Review of Mental Health and Wellbeing services in Guernsey and Alderney

Report by David Gedze
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Headlines

- Guernsey has a rich network of voluntary sector organisations that provide mental health services and support, in addition to that provided by the statutory services
- Mental health and wellbeing support is also provided by schools and many employers
- The services are well resourced, but there are some gaps
- The statutory services based at Oberlands provide a highly specialised time-limited service for people with the most complex needs and those experiencing an acute crisis
- This is appropriate, but there is sometimes an assumption that these services should be providing support for all mental health needs
- Rebranding these services as Guernsey Specialist Mental Health Services could help to clarify their role
- A mental health and wellbeing strategy group is recommended to bring together all the organisations providing mental health support
- This would improve partnership working and links between the organisations
- Many of the recommendations from 2018 and 2019 have been implemented
- The experiences of service users and their families varied and some people felt that services had failed them completely
- This review did not look into individual issues but identified themes

1. Summary

The review consisted of an assessment of:

- the progress made in secondary care services on the implementations of previous recommendations
- areas for improvement and previously unidentified service gaps
- the stakeholder experience, including service users, families, third sector providers, other organisations and former staff

The findings of the review are that where previous recommendations have been fully implemented they have been successful, and partnership working has improved. I found that there is now a need to progress the approach to partnership proposed in the Mental Health & Wellbeing Plan for Guernsey (2017-2020) and the 'Partnership of Purpose' policy letter (2017), where providers would work collaboratively across organisational boundaries to create an integrated mental health pathway.

Stakeholder organisations identified gaps, particularly in crisis and out of hours services, and propose that secondary care mental health services put more resources into these areas. There is a view that people whose mental health is more stable should be discharged to primary care and signposted to the third sector. Gaps in services for children and young people were identified at the first three steps of the pathway, and transition to adult services is said to be problematic. The prison staff said prisoners need better access to mental health services.

The experiences of service users and their families varied. A few people recounted negative experiences, in which they said that secondary care mental health services had completely failed them. Others had more positive or mixed experiences. I was not able to investigate individual issues, but identified themes. There was positive feedback about permanent staff, but agency staff are said to often lack compassion. Others reported being discharged from services abruptly with no signposting, and several people wanted more sessions of psychological therapy than is offered.

The main recommendation is that the gaps identified in section 6 of the report are added to the Guernsey and Alderney mental health and wellbeing service map, and the group reconvenes to address them. I also recommend that a mental health strategy group for Guernsey and Alderney oversee the implementation of strategic objectives to strengthen partnership working across organisations. The other recommendations are for smaller changes that could make a significant improvement to the experience of service users and their families.

2. Introduction

2.1 My background

I have a degree in psychology and qualified as a social worker at the University of London in 1984, and as an ASW in 1987. I worked as a social worker and mental health social work team manager until 2001, when I joined CNWL NHS Foundation Trust as a Service Manager for a range of mental health services. I became the Service Director of Brent Mental Health Service in 2004 and then for Specialist Mental Health Services in 2011. I continued in this post until I retired from the NHS in 2018.

I was offered the opportunity to review the secondary care mental health services in Guernsey in October 2018. I was approached by a CNWL colleague who provides consultancy in Guernsey, and the position was confirmed after an interview with the Clinical Director and Service Manager. I had no links with Guernsey and had not previously visited the island.

2.2 Conflict of interest

I work independently and there is no conflict of interest. I have no friends or family in Guernsey and my only involvement has been in a professional capacity.

2.3 Context

I worked in Guernsey on a freelance basis from October 2018 to November 2019, reporting to the Clinical Director and Service Manager of the secondary care mental health services. I produced my first report on 07.12.2018 with initial findings and proposals for service development. This was based on interviews with staff within the service and others in HSC, meetings with teams and reading strategic documents, plans and operational policies. The report was accepted and I was asked to implement the proposals.

The second stage of the review consisted of meetings with partner agencies both within HSC and in the third sector. I worked with the managers of the service to strengthen the management structure, develop partnership working and put in place the other service developments that I had proposed. This involved awaydays for teams and strategic meetings on the Mental Health & Wellbeing Plan for Guernsey.

It was suggested that I return to Guernsey in 2020 to review the changes, but this visit was postponed due to the pandemic.

2.4 The review

I was invited to return to Guernsey at a meeting with the Committee *for* Health Social Care on 14.02.2022, and to produce a written report to be published on the States of Guernsey website.

The objectives of the review were set out as:

i. Conduct an assessment of the Mental Health and Wellbeing Mapping Exercise, with a particular focus on the scope of existing services and identifying and service gaps.
ii. Conduct an assessment of the progress made following the previous visit with specific regard to the progress made on the implementations of previous recommendations.
iii. Evaluate our stakeholder experience, by meeting with service users, carers, third sector providers and former staff.
iv. Meet with the MIND CEO and board.
v. Meet with the Healthy Minds staff and service users and visit new facility.
vi. Meet the Committee *for* Health & Social Care members.
vii. Meet with other States of Deliberation members, as required.
viii. Offer confidential staff interviews.
ix. Offer confidential interviews to the public.
x. Gather views from stakeholders (service users, carers, former staff and third sector providers) which may inform recommendations for service development or change.

I spent 6 days in Guernsey in May 2022, and spoke to service users, family members, States of Deliberation members, current and former staff of the secondary care services and representatives from several organisations. I set up further meetings by video link in June 2022.

Invitations to contribute to the review were sent to stakeholders, including current and previous service users and their families. Everybody who responded was then offered a time to meet with me. Not all of the stakeholders responded and so I just met with those who did, for example one school and one primary care practice. I asked them if they felt their views were representative of similar services, and they strongly felt that they were.

3. Progress made against the recommendations of the 2018 report

3.1 Summary of recommendations made in 2018

- Stronger partnerships with other statutory services, the third sector, community and service user groups to improve the perception of the service, and a co-production approach to service improvement
- Clear criteria for secondary care in line with the strategy for mental health and wellbeing
- A robust management and professional leadership structure to strengthen the identity of the service internally, and improve communication with partners and the community
- A single community team with a dedicated manager, to streamline pathways and reduce duplication and gaps, without losing the specialist components of the existing teams
- A wider range of interventions in the adult in-patient ward provided by the Recovery and Wellbeing Service (RAWS)
- An operational manager for the whole of CAMHS reporting to the Service Manager
- A pathway for people diagnosed with personality disorder, including appropriate therapies and discharge planning, linking people into relevant support in the community and third sector
- Minimal changes to improve services for people with eating disorders and substance use problems
- A link worker for Alderney, who visits regularly
- A creative recruitment and retention strategy with regular campaigns and rotation posts

In 2019 I made a further recommendation, which was to further strengthen the identity of the service, with the name Guernsey Specialist Mental Health Service.

3.2 Stronger partnerships

Findings in 2018

I found that there was little constructive partnership working or relationship management between secondary mental health services, other statutory services and third sector organisations. There were high expectations of the secondary mental health service across the island, as their criteria as a specialist service and their role in relation to other mental health providers was not clear to people.

Proposals in 2018

I proposed that partnership working should be developed with statutory and non-statutory organisations, including the Emergency Department (ED), Learning Disability services, the police, voluntary sector, service user and carer groups. The secondary service should fully engage with other organisations, developing a constructive approach to partnership working, with a clear message in line with the Mental Health & Wellbeing Plan for Guernsey and the Partnership of Purpose policy.

There would be more opportunity to discharge people to primary care, by working more closely with GPs. For example, each practice could have a named professional in the service, to supplement the linked consultant psychiatrist, which may encourage them to accept more patients.

I proposed a co-production approach to service improvement, engaging with service user representatives, who have a say in how services are developed within existing resources.

Progress made

There has been some progress, but this is an area for further development. There is the potential to adopt a more strategic approach through embracing partnership working. There was feedback that charities are more akin to working in partnership than statutory services, but the secondary care services and Guernsey Mind are forming closer links, to improve the pathway in and out of secondary care.

The older adults service reported an improvement in communication and stronger links with the third sector, including the Alzheimer's Society and other dementia organisations. They said the biggest problem was the link with social services and a lack of reviews of care packages.

GPs reported that there is not a named professional in the service for them to liaise with, but that this would be helpful.

There are plans to develop a co-production approach, with service user representatives involved in recruitment. One service user said that this has happened previously and is a good approach.

More detail is given below in section 4 - feedback from stakeholders.

3.3 Clear criteria for secondary care services

Findings in 2018

I reported that people were frequently disappointed by secondary care services, which were not meeting all of their needs, leading to many complaints, including to the States of Guernsey and on social media. This reinforced the public perception that services were failing people.

The response of the service was sometimes to provide services to people who did not meet the criteria for secondary care, but there was a lack of consistency, resulting in dissatisfaction. Many of these people would have been more appropriately supported by third sector and community organisations.

Proposals in 2018

I proposed that the service develop clear criteria in line with the Mental Health & Wellbeing Plan for Guernsey, and maintain boundaries, even when there were complaints. Public health would reinforce this approach, to help people to access support appropriately and reduce dependence on secondary care.

The service should give a suitable response to social media complaints, such as a standard message, apologising that the person had a poor experience, but offering to meet with them, and clarifying service criteria.

Progress made

I found that people are still not always clear about the role of secondary care services and there is disappointment that more is not offered to them. A number of people said that they want more psychological therapies and they find that the service they receive is not sufficient to meet their ongoing needs.

3.4 A robust management and professional leadership structure

Findings in 2018

I found that management was surprisingly light for the size of the service, with the Service Manager having at least 20 staff reporting directly to her.

Proposals in 2018

I reported that there was a need for more dedicated managers, who were skilled in management and committed to the role. I proposed a clear professional leadership structure, in which all staff would be aware of their professional lead and the distinction between this and their line manager. This was to include a Lead Mental Health OT and Lead Mental Health Social Worker.

The proposed management structure would also help to change the perception that the service was hierarchical and run by psychiatrists, with the service visibly led by a Service Manager working in close collaboration with the Clinical Director.

The Service Manager post would focus on uniting the staff, giving them a sense of identity as part of a single mental health service for people of all ages. This role would be the external face of service, leading on partnerships, service improvements and implementing new initiatives, and taking on some the management responsibilities of the Clinical Director.

Progress made

In 2019 I created three dedicated Band 8a Operational Manager posts with minimal direct clinical work, and helped to recruit into these posts:

- Operational Manager (community) to manage an integrated community team, integrating the elements of the existing teams to streamline processes, while ensuring the team as a whole meet the needs of all patients

- Operational Manager (in-patients) to oversee all in-patient services, provide strong management and clinical leadership to the wards and integrate the work of RAWS with the ward.

- Operational Manager (CAMHS) to integrate the team and oversee its work, ensuring an equitable distribution of the workload with no gaps in provision. The manager would work closely with senior managers in children's social services and adult mental health.

This left the Service Manager with fewer people to line manage, giving capacity for the additional responsibilities outlined above.

There is now a Lead Mental Health OT, who has dedicated time for professional supervision and to keep abreast of research and professional matters, providing support across the service, including to the lighthouse wards.

There is still no Lead Mental Health Social Worker as the role has been put on hold pending the introduction of mental capacity legislation, which will bring about a change in the roles and deployment of social workers. This was not raised as a problem and the responsibilities have been covered to a large extent by the Senior Practitioner in the duty team.

Feedback from staff was that the changes have been successful in CAMHS and to a large extent in adult services. The Service Manager post has become the Associate Director for Mental Health and Adult Disabilities with additional duties. This has improved partnership working between mental health and learning disability services, but there is not now the capacity for the role to cover all of the areas proposed.

3.5 A single community team

Findings in 2018

I found that staff tended to identify with their team, rather than with the whole mental health service, and the number of small teams contributed to silo working with duplication, such as internal referrals, multiple assessments, gaps and a lack of clear care pathways. The functions of the teams were good, but there was fragmentation.

I found that the pathway from the point of referral was unnecessarily complicated, and there were gaps in the service, where the needs of patients did not fit the brief of any team. This included people with long term problems, including psychosis, personality disorder and depression, which was filled by the outpatient service without the benefit of a multi-disciplinary team (MDT) approach.

Proposals in 2018

I proposed a new management structure and established this in 2019, whereby the teams were brought together as a single community team under a single manager. The team was to retain the specific functions, each led by a senior practitioner reporting to the manager, eliminating internal referrals and multiple assessments. The manager and senior practitioners would ensure no gaps in the service.

Progress made

This has been somewhat successful, with feedback that there have been improvements in the way the duty team works, and that the service is more responsive with case discussions across teams. The duty team now works well with the psychological therapies team (PTT), sharing responsibility for risk, and previous problems and tensions have gone.

The medical out-patient model is gradually changing, and people referred to services are now much more likely to get a multidisciplinary assessment and appropriate time limited treatment.

However there have been deviations from the model proposed. The senior practitioners are still referred to as managers, and the community team does not feel like a single integrated team with the manager and senior team all working together for the needs of the people using the service. They are still seen as separate teams with their own manager, so there remains an element of fragmentation. This is an area for further discussion and improvement.

The PTT manager reports directly to the Service Manager and Clinical Director, and not to the Operational Manager (community). There are different views about whether this is the right model, but it is not reported to be problematic, as PTT is not seen to be disconnected from the community team.

Feedback from the older adults clinicians is that the changes have been good but there is still a risk of older adults being second place. There is continuity from community to inpatient services, and the old age seniors meeting has become more collaborative.

3.6 A wider range of interventions in the adult in-patient ward

Findings in 2018

I found that the wards were well resourced with sufficient beds, but people were occasionally admitted inappropriately because of social circumstances. Patients sometimes stayed too long on the ward because of poor discharge planning or waiting for the weekly ward review. I reported that Crevichon ward provided for patients with the highest risks and greatest needs, yet had limited provision of therapies and psychological consultation compared to the community teams.

Proposals in 2018

I recommended that RAWS be closely aligned to the wards and its balance of work shifted to providing more for acute patients. There should be a speciality doctor in the Crevichon team to review patients daily, attend ward reviews, drive discharge planning and provide a link between the team and the consultants.

Progress made

RAWS is now more closely aligned to the wards and has an acute pathway, with inreach work and daily handovers in Crevichon ward and some work with Tautenay ward

patients. Their focus is on recovery and discharge, including for people who are acutely unwell, linking with community organisations, such as Guernsey Employment Trust (GET).

The feedback is that good progress has been made, but it could be further developed. The balance of work in RAWS has shifted, but they still provide services that could be more appropriately provided in primary care or by community organisations. The Open Door group was given as an example of this, although RAWS now only supports the group for one day a week, as Mind provides support on other days.

The community team has more input to Crevichon ward, particularly the Recovery and Rehabilitation team (R&R) and duty, and PTT offers consultancy. However one family member commented that R&R does not work well with Crevichon.

There is now a ward psychiatrist for Crevichon, and this has been a positive development, as envisaged. I was informed that all admissions to the ward are now appropriate.

3.7 An Operational Manager for CAMHS

Findings in 2018

The main problems I identified were that there was no dedicated manager for CAMHS, and the service was divided into two small teams (generic and outreach) which was not effective. Senior clinicians took on some management tasks, but did not have management authority. I found that there were a lot of specialist skills in the team, but a reluctance to take on generic work, and problems remained unresolved without a manager to allocate work and give direction.

Proposals in 2018

I recommended that CAMHS operate as a single team, with a single Operational Manager reporting to the Service Manager, and I supported the service to establish this in 2019.

Progress made

CAMHS is now a single integrated team with a single manager and this has worked well. However the workload has increased, both for routine work, in-patient admissions and emergencies. The total caseload has risen from 400 in 2018 to 550, and has not reduced since the pandemic. This is partly because other services are understaffed, with vacancies in the children's social work and school nursing. This leads to urgent referrals to CAMHS, in the absence of preventative work.

The senior clinicians do not carry management responsibilities, giving more capacity for clinical work. However the CAMHS Operational Manager reports to the Operational Manager (community), which seems to work in practice, although it's an unusual structure as they are equivalent roles. Both managers acknowledge this and say they make it work.

A number of people reported that the ASD diagnostic service is a good development.

3.8 A pathway for personality disorder

Findings in 2018

There was a high incidence of people with a diagnosis of personality disorder and different approaches to managing them. Some staff said that people stayed on caseloads indefinitely, as there was no care pathway for them.

Proposals in 2018

I recommended that the Operational Manager (community) and lead professionals develop a pathway for people diagnosed with personality disorder, including appropriate therapies and discharge planning, linking people into relevant support in the community and third sector.

Progress made

A pathway has now been established for people diagnosed with emotionally unstable personality disorder (EUPD) which includes individual therapy delivered by PTT clinicians, and groupwork run by RAWS. This is an important development, although there is some feedback that more could be offered. A minimum of ten people are needed for the group and there are not always sufficient referrals.

The pathway could be extended further through partnership with third sector organisations, such as MIND, to provide ongoing therapy and a peer support group, focusing on decider skills to refresh people's experience. The decider skills programme is seen by people as helpful. It was developed in Guernsey and has been used in many UK services, as it is evidence based and accredited.

3.9 Changes to eating disorders and substance use services

Findings in 2018

I found that the level of need did not warrant a dedicated eating disorders service, but an effective virtual team with a pathway. There was a consultant psychiatrist responsible for CAMHS cases which worked well, but no consultant with responsibility for adults.

I reported that the Community Drug and Alcohol Team [CDAT] was well resourced and multi-disciplinary, but that there were interface issues between teams, particularly where people had substance use and mental health issues. They also found it difficult to discharge people who were on high doses of prescription drugs.

Proposals in 2018

I recommended that the community team develop a multi-disciplinary approach to eating disorders with a responsible lead consultant psychiatrist. I reported that the interface issues between CDAT and other teams could be resolved in an integrated community team.

Progress made

There is a more robust eating disorders service now, with an effective multi-disciplinary approach, a responsible consultant psychiatrist and associate. The feedback is that this model works well.

CDAT is now part of the community team, and there are fewer people on high doses of prescription drugs, due to an improved clinical model. The mental health professionals lead on work with people with substance use and mental health issues, which is appropriate.

3.10 A link worker for Alderney

Findings in 2018

There were no dedicated mental health professionals working in Alderney.

Proposals in 2018

I recommended that there should be a link worker for Alderney, who visited regularly, liaising with community groups on the island and helping people to access the support they needed.

Progress made

The service has found that there is not sufficient secondary care need for a dedicated worker on Alderney. However there are plans to develop remote working with video calls, to supplement service provision on Guernsey. People in Alderney are funded to travel to Guernsey for treatment when required.

3.11 A creative recruitment and retention strategy

Findings in 2018

It is always likely that staff from other countries will stay in Guernsey for a limited period of time, except for those who settle with partners on the island. Recruitment and retention incentives and pay-scales will have some impact, but not change the pattern significantly.

Proposals in 2018

- Regular creative and focused recruitment campaigns to attract people for two years, with the option of staying permanently
- Rotation posts to enable newly qualified staff to gain a wide range of experience and a link with a university to enhance this with accredited learning
- Managers and HR partners ensure no delays in the recruitment process, and keep in contact with successful applicants
- A buddying system for new staff to help them adjust to life on the island

Progress made

Recruitment and retention remains a problem, particularly for nurses. Staff from overseas often leave after two years when housing subsidies end, and so it's difficult to retain staff and recruitment is ongoing. House prices and rents have increased, confounding the problem.

The pandemic created additional challenges, but there was feedback that mental health services responded positively, maintaining a high level of service delivery throughout.

3.12 Identity of the service

Findings in 2019

I came to the view that the secondary care service needed a stronger identity, both for the benefit of the Guernsey population and for the staff. I found that people were often unclear about what the service should be providing, and often thought that it had responsibility for mental health as a whole. It was not clear to people what interventions they should expect from secondary care, and what should be provided in primary care or by third sector organisations.

There were therefore expectations that secondary care should provide a wider range of services, including social interventions for people whose mental health was stable, which understandably led to dissatisfaction. I found that most of the service users and family members referred to the service as Oberlands, as they had no other way to identify it. They rarely called it secondary care. Partners usually referred to the service as HSC.

Staff often felt that they were not part of a coherent service, and unsure which teams were part the secondary care services, e.g. the lighthouse wards. It seemed confusing to staff and service users that CAMHS was part of the adult disability department.

Proposals in 2019

I made a proposal that the secondary care services were rebranded as Guernsey Specialist Mental Health Services (GSMH) with a strong identity. The leadership, service provision and the teams included would be made clear to everyone. It would be the equivalent of MSG, which people understand.

Progress made

I wrote a paper in 2019, which was to be considered by the Committee *for* Health and Social Care. However it was delayed and eventually postponed because of the pandemic. In this review I found that people's expectations of the service has not changed, and that it is still generally described as Oberlands.

4. Stakeholder views

4.1 States of Deliberation members

Some of the deputies said that there is not enough preventative and early intervention work on the island, and that services wait for a crisis before intervening. One deputy said that more could be done to raise mental health awareness and support people in self management of their mental health. Initial access and signposting was identified as a problem, with not enough life skills support. This is a particular issue for child and adolescent mental health, with feedback that more support should be available, with school counsellors in addition to mental health first aid training.

The autism diagnosis service for children is seen as a positive development, but more testing is needed. There is also a view that the transition from adolescent to adult services should be smoother, particularly for young people with autism.

Another deputy said that there are too many small charities, and they could be coordinated by merging or forming partnerships. There is an opportunity for the third sector to provide more, as it is seen as a safer space and less stigmatising. There are good third sector organisations for people with autism, including self help groups and support for parents.

There is a view that secondary care is a traditional psychiatric service and better at dealing with psychosis than personality disorders. There are silos, and often a disconnect with other parts of the system. There was a comment that people are held in secondary care services for too long, which could make them dependent, and although many people would like more services at Oberlands, it would be wiser to invest more in Healthy Minds.

One of the deputies commented on the high staff turnover in secondary care, with a view that this is sometimes because of negative reporting in the media and sometimes because of disagreements with managers. Someone else commented on a letter from former staff criticising the management of the service.

Social prescribing is seen as a positive development and access to services outside office hours a gap.

4.2 Guernsey Mind

Guernsey Mind has a good brand and reputation on the island and demand for their services is high and increasing.

Guernsey Mind see people receiving primary care services, who do not have high risk. The referrals come from GPs, secondary care and Healthy Minds. They are funded by donations, and not for anything provided by secondary care. They provide a coaching service, therapies and groups, as well as raising awareness, running campaigns and training, including mental health first aid and prevention of suicide. They also provide complimentary therapies for 6 to 12 sessions and signposting to social prescribing, support and community groups.

There had previously been limited communication between Mind and secondary care, but board members and staff report that this has improved. There are good relationships and have been productive meetings, planning the way forward for working together in partnership. However services are not yet coordinated and the staff said that a link with secondary care would be brilliant. They said that the service is often excellent, but describe it as something of an enigma and are still not clear of the criteria.

There is no direct pathway between the two services and if people using Mind services need secondary care, the referral has to be made by the GP, although Mind would be better placed to refer. The aim is to create a pathway, particularly for psychological therapies, looking at how the services complement each other. When people are discharged from secondary care they often contact Mind for more support and an established pathway could facilitate a smoother discharge route from secondary care.

Healthy Minds and Guernsey Mind work well together and communicate well. There is some crossover between the services, but this not a problem because of good coordination. Referrals between the two organisations go smoothly.

4.3 Healthy Minds

Healthy Minds receive approximately 100 referrals a month, 85% of which are self referrals, and the majority of which are accepted. The team is led by a clinical psychologist and comprises psychological wellbeing practitioners (PWPs), therapists, counsellors and a counselling psychologist. They are trained in trauma informed approaches and offer 6 to 8 sessions, or 12 for high intensity therapy.

The team gave feedback that they work closely with secondary care and also with Guernsey Mind and other third sector providers. They signpost people to other organisations, including the social prescribing pilot, where people have six sessions for support, including housing and employment with links to community groups. This is seen as a positive new development.

The team are receiving more referrals from people with long term physical conditions and suggested that they could develop their service by having a dedicated PWP with specialist skills in this area.

Healthy Minds are well regarded, and people generally report a positive experience of the service. However some people have not heard of them and there was a comment that they need a higher profile.

4.4 Prison

The prison staff reported that up to 70% of prisoners have some mental health issues, but that there is minimal mental health input to the prison. They said that a psychiatrist used to run a weekly clinic, but the situation has deteriorated. There is a therapist employed by the prison who fills a gap.

They said that it is difficult to get psychiatric services involved and a psychiatrist only visits occasionally to see individual patients. There is no formal or informal agreement with mental health services and no established pathway. There is no governance or process established, unlike other areas of medicine.

4.5 Police

The police representatives reported that they have developed good relationships with mental health services. The police station's use as a place of safety has reduced drastically, but it is still used at times. They suggested an area in Crevichon ward could be used as a place of safety.

They said that the MOU with ED and HSC has reduced the amount of time the police spend waiting in ED with people. The situation has improved, but not as much as they would like, and they see the gap as being in a crisis response.

They find the out of hours duty psychiatrists inflexible as they do not usually get involved in community assessments or with anyone not known. The police are told not to contact the ASW on call, but the duty psychiatrist.

4.6 Primary care GPs

The GPs I spoke to said that the psychiatrists in secondary care mental health services are excellent, but they have no direct link to a psychiatrist, which would be helpful. They find RAWS, CAMHS and Eating Disorders services to be good and improved since recent changes.

The GPs said that about half of their work is mental health and they manage most of it themselves, whereas in other specialties people are seen and assessed. They said that they rarely refer to secondary care mental health services, as referrals are often triaged without the person being seen and then rejected. They said that the transition from CAMHS to adult services is problematic.

They acknowledged a capacity issue for secondary mental health services and suggested people could be treated and discharged back to general practice quickly. Their view is that secondary care hold on to people too long in outpatients, when the GP is the right person to see stable patients. They said that they would happily prescribe, if a psychiatrist puts the patient on the medication and stabilises them. There was a problem in the past, where there was over prescribing and GPs didn't support it, but this is not the case now.

The GPs said that Guernsey Mind provides some excellent services, as do some other third sector organisations. However there are a lot of unregulated therapies in Guernsey, which can be dangerous.

They said that they often ask people to refer themselves to Healthy Minds, which provides a good service. However they only give brief therapy and are not a gateway to secondary care.

4.7 Union representatives

The union representatives said that they find the leaders of secondary care services to be easy to work with. However they feel that there is an inability to change the culture of the service, and there is a perception that it is not a safe environment in which to hold an alternative view. They found the service to lack good multi-disciplinary working, and there is not always a willingness to learn from others.

They said that services could be improved by more openness and transparency. They suggested that exit interviews should always be given and the information shared within the department. They also said that staff retention would improve if housing subsidies were extended beyond two years.

4.8 Emergency Department staff

The ED staff I met reported an improvement in working with the HSC mental health services, and said that it is much better than four years ago. They said that the duty team work hard and are very good at what they do, and that the the Operational Manager (community) is their 'go to' person. They said that she and the duty senior lead from the front and do the leg work in the day, but don't have the resource for an on call service out of hours. The Operational Manager attended the governance meeting with partners in January, and this was described by ED as the most productive of the meetings.

The staff said that some headway has been made and there is now an MOU with the police and mental health services to clarify responsibilities, particularly out of hours. This has improved partnership working.

There is a longstanding issue about psychiatric assessments out of hours. There are two psychiatrists on call, but they do not attend in the night to assess a person intoxicated by alcohol. The team accepts this, but propose that they attended at 7:00 or 8:00. They are frustrated that they sometimes have to wait until 11:00 for an assessment by the duty team, when the department is busy. They said that the duty team are great when they arrive, but patients don't want to be kept waiting for hours.

The team said that the lack of sharing records is an issue, as they don't have have access to mental health records, and so it can take them a long time to assess a situation. A new system proposed for next year may improve this.

4.9 Guernsey grammar school

I spoke to several managers and senior staff at the school, and I was assured that all schools would give similar feedback.

The staff I spoke to identified positive developments, including an Alderney worker and a new step 2 wellbeing service, being established. They also described the reparative care team for sex abuse or looked after children as being excellent. They reported that the new diagnostic team for autism is very welcome, but the team is working through a backlog and there is a two year wait.

They said that CAMHS has some very dedicated staff who make an amazing difference, but that there are not enough of them at all levels. However, they said that sometimes their intervention is not creative, only using decider skills, which the school can do themselves.

They see a high level of serious distress including self-harm, eating distress and suicidal thoughts, and this increased during the pandemic, leading to school avoidance. They acknowledged that CAMHS has to prioritise high levels of need, which means their referrals are not always accepted.

They said that If primary schools can't get a referral through, the problems continue through to secondary schools and sixth form, with difficult issues and behaviour. There is a view that the service should be more flexible, for example offering a different therapist if a child or young person does not get on with their allocated therapist. They also feel that CAMHS sometimes discharges people too quickly.

They said that when people receiving treatment in CAMHS reach eighteen they often have no contact with adult services and there is a void. They felt that CAMHS has a poor reputation on the island, and it needs to be improved.

The school found it was beneficial to have family meetings with CAMHS, but these have not happened since 2016 because of GDPR. They said that a termly liaison meeting would be helpful.

They identified capacity issues at all levels, which are summarised in section 6 about service gaps.

4.10 Autism Guernsey

The service receives referrals from secondary care mental health teams and liaises with them, but said it is not partnership working. They work more closely with Guernsey Mind and other charities and have links with Healthy Minds, the police and prison services. They said that there is a a need for an adult diagnostic service, but that there is a good diagnostic service for children.

4.11 Former staff

I met with four people who have recently resigned from secondary care services. Three of these have left PTT and reported that there were tensions in the team. They have extensive experience in providing psychological therapies, including research and publishing in journals, and are highly critical of changes in the provision of psychological therapies. They said that the therapies offered are inadequate for secondary care, seeing people for just 50 minutes a session. However, one of them said that Healthy Minds provides a very good service.

One former staff member said that they were told that they were resistant to change and would not adapt to new ways of working, which they disputed. Another said that they were told that they did not follow guidelines, but argued that this was not the case and

that they were told to discharge clients inappropriately. One person said that the service should move towards a more systemic, client-centred service with a joined up approach.

They all had a slightly different perspective and one person argued that the service changes have been good for service users but not for the management of staff. Another said that the new approach worked very well for some service users.

It is not unusual to find strong opposing views among very experienced clinicians providing psychological therapies, depending on the specialism in which they have trained and practised, and the arguments need to be carefully considered and widely discussed. However many secondary care services have moved to providing shorter interventions with the delivery of more evidence based treatments. Staff currently working in the service who commented, said that these have been positive changes.

A former staff member from another team reported being treated harshly for making a small mistake, and said that some staff are favoured over others. They said that most of the clinicians are excellent, but they found that the management and HR approach could be bullying.

These issues had been raised with the service and some with deputies, and have been investigated. I was not able to carry out further investigation as part of this review, but note the strong feelings from these former staff.

5. Views of service users and family members

I was entrusted with personal stories from seventeen individuals who had used the services. I also spoke to family members of fifteen service users, some of whom described themselves as carers. There was feedback about gaps in services, which is included in section 6.

Most people related negative experiences, with some positive elements of their care and treatment in secondary care. A small number of people recounted experiences, in which they said that services had completely failed them. These had already been taken up in formal complaints to the service or to deputies. Some cases had been reported in the media. I was not able to investigate individual issues, but picked out the following themes.

5.1 Compassion

Several people said that they do not feel they are treated with compassion or empathy by secondary care services. A few people said that the services don't involve people enough in their care and treatment. One person described a doctor as aloof, but had not been allowed to change to a different doctor.

There was anecdotal feedback that people feel as if they are 'passed from pillar to post'. There was one comment that the service feels opaque and another that services are guarded and defensive. Some of the family members said that people do not always feel they are listened to by Oberlands staff, and one person said that the staff think they know best and that medication is too often seen as the answer. Another person said that the service did not give condolences after the tragic death of a family member.

Two people said that the doctors in ED can be abrupt. One family member found the assessment in ED to be an intimidating process, with no attempt to build a rapport, although they said the psychiatrist did then try to build rapport and be helpful.

5.2 Signposting

Several people said that they were discharged from secondary care without any follow up or signposting to other services, other than the GP. One person said that the service feels uncoordinated and they experienced being passed around a lot of staff and then back to the GP. The GP then pointed them in the right direction with medication, and encouraged talking therapies.

5.3 Crevichon ward

Everyone I spoke to who had been an in-patient in the ward, was complimentary about the permanent staff, who were described as 'very good', 'brilliant' and 'respectful'. People also said that 'they had been looked after very well' and that 'the care was very good'. There were criticisms of agency staff, some of whom were described as rude or lacking understanding. This was echoed by a family member who said that there are 'some good, nice, kind staff, probably the permanent staff, and some terrible, possibly agency'.

One person complained about a lack of activities on the ward in 2019, but this has improved since RAWS have been more present. They also said that staff spend too much time in the office.

One family member said that it would be useful to have written information about the ward. They were not aware, for example, that there is a named nurse whom they could contact. Two people reported problems in getting toiletries and there was a suggestion that all patients be given a welcome pack on admission, including key information and a pack of toiletries. One person said that their family member's brand new clothes disappeared on the ward.

5.4 Psychological therapies

Several people said that the therapy they had received from secondary care services was good, but that they had needed more. One person said that EMDR therapy had ended abruptly after a few sessions. Another said that they needed two years of intense therapy, but were only offered eight sessions. There was a comment that there is too much reliance on CBT, mainly in groups, but one person said that they enjoyed the therapy groups in RAWS.

The feedback about EMDR provided by secondary care services and Healthy Minds was positive, particularly for Post-Traumatic Stress Disorder (PTSD). Two people said they would have benefited from it years ago, before it was widely available in any services.

Several people reported that the therapy provided by Guernsey Mind is very good. One person said that Mind gave twelve sessions of trauma therapy, after Oberlands had not provided it. There was also very positive feedback about the service provided by Healthy Minds and the decider skills therapy, which is given to people while waiting for Healthy Minds.

5.5 Rare conditions

A few people told me that they have a rare condition, which secondary care services do not know how to manage, although the pain psychologist is said to be very good and there is some local support from third sector organisations, such as Autism Guernsey. There was said to be a need for specialist interventions, which can only be found in the UK, or on online forums.

5.6 Alderney

A family member from Alderney said that there is a big problem with the health care on the island, but that it is much better in Guernsey. They suggested that a nurse with mental health crisis knowledge hold a weekly mental health clinic in Alderney.

5.7 Family support

Several family members said that they didn't receive any support from secondary care services. One said that there is not a lot of information for friends and families, who often find Oberlands to be unwelcoming, and that communication with families could be improved.

One family said that they had a traumatic experience of services, because they were not given advice that they said was crucial, and there was poor communication between mental health services and other teams in HSC.

One family member said that the therapy provided by Mind was amazing but overrun. Others said they had approached Carers Guernsey for support and to be listened to.

5.8 Positive feedback

Several people said that the staff are generally good, but one said that the system is not. There was also a comment that services such as duty do their best, but it's time limited, and they do not have a magic wand to fix things. A family member said that the staff in R&R are very helpful and communicative. One person said that involving service users in staff recruitment is a positive development. ADHD assessment at Oberlands is said to be good, with waiting times much better than in the UK, but not perfect. There was feedback that the Oberlands cafe is a good place for service users.

There was positive feedback about Guernsey Mind, Healthy Minds and Autism Guernsey. There was a comment that they don't have the stigma associated with secondary care services. A family member said that they could not fault the care given in the prison service, and gave an example for a week-long course for prisoners to help manage autism.

5.9 General comments

One service user said that the problems are in society, such as the living wage being too low and many people had no hope, for example of ever being able to own a house. Two people said that secondary care services could be better if they had more funding, and R&R was said to be under resourced. A family member said that there has been chronic underfunding of mental health services for forty years.

One family member said that staffing issues are problematic, as many staff don't stay in post for long. The high staff turnover rate was attributed to the cost of living on Guernsey, particularly the cost of housing.

One family member said that there is a lot of domestic abuse on the island, which can lead to emotionally unstable personality disorder (EUPD). They said that EUPD is not generally understood, and that workplaces should understand it as well as doctors and nurses.

Several people said mental health issues had risen during the pandemic, particularly for children.

6. Areas of improvement and previously unidentified service gaps

The Guernsey and Alderney mental health and wellbeing service map shows the provision across the islands for pregnancy, children and young people, adults and older adults across five steps. It then identifies gaps in provision. I have not documented these gaps, except where they were highlighted in this review. I include areas where demand for a service is reported to exceed its capacity.

6.1 Children and young people

Step 1: Recognition, prevention, self management

One service user said that the approach to mental health is too medical, and there is a need to start with children and young people to empower them. Some of the deputies identified initial access and signposting as a gap, with not enough life skills support for children and adolescents.

This links with feedback from the grammar school staff, who said that there are capacity issues, with high need and limited resources. They identified the following gaps:

- A mental health and wellbeing coordinator in the school: there used to be one.
- Sufficient school nurses: they are said to be good at coordinating care, but each school nurse is responsible for several schools and has an enormous workload.
- Sufficient attendance officers: schools are often left to manage emotionally based school avoidance.
- Supervision or support for school staff: to offload after worrying issues are disclosed to them, which affects their wellbeing.

Step 2: Guided self-management, brief talking therapies

- Guernsey Mind service for 16-18 year olds: this was provided by one social worker and was said by several stakeholders to be brilliant and very busy, but there is currently no funding for it. Guernsey Mind said that they need to seek more funding as there is a huge need, particularly in schools.
- Capacity in the youth commission talking service: the grammar school staff said that this service is very good for issues such as bereavement and gender dysphoria, but they do not have the capacity to meet the needs.
- Capacity of the Emotional Literacy Support Assistant (ELSA): there is one person who deals with serious issues, but capacity is limited and the school can only make six referrals.
- A family member said there is no support for a child with asperger's syndrome on the island.

Step 3: Medication, complex talking therapies, social support

The grammar school staff said that CAMHS only accepts referrals when there is a mental health issue and identified the following gap:

- Support for children and young people with with developmental trauma, who have experienced domestic abuse: the Trauma Recovery Centre provides this, but it is only one person working for two days a week, so there is a waiting list.

6.2 Adults

Step 1: Recognition, prevention, self management

There was feedback from service users and families that mental health and personality disorders, particularly EUPD, are not well understood by the public, including employers. A public health campaign to raise awareness would help this.

Step 2: Guided self-management, brief talking therapies

Guernsey Mind staff said that there is signposting, advocacy, coaching and drop in support on Alderney, but no counselling, as there is no funding for it. They could provide it by zoom, but there is a capacity issue.

Healthy Minds said there is limited psychological support for people with long term health conditions; currently a neuro psychologist and pain psychologist, but no pathway. They are planning training in long term conditions for some PWPs.

They also said that people with suicidal ideation who can't access mental health services, sometimes present at ED and need some follow up. This could just be a daily phone call for a while, so they have someone to talk to. A service user said that sometimes people just need to be able to talk to professionals.

Several service users and family members said that there should be more early intervention and prevention work, giving people their own tool box. One person suggested a permanent base for Horizons and said that they would like more activities, groups and self help; something to occupy people's minds and make them feel happy.

Several people said that a funded diagnostic services for adults who may have autism is a gap, and one person said there is no expertise to diagnose aspergers. This service would probably require two dedicated staff. A need for low level practical support and therapeutic couple work for people with autism was identified.

GPs identified sleep clinics or groups as a gap.

Step 3: Medication, complex talking therapies, social support

GPs and the union representatives highlighted a gap in the provision of psychological therapies. A service user said that they needed something more than CBT, but longer term psychotherapy is not available. The group therapy that is offered in RAWS is said to be good, but some people don't have the confidence for groups and need individual therapy.

Service users, family members, Healthy Minds and secondary care have identified a gap for people with EUPD, who need longer term therapy than services currently provide. These people do not have a major mental illness or clinical risk, but they have a more chronic problem that requires a longer term therapeutic approach. These service users would generally be people who have suffered trauma as children or adults, but who are functioning at some level in society.

Healthy Minds have made a proposal to run a pilot to cover this gap in provision. People would be offered up to twenty sessions of therapy and two additional staff would be required to provide it.

One person said that the talking therapies offered are not appropriate for people with autism, and that the therapy provided by the Learning Disability psychologist is very helpful, but there needs to be more.

Step 4: Community outreach

The prison staff suggested that it would be helpful to have a Community Psychiatric nurse (CPN) in the prison health care team. Otherwise they need a weekly visit from a CPN for consultation, access to talking therapies and a monthly visit from a psychiatrist. The prison staff are keen to have a conversation with HSC about funding possibilities for a CPN and the Operational Manager (community) has acknowledged this need.

There is a view from ED that a good psychiatric liaison service is needed for the whole hospital, but there are different views about whether the level of need is high enough to justify the service. However, one person from ED said that a liaison service incorporating a duty team operating out of hours would be highly beneficial.

The police staff said that some of the mental health resources are at the wrong end and there should be a crisis team in the community. Otherwise the police take on this role by default. ED staff also said that mental health resources should be at the front end. One family member said there should be a crisis services to prevent hospital admission.

A family member said that it is inappropriate for people at risk to have to present at ED, and then wait for an assessment from secondary care. Another person said that it was unrealistic to take very unwell people to ED and there should be dedicated mental health resource.

Some service users and family members reported a need for more aftercare to help get people back to society. There was a comment that more discharge planning is needed with follow up from a therapist or care worker.

Step 5: Intensive support

A family member said that ECT is not provided on the island and people who need it have to go to the UK. A service user said that people with mental health issues need family and friends around them and should not sent away from the island.

There was a comment that secondary care should employ more nurse prescribers and have fewer consultant psychiatrists.

6.3 Older People (specifically)

Step 4: Community outreach

There was feedback that there are not enough resources for care packages in the community, and this results in older people being admitted to a care home or a ward. More community services would enable people to stay in their homes for longer, which is generally what they would want.

7. Conclusion

7.1 Partnership working

The findings of the review are that secondary services have developed in some areas and many of the recommendations from 2018 have been implemented. I found that where more emphasis has been placed on partnership working, service delivery and the perception of services across the island has improved. However, progress has been slow and the most important development now is to progress the approach to partnership, as proposed in the 2017 policy letter 'A Partnership of Purpose: Transforming Health and Care', particularly:

- A universal offering giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them
- A partnership approach recognising the value of public, private and third sector organisations, and ensuring people can access the right provider
- Empowered providers and integrated teams supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes

There is a wide range of services across the island, but this is not the public perception. Some organisations with a high profile, such as Guernsey Mind, are very good at public facing and generally well regarded. There are other highly regarded third sector services, such as Guernsey Bereavement Service, Guernsey Counselling Service and Guernsey Employment Trust. A great deal more could be achieved through further work on the coordination of services, both within the third sector and between secondary care and the third sector.

The creation of the Operational Manager posts is seen as a good development that has strengthened the management structure of the service and improved partnership working to some extent. It could be progressed further by giving the the Operational Manager (community) a specific responsibility for developing partnerships and working with other organisations to create an integrated mental health pathway.

7.2 Strategy

A mental health strategy group for Guernsey and Alderney, including representatives from all organisations involved in mental health and service users and families, could oversee the implementation of strategic objectives as set out in the Mental Health & Wellbeing Plan for Guernsey. This would include addressing the gaps identified in the mapping exercise and considering service provision to meet the identified gaps.

The group would operate as a senior team, giving an opportunity to discuss interface issues, coordinate funding streams and find solutions. It would give smaller charities an opportunity to coordinate by developing partnerships. The involvement of service user and carer representatives, would facilitate a coproduction approach to service development.

An effective strategy group would communicate the message that secondary care is responsible for responding to crises and providing specialist interventions for people who are acutely unwell, and that longer term support is provided in the third sector. A public document setting out a seamless integrated pathway with the criteria for each service would help people to understand how their needs could best be met.

It will always be necessary for highly specialist interventions, particularly for people with rare conditions, to be provided off island. The public document could give an outline of these and clarify the pathway to accessing the services.

Secondary care services would not then feel opaque to people, and an integrated pathway with good coordination and signposting at every step would improve the experience of service users. Rebranding secondary care as Guernsey Specialist Mental Health Services (GSMH) would give further clarification.

7.3 Developments in secondary care

The review found there have been positive developments in the service and recommends that they are taken further. The specialities of the community team would work more effectively with further integration as a single integrated community team with a strong team of senior staff overseeing the work.

The service could introduce some small changes that would make a big difference to service users and carers, such as a welcome pack on admission to the wards, with an information leaflet and a pack of toiletries. Families should be given information on organisations which provide additional support, such as Carers Guernsey.

7.4 Crisis response

Many of the stakeholder organisations and deputies said that resources in secondary care services should be at the front end, responding to crises and acute needs. However, there was consistent feedback that the crisis cafe pilot at Christmas didn't work. It was used by very few people, even though it was held at an exceptionally stressful time for people with mental health issues. Although there is a need for people in crisis, this proved to be the wrong approach to meeting these needs.

A mental health strategy group could consider the best service to meet the need, particularly out of hours. There needs to be further consideration of a psychiatric liaison team, which has been proposed, but rejected because the need would not warrant it.

Other options could be to strengthen the out of hours response, for example by coordinating the duties of the ASW and psychiatrist on call, possibly including a mental health nurse. This would enable an earlier response to ED when people present out of hours. An area of Crevichon ward could be considered for a place of safety, if this is feasible.

7.5 Discharge from secondary care

The secondary mental health services could discharge people earlier as Primary Care, Healthy Minds, social prescribing and third sector organisations provide services for

people whose mental health is stable. This could include most of the people who only attend the medical outpatient clinics and social groups. More resources in secondary care could then be put into providing a more comprehensive crisis response. The partnership approach proposed would ensure good communication and signposting to facilitate a smooth transfer between services.

7.6 Children and young people

The review found that developments in CAMHS have resolved previous problems, and that the gaps in services for children and young people are mainly at steps 1 to 3. This is because of staff shortages in other areas, and third sector organisations having limited capacity. A mental health strategy group would be able to examine this and make decisions on where resources need to be allocated to best meet the needs.

The suggestion of a termly meeting with schools should be considered by CAMHS, as although resources are very stretched, it could be time effective by enhancing partnership working.

Several stakeholders said that the transition from adolescent to adult services is problematic and often does not happen. This is an area for CAMHS and the adult community team to consider.

7.7 Personality disorder

The review found that the pathway for people diagnosed with a personality disorder, providing time limited psychological therapies, is appropriate for a secondary care service, although some former staff hold a strong view that there should be a wider range of longer term therapies offered and service users sometimes feel they are discharged too soon.

The focus of the service is rightly on the most severely unwell people in the community, and most of the stakeholder feedback was that more resources should be directed towards this group. The pilot proposed by Healthy Minds would address the gap for people with EUPD who need a longer period of therapy.

More emphasis on signposting to third sector organisations and community groups for longer term support is needed. Guernsey Mind staff said the aim is to create a pathway, particularly for psychological therapies, looking at how the services complement each other.

Regulation of therapies in Guernsey is something to be considered by HSC.

7.8 Prison

There is an acknowledgement that more mental health interventions are needed in the prison, and discussions on the best way of providing this, such as a CPN in the prison health team, should now take place between secondary care and the prison authorities. A CPN could be the link to accessing other mental health services for prisoners, such as talking therapies.

7.9 Alderney

The plans to develop remote working with people in Alderney will reduce the need for them to travel to Guernsey for treatment. It would increase provision for people who need a service at steps 1 to 3, including psychological therapies.

7.10 Staff recruitment and retention

Staff recruitment and retention is still a challenge, particularly for nurses, as is the case in the UK and other countries. There is a high use of agency staff, some of whom are said to lack compassion.

A review of incentives offered is now recommended, as some of them seem not to be effective, particularly the housing subsidies stopping after two years. There was a suggestion that an effective incentive would be to offer secondary care staff on lower salaries one or two free flights to the UK every year.

Exit interviews should always be given and the information used to improve staff retention.

8. Recommendations

1. The gaps identified are added to the Guernsey and Alderney mental health and wellbeing service map and the group reconvenes to address them
2. There is a mental health strategy group for Guernsey and Alderney that oversees the implementation of strategic objectives as set out in the Mental Health & Wellbeing Plan for Guernsey and Partnership of Purpose letter
3. The Operational Manager (community) has a specific responsibility for developing partnerships and working with other organisations to create an integrated mental health pathway
4. The secondary care mental health services are rebranded as Guernsey Specialist Mental Health Services (GSMH)
5. The service considers discharging all people whose mental health is stable and put more resources into providing a crisis response
6. The process of transition from adolescent to adult services is reviewed by the Operational Managers for CAMHS and the community team
7. A termly meeting for CAMHS and schools is considered
8. Further integration of the community team with a single manager and team of senior practitioners is progressed
9. Primary Care practices to have a named professional in secondary care to refer to
10. The service considers how to make the Oberlands feel more welcoming and to offer support and signposting to family members as appropriate
11. Welcome packs to be given to people admitted to the wards
12. Recruitment and retention incentives to be reviewed and exit interviews to be offered
13. A system for regulating therapists practising on the island is considered