating with them. However, only 35% of people thought that staff were good at communicating with carers of family. The worst performer in this regard was hospital-based CAMHS services where 64% of respondents thought that they were not good at communicating with their family or carers. During our meeting with young people at the Youth Enquiry Service they suggested that CAMHS was not good at communicating with GPs.

101. Respondents were not very satisfied with how flexible mental health staff were. Overall, 38% of respondents agreed that staff were flexible and able to deal with problems and emergencies compared to 39% who did not. Again, 64% of respondents thought that hospital-based CAMHS services were not flexible compared to 36% who thought that they were. Similarly, 48% of respondents thought that community-based CAMHS services were not flexible compared to 32% who thought that they were. Hospital-based adult services also scored poorly with 45% of respondents who thought that they were not flexible compared to 34% who thought that they were.

102. Respondents did not seem to think that mental health staff were available when they needed them. 43% of people thought that they were available compared to 45% who did not. 71% of respondents thought that hospital-based CAMHS services were not there when the respondents needed them compared to 28% who said that they were. 57% of respondents thought that community-based CAMHS services were not there when needed compared to 37% who thought that they were. And 55% of respondents thought that hospital-based adult services were not there when needed compared to 34% who thought that they were.

103. Several of respondents who disagreed with the statements in Figure 3.12 still highlighted positive things about mental health staff who they thought were supportive. Indeed, some respondents highlighted other factors which they believed had contributed to a less than satisfactory experience. This included, for example, a high work load for staff, adherence to guidelines and procedures rather than focusing on the patient, a lack of staff training or

## Assessment of Mental Health Services

experience, a high turnover in staff and too few staff in general. One respondent summed up some of these sentiments stating:

*My experience with staff was mixed - some were really great and were very compassionate others I think had the love of the job beaten out of them by the system - it seems they know that the service could be better but are stuck in a system that doesn't work the best it could.*

*Occasionally I would say something and then find the opposite of what I said in the notes of the meeting - it felt frustrating.*

*I also felt a great divide in how staff approached treatment. Some were clearly more behind medication whilst others were reluctant to give it out - this could be quite frustrating at times - I didn't feel I got to choose so had to adjust depending on who I was seeing.*

*The staff turnover seemed very high - I had 3 CPN's over 2 years as the first two left. I didn't feel the handover was good at all - they seemed to judge you by your notes and weren't interested in adjusting previous recommendations despite the state of your mental health having changed.*

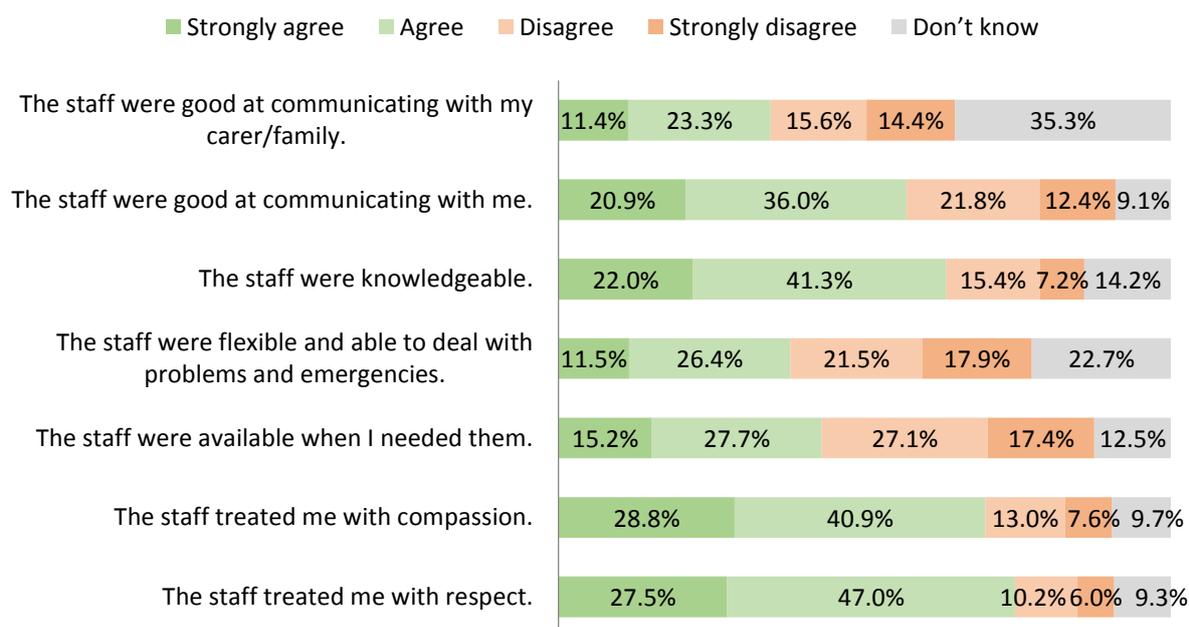
*I felt the service was staff centered rather than people centered. When they felt you were ready was how it was run rather than when you felt you were ready.*

*I feel the staff always said 'it's down to personal responsibility' not acknowledging the fact that you are unwell.*

*They were absolutely terrible at communicating with my family or even actually listening to them. They would assume that how was for the one hour session was representative of how I was the whole week. My mother was calling but it all fell on deaf ears - it was easier to ignore than acknowledge. Instead of accepting what was going on and trying to find a reason my mum was told to 'just call the police' - this really upset both her and I. I also wanted / needed my mum to be part of my recovery but found it difficult as being over 18 staff were reluctant to share information with family even when you had agreed to it - when you are unwell it is vital as I could have been going in and acting fine for a one hour session but in reality hope life could have been very different.*

*When your CPN is sick I don't always think it's handled the best. I would have preferred being called ahead of time and told so I could decide if I wanted to see someone different. When a member of staff sees you who you haven't seen before I feel they haven't read your notes properly and pre judge you.*

**Figure 3.12 Satisfaction with mental health staff**



104. Respondents to the survey had mixed views about their involvement in their own mental health treatment (Figure 3.13). 48% of respondents said that they were involved in developing their care plan compared to 34% who did not. Similarly, 48% said that they had a say in how they were treated compared to 38% who did not. During our meeting at the Youth Enquiry Service we heard that CAMHS was not always empowering young people to make decisions about their care – which was something they felt was important.

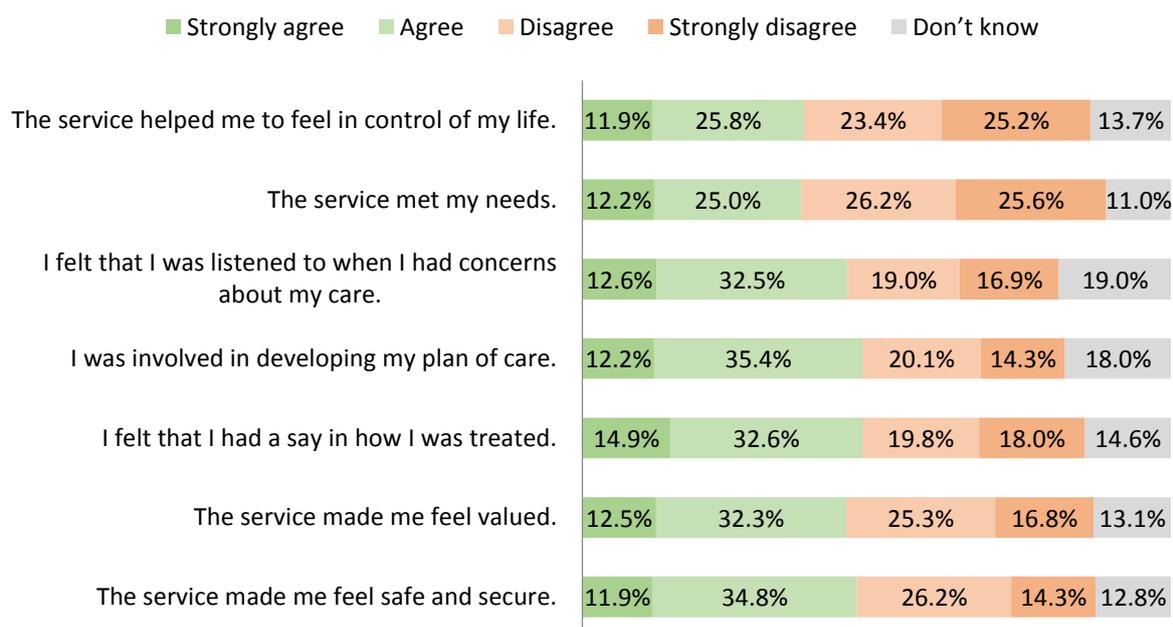
105. 45% of respondents thought that they were listened to when they had concerns about their care compared to 36% who did not. The services scored similarly in terms of making respondents feel valued, safe and secure. Several respondents commented that they did not feel safe in Orchard House (the adult in-patient service). One respondent stated:

*[...] Sometimes dangerous patients are not monitored in Orchard house and I haven't felt safe, perhaps alone in a room with them without staff is not safe.*

106. Where the services performed less well according to respondents was in relation to helping them feel in control of their lives and meeting their needs. 38% thought that the service helped them to feel in control compared to 48% who did not. Respondents from hospital-based CAMHS services (79%), community-based CAMHS services (58%), hospital-based adult services (59%) and community-based adult services (56%) did not think that the service made them feel in control.

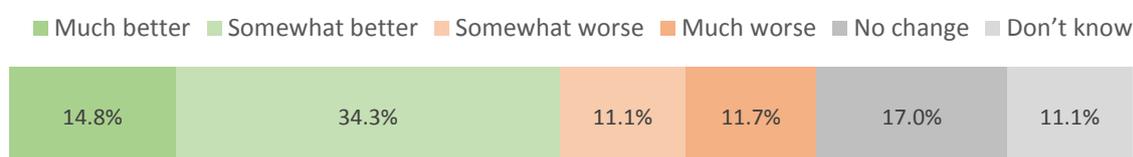
107. Similarly, 37% thought that the service met their needs compared to 52% who did not. Respondents from hospital-based CAMHS services (76%), community-based CAMHS services (65%), hospital-based adult services (63%) and community-based adult services (51%) did not think that the service met their needs.

**Figure 3.13 Satisfaction with user involvement in mental health services**



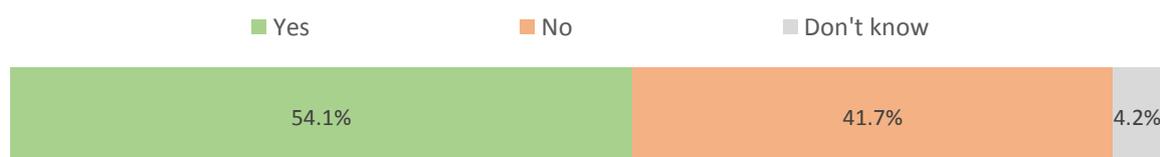
108. 49% of respondents said that their mental health had got better since using mental health services (Figure 3.14). This is compared to 23% who said that it had got worse and 17% who said that there had been no change.

**Figure 3.14 Has your mental health changed since using the service?**

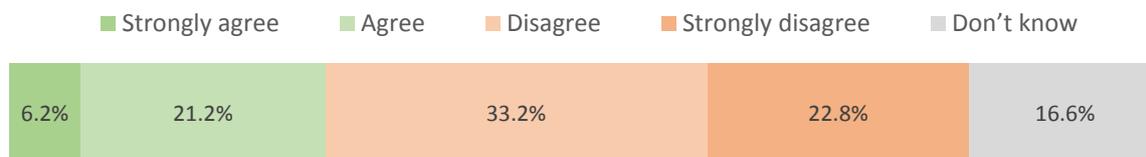


109. Over half (54%) of respondents said that more than one mental health professional or service had been involved in their health care (Figure 3.15). Of these respondents, 27% though these professionals and/or services had worked well together compared to 56% who did not think that they had worked well together (Figure 3.16).

**Figure 3.15 Has more than one mental health professional, or service, been involved in your health care over the last 2 years?**



**Figure 3.16** How much do you agree or disagree that: “the different mental health professionals/services worked well together to manage or improve my mental health”.



**KEY FINDING 4:** In general, mental health service users had a positive experience when using mental health services. However, we note that over a third of respondents said that their mental health had not changed or got worse since using mental health services. Staff in mental health services were considered to be respectful, compassionate and knowledgeable. However, there were a number of issues including unwelcoming services, a lack of out of hour's services, a lack of flexibility, poor communication with families and carers and failing to meet service users' needs.

**KEY FINDING 5:** We believe that our survey has provided a valuable insight into the current state of mental health services. It has highlighted the importance of asking service users their views and opinions about the quality of mental health services.

**RECOMMENDATION 3:** The Government should regularly ask service users for their views and opinions on the quality of the mental health services it provides. In light of our survey, the Government should start this regular engagement in Q1 2020. Regardless of the tools that the Government uses to collect user feedback, the results should always be published.

## 4. Priority Issues to be Addressed

110. During our review, it became clear that there were a number of issues that needed to be addressed as a priority. These included leadership and accountability; investment in services especially in recruitment and retention and improvements to the mental health estate; and improving the “parity of esteem” between mental and physical health.

### Leadership and Accountability

111. The Mental Health Strategy (the Strategy) established leadership and accountability as one of its priority areas. The Strategy stated:

*Effective leadership, both operational and strategic, should be central to the process of transformative change and the embedding of a culture that seeks to promote co- production, recovery and independence within mental health services.<sup>15</sup>*

112. In the “what we will do section”, the Strategy stated that it would do a number of things to help improve leadership and accountability. These included developing “effective service improvement mechanisms”, working towards “a defined set of outcome measures” to “measure the impact and success of services”, and establishing a “monitoring system audits and reviews” mental health services.

113. During our review it became clear that leadership had been an issue since the publication of the Strategy. Contact Consulting stated:

*The initial progress on implementation appears to us to have slowed in more recent times. In our judgment the loss of the Deputy Director of Commissioning, [...] had a direct impact on delivery. [...]. The subsequent splitting of that role, combined with the impact of structural and organisational change has resulted in a lack of day to day, focused leadership.<sup>16</sup>*

114. Stephen McCrimmon, Carer and Family Support Manager at Mind Jersey said that for a period of time there was “no leadership per se” which impacted his organisation but also those people accessing and using services.<sup>17</sup> A submission from Dr Jake Bowley, a Consultant Clinical Psychologist, which included a summary of opinions from his colleagues, also alluded to problems with leadership.<sup>18</sup>

115. It became clear that this lack of leadership had still not been addressed. Contact Consulting stated:

*Over the past 18 months the link between strategy and operational delivery has not been clear enough and this has hampered progress. In the midst of the current organisational change there is a very real risk that mental health development could continue to stutter. It is our view that it requires dedicated*

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<sup>15</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p73

<sup>16</sup> [Contact Consulting](#)

<sup>17</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p20

<sup>18</sup> [Dr Jake Bowley](#)

## Assessment of Mental Health Services

*leadership that is empowered to take forward implementation over the remaining life of the current strategy.*<sup>19</sup>

116. Beth Moore, Manager of Jersey Recovery College said that “there has been so much change, particularly this year, [...] we are not quite sure who the leaders are who should be accountable”.<sup>20</sup> A submission from Jersey’s Child and Adolescent Mental Health Services (CAMHS) suggested that regular changes in leadership were unsettling:

*[...] regular changes in the leadership team are unsettling and lead to frustration as history is lost and much time is spent focusing on structural changes rather than attending to business as usual and clinical governance.*<sup>21</sup>

117. Following our hearing with Mind Jersey and the Jersey Recovery College, it was announced that executive responsibility for mental health would lie with the Group Managing Director of Health and Community Services and clinical leadership would lie with the Chief Nurse and a newly appointed Acting Clinical Director for mental health.<sup>22</sup>

118. The Minister for Health and Social Services told us that these changes were made as part of the Department’s new Target Operating Model.<sup>23</sup> Robert Sainsbury, the Group Managing Director said, “there was always going to be one managing director for the service taking over the whole of the Health and Community Services structure; there were previously 2 managing directors”.<sup>24</sup> The new Acting Clinical Director said that the opportunity “just materialised in the last two weeks”.<sup>25</sup>

119. During our review we learnt that a new Mental Health Improvement Board had been established.<sup>26</sup> The Minister said that it had been set up to “ensure that we make improvements and meet people’s needs”.<sup>27</sup> The Board is chaired by the Director General for Justice and Home Affairs Department. Its membership consists of Officers and some external stakeholders such as Mind Jersey. While the Board had heard from service users, it does not include anyone with “lived experience” of mental health.<sup>28</sup> The Minister said, “that sort of user interface I would hope might come through the user body that we intend to establish with the new governance board that we are going to be setting up shortly”.<sup>29</sup> The Board reports to the Director General of Health and Community Services.

120. Stephen Appleton from Contact Consulting said that he thought it was “inappropriate” for the Board to be chaired by the Director General of Justice and Home Affairs. He said:

*[...] 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*

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<sup>19</sup> [Contact Consulting](#)

<sup>20</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p20

<sup>21</sup> [Child and Adolescent Mental Health Services \(CAMHS\)](#)

<sup>22</sup> Email from Interim Director General for the Department of Health and Community Services to Departmental employees, 11 December 2018

<sup>23</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p3

<sup>24</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p4

<sup>25</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p5

<sup>26</sup> Health and Social Security Panel [Minutes](#), 2018

<sup>27</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p5

<sup>28</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p6

<sup>29</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p6

*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.*<sup>30</sup>

121. We asked why the Director General of Home Affairs was chairing the Board. The DG was described as “an independent chair” that would “provide scrutiny” on the departments progress.<sup>31</sup> The Minister said that this was “valuable because it underlines the fact that this is a service that cuts across so many departments and aspects of States working, so Mr. Blazeby brings his experience within the police service and the justice system, which have that crucial role within mental health issues as well. It means that I hope we can work better or have a better overview of all needs within the service”.<sup>32</sup>

122. We asked the Minister how he is kept informed of developments in relation to health and mental health. The Minister said:

*Yes, once a month, or perhaps not exactly once a month, but they are ministerial meetings at which I meet with various heads of service within the department and I receive briefings on all that is going on and we discuss issues of importance. I also receive the agenda and background papers for the management executive and am able to ask questions. I have regular meetings with the director general and with Mr. Sainsbury and of course there is just the normal day-to-day inquiries that we make, the emails that fly between us, the casual meetings or more organised meetings about specific subjects. So there is a lot of activity.*<sup>33</sup>

123. We also asked the Minister what his impression was of the current state of mental health services. He said:

*My impression is of a service that has been put under very great strain and is obviously, we know, not staffed as fully as it should be at the moment, but nevertheless those who work in it are producing excellent work under a lot of pressure and are dedicated people and care deeply for the people they have under their care. But they need support, better support, and we need to complement them with additional appointments and to bring our numbers up. That is clearly the greatest pressure we face at the moment I believe.*<sup>34</sup>

**KEY FINDING 6:** There has been a lack of political and executive leadership focused on improving mental health services in Jersey. This has had a detrimental impact on efforts to implement the Mental Health Strategy and improve services.

**RECOMMENDATION 4:** The Government should consider the merits of having a designated Minister for Mental Health to provide sufficient leadership for mental health in Jersey. Alternatively, the Government should transfer official responsibility for

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<sup>30</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p12

<sup>31</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p7

<sup>32</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p7

<sup>33</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p8

<sup>34</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p8

**mental health to a designated person. The Government should demonstrate that it has considered this matter and set out its decision in response to this report.**

**KEY FINDING 7:** We are seriously concerned about the structure of the Mental Health Improvement Board. We are concerned that it is chaired by the Director General of the Department of Justice and Home Affairs and we are concerned that it does not have anyone with lived experience of mental health services on the Board.

**RECOMMENDATION 5:** The terms of reference, membership and reporting lines of the Mental Health Improvement Board should also be made public. The Board should be chaired by a senior officer in Health and Community Services. Membership of the Board should include operational representatives from all frontline services that interact with mental health as well as appropriate third sector organisations. Its membership should also include at least two people with lived experience of mental health problems.

## Investment in People and Places

124. The Mental Health Strategy described the “financial landscape” for mental health in 2015. It highlighted that a number of investments had been made in preceding years to establish, for example, Jersey Talking Therapies. The Strategy also stated that the “financial landscape in Jersey is changing”. It highlighted that “Jersey faces the challenge of providing high quality services at a time when the allocation of public resource and the provision of new investments is more limited than has perhaps been the case in the past”. It went on to state:

*The scope for further investment will, in the view of most stakeholders, need to be balanced with a sharper focus on productivity and effectiveness, and working in new and innovative ways that will cost the same or less.<sup>35</sup>*

125. During our review it became apparent to us that a lot of the improvements required in mental health services were dependent on financial investment. Some of these were essential to ensure that the service was able to function properly and included recruiting and retaining staff and investing in the mental health estate.

126. Stephen Appleton from Contact Consulting described a change from when the Mental Strategy was published in 2015 to now:

*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, [...]. 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 [...].<sup>36</sup>*

127. Dr David Bailey, a GP and representative from the Primary Care Body neatly set out the impact this change in investment was having on the Drug and Alcohol Service where he provides his services:

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<sup>35</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p43

<sup>36</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p12

## Assessment of Mental Health Services

*It all just boils down to the money. For example, the Alcohol and Drugs Service, it runs out of an old building that is dilapidated; it is not fit for purpose. [...] If you look at the Health and Community Services playing our part in the government, which was emailed to us last week, one of the underlying themes is that: "We must work within available budgets", bold. That seems to come through as very much the theme that they are trying to ask for more and more with ... there is an increasing demand from C.A.M.H.S., for example, and the budget is not there. The Alcohol and Drugs Service have got half in equivalence of consultant psychiatrists; they need a full-time psychiatrist. Despite trying to get more G.P.s involved in looking after people with substance misuse, there is only me and another part-time G.P. who is about to leave the Island. There is no funding for it. Mental Health are not going to increase the amount of psychiatric support for the Alcohol and Drugs Service anytime soon.<sup>37</sup>*

128. In general terms, both the Minister and the Group Managing Director agreed that more investment in mental health services was required.<sup>38</sup> The Group Managing director said how this would be done:

*There needs to be more investment undoubtedly. We need to shift our transformation funding into the mental health remit. The area where we have identified we would probably do that is crisis prevention and intervention. We think that is quite sizeable, it is over £1 million, potentially up to £1.2 million that we would need to invest. I just need to caveat that with: we cannot establish these services until we have addressed our overall staffing deficits because you would just be taking staff from a really hot area into another area, making it even worse; so we have got to get our vacancies sorted. We then, once we have done that, can then start to build on those kinds of transformation approaches.<sup>39</sup>*

**KEY FINDING 8:** Mental health services have suffered from a lack of investment over a sustained period of time. The improvements required in mental health services are dependent on increased financial investment. Some of these improvements are essential to ensure that the service is able to function properly and include recruiting and retaining staff and enhancing the mental health estate.

## Recruitment and Retention

129. The Government's response to our review suggested that there were likely to be long term issues with recruitment of key staff such as psychiatrists and mental health nurses.<sup>40</sup> It became clear, however, from the evidence we received from clinicians that recruitment was a past and ongoing problem. Dr Miguel Garcia, Consultant Psychiatrist in Adult Mental Health Services said:

*There has been a history of chronic underfunding and a reasonable level of vacancies between 20 per cent of medical staff.<sup>41</sup>*

<sup>37</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p10-11

<sup>38</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p13-14

<sup>39</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p14

<sup>40</sup> [Health and Community Services Department](#)

<sup>41</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p9

130. Mike Swain, a clinical nurse practitioner with the Adult Mental Health team said that money was available for their vacant posts but that they couldn't get anyone to fill those posts.<sup>42</sup> A submission from Child and Adult Mental Health Services (CAMHS) stated that they had struggled to recruit nurses because "salaries are not sufficiently competitive to attract candidates from the UK to move to Jersey". The submission explained that "people accept posts and then decline them once they have visited estate agents and understand the poor quality of accommodation that they can afford".<sup>43</sup>

131. Beth Moore, Manager of Jersey Recovery College highlighted that staff shortages in clinical roles had impacts on other services in the Island. For example, staff shortages had impacted the Recovery College's ability to fulfil its remit because it worked with clinicians to deliver its courses.<sup>44</sup> This was echoed by Stephen McCrimmon, Carer and Family Support Manager at Mind Jersey who said:

*I would just echo that. I was at a meeting on Thursday and our community psychiatric nurse informs me that the community team are 12 members of staff down, so for us to try to work in joint partnership when they are trying to work from a caseload that they are just taking more and more on is really difficult.*<sup>45</sup>

132. The Minister for Health and Social Services and the Group Managing Director said that increasing staffing levels was a priority.<sup>46</sup> In relation to mental health nurses, this would target experienced staff from off the Island as well as training staff locally. Rose Naylor, the Chief Nurse, said that they had 5 nurses on a training programme at present. She said that their aim was to work with Guernsey to offer more opportunities locally and have a "Channel Islands programme" by 2020.<sup>47</sup>

133. To attract nurses from off Island they were promoting C.P.D. (Continuous Professional Development) opportunities such as degree and masters courses. They were also working on improving how people move to the Island by supporting, for example, their initial accommodation and housing needs. In addition to this they were also going to launch an "on boarding" service called "Welcome Jersey". Local companies would provide a single point of contact to successful applicants and assess their housing needs, their child care needs and help them to obtain a social security number.<sup>48</sup>

134. Dr Laura Posner, Consultant Clinical Psychologist at CAMHS told us that they also had trouble recruiting but that they were proactive and that staff in the team were providing "goodwill" in their own time to support new colleagues to come to the Island, including helping them to look for accommodation.<sup>49</sup>

**KEY FINDING 9:** Prospective candidates applying for mental health roles often reject offers when they understand the implications of Jersey's high cost of living. These recruitment problems have led to a lack of staff in mental health services.

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<sup>42</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p19

<sup>43</sup> [Child and Adolescent Mental Health Services \(CAMHS\)](#)

<sup>44</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p10

<sup>45</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p11

<sup>46</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p13-14

<sup>47</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p10

<sup>48</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p12

<sup>49</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p20

**KEY FINDING 10:** Programmes to increase the pool of home grown mental health staff in Jersey is very positive. However, it is unlikely to solve the immediate staff shortage problem.

**RECOMMENDATION 6:** If prospective candidates applying for mental health roles cannot afford to live in the Island then either salaries need to increase or a way of mitigating the high cost of living need to be found. The salaries of key mental health staff should be reviewed and adjusted so that they are competitive with the UK when Jersey's cost of living is taken into account.

**RECOMMENDATION 7:** In addition to assisting with pay and cost of living, the Government should do more to help successful applicants with moving and settling in the Island. The Government could provide for example, resettlement loans/grants, assistance with the cost of importing a vehicle, registering for a driving licence, obtaining a registration card and childcare.

**RECOMMENDATION 8:** Recruitment and retention problems in Jersey's mental health services should not prevent the Government from making progress on improving these services. Regardless of whether the number of staff increases, the Government should focus on improving ways of working within current resource constraints and focusing on investing in existing staff by giving them access to, for example, appropriate training.

## Mental Health Estate

135. The Mental Health Strategy recognised that the buildings from which mental health services are run require development and money to be invested. The Strategy stated that "the need to re-provide the existing adult acute inpatient service (Orchard House) in more suitable accommodation has been identified as a priority". The Strategy said that a "detailed mental health estates strategy" would be developed "to identify the longer-term mental health inpatient and community services requirements in relation to buildings and office accommodation".<sup>50</sup>

136. During our review the mental health estate was repeatedly flagged as being "not fit for purpose" by most of the people we spoke to. The quality of the estate was having a detrimental effect on both staff and service users. This was supported by the results of our review (see Chapter 3) and by our own visits.

137. Our impression of Orchard House (adult in-patient services) was that it was dilapidated and uninviting. It is tucked away out of sight behind the old St Saviours hospital which is dilapidated and looms over the building. You have to walk past St Saviours hospital to reach Orchard House. In a non-patient area, there were pictures on the wall detailing how staff would restrain patients in the event that they were violent. The communal areas were tired with nothing much to do but watch TV. At the time of our visit there was no visible interaction between staff and patients or between patients. There appeared to be no therapeutic practice taking place with patients. People's rooms felt like prison cells, again with little, if anything, to do. Some patients appeared to be wearing hospital style clothes and others were wearing their personal clothes.

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<sup>50</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p12

## Assessment of Mental Health Services

138. When we were collecting personal testimony several people comments on Orchard House. One person told us:

*[Orchard House] was not a place really where somebody with severe anxiety is going to get better. It was not a great place to be.*

139. Another person said:

*That was the most unwelcoming place to go into, and yet there are some fantastic people up there.*

140. La Chasse (adult out-patient services) was similarly uninviting with a small and cramped reception room, small run down meeting rooms with walls so thin that you can hear conversations in adjoining rooms.

141. Jersey Talking Therapies (JTT) and Child and Adolescent Mental Health Services (CAMHS) services were in new offices. However, this presented its own challenges. JTT was housed with a number of private businesses. People visiting had to announce themselves at a general reception and wait with people visiting other businesses. They then had to walk down a very long corridor past the other businesses on the floor. CAMHS is situated on a main thoroughfare on a prominent route for school children walking from school to town.

142. In response to our review, the Government stated that work to improve the mental health estate was still ongoing. It had completed a “Strategic Outline Case” following a “feasibility study”. The Government said that this work described a “case for change” and that it was “currently being reviewed” to “ensure the business case is fit for purpose in the current context”.<sup>51</sup> It is not clear what this means. We note that the Government stated in response to a written question that the Department for Health and Community Services was looking into “the anticipated costs for general maintenance for the community sites, including Orchard House and La Chasse”.<sup>52</sup>

143. In 2018 health and safety improvement notices were served by the Health and Safety Inspectorate in relation to Orchard House. These had been issued for “failure to adequately manage violence and aggression and ensure a safe environment in a healthcare setting”.<sup>53</sup> We understand that money is being invested into Orchard House in order to comply with these notices, despite plans to close Orchard House in the medium-term.<sup>54</sup> The Minister said:

*So there is work being carried out on Orchard House at the moment, complying with the statutory notice that was served on the department, but the medium-term intention is that Orchard House should be closed and that we should create a new facility across the road at Clinique Pinel and there are plans being worked up to create that facility. There is a wider or broader plan to move all those facilities presently in St. Saviour to Overdale, but I think at the moment we have kind of put a pause on that because you cannot do too much at once and I think we have got to make sure that Orchard*

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<sup>51</sup> [Health and Community Services Department](#)

<sup>52</sup> [Written Question](#) to the Minister for Health and Social Services by deputy Kevin Pamplin of St. Saviour, Tuesday 26th February 2019

<sup>53</sup> Enforcement notices issued by the Health and Safety Inspectorate, January to June 2018

<sup>54</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p16

## Assessment of Mental Health Services

*House is safe and improved for the very short term, and then we have got to concentrate quickly on getting the work at Clinique Pinel done.*<sup>55</sup>

144. The Group Managing director said that up to £2.4 million had been allocated for an “alternative physical environment”.

**KEY FINDING 11:** The quality of the mental health estate is completely unacceptable. Many of the buildings are dilapidated, uninviting and not fit for purpose. This is having a detrimental effect on staff and service users. In some cases the poor quality of the estate is failing to keep both service users and staff safe. It is highly likely that this is having a negative impact on recruitment of mental health staff.

**KEY FINDING 12:** Orchard House (the Islands adult in-patient mental health service) is particularly bad. It recently failed a health and safety inspection. We received a significant number complaints about Orchard House via our survey, when collecting personal testimony and from our expert witnesses. In particular we note that there appeared to be little therapeutic activity for patients to do while they are there.

**RECOMMENDATION 9:** The government should prioritise finding a replacement for Orchard House in the short to medium term. The Government should also improve governance within Orchard House including setting appropriate standards and performance processes to ensure that staff but especially service users remain safe. These should be developed and implemented by the end of 2019.

## Co-locating Services

145. During our review we asked stakeholders how the issues around the mental health estate could be improved. In particular, we asked people whether they thought mental health services should be co-located with physical health services such as the future hospital. We note that some mental health services used to be located in the General Hospital and that some emergency CAMHS services are currently located in the General Hospital.

146. Robert Sainsbury, Group Managing Director of the General Hospital described how services were organised in the UK and said that it varied. Some mental health services were integrated into hospitals, some were situated side by side on a campus and other facilities are standalone.<sup>56</sup>

147. The Minister said that there were some instances where it would be appropriate for mental health services to be located in a general hospital but others where it would not:

*[...] there is no easy answer that it should be one or the other, and the truth of the matter is you should probably provide some mental health services within a general hospital because there will be people with needs that are physical and mental and there will be those acute needs too. But there are also needs that could well be better served separated from a general hospital.*

<sup>55</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p16

<sup>56</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p19

## Assessment of Mental Health Services

148. Dr Miguel Garcia, Consultant Psychiatrist for Adult Mental Health said that for him the important thing was that regardless of where the services were sited, proper integration needed to happen between physical and mental health:

*[...] the important thing is that whatever the building that it really captures the needs of proper integration and there has to be a shared care approach to patients in general. It is now widely recognised that anybody who is in the hospital with any sort of physical health issues with a comorbidity with mental health issues that is in different addresses, different places is going to be much less appealing. For me it is not so much about the building as much as it is that it really promotes and ensures that integration is happening.<sup>57</sup>*

149. In written evidence, Mind Jersey recommended that “a comprehensive redevelopment plan for the mental health estate is urgently required to bring together disparate services onto a new health campus – co-located with other services – in order to improve patient experiences, increase efficiency, retain staff and reduce stigma.”<sup>58</sup>

150. Beth Moore, Manager at Jersey Recovery College said that she though the question about where future mental health services should be located needed to be consulted on widely and co-produced between those who deliver the services and those who use them:

*[...] To really understand the answer to that question, I think there should be a huge piece of coproduction work between those who deliver services and those who use them to find exactly what people want, so the employees that will be working in this space feel that it is appropriate for them and people accessing services and their families feel it is appropriate for them too.<sup>59</sup>*

**KEY FINDING 13:** The Government has the potential to create a world class mental health facility. In order to achieve this, we believe that as far as possible, mental and physical health services should be co-located. The redevelopment of Jersey’s general hospital means that this is an ideal time to incorporate mental health it into the planning for the future hospital.

**RECOMMENDATION 10:** As part of its work to develop a new General Hospital, the Government should conduct an assessment of what mental health services could be co-located with the future hospital.

## Place of Safety

151. For people suffering from a severe mental disorder, Jersey’s mental health law allows police officers to detain people in a “place of safety” where they may be assessed by a doctor.<sup>60</sup> In Jersey people are often detained in cells in the Police Headquarters. However, we also know that people are sometimes detained at Orchard House and that children are sometimes held in the children’s ward (called Robin Ward) at the General Hospital. It was generally agreed that environments such as police cells were not appropriate for people suffering from a mental disorder.

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<sup>57</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p24-25

<sup>58</sup> [Mind Jersey](#)

<sup>59</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p19

<sup>60</sup> [Mental Health \(Jersey\) Law 2016](#)

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152. The Mental Health Strategy stated that “we will work with the Home Affairs Department to establish an appropriate site and operational service model for a Place of Safety in Jersey. This will include specific provision for medical and nursing support within the Place of Safety when it is occupied”.<sup>61</sup> In response to our review the Government stated that work was ongoing with health and the criminal justice system to develop a “place of safety”.<sup>62</sup>

153. In written evidence, the States of Jersey Police (SOJP) highlighted that there was a lack of “appropriate secure facilities and suitably qualified staff to restrain and manage problematic patients as well as an appropriate place of safety suite”. The SOJP highlighted that young people and adults suffering from mental health problems often end up in police cells. It stated:

*At present, ideally children get routed through the Emergency Department (ED) to Robin Ward as a place of safety and adults go from ED to Orchard House with an overflow to Emergency Admission Unit (EAU). However, the reality is the police often end up with young people and adults in police cells due to inadequate facilities and insufficient resource levels. [...] The default position is that Police and ED staff are often left to use either ED or police cells/facilities as an operational workaround.*<sup>63</sup>

154. Stephen McCrimmon, Carer and Family Support Manager at Mind Jersey described how this might work in practice:

*[...] I always try to relate it to a loved one, so I think of my daughter, who is 21, and I think that if she developed a mental health crisis, I phone the police, the police turn up with their flashing lights, she goes into the car, sometimes that can be traumatic in itself. They then take her to the place of safety, which can be the police station, so she is in a cell where she has got to wait for a psychiatrist to come in. The whole experience ... and this is for a mental health problem, this is not for somebody that has broken the law, but this is all we have got in Jersey.*<sup>64</sup>

155. David Ogilvie, Managing Director, Resilience Development Company described the lack of a place of safety as “Victorian” and “inherently wrong”.<sup>65</sup>

156. In relation to young people, Dr David Bailey, Primary Care Body said that having nowhere to admit children was “shameful”.<sup>66</sup> During personal testimony we heard about one person’s difficulty of being based in Robin Ward, which lacked staff trained to look after children and young people in mental health crisis. Ben Bennett, Chair of the Board of Jersey Recovery College said that he thought child and adult places of safety should probably be separate. Liz Kendrick-Lodge, Service Development Manager at Mind Jersey added that the just because a person has turned 18 doesn’t necessarily mean that they

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<sup>61</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p68

<sup>62</sup> [Health and Community Services Department](#)

<sup>63</sup> [States of Jersey Police](#)

<sup>64</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p12

<sup>65</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p30

<sup>66</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p28

should be in a place of safety with adults.<sup>67</sup> We heard from Deborah McMillan, the Children's Commissioner and from Stephen McCrimmon at Mind that young people as young as 16 and perhaps younger have been detained at Orchard House.<sup>68</sup>

157. Much of this was confirmed during our meeting with young people at the Youth Enquiry Services. The young people we met highlighted that it was inappropriate for young people to have to go to A&E when they had mental health problems. Their issues included a lack of privacy in the A&E waiting room, having to wait for long periods of time before being seen, being seen by an adult mental health clinician rather than a CAMHS clinician, and a general sense that A&E staff see people with poor mental health as a problem, especially if they don't have physical problems. The young people we spoke to said that they would like a safe place, such as a house with a homely environment, specifically for young people where they could stay.

158. Stephen Appleton, Managing Director at Contact Consulting said that setting up a place of safety in Jersey should have been achieved some time ago:

*The provision of a place of safety, [...] 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.<sup>69</sup>*

159. The Minister told us during our public hearing that a place of safety was being "created now" in the hospital and was not part of the emergency department.<sup>70</sup> Robert Sainsbury, the Group Managing Director of Health and Community Services, said that:

*We have got the space, the room. We have sorted that. We have a capital plan around that, but the limitations are you have got to have staff who are able to respond to a crisis, do the assessment, provide the support required and then support the pathway, wherever that would be. That is why our plan for the place of safety, similar to the crisis prevention initiative overall, is so intrinsically linked to how we address the current issues with staff across our units, not just inpatient but the community as well. You have got to sort that first before you can offer that kind of a service.<sup>71</sup>*

160. The Group Managing Director of Health and Community Services, said that he was looking at the problem of keeping children suffering with severe mental health problems in Robin Ward in the General Hospital. He said that the situation was "very challenging and difficult" and that there was work being undertaken to try and improve the situation in the short-term but also looking at how it could be improved in the long-term.<sup>72</sup>

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<sup>67</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p13

<sup>68</sup> Public hearing with the [Children's Commissioner](#), 10 December 2018, p14; Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p13

<sup>69</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p10

<sup>70</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p20

<sup>71</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p22

<sup>72</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p23

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161. In addition to places of safety for severe cases, the Minister also described other places that they were looking to create, where people could go to receive help in a time of need, including a “listening lounge”. He said “it is not an emergency department, it is not a police station. It is a place where people can go, it is non-threatening, and receive some therapy, some help”. We note that this idea sounds similar to Clairvale House which used to provide similar services but which was closed down several years ago. During personal testimony several people mentioned the detrimental impact the closure of this service had had on them or their loved ones.

162. Karen Wilson, Interim Director of Quality, Governance and Nursing (Community) said that they were also looking at what services could be supported by other organisations and through technology.<sup>73</sup>

**KEY FINDING 14:** Jersey does not have an appropriate place of safety for children or adults in a mental health crisis. People in crisis are often detained in inappropriate environments such as police cells. It is inappropriate for young people to be detained on Robin Ward (the children’s ward in the General Hospital) or Orchard House (the Islands adult in-patient mental health service).

**RECOMMENDATION 11:** An appropriate place of safety should be created within the existing hospital until an alternative arrangement can be found. Children and adults in mental health crisis should be separated.

**RECOMMENDATION 12:** The Government should explore alternative options for dealing with people in crisis. This could include, for example, “crisis intervention teams” which provide a more patient centred approach.

## Parity of Esteem

163. The Mental Health Foundation describes “parity of esteem” as valuing mental health equally with physical health.<sup>74</sup> This means that those with mental health problems would benefit from equal access to the most effective and safest care and treatment. It also allows health and social care services to provide a “whole-person” response to a person’s care with their physical and mental health needs treated equally.

164. David Ogilvie, Managing Director, Resilience Development Company:

*There is an argument when we are talking about mental health, which is just exactly the same as physical health, exactly the same. Where we can get to the point where we are able to talk about mental health in exactly the same way as physical health; that is when we would have moved on. [...] <sup>75</sup>*

165. Liz Kendrick-Lodge, Service Development Manager at Mind Jersey said that parity of esteem between physical and mental health was being taken more seriously in the workplace:

*There is much more of a recognition now that in the workplace we need that kind of parity of esteem between physical and mental health. Nobody has a*

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<sup>73</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p20-21

<sup>74</sup> [Mental Health Foundation](#)

<sup>75</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p30-31

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*health and safety policy that does not include some sort of procedure around how your physical first aiders are in the workplace, what percentage of them et cetera, is it a requirement, is it not? But we are not quite there yet when it comes to mental health. You are much more likely in the workplace or in a school, in an education setting, to come across a young person who is experiencing mental distress or a colleague who is experiencing mental distress than you are a lot of physical health conditions. I think there is still quite a way to go.<sup>76</sup>*

166. This was evidenced by Mark Le Feuvre and Lee Beech from JT who described the work their organisation was doing to address mental health including securing a Director level sponsor, improving HR policies and providing mental health first aid training to staff.<sup>77</sup>

167. The Mental Health Strategy references parity of esteem in the context of “co-morbidity” where physical health problems, especially long-term health problems, cause mental health problems. The Strategy highlighted that given mental health services were separate to physical health services achieving parity was difficult. It stated:

*In Jersey 10% of the population has a long-term illness or condition that affects their day- to-day life. The top three causes of death in Jersey are ischemic heart disease, stroke and lung cancer. This suggests that there is a high likelihood of significant co-morbidity in relation to mental ill health. Given that mental health services in Jersey, as in many other places, are separate from physical health services, there remains a challenge in responding to mental health and physical health needs with any degree of parity.<sup>78</sup>*

168. In describing how mental health services had changed since the launch of the mental health strategy in 2015, the Government’s written response stated:

*Parity of esteem: We are in the early phases of improving the parity of esteem between physical and mental health issues across all our services but the message is getting through and getting recognized.<sup>79</sup>*

169. Lucy Nicolaou, Mental Health Nurse and Manager at L.I.N.C. Mental Health & Wellbeing suggested that service users would probably not get the impression that physical and mental health had reached parity of esteem because of the quality of the mental health estate.

*When we are working with people they are very receptive to the environments in which we are supporting them in. If they are getting the message that the furniture is old and things are falling apart and it does not really send a message that they are valued and that we care and that they are important. You would not expect to walk into the General Hospital and see the same kind of issues I think that you would sometimes walking into mental health facilities. There is definitely a difference; it is quite stark. I think it goes back to what you were saying, there should not be any difference in*

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<sup>76</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p8

<sup>77</sup> Public hearing with [JT](#), 13 December 2018

<sup>78</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p26

<sup>79</sup> [Health and Community Services Department](#)

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*the way that we deliver care, the way we consider mental health care; it should not be any different.*<sup>80</sup>

170. This point was also made by Dr Catherine Keep, Consultant in Child and Adolescent Psychiatry at C.A.M.H.S. who said:

*I think it comes down to one of the things again about parity of esteem for mental health problems as well, the buildings that we see our patients in being of equal quality to the buildings where we would see people with physical health problems. Also I think this is a great opportunity to build those links between mental health and physical health with all the discussions that are going on about the health estate at the moment. But I think it is just something about recognising that mental health problems are as important as physical health problems.*<sup>81</sup>

**KEY FINDING 15:** Parity of esteem, treating physical and mental health equally, has benefits for patients and staff. It allows health and social care services to take a “whole person” approach to peoples care.

**RECOMMENDATION 13:** The Government should adopt the parity of esteem concept and develop a plan for how it will be integrated into health and social care services. This concept should be reflected in the Mental Health Improvement Board’s terms of reference.

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<sup>80</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p32

<sup>81</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p21-22

## 5. Other Areas to be Addressed

171. In addition to the priority areas outlined in Chapter 4, we have identified a number of other areas that we feel could be improved within Jersey's mental health services. These include co-production, partnership working, the role of general practitioners (GPs), issues around the proposed separation of child and adult services, models of care and transgender pathways.

### Co-production

172. Jersey Recovery College included a definition of co-production in its written evidence. It defined co-production as:

*Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.*

173. In written evidence, Contact Consulting, a company that was involved in the development of the Mental Health Strategy, stated that "the approach taken [to developing the Strategy] was one of co-production with local professionals and organisations. Engagement with the public, professionals and service users was a central part of the process".<sup>82</sup>

174. In the Mental Health Strategy itself, it mentions co-production in the priority area, leadership and accountability. It states:

*Effective leadership, both operational and strategic, should be central to the process of transformative change and the embedding of a culture that seeks to promote co- production, recovery and independence within mental health services.*<sup>83</sup>

175. In the 'what we will do' section it states that it will establish a "multidisciplinary Community of Practice for Mental Health, which will include service users and carers and support practitioners from different disciplines not only to work together, but to explore how they are accountable to each other".<sup>84</sup>

176. The Recovery College highlighted how it used co-production to design and run its service.<sup>85</sup> Beth Moore, Manager at the Recovery College said that one of its charitable aims was to promote the benefits of co-production. She stated:

*[...] the recovery colleges sit as catalysts for change within mental health services. The way that that works is that practitioners work within recovery colleges, they design and deliver courses alongside people with lived experience, they sit on our board, they help us shape our service. Everything we do is coproduced with mental health professionals and they take that recovery-focused practice and those insights from people with lived*

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<sup>82</sup> [Contact Consulting](#)

<sup>83</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p73

<sup>84</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p75

<sup>85</sup> [Jersey Recovery College](#)

*experience back into their day-to-day practice. That is how you influence change.*<sup>86</sup>

177. Ben Bennett, Chair of the Board of Jersey Recovery College pointed out that co-production “starts from the bottom-up and can’t be rushed”.<sup>87</sup> The representatives from Mind Jersey and Jersey Recovery College who attended our public hearing highlighted that people with lived experience were not a homogenous group – which requires those people who are designing services to work with service users in different ways. These representatives also argued that these service users needed to be remunerated for their contribution.<sup>88</sup> They observed that when service users were asked to contribute, they were often asked to contribute significant amounts of time and expertise for free.

178. Liz Kendrick-Lodge, Service Development Manager at Mind Jersey argued that without co-production we will never have quality services:

*We will never in Jersey have a quality mental health service unless we have coproduction and participation. We will never have a quality service. It will not exist, because it is impossible. We have to have coproduction and we need to be listening to the voices of those people using services.*<sup>89</sup>

179. Despite this, the representatives from Mind Jersey and Jersey Recovery College described how consultation with people with lived experience was often an “after thought” or “tokenism” that happened towards the end of a project rather than at the beginning.<sup>90</sup>

180. In its written response to our review, the Government said that it was using “engagement and participative approaches such as the Citizens Panel and action learning sets have helped to deliver the priorities identified in the strategy”. However, this work appears to have been focused on awareness raising and engagement programmes and events only.<sup>91</sup> It also highlighted that services across the States of Jersey had signed up to a new “Target Operating Model” as part of the new One Government plan that aimed to ensure, among other things, co-production with individuals and families.<sup>92</sup>

181. Rob Sainsbury, Group Managing Director at Health and Community Services said that the Mental Health Improvement Board had “brought in some service users to the board so we can hear their experience of the service”. However, as we established in chapter 4, service users are not members of the Board. The Minister said, “That sort of user interface I would hope might come through the user body that we intend to establish with the new governance board that we are going to be setting up shortly. We want a user group in that, which I anticipate would include those sorts of people you have just spoken of”.<sup>93</sup>

182. The clinicians we spoke to were very clear that they worked with people to develop care plans in collaboration. Mike Swain, clinical nurse practitioner with the Adult Mental Health team said, “we work on a co-constructed model where, you know, nothing about me without me basically ... that we would ask people to be involved in every stage of their care

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<sup>86</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p10

<sup>87</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p22

<sup>88</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p25

<sup>89</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p23-24

<sup>90</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p22

<sup>91</sup> [Health and Community Services Department](#), p9

<sup>92</sup> [Health and Community Services Department](#), p22

<sup>93</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p6

plan and their treatment. [...] Everything is individualised [...].<sup>94</sup> Dr Miguel Garcia, consultant psychiatrist said, “it is a joined-up way of working”.<sup>95</sup> Dr Catherine Keep, Consultant in Child and Adolescent Psychiatry in Child and Adolescent Mental Health Services (CAMHS) said, “we do not use terminology like co-production quite so much but it is that theme that we are working together to come up with a care plan that is going to work for the child and family together”.<sup>96</sup>

**KEY FINDING 16:** Co-production means delivering mental health services in partnership with service users and mental health professionals. There is evidence to suggest that empowering service users is a good way to deliver services. The Government has said that it uses co-production but we have seen little evidence that this is the case – especially in relation to refreshing the Strategy and improving services through the Mental Health Improvement Board.

**RECOMMENDATION 14:** The Government should adopt a genuine co-production approach to the design and ongoing delivery of Jersey’s mental health services. People with lived experience should be empowered and involved in all aspects of mental health strategic and operation development including having a voice at corporate management level. These people should also be remunerated for their contribution.

## Partnership Working

183. Partnership working was something that we specifically asked about in our terms of reference at the start of our review. We asked:

*What support is in place to ensure the organisations which provide mental health services are able to work in partnership in the best interests of the individual concerned?*

184. The Mental Health Strategy set out an overview of the mental health system. Included within this are a range of community and voluntary organisations such as Mind Jersey, the Jersey Alzheimer’s Association, the Youth Enquiry Service (YES), the Shelter Trust and a range of nursing and home care organisations. During our review we spoke to these organisations as well as several others such as Jersey Recovery College, Youthful Minds, Autism Jersey, the Resilience Development Company, the Primary Care Body, L.I.N.C Mental Health Wellbeing and JT. All of these organisations play a role in Jersey’s mental health system.

185. It was clear during our review that these organisations provide a very valuable role across the mental health spectrum. It was also clear that the Government appeared to be heavily reliant on these organisations to provide important services on the Government’s behalf. Indeed, Dr Miguel Garcia, consultant psychiatrist said, “we are relying more and more on the third sector and that is key, which instead of separate silos, we are working together”.<sup>97</sup>

186. One of the most pertinent examples we heard was in relation to accommodation. John Hodge, Director of Shelter Trust explained that, “we think at Shelter, stable accommodation is one of the very basic needs that everyone requires to live a reasonably

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<sup>94</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p12

<sup>95</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p12-13

<sup>96</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p13

<sup>97</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p30

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satisfied life”.<sup>98</sup> He described how people with mental health difficulties are being referred to Shelter for accommodation. He explained:

*I would say that we certainly see more people than we should coming to us from recent episodes of mental health illness. So I would say that there is at least a kind of anecdotal set of evidences that there might be a shortage there for people who have been inpatients in mental health services coming out to something other than homeless hostels. Obviously not everyone who has been an inpatient is coming to Shelter, that is just not the case. But it happens more often than I think is healthy for those discharged patients.<sup>99</sup>*

187. Trevor Garrett, Trustee of Shelter Trust highlighted that Shelter was a service for people who had reached the lowest point in their lives. He said that he would like to see support provided which prevented these people from reaching this low point. In addition to this preventative action, John Hodge went on to argue that if someone with mental health problems also has housing issues, then the mental health services should take that into consideration early on.

*[...] if someone becomes an inpatient as a mental health patient and they go into that inpatient episode as someone who is precariously housed, I think it behoves the mental health services to be thinking about that person's housing from day one, when they are an inpatient, so that when they are no longer an inpatient they go back to stable accommodation rather than coming to Shelter.<sup>100</sup>*

188. During personal testimony we heard examples of people with mental health problems who were known to the mental health services living in substandard accommodation. We heard examples of people being made homeless as a result of being detained by the mental health services who reportedly then received no help to find alternative accommodation once they were released. And we heard examples of people with poor mental health using Shelter and how this was not an ideal place for these people.

189. In addition to the example of Shelter, there were numerous other examples where community and voluntary organisations supported mental health services and provided their own services to support people suffering with poor mental health. In cases where these organisations were providing key services they would often have a “service level agreement” with the Government. For example, Stephen McCrimmon, Carer and Family Support Manager at Mind Jersey said that his organisation had one agreement to run the Carer and Family Support Service. He said that there was a shortfall of about £25,000 to run that service.<sup>101</sup>

190. Issues around funding and the length of funding contracts were echoed by other organisations. Sean Pontin, Manager, Jersey Alzheimer's Association highlighted that his charity runs a day centre on a Saturday for people with dementia. He said that the service costs considerably more to run than he receives from the Government and described how

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<sup>98</sup> Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p4

<sup>99</sup> Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p5

<sup>100</sup> Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p10

<sup>101</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p6

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the funding he does receive is on a yearly basis. In a 6 month period he said he had 5 separate conversations with 5 different civil servants to discuss ongoing funding arrangements.<sup>102</sup> Sean Pontin said:

*[...] it is not right that I have that same conversation with 5 different officers about my contract that only lasts for 12 months and it is £40,000 less than it needs to be. It is not right, that 12-month rolling contract. What does that mean for a member of staff? How do I employ people and give them consistency? How do I help them to live their life that we have talked about, they need to live in Jersey and pay their bills? But in reality, I do not know what has happened. We should be able to say quite clearly that there is a need for a day centre on a Saturday for people with dementia for more than 12 months because these numbers are terrifying for 2050. Somebody somewhere might be able to get me a slightly longer contract than that.*<sup>103</sup>

191. The Minister seemed to sympathise with this position suggesting that the Government would look at providing more certainty to the community and voluntary sector. He said:

*[...] So perhaps additional finance, not necessarily within the services we provide but also to be directed towards the partners in the field. I know that the likes of Mind and the Jersey Recovery College have an understandable concern that they are only funded for very short periods at the moment, and that is the difficulty about the way we operate as Government and States, is it not; we have these plans which last for a finite time. But I can see how much more secure their services would be if we could say: "You have guaranteed funding for a period of time" and they can bring great user experience, expert experience by reason of their stories they have, to help people with mental health difficulties.*<sup>104</sup>

192. Some of these organisations argued that partnership working had not reached its full potential because of a lack of leadership. In Mind Jersey's written evidence it suggested that a lack of leadership had prevented different services from being more joined up.<sup>105</sup> In a submission from Dr Jake Bowley, a Consultant Clinical Psychologist, which included a summary of opinions from his colleagues, it stated that the "initial enthusiasm and momentum" for improving partnership working between services had "stalled due to leadership".<sup>106</sup>

193. However, some organisations suggested that recently they had had more positive engagement with the Health and Community Services around issues of funding which gave them some optimism.<sup>107</sup>

194. Finally, we heard from JT, a telecommunications company, which set out some of the initiatives it had developed to promote good mental health in the workplace and to support

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<sup>102</sup> Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p17

<sup>103</sup> Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p17

<sup>104</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p13-14

<sup>105</sup> [Mind Jersey](#)

<sup>106</sup> [Dr Jake Bowley](#)

<sup>107</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p15, Public hearing with [Shelter Trust, Jersey Alzheimer's Association, Autism Jersey](#), 10 January 2019, p17

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staff who are experiencing mental health problems. Mark Le Feuvre, Head of Access Networks at JT said that JT had developed a “work group” to focus on mental health. As a result, it had developed an up to date mental health policy, it had trained 8 mental health first aiders (people trained to provide initial support to people with mental health problems), and it had secured a director to sponsor or champion mental health.<sup>108</sup>

**KEY FINDING 17:** Jersey’s community and voluntary organisations provide a range of valuable services which support people with mental health problems. It is clear that the Government wants these organisations to fill the gaps which are not covered by statutory services. The gaps are so large, however, we are not sure that they can be filled by the community and voluntary sector.

**KEY FINDING 18:** It is clear that responsibility for promoting good mental health extends beyond the Government and community and voluntary organisations. Mental health is everyone’s business. We note that some private sector organisations are starting to promote good mental health in the workplace and supporting staff who are experiencing mental health problems.

**RECOMMENDATION 15:** If the Government wants the community and voluntary sector to provide what are essentially frontline mental health services then it needs to provide realistic support to these organisations. The Government should provide adequate funding to, at the very least, cover the cost of delivering services, as well as longer-term contracts to these organisations (which could still be reviewed intermittently) in order to ensure that these services can provide the services required.

## Role of General Practitioners

195. There are a few pathways for accessing mental health services in the Island. We know that General Practitioners (GPs) provide an important role in supporting people with mental health issues and referring people into mental health services. In our survey 61% of respondents said that they were referred by a GP.

196. When taking personal testimony from people we heard a number of different experiences in relation to GPs and mental health. Some people had very positive experiences with GPs. One person described their GP as “lovely” and “understanding”. We heard how another GP went out of their way to help a patient when they were in crisis. One person said:

*I had to wait to get him in but she was very good. The one time when I said: “Look, think whether I can get him in” and, to be fair to her, she just dropped everything and saw him that morning. He was not registered as such with her; registered him as I walked through the door and the receptionists were a bit like: “But he is not here, he is not registered.” “I know, it is all right, I am fine, I am sorting it out.” She was really, really good.*

197. However, others had less positive experiences. One person described how, while their GP was sympathetic about their mental health problem, the GP didn’t really know how to help.

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<sup>108</sup> Public hearing with [JT](#), 13 December 2018, p3

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*So my G.P., he is a lovely G.P. My own G.P. does not get mental health. He really does not understand it. [...] Now please do not think I am slating him because he is a lovely doctor and he has said to me before: "I do not really know", so I went to him when I was struggling after a few issues [...]. I said: "Look, I am really struggling, what do I do?" He is like: "I just do not really know what to say. The best thing you can do is probably contact Mental Health and see if they can advise you."*

198. Another person described an experience where they called a GP to help a loved one but the GP said that they were unable to help:

*[...] He would not come home, he went off and we found him in a park, stood in the park, phoned the G.P. and the G.P. said he could not do anything, he could not come out. I would have to get him to go to the practice or to take him down to A. and E. But if you are dealing with mental health, they are all so stubborn, they are very, very strong-willed and very stubborn and obviously quite poorly, you do not like authority, it makes you challenge authority a bit. It is very difficult to get someone. But he said he could not treat him unless I got him down to the practice, which was not going to happen. [...].*

199. Under Key Priority 2: Prevention and Early Intervention, the Mental Health Strategy stated:

*We will work with the Primary Care Body and Primary Care Medical Director to put in place a continuous professional development programme to further inform and educate GPs and other primary care professionals in relation to mental health and wellbeing.<sup>109</sup>*

200. We asked Dr David Bailey, a GP and representing the Primary Care Body, his views on whether GPs knew enough about mental health and whether he thought that they needed additional training. He said:

*By nature, as a general practitioner, you are a generalist. There are people with special interests and those dealing mental health problems. But because we deal with a lot of mental health problems, G.P.s do provide a lot of mental health support. I think that if you provided more training, then it is never going to go amiss, of course. But I think the most important thing would be to provide ... the mental health first aid type things are really good initiatives. If people knew about them and could access them, be it face-to-face or online, would be important. Perhaps empowering people to treat themselves or help themselves, make themselves more resilient, is just as important as providing training for general practitioners. There is a lot of training out there for G.P.s online as well and a lot of G.P.s go off Island to get training as well. Providing training would be good but it is not essential. You would get more bangs for your buck by providing it at the coalface.<sup>110</sup>*

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<sup>109</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p65

<sup>110</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p23

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201. We also heard that GPs were not always involved in a person's care once they had entered into the mental health service especially in relation to their care or medication. Dr David Bailey highlighted that GPs were not well supported by secondary care services.<sup>111</sup> Indeed the Mental Health Strategy found that communication between primary and secondary care was poor.<sup>112</sup> During our meeting with young people at the Youth Enquiry Services we heard concerns about a lack of communication between GPs and Child and Adolescent Mental Health Services (CAMHS).

202. During personal testimony and during oral evidence we heard that doctors' upfront surgery fees had an impact on whether people sought their GP's help and advice in relation to their mental health. During our meeting with young people at the Youth Enquiry Services we heard that GP surgery costs put people off going to see the doctor. Describing her GP, one person stated:

*[...] she was lovely and understanding but you do not want to keep paying to go back to talk to the G.P. basically. It takes up their time, you do not want to have a quick 10 minute snippet, it is not possible really.*

203. Another person told us:

*So for me every time I felt really low ... I know the various G.P.s did say, you know: "Feel free to come back to us" but then I am just like: "Well, not when I paying £50 every month or every couple of weeks, every time I do not feel that great".*

204. Dr David Bailey highlighted that people on low income may struggle to access GP services because of the upfront cost:

*With regards to primary care, I think there is limited access to people who have poor income. People with chronic mental health problems, long-term alcohol problems, who may be out of work or on a low income, are going to struggle to get primary care services. People with chronic relapsing severe mental health problems, likewise, will have poor income and, therefore, not likely to have access to primary care and, therefore, more likely to use the Accident and Emergency Department. It is not appropriate for them to be seen there, they will often get told: "It is a G.P. problem; go and see your G.P.", so there is no way for them to access mental health services.<sup>113</sup>*

205. Dr David Bailey, also said however, that GPs often reduced their fees for people on lower incomes:

*People often sort of say: "The average fee for a G.P. is £40 or £50." But in fact the average charge per patient is about £24 because general practitioners in primary care appreciate when people are hard up and are not in work and are not able to access services from across all businesses*

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<sup>111</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p16

<sup>112</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p50

<sup>113</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p4

*here. I think it is only recently that people with mental health problems have had any sort of voice and it just gets shouted out by other areas.*<sup>114</sup>

206. We note that Jersey Consumer Council's Jersey Health Watch website provides a selection of GP surgery prices as at 1 September 2018. It shows that the price of an adult consultation ranges from £43 to £33. The price of a consultation for 5 to 15 years olds ranges from £27.50 to £5. The price of a consultation for under 5 year olds ranges from £27.50 to £0. Finally, the price of a home visit (in surgery hours) ranges from £95 to £70.<sup>115</sup>

207. Robert Sainsbury, Group Managing Director for Health and Community Services questioned whether paying to access GPs was sustainable in the long term. He said:

*[...] is this sustainable, though, long term? Because for a lot of people, their first intervention is going to see the G.P., which starts at least sometimes a referral process instead of coming from absolute crisis into hospital. But you have to pay generally to see your G.P. We are starting to see trends come along where people are choosing not to see their G.P. because they do not want to pay that money, so they miss that early intervention where they could be picked up and referred on to a service. Is it not fair to suggest while this is the model you have described at the moment but in the long term are there plans afoot to say is this really sustainable? Is this the right approach for Jersey? How do we change what we are seeing to help people who are not making that first step because they do not want to pay the average fee of £40? [...]*<sup>116</sup>

**KEY FINDING 19:** General Practitioners (GPs) play an important role in supporting people with mental health issues and referring people into mental health services. However, people's experience of GPs in relation to mental health has been mixed suggesting inconsistency across the profession. This has potentially negative implications for those people who are under the care of GPs who do not know much about mental health or the services on offer in the Island.

**RECOMMENDATION 16:** The Government should offer to all Jersey's General Practitioner (GP) practises, training on mental health and information about Jersey's mental health services.

**KEY FINDING 20:** Jersey's General Practitioner (GP) practices are private businesses who charge a range of prices for a consultation with a GP. The up-front surgery costs associated with visiting GPs had an impact on how involved GPs were with a person's ongoing mental health. We have heard that people may avoid seeing their GP to discuss their mental health because of the cost involved.

**RECOMMENDATION 17:** The Government should review the fees charged by General Practitioners (GPs) in relation to mental health. It should explore, in close consultation with GPs, whether a different funding method could be used if a patient presents to a GP with mental health problems rather than physical problems.

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<sup>114</sup> Public hearing with [Primary Care Body, L.I.N.C. Mental Health & Wellbeing and Resilience Development Company](#), 10 December 2018, p9

<sup>115</sup> Jersey Health Watch, [Doctors prices](#), 1 September 2018

<sup>116</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p32

## Moving from CAMHS to Adult Services

208. The Mental Health Strategy highlighted the importance of having integrated services to ensure that people have a smooth transition between different levels of service. It stated under Key Priority 3. Service Access, Care Co-ordination and Continuity of Care:

*We will work with service providers to review and implement protocols to ensure more effective transition between services, e.g. between CAMHS and adult services and between adult and older people's services between criminal justice system and mental health services.*<sup>117</sup>

209. Similarly, under Key Priority 4: Quality Improvement and Innovation, it stated:

*We will work with clinicians to develop operational protocols between all mental health services to ensure more seamless transition, but also to ensure effective joint working, transfer of cases and co-ordination of responses, particularly at times of crisis.*<sup>118</sup>

210. Under the current system, we understand that people are cared for by the Child and Adolescent Services until they are 18 years old. Once they are 18 they are cared for by Adult Mental Health Services. Dr Laura Posner, Consultant Clinical Psychologist at C.A.M.H.S set out how the system works at the moment:

*I think that would depend on their needs at the time. I do not know the actual figures but a small proportion will have ongoing mental health needs of a serious nature that will need ongoing care from adult mental health services. At that point we would help them make the transition to adult mental health services. I think there is a need to develop more robust procedures for that happening. As I mentioned in my figures at the start, that there is a high proportion of difficulties in that 17 to 19 age group, so there is quite a lot of need there. I think thresholds are different between C.A.M.H.S. and adult mental health services. We talked about one example about the young people prescribed psychotropic medication that would all be done by C.A.M.H.S. whereas when people turn 18 and become adults, G.P.s are more prepared to take on some of the responsibility for prescribing in that age group, so that is one of the differences. But we would also look to other services that may be able to support young people, such as Jersey Talking Therapies and maybe primary care could go on to support them and some of the other psychosocial supports that we have talked about. The Social Security Department have developed quite a lot of support through a different team for people who need support into the workplace. It is really a negotiation; from around the age of 17½ we will start to talk to young people about what would they like to be doing in terms of support. Do they want to have a break and see how they get on without mental health services involved? There are some different options just talking about it around the mental health team.*<sup>119</sup>

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<sup>117</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p68

<sup>118</sup> States of Jersey, [A Mental Health Strategy for Jersey \(2016 - 2020\): Planning together, for our future](#), November 2015, p71

<sup>119</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p25

211. The appropriateness of the current arrangements were challenged by several respondents. During our meeting with young people at the Youth Enquiry Services we asked them their views on “transitioning” between the services. One person who had lived experience of moving between the services described the process as “dangerous”. This person described how, when she reached 18, CAMHS decided that she didn’t require any additional support and so didn’t transfer her to adult mental health services. She told us that she subsequently ended up in A&E.
212. During our meeting at the Youth Enquiry Service we also heard that when CAMHS had to send young people off Island for treatment – because the service was not available on Island – the transfer process was not good. This was corroborated during personal testimony. We heard from one family whose child had to go off Island for treatment. They highlighted a lack of communication as well as a lack of administrative and financial support for family members during these difficult times.
213. Deborah McMillan, the Children’s Commissioner reported a number of comments that had been given to her by children. In relation to transitioning between services she said, “They also talked about transitioning into adult services and how that was difficult”.<sup>120</sup> She also said, “Transition is the other bit that children would be worried about; not just the age of transition but what that process looks like for them”.<sup>121</sup> When we asked her about this in more detail, she highlighted that she had not done an in depth piece of work on this but again reported a conversation she had had with a 17 year old transitioning between services. She said:

*It is not an area I have carried out any in-depth review of, but I have spoken to some older young people who are at that stage. Just last week I met with a young person who is 17 who feels that they are in an in-between time where they feel nobody is in charge of their care. So, for example, this young person was saying that out of hours, when they are feeling really down and need somebody to speak to the out-of-hours service is an adult service and she felt that when they were talking to her that she was being treated as an adult, whereas she wanted to be treated as a young person in that transition period. You have heard some of my quotes earlier, so I will not repeat them, but it is clear that transition perhaps should be based not on age but on a child’s needs. Some young people at 17 are more than happy to transfer into adult services and to have a very strong say for themselves. Other children clearly cannot. [...].<sup>122</sup>*

214. This was echoed by Stephen McCrimmon, Carer and Family Support Manager at Mind Jersey who told us:

*[...] we have heard from young people what it is like to access C.A.M.H.S. services, which is very much wrapped around the family and works systemically with the family, and then to transition into adult services, where it is very much personal empowerment and a very different way of working.<sup>123</sup>*

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<sup>120</sup> Public hearing with the [Children’s Commissioner](#), 10 December 2018, p7

<sup>121</sup> Public hearing with the [Children’s Commissioner](#), 10 December 2018, p13

<sup>122</sup> Public hearing with the [Children’s Commissioner](#), 10 December 2018, p14

<sup>123</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p13

215. It was emphasised to us that it was important to listen to young people about what it is like to be young or an adolescent allow that to inform how these groups are cared for. Liz Kendrick-Lodge, Service Development Manager at Mind Jersey said:

*One of the things that we have done as a service, we have listened to the voice of children and young people and asked them: "What does a youth-friendly service look like?" and they have helped us develop that. I think when we are coming back to the question around place of safety, a 21 year-old young person perhaps needs to access somewhere similar that maybe the 18 year-old, 17 year-old et cetera is accessing. I think we need to listen to children and young people more around what it is like to be a young person, to be an adolescent and not just place them somewhere where other adults go, because that is really frightening and it is very scary.<sup>124</sup>*

216. Some stakeholders argued that the transition period should range from as low as 16 to as old as 25.<sup>125</sup> When someone transitions between a services would be based on the individual in question and what was right for them. This was also supported by CAMHS clinicians, Dr Laura Posner, Consultant Clinical Psychologist and Dr Catherine Keep, Consultant in Child and Adolescent Psychiatry. Dr Keep, however, caveated this by highlighting resource constraints:

*In the ideal world, I would personally like that it is not as it is now. You get to 18 or just close to 18 and then you go to adult. For me that does not make much sense. I think it would make more sense to have like a dedicated service that is just looking after aged 16 to 25, 27, and that is really going to ensure that there is going to be consistency and clarity at this crucial part of their development and their adapting into society. This current system is not working, in my opinion, as well as this other one would. It is again going to come down to are we really going to be able to have the resources in place to implement it, because at the moment we are constantly in the reactive mode. As we finish here, we will go to work and we will suddenly be landed with so many demands that we will have to prioritise let alone plan forward to develop.<sup>126</sup>*

**KEY FINDING 21:** Currently, children and young people with mental health problems are cared for by the Child and Adolescent Mental Health Service until they are 18 at which point they transition to being cared for by Adult Mental Health Services. The appropriateness of this cut-off was challenged by several stakeholders including CAMHS clinicians. It was generally agreed that people should transition between services when it is right for them or up to their mid-twenties. However, the ability for CAMHS to support this is dependent on adequate resources which it does not have at present.

**RECOMMENDATION 18:** Until mental health services are better staffed it will be challenging for them to provide appropriate transition arrangements between CAMHS and adult mental health services. However, we believe that CAMHS should start sharing a person's file with adult services once they have reached a certain age – even if that person isn't referred to adult services when they leave CAMHS.

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<sup>124</sup> Public hearing with [Mind Jersey and Jersey Recovery College](#), 10 December 2018, p13

<sup>125</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p25

<sup>126</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p25-26

## Separation of Adult and Child Services

217. As part of the One Government changes to Jersey's civil service, it was announced that Child and Adolescent Mental Health (CAMHS) Services would be moved from the Department for Health and Community Services to the Department for Children, Young People, Education and Skills.<sup>127</sup> This would mean that CAMHS services would be overseen by the Group Director of Children's Services rather than the Group Managing Director Hospital and Community Services.

218. The Department for Children, Young People, Education and Skills includes Children's Services. This includes a range of services which provides support to children and young people some of which includes helping them with mild to moderate mental health issues. These services include school councillors and social workers. Child and Adolescent Mental Health (CAMHS) Services by contrast provide psychological therapy and medication for children and young people experiencing moderate to severe mental health problems.

219. During our meeting with young people at the Youth Enquiry Services we heard some examples of the support offered by Children's Services in relation to mental health. In relation to school councillors, we heard that the system is not very private or discrete. One person said that when they had an appointment for a school councillor they were presented with a "yellow ticket" in the middle of a class so that their classmates knew they were seeing the councillor. The young people thought that there was room for improvement and that teachers needed more training to deal with mental health issues – teachers may be the first person a young person reaches out to, to discuss their mental health.

220. We asked about this change as part of our terms of reference. In its written response, the Government stated:

*Currently Children's mental health services (Specialist CAMHS) are located in Health & Community Services and follows the specialist health services models recognised by the UK and international community. Specialist CAMHS, which is often referred to as secondary/tertiary health services, provides care and treatment interventions (sometimes under legal detention) for those children and young people with the more severe, diagnosable mental disorders often presenting with co-morbidity e.g. mental illness/epilepsy, mental illness/eating disorder, mental illness/substance misuse etc. and hence sits within health services, staffed by mainly health professionals and functions within a clinical governance system. The children's emotional and wellbeing services are located within Education and other children's services through the P82 investment programme. Close links are maintained between all the services.<sup>128</sup>*

221. In its written response the Government set out a number of benefits and risks associated with moving CAMHS to Education from Health. We note that the Government itself had highlighted more risks than benefits. For each of the risks the Government set out how these would be mitigated. For several answers the Government said that it would use

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<sup>127</sup> States of Jersey, [One Government Structure](#), p5

<sup>128</sup> [Health and Community Services Department](#), p22-23

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“governance frameworks” to mitigate any risks. This was repeated by the Minister for Health and Social Services during our hearing. He told us:

*[...] The thinking has been that there could be governance arrangements that would allow the service to be placed within children and young people but still be governed within the health service structures and the professional structures that exist. [...].<sup>129</sup>*

222. Robert Sainsbury, Group Managing Director in Health and Community Services said:

*I do not think it is right for either portfolio to believe that they own that service in entirety in any way because they should work together, the Department of Health and the Department for Children, Young People, Education and Skills should be working together to address how we provide good mental health services for young people.*

223. Robert Sainsbury went on to say:

[CAMHS] need to know who they are accountable to and it is really clear that the medical fraternity needs to be part of our medical fraternity. It cannot be anywhere else [...]. However, I do think what we have got to focus on is how working together with children and young people drives a better pathway for people, but I think that is a journey. The service has not transitioned at the moment. We are talking about a joint board arrangement to monitor how that goes. This is different to the ambulance position and I think we need to feel our way with how that is going, because it is again a pressured service and we need to stabilise it a bit before we start making huge changes to it, would be my view.<sup>130</sup>

224. In its written response CAMHS stated its view that it should stay within Health and not move:

*We have always been a small part of a larger organisation with high expectations placed upon what it is possible for us to deliver. We are unclear as to how it will improve service provision for us to sit under a children’s umbrella. We need to maintain professional links with our colleagues in health. Tier 3 camhs services are traditionally viewed as health services as they offer medication, support for inpatient treatment, nursing and therapeutic interventions.*

*We are concerned about how the support that we receive from the health department will be replicated under the new organisational structure, however as the new structure is not yet in place we are not yet clear as to how these concerns will be addressed.*

*The vision that has been shared with us of a one stop shop for children and families we do not believe to be an attractive idea for families. Parents have fed back to us that they are concerned that we are now in the same building as the children’s service. We need an independent identity, this is a small island service users have little choice in where they go for support. For some*

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<sup>129</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p24

<sup>130</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p24

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*families the thought of entering a building full of social workers leaves them feeling anxious and for those who struggle with trust ask us if we are independent.*<sup>131</sup>

225. Stephen Appleton, Managing director of Contact Consulting, said that he thought separating CAMHS from other mental health services increased the risks around transitioning people between mental health services. He said:

*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.*<sup>132</sup>

226. Despite CAMHS not having formally moved from Health to Education, CAMHS was already co-located with Children's Services. Deborah McMillan, the Children's Commissioner reported a number of comments that had been given to her by children. In relation to the location of CAMHS she said:

*One of the things that children have said to me quite clearly is that the co-location with children's social workers is something that they find difficult, because they say that they do not trust social workers and therefore going into the building where they are makes it harder for them, so that was one of the issues. There are all the issues around the building itself, the lack of private space, confidentiality, the playing of the radio, all those things they mentioned. I think the co-location in itself is a good thing, because we talked earlier about the need for professionals to work together more closely, but maybe the issue there is children saying: "I just do not trust social workers." That is the bit we have got to fix, rather than move a service away, because co-locating services is something that the adults have mentioned is a good thing, the children have said it is a good thing that professionals speak to each other, so if the issue is not trusting others who might be sharing a building then that is the issue we have to tackle.*<sup>133</sup>

227. CAMHS clinicians said that they had had a range of feedback about the location and the building. One the one hand it is a "newer, brighter building" but on the other hand the location of the building is very "visible" and doesn't necessarily offer people privacy. Dr Laura Posner, Consultant Clinical Psychologist at CAMHS said:

*On your comment about how it makes people feel coming into the building, to my mind it was not at the heart of the spec in the many conversations we had about moving. To me, it felt as if the move was about an idea of corporatising a one-stop shop, a one.gov children's service all together. I think if you had asked our clients - and we do ask and talk to our clients regularly - about their ideal provision for a child mental health service, they*

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<sup>131</sup> [Child and Adolescent Mental Health Service \(CAMHS\)](#)

<sup>132</sup> Public hearing with [Contact Consulting](#), 13 December 2018, p24

<sup>133</sup> Public hearing with the [Children's Commissioner](#), 10 December 2018, p15

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*would have come up with a different concept, something with more privacy, something a little bit more discreet that they could go to without ... it is difficult. Jersey is such a small Island and people come to our service and, okay, we want to reduce the stigma but people are coming and they bump into people they know all the time and it is difficult. We are trying to encourage people to come to us rather than us go on home visits, for that practical reason of our time management, so we really need to provide an environment that is warm and welcoming.*<sup>134</sup>

228. On the 13 February 2019, the government confirmed its intention to transfer responsibility for CAMHS from one ministerial portfolio to another. It stated:

*Responsibilities for Children's Services and Children's and Adolescents Mental Health Services are being transferred from the Minister for Health and Social Services to the Minister for Children and Housing. This will better enable the Children's Minister to focus on the commitment of the Council of Ministers to put children first.*<sup>135</sup>

**KEY FINDING 22:** While we can understand the theory behind moving CAMHS from health to education, we do not think that this will work in practise. There are a number of risks associated with this change. We do not believe that the Government has sufficiently justified this change or demonstrated how the risks will be mitigated. It is also not clear who CAMHS staff will be reporting to and how clinicians will maintain links to other clinical organisations.

**RECOMMENDATION 19: CAMHS should remain part of the Department for Health and Community Services.**

## Models of Care

229. During our review we heard a number of concerns about the amount of prescription drugs that were being prescribed for mental health in Jersey. Indeed, the Government's response to our review showed that prescriptions were predicted to be at an all-time high in 2018. The Government's response showed that:

*There has been a long and steady increase in antidepressant prescribing (mirrored in the UK) and a fairly steady use of anxiolytics (principally diazepam).*<sup>136</sup>

230. Lucy Nicolaou, Mental Health Nurse and Manager from L.I.N.C suggested in her written evidence that part of the reason for this was GPs were prescribing because waiting times to access psychological therapies. She told us:

*Reliance on pharmacological interventions within primary care. The prescription rate for antidepressants has risen and we have seen numerous people at LINC who have been prescribed medication for either depression or anxiety while waiting to access talking therapies. It seems GP's are often in a difficult situation in which, knowing the lengthy waiting times to access*

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<sup>134</sup> Public hearing with [mental health clinicians](#), 18 December 2018, p23

<sup>135</sup> Ministerial decision reference [MD-C-2019-0016](#)

<sup>136</sup> [Health and Community Services Department](#), p7

*JTT, they are left with little alternative but to rely on drug treatments to support patients experiencing mental distress.*<sup>137</sup>

231. During our meeting with young people at the Youth Enquiry Services it was their perception that GPs were reluctant to refer young people to avoid putting pressure on secondary services. The young people suggested that GPs would either prescribe medication instead of referring patients or prescribe medication while patients were waiting to access services.

232. In addition to high levels of prescribing from GPs, we heard that secondary mental health services were potentially over reliant on a “medical model” for treating mental health problems. Definitions of the medical model vary and we do not wish to provide a detailed discussion of this here. In general, however, the medical model described a form of treatment that is “paternalistic” and uses medication by doctors in a clinical environment to treat physical or biological symptoms. This is sometimes contrasted with “social models” which describe more “holistic” care based on psychological therapies.

233. Deborah McMillan, the Children’s Commissioner told us:

*[...] Now, I am no professional in this field and I do not have a professional opinion, but I was fortunate enough to be able to go to the European Network of Ombudspersons for Children conference earlier this year and the focus was emotional and mental health, and children across Europe had come together and had spoken quite clearly about how it is for them growing up in different countries across the world and there were professors there far more clever than I am in this field who were talking about the discourse around the medical model and whether that medical model should be based on a psychiatric response or whether it should be based on a psychological response. We do not want to get into that here, nor do I, but children were quite clearly saying they feel medicalised when they go to C.A.M.H.S. and it might not be suitable for them.*<sup>138</sup>

234. Dr Miguel Garcia, Consultant Psychiatrist in Adult Mental Health Services also touched on this when we was talking about communication between doctors and patients. He described how, staff in mental health services had to move away from the paternalistic approach:

*As I was listening to my colleague I was just writing a few points. I wrote corporate action, collaborative work, involve plenty of carers, moving away from the paternalistic approach in which we are health professionals: “We know best, therefore we tell you what you have to do.” It is a joined-up way of working. We have to bear in mind that it is very difficult to have a blanket role. I think we should be looking, as my colleague said, at individualised care packages. It might be the case that we are dealing with young people who are very much with social media and they would rather use that as opposed to the face to face. I think we have to be creative. It is often the case that patients need to feel safe and the place where they feel the most safe is their own home. So this thing about getting them out of the house to go to accident and emergency or to come to see us in the community I do*

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<sup>137</sup> [L.I.N.C Mental Health and Wellbeing](#), p1-2

<sup>138</sup> Public hearing with the [Children’s Commissioner](#), 10 December 2018, p7

*not think is necessarily the way forward. So I think that needs to be explored and communication is the key to success and that it is clear and is consistent. I think that is why it is essential that in the reconciling of our services that patients and carers have a very relevant input otherwise it will be ourselves figuring it out for them, which is not right.*

235. Service users concerns about how they were treated during their care was highlighted in the responses to our survey (see Chapter 3). Similarly, during personal testimony, we heard about the lack of a local family-Centred approach to treating children and a lack of aftercare advice for children and their family, once discharged home.

236. It was clear that efforts were being made to introduce alternative forms of care as evidenced by the development of Jersey Talking Therapies (JTT), which provides psychological rather than medical-based treatments for mental health problems. However, as shown in chapter 3, this service is so oversubscribed and the waiting lists so long that this service isn't filling the gap. We heard several times during our visits that pressure on JTT meant that people, which could have been treated in that service, were being passed on to other services.

237. This led us to explore what alternatives were available. We heard, when collecting personal testimony, about a method called "Open Dialogue". Open Dialogue was developed in Western Lapland in the 1980s. It involves a consistent family/social network approach to care, in which the primary treatment is carried out through meetings involving the patient together with his or her family members and extended social network.<sup>139</sup>

238. One person told us how they found out about this approach on the internet. This person reflected on how this approach contrasts with the approach in Jersey:

*[...] they assess a situation where they have an emergency response team. So when someone presents with a psychosis like my [...], the person who takes the call takes control so you do not get passed over to anybody. You have a psychiatrist, a nurse or however many nurses are needed, and everyone is involved. The whole family are involved, friends are involved, everybody. They start what they call an open dialogue and they find in that process ... and the person who is suffering as well. In that process they find out what, you know, over time, over the length of time, what was the cause and how to resolve it. What they do not do is give medication except for very extreme cases and only very minor medication for very short periods of time, which is the opposite of here because what I was told was my [...] had to go on the medication and it had to go to the maximum dosage as quickly as possible and then she would be ... they termed it at a therapeutic dose and then they ... that was their answer. When she got to that dose there was no therapy and it was not working.<sup>140</sup>*

239. We asked a range of stakeholders including clinicians and the Government about Open Dialogue but it seemed that this approach or other approaches were not being explored. However, Karen Wilson, Interim Director of Quality, Governance and Nursing (Community) said, "I think as part of our planning, we should build these kinds of care models into the

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<sup>139</sup> Psychology Today, [Open Dialogue: A New Approach to Mental Healthcare](#), 12 July 2015

<sup>140</sup> Personal testimony

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overall offer going forward. We have not described those in terms of our current pattern of service”.<sup>141</sup>

**KEY FINDING 23:** We heard some suggestions that mental health services were focused on a “medical model” for treating people with mental health problems rather than alternative non-medical therapies. Although the Government has made efforts to improve therapeutic services with the establishment of Jersey Talking therapies, the service is so oversubscribed and the waiting lists so long that this service isn’t filling the gap. We heard about an alternative form of therapy called Open Dialogue but it was not clear that mental health services used this or other alternative therapies when caring for people with mental health problems.

**RECOMMENDATION 20:** The Government should review the model of care that is used in Jersey’s mental health services. As part of this, the Government should define the model of care that it uses. This definition should include elements used in Open Dialogue including collaborative and joined up approaches to care. This should be published in Q2 2020.

## Transgender Pathways

240. During our review, we heard from Liberate, an equality and diversity charity, who were concerned about the pathways for transgender people which included interaction with the mental health system. Vic Tanner Davy, Honorary Chief Executive Officer at Liberate Jersey described the current pathway for a person with gender dysphoria (a transgender person):

*Your transgender patient goes to see their G.P. (general practitioner), that is the first port of call. Their G.P. will refer them into mental health services on the Island. All of this is in Jersey at the moment. At that point, the mental health services practitioner may decide that it is appropriate that they refer them into the N.H.S. (National Health Service), and this is the point at which we cross borders and we head off to the gender identity clinics in the U.K. and we get referred into there. Obviously, there is a cost associated with that, a cross-charge from Jersey to the U.K. Then at that point the gender identity clinic in the U.K., through the N.H.S. may decide that it is appropriate that the transperson starts on hormones, at which point that will come back to Jersey. We would go and see the Endocrinology Department in the States of Jersey Health Service and the Endocrinology Department will work with either our mental health professional or our G.P. to provide the hormone therapy. If we want to go for surgery, which usually comes after hormone therapy, then again the process starts all over again, so we go back into the mental health services, they then assess whether we are sufficiently capable to decide that we want surgery, at which point they will refer us into the N.H.S. gender identity clinic again, at which point there will be a cost associated with that. At the point at which your gender therapist decides that you and he are ready to go for surgery, you will get surgery on the N.H.S.*<sup>142</sup>

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<sup>141</sup> Public hearing with the [Minister for Health and Social Services](#), 10 January 2019, p33

<sup>142</sup> Public hearing with [Liberate Jersey](#), 9 January 2019, p2-3

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241. Vic Tanner Davy highlighted that gender dysphoria had been declassified by the World Health Organisation which means that it is no longer considered as a mental health condition.

242. We heard from Stuart Barette a Member of Liberate Jersey and a transgender person, who described the impact the process had on him:

*Well, quite frankly, in most of them, it results in extreme stress and quite a lot of suicidal ideation, which means they then get referred back to acute mental health services to deal with them. But ultimately nothing is going to change until we get the treatment that we need. So it is just them trying to keep the person afloat until such time they get to the front of the queue.<sup>143</sup>*

243. Liberate suggested that an alternative pathway would reduce waiting times, the impact on transgender people and the impact on mental health services. Vic Tanner Davy described three potential pathways:

*For some transgender Islanders you would not have to touch mental health services at all. For others, it might be at a very low level and then for others it may be that the current pathway is entirely appropriate. But what we are trying to say is that it should not be for everybody [to go through Mental Health Services] because you are pushing everybody through critical mental health services, which we know are overstretched. Why would you want to put extra people through them?<sup>144</sup>*

244. Important in this role were GPs. Vic Tanner Davy said:

*[...] that is where I see the G.P.'s role being. You go to your G.P. and if you have a mental health condition they are the first port of call for you. Whether you get referred in is up to your G.P. If they are looking at you and saying: "Yes, I think there is ...", if they are a good G.P. they will recognise it and they will say: "Yes, this is not something I can do as a G.P. This is something that needs to be referred in." I think it is exactly the same for transpeople. If they are presenting with a mental health condition refer them in. If they are not presenting with a mental health condition then: "How can we assist your transition?" It is making that decision at the G.P. level, I think. Bringing it back to primary healthcare.<sup>145</sup>*

245. This was pertinent because the number of people questioning their gender had increased. Vic Tanner Davy said:

*In terms of the number of transgender people in the Island, we are about the same as any other population. So about 0.02% of the population will be transgender. That was when I started doing this work in 2014. You are talking about on an island population of 100,000, 25 people. It is not that now. We have seen a massive increase, particularly with young people examining their gender, asking questions about their gender. Not necessarily going all the way and transitioning but certainly wanting to have*

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<sup>143</sup> Public hearing with [Liberate Jersey](#), 9 January 2019, p2-3

<sup>144</sup> Public hearing with [Liberate Jersey](#), 9 January 2019, p7

<sup>145</sup> Public hearing with [Liberate Jersey](#), 9 January 2019, p8

*those kinds of talking therapies where they are talking about it. I would say we probably doubled that in the last 4 years.*<sup>146</sup>

**KEY FINDING 24:** The current pathway for transgender people to transition is long and complex which can have a detrimental impact on their mental health. We did not have the opportunity to look into this issue in more detail. However, we think that the arguments presented by Liberate Jersey have merit and should be explored further.

**RECOMMENDATION 21:** The Government should commit to meet with Liberate Jersey to discuss their concerns and proposals in relation to pathways for transgender people. It should also review the current pathway for transgender people and consider if it would be possible to improve the process. This work should be made public.

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<sup>146</sup> Public hearing with [Liberate Jersey](#), 9 January 2019, p5

## 6. Conclusion

In this report we have found that mental health services have suffered from a lack of political and executive leadership and a lack of investment over time. This has had a detrimental impact on service users, the staff running mental health services and the quality of the mental health estate.

We believe that if the Government prioritises developing strong leadership and increasing investment in staff and the estate, Jersey has the potential to have world class mental health services.

Mental and physical health need to be given parity and treated equally. The Government's plans to develop a new general hospital provide an ideal opportunity to give mental health parity of esteem with physical health.

Service users should be put at the heart of any changes and improvements to mental health services. The Government should regularly ask service users their views on the services and incorporate them into the design and delivery of these services.

The same can be said of the community and voluntary sector, much of which fills gaps left by statutory services and provides what are essentially frontline services.

We hope that the Government will consider the findings and recommendations in our report carefully and that they will assist the Government in improving mental health services.

## Appendix

### Panel Membership

The Members of the Panel are:



Deputy Mary Le Hegarat (Chairman)



Deputy Kevin Pamplin (Vice-Chairman)



Deputy Carina Alves



Deputy Trevor Pointon

The Scrutiny Officer was Tom Leveridge

### Terms of reference

The Panel's terms of reference for this review were:

- What are the current trends in mental health in Jersey?
- What progress has the States of Jersey made on implementing its mental health strategy? What further work is required?
- How have mental health services changed since the launch of the mental health strategy in 2015?

## Assessment of Mental Health Services

- What support is in place to ensure the organisations which provide mental health services are able to work in partnership in the best interests of the individual concerned?
- What are the potential risks and benefits of separating child and adult mental health services? How could any potential risks be mitigated?
- What examples of best practice are available from other jurisdictions that Jersey could learn from?

## Oral evidence

The Panel held 15 private hearings to collect personal testimony between Friday 23 November 2018 and Thursday 7 February 2019. The hearings were held in private in accordance with the Freedom of Information (Jersey) Law 2011 (as amended) under Absolute Exemption Article 25.

The Panel held the following public (and one private) hearings:

### Monday 10 December

**Dr David Bailey**, Primary Care Body; **Lucy Nicolaou**, Mental Health Nurse and Manager, L.I.N.C. Mental Health & Wellbeing; **David Ogilvie**, Managing Director, Resilience Development Company

**Liz Kendrick-Lodge**, Service Development Manager, Mind Jersey; **Stephen McCrimmon**, Carer and Family Support Manager, Mind Jersey; **Beth Moore**, Manager, Jersey Recovery College; **Ben Bennett**, Chair, Jersey Recovery College

**Deborah McMillan**, Children's Commissioner; **Tara Murphy**, Policy Principal

### Wednesday 12 December

**Patricia Winchester**, Executive Director, Independent Advocacy My Voice Jersey [This meeting was held in private in accordance with the Freedom of Information (Jersey) Law 2011 (as amended) under Absolute Exemption Article 26]

### Thursday 13 December

**Mark Le Feuvre**, Head of Access Networks, JT; **Lee Beech**, Health and Safety Manager, JT

**Stephen Appleton**, Managing Director, Contact Consulting

### Tuesday 18 December

**Dr Miguel Garcia**, Consultant Psychiatrist, Adult Mental Health; **Dr Catherine Keep**, Consultant in Child and Adolescent Psychiatry, Child and Adolescent Mental Health Service; **Dr Laura Posner**, Consultant Clinical Psychologist, Child and Adolescent Mental Health Service; **Simba Kashiri**, Acting Head of the Alcohol and Drugs Service; **Mike Swain**, Clinical Nurse Practitioner, Adult Mental Health

### Wednesday 9 January

**Vic Tannery Davy**, Honorary Chief Executive Officer, Liberate Jersey; **Stuart Barette**, Member, Liberate Jersey

## Thursday 10 January

**John Hodge**, Director, Shelter Trust; Trevor Garrett, Trustee, Shelter Trust; **Sean Pontin**, Manager, Jersey Alzheimer's Association; **Lionel Gomes**, Interim Director, Autism Jersey

**Deputy Richard Renouf**, Minister for Health and Social Services; **Robert Sainsbury**, Group Managing Director for Health and Community Services; **Karen Wilson**, Interim Director of Governance, Quality and Nursing (Community); **Dr Miguel Garcia**, Consultant Psychiatrist and Acting Clinical Director; **Rose Naylor**, Chief Nurse

## Written evidence

The Panel received the following written evidence:

[Liberate](#)

[Shelter Trust](#)

[CAMHS](#)

[Mind Jersey](#)

[States of Jersey Police](#)

[Dr J Bowley Submission](#)

[Family Nursing and Home Care](#)

[Jersey Recovery College](#)

[L.I.N.C Mental Health and Wellbeing](#)

[States of Jersey Prison](#)

[The Reverend Beverley Sproats](#)

[Jersey Alzheimer's Association](#)

[Minister for Education](#)

[Contact Consulting Ltd](#)

[Minister for Health and Social Services](#)

[Resilience Development Company](#)

