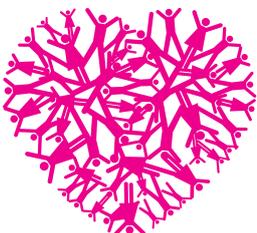
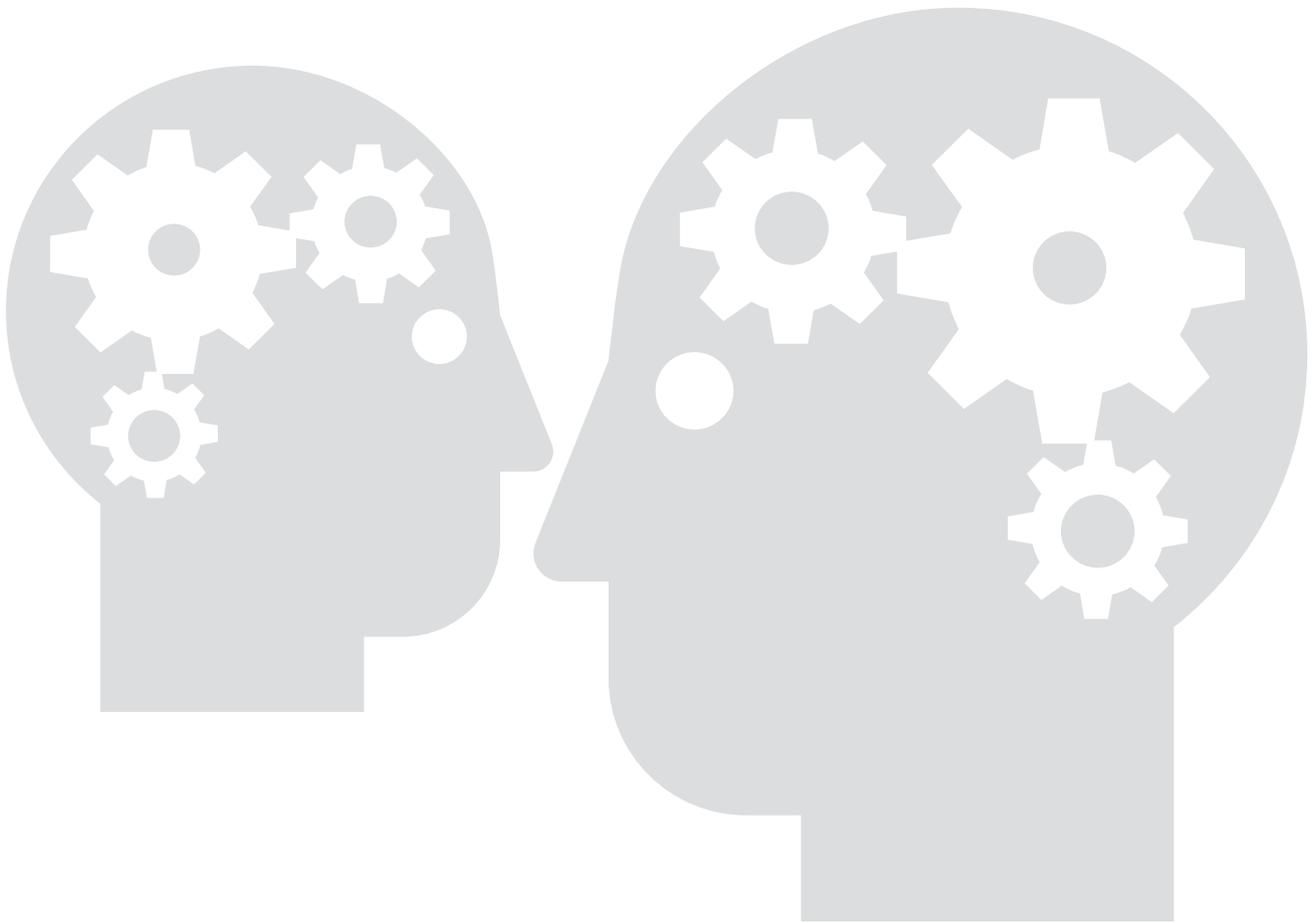


# A Mental Health Strategy for Jersey (2016 - 2020)

Planning together, for our future



## Ministerial Foreword

Mental Health and wellbeing really is everyone's business. Jersey is no different. We know that:

- one in four people will experience a mental health problem at some point in their lifetime one in six adults have a mental health problem at any one time
- one in ten children aged between five and 16 years has a mental health problem many continue to have mental health problems into adulthood.
- among people under 65, nearly half of all ill health is mental illness

In other words, nearly as much ill health is mental illness as all physical illnesses put together. There really is no health without mental health.

Mental health problems can have a wide ranging impact for individuals in a number of areas of their lives including housing, education, training, physical health and relationships with family and friends. It affects people of all ages and cultural backgrounds.

Investment has already been made to improve and develop services but addressing the impact of mental ill health and emphasising the importance of mental wellbeing for citizens, for local services and for the economy of our island continues to be a priority.

This strategy sets out our vision for:

- promoting mental wellbeing
- preventing mental ill health
- for services that will most effectively meet the needs of people with mental health conditions which can assist them in their recovery

It identifies the areas for change needed across Jersey so that we can ensure high quality mental health services for Islanders, no matter when they need them.

As the Ministerial Team for Health and Social Services we know that there has already been a considerable amount of work undertaken in producing this strategy. We would like to thank everyone involved in contributing to its contents and look forward to their support in the future as we begin the journey of implementation. With your help we are confident we can make a positive difference to people's lives.

Senator Andrew Green, MBE: Minister for Health and Social Services

Deputy Peter McLinton: Assistant Minister for Health and Social Services

Connétable John Refault: Assistant Minister for Health and Social Services

## Executive Summary

In 2012 the States Assembly endorsed the strategic plan for Health & Social Services called '*A New Way Forward for Health and Social Care*' (P82/2012). The vision described an integrated health and social care system and a programme of change that will meet the challenges facing the Island's Health and Social Services whereby services are safe, sustainable, affordable and where:

- Services are 'wrapped around the individual', with a single point of access for patients/service users and for care professionals, and individuals making informed choices and caring for themselves as much as possible
- More health and social care services are available in individuals' homes, and in community and primary care settings, with services provided by a range of professionals and care designed for the individual
- Efficient, effective, productive, integrated care which is received in the most appropriate place, provided by the most appropriate professional
- Telehealth, telecare and telemedicine as part of an integrated set of services
- Improved identification of those individuals who are in need or at risk, with a holistic assessment of health and social care needs
- Care provided in less institutional settings, including an increase in fostering for children
- Improved value for money and robust contract management. Services available from a greater range of organisations, with the Voluntary and Community Sector and other providers having opportunities to provide more care, and individuals have more choice and control over the care they receive
- A workforce which is better developed and deployed, with more services available locally wherever practical and affordable. Patients will be encouraged to support one another, and individuals will receive care from a range of professionals, including therapists and nurses

As part of this transformation programme a system-wide review of mental health services has been conducted using innovative participatory approaches which have included:

- A Citizens Panel to identify key building blocks for the future system
- Action Learning Sets of front line practitioners and service users to identify practice challenges
- Customer voice exercises, which enabled people who have used services to describe what went well and what could have gone better
- A System wide engagement event which used participatory approaches such as 'open space' to test and endorse the findings of the review process

These approaches have led to new insights into the challenges facing mental health. The different dimensions of these challenges were summarized in nine emerging themes:

- Securing joint working across the mental health system
- Developing the workforce
- Awareness raising, prevention, early help and support for young people and children
- Improving the money flow in the system to follow the service user
- Enabling workplace mental health interventions
- Building educational approaches to recovery
- Improving the service environment
- Developing mental health services in the criminal justice system
- Establishing outcomes, quality and measurement
- Culture and leadership

This work has informed the development of five priorities of the mental health strategy which offers a comprehensive strategic direction for future whole system development:

1. Social Inclusion and Recovery
2. Prevention and Early Intervention
3. Service Access, care coordination and continuity of care
4. Quality Improvement and Innovation
5. Leadership and accountability

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# Section One

## **Here and now**

## 1.1 Introduction

This mental health strategy identifies five high level priorities for:

- promoting mental wellbeing,
- preventing mental ill health
- delivering services that will most effectively meet the needs of people with mental health conditions

Building upon evidence and views gathered from practitioners, from service users and using innovative methods of public and service engagement it sets out the challenges and the proposed transformation of services and support.

Jersey has a continuously changing population profile. The overall population is predicted to continue to grow over the next 10-15 years. Within that growth are some important trends, in particular that by 2030 the number of people aged 85 or over will have more than doubled. In the same time frame the number of people aged 65 or over will comprise just over 23% of the total population of the island.

One in four people will experience a mental health problem at some point in their lifetime and one in six adults have a mental health problem at any one time<sup>1</sup>. One in ten children aged between five and 16 years has a mental health problem, and many continue to have mental health problems into adulthood<sup>2</sup>. Among people under 65, nearly half of all ill health is mental illness. In other words, nearly as much ill health is mental illness as all physical illnesses put together<sup>3</sup>. People with severe mental illnesses die on average 20 years earlier than the general population.<sup>4</sup> The increase in people living longer is likely to see an increase in the number of people living with dementia as well as other long term limiting condition.

50% of lifetime mental health problems have already developed by the age of 14.<sup>5</sup> The transitions from childhood to adulthood and then to older age are all important stages in an individual's life, perhaps even more so if they experience mental health problems.

A large body of evidence now ties experiences in early childhood with health throughout life, particularly in adulthood.<sup>6</sup> Strong evidence also demonstrates that it is possible to turn vicious cycles into paths to health, by intervening early.<sup>7</sup>

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<sup>1</sup>McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey* Leeds: NHS Information centre for health and social care

<sup>2</sup>Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004* Basingstoke: Palgrave Macmillan

<sup>3</sup>The Centre for Economic Performance's Mental Health Policy Group (2012) *How Mental illness loses out in the NHS*: London School of Economics

<sup>4</sup>No Health without Mental Health Department of Health 2011

<sup>5</sup>No Health without Mental Health presentation, O'Connor, Dr. S. RCPsych

<sup>6</sup>*Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America*. Braveman P and Egerter S for the Robert Wood Johnson Foundation, 2008

<sup>7</sup>Issue brief 1: early childhood experiences and health, Braveman P for the Robert Wood Johnson Foundation, 2008

Identifying and addressing mental and physical health needs in early years and with children and young people will help lay the foundations for improved wellbeing and reduce reliance on statutory services later in life.

Mental health problems can have a wide ranging impact for individuals in a number of areas of their lives including housing,, employment, education, training, physical health and relationships with family and friends. It affects people of all ages and cultural backgrounds.

Mental health problems in Jersey are present across all sectors of the population. Some of the determinants of mental ill health are also significant across the island. These include high levels of alcohol use, misuse of substances, social isolation and access to employment and housing.

This highlights the need to ensure that through this strategy and its intentions, the aim should be to identify and where appropriate, address the needs of all sections of the population.

The importance of public mental health and wellbeing is now well recognized to prevent mental ill health through population based interventions to:

- Reduce risk and promote protective, evidence-based interventions to improve physical and mental wellbeing
- Create flourishing, connected individuals, families and communities.<sup>8</sup>
- Develop population based interventions to create conditions that promote mental health and wellbeing that enhance population well-being in general and reduce incidence of mental health problems more effectively than interventions targeted only at at-risk/vulnerable individuals.<sup>9</sup>

As well as adopting a life course approach, this strategy is about how the other departments, service users and the citizens of Jersey can work together to promote and improve wider public mental health and wellbeing, reduce stigma and discrimination and achieve greater equity between mental and physical health. The strategy reflects these changes; the local imperatives as well as the policy and legislative requirements placed on health and social care.

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<sup>8</sup> No Health without Mental Health Department of Health 2011

<sup>9</sup> A new approach to reducing disorder and improve well-being Perspectives on Psychological Science 4 (10):108-111Huppert, F 2009

The development of a mental health strategy, which includes wellbeing, is the start of a process of development, innovation and delivery that will help to:

- Promote population mental health and wellbeing
- Improve the range of and access to mental health services
- Achieve States of Jersey policy imperatives
- Deliver good outcomes and improved value

The priorities identified within the strategy have been informed by other parts of the Health and Social Services transformation programme which include the Out of Hospital System, Sustainable Primary Care and the Acute Services Strategy. Joint working established during the strategy development period will continue into the implementation planning. In addition the mental health legislative and estate programme plan has also been an integral part of the strategy development process.

The strategy has been delivered at a time of financial constraint in Jersey. The costs of mental health services and the ongoing pressure on public finances mean that all services will continue to be scrutinised for value for money as well as clinical effectiveness. To deliver effective mental health services the Health and Social Services Department (HSSD) will develop its focus on what delivers the best outcomes and from that make informed decisions about how best to invest the resources available. HSSD will work together with its partners to review our spending, but retain a focus on improving mental health services across Jersey.

## 1.2 Policy and legislative précis

In conducting the review and in developing this strategy, consideration has been paid to a number of policy and reform objectives and imperatives. A short précis of the relevant areas is set out here. It is not an exhaustive list but is intended to provide a broad view of the policy context.

### **Health and Social Services: A New Way Forward – P82/2012**

In common with jurisdictions and countries across the world, Jersey faces significant challenges in ensuring the availability of high quality health and social care within a financially affordable sum. There are also some unique challenges, for example workforce pressures, limited services in the community, clinical viability and cost pressures due to diseconomies of scale. All health and social care systems are reforming and changing to meet the challenges of demand, cost and quality. And all systems are spending increasing amounts year on year, on health and social care.

Health and social care services are continually developing in order to improve quality and maintain safety. However, changes will not be able to keep pace with increases in demand due to a combination of significant ongoing funding pressures and the scale of challenges which Jersey faces in the next 10 years. A system wide view is required, with significant strategic service investment.

P82/2012 describes the vision of a health and social care system for Jersey which is safe, sustainable and affordable. This followed the publication of a Green Paper and White Paper “*Caring for each other, Caring for Ourselves*” in 2011 and 2012 respectively. Those two documents outlined the agreed strategic principles and the proposed key investments in service and system redesign required to meet the existing and future known service gaps and challenges.

In particular P82/2012 made the case for delivering more health and social care services in community and primary care settings. It also advocated for multi-disciplinary services where teams are comprised of a range of professionals, with a focus on a more holistic approach to assessment and interventions and services that are evidence based, efficient, effective, productive, integrated and provided in the right setting by the right people.

P82/2012 has already brought about investment directly into mental health services with the establishment of Jersey Talking Therapies and a service redesign of Alcohol Services.

An implementation plan has also been agreed for the development of community mental health services for older people including those with dementia.

There has also been investment in children’s early intervention services delivered by Health Visitors during the first few years of childhood.

Jersey Talking Therapies is a new service offering psychological therapies for people over the age of 18 years who feel anxious, worried, low or sad. This can include people who

have issues such as depression, anxiety, obsessive compulsive disorder, phobias, panic and post-traumatic stress disorder or are drinking up to 15 units of alcohol daily.

The redesigned alcohol service is now able to offer increased opportunities for detoxification and relapse services in non-hospital settings and has extended the choice and increase the efficacy of relapse prevention programmes available to people recovering from alcohol dependence.

The Maternal Early Childhood Sustained Home Visiting improve child and maternal health and wellbeing by providing a structured, evidenced- based program of sustained support in the home for families at risk of poorer maternal and child health and development outcomes.

The full document can be found at:

<http://www.statesassembly.gov.je/AssemblyPropositions/2012/P.082-2012.pdf>

### **Sustainable Primary Care**

In the adoption of P82/2012 the States Assembly *“requested that proposals to develop a new model of Primary Care (General Medical Practitioners, Dentists, High Street Optometrists and Pharmacists)”*

The demands on health and social services are changing. The growing number of older people, the rising demand for Children’s Adolescent Mental Health Services and mental health services are recognised as requiring a new approach to the provision of primary (as well as secondary) care services. In particular a new approach must deliver care, treatment and support closer to home, enable people to be independent and exercise choice and control over that care.

The development of a Primary Care Strategy and anew model of primary care that to be safe, sustainable and affordable offering value for money a central element of reform.

The Sustainable Primary Care Programme will set out a vision for the future that includes:

- An inclusive registration system
- Funding mechanisms that have long term viability, support and incentivise the provision of care out-of-hospital, optimise access and equality, and give value for money for the States and for Islanders
- A flexible workforce model designed to deliver high quality care across integrated care pathways, with the right staff and teams providing modern, accessible care in the right locations
- Information Technology that facilities an Integrated Care Record and provides data to support clinical decision making and assessment of quality, including patient-reported quality outcome measures

By January 2015 a set of ‘principles’ for sustainable Primary Care had been produced

through a series of workshops that took place in the latter part of 2014. Work is now ongoing to develop the strategy, by identifying the elements of a new model for Primary Care.

The next steps of the programme include modeling different scenarios based on the agreed principles. The results of this work will generate insights as to the strengths and weaknesses of particular scenarios and inform future service models. The strategy will be completed by the end of August with a public consultation following in the autumn of 2015.

### **The “Out of Hospital” System (OOH)**

The concept of the out of hospital system is a direct result of P82/2013. The overarching aim is deliver a person-centred approach which:

- enables people to stay in their own homes
- increases people’s quality of life and independence
- reduces demand on hospital and long term care beds
- improves clinical outcomes
- delivers value for money

Services are promoted through partnerships, including primary care, community voluntary sector and statutory services. The benefits of such an approach are twofold in that it builds greater community resilience and reduces individual dependence on services. In time, services will be able to focus on those who need them most; this reduces demand for building based services, including institutional forms of care and support, such as hospital, residential and nursing home services.

The next steps for this service development will be to include elements of mental health services which will integrate into the service model. In the first instance this will include the Older Adult Mental Health Liaison Service followed by integrated pathway development in long term conditions which will address people with co morbidities including depression, anxiety and dementia.

### **The Future Hospital Project**

The States of Jersey has considered the options for change and consulted with Islanders about the way forward. The Future Hospital project, is taking forward a series of plans for redevelopment of the hospital.

As part of the development of the Future Hospital, mental health issues are being carefully considered. For example, the project is committed to dementia friendly wards; the Emergency Department will have facilities to provide a place of safety for vulnerable children and adults to be assessed and helped to access appropriate services.

A feasibility study about the proposed plans began in January 2014. This is expected to be considered by the States Assembly in September 2015 and if approved, work on the Future Hospital development will begin in January 2016.

## **Community Social Services Estates Planning**

The provision of safe, suitable accommodation from which services operate has been acknowledged as an area that requires development in Jersey. A series of proposals and plans are in train to address particular service needs, most of which require some degree of capital investment in order to be realised.

The need to re-provide the existing adult acute inpatient service in more suitable accommodation has been identified as a priority. The option of co-location with older adult inpatient service provision is being explored. Alongside this there are also proposals for the relocation of day services for people with dementia and through vacation and refurbishment, the provision of updated accommodation for some community teams.

A detailed mental health estates strategy will be developed that will identify the longer-term mental health inpatient and community services requirements in relation to buildings and office accommodation.

## **Regulation of Care Law: Proposals**

In 2006 The States of Jersey acknowledged that the current legislation regulating health and social care was outdated and no longer fit for purpose.

It is proposed that the existing legislative framework for the regulation of health and social care in Jersey should be replaced with a single enabling Law, supported by specific regulations and codes of practice.

This will provide clear, modern definitions of regulated activities and provide for the comprehensive regulation of nursing agencies, domiciliary and primary care, including care provided by the States, within the same framework. It will require those managing services or working with people in need of health and social care to have appropriate qualities, skills and expertise to be safe and competent practitioners. It will also enable clear, comprehensive and enforceable standards to be set for the provision of different types of care to be set.

The law will establish a new independent Commission that will command public confidence to regulate the provision of health and social care and promote improvements in standards of care. The Commission will be established in 2016 and will lead a phased implementation of regulatory reform <sup>10</sup>

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<sup>10</sup> Regulation of Care Law: Proposals States of Jersey May 2013

## **Long-term care benefit**

Jersey faces a substantial increase in both the number and proportion of older residents over the next 30 years, with care costs predicted to more than double by 2044. The introduction of a long-term care scheme was designed to share long-term care costs more fairly across the community; and the scheme established a clear and simple process to help individuals and their families understand the choices available and plan for the cost of long-term care.

The scheme provides financial support to Jersey residents who have significant long-term care needs and who are being cared for either in their own home or in a care home.<sup>11</sup>

A considerable number of claimants for this new benefit will have mental health needs and will qualify for the benefit. It is important that support is in place for people to realise the opportunity of constructing a package of care that is personalised to them. This represents a significant shift in service provision and learning for claimants and service providers remains ongoing.

## **Mental Health Law review and capacity law**

Jersey's Mental Health Law is currently being reviewed. During the next 2½ years HSSD will be working with the Law Officers Department (LOD) to deliver both a new Mental Health Law and a Mental Capacity Law.

There is a recognised need for fit for purpose legislation which can address the deficits of the existing Mental Health (Jersey) Law 1969 and Criminal Justice (Insane Persons) (Jersey) Law 1964 (the "1964 Law") alongside an urgent need for Jersey to comply with the European Convention on Human Rights (Right to liberty). There is also a need for appropriate powers for courts to deal with cases involving Mentally Disordered Offenders ("MDOs") and to replace the 1964 Law.

The proposed new Mental Health Law has a number of key guiding principles:

- The establishment of new definitions and roles to ensure higher standards of care and better decision making
- Nominated Representatives and Nearest Relatives to give greater choice, but ensure efficacy of the law
- Compulsory detention for treatment revised to provide new, shorter time periods before each review of detention giving better protection for those detained
- Changes to leave of absence to encourage recovery and increased treatment in the community, subject to appropriate safeguards
- Express provision about consent to treatment and safeguards on compulsory treatment to provide greater clarity for professionals and better protection for vulnerable patients

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<sup>11</sup> Draft Long-Term Care (States Contribution) (Jersey) October 2013

- Provision for mental disordered offenders and replacement of the Criminal Justice (Insane Persons) Law 1964 to provide appropriate powers for the Courts to divert people from the criminal justice system where appropriate
- Continuing the role of the Mental Health Review Tribunal and maintaining and enhancing existing safeguards.

There has been no legislative framework to assess and support people who lose capacity in accordance with their human rights and the development of a Mental Capacity Law will address this gap.

The Capacity Law has a number of guiding principles:

- Test for assessing capacity and best interests to ensure better and more consistent decision making
- Lasting powers of attorney (LPA) to enable people to plan for their future
- Powers for the Royal Court to make decisions and appoint delegates thus, enabling decisions to be made in contentious cases and where there is an absence of an LPA
- Advanced decision to refuse treatment to provide better protection for patients and guidance for staff, and respecting people's wishes and dignity
- Clarifying when restraint can be used thus ensuring human rights compliance and providing greater safeguards for patients and staff
- Capacity and Liberty (CAL) assessments and authorisations thus ensuring human rights compliance and safeguards for patients and staff
- Wilful neglect and ill treatment, introducing a new offence that will provide more comprehensive protection for vulnerable people.

The developing and drafting of the legislation is ongoing and a significant body of work remains to be undertaken. At present, it is anticipated that both pieces of legislation will be enacted by spring 2018.

### **The Independent Jersey Care Inquiry**

The Independent Jersey Care Inquiry has been set up to establish what went wrong in the Island's care system over many years and to find answers for people who suffered abuse as children.

The hearings will be held in public, although at times the Panel may hear evidence in private session. The hearings will start in due course, once all necessary arrangements are in place. At present the Inquiry Team is collecting evidence from potential witnesses. These include people who were in care, those who worked in Jersey care services or came into contact with them, whatever their perspective.

The Inquiry Panel wants to build up as full a picture as possible so that it can then be in a position to make recommendations, ensuring that the Island's care system is fit for its purpose of caring for vulnerable children and young people.

One of the key tasks for the Independent Care Inquiry that is set out in its terms of reference is to set out what lessons can be learned for the current system of residential and foster care services in Jersey and for third party providers of services for children and young people in the Island.

In addition the Independent Care Inquiry is also required to report on any other issues arising during the Inquiry considered to be relevant to the past safety of children in residential or foster care and other establishments run by the States, and whether these issues affect the safety of children in the future.

### **Recent reports that link to this strategy**

#### **Suicide Prevention - A Strategic Framework for Action**

As a cause of early death, suicide represents a real public health problem for our community. Many more years of life are lost by suicide than other more common causes of death that tend to occur later in life.

The framework acknowledges that suicide is not an inevitable outcome and that it can be prevented. This document scopes the nature and size of the issue of suicide in Jersey and proposes ways of reducing it. It recognises that the prevention of suicide is a shared responsibility requiring a breadth of sustained approaches and actions across services, agencies and the community.

It identifies four high level objectives on which to base future actions:

**Objective 1:** Improve mental health and wellbeing in vulnerable groups

**Objective 2:** Reduce stigma about suicidal feelings

**Objective 3:** Reduce the risk of suicide in high-risk individuals

**Objective 4:** Improve information and support to those bereaved or affected by suicide

Further to Ministerial approval for the endorsement of the framework an action plan will be developed and integrated into the implementation plan for the Mental Health Strategy.

#### **Child & Adolescent Mental Health Services (CAMHS) - Scrutiny Report**

In June 2014 the Health, Social Security and Housing Scrutiny Panel published their report of their review of CAMHS in Jersey. The Scrutiny Report built upon work undertaken by a specialist advisor who was commissioned to advise on improvements to services provided to children, young people and their families who need to access specialist CAMHS in Jersey. This followed on from a review conducted by the charity Young Minds in 2006.

The Scrutiny Report required that a range of changes and improvements be taken forward, in particular these related to:

- Early intervention

- Emergency access and in-patient services,
- Governance and information management

The Scrutiny panel also made 10 specific recommendations in the report that directly addressed areas of concern in relation to gaps in service.

The full report can be found at:

<http://www.statesassembly.gov.je/ScrutinyReports/2014/Report%20-%20CAMHS%20-%2016%20June%202014.pdf>

In response to the Scrutiny report the CAMHS team spent a week working with experts in LEAN methodologies, to redesigning the service. Partner agencies were involved in this process. The redesigned service model is now established and has led to significant improvements including reducing waiting time to first appointment, which has dropped from 14 weeks to under 3 weeks and more efficient processing of referrals.

A range of clinical pathways have been developed to ensure that treatment is evidence based and benchmarked to monitor the effectiveness and efficiency of the provision. Work has been completed to standardise questionnaires to monitor outcomes and satisfaction with the service. Planning is in place to benchmark the service against national outcome data through the CAMHS Outcomes Research Consortium (CORC).

A fully implemented Systemic Family Therapy service for children and young people with significant mental problems and their families so that therapeutic intervention can be targeted to all family members when required. The recommendations made by Young Minds have now been implemented or superseded.

The Ministerial response was published in July 2014 and can be found at:

<http://www.statesassembly.gov.je/ScrutinyReports/2014/Ministerial%20Response%20-%20CAMHS%20-%2031%20July%202014.pdf>

## **Disability in Jersey**

A commitment to the development of a disability strategy was made by the States of Jersey in early 2014. Prior to that, a range of work is being conducted to establish the prevalence, profile and perceptions relating to disability through a focused research project. It has three main aims:

- To achieve an accurate set of data about the number and types of disability in Jersey
- To understand more about the lives of islanders with a disability
- To identify the needs and aspirations of islanders living with a disability

This work is expected to be completed by October 2015 with a view to informing the strategy which is expected to be complete by early 2016.

## **Acute Services Strategy**

This strategy is part of “*Caring for each other caring for ourselves*” and has been developed in the context of the changes described in the Future Hospital plans. It sets out proposals for the development of service models that will enable the delivery of acute care services to islanders, drawing upon best practice examples and has three core objectives:

- Preventing patients being admitted to hospital where safe and effective alternatives can be provided
- Treating patients as effectively and efficiently as possible when they are admitted
- Discharging or transferring them in a timely way when they are ready to go home or to an out of hospital service

It is important that all parts of the community have equitable access to acute health care at time of need. Research evidence shows that people with enduring mental health problems have poorer health outcomes than comparative groups in the population. In addition people with co morbidities presented challenges to acute health care services where the focus remains on one particular area of health or illness.

## 1.3 Overview of the Current Mental Health System

In planning for the future and considering the priorities for change in relation to mental health services it is important to consider a range of other associated information and data. In particular an understanding of the composition of the population, the demography and the current or predicted levels of prevalence for particular conditions is helpful when considering service development that can respond to those changes.

### Population – Demography

A census of the population of Jersey was held on 27 March 2011; the total resident population of the Island on this date was 97,857.

**Table One - Population from 2011 Census**

Age	Male	Female	Total
0	509	522	1,031
0 - 4	1,957	2,027	3,984
5 - 9	2,470	2,382	4,852
10 - 14	2,729	2,573	5,302
15 - 19	2,863	2,632	5,495
20 - 24	3,006	2,938	5,944
25 - 29	3,351	3,354	6,705
30 - 34	3,670	3,566	7,236
35 - 39	3,615	3,610	7,225
40 - 44	4,183	4,180	8,363
45 - 49	4,187	4,170	8,357
50 - 54	3,536	3,662	7,198
55 - 59	2,955	3,087	6,042
60 - 64	2,832	2,818	5,650
65 - 69	1,938	2,110	4,048
70 - 74	1,732	1,900	3,632
75 - 79	1,343	1,550	2,893
80 - 84	822	1,183	2,005
85 - 89	446	779	1,225
90 - 94	115	368	483
95+	37	150	187
<b>Totals</b>	<b>48,296</b>	<b>49,561</b>	<b>97,857</b>

Source: [www.gov.je](http://www.gov.je) - Census 2011.

Table one shows that the largest population age group is currently between 40-49 years. There are a greater proportion of females in the older age groups (65+), which reflects the increased life expectancy of women over men at these ages with particular pressure on mental health services for younger people and older adults.

Approximately 27% of the population of Jersey are under 25 and 16% of the population are aged 65 and over.<sup>12</sup>

<sup>12</sup> Report on the 2011 Jersey Census – States of Jersey Statistics Unit 2012

The States of Jersey Statistics Unit estimate that the proportion aged 65 and over in the population will increase over the coming years, which will consequently increase demand on local health services.

## Population Density

Jersey has an area of 119.5 km<sup>2</sup> at high tide. This translates to a population density of 828 people per square kilometre in 2012. A third of the Island's population lived in St Helier at the time of the census.

## Dependency ratio

The Jersey dependency ratio for year-end 2012 was 48% meaning there are 48 dependent children and adults for every 100 of working age. Essentially for every one child or person of pensionable age, there are two people of working age.

Under a population projection scenario, which maintains the current registered population, this ratio will increase to 66% in the medium term (2035). So, in future, Jersey is likely to have a higher proportion of dependent children and adults in its population (66 for every 100 of working age by 2035)<sup>13</sup>

## Population growth

Table two sets out the predicted growth in the population of Jersey up to 2030. It shows that by 2030 the number of people aged 85 or over will have more than doubled. Looking more broadly, the number of people aged 65 or over will have grown by over 10,000 and will comprise just over 23% of the total population of the island. Those aged 15-64 will comprise just under 62% of the total population of the island by 2030.

The total population of Jersey will increase by just over 8% by 2030 to 106,200, a growth of just over 8,000 people. This growth in population, and its pattern, highlights the challenges that public service reform in Jersey is designed to address.

## Table Two

### Population projected to 2030 - States of Jersey

	2011	2015	2020	2025	2030
People aged 0 - 14	15,169	15,800	15,900	15,600	15,300
People aged 15 - 24	11,439	11,300	11,300	11,300	11,600
People aged 25-34	13,941	13,100	12,900	13,000	12,700
People aged 35-44	15,588	14,500	14,000	13,600	13,600
People aged 45-54	15,555	16,400	15,100	14,000	13,800
People aged 55-64	11,692	12,700	14,400	15,200	14,100

<sup>13</sup> Jersey's Resident Population - States of Jersey Statistics Unit 2012

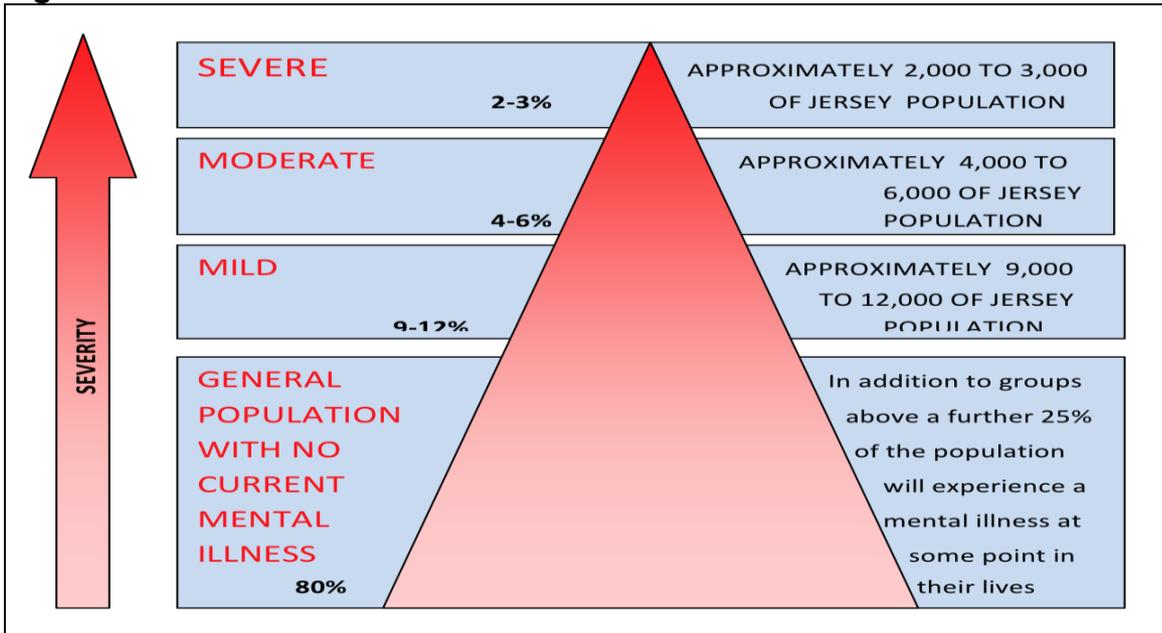
People aged 65-74	7,680	9,000	10,300	11,200	12,900
People aged 75-84	4,898	5,500	5,900	7,200	8,200
People aged 85+	1,895	2,200	2,800	3,400	4,000
<b>Total population aged 0-14</b>	<b>15,169</b>	<b>15,800</b>	<b>15,900</b>	<b>15,600</b>	<b>15,300</b>
<b>Total population aged 15-64</b>	<b>68,215</b>	<b>68,000</b>	<b>67,700</b>	<b>67,100</b>	<b>65,800</b>
<b>Total population aged 65 and above</b>	<b>14,473</b>	<b>16,700</b>	<b>19,000</b>	<b>21,800</b>	<b>25,100</b>
<b>Total population - all ages</b>	<b>97,857</b>	<b>100,500</b>	<b>102,600</b>	<b>104,500</b>	<b>106,200</b>

Table Two - 2011 population data taken from the census. All projections taken from States of Jersey Population Projections 2013 release.

### Estimates of Future Prevalence of Mental Illness

The figure below shows the estimated percentages and numbers of people who may experience mental illness in the population of Jersey over a 12-month period. This number is broken down by severity, based on diagnosis, disability and chronicity. The estimates of prevalence demonstrate the need to have a range of mental health services that can respond effectively to different levels of mental health need. It also shows the importance for integrated services to ensure that people have a smooth transition between different levels of service.

Figure One



Source: Contact Consulting (Oxford) Ltd 2015 based on modeling used in COAG National Action Plan on Mental Health 2006-2011

Figure One shows that the majority of the Jersey population is not currently diagnosed with a definable mental illness. However, from that group statistically around a quarter may develop some form of mental illness at some stage in their life. This has been a factor in the development of preventative forms of care and the raising of awareness so that emerging mental illness can be identified. This enables early interventions to be provided to reduce longer term reliance on statutory services. It also demonstrates that general practice is key in identifying emerging mental illness in the vast majority of the population.

Mild forms of mental ill health may be present in around 12% of the population, and many of these cases will be supported by primary care. Where appropriate liaison with secondary care and other services is in place, this segment of the population should not require the sustained input of specialist services.

Mental ill health at the moderate and severe tip of the diagram shows that a relatively small percentage of the population should experience mental illness that requires specialist intervention from secondary care services.

Overall, the figure shows that approximately 21,000 people may experience some form of mental ill health at some point, highlighting the need for the right range of services to meet those needs.

**Table Three**

**People aged 15-64 predicted to have a mental health problem, by age, projected to 2030 States of Jersey**

	2011	2015	2020	2025	2030
People aged 15-64 predicted to have a common mental disorder	10,982	10,948	10,899	10,803	10,594
People aged 15-64 predicted to have a borderline personality disorder	307	306	305	302	296
People aged 15-64 predicted to have an antisocial personality disorder	239	238	237	235	230
People aged 15-64 predicted to have psychotic disorder	273	272	270	268	263
People aged 15-64 predicted to have two or more psychiatric disorders	4,911	4,896	4,874	4,831	4,737

In 2011 there were 10,982 people predicted to have a common mental health disorder, this figure is set to reduce by 3.5% in 2030 to 10,594. Whilst the predicted number of people to have a common mental health disorder reduces the percentage of the total population within the same age range remains at a constant level at around 21%.

The trend illustrated by the figures within those people with a common mental health disorder is mirrored within the figures for those people predicted to have a borderline personality disorder. The reduction through the period 2011 to 2030 is slightly higher at four percent from 307 down to 296 but again given the reduction in the total population aged 15-64 in the same time period the proportion of those predicted to have a borderline personality disorder remains constant and in line with this.

The pattern is repeated through the rest of the table with reduced numbers of the population predicted to have a mental health problem through the period to 2030. This is counter intuitive to the current demand for access to services if taken in isolation but as has been shown the reduction is in line with the projected reduction in the total population and therefore the demand as a percentage of that population remains the same.

#### Table Four

##### People aged 65 and over predicted to have depression, by age, projected to 2030 States of Jersey

	2011	2015	2020	2025	2030
People aged 65-74 predicted to have depression	635	745	852	927	1,067
People aged 75-84 predicted to have depression	435	488	524	639	728
People aged 85 and over predicted to have depression	154	178	227	275	324
<b>Total population aged 65 and over predicted to have depression</b>	<b>1,224</b>	<b>1,411</b>	<b>1,603</b>	<b>1,841</b>	<b>2,119</b>

The numbers in this table relate to predicted prevalence of mild to moderate depression.

An overall increase of 73% can be seen in those aged 65 and over predicted to have depression, rising from 1,224 people in 2011 to 2,119 in 2030.

The greatest increase in those predicted to have depression can be seen in the age cohort 85 years and over showing an increase of 110% from 154 in 2011 to 324 in 2030.

The total number of those people aged 65 and over predicted to have depression stands at around 8% of the total population in the year 2011. Whilst there is an increase of those

predicted to have depression in 2030 this figure stands at a little over 8% of the total population aged 65 and over in 2030 and therefore a real terms constant level of demand between 2011 and 2030.

**Table Five**

**People aged 65 and over predicted to have severe depression, by age projected to 2030 States of Jersey**

	2011	2015	2020	2025	2030
People aged 65-74 predicted to have severe depression	157	184	211	230	264
People aged 75-84 predicted to have severe depression	159	179	191	234	266
People aged 85 and over predicted to have severe depression	74	86	109	133	156
<b>Total population aged 65 and over predicted to have severe depression</b>	<b>389</b>	<b>449</b>	<b>511</b>	<b>597</b>	<b>686</b>

There is predicted to be a steady increase in those aged 65 and over to have severe depression between 2011 and 2030. 389 people over 65 years were predicted to have severe depression with this number rising by just above seventy six percent to 686 people in 2030.

The greatest overall rise can be found in those aged 85 and over which shows a predicted rise of around 111% through the period 2011 to 2030.

A 26% rise is predicted for those aged over 85 in the period between 2015 and 2020. This is the single greatest increase that can be seen anywhere on the table of predictions.

The predicted increases shown in Tables Four and Five should also be seen in the wider context of the possible current or future usage of other forms of health and social care and the potential presence of co-morbidity (other health conditions experienced alongside mental ill health). The parity of mental health in relation to physical health therefore comes into sharper focus when considering the likely rise in prevalence and practitioners will need to be equipped to identify and meet these needs.

**Table Six****People aged 65 and over predicted to have dementia, by age, projected to 2030**

	2010	2015	2020	2025	2030
People aged 65-74 predicted to have dementia	229	258	311	316	354
People aged 75-84 predicted to have dementia	429	498	573	683	812
People aged 85 and over predicted to have dementia	489	566	730	936	1,181
<b>Total population aged 65 and over predicted to have dementia</b>	<b>1,147</b>	<b>1,322</b>	<b>1,614</b>	<b>1,935</b>	<b>2,347</b>

See footnote<sup>14</sup>**Rates for men and women with dementia are as follows:**

Age range	% males	% females
65-69	1.5	1.0
70-74	3.1	2.4
75-79	5.1	6.5
80-85	10.2	13.3
85-89	16.7	22.2
90+	27.9	30.7

See footnote<sup>15</sup>

Table six highlights an 104% increase between 2010 and 2030 in the population over 65 predicted to have dementia from 1,147 to 2,347. The increase in predicted numbers of those with dementia is also a real term increase when measured against the total population for those aged 65 and over.

The age cohort that illustrates the most significant increase is within those aged 85 and over where an increase of 141% can be seen from 489 to 1,181 between 2010 and 2030.

<sup>14</sup> Figures calculated using Jersey population model 2009 & Alzheimer's Research UK Defeating Dementia statistics 2012

<sup>15</sup> The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

To calculate the prevalence rates for the 90+ population, rates from the research for the 90-94 and 95+ age groups have been applied to the England population 2006 to calculate the numbers in each age group, the sum of these groups is then expressed as a percentage of the total 90+ population to establish the predicted prevalence of the 90+ population as a whole.

## Table Seven

### People aged 15-65 predicted to have a drug or alcohol problem, by age, projected to 2030 States of Jersey

	2011	2015	2020	2025	2030
<b>Total population aged 15-65 predicted to have alcohol dependence</b>	4,092	4,080	4,062	4,026	3,945
<b>Total population aged 15-65 predicted to be dependent on drugs</b>	2,319	2,312	2,302	2,281	2,237

The table shows a decrease in the number of people predicted to have alcohol dependence from 4,092 in 2011 down to 3,945 in 2030. As a proportion of the total population the number of people predicted to have alcohol dependence remains constant at around 3% throughout the same time period.

This pattern of projection is repeated within the table within those predicted to have a dependency on drugs with the figures reducing through the time period but remaining at a constant level when set alongside the total population projections.

Alcohol use has been recognised as a particular issue in Jersey and the annual Alcohol Profile contains more detailed information about rates of drinking among the island's population. Around 2% of all deaths annually are caused by deaths from alcohol specific causes, such as alcoholic liver disease and alcohol poisoning and account for around 300 years of life lost each year.

Deaths caused specifically by alcohol have increased in the past decade in Jersey In 2012 there were 13 deaths from such causes. Over the past three years there has been an average of 12 alcohol-specific deaths each year, giving a death rate of 11.2 per 100,000 population (2010-12). The majority of these deaths were due to chronic liver disease, accounting for 9.9 per 100,000 of the overall rate of 11.2 per 100,000.<sup>16</sup>

## Co-morbidity

People with long-term physical health conditions who are often the most frequent users of health and social care services often experience mental health problems. This can lead to poorer health outcomes and reduced quality of life.<sup>17</sup>

Depression is two to three times more common in a range of cardio-vascular diseases. People with diabetes are two to three times more likely to have depression than the general population and mental health problems are approximately three times more common among people with chronic obstructive pulmonary disease.<sup>18</sup>

<sup>16</sup> Alcohol Profile for Jersey Health & Social Services States of Jersey January 2014

<sup>17</sup> Long-term conditions and mental health The King's Fund 2012

<sup>18</sup> *ibid*

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.<sup>19</sup> 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.

Parity of esteem is a principle that is increasingly being adopted whereby mental health is given the same priority as physical health. By doing this, the range of co-morbidities is more easily identified and interventions that seek to support the whole person, rather than individual diseases or disorders can be delivered.

## **Child Sexual Abuse, Trauma and Mental Health**

It is becoming clear from the evidence presented by neuroscience that it is experiences laid down throughout our childhood that provides the blueprint for our future mental and physical wellbeing. Emerging research<sup>20</sup> supports the case for the development and provision of mental health services that are trauma informed. Key principles include but are not limited to;

- Child sexual abuse (CSA) is linked to many mental health disorders as well as self-harm and other non---psychiatric problems such as substance misuse, making lines of treatment diverse and requiring co---ordination.
- The likelihood of suffering from a mental illness in adulthood is increased four times if there is experience of CSA.
- Experience of multiple abuse or complex trauma in childhood can affect child development, with consequential impacts on health, educational achievement, and work and life chances.
- Personality disorder is increasingly associated with sexual abuse: 91% of patients with borderline personality disorder reported being sexually abused<sup>21</sup>
- NICE Guidance on PTSD (2006) reported that 50% of people with simple trauma had co---morbid affective disorders, anxiety and substance misuse.
- Professionals working with children and young people and with adults with a mental illness need to sensitively and routinely enquire about patients' experience of trauma and be confident that, when necessary, they can respond in a ways that are helpful and healing

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<sup>19</sup> Jersey Annual Health Profile 2014

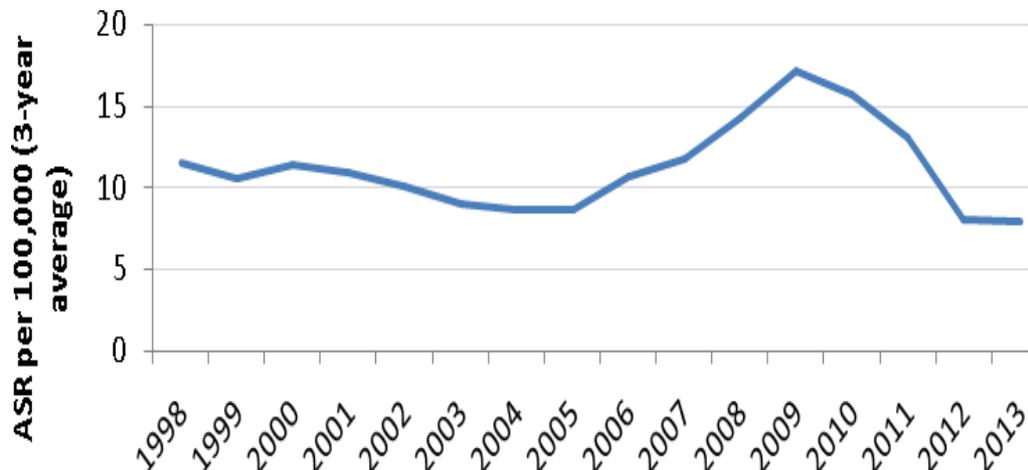
<sup>20</sup> National Centre Social Research: 2014: Violence, Abuse and Mental Health in England: Preliminary Evidence Briefing

<sup>21</sup> (Zannarini Et al, 1997, 2000).

## Suicide

Graph One shows the rate of suicide in Jersey from 1998 to 2012, using three-year rolling averages. This shows a peak in suicides in 2009 (17 per 100,000), which then reduces between 2010 and 2013 (8 per 100,000). Due to Jersey's small population, suicide rates can fluctuate year to year. Three year rolling averages are an average of the current year and the two previous years. Doing this allows trend data to be seen.

**Graph One:** Rate of suicide in Jersey from 1998 to 2012,



The most recent rate for suicide in Jersey is 8 per 100,000. This is lower than the most recent available European rate, which was 12.3 per 100,000 in 2010.<sup>22</sup>

## Community Mental Health Services – An overview of services

Throughout the review process a range of data and information has been provided which describes different aspects of the community mental health services. This information has included:

- Inpatient bed usage and length of stay information
- Community Mental Health Services
- GP prescribing for mental health
- Current capacity for Nursing & Residential Homes

<sup>22</sup> Preventing Suicide in Jersey: A Strategic Framework for Action (2015)

- Overview of Mental Health Services Provided by Community Voluntary Sector mental
- System performance data (Making Care Appropriate to Patients) Survey)
- Workforce information
- Financial information

In this section the data made available is presented and analysed to provide insight into trends or common themes, and to highlight issues relating to the performance or quality of services that have informed thinking about how to address gaps or build on strengths within the existing system.

### **Adult Mental Health Inpatient Services**

**Orchard House** is a 17 bed acute admissions unit for adults (17-65 years) experiencing acute mental illness or disorder. The unit also provides in-patient support for people experiencing acute episodes of mental ill health who are in La Moye prison. Orchard House received a total of 180 admissions in a twelve-month period, of which 59% (101) were male. In the same twelve-month period there were 183 discharges. Overall the ward operated at 80% of capacity.

The majority of those admitted (59%) were directly from their usual place of residence, 26% from other wards or departments of H&SS. 10% were admitted by the Police. The average length of stay was 2-3 weeks but with a range from less than a day to 52 weeks. The majority (74%) were discharged to home.

**Maison du Lac** provides a daily therapeutic recovery based programme of activities, tailored to meet the individual needs of people using in-patient facilities. No usage data has been supplied.

**The Liaison Service** received 583 referrals of which 340 (58.3%) were from A&E and only 15% from General Practitioners.

**The Clairvale Recovery unit** with 10 beds received 36 admissions within the twelve-month period and had 36 discharges, maintaining an average occupancy rate of 87%.

### **Older Adult Mental Health Inpatient Beds**

**Cedar Ward** is a 14 bedded acute mental health unit providing an in-patient assessment service primarily for Older Adults with functional mental health needs. In the course of twelve months there were 58 admissions, of whom around two thirds (37) were female. In the same twelve-month period there were 47 discharges. These figures include 6 return admissions during the data capture period. The average length of stay at discharge was 103 days, representing a range from 3 days to 876 days. Whilst the average stay for female patients was shorter than for male they made up the majority of those within the longest period.

The majority of patients discharged (51%) had a stay of 56 days or less but there was a significant cluster (8%) with stays of 197 days or longer. Overall the ward operated at 95%

capacity. The majority of admissions (53%) and of discharges (55%) were from or to the patient's home address.

**Beech Ward** is a 10 bedded acute mental health unit providing assessment of dementia and cognitive impairment. Traditionally focused on patients 65 years of age or over it currently focuses on presenting condition rather than age. In the course of twelve months there were 53 admissions of which 58.5% were female. In the same period there were 41 discharges. These included two return assessment admissions. Two admissions were for respite care. Average length of stay (excluding respite stays which averaged 7 days) was 73 days with a range from 3 to 286 days. The majority of patients had a stay of between 29 and 84 days. Overall the ward operated at 99% of capacity.

The majority of admissions (56%) came from the patient's home address with 22% coming from a General Hospital Ward and 18% from Community Residential Homes. Only 20% were discharged to home with the largest number (32%) going to Community Residential Homes 24% going to Oak Ward and 12% to Maple Ward.

**Maple Ward** is a 16 bedded continuing care / intermediate care ward for individuals with complex mental health requirements for whom return home or transfer to other long-term setting is not currently possible due to the level of mental health support they require. In the course of twelve months there were 23 admissions, of whom around two thirds (15) were female. In the same twelve months there were 11 discharges. These figures include one patient re-admitted during the period under study.

The average length of stay was 419 days, representing a range from 149 days to 1,427 days. Male patients had a substantially longer average stay at 526 days, compared with 312 for female patients, but this average may be distorted by a small number of male patients with very long stays. The majority of female patients spent between six months and a year on the ward. Overall the ward operated at 99% capacity.

The overwhelming majority (86%) of patients were admitted from a Mental Health Assessment ward with the remainder being admitted from A Community Nursing Home. 22% of patients died whilst patients on Maple Ward within a further 11% being discharged to General Hospital wards. 34% continued their care on Oak Ward and 22% in a community Nursing Home.

**Oak Ward** is a 26 bedded continuing care ward for individuals with complex mental health requirements for whom return home or transfer to other long-term setting is not currently possible due to the level of mental health support they require. In the course of twelve months there were 32 admissions, of which around 60% (19) were female. In the same twelve months there were 10 discharges. There were eight admissions for respite care; all of these were male patients. Average length of stay for those discharged in the year (excluding respite stays which averaged seven days) was 312 days with a range from three to 1,738 days.

The majority of patients had a stay of between 29 and 84 days. Overall the ward operated at 85% of capacity. The majority of admissions (69%) came from a Mental Health Assessment ward with 15% from General Hospital wards and 18% from Maple ward.

Unlike the NHS, Jersey continues to provide continuing nursing care beds which extend stays in inpatient units. When comparing the older people's assessment beds, Cedar and Beech with the statistics from the NHS Benchmarking Network, the UK mean length of stay for older adult wards was 72 days, compared to 73 days in Beech and 103 days in Cedar.

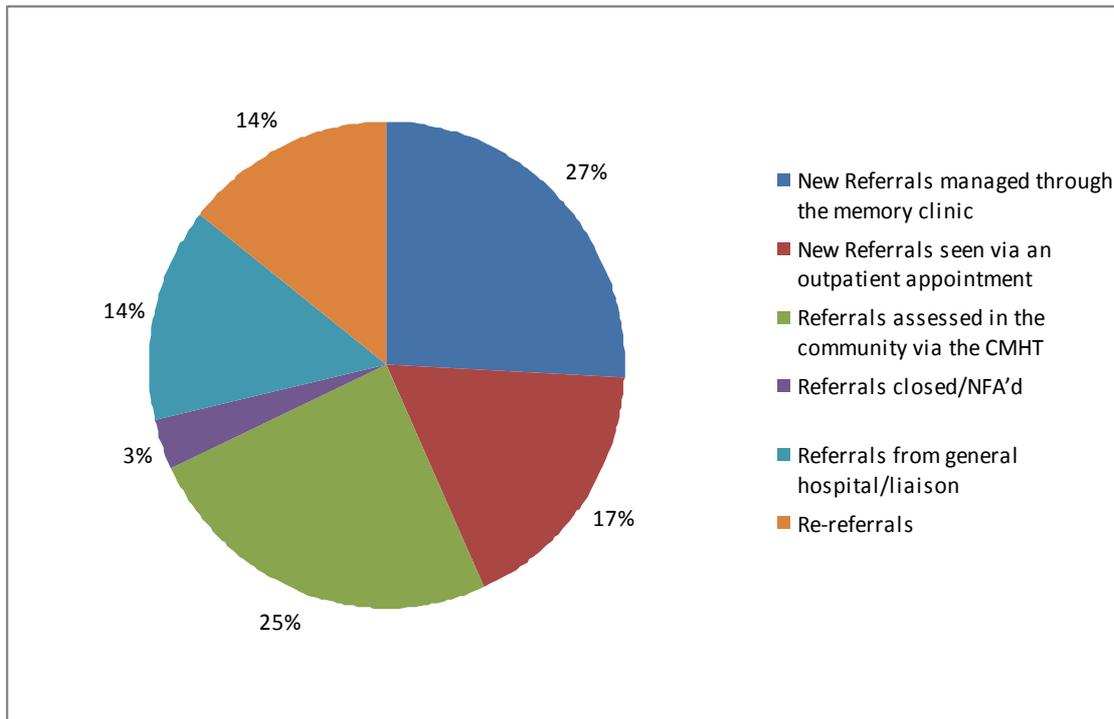
The data therefore suggests that the average length of stay is comparable. What it does not indicate is the appropriateness of ongoing provision of continuing nursing care within hospital environments.

### **Community Older Adult Mental Health Service**

The main function of the current Multi-disciplinary team is to provide an integrated, whole systems, person-centred, assessment, treatment, care planning, and ongoing management to older adults and their carers living in their own home or within a care setting. The memory assessment and diagnosis service is an integrated part of the team with a focus on early diagnosis and support to families. The memory service is accredited by the Memory Service National Accreditation Programme (MSNAP).

The team works closely with the GP's and other professionals to provide advice, information and training to equip them with basic knowledge and skills to work with the service user group.

**Graph 2: Referral Activity to the Community Mental Health Older Adult Services (June 2012 – June 2014)**



### Mental Health Liaison Service

The Mental Health Liaison Service offers early and timely assessment and interventions for people who are in crisis and experience mental health problems. The standard response time is within 30 minutes. The person will initially be assessed by a registered mental health nurse and if required supplemented by additional assessments from a Staff Grade Doctor, Consultant Psychiatrist and/or a social worker. The Liaison Service is accredited by the Royal College of Psychiatrist. In 2013 there were 563 new assessments were made by the service with 270 people attending follow up appointments. There was an upward trend in referrals during 2014.

**Table Eight  
Sources & Number of Referrals for Mental Health Liaison Service (2013)**

Source of Referrals													
Referrer:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
<b>A&amp;E Department</b>	32	23	29	27	20	21	25	20	36	30	41	36	<b>340</b>
<b>General Practitioner</b>	7	8	6	7	5	11	9	8	2	5	7	13	<b>88</b>
<b>Police</b>	2	2	0	1	1	1	0	1	2	0	6	2	<b>18</b>
<b>Emergency Assessment Unit or Jersey General Hospital</b>	7	7	5	3	12	15	5	11	11	5	19	16	<b>116</b>

<b>Other</b>	1	0	1	1	0	2	3	1	2	6	4	0	<b>21</b>
<b>Total</b>	<b>49</b>	<b>40</b>	<b>41</b>	<b>39</b>	<b>38</b>	<b>50</b>	<b>42</b>	<b>41</b>	<b>53</b>	<b>46</b>	<b>77</b>	<b>67</b>	<b>583</b>

## Community Mental Health Team

The Community Adult Mental Health Team is composed of mental health professionals from medical, nursing social work occupational therapy and psychology. The team is supported by an operational manager, clinical team leader, consultant nurse and clinical lead (medical).

People referred to the team are experiencing a range of mental health or emotional difficulties such as anxiety, psychosis, bi-polar disorder, depression. Referral is managed through the Single Point of Referral for Community Services. Routine referrals managed through a weekly multi disciplinary referral and allocation forum.

**Table Nine**

<b>Referrer:</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>	<b>Total</b>
<b>General Practitioner</b>	39	42	41	36	29	27	43	28	32	29	46	24	<b>416</b>
<b>Perinatal</b>	5	2	3	4	1	2	1	1	5	2	2	4	<b>32</b>
<b>Medical Cons</b>	0	2	0	0	0	1	0	0	0	0	0	0	<b>3</b>
<b>Psychology</b>	0	0	0	1	1	3	0	0	2	1	0	2	<b>10</b>
<b>General Hospital Wards</b>	0	0	0	0	0	2	1	0	0	0	0	0	<b>3</b>
<b>Prison</b>	0	0	0	0	0	0	0	0	0	0	1	0	<b>1</b>
<b>Other</b>	0	1	4	2	0	3	1	2	0	3	4	2	<b>22</b>
<b>Total</b>	<b>44</b>	<b>47</b>	<b>48</b>	<b>43</b>	<b>31</b>	<b>38</b>	<b>46</b>	<b>31</b>	<b>39</b>	<b>35</b>	<b>53</b>	<b>32</b>	<b>487</b>

## Source & Number of Referrals to Community Mental Health Team (2013)

### Children and Adolescent Mental Health Services (CAMHS)

The statistical data available in relation to CAMHS is limited. In the year 2013 446 referrals were received. Information suggests that the largest numbers of referrals come from adolescents from the age of 14 and 17, this cohort represents around three quarters of the total referrals and peaks among those who are 15 at the point of referral. Referrals among those between six and ten years of age run in the low to middle thirties for each age cohort, rising to mid-forties to 50 per year for those in each year of age from 11 to 13.

There appears to be some seasonal variation in referrals that may have a degree of convergence with the school year but the data is too imprecise to draw a definite conclusion.

## Primary Care Activity – Mental Health

Primary care has an important role to play in delivering mental health services. General Practitioners have been an important key gateway to services. An indicator of mental health activity in primary care has been the extent of prescribing for certain mental health conditions. In the future it is hoped that with better coding and integrated information technology systems more detailed analysis of primary mental health care will be able to be identified.

**Table Ten**

**Total number of prescription items dispensed for drugs used in mental health (2011 – 2014)**

Total number of prescription items dispensed for drugs used in mental health										
Number of prescription items dispensed	Alcohol dependence	Opioid dependence	Antipsychotics (including depot injections)	Drugs for mania/hypomania	Antidepressants	Anxiolytics	Hypnotics	Drugs for dementia	TOTAL	% annual growth
2011	416	27	5,229	1,620	76,333	15,292	27,383	2,986	129,286	
2012	426	39	5,451	1,591	81,240	15,683	25,256	3,725	133,411	3.2 %
2013	507	16	5,815	1,561	87,427	16,367	25,042	4,036	140,771	5.5 %
2014	628	10	6,408	1,605	91,053	15,587	23,044	4,607	142,942	1.5 %

## Jersey Talking Therapies (JTT)

This new service was launched in December 2014. The aim of JTT is to offer Islanders a service staffed with professionally trained therapists who will support them through a range of psychological therapies. Common mental health problems which someone might seek treatment for include anxiety, depression, obsessive compulsive disorder, phobias, issues to do with alcohol, and post-traumatic stress disorder. It is for people aged 18 and over. Referrals to the new service began in September, and 740 referrals have been received so far, mainly from GPs, with an average of 54 referrals a week. To date, a total of 154 people have been successfully discharged, while others are receiving ongoing therapy.

## Mental Health and a Place of Safety

In Jersey the Mental (Jersey) Health Law 1969, Article 47, gives Police Officers the power to remove a person who appears to be suffering from a mental disorder and is in need of immediate care and control and who is in a public place and is apparently a danger to him/herself or to other people, to a 'place of safety' where they may be assessed by a doctor. In Jersey there is no designated place of safety other than States Police

Headquarters to detain people who are considered at risk of self harm or harm to the public.

In Jersey, mental health assessments are requested by Forensic Medical Examiners (FME) for detainees they consider to be in need of hospital treatment for either self-injurious behaviour or concerns regarding serious mental illness. Health provides a mental health assessment service 24 hours a day and can be contacted by the FME as required.

Care of the vulnerable in any society is a joint responsibility. The table below shows the rising number of vulnerable people being detained in Police custody as a place of safety.

Custody - place of safety	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2012	13	3	12	7	5	7	8	3	1	3	9	9	80
2013	5	4	3	2	5	6	8	11	6	2	7	7	66
2014	8	8	5	9	10	10	18	10	2	6	4		90
Total	26	15	20	18	20	23	34	24	9	11	20	16	236

In Jersey 90 people per 100,000 population were removed to a place of safety in 2014, whilst in England during 2014 42 people per 100,000 were removed to a place of safety.<sup>23</sup>

### Return to Work Initiatives

The Social Security Department helps jobseekers back into work and aims to improve the prospects of finding sustainable work for all people, including those with poor mental health. The department recognises that worklessness is detrimental to health and wellbeing and its policies reflect the additional barriers faced by people with a mental illness.

The 'Work Right' and 'Occupational Support Unit' support jobseekers with significant employment barriers. The teams work in partnership with other agencies such as Jersey Employment Trust and Jersey Talking Therapies

A new assessment structure will ensure bespoke support is offered to those with the most challenging circumstances. Those who, initially, are considered to be unable to benefit from an employability provision due to severe barriers such as dependency and violent offending, are provided support from the Occupational Support Unit in partnership with other agencies to enable them address and manage their issues. People who have limitations meaning they are potentially employable, but a long way from work (problems such as addiction, a criminal record, long periods of unemployment, long periods of poor health) are assigned an Employment Advisor who will work closely with them. Their Advisor will agree actions and goals and will identify suitable and realistic employment opportunities and training to address barriers such as motivation, literacy or communication skills. As people progress closer to work they are given specific skills training and more intensive job search support.

<sup>23</sup> Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983, Review Report and Recommendations, Department of Health, Home Office, 2014.

## **Jersey Employment Trust (JET)**

The primary role of JET is to assist people with a disability or long term health condition (including mental health) to find and sustain open employment. JET is made up of a number of specialised support services which enable people to access a flexible range of options that can be tailored to their specific needs. Recent figures show a significant increase of referrals for individuals with a mental health condition (From 35 referrals in 2012, to 93 in 2014, going onto 100 referrals for the first 6 months of 2015), mental health now make up approx. 25% of JET's total caseload.

JET recognizes the need for mental health support, recovery and in employability for the overall health of an individual<sup>1</sup>. As such, within JET's services is a wellbeing support unit, which is made up of two health professionals, implementing evidenced based practice in mental health intervention and support. This includes, primarily, up skilling JET Staff with education, training and mentoring in mental health, to manage identified barriers or issues with referred clients. Other areas of support include education, training, advice and one to one support for clients in developing essential skills to either maintain employment or meet prospective employment needs. This intervention has laid the foundation for effective support and is evident in the increase in sourcing and supporting paid Job placements across all sectors (from 80 in 2013, to 152 in 2014, and in 2015 JET is on target for 200 paid job placements), with 28% of those placements being with a client with a defined Mental Health condition.

As an adjunct to the increased prevalence of referrals for clients with a mental health condition, JET recognizes, co-morbidity of mental health with other long term health conditions, and therefore refer to the wellbeing support for guidance. The wellbeing unit will then assess and support accordingly, to either provide clients and support staff with support measures or liaise with HSS for other support.

## **Overview of the Community & Voluntary Sector – Mental Health Services**

### **MIND (Jersey)**

Mind Jersey is an independent local charity that provides support to people living with mental illness. It sponsors the activities of an Independent Mental Health Advocate, whom provides invaluable support and advice, ensuring that those in need are heard and listened to. During October 2013 and October 2014 the charity received 268 referrals to its Mental Health Advocacy Service and supported 154 people under 65 and 114 people over 65 with choices about treatment, understanding their rights and accessing information about their care and treatment. The charity also delivered 500 hours of training during the same period playing an active role in the delivery of professional training ahead of changes to mental health law and capacity law.

The charity employs a family and carer's support worker whom works closely with the families and friends of people experiencing mental health illness. Mind Jersey has recently introduced a Peer Support scheme run by volunteers who have lived experience of mental health problems.

Mind Jersey also campaigns for a greater public understanding of mental illness and works closely with the statutory services seeking to influence decisions and policy that might lead to improvements in the range of mental health services provided. An area for early

attention and investment is in relation to Mental Health services that should be provided to young people, as it is recognised that early and low intensity interventions can be very effective.

## Jersey Alzheimer's Association

Jersey Alzheimer's Association provides help and support to local people with dementia and their families. The charity has a Drop-in/Office in St Helier and employs a full-time Educator to teach about dementia in a wide variety of settings. One of the services offered is the Saturday Club which is held every week from 9 am until 3.30 pm at the Poplars Day Centre, and is open to anyone who has dementia. This facility enables up to 25 families and carers to have a break while the person with dementia is cared for in a safe and stimulating environment by our Person-Centred Dementia Care trained staff. The charity also operates an answerphone Helpline and provides weekly art as therapy and music therapy classes. JAA works alongside HSSD staff to provide a monthly dementia café and weekly swimming class too. The total cost of providing the charity's services is £200,000 per annum, 90% of which comes from public donation.

## Youth Enquiry Services

The Youth Enquiry Service (YES) helps young people access information and advice so that they can make informed choices on a range of issues in their lives. YES is a 'One Stop Shop' for young people to access free, independent & confidential support & counselling via the drop-in centre, by phone, text, e-mail and through its website.

Open to all young people age 14 - 25, YES offers a universal access point to targeted and specialist services, supporting young people on a diverse range of issues that are frequently inter-related:

- social welfare issues e.g. benefits, housing, debt, employment
- mental and emotional health issues e.g. depression, low self-esteem,
- self-harm, family problems and stress
- wider personal and health issues e.g. relationships, sexual health, drugs and alcohol, healthy eating
- practical issues e.g. careers, money management, independent living skills

The table below shows the increase in referrals and appointments made by the service between 2008 and 2014

Number of new counselling referrals in 2008 (May – Dec)	Number of new counselling referrals in 2009 (Jan – Dec)	Number of new counselling referrals in 2010 (Jan – Dec)	Number of new counselling referrals in 2011 (Jan – Dec)	Number of new counselling referrals in 2012 (Jan – Dec)	Number of new counselling referrals in 2013 (Jan – Dec)	Number of new counselling referrals in 2014 (Jan – Dec)	Total
12	49	71	90	92	125	158	597
Number of							

counselling appointments in 2008 (May – Dec)	counselling appointments in 2009 (Jan – Dec)	counselling appointments in 2010 (Jan – Dec)	counselling appointments in 2011 (Jan – Dec)	counselling appointments in 2012 (Jan – Dec)	counselling appointments in 2013 (Jan – Dec)	counselling appointments in 2014 (Jan – Dec)	Total
31	213	474	607	735	919	1266	4245

## Shelter Trust

Aztec House provides 'walk in' emergency accommodation with provision of 35 units of accommodation. This includes the Drunk and Incapable Unit Accommodation consists of four secure single occupancy rooms situated at Aztec House.

Strathmore provides emergency single occupancy accommodation with provision of 16 accommodation units for homeless Young Adults aged 16 – 25 years.

Evans House provides single room occupancy accommodation for a maximum of 22 people. It offers medium term settled accommodation and resettlement support for previously homeless people now aged over 25 years. During 2014 the bed occupancy was approximately 50%

Midvale Road provides 17 self contained 17 single occupancy studio flats accommodation for medium term accommodation and resettlement support for previously homeless people now living independently. During 2014 the bed occupancy was approximately 65%.

## Residential and Nursing Home Provision

There are a range of Nursing and Residential homes. The table below shows that there is a total capacity of around 950 residential and nursing beds available in the private sector. There are four nursing homes that offer placements for people with diagnosis of dementia and one nursing home that has four beds for people with dementia. There are two residential homes that offer respite.

**Table Eleven**  
**Estimate of Private Nursing & Residential Beds**

Name	Nursing/Residential	Category of home	Total capacity
Glanville	Residential	Elderly	29
Glanville	Residential	Elderly (Respite)	0
Glenferrie	Residential		9
La Haule	Residential	Elderly - Dementia Care	55
Lavender Villa	Residential		20
Les Houmets	Residential	Elderly	26
Maison La Corderie	Residential	Elderly	32
Maison La Corderie	Residential	Elderly (Respite)	32
Pinewood	Residential	Elderly	48
Ridout	Residential	Elderly	9
Roncera y	Residential	Elderly - Dementia Care	25
St Helier House	Residential	Elderly	56
Stuart Court	Residential	Elderly	28
Little Grove	Nursing	Elderly	31
Palm Springs	Nursing	Elderly	25
Beaumont Villa	Nursing	Elderly - Dementia Care	4
Beaumont Villa	Residential	Elderly - Dementia Care	20
Clifton Care Home	Nursing	Elderly	27
Clifton Care Home	Residential	Elderly	7
Highlands Luxury Care Home	Nursing	Elderly	15
Highlands Luxury Care Home	Residential	Elderly	19
Jeanne Jugan Residence	Nursing	Elderly	14
Jeanne Jugan Residence	Residential	Elderly	66
Lakeside	Nursing	Elderly	28
Lakeside	Residential	Elderly	39
Lakeside Manor	Nursing	Elderly	15
Lakeside Manor	Residential	Elderly - Dementia Care	40
L'Hermitage	Nursing	Elderly	24
L'Hermitage	Residential	Elderly	17
Maison St Brelades	Nursing	Elderly	49
Maison St Brelades	Residential	Elderly	2
Silver Springs	Nursing	Elderly	34
Silver Springs	Residential	Elderly	33
St Ewolds	Nursing	Elderly	5
St Ewolds	Residential	Elderly	61
			<b>944</b>

## **Residential respite for People Diagnosed with Dementia – Pilot Project**

Having access to regular respite for carers supporting family members with dementia is extremely important. As part of the investment in the first phase of P82 a pilot scheme was set up to increase carers access to respite services.

Respite involves providing a care service in the individual's home, allowing the carer to go out and attend social activities and reduce social isolation or to remain at home but not be responsible for the care needs of their loved one. These types of packages can include weekly sitting services, 24 hour home care, and weekly overnight care.

For those people who received residential care wherever possible the carer was given the residential care home of their choice for the period of respite.

Dementia respite provision is available to carers of adults with dementia irrespective of the age of the person living with dementia. During 2014 there were two main types of short break /respite provided:

- Residential respite: There were 34 people accessing residential respite with a total of 873 days over 10 different residential homes.
- Community respite: There were 15 people accessing community respite with approximately 1,717 hours used over 8 independent domiciliary care providers.

There remains anecdotal evidence, including that from Jersey Alzheimer's Association that the demand for respite care continues to outstrip supply, and may continue to do so as incidence rates rise.

## **Making Care Appropriate to Patients (MCAP) data**

As part of wider system reform, the Oak Group<sup>24</sup> were commissioned by HSSD to conduct a study of service outcomes across health and social services. The findings were first presented in December 2014 and give an insight into how the system is performing as a whole. The key areas of note in relation to mental are set out here, and were presented during the action learning set process as a means of contextualising participants practice challenges.

### **Overall key themes**

- Of the 75 mental health patients reviewed 36% of admissions and 55% of continuing days of stay were "non-qualified". That is to say admission and continuing stay were unnecessary for the effective treatment of the patient.
- Overall 73% of non-qualified days could have been provided in a supported living environment.

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<sup>24</sup> The Oak Group supplies medical intelligence to increase efficiency in providing healthcare by ensuring that patients receive the right care in the most appropriate care setting.

- Reviewing the reasons that blocked a patient from receiving the correct service level the Oak Group Report identifies:
  - Nursing home: clinician records predominate.
  - Home with support services: discharge issues are most important.
  - Residential: alternate care issues are the majority.
  - Outpatient services such as crisis intervention, detox services, and secondary care: alternate care issues are dominant.

### **What the data shows in relation to processes leading to admission**

- 63% of admissions came through transfers from other wards or hospitals. Of these 33% were “non-qualified”
- 23% came from direct CPN referrals of which 53% were unqualified.
- 14% of admissions came from other sources.

### **What the data shows in relation to discharge planning**

- Only 7 of 75 (9%) of patients had some discharge planning notes that were done after admission.
- None of the dementia patients had a discharge plan.
- 4 of 75 (5%) of patients had an estimated date of discharge (EDD).

None of the dementia patients reviewed had an EDD.

### **What the data shows in relation to alternatives to admission**

- 24% of primary reasons for the occurrence of a “non-qualified” day when the patient could have been treated at a lower level of care related to the inadequate availability of alternative service levels.
- 81% of non-qualified admissions could have been prevented by providing a supported living environment.
- 95% of non-qualified days related to dementia could have been avoided with a supported living environment.
- 52% of acute non-qualified days could have been avoided with a supported living environment.
- 25% of non-qualified acute days required a variety of outpatient mental health services.

### **Conclusions that may be drawn from the MCAP data**

- That the mental health service is more focused on admission than discharge.
- That early pro-active planning for discharge and continuing care planning (where appropriate) is under-developed.
- That a substantial proportion of those admitted, or retained as in-patients, might have been effectively treated in other environments.
- That there is a shortage of housing based alternatives to provide a safe and appropriate context that offers an alternative to admission and in-patient care.

## Mental Health Workforce

In common with other jurisdictions Jersey faces workforce challenges. A summary of local workforce data was presented during the review process. It was recognised that this data was not complete and therefore benchmarking it appropriately is difficult. However, four key issues arose from the review of that information:<sup>25</sup>

- Low staffing numbers
- Low attrition in all services i.e. few starters and leavers through the year
- High sickness levels
- An ageing workforce; loss of experienced staff and difficulties in recruitment

### Low staffing numbers

Staffing in health and social care is relatively light and highly reliant on very small numbers of individuals. This is an issue as many health and social care staff are approaching retirement age. There are relatively low numbers of staff involved in mental health services compared to similar sized populations (or localities) in other services in the UK across mental health services. This was borne out by stakeholders who consistently referenced workforce capacity pressures. This has the potential to create a limited career structure in an area of health care not always regarded as a popular specialism. This may have had some impact on the quality of staff providing services and will probably mean that those with the necessary level of expertise and skill are more stretched.

### Low attrition rates

Attrition (staffing turnover) is currently very low in adult and children's mental health services i.e. 5.7% and 4.6 % respectively. Across health services generally, turnover would normally be in the region of 10% to 14%. High turnover means new staff with fresh ideas coming into an organisation and at the same time maintaining services safely whilst retaining skills and expertise. The situation in services for older people is slightly better in that attrition is around 9.6% however this would still suggest a relatively static workforce. Insights gained from stakeholder interviews and the shared experiences of front line staff attending Action Learning Sets suggest similar patterns across other statutory and large voluntary sector services.

Often in circumstances where attrition is low there is also a propensity towards '*this is how we do it here*'. In the stakeholder interview process a clear theme was an expression of a culture of paternalism and that over many years custom and practice had developed that, when set alongside the low turnover and lack of incoming staff with experience of other systems, created one that was hard to change in terms of the approach to practice and service delivery. This perceived reluctance to change may have a negative impact on new staff in that there could be a risk of them feeling marginalised and therefore unlikely to stay long enough for any new ideas to be adopted.

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<sup>25</sup> As with other data provided and reviewed, there were some discrepancies, in this case this was in relation to staffing numbers in services that did not match across various sources of data.

## **High sickness absence levels**

Using the English NHS as a benchmark, sickness targets have been set at 3% with a number of providers now achieving around 2% to 2.5% sickness absence. On average 1% of sickness equates to approximately £1m in additional costs to health care organisations.

Currently, the sickness level in the Jersey mental health services is running at around 7%. The impact of this is likely to be adverse in terms of quality, capacity and morale. It is not currently possible to offer a comparison with sickness absence rates across primary care and community voluntary sector organisations.

## **Ageing workforce**

The age demographic of staff working in mental health services has been an issue for some time and not only in Jersey. The same trend is likely to be seen across primary care and community voluntary sector organisation. The current pressures and those over the next decade locally are those related to experienced staff reaching retirement age and being lost to the service. This will leave gaps in skills, knowledge, competence and management capacity.

## 1.4 The financial landscape

Although savings were made in the mental health budget between 2011 and 2013, mental health has been relatively protected from the impact of previous budget challenges. Investment has been made, some of which has been a direct result of the priorities set out in the White Paper P82/2012 *Caring for each other caring for ourselves*.

That investment has included resources to develop Jersey Talking Therapies, a new service being delivered in partnership between HSSD and Jersey Mind. The service provides psychological therapy and interventions for people experiencing common mental health problems such as anxiety or depression.

White paper monies have also been used to invest in the Maternal Early Childhood Sustained Home-Visiting (MESCH) service. MESCH is a structured programme of sustained nurse home visiting for families identified to be at risk of poorer maternal and child health and development outcomes. It is being delivered by the Family Nursing and Home Care charity as part of a comprehensive, integrated approach to services for young children and their families.

However, the financial landscape in Jersey is changing. Like many health and social care economies where secondary care is resourced through public funding raised by taxation, Jersey faces the challenge of providing high quality services at a time when the allocation of public resource and the provision of new investment is more limited than has perhaps been the case in the past.

As part of the review process, figures for mental health service budgets were reviewed and the following section sets out in summary the key messages from the analysis of the figures presented.

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.

Taking the budget figures for Mental Health Services from each of the three divisions: Children and Adolescents, Adults and Older Adults; the combined budget for Mental Health Services for 2014 was £20,513,663.

Of this budget the CAMHS and the adult mental health service budgeted to spend a combined total of £3,516,054 on out of areas placements in the UK.

## **Children and Adolescent Mental Health Service (CAMHS)**

The total budget for CAMHS in 2014, which combines on-island services and UK placements for children, was £2,624,365, an increase of £390,523 between 2012 and 2014.

Of this spend £1,810,210 relates to UK placements of children which is an increase from the out-turn figure for 2011 when the budget of £1,360,210 was overspent by £422,904. This increase in spend reflects the priorities that were being tackled in this time frame in relation to the care of children with mental health problems in Jersey.

## **Adult Mental Health Services**

The total budget for Adult Mental Health Services in 2014 was £11,074,790, an increase of £1,256,892 over 2013 when there had been a negative variance against budget of £127,125.

The structure of budget lines makes the attribution of costs to particular service configurations challenging as some lines relate to specific services and others to elements that may contribute to more than one aspect of service.

For example: in estimating the cost of in-patient provision for Orchard House what proportion of the costs shown as “In patient team clinical lead” should be attributed. The headline cost for the 17 bed Orchard House in-patient facility is budgeted at £1,263,275 which, when taken with the bed occupancy data shows an occupied bed cost of £251-60p per night.

The budgeted cost for UK placements for adults fell from £1,827,004 in 2011 to £1,705,844 in 2014.

## **Older Adult Mental Health Services**

The budget for Older Adult Mental Health Services rose from £5,513,575 in 2012 to £6,814,508 in 2014, an increase of 23.6%. Around 60% of that increase is accounted for by exceptional items such as building works at Clinique Pinel.<sup>26</sup> The out-turn figures have shown negative variance against budget in each of the years for which we have complete data: £224,788 in 2011, £124,067 in 2012 and £100,944 in 2013. These deficits have been driven by the financial performance of in-patient provision.

Beech Ward has moved from deficit to around break-even but Cedar, Oak and Maple Wards have all shown negative variance against increasing budgets. These four wards represent around 55% of the total budget for Older Adult Mental Health Services. The financial position in Jersey means that the sustainability of health and social care services is a key issue and mental health cannot stand to one side of that. To do new

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<sup>26</sup> In 2014 the budgets of all services were impacted by the implementation of a 9% salary increase for nursing staff.

things, or to maintain those that are effective may mean stopping doing other things. Innovation and changing practice will be at least as important and valuable as any future investment arising from the implementation of this strategy.

## Section Two

# **Insights from the review process**

## 2.1 Summary of the approach taken for the review

In order to fully understand the potential options for providing high quality mental health services in the future, a system-wide review was completed to guide the development of the mental health strategy. Without a whole-system review it would have been difficult to identify service areas that are performing well, when compared to other jurisdictions, and which service areas are not. This would have meant an increased risk of future services delivering poor patient experience and poor treatment outcomes. A full description and report of each element of the review is provided in the appendices of the strategy. An overview is provided here along with the key insights gained from each element of the review process:

- *Phase 1 (Preparation)* A desk top needs assessment of public mental health needs with further description of current spend and activity of existing mental health services was completed. Stakeholder interviews were also conducted with Directors and senior managers from across the mental health system.
- *Phase 2 (Citizen Jury)* A Citizen's Forum was convened to collect perspectives, from the public and identify the key building blocks that should underpin any future mental health system.
- *Phase 3 (Learning Sets)* Action learning sets were set up and clustered around four focus areas which will included, prevention (building reliance), early intervention (nipping problems in the bud), acute intervention (when things take a turn for the worst), recovery and support (what helps us cope). Each action learning set will meet 5 times over the course of the review period.
- *Phase 4. (Customer Voice Exercise)* A range of methodologies were used to engage service users and gain insights into their experience and viewpoint.
- *Phase 5 (Engagement Day).* An invited audience of 110 key stakeholders to test and shape emerging themes which have been developed as a result of previous work during the review. Resulting detailed themes then used to inform priorities which featured in the Mental Health Strategy.

## **2.2 Key insights**

### **2.2.1 Stakeholder Interviews**

The following is a summary of the key issues and our impressions arising from the interviews grouped by theme:

#### **Culture and practice**

- Culture was highlighted a key factor in the way services have been designed and operated over the years. The consistent word used to describe services was 'paternalistic'. This is borne out by a clearly articulated commitment to help and support people, but it was reported that this commitment is sometimes misdirected and leads to an over-reliance and long-term dependence on support from statutory services.
- The ability to engage in positive risk management was reported to be limited and that an overly cautious approach that focuses simply on safety further promulgates a paternalistic approach to the provision of services.
- It was reported that the threshold for the receipt of services is not well defined. This in turn was felt to cause considerable problems in relation to capacity management, waiting times, inappropriate referral and move on to other services.
- People's expectations about services and what they should receive remain high.
- It was reported that the services are still heavily dominated by a medical approach to intervention.
- Change has tended to be organisationally driven rather than led by the needs of the population. The need to engage in a culture change was felt to be overdue, but it was recognised that this will not be the work of a moment but would require not only support and sign-up, but sustained focus.

## **Quality and Governance**

- It was reported that that governance systems have not been well developed but that work was in train to address this.
- It was felt by some that there remain issues in relation to professional and clinical leadership and how this is structured, operationalised and fed into any system of quality assurance and governance.
- Some concerns persist among stakeholders about the robustness of regulation and oversight of professionals.
- Agreement that data is variable in quality and there has not been enough focus on outcomes.

## **Recruitment, retention and leadership**

- It was reported that a skills gap remains across the range of professions and that services were heavily slanted towards a medical model of leadership and practice.
- Attracting new people to work on the island remains difficult for a range of reasons, including cost of living, concerns about professional atrophy, a glut of specialists and a dearth of generalists.
- According to some stakeholders, the balance of roles need to change and a more diverse professional workforce is needed that can work in a multi-disciplinary way. Although work is underway, the lack of a mental health workforce plan or strategy, allied to the lack of accurate data about the workforce composition was recognised as a deficit that impedes strategic planning.
- The need to strengthen both clinical and managerial leadership across the system in order to lead and build sustainable change was reported during the interviews. Hearts and minds will need to be captured if the ideas developed in coming months are to be implemented and that 'champions' will be needed to lead and support the change process.

## **Finance and information**

- Although savings have had to be made it was recognised that mental health has been relatively protected from the impact of previous budget constraints.
- Investment has been made in mental health and this was widely recognised, notably in relation to Jersey Talking Therapies. 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.
- The financial position across the island means that the sustainability of services is a key issue and it was recognised that mental health cannot stand to one side of that. To do new things, or to maintain those that are effective will mean stopping doing other things. In other words, it was felt that the need to decommission should not be overlooked when thinking about what might be re-commissioned or newly commissioned. Innovation and changing practice will be at least as important (and valuable) as any investment.

## **Primary care**

- Primary care featured consistently in the discussions with stakeholders and this reflects the importance of the work being led elsewhere by HSSD on sustainable primary care for Jersey.
- There was concern among stakeholders that the 'perverse' incentives in the current system that have had an impact on the nature of intervention, a reliance on a pharmacological model and a sense of poor engagement and communication between primary and secondary care.
- It was reported that communication between primary care and secondary care requires improvement from both sides. A clear wish to engage GPs in a meaningful debate about joint working, risk management and developing the links between physical and mental health was expressed throughout.

## **Prevention**

- Stakeholders consistently cited the need to invest upstream in more effective prevention services with the aim of reducing the need for statutory services in the future.
- Views differed about the nature of 'early intervention' and how this might be delivered but there was a recognition of the need for a balance to be struck between 'statutory' early intervention for young people who require some form of support because they have symptoms of illness and the need to develop a set of prevention interventions that may be more of a public health lead approach that seeks to reduce stigma and raise awareness.
- Stakeholders believed that the role of schools, the education department and of employers in developing and delivering a programme of preventative action would need to be explored if a more resilient community is to emerge in Jersey.

### **2.2.2 The building blocks of a better future mental health system**

These building blocks were developed and agreed by the Citizen Panel and then used as an ongoing reference point for the other elements of the review including the shaping of the key themes that emerged in the ALS, Customer Voice and Engagement Day discussions.

## **The Building Blocks**

### **1. Continuity of care and services working well together**

- a) Services need to be integrated
- b) Someone who comes back to you and someone you know and trust
- c) Coordination of services, working together holistically, but to do this there needs to be an awareness of all that is involved in mental health.

## **2. Accountability**

- a) Complaints about patient care; who do you complain to? What can be done? Are staff disciplined if they have broken care guidelines etc?
- b) Is psychiatry a job for life? Can you get the sack for bad performance – high suicide rates / bad feedback from patients / please ask for feedback
- c) Bad practice: psychiatrists who perform badly, issue wrong prescriptions, call you by the wrong name when it's on the computer in front of them they have known you for years. Who do you complain to when they all stick together?
- d) Accountability in mental health services to address complaints about staff.

## **3. Not tolerating stigma amongst the public and professionals around people with mental health problems**

- a) Challenging stigma-education
- b) Non judgmental
- c) There needs to be education on mental health (what it is....)
- d) Why do general clinicians need to know mental health diagnosis when it is not necessary for physical diagnosis as this causes stigmatisation and often defers from an actual physical diagnosis i.e. its in your head.
- e) Why is mental health services department separated from the general hospital? Makes stigma more prevalent, difficulty then getting to pharmacy.
- f) Physical health of mental health sufferers can be overlooked by medical staff who effectively 'stigmatise' the patient as having mental health issues.
- g) Medical staff need to be more understanding and treat patients as human beings, involve the patient in treatment where possible not referring to patients as 'revolving door'

## **4. Adequate numbers of trained and well supervised people working in mental health with suitable working conditions**

- a) No 24 hour local mental health support on the phone
- b) Hospital casualty staff need better training
- c) We need a system that considers the future demographics e.g. aging population therefore increased risk of dementia e.g. alcohol and drug use.
- d) We need a system that learns from elsewhere e.g. links with Guernsey and the UK
- e) The need for staff at school to be aware of/look out for mental health issues in children.
- f) Key workers in schools with children with behavioural problems need training and support. Staff need to be compassionate.

## **5. Recognise the impact of suicide in Jersey**

- a) Suicide prevention what would it look like?
- b) The shock and horror of unexpected suicide here in Jersey in a very small community is hard to describe. There is a massive need for a bereaved family to receive professional support, counselling at the right time is so important.
- c) Could there be a local advertising campaign that highlights the effect of suicide and support available encourage to tell someone if they have thoughts.

## **6. Recognise the causes of mental health (e.g. unemployment, stress, loneliness, isolation)**

- a) Some people can't afford a GP appointment
- b) Challenge loneliness and isolation

## **7. Speedy response at the time of need with someone coming back to you**

- a) Need emergency cover 24/7
- b) Need improvement to services
- c) Long waiting times
- d) Timely action to every inquiry
- e) Someone who comes back to you
- f) Transition from different services and departments

## **8. The need for confidentiality**

- a) Someone you knew and trusted
- b) Trust and confidentiality in medical staff

## **9. A focus on prevention including investment**

- a) Learning mindfulness
- b) Family/friends and support for them
- c) Use exercise to promote wellbeing
- d) We need to recognise that the children with behavioural problems now in schools are the future of our mental health resources.
- e) Robust anti-bullying protocols in schools/companies
- f) Preventative therapies: relaxation etc, promote wellbeing before the tipping point
- g) Build self esteem
- h) Educating children to pursue happiness, follow their dreams, not to listen to other people's negativity, set their goals, dream big, build self-esteem and resilience.
- i) Helping make sure children develop coping strategies but also learn from experience.
- j) Prevention: ante/post natal input, meditation/massage
- k) Education for with children with behavioural problems, CAMHS is under resourced.
- l) Family and home support, build up the parent

## **10. Easily accessible information about services and where to find help and support**

- a) It would be very useful to have a list of GPs who have an interest / specialty in mental health as my previous GP was unaware what was available from the psychology department.
- b) A big need for a central access point to gain information and direction for your issues.
- c) Need to publicise available helplines
- d) Need doctors to explain to me what is happening to me and what pills will do? (e.g. side effects and addictive nature)
- e) Some people don't know what support is available.
- f) There should be a centre where people can go when they need help. That centre should be able to advise what direction to go in.

- g) GP availability
- h) Who to speak to?
- i) Central point of where to find information
- j) If States of Jersey weren't so selfish my friends would still be here.

**11. Value and support the role of people and organisations outside the formal / state system (e.g. families and carers, friends, church, charities, work, youth services etc)**

- a) Support for carers, meetings and respite
- b) Needs to be a whole system that incorporates 'non-mental health' services i.e. church/exercise/family/charities.
- c) Support for carers and family as sometimes they are the most useful
- d) Volunteering, give something, getting something back
- e) There needs to be support for Jersey (e.g. MIND) charities not UK based charities (like Macmillan Cancer research)

**12. Explore, offer and invest in different therapies/support and ways of delivering them because one size doesn't fit all.**

- a) Family support services (e.g. Bridge) should get funding from the state but not if it means it loses its independence.
- b) People have been trained in family therapy but family therapy is not available, it needs to be.
- c) Possibly the reason there is not higher bed occupancy at Orchard house is because mental health staff deny access on principle when some patients with recurring problems/emergencies are unsafe need respite a place of safety because we don't take people into hospital now / call me in a week, by which time so low couldn't use the phone, no-one called back to check on me.
- d) Accessibility to services and visiting transport (voluntary/bus/hospital transport)
- e) Exercise referral
- f) Goal programme
- g) Schema therapy, resolves maladaptive coping strategies for those who need it.
- h) Bereavement counselling for children and for family problems
- i) Jersey talking therapies
- j) One size does not fit all, some people need respite from life, to keep them safe, albeit briefly i.e. hospital admissions
- k) Use internet as a resource (but recognise not everyone has computers).
- l) Mental health forum support
- m) Teach 12 step philosophy
- n) Peer to peer support
- o) Group therapy
- p) Complimentary therapy, flower remedies, aromatherapy, reiki therapy
- q) Parents should listen to their children and acknowledge their feelings and need

### **13. The need for choice**

- a) Need to be able to choose my CPN
- b) Want to be involved in care planning and have choice about the services to be received

### **14. Support in the workplace**

- a) Society needs awareness of different mental illnesses.
- b) Being open with employers about capabilities, helps with expectations of both parties, supportive staff, colleagues.
- c) Trust and confidentiality in employer
- d) Employer being knowledgeable and understanding
- e) Raising the profile of mental health especially in the work place.
- f) Being employed

The building blocks are further illustrated and supported by the personal testimony of Citizen Panel members and through case vignettes. These are included in the full report of the work of the Citizens Panel which can be found at Appendix Two.

### **Findings from the Customer Voice exercise**

The Customer Voice exercise had three elements, an online survey, focus groups and one to one interviews. The key findings from the three elements of the exercise have been aggregated and are set out here in summary form.

### **Summary of survey findings**

222 people completed the on-line survey between 19<sup>th</sup> January 2015 and 6<sup>th</sup> February 2015. The survey generated a great deal of interest with varied reactions, including some critical feedback but positive feedback from individuals around the subject areas. The key response results are set out here along with quotes to provide context and corroboration:

- 91% of respondents thought that joint working and partnerships were key to improving mental health outcomes and experiences.
  - *"I wish things were more joined up"*
  - *"When people talk across boundaries and work together it improved our care no end"*
  - *"Why cant they just work together?"*
- 78% of respondents thought that all mental health services in Jersey could be more recovery focused.
  - *"There's so many recovery based things my son would enjoy but the whole things needs to be more ambitious"*
  - *"Recovery centres and colleges could be run between users and charities"*

- “Create a recovery centre/college co-managed with us and carers”
- 87% of respondents thought there was not enough mental health intervention in primary care.
  - “Some GPs have a lack of understanding around mental health issues”
  - The cost of going to a GP really puts people off, if you have to go back to chase things or because things have got worse then we have to pay again”
- 94% of respondents thought early intervention was essential.
  - “The school counsellor was a good port of call when you didn’t know who else to ask for help it’s a pity there isn’t more of them”
  - “There was no children’s crisis service – would be good to have someone you could call if you were in crisis”
- 88% of respondents thought that there was not enough mental health promotion in Jersey
  - “Employers need so much more education around mental health”
  - “Becoming a peer support worker was a real job and gave me a proper purpose”
  - “My colleagues just had no clue what to say to me”
- 8% of respondents thought that service users should have their views listened to routinely
  - “We often don’t know what questions to ask to get the answers we need in terms of getting the right care and support for Dad”
  - “How do we know whether its good quality or not?”
  - “The culture needs to change from being a defensive system to being open and all about improvement”
- 97% of respondents thought that the families of people using mental health services should have their views listened to.
  - “Communication is often poor if not terrible”
  - “We have to fight to be engaged with and it’s exhausting”
  - “We want to be involved in our own care and that’s that”
  - “We need a much bigger voice and we need to believe that the politicians and managers are actually going to change things when we speak out”

- 75% of respondents thought that people using mental health services in Jersey would benefit from more choice.
  - “There needs to be proper investment in mental health services”
  - “We need more choice of what the money gets spent on”
  - “The lack of social care providers is a real issue”
  
- 81% of respondents thought that mental health services in Jersey do not respond quickly enough to peoples needs
  - “There was a long wait for an appointment for my initial assessment even though I was already in the system and involved with other services.”
  - “The waiting list is a huge issue”
  - “How can they tell me to be 10 minutes early and then be over 25 minutes late themselves?”
  - “My CPN is really responsive and gets back to me really quickly”
  - “There wasn’t really a wait to get assessed by CAMHS”

The responses to the survey link closely with the building blocks developed by the Citizens Panel and to the overarching themes to have emerged from the other elements of the review. The response rate was extremely high for a survey of this kind in a mental health setting.

The interviews and focus group sessions built upon the survey findings, which were monitored and analysed throughout the exercise.

The key issues which emerged from the interviews and focus groups were:

The importance of customer feedback should not be underestimated. Service Users and their family carers and supporters want to give feedback safely and want to be engaged in their own care and the development of services.

There are examples of good work and committed staff. There was a great deal of praise for individual mental health professionals from all settings and teams.

Waiting times for services remain a cause of concern for customers, with waits for psychology being highlighted as significant issue.

Recognising and responding to the needs of carers and the provision of support and bespoke respite is an outstanding need in the view of many customers and their families.

Customers report that the provision of early intervention and support is a gap, particularly in schools, however the work of school counselors is highly valued and was particularly praised.

The quality and safety of buildings from which services are delivered matters to customers. Examples of poor quality environments, inappropriate reading material in waiting areas and poor décor in service settings were all issues for customers.

Customers hold the perception that adult mental health staff in all settings have very low morale and that their wellbeing is a problem. There was expressed in terms of customer concern for those staff and a recognition of the environments and circumstances in which they have to work.

Communication on every level between professionals and customers was highlighted as a priority area for improvement.

Customers and carers want to see the services grow stronger, be better resourced and build on current strengths. They value what they have but want to see it developed, invested in and for it to improve.

## Section Three

### **The strategy for mental health: Our vision for the future**

## 1. The key strategic themes

The process of review has highlighted consistent issues and themes running through the activities of the Citizens Panel, action learning practice challenges and the Customer Voice exercise. This enabled the establishment of a set of key themes that were further developed during the Engagement Event:

- Securing joint working across the mental health system
- Developing the workforce
- Awareness raising, prevention, early help and support for young people and children
- Improving the money flow in the system to follow the service user
- Enabling workplace mental health interventions
- Building educational approaches to recovery
- Improving the service environment
- Developing mental health services in the criminal justice system
- Establishing outcomes, quality and measurement
- Culture and leadership

These nine themes were then further distilled to create five overarching areas of strategic priority for mental health and wellbeing in Jersey. Each area of intent is further supported by examples of relevant research or best practice drawn from the literature review conducted by the Health Services Management Centre alongside other relevant examples. A case vignette that has relevance to the area of strategic intent is included to underpin it via the sharing of lived experience and personal testimony, followed by a summary of areas for consideration to meet each priority.

By presenting the areas of strategic intent in this way, the strategy demonstrates a golden thread that runs from the insights generated by the review process towards the priorities identified in the strategy, thus closing the circle from review to strategic intention.

## Key Priority 1: Social Inclusion & Recovery

Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers that lead to social exclusion such as stigma, negative public attitudes and discrimination in health and community settings.

Mental health service providers should work within a framework that supports recovery both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person's strengths including coping skills and resilience, and capacity for self-determination. This may require a significant cultural and philosophical shift in mental health service delivery.

Building Blocks	Emerging theme
Not tolerating stigma	Building educational approaches to recovery
Recognise the impact of suicide	Enabling workplace interventions
Understand the causes of mental illness	Securing joint working across the system
<b>Customer Voice</b>	
<i>78% of respondents thought that all mental health services in Jersey should be more recovery focused</i>	
<i>88% of respondents thought that there was not enough mental health promotion in Jersey</i>	

### The supporting evidence from literature

Anti-stigma interventions have been associated with a small, but significant reduction in personal stigma. Educational interventions alone or when combined with other interventions are generally associated with a reduction in personal stigma for different types of mental illness diagnosis. One example of good practice is the delivery of events to raise public awareness around mental health issues to reduce stigma have been delivered by the Australasian Centre for Rural and Remote Mental Health (ACRRMH). ACRRMH organised mental health 'road shows' aimed at increasing awareness of mental health issues.<sup>27</sup>

Recovery-focused services are a central component to making health services fit for the twenty first century. At the heart of the concept of recovery is a set of values about a person without the continuing presence of mental health symptoms. Recovery emphasises the importance of hope in sustaining motivation and supporting expectations of an individually fulfilled life. In Making Recovery a Reality (Shepherd et al., 2014) the authors argue that recovery does not necessarily mean cure. Instead it focuses on "the

<sup>27</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015

unique journey of an individual living with mental health problems to build a life for themselves beyond illness ('social recovery'). Thus, a person can recover their life, without necessarily 'recovering from' their illness."

Peer support is an emerging area of good practice. It may involve social, emotional or practical support. In the area of mental health, peer support is considered as important in the building on shared experiences developing empathy and it's focused on an individual's strengths. The Mental Health Foundation defines peer support as the "help and support that people with lived experience of a mental illness or a learning disability are able to give one another".<sup>28</sup>

An example in practice is The Brighter Futures project, which worked across three areas in Scotland to pilot a peer mentoring approach for isolated older people. The project was led by the Mental Health Foundation in partnership with Glasgow Association for Mental Health (South Glasgow), Recovery Across Mental Health (RAMH), (East Renfrewshire) and Seniors Together (South Lanarkshire).<sup>29</sup>

The aim of project was to work with older people to deliver a peer mentoring service aimed at improving the wellbeing and the quality of lives of more isolated older people through enhancing their social networks and enabling meaningful community engagement through, for example, universities, arts groups, exercise classes and faith community groups. The outcomes of the project included: improvements in self-esteem for all participants, and 74% of the participants reported improvements in perceived social isolation.

### **Case vignette**

*When R was discharged from Orchard House she felt quite lost, not ready to go back to work but wanting to build towards that day when she could get a job again and feel able to cope with it. R had really enjoyed sessions in the recovery centre while she was in hospital but now she was home transport was difficult and she just couldn't face going back to the same building for anything. R used to be very involved in music in her younger days and kept thinking about how she would like to be able to do music again in a safe but mainstream environment and how some Pilates and meditation would help too.*

*Going to a totally 'everyday' setting without some morale support felt like a step too far and there was nothing that she knew of in the community where she could work on her recovery and support others with theirs. R also welcomed the idea of learning from others who had been through similar experiences and over time wanted to help others who had experienced mental ill health.*

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<sup>28</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015

<sup>29</sup> ibid

## **What we will do**

- We will continue to work using engagement and participative approaches such as the Citizens Panel and action learning sets to deliver the priorities identified in this strategy.
- We will work with other States of Jersey Departments, Community and Voluntary Sector organisations and local business to address issues of mental health and wellbeing in the workplace by developing an awareness raising programme.
- We will work towards the establishment of a Recovery College which is service user led with support from mental health organisations and professionals.
- We will review the evidence from IMRoC and the other extensive work conducted in the UK and seeks advice from recovery experts to help deliver this change.
- We will place the concept of recovery at the centre of all mental health related training and practice development across the life course in mental health services.
- We will work with service providers to establish the principles of a recovery based approach which will be embedded within all policies, protocols, strategies and processes.
- We will work closely with the Public Health Department and the Community and Voluntary Sector to build a co-ordinated programme of mental wellbeing awareness delivered with the aim of reducing stigma and discrimination.

## Key Priority 2: Prevention and Early Intervention

Mental health promotion, prevention and interventions need to include consideration of the spectrum from health and wellbeing to mental health problems to mental illness. The range of service options needs to include those illnesses that are most often managed within the primary care sector, as well as those that may require greater specialist involvement. Services should be provided on the basis of need, not diagnosis or whether an illness is common or uncommon. Service options need to be responsive to the needs of different age groups, including young children and older people, and to the differing needs of those who suffer particular illnesses.

Building Blocks	Emerging theme
Speedy response at the time of need	Awareness raising, prevention, early help & support for children & young people
Increase the focus on prevention	Improving the Service Environment
Support in the workplace	Enabling workplace interventions
<b>Customer Voice</b>	
<i>81% of respondents thought that mental health services in Jersey do not respond quickly enough to peoples needs</i>	
<i>94% of respondents thought early intervention was essential</i>	

### The supporting evidence from literature

Evidence to support the development of awareness, prevention, early help and support for mental health and young people was found with the importance of school-based educational programmes to prevent, reduce stigma and identify mental health issues in young people were demonstrated in Canada and Australia. The emergence of web-based services to support access to mental health support was demonstrated.<sup>30</sup>

An example practice can be found in Canada where the development of the Mental Health and High School Curriculum guide (Teen Mental Health, 2015) has resulted in the development of school based resources to support mental health literacy in schools, defined as:

- Understanding how to obtain and maintain good mental health
- Understanding mental disorders, their identification and treatments
- Decreasing stigma
- Understanding how to seek help effectively.<sup>31</sup>

<sup>30</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. March 2015

<sup>31</sup> *ibid*

The Canada school-based mental health programmes focus on positive psychology and positive mental health. Initiatives emphasise health promotion and illness prevention strategies including safe and supportive environments; student engagement/empowerment through engagement in school activities; resilience and self-determination.<sup>32</sup>

The Centre for Mental Health published findings relating to the benefits of investing in mental health services for children and young people. They found that the most common mental health conditions affecting children and young people are conduct disorder (i.e. severe behavioural problems), anxiety, depression and attention deficit hyperactivity disorder.<sup>33</sup>

The review of the evidence showed that for all these conditions there are interventions that are not only effective in improving outcomes but also good value for money, in some cases outstandingly so, as measured by the surplus of measurable economic benefits over the costs of intervention.<sup>34</sup>

### **Case vignette**

*L went to see her GP to talk about her mental distress; the appointment was short and she didn't feel like it was worth the £40. The doctor said he would refer her onto the mental health service and that she was to go home and wait. Two weeks later L was assessed and although she was beginning to self-harm she ended up on a waiting list for 10 months for psychology.*

*During that time things just got worse, not sleeping or eating and the cutting was getting more risky all the time. L considered going back to the GP but the £40 just didn't seem worth it, as she didn't think that the doctor had any interest or experience in mental health.*

*L knew that the Hospital's Emergency Department (A&E) would have to see her if she went there, and so one evening when she was feeling suicidal and had cut herself badly she walked in a dream like state into the hospital. The staff in the reception of the Emergency Department were kind and efficient and the building looked so much better than when she had been there before. The nurses attended to her cuts and then she was put in the 'Mental Health' quiet waiting room.*

*L became anxious and more distressed and was admitted into Orchard House and ended up with an elongated stay before being discharged and getting the psychology treatment that she had needed months earlier. L maintains that if she had been able to access out patient psychology sooner she would never have needed an inpatient stay.*

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<sup>32</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. March HSMC2015

<sup>33</sup> Investing in Children's Mental Health – Khan, L. Parsonage, M. & Stubbs, J. CFMH February 2015

<sup>34</sup> *ibid*

## **What we will do**

- We will continue to develop integrated care as part of the Out of Hospital and Sustainable Primary Care programmes, to ensure GPs have rapid access to mental health services across all ages.
- 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.
- We will continue to develop primary care based mental health services such as Jersey Talking Therapies that have been shown to address mild and moderate needs both directly and through support to GPs.
- We will put a greater focus upon early intervention with children and young people and develop services to specifically address their needs with less need to resort to residential solutions.
- We will work with MAST teams in Schools and Colleges to develop an education-based programme of mental health and wellbeing awareness raising.
- We will work with key service providers so that that all sites to which the public have access provide a range of information about the services offered at that site, as well as information about other services including mental health advocacy and the services provided by voluntary and community organisations.

## Key Priority 3. Service Access, Care Co-ordination and Continuity of Care

While recognising that different service types and locations are important, services across the spectrum of age and need should be developed and delivered in a way that reduces the risk of people falling through gaps, that reduces unnecessary duplication and complexity and promotes information sharing. This depends on both collaboration between services at all levels, and integrated models of service delivery.

Building Blocks	Emerging theme
Continuity of care with services working well together	Securing joint working Mental health services in the criminal justice system
Easily accessible information about services and where to find help and support	Awareness raising, prevention, early help and support for children and young people
Adequate numbers of well trained and supervised staff	Developing the workforce
<b>Customer Voice</b>	
<i>87% of respondents thought there was not enough mental health intervention in primary care</i>	
<i>91% of respondents think joint working and partnerships are key to improving mental health outcomes and experience</i>	

### The supporting evidence from literature

A study of a multi-professional approach to care delivery; structured management (non-clinical case worker); scheduled patient follow-ups, and enhanced inter-professional communication. This approach was found to deliver improvements in patients with depression or anxiety when supported by a collaborative care model compared to usual care. Collaborative care was associated with improvement in depressive symptoms.<sup>35</sup>

Evidence to support police officers to deal with individuals presenting with mental health issues and the benefits of cross-sector working are present in the literature. A briefing by the Centre for Mental Health (Bather et. al, 2009) argued that “police officers need more and better training in mental health issues. “

An example in practice has been the establishment of Street Triage pilots in the UK, in these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person’s condition, or appropriate information sharing about a person’s health history.

The aim is, where possible, to help police officers make appropriate decisions, based on a

<sup>35</sup> Characteristics of Effective Collaborative Care for Treatment of Depression, Coventry et al (2014) in Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015

clear understanding of the background to these situations.

The need for better mental health care in prisons has been evident for some time, and mental health in-reach teams have developed to provide a range of services to ensure equivalence of access for prisoners. They have also enabled closer liaison between prison staff and health professionals.

There is some evidence to indicate that the use of Mental Health First Aid is a potentially useful approach to training that would help the police and prison staff in dealing with mental health needs. Mental Health First Aid is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health problem. In the same way as we learn physical first aid, mental health first aid teaches you how to recognise those crucial warning signs of mental ill health.<sup>36</sup>

Developed in Australia in 2000 and now internationally recognised in 23 countries, the MHFA course teaches people how to recognise the signs and symptoms of common mental health issues, provide help on a first aid basis and effectively guide those towards the right support services.<sup>37</sup>

### **Case vignette**

*L was arrested on a Class A drugs charge and remanded on bail. During this time, he drank quite heavily as he was scared and couldn't see another logical approach to escaping the fear of a prison sentence. He lost his job, his flat, his friends, and his life, as he knew it. He was seen at Drugs and Alcohol service (referred by GP) but only attended a couple of appointments, as he was not ready to stop self-medicating through alcohol.*

*L saw a probation officer once before sentencing. Sentence was eventually passed and he received a two and half year prison sentence. Due to the nature of his charge being drug related, L saw a counsellor from the Drugs and Alcohol service on a weekly basis whilst at La Moye. L appealed his sentence, not the verdict but the sentence.*

*L's case was heard and he was released, having the sentence turned over to community service, three and half months after his imprisonment.*

*L had a sentence plan in place, which if had he had served his full term, would have been executed and included pre-release preparation. As it was, his sudden release came as a total surprise with no support for return to the real world. Three and half months was long enough to become institutionalised to an extent and L was very shocked and frightened by his release.*

*L doesn't feel that he was shown a duty of care on his release. He does not however hold anyone individually accountable for this, as he believes that he should never have broken the law. L does feel that it is an area that needs to be addressed. L feels that it was the single most disturbing incident of his life. L fell through the cracks in the system; he is still dealing with the long-term impact of having a criminal record and trying to return to the working world.*

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<sup>36</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015

<sup>37</sup> MHFA England

## What we will do

- We will work with primary and secondary care professionals, service users and managers to review current service models to ensure an improved focus on assessment, diagnosis treatment and recovery based in community settings. As part of this work we will establish integrated care pathways supported by a coherent co-ordination function across key services.
- We will develop further 'partnership' arrangements with a provider to secure a more consistently accessible and cost effective forensic medium and low secure mental health inpatient service.
- 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.
- We will review and consider the most appropriate model for Consultant provision. Specifically, whether a Consultant should continue to be the responsible clinician for community service users during any in-patient stay.
- We will establish clear information sharing protocols between primary and secondary care, as well as with external agencies. This will enable more effective sharing of relevant information about service users and their needs, their care plans and risk factors.
- We will explore the role of a specific service to provide early intervention and support to children and young people who are experiencing their first episode of mental illness.
- 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.
- We will work with key service providers including the Probation Board and the Courts to review the existing provision of Court Liaison and Diversion services for people with mental health needs, with a view to developing a business case for the establishment of an improved service.
- We will work with the Home Affairs Department to explore and develop a model for an efficient, sustainable and safe mental health prison service at HMP La Moye, using evidence-based multidisciplinary in-reach models.

## Key Priority 4: Quality Improvement and Innovation

Quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice. As such this places an emphasis on the provision of services that should produce positive outcomes for service users and make the best use of current knowledge and technology and that seek to innovate.<sup>38</sup>

Mental health services, whether in the primary care or specialist sector, cannot be provided as a 'one size fits all' across the age range. Our community is rich in diversity. It embraces cultural and religious differences. This brings many strengths and opportunities, but we also need to recognise the challenges faced at times by some within our community. There should be demonstrated cultural competency in the planning and delivery of responsive and high quality mental health services.

Building Blocks	Emerging theme
Value and support the role of people and organisations outside statutory services	Securing joint working Developing the workforce
Explore, offer and invest in different therapies and support because one size doesn't fit all	Improve the money flow in the system to follow the service user
Need for choice	Improve the service environment Building educational approaches to recovery
<b>Customer Voice</b>	
<i>75% of respondents thought that people using mental health services in Jersey would benefit from more choice</i>	
<i>98% of respondents thought that service users should have their views listened to routinely</i>	

<sup>38</sup> Quality Improvement in Mental Health WHO 2003

## The supporting evidence from literature

Several frameworks have been developed to inform the measurement of outcomes and quality in mental health services and the factors which enable service transformation. Fossey and Parsonage (2014) describe a framework for measuring outcomes and performance in liaison psychiatry, to be used for such purposes as accountability, performance management and service improvement. They suggest the need for a 'balanced scorecard' approach, including a mix of measures or indicators drawn from the three dimensions of structure, process and outcome and covering multiple outcomes.<sup>39</sup>

An important example of practice is the Enhancing the Healing Environment programme. Led by The King's Fund it encouraged and enabled multi-disciplinary teams to work in partnership with service users to improve the environment where care was delivered. It put service users at the heart of design, and challenged both thinking and attitudes to the delivery of care, as well as highlighting the important role that the physical environment can play in supporting innovation in service delivery and in improving the patient experience.<sup>40</sup>

The programme, which was evaluated, has now concluded. Further work is now being led by the University of Worcester in relation to environments specific to people with dementia.<sup>41</sup>

## Case vignette

*B found the waiting area so disturbing that he almost didn't get to see the professional he was waiting for. The magazines on display were old and inappropriate and on the front page of one had a sleazy heading about domestic violence towards men being less significant for individuals experiencing it than for women. B felt disrespected, vulnerable and as if his whole story had been exposed somehow.*

*The poster on the wall made him feel worse as it talked about how aggression towards staff would not be tolerated. As he sat there he wondered if he was unsafe, his personal experiences of violence meant that the poster scared him and he reflected on how vulnerable he was in that moment. Once he had realised that the other people waiting didn't look remotely violent he became annoyed at the tone in the poster, the inference that staff needed to be safe, but not patients.*

*In the times B sat in the waiting area and over time he planned more constructive and valuing wording for the poster and had thoughts of all the positive mental health publicity that could be available instead of magazines and how with a small amount of investment the whole waiting experience could be valuing and calming.*

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<sup>39</sup> Mental Health Services Literature Synthesis, Stevens, S. & Conroy, M. HSMC March 2015

<sup>40</sup> Sharing success in mental health and learning disabilities: The King's Fund's Enhancing the Healing Environment programme 2004-2008 The King's Fund 2008

<sup>41</sup> [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

## What we will do

- We will work with clinicians to review the thresholds for access to all mental health services and ensure these are explicit within operational policies. These will also be clearly communicated to service users, referrers and the public.
- 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.
- We will develop a greater choice of interventions and services wherever possible and make clearer those choices for all who use mental health services.
- We will work with the Strategic Housing Unit and other Housing providers to:
  - develop housing and support options for older people, including those with dementia to reduce the reliance on residential and nursing home care, delivering care close to home and increasing independence.
  - provide both greater choice through an appropriate range of housing options for young people and adults.
- We will engage with workforce experts and Directors of Services to establish a plan for workforce development which will include a more detailed review of current staffing, in order to support a diverse, trained, skilled and appropriately experienced workforce across all areas of mental health. This work will include an exploration of the role the independent and private sector workforce.
- We will refresh and establish training, both mandatory and voluntary to develop a renewed and updated programme that will better meet the needs of professionals in their daily practice.
- We will Implement a robust recruitment and retention plan which will be supported by effective mentorship/mentoring/coaching arrangements.
- We will work Service Directors to establish a productivity based approach to innovation, to assist in improving efficiency and effectiveness.
- We will work with Jersey Property Holdings and service providers to complete an audit of inpatient and community services sites which will provide an accurate assessment of their fitness for purpose. This will include review of potential risks to patient, staff and visitor safety. As a minimum it will be expected that there is sufficient space for confidential discussions between staff and between staff, service users and carers.
- We will establish a task and finish group to progress a suitable option for the re-provision the adult inpatient services at Orchard House.

- We will produce a service map for service users and their families, which will describe the various mental health services, how they link to each other and information about how to contact them.
- We will establish a joint mental health and criminal justice forum. This will be comprised of mental health service senior management and representatives of HMP La Moye, the probation service and Jersey Police. It will serve as a forum for addressing operational issues and concerns, as well as providing oversight in relation to service developments.
- We will establish a joint programme of training and development between criminal justice services and mental health services so that each may gain a deeper and more detailed understanding of each others services, roles, responsibilities and priorities.
- We will establish a mentoring programme, focused on equipping prison staff, police and probation colleagues with the skills to identify and respond to the signs of mental illness, complemented by a similar approach to equip mental health service staff to better support those with offending backgrounds and those who are resettling in the community.
- We will work with key service leads across public and voluntary and community sector organisations to establish a common understanding and shared approach to risk, its assessment and management. As part of this work:
  - Current risk assessment and risk management approaches will be reviewed and updated.
  - Common approaches to positive risk management will be established with guidance on how to include positive risk management into joint care planning with service users and their carers (where appropriate).
- We will develop a robust Quality Assurance and Governance system for mental health services in Jersey, which will provide accountability back to senior management, who in turn can then be held to account for the quality of services.
- We will introduce a quality framework that will include:
  - Compliance (standards being met, regulatory, statutory and outcome measure compliance is being achieved)
  - Assurance (Risks to the service, including its value and goals are identified and managed)
  - Improvement (Services are being improved and transformed in line with agreed priorities and that innovation is supported and encouraged)
- We will produce an annual Quality Report for the public, which will incorporate:
  - Patient safety (including serious incidents and near misses)
  - The effectiveness of treatments that patients receive
  - Patient feedback about the care provided

## Key Priority 5: Leadership and Accountability

Families and carers should be informed to the greatest extent consistent with the requirements of privacy and confidentiality about the treatment and care provided to the consumer, the services available and how to access those services. They need to know how to get relevant information and necessary support. The different impacts and burdens on paid and unpaid carers need to be acknowledged.

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.

Building Blocks	Emerging theme
Develop clear lines of accountability	Establish system outcomes, quality and measurement Developing the workforce Improve the money flow in the system to follow the service user
Not tolerating stigma amongst the public and professionals around people with mental health problems	Developing the workforce
Adequate numbers of well trained staff working in suitable conditions	Improve the service environment Enabling workplace mental health interventions
<b>Customer Voice</b>	
<i>91% of respondents think joint working and partnerships are key to improving mental health outcomes and experience</i>	
<i>57% of respondents felt hopeful about the outcomes of the Mental Health Services Review</i>	

### The supporting evidence from literature

In *Service Transformation – Lessons from Mental Health* (Gilbert et al., 2014) the factors that enabled change to happen in mental health were explored. Among these was the need for high-quality, stable leadership to manage change, handle unexpected demands and results, and ensure integration of expertise, both within the organisation and among voluntary and independent providers.

The King's Fund have found that the business case for leadership and engagement is compelling: organisations with engaged staff deliver better patient experience, fewer

errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress.<sup>42</sup>

An emerging evidence base is developing around the role of workplace mental health interventions. In their debate piece for the BMC Psychiatry in May 2014 LaMontagne et al review the evidence to support an integrated approach to workplace mental health and the authors argue that to realise the greatest population mental health benefits, workplace mental health intervention needs to:

- comprehensively protect mental health by reducing work–related risk factors for mental health problems- include job insecurity, bullying or psychological harassment, low social support at work,
- promote mental health by developing the positive aspects of work as well as worker strengths and positive capacities;
- address mental health problems among working people regardless of cause.

The conclusion reached is that in practice an integrated approach to workplace mental health can expect near-term improvements in mental health literacy, to be followed by longer-term improvements in working conditions and job quality—given adequate organisational commitment, support, and time to achieve organisational change. These changes should, in turn, lead to improvements in mental health and wellbeing.

### **Case vignette**

*J had struggled with low moods and anxiety ever since he started secondary school and none of his teachers seemed to recognise what was happening for him, however when he was in year 10 his teacher referred him into see the school counsellor which was incredibly helpful and although he still felt very unwell there was a sense that someone was listening and understood what was he was going through. After a few months his school counsellor suggested that Joe might need some more specialist help and also access to youth services for on-going support.*

*J was referred and accepted into CAMHS and also linked into the Youth Enquiry Service. J got on well with both his psychologist and psychiatrist at CAMHS and although he was now diagnosed as having depression, anxiety and OCD felt that his needs were being met. He had access to some art therapy, which really helped. When things went well people really talked to each other and knew what other services would be appropriate and things seemed joined up for J.*

*At the end of his time at CAMHS he was transferred on to Adult Mental Health and discovered that there was almost no transition or proper handover, his CAMHS worker just said that J had to move on in two weeks and that was that.*

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<sup>42</sup> Report from The King's Fund Leadership Review 2012

*When J arrived at his first appointment in adult services he discovered that although they were nice they knew nothing about him and J had to tell his story all over again on several occasions. J wished that people had talked more about his transition and that both children's and adult mental health services had planned the change with him.*

## **What we will do**

- We 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.
- We will conduct a detailed review of current mental health spend for Jersey which will cover public, non-profit and the private sector. This will create a baseline from which to build plans for future funding.
- Building on mechanisms used in P82/2012 and this mental health strategy we will develop effective service improvement mechanisms which engage effectively with professionals and the public.
- We will work towards a defined set of outcome measures for mental health services across the life course. The agreed metrics will seek to measure the impact and success of services and interventions against agreed criteria. This will inform future outcomes based model to drive further improvement.
- We will establish a monitoring system that regularly audits and reviews defined outcome measures and identifies trends and areas for ongoing improvement, as well as shaping new outcome measures.

## Our intentions and next steps

This strategy has been developed as a result of P82/2012 '*A New way forward for Health and Social Care*'. It is consistent with the vision presented in our Green Paper, and the subsequent White Paper, of '*Caring for each other, Caring for Ourselves*' - providing care closer to home, in the right place at the right time applies equally to mental health services as it does to other areas of health and social care.

**Our intention** is to make this a reality, starting with the development of a clear and deliverable implementation plan, to take forward this strategy in a phased way that will help deliver the vision approved by Islanders and the States Assembly.

This mental health strategy has been developed through a number of deliberative steps. Engagement has played a pivotal part in the process that has led to the five priority areas. The 'golden thread' of issues that link the building blocks, the emerging themes and the areas of strategic intent have all been informed or developed by people who work in, use or have an interest in mental health services in Jersey.

The process has demonstrated the value and importance of that engagement, reaching out beyond professionals, to the public, service users and other organisations in the community and voluntary sector to seek and include their views. In addition, by engaging with staff from the mental health services and allied agencies including primary care and enabling them to learn together and create change from the ground up.

**Our intention** is to continue this engagement and extent this way of working to other areas of strategy development.

The development of this strategy has also highlighted the importance of being able to access good quality information to inform future planning and the vital role that culture and leadership will play in shaping the way in which the areas of strategic intent are taken forward.

This strategy sets the priority areas for the future delivery of mental health and wellbeing services in Jersey. Implicit in these is a commitment from all involved to enhancing recovery and sharing a common set of values about promoting high quality, outcome driven services. The changes to make these intentions a reality will need to happen within a more constrained financial settlement and will require partnership at all levels to be successful.

**Our intention** is to be clear on the benefits as a result of this strategy both in terms of quality and value for money.

The work underpinning this strategy has identified a number of current issues which can be acted on in the short term.

**Our intention** is to begin to act on those issues in a timely manner where we can.

The **next step** now is to begin a communication process with Islanders and key organizations before finalising the strategy in late June. An implementation plan will then be developed which sets out priorities for action over the next five years with detailed costs and clear links to other strategies such as sustainable Primary Care.

## ***Acknowledgements***

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We could not have successfully completed this piece of work without the knowledge, help and expertise of colleagues from both the community and voluntary sector and in other States of Jersey departments giving up their time to give their input.

Thanks also to Contact Consulting and the University of Birmingham whose expertise and knowledge have helped to make the process the success it has been.

**Senator Andrew Green, MBE**  
**Minister for Health and Social Services**



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