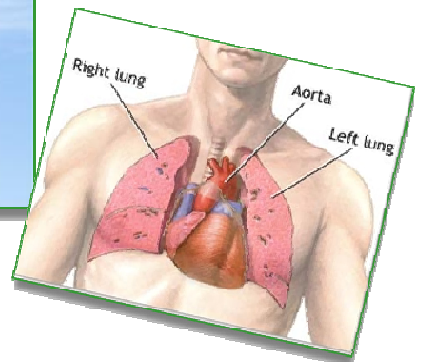


112th ANNUAL MOH/DPH/CMO REPORT Bailiwick of Guernsey

Special theme:

'Prevention of Child Maltreatment'

Report for Year 2010/11



STATES OF GUERNSEY



Dr Stephen Bridgman

MBChB, DBiomech, MD, MPH,
FRCS(Ed), FRCS (Glas), FFPH

Medical Officer of Health (MOH),
Director of Public Health (DPH),
Chief Medical Officer (CMO),
Bailiwick of Guernsey

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SUMMARY

I am very pleased to invite you to read the 112th annual Medical Officer of Health Report for the Bailiwick.

Child maltreatment is associated with major quality of life issues for victims, both immediate and longer-term, including poor educational attainment, unemployment, conduct disorder and criminality and an increased chance of higher risk lifestyles (such as drug and alcohol abuse, smoking, mental health disorders and obesity issues).

There is now robust research evidence that investment in a population based approach to improve parenting, such as the Positive Parenting Programme (Triple P), can reduce the proportion of children who suffer maltreatment, out of home placements, accident and emergency attendances, conduct disorders in children and can have other positive benefits.

I have advised a range of actions to help the island to reduce the prevalence of child maltreatment, including improved surveillance, a population measure of our success in child development, the creation of child maltreatment prevention and community development strategies, a debate on whether smacking should continue to be permitted in the islands and that the islands should aim to adopt the UN Convention on the Rights of the Child.

Tobacco is the single greatest cause of preventable death in the world, and it remains a major health issue for the islands. Among other diseases, tobacco smoking causes about 90% of our lung cancers, the most common cancer in the islands.

Work with the Chest and Heart service has shown that in first-time new attendees to the service the proportion of people who smoke has halved from around 33% in 1975-9 to 14% in 2005-9. Trends are similar to those in the Guernsey Lifestyle Survey which has been carried out since 1988.

Currently, over 30 islanders die from lung cancer each year – but with the reduced proportion of people smoking today compared to thirty years ago, it is highly likely that the number of annual deaths from lung cancer will also decrease in years to come.

However, there are still too many people smoking and so it is likely in future that we will see the equivalent number of people dying in one year from lung cancer caused by smoking as one Trislander plane crash with no survivors, compared to the current equivalent of two crashes.

The proportion of first attendees at Chest and Heart who were obese has doubled in the last 30 years, confirming the results from the Healthy Lifestyle Survey. While the rate of increase over the last decade has slowed or even halted, it has done so at a relatively high level – which is still associated with many health problems such as diabetes.

In addition to the States investing in the second phase of its obesity strategy, I advise that it should introduce a systematic approach of health impact assessment for proposed new major developments and investments – such as new schools, other building developments or transport infrastructure, as opportunities are being missed to get much more health value and therefore financial value out of these initiatives.

While the islands are making progress in the race to prevent the appalling burden of diseases caused by obesity and smoking, we are only near the starting line in preventing mental health problems.

At the turn of this century, the World Health Organisation considered depression a major contributor to the global burden of disease and that by 2020 the condition would become relatively even more important.

For the first time, an Emotional Wellbeing Survey has been undertaken in the Bailiwick. This has demonstrated just how common anxiety and depression are in the islands, with 20% and 5% of respondents respectively reaching a level consistent with a clinical case.

A mental health and wellbeing strategy is being developed that will provide direction for the short and long term work that will be required to bring the burden of mental health problems in the islands under control. Decades more work will be required.

I have recommended a range of actions, including the development of a mental health promotion strategy and investment in a mental health promotion officer.

The survey also provides a population measure for wellbeing, which can be used to monitor progress in the future.

The final part of the report looks at the many achievements and challenges for business units directly managed within the Public Health Directorate. A *Chlamydia* screening programme is recommended as a spend to save preventative initiative.

Dr Stephen Bridgman,
Medical Officer of Health, Director of Public Health, Chief Medical Officer

November 2011



TREATMENT AND MALTREATMENT OF CHILDREN – A MAJOR PUBLIC HEALTH ISSUE

Background

Whenever researchers have studied child maltreatment in different societies and communities across the world, it has been found to be alarmingly common (WHO, 2006).

Maltreatment of children by adults within the family is one of the least visible forms, much taking place in the privacy of domestic life, but has been found to be prevalent in all societies that have been studied (WHO, 2006).

While the nature and severity of maltreatment and its consequences vary widely, child maltreatment is associated with significant ill health (Felitti et al, 1998), and occasionally the death of a child.

The consequences of child maltreatment today will have a great impact both socially and financially to the end of this century and beyond.

There is now strong scientific evidence that early intervention can improve the health and life chances of children, particularly vulnerable children, and improve local economies through problems being prevented. Prevention can save lives, increase good health, save money and improve future prosperity.

Public Health model to prevent child maltreatment

The Public Health approach involves considering host factors (in this case children), agents of the disease (e.g. parental or carer behaviour) and interventions to tackle the problem (e.g. parenting or welfare programmes); in the case of child maltreatment, both agent factors and interventions are complex and multi-layered as will be discussed later.

Definitions

In a Public Health approach, definitions of the problem are essential to be able to describe the problem, monitor progress and plan and deliver strategy; they also enable valid comparison of changes over time and with other jurisdictions.

Until recently, attempts to control child maltreatment have been hampered by lack of a Public Health definition, so that terms have been used in different ways and different terms have been used to describe the same acts; not surprisingly, this has contributed to varied conclusions about the size of the child abuse and neglect issue.

Child maltreatment is defined as any act or series of acts of commission or omission by a parent or other care-giver that results in harm, potential for harm or threat of harm (CDC, 2011).

Acts of Commission (Child Abuse)

These are words or overt actions that cause harm, potential harm or threat of harm to a child. Acts of commission are deliberate and intentional; however, harm to a child may or may not be the intended consequence. Intentionality only applies to the care-givers' acts, not the consequences of those acts.

For example, a care-giver may intend to hit a child as punishment (i.e. hitting the child is not accidental or unintentional), but not intend to cause the child to have a head injury, break a bone or develop conduct and emotional problems.

The following types of maltreatment involve acts of commission:

- Physical abuse
- Sexual abuse
- Psychological abuse

Acts of Omission (Child Neglect)

The failure to provide for a child's basic physical, emotional or educational needs or the failure to protect a child from harm or potential harm.

Like acts of commission, harm to a child may or may not be the intended consequence.

The following types of maltreatment involve acts of omission:

- Failure to provide
 - Physical neglect
 - Emotional neglect
 - Medical/dental neglect
 - Educational neglect
- Failure to supervise
 - Inadequate supervision
 - Exposure to violent environments

The World Health Organisation consider that one definition of child abuse cannot serve all purposes and so Public Health definitions may vary from those used for service delivery, legal purposes or research (WHO, 1999); this also has the potential for confusion.

Uniform definitions for use in child maltreatment surveillance were published by the Centre for Disease Control in 2008.

To permit valid comparisons between Guernsey and other jurisdictions and within Guernsey over time to enable valid local research on child maltreatment, I recommend that Guernsey adopts internationally agreed definitions for child maltreatment surveillance.

Recommendation 1:	Guernsey to adopt internationally agreed definitions for child maltreatment surveillance.
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Data Sources

Consistent information about the number of children affected by maltreatment is needed to estimate the size of the problem and changes over time, to identify those groups at highest risk who might benefit from focused intervention or increased services and to estimate the effect of interventions (Saltzman et al, 1999).

Child Protection Register Statistics 2006–2010

Guernsey keeps statistics of children in contact with the child protection services and specifically records on those on the Child Protection Register (CPR).

Figure 1 The total number of child protection registrations between 2006 and 2010 was 193

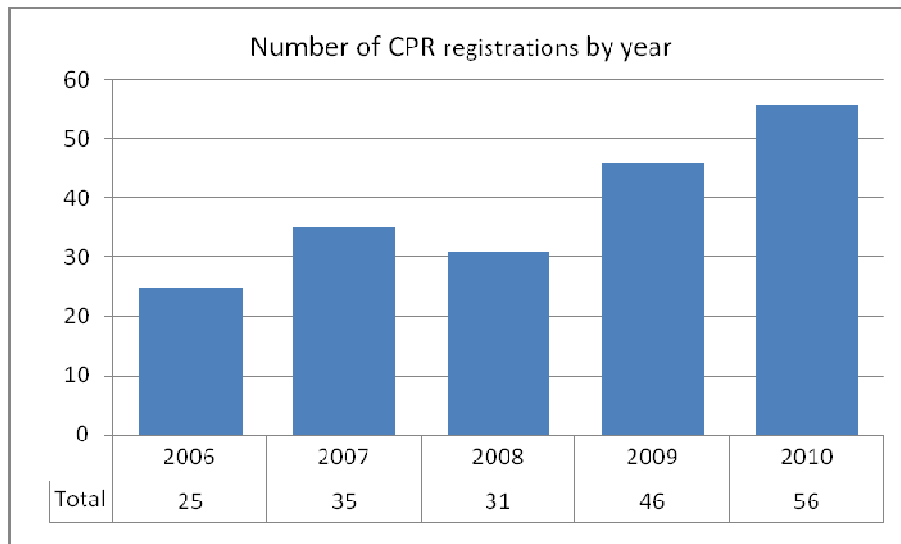


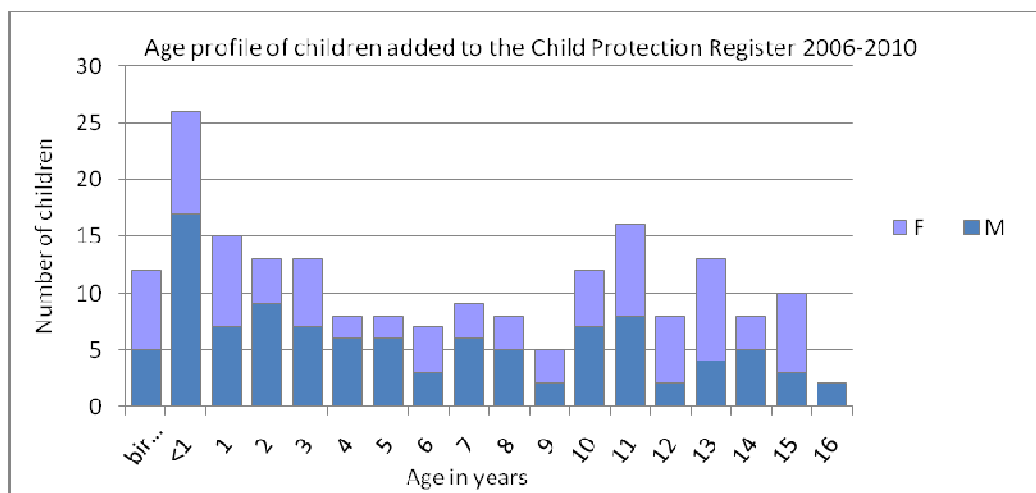
Table 1: The rates per 10,000 children aged 18 or less¹ are shown below (unpublished denominator data from Policy Council Research Unit)

Year	Registrations per 10,000 <18
2006	19.2
2007	26.8
2008	23.9
2009	35.6
2010	43.9

¹ [http://www.guernsey.gov.gi/children](#)

Age and Sex

Figure 2 The age and sex profile of children placed on the register is shown below



The most common age at registration was between 0 and 1 year. More boys were placed on the register than girls overall (104 boys compared with 87 girls), but more girls were placed on the register in the older age groups (ages 12+).

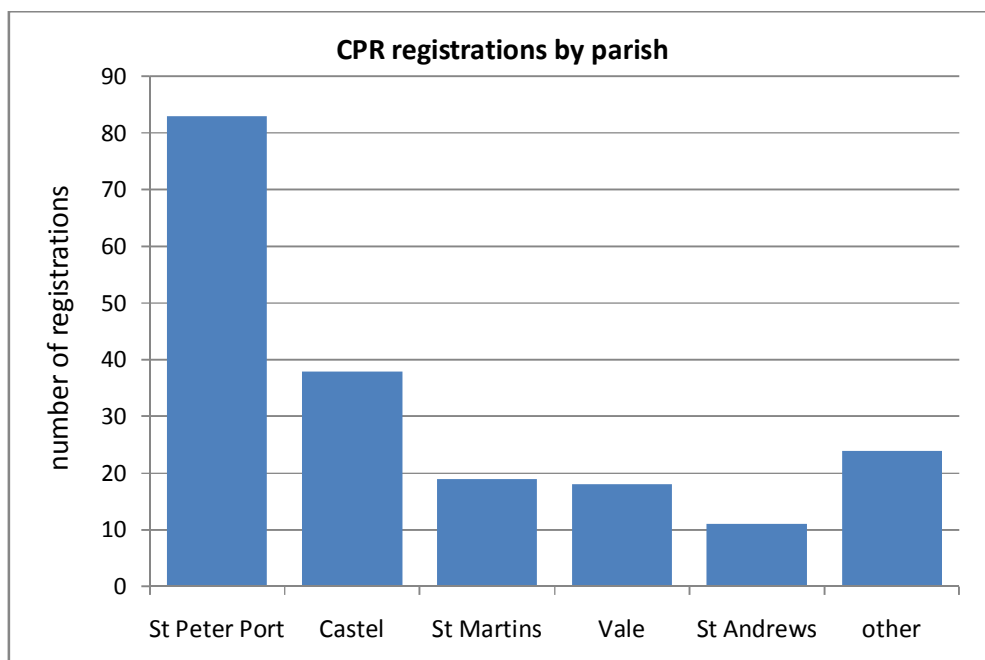
Parish

Registrations were most numerous for children living in St Peter Port, with children from this parish accounting for 43% of the total; the next most frequent parish was the Castel, which accounted for a further 20%. These figures are likely to reflect population density as St Peter Port and the Castel are the most populous parishes.

Further work will be needed to establish whether there are disproportionately high numbers of registrations for particular parishes after controlling for population size.



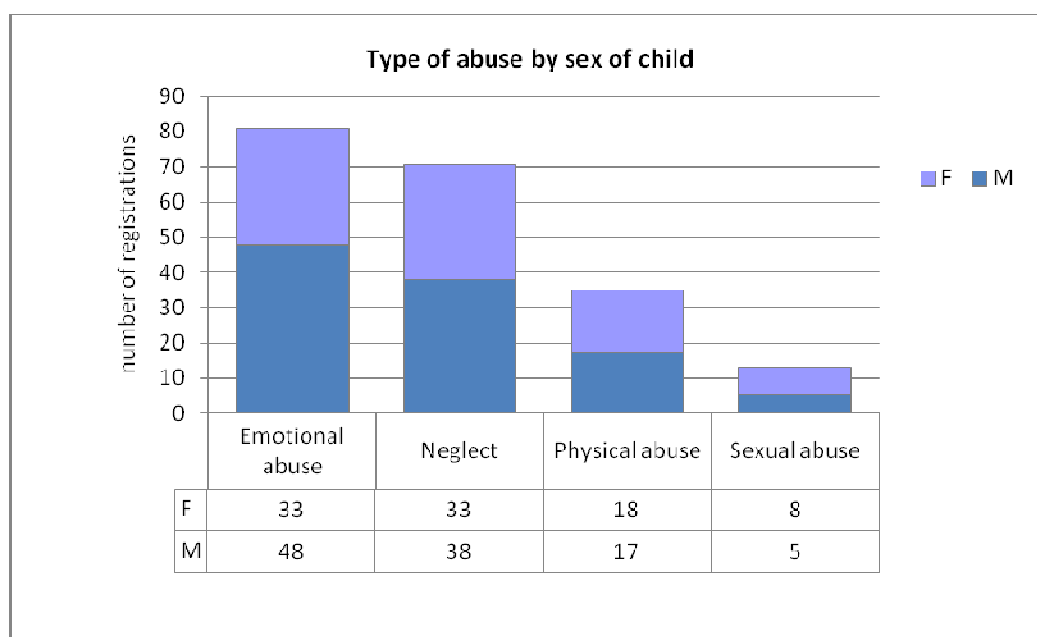
Figure 3 Child Protection Register (CPR) registrations by Parish



Category of Abuse

Eighty-one registrations were for emotional abuse, 71 for neglect, 35 for physical abuse and 13 for sexual abuse; Eight children were recorded as experiencing two types of abuse at the same time, either emotional abuse and physical abuse or sexual and physical abuse.

Figure 4 Type of abuse by sex of child



Time on register

For those children who were placed on the register and then taken off before the end of the five-year period (i.e. not counting those still on the register or those who moved away from the island whilst on the register), the average time on the register was 275 days (around nine months); of these children, 128 were on the register for less than one year, 35 for between one and two years and three for between two and three years.

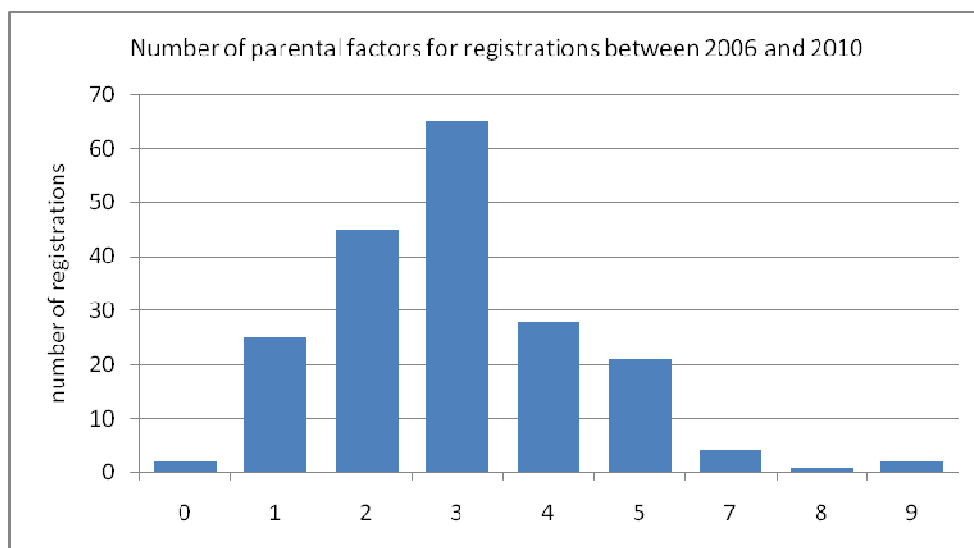
Re-registrations

Of the 193 registrations between 2006 and 2010, 48 (25%) had definitely been placed on the register previously and another five were thought to have been placed on the register previously; 136 children were placed on the CPR for the first time; in the four remaining cases, previous registration status is not recorded.

Parental factors

Of the 193 children added to the register, 191 had parents with 'factors' relevant to the registration; the number of parental factors ranged from zero to nine. The modal (most frequent) number was three.

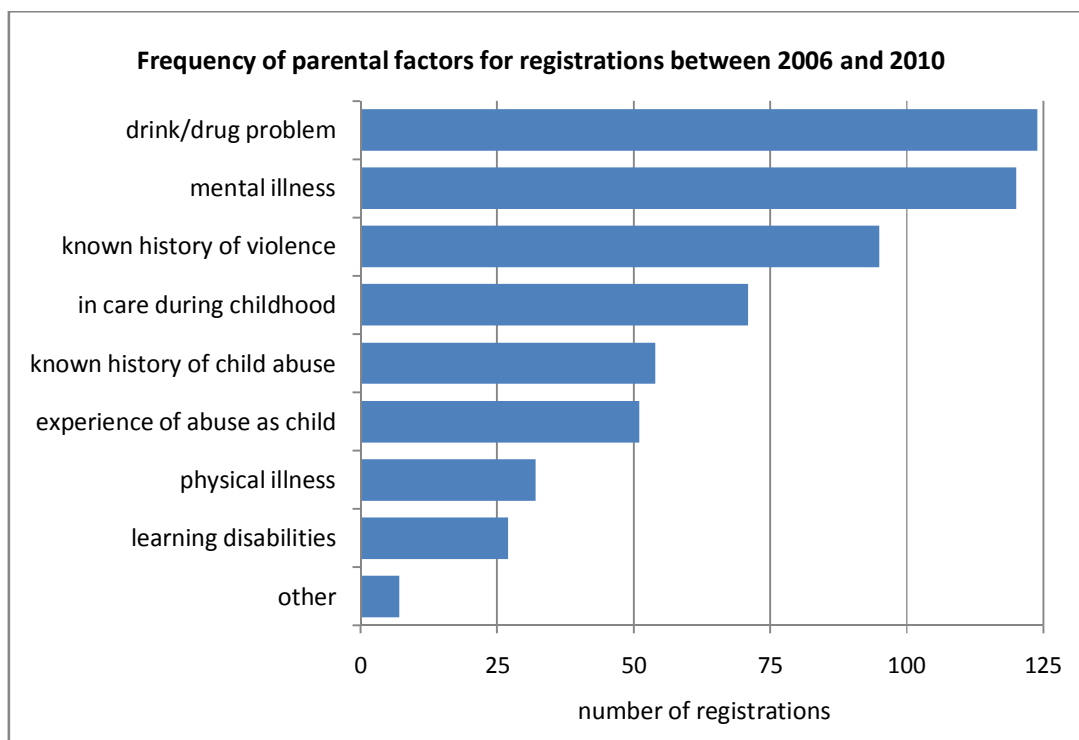
Figure 5 Number of parental factors for registrations between 2006 and 2010



The most frequently reported factor was 'drink/drug problem', with 64% of children added to the register having one or more parents with a drink/drug problem (124/193); this was followed closely by 'mental illness', with 62% having one or more parents with a mental illness (120/193).



Figure 6 Frequency of parental factors for registrations between 2006 and 2010



Further work on child protection statistics is planned, including consideration of the number of families and unique parents involved; for instance, if there was a family of five children, all of whom were placed on the register, and a parent had mental illness as a key parental factor, this would be counted five times in the statistics above.

The number of children subjected to maltreatment and not reported to child protection services is unknown and is almost certainly much larger than those known to services.

Death statistics

Death statistics are a reliable source of data. No confirmed deaths from child maltreatment have been recorded in the Bailiwick between 2001-10; during that period 30 deaths of children were recorded, about half of which were children less than one year old.

Accident and Emergency Data

Child injuries are referred to the child health services and cases are followed up by health visitors and school nurses if necessary, with some elementary analyses carried out of injuries in children; further analyses on repeat attendees and improvements in data for comparison with other jurisdictions is recommended.

Recommendation 2:	Further analyses on repeat A&E attendees and improvements in data for comparison with other jurisdictions is recommended.
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Health Visiting and School Health data

Guernsey follows the Healthy Child Programme model in the UK, which includes a programme of routine population child health surveillance assessments at prescribed times – namely birth, 6 weeks, 8 months, 2 years and 3.5 years.

Risk and protective factors can be recorded at these assessments and health visitors also keep a record of families of concern, in addition to those formally on the child protection register. This data has yet to be used systematically to monitor population child health.

I recommend further consideration is given to the use of this data for monitoring risk and protective factors in child maltreatment.

Recommendation 3:	Further consideration is given to the use of health visiting and school health data for monitoring risk and protective factors in child maltreatment.
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Survey of the Prevalence of Child Maltreatment

Based on a survey using self and parent reports, about 1 in 7 children in the USA between the ages of two and 17 years were subjected to maltreatment in one year (Finkelhor et al, 2005).

A recent review found a prevalence of maltreatment of 10% based on retrospective population-based surveys (Gilbert et al, 2009).

If these figures were applicable to Guernsey, then it would suggest that the vast majority of children who experience maltreatment are not currently identified by agencies – and so neither the children nor their families will be receiving help. I am unaware of a previous population survey in Guernsey.

Recommendation 4:	A population based survey using validated tools is carried out in the Bailiwick to measure the prevalence of child maltreatment and the association between past maltreatment, high-risk behaviour, current health status and socio-economic inequalities.
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Population Child Health and Development Measurements

Maltreatment is linked to social inequality and can have a major effect on child development; there is good evidence that attention to early years can help reduce maltreatment and improve child development in both the generation of interest and future generations.



How do we know whether, in Alderney and Guernsey, we have succeeded in producing the best child health and development across our whole child population over time?

Clyde Hertzman and colleagues in Canada have developed the Early Development Instrument (EDI), which is a population measure to answer this question (Irwin et al, 2007); their questionnaire consists of 103 questions that measure child health and development at population level across the domains of:

- Physical health and well-being
- Social competence (e.g. ability to concentrate on tasks and work effectively in groups)
- Emotional maturity (e.g. ability to negotiate in difficult situations, empathy, helpfulness, etc)
- Language and cognitive (thinking and reasoning skills)
- Communication skills (understanding and being understood)

These domains map across key areas identified by the UN Convention on the Rights of the Child, with the tool taking nursery teachers just 15 minutes to fill out and it acts like a report card.

The data is analysed not on a school basis, but from the neighbourhood in which the children grow up – because the main influences on a child's development at the end of the early childhood period are from the family and neighbourhood in which the child grows up, not the school.

The EDI acts as a proxy measure of how well a community is performing in raising their children and has been shown to be a powerful catalyst for communities and agencies to take action.

The opportunities for children to develop on these domains vary greatly depending partly on where the children sit on the socio-economic grid.

Consistently across different countries in the world the proportion of vulnerable children increases with poverty.

Recommendation 5:	The adoption of a population surveillance programme in Guernsey and Alderney, along the lines of the Early Development Instrument used in Canada and many other countries. This can then be used to monitor our success in child development for the whole of the islands and also in sub-groups of our population.
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Risk and Protective Factors for Child Treatment

Risk factors are those characteristics associated with child maltreatment and protective factors are those associated with a lower risk of child maltreatment (CDC, 2008). They may be described at the individual, relational, community or societal levels. Risk factors may or may not be the direct causes of maltreatment.

Risk Factors for Victimization – Individual Risk Factors

- Children younger than 4 years of age
- Special needs that may increase care-giver burden (e.g., disabilities, mental retardation, mental health issues and chronic physical illnesses)

Risk Factors for Perpetration – Individual Risk Factors

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues, including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, low income
- Non-biological, transient care-givers in the home (e.g. mother's partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviours

Family Risk Factors

- Social isolation
- Family disorganisation, dissolution and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships and negative interactions; in particular, parents who maltreat children compared to those that do not tend to have:
 - A more negative, hostile and punitive attitude than non-maltreating parents
 - More negative reactions to ordinary parental challenges (e.g. infant crying)
 - Inappropriate expectations of young children
 - Less ability to be aware of child's needs
 - Strong belief in the value of punishment (haphazard, uncontrolled and impulsive discharge of aggression)
 - Significant role reversal in which parent looks to the child for satisfaction of their own emotional needs



Community Risk Factors

- Community violence
- Concentrated neighbourhood disadvantage (e.g. high poverty and residential instability, high unemployment rates and high density of alcohol outlets) and poor social connections

Protective Factors for Child Maltreatment

These factors also exist at various levels, but have not been studied as extensively or rigorously as risk factors; identification and understanding of protective factors are as important as researching risk factors.

There is scientific evidence to support the following protective factors:

Family Protective Factors

- Supportive family environment and social networks

Possible Family Protective Factors

- Nurturing parenting skills
- Stable family relationships
- Household rules and child monitoring
- Parental employment
- Adequate housing
- Access to health care and social services
- Caring adults outside the family who can serve as role models or mentors

Community Protective Factors

- Communities that support parents and take responsibility for preventing abuse

Consequences of Child Maltreatment

There are physical, psychological and behavioural consequences for child maltreatment.

Immediate consequences of child maltreatment include isolation from friends, difficulty having positive social relationships, anxiety and depression.

Individuals who have experienced multiple forms of child maltreatment early in life are more likely to engage in risky behaviours (e.g. smoking, heavy alcohol use, risky sex and drug use) that are associated with diseases such as cancer, heart disease, respiratory illness and liver damage in later life (Edwards, 2004).

The stress of “hyperarousal” from maltreatment may lead to hyperactivity and sleep disturbances in children. In one long-term study, 80% of children subjected to maltreatment had a psychological problem by the age of 21 years, such as depression, anxiety, eating disorders or suicide attempts (Silverman, 1996).

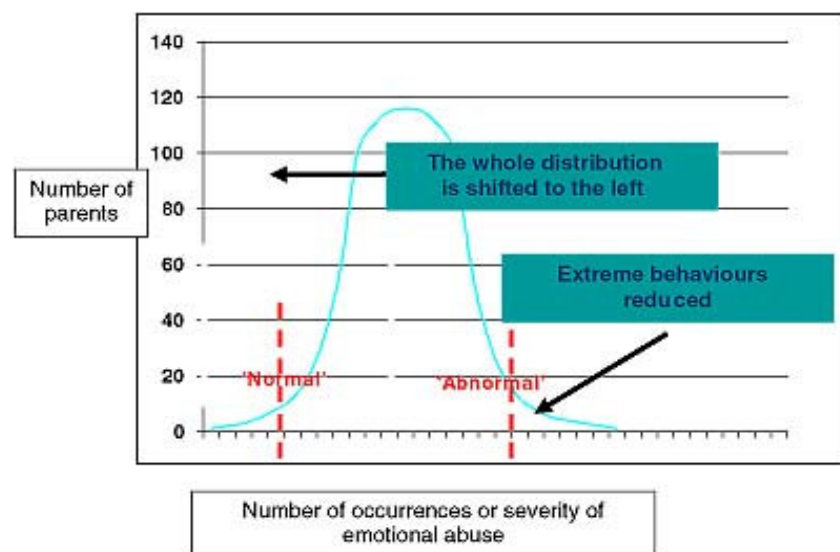
Abused children are at much higher risk of poor educational attainment, unemployment, conduct disorder and criminality. The costs to society are also significant – involving Social, Health, Education, Mental Health, Welfare, Police, Probation and Prison Services.

Public Health Strategy for the Prevention of child maltreatment

The strategic objective for child maltreatment prevention is to prevent child abuse and neglect from happening in the first place. The solutions are complex as are the root causes of the problem.

Prevention efforts at a population level aim to reduce the mean level of *risk factors* that increase the probability of child maltreatment and increase the mean level of protective factors that decrease the probability of child maltreatment. A graphic example of this whole population approach is shown in Figure 7.

Figure 7 Number of occurrences or severity of emotional abuse (Source: J Barlow and Calam (2011), University of Warwick Personal communication).



Barlow’s graphic also shows that there is no clear cut-off point between what is regarded as being acceptable and what is unacceptable – that is maltreatment may be seen as a continuum with families at low risk of maltreatment who use developmentally appropriate, warm, responsive, assertive, positive parenting at one end and high risk families who use a range of risky, coercive, emotionally and physically abusive and neglectful parenting practices that harm child well-being on the other (Barlow & Calam, 2011).



The middle-ground includes most parents who use a mixture of helpful and unhelpful strategies to varying degrees, often depending on outside stressors.

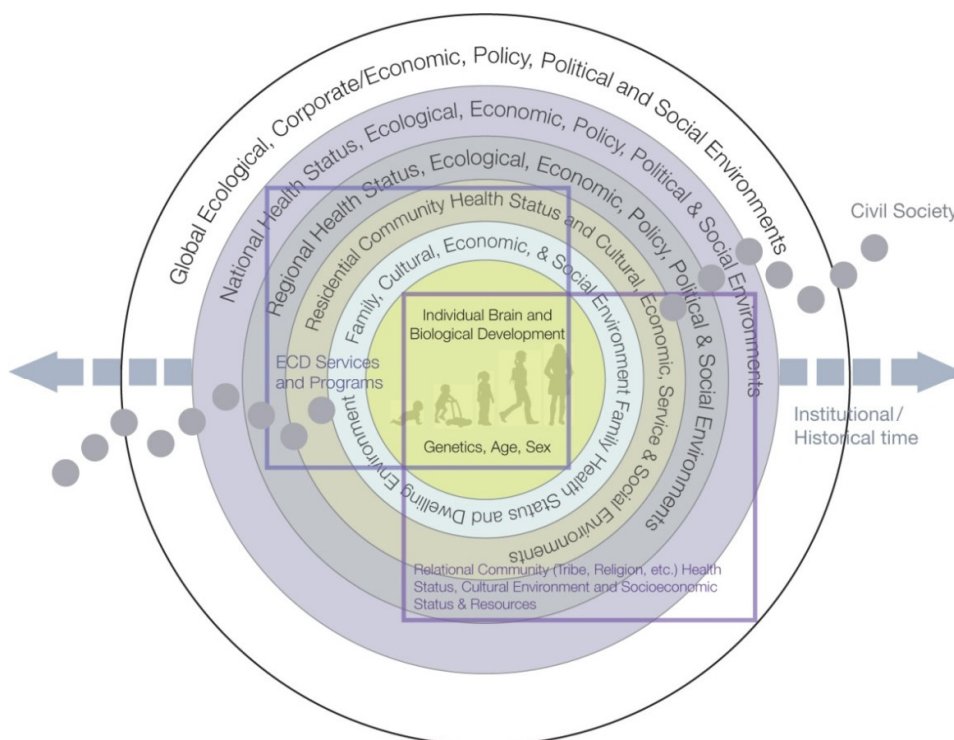
Although families most at risk of maltreating children are at the far right of the curve, the object of the Public Health approach is to bring a shift to the left of the entire population, in order to reduce the proportion of people using unsafe parenting practices.

Acceptability can and has changed with time. Preventative strategies aim to change society's view of what is normal behaviour where this reduces maltreatment risk.

A report for the World Health Organisation's Commission on Social Determinants of Health considered a variety of spheres of influence on child maltreatment and child development – including individual, family and dwelling; residential and relational communities; programmes and services; regional, national and global environments (Figure 8).

In each sphere of influence, social, economic, cultural and gender factors affect its nurturant qualities.

Figure 8 Spheres of influence on early childhood development.
(Irwin, Siddiqui and Hertzman, 2007)



Individual, family, and dwelling

Early years are particularly important because they have a major effect on health and well-being throughout the rest of a child's life cycle. For instance, one-third to half of children in the second year of life are physically aggressive in fighting for a toy or something similar – and the best chance to end physically aggressive responses and replace them with language and social negotiation skills is between the ages of 2 years and 5 years (Irwin et al, 2007).

Language is also very important and children who are spoken to a lot in early childhood may hear tens of millions of words more than other children – and this makes a major difference in language abilities in later life. Hertzman uses the phrase 'Equity from the Start' as his clarion call for action.

In Guernsey there is the perception of major differences in life opportunities for children. Child poverty and health will be considered further in a future report, but available research indicates that investment in children in their early years prevents future problems and expenditure and is cost-effective.

Residential and relational communities

Population based interventions are only likely to be effective with community support. The general public need to be able to recognise the problem, know where to go for help and be able to refer for help without fear of repercussions. Relational communities include non-geographic communities (e.g. religious, ethnic, occupational, sports).

Currently, Guernsey has a range of community-based initiatives, but not a community development strategy.

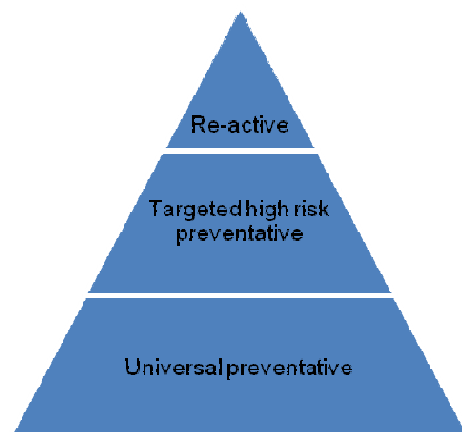
Recommendation 6: A community development strategy is drawn up which considers both residential and relational communities.
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Programmes and Services

Guernsey has in place a wide range of services to support the children's health and well-being agenda, including health visiting and school nursing (family partnership services), social work and child and adolescent mental health services. For community based services, the framework followed locally is the English "Healthy Child Programmes", which consider both universal and targeted services. A schematic diagram of the tiers of services is given below.



Figure 9 Levels of service in children's services



Islands Child Protection Committee have developed a comprehensive child protection plan and child protection guidelines, which can be readily accessed and set out all agencies and individuals responsibilities for child protection (SOG n.d.).

Child protection services locally are predominantly reactive services that do not tackle prevention, with the thresholds for intervention dictated by the resources available. Children may be placed on the Child Protection Register if they are considered by professional staff to be at significant risk of harm. The dangers of an overloaded Child Protection Service are a failure to protect if thresholds are lowered and resources constrained.

Recognition of child maltreatment by professionals and lack of preventative services are both local and international issues in controlling child maltreatment, improving outcomes and reducing long-term community costs.

Evidence-Based Population Programmes

The Triple P (Positive Parenting Program) is a whole-population based approach to improve parenting, developed by Sanders and colleagues at the University of Queensland (Prinz et al, 2009) over several decades and includes early intervention when problems arise throughout the age range.

Triple P is a multi-level preventative intervention system designed for families with at least one child in the birth to 12-year age range. The levels are:

1. Universal parenting advice that all parents can access
2. Light touch brief interventions that parents experiencing some difficulties may wish to access
3. Targeted levels for families with significant difficulties, including those at high risk or who have maltreated their children, who are worked with intensively to help change.

Programmes are delivered to parents rather than to children and on five core parenting principles:

-
1. Ensuring a safe and engaging environment for children
 2. Creating a positive learning environment for children
 3. Using assertive non-violent discipline
 4. Having realistic expectations, assumptions and beliefs about the causes of children's behaviour
 5. The importance of parental self-care

The social marketing of the programme aimed to de-stigmatise parenting and family support, to make effective parenting strategies available to all parents and to encourage help-seeking by parents. Other aspects of the programme aim to meet higher needs. The programme was designed using the concept of the minimum amount of resource to address and solve parenting problems.

In the USA, the system was the subject of a community randomised trial, with communities being counties in South Carolina with population sizes of 50,000 to 175,000. The trial demonstrated significant reductions in three population outcomes.

For every 5000 children under eight years of age (which is approximately the number of children Guernsey has), substantiated child maltreatment was reduced by about 15 children a year; out of home placements reduced by five children a year and injuries requiring hospital or emergency room treatment reduced to one to two cases a year.

The Triple P system has been adopted in parts of the UK (e.g. Glasgow) for a variety of reasons, including that it is the only system with a robust published evidence base – with evidence of effectiveness at both the levels of families and children and also at a population level.

An evidence based alternative to Triple P at the level of families and children is a system called the Incredible Years, developed in the USA; some local staff have recently been trained in this system, but there is no evidence yet for its effectiveness at a population level. There is no existing evidence that a mixture of different programmes delivers the improved outcomes that are required.

Recommendation 7: Guernsey invests in an evidence-based multi-level service for both families and children and the whole population to improve parenting, reduce child maltreatment and reduce longer-term costs in remedial services.

Regional, National and Global Environments

National Environment

A very important recent achievement in protecting local children has been the introduction of the Guernsey and Alderney Children's Law in 2010. There is a comprehensive website that provides further information; (<http://www.childrenlaw.gg/parents.html>).



The Law sets out parental responsibility classified as seven duties to a child as follows:

1. To safeguard and promote the child's health, education, development and welfare.
2. To provide care, direction, guidance and control in a manner appropriate to the child's age and understanding.
3. To determine all aspects of upbringing.
4. To provide a home, directly or indirectly.
5. To maintain relations or regular contact if not living with the child.
6. To act as the child's legal representative.
7. To safeguard and deal with the child's property.

These duties are to be performed as far as possible in the interests of the child and take into account the child's own evolving capacity to contribute to decisions. Those with Parental Responsibility have a right to exercise it without interference from others.

Smacking

Sweden banned smacking in 1978 and saw a change in public attitudes from around 50% to 10% of adults who supported corporal punishment.

Recently the Welsh Assembly has voted for legislation to ban the smacking of children, following several other European countries (Welsh Assembly 2011).

The [UN Convention on the Rights of the Child](#), require that children should be protected from all forms of physical or mental violence. In addition, hitting children teaches them that violence is an appropriate way to resolve a conflict. The alternative is non-physical means of resolving conflicts with children.

Recommendation 8: There should be a debate on smacking children.

Global environment

The United Nation's Convention on the Rights of the Child (UNCRC) was developed to apply to all children and young people aged 17 years and under. The Convention is separated into 54 'articles' and most give children social, economic, cultural or civil and political rights, while others set out how governments must publicise or implement the Convention.

The Convention was adopted by the United Nations in 1989 and came into force in the UK in 1992. Article 19 specifically relates to child protection and includes the following two key paragraphs:

1. *States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*

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2. *Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.*

The islands have not yet signed up to this Convention, but I believe doing so would demonstrate to the international community our commitment to children's rights.

Recommendation 9: Guernsey should aim to formally adopt the UN Convention on the Rights of the Child.

Interaction of Child Maltreatment with other Strategies

As noted above, risk factors for child maltreatment include domestic violence, drug misuse (both legal and illegal), mental health problems in carers and poverty. Therefore, I recommend that child maltreatment is given specific consideration within these existing States strategies.

Recommendation 10: That child maltreatment is given specific consideration within States strategies.

Do we need a child Maltreatment Strategy?

Addressing child maltreatment prevention will have major social, health and economic benefits for decades to come.

Therefore I recommend that the Bailiwick develops a child maltreatment prevention strategy, including interventions at all levels of the ecological model of intervention – infant and child, parent and family, community and society (WHO, 2006).

Recommendation 11: That the Bailiwick develops a child maltreatment prevention strategy, including interventions at all levels of the ecological model of intervention – infant and child, parent and family, community and society (see WHO 2006).

What can people do at a personal level?

Bringing up children is not easy. There is a lot citizens can do practically to help relatives, friends or other members of the community and reduce the strains associated with bringing up children.

Recommendation 12: That it is every citizen's responsibility to help struggling families



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Footnote

The Human Early Learning Partnership (HELP) at the University of British Columbia acted as the World Health Organisation (WHO) knowledge hub for Early Childhood Development (ECD) during the preparation of the WHO commissioner' report on Social Determinants of Health (2005-2007). Upon completion of the Commissioner's report and since 2008, WHO has designated HELP as the Global Knowledge Hub for ECD (GKH-ECD).



MENTAL HEALTH: THE NEED FOR A MENTAL PROMOTION STRATEGY

The States Strategic Plans aim to improve the health and wellbeing of Bailiwick residents, (Billet d'État XXVI 2009).

Mental ill health is emerging as one of the most important causes of preventable ill health in the world. Beside mental ill health, potentially mental wellbeing can be improved and maintained in all residents.

It is now becoming clear that the presence or absence of positive mental health or 'wellbeing' also influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life.

Depression is a common mental health problem and is estimated to be the world's leading cause of years of life lost from disability. In 2000, depression was considered the fourth largest contributor to the global burden of disease and the World Health Organisation (WHO) predicts that by 2020 it will become the second largest contributor.

Depression is characterised by low mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration. It can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities; at its worst, depression can lead to suicide. While prevalent in all ages and both sexes, it is particularly prevalent in working age adults.

Estimates of Common Mental Disorder: Morbidity Survey

Using figures from the UK National Psychiatry Morbidity Survey, it is estimated that at any one time 8,000 islanders are suffering with a common mental disorder (Public Health Directorate, 2010).

Mental Disorders in Guernsey

At a snapshot on a day in June 2011, the Social Security Department reported that over 900 people were on invalidity benefit, an increase of about 20% since 2008. Over 30% of those people were recorded with a mental health related illness as the primary cause of disability, of which depression was the single largest cause; it was considered highly likely that many of the others would have a secondary mental health condition (Billet d'Etat XIII, July 2011).

Consequently the Social Security Department financed, through the Health Service Fund, a two-year pilot for the provision of psychological therapies at primary care level; this started in September 2011 and is aimed at reducing the number of people whose mental health disorder becomes chronic (Billet

Guernsey Emotional and Wellbeing Survey (GEWS)

Good mental health is a key part of the improved wellbeing that our Government aims to achieve for us all.

The World Health Organisation (2011) defines mental health not solely as the absence of mental health problems, but rather as:

“A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”

Psychological wellbeing can be seen as a combination of feeling good (e.g. happy, content, interested, engaged, confident and showing affection for others) and being able to function effectively (e.g. developing one's potential, having some control over one's life, a sense of purpose, experiencing positive relationships) (Huppert, 2009, Johnson et al, 2011).

The GEWS was the first attempt locally to measure mental wellbeing and the experience of common mental health disorders (depression, anxiety and both together) for the populations of Guernsey and Alderney (Johnson et al, 2011).

Two objectives of the survey were:

1. To establish a baseline of mental wellbeing in the population of Guernsey and Alderney from which future changes in population mental wellbeing can be measured.
2. To estimate the prevalence of mild to moderate anxiety and depression in Guernsey and Alderney.

The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) was selected as the measure of wellbeing, while the Hospital Anxiety and Depression Scale was selected to measure the prevalence of these common mental disorders.

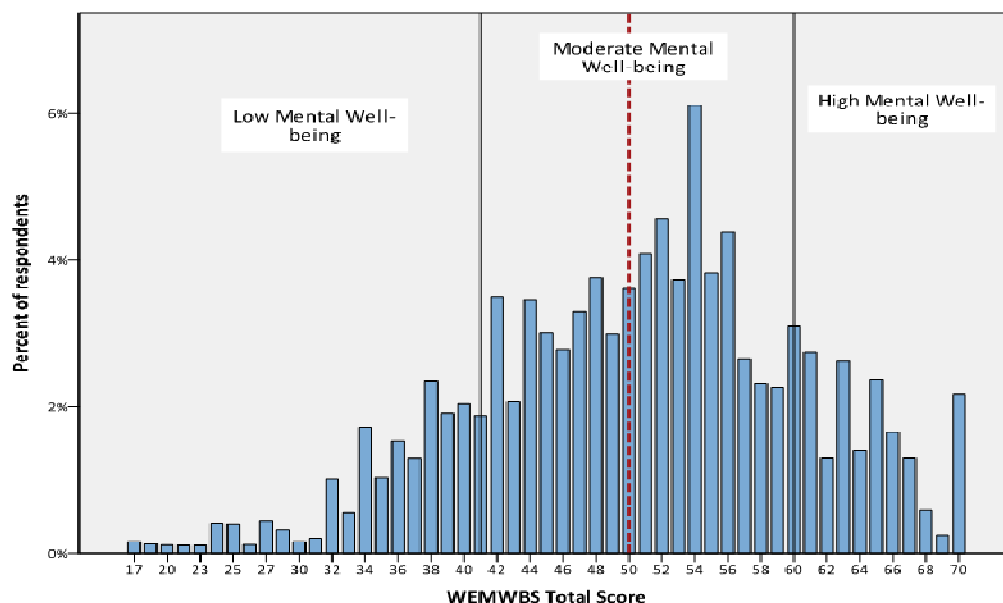
A 5% sample of the Social Security Department database of adults (defined as over 16 years old) was used and the response rate was 26% (722/2761).

Overall 78% of responders rated their health as very good or good.

The distribution of the WEMWBS scores is shown in Figure 10. The mean score was 50.5.



Figure 10 Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores in the Guernsey and Alderney Emotional Wellbeing Survey 2010 (n = 722 respondents)



20% of respondents had anxiety and 5% had depression, while 5% had both anxiety and depression to a clinical level as indicated by their scores on the Hospital Anxiety and Depression Scale.

Unexpectedly in the Guernsey and Alderney sample, there were no sex differences and while the proportion of women respondents with a common mental disorder were equivalent to other areas, those reported in men were higher; while it is possible that differences in survey methods resulted in different respondent profiles, this survey suggests that a slightly higher proportion of the population of Guernsey and Alderney suffer anxiety and depression at clinical levels compared to Jersey and the UK.

21% of unemployed respondents reported experiencing anxiety and depression, but only 5% of the people who were in work – while the lowest income group reported the greatest incidence of self-reported anxiety and depression symptoms (18% meeting ‘case-ness’). 53% of unemployed respondents had low mental wellbeing.

The large proportion of our population with common mental disorders suggests that most islanders will know someone who is suffering, if not themselves, and it will be an issue for most island organisations.

The scale of the mental health issue is so large that a population approach is required to prevent problems in future (Huppert, 2009). In addition to improving health locally, such an approach is likely to be an ‘invest to save’ initiative – with significant economic benefits from the reduction of problems.

Mental health issues in adults and parents are also linked to issues in children's wellbeing (these are briefly explored in the section in Child Maltreatment). Preventing and intervening early with mental health issues is also likely to contribute to a reduced prevalence of child maltreatment.

Work has begun on the development of a States wide mental health and wellbeing strategy. The strategy will consider the development of emotional resilience and measures to improve and maintain well-being. It is anticipated that this will be completed in 2012.

Recommendation 13:	Guernsey and Alderney complete and adopt a mental health and wellbeing promotion strategy at a population level.
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Recommendation 14:	Investment is made in a Mental Health promotion policy officer, to assist in the development and implementation of a mental health promotion strategy at a population level (including the support of businesses).
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Recommendation 15:	Health and Social Care and other States staff to receive training in evidence-based brief interventions in mental health promotion.
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Recommendation 16:	The emotional wellbeing survey is repeated on a periodic basis, to measure changes in wellbeing of the Guernsey and Alderney population.
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Recommendation 17:	Further research is carried out on population mental health using a face-to-face survey in addition to the postal survey carried out to date.
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SMOKING UPDATE

Smoking remains one of the most important preventable causes of premature death and ill health in Guernsey and Alderney; it causes many diseases, with lung cancer being one which is the commonest cause of cancer death in men. Thirty-three men died from lung cancer in 2009, equivalent to two full payloads of a Tri-Islander. Each preventable death is a tragedy and each diagnosis is devastating for the patient and their loved ones.

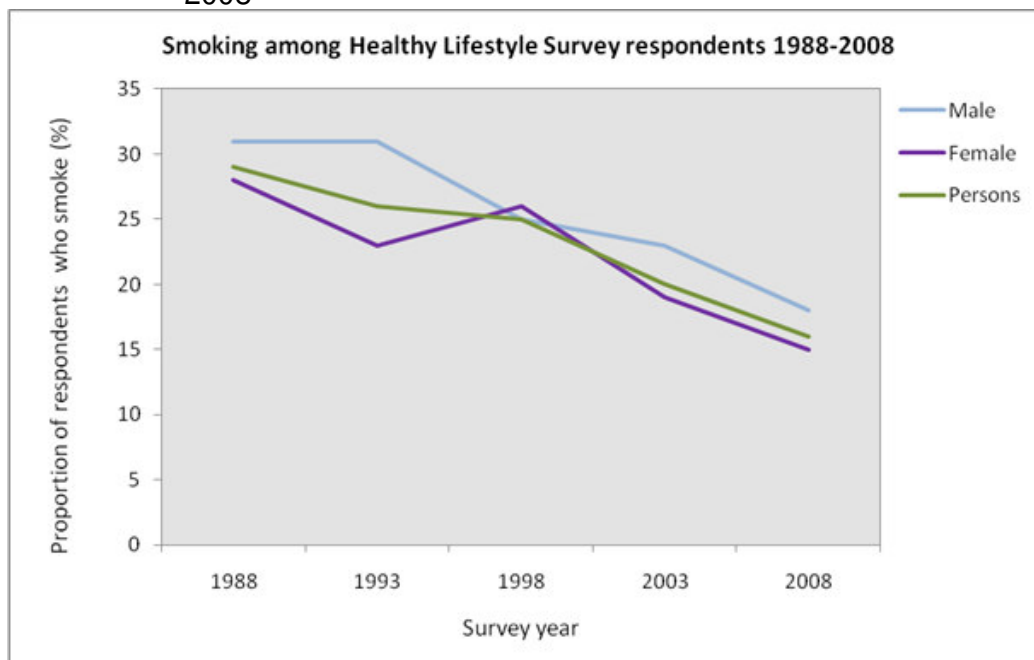
There continues to be significant progress in the local smoking strategy (e.g. the passing of *smoke-free Guernsey and Alderney* legislation) and the revision of the HSSD's smokefree environment policy. A formal report will be produced in early 2012 on the progress for 2010/11 and this will be the starting point for a refreshed five-year strategy when the current one finishes in 2013. Some of the complexity and breadth of efforts to control the health effects of smoking are shown in Table 2.

Given the size of the smoking-related burden of disease in Guernsey and Alderney, these efforts are supported with a very modest budget compared to the size of the problem and its economic impact on the island.

Further work is required in protecting third parties and children in particular – in private motor vehicles, homes, outdoor areas and in the prison. The exposure of children to marketing of duty-free tobacco is a scandal and international action is needed to protect our children.

The Healthy Lifestyle Survey, carried out every five years, indicates that smoking prevalence is reducing, but still remains a very significant health issue (Figure 11).

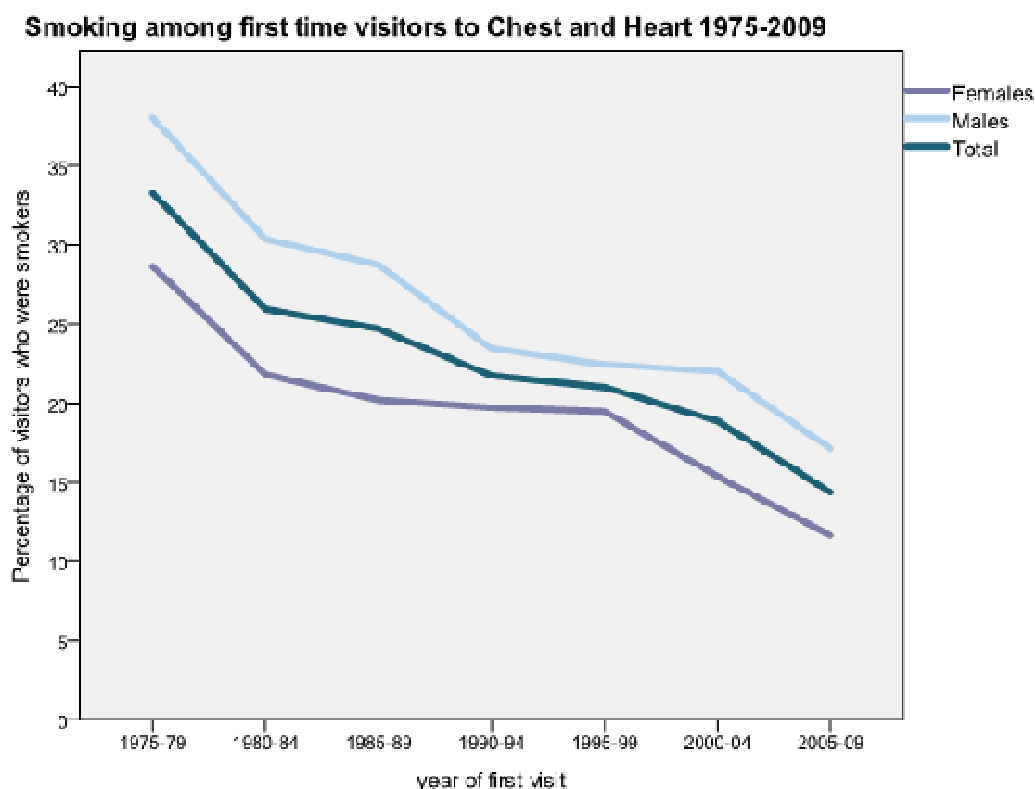
Figure 11 Smoking among Healthy Lifestyle Survey respondents 1988-2008



More recently, the Public Health Directorate has had the opportunity to work with the Guernsey Chest and Heart LBC (<http://www.chestandheart.org.gg>).

This highly respected local charity has the objectives of the prevention and treatment of, and research into, respiratory and circulatory diseases. Chest and Heart have had the foresight to provide free health screening to the residents of the Bailiwick of Guernsey since 1974; their work also provides a potentially very important dataset to understand changes in risk and protective factors in our local population over the last nearly 40 years that may help us to improve our local preventative services.

Figure 12 Trends in prevalence of Smoking among first-time attendees to Chest and Heart 1975-2009



This first joint research with the charity has included an exploration of smoking and obesity trends in first-time attendees for health screening. The number of first time visitors was around 5,700 in 1975-9 and then varied from 1,700 to 4,200 per five-year period from 1980 to 2009. The trends in Chest and Heart data show a similar decrease to those from the Healthy Lifestyle Survey, which increases confidence that there has been a real reduction in this dangerous habit – which is good news for the future of many islanders (Figure 12).

In future, because the proportion of the population who now smoke is less than half what it was in the 1970's, this is likely to be mirrored by a reduction in lung cancer and other related deaths; however, tobacco-related disease still remains a very important problem.



Recommendation 18:	Protection of children from smoke inhalation in homes, motor vehicles and outdoor areas.
Recommendation 19:	Protection of adults from smoke inhalation in outdoor areas
Recommendation 20:	Protection of healthcare and prison staff from smoke inhalation in indoor areas
Recommendation 21:	Protection of children from marketing of cigarettes at ports and in international waters.
Recommendation 22:	International work to lobby for outlawing the sale of cigarettes free of tax.
Recommendation 23:	Implementation of HSSD policy on smoke-free sites.

Table 2: Progress on the Tobacco Control Strategy – 2009-2013

Environmental Exposure	Marketing/ Sales	Services	Supporting Work
Smokefree – Work Places	Tobacco Advertising (Guernsey) Regulations 2010	Quitline stop smoking service	No Smoking Day Campaign
Smokefree – HSSD Grounds	Increase duty on Tobacco	Inequalities	Guernsey Adolescent Smokefree Project (GASP) – lessons
Smokefree – Prison	Ban on display of tobacco products	Pregnant women	PSHE Education
Smokefree – Cars	Licensing tobacco outlets	Stop smoking specialists	Brief Intervention training for health and partner staff
Smokefree – Homes	Ban on vending machines	Young people and families	The Tobacco Products (Enabling Provisions Guernsey) Law 2010
Smokefree – Parks	Ban packs less than 20 cigarettes	Prison	Chest and Heart research
Smokefree – High Street	Plain Packaging	Mental health	Research on tobacco impact on Guernsey
	Ban duty-free tobacco products	In-patients	Air pollution Monitoring
		Free Nicotine Replacement Therapy	

Green	Completed on going
Orange	Making progress
Blue	Future plans



OBESITY

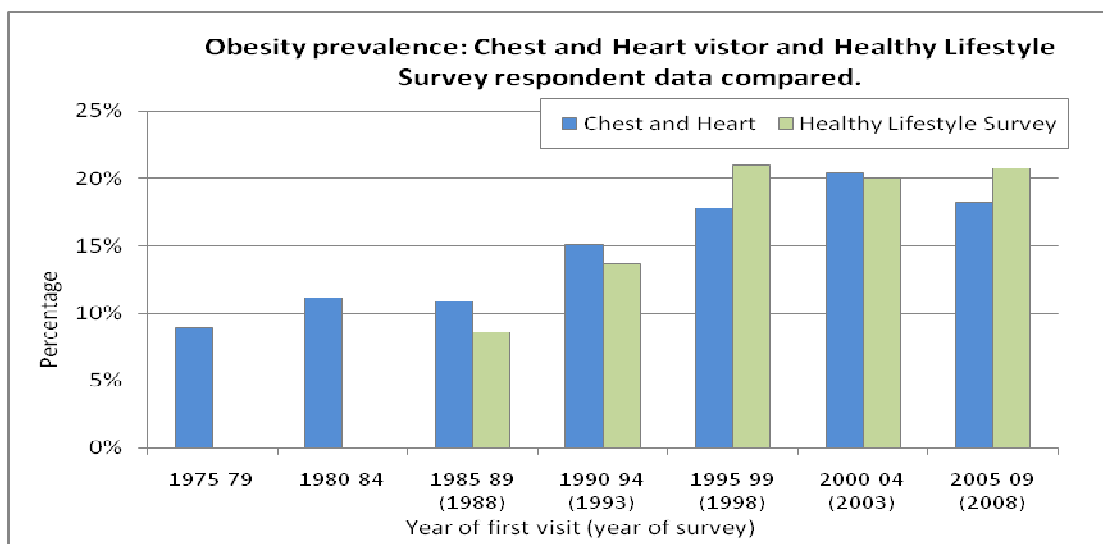
Obesity is a major health and economic issue, as noted in previous MOH annual reports. In 2011 the States funded the first phase of the States Approved Obesity Strategy (Billet D'Etat 25th November 2009) and this has led to positive early progress – which it is important to consolidate and build upon.

The current situation

Guernsey's Healthy Lifestyle Survey, which is carried out every five years, has been used as the source of data for monitoring changes in obesity in the islands; in addition to this tool, the Public Health Directorate has been exploring other tools that might help in monitoring the situation. With these objectives, we have teamed-up with Chest and Heart (see above under smoking) to study obesity in first-time visitors to their service. Chest and Heart measure the height and weight of attendees using calibrated instruments, from which the Body Mass Index (weight in kilograms divided by the square of height in metres) is then calculated. Body Mass Index (BMI) is used as the measure of the prevalence of obesity at a population level. A person with a BMI of 25-30 is classified as overweight and above 30 they are classified as obese.

A comparison of the prevalence of obesity measured in new attendees at the Chest and Heart service and that in the Healthy Lifestyle Survey is shown in Figure 13. The two datasets show similar trends for obesity; in adults the prevalence appears to have risen from around 10% in the 1970s to approximately 20% in the more recent figures – a level that has remained relatively stable for the last 10 years.

Figure 13. Trends in Obesity prevalence: Chest and Heart attendees and Healthy Lifestyle Survey respondents compared



Achieving a Healthy Weight

This section is a reminder that there are two essential elements to achieving or maintaining a healthy weight.

1. The first is eating a low-fat & high-fibre diet of around 2,000 calories per day for women and 2,500 calories per day for men. People should eat a balanced diet and in particular aim to eat at least five portions of fruit and vegetables a day.
2. The second is that adults should follow the 2011 UK Chief Medical Officer's guidelines of at least 150 minutes of moderate intensity activity in bouts of 10 minutes or more over a week. One way to reach this total is to undertake moderate exercise for a minimum of 30 minutes at least five times per week. The risks of engaging in physical activity are low for most of the population, but the risks of poor health resulting from inactivity are high; there is a clear link between physical inactivity and chronic disease. To be sustainable exercise should be either part of routine and/or enjoyable.

The following section gives a summary of some top tips for any of us who consider that we need to take more exercise. A key principle is that simple things that are part of everyday life for people who are otherwise inactive, can be the most effective interventions.

Practical examples could include:

- i. Cycling or walking to work instead of driving
- ii. Using the stairs instead of the lift
- iii. Parking a bit further away if you drive to work or the shops
- iv. Walking the dog
- v. Swimming
- vi. Dancing
- vii. Heavy housework
- viii. Gardening
- ix. Playing games in the park with the children

Environmental Measures

Given the high proportion of our residents who are overweight or obese, and the fact that many of the factors to tackle obesity are environmental, it is important that the States take every opportunity to systematically consider the impact of key environmental strategies or projects on the health and social wellbeing of the public.



Examples would be the Land Use Strategy and Policies and the Transport Strategy and Policies, where providing safe and pleasant land for people to walk and cycle may move us away from the existing car-dominated culture and towards one where walking and cycling are seen as the usual way of getting around.

An important mechanism to help us achieve greater health and social value from our environment would be for the States to ensure that key strategies, developments and investments are subject to a Health Impact Assessment.

Obesity Strategy Phase 2

Reduction in the prevalence of obesity will have a major impact on both the islands' health and wealth in future. Phase 1 of the strategy was agreed in 2010, while Phase 2 requires additional funding to:

- Employ staff to work with children under five years of age and their families who have been identified as being at risk of overweight or obesity
- Fund Sports Commission staff to train primary school teachers, in order to deliver better quality physical activity, sport and exercise classes within schools
- Provide evaluated and specialised weight management interventions for children
- Provide accessible and affordable weight management interventions for adults.
- Employ an additional Community Dietician to work with weight management referral schemes and to offer support and advice to professionals on weight management issues.

Surgical Treatment of Morbid Obesity

Surgical treatment of severe obesity is now an established treatment in some jurisdictions for a small minority of people that have severe obesity and other associated problems and who do not respond to other interventions. Currently obesity surgery is excluded from the contract that the States hold with the Medical Specialist Group that was drawn up in the last decade. This policy should be reconsidered.

Recommendation 24: That the States should fund Phase 2 of the Obesity Strategy, given the health and economic impact of the problem.

Recommendation 25: The States should introduce systematic Health Impact Assessment for key strategies, developments and investments.

Recommendation 26: The States should reconsider commissioning surgical treatment of morbid obesity for selected people.

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Exercise and fitness website

<http://www.nhs.uk/LiveWell/Fitness/Pages/Fitnesshome.aspx>

Healthy eating tips <http://www.eatwell.gov.uk/>



OTHER PUBLIC HEALTH HIGHLIGHTS

Environmental Health (EHU)

Achievements:

1. The Ordinance to control overcrowding in residential housing was passed by the States and is now being administered by EHU
2. Technical and scientific advice provided on a range of issues (e.g. air quality, water quality, etc.)
3. A new electronic information database has improved data management.
4. Joint working of EHU with Jersey being trialled
5. A range of activity undertaken – including 554 samples of sea water taken at 33 sites, 843 pest control visits, 345 environmental complaints requiring intervention (137 bonfires and 101 noise), 144 infections requiring investigation, 215 food premises inspections, 73 planning application responses, 67 licensing consultations.

Future Developments:

1. Develop health impact assessment projects
2. Develop environmental health technical officer to undertake low risk activities
3. Drafting legislation for food supplements, nutritional information and health claims
4. Drafting new legislation for Food Safety
5. Developing a Tobacco products licensing scheme

Health Promotion

Achievements:

1. Recommendations from Phase 1 of the Obesity Strategy which did not require extra funding were set in motion; these included working with the Education Department to look at food served in Guernsey secondary schools, training pre-school and nursery staff on healthy eating for under fives and planning a public awareness campaign for January 2011.

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2. The States approved the ban on Tobacco Displays and Vending Machines in Guernsey (Billet d'Etat XV, June 2010). The Tobacco Advertising (Guernsey) Regulations, 2010, were approved and will be implemented in August 2011. The Tobacco Products (Enabling Provisions) (Guernsey) Law 2010 was approved by the States of Deliberation in November 2010 and will enable ordinances to be made to further control the harm from tobacco products. Regulations to control smoking in public places in Alderney were introduced on 1st June 2010.
 3. A multi-agency control group was formed to oversee The Tobacco Strategy.
 4. Health Promotion Unit staff worked closely with the Chest and Heart Association on a variety of drop-in days for 'hard to reach' groups, resulting in many participants who would not normally access preventive services. They also worked with the Education Department on the 2010 Young Peoples Survey, with the Personal, Social and Health Education Advisor to support work in schools, with practice nurses on the prevention and early diagnosis of breast cancer and with the Teenage Cancer Trust to set up a very successful week of lessons in all of the island's secondary schools.

Future developments:

1. Implement Phase 1 of the Obesity Strategy, including the appointments of a community dietician and a school nurse for weight management.
2. Prepare the business case for Phase 2 of the Obesity Strategy
3. Advertise and set up a training course for a new group of Health Trainers to work with clients on a one-to-one basis on healthy lifestyle issues
4. Prepare further tobacco control legislation and support the HSSD in developing its *smoke-free* policy
5. Continue to support schools to achieve the National Healthy School Standard and work with Jersey to ensure continuation of this scheme after UK Department of Health central funding ceases
6. Increase usage of the Health Promotion Unit's Resources Library.

Infection Prevention and Control

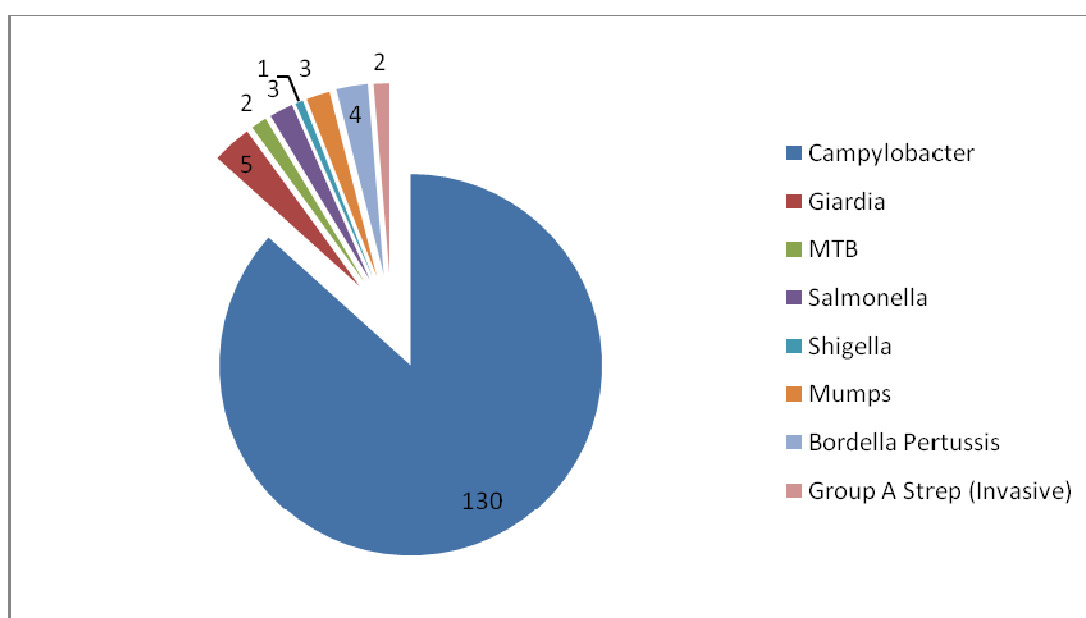
Infection prevention and control services aim to prevent infection and control the spread of infections when they occur, both in hospitals and in the community.



Achievements:

1. Production of the 6th Infection Prevention and Control Annual Report.
2. Continued correlation of notifiable diseases in the Bailiwick – including mumps, measles, rubella, tuberculosis and food poisoning; this data is used immediately (e.g. in suspected food-borne outbreaks requiring Environmental Health Unit investigation or for supporting immunisations and vaccines strategies).

Figure 14 Notifiable diseases throughout the Bailiwick
(MTB = Multi Drug Resistant Tuberculosis)



3. Established work on Caesarean section infection control surveillance system.
4. Excellent management, in collaboration with the Sark MOH, of a Group A Streptococcal outbreak in Sark children.
5. Introduction of revised antibiotic policies in primary care and hospital, which are helping to further reduce our already low *C.difficile* rates.

Future Developments:

1. Develop infection control standards in dental practices.
2. Introduce high impact intervention care of urinary catheters in the HSSD.
3. Complete nursing and residential home infection prevention and control audits and introduce essence of care.

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4. Complete decontamination audits in primary care.
 5. Introduce new audit control tool throughout the HSSD.

Clinical Audit and Quality

Achievements:

1. The HSSD's first clinical and social care audit policy was ratified at the end of the year.
2. National Hip Fracture Database report shows that the PEH ranked top for completeness of data submitted in 2009/2010.
3. Examples of clinical audit in practice:
 - i) Clinical audit has been used in 2010 to provide assurance on the successful implementation of the WHO "Safety Checklist" for the Radiology Department.
 - ii) A 2009 audit in the Adult Disability and Supported-Employment Services of accessible service user information led to a review and update of the HSSD policy on patient/service-user information and included the introduction of training on production and appraisal of accessible patient information. Some recommendations were not implemented due to resource constraints, but re-audit is under way which will examine effectiveness of change and record any deficiencies that need to be addressed. This audit involved service users from the beginning and community learning disability leaflets now routinely pass through the Service User Council during development.
4. Development of systematic way to assess new and revised clinical guidelines, policies, procedures, protocols and integrated care pathways within the Clinical Guidelines Committee.
5. System introduced to establish base line assessments of Guernsey in relation to NICE clinical guidelines and appraisals.

Future Developments:

1. Increase proportion of audits carried out that are registered with clinical governance
2. Participation in more multi-organisational national audits with the UK
3. Managing database of implementation on NICE guidance

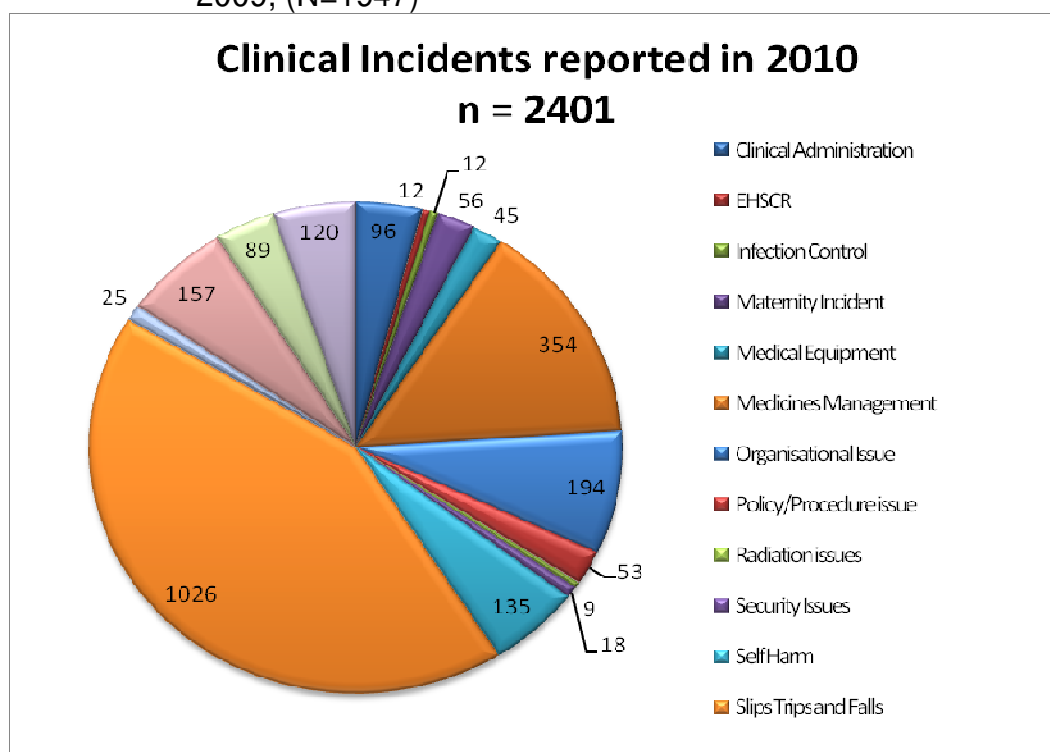


Patient Safety/Clinical Risk

Achievements:

1. Improved reporting of incidents (with a 40% increase), particularly from Medical Specialist Group Consultants and Social Workers.
2. Increased request for training was achieved.
3. Identification of risks of fractures following falls has led to the introduction of hip protectors for high risk patients and extra 'falls' beds have been purchased for use in the Corbinerie Units and Alderney.
4. Further developments of the electronic reporting system (Safeguard) to improve efficiency of meetings and reporting.

Figure 15 Number of incidents reported to clinical risk by categories of risk in 2009, (N=1947)



Future Developments

1. Development of integrated risk strategy
2. Increase patients and service users involvement and feedback
3. Automated reporting of information to the wards for their clinical governance meetings to include all necessary information on risks.

Healthcare Information, Clinical Coding and Epidemiology

Healthcare Information

At the end of the year, after long and distinguished service within the Public Health Directorate, Jenny Elliott transferred to the newly-formed “*Business Intelligence Unit*” within the Finance Directorate (which will be looking to integrate finance, activity and staff information).

Clinical Coding

Achievements:

Two coders code around 20,000 finished consultant episodes

Future Developments:

Coding “Dashboard” being developed for coding performance.

International Classification of Diseases Version 11 being rolled out in April 2012 and training required for coders.

Resolution of remaining errors from new clinical information system

Epidemiology

Jenny Cataroche took up the post of Epidemiologist in April 2010.

Epidemiology literally means “*a study of what is upon the people*” and is the study of how and why diseases occur in groups; this typically involves the measurement of health outcomes when certain populations are at risk.

Information derived from epidemiological studies is used to plan and evaluate strategies for preventing illness and can guide the management of patients in whom disease has already developed; for public health improvement, epidemiology is a fundamental tool – as the old adage illustrates “*if you cannot measure it, you cannot manage it.*”

Many developments were made in epidemiology between the 17th and 19th centuries, during times when huge numbers of people were succumbing to infectious diseases; the techniques of the discipline are now also used to address major chronic diseases of the Western world, such as cancer, heart disease and mental health conditions.



Achievements:

1. The Health Profile for Guernsey 2008 was structured on 40 health indicators, which are quantifiable measures that can be used to define and gauge progress against health goals arranged into the following themed groups: Demography; Fertility; Maternal and Infant Health; Life Expectancy; Disease Prevalence and Mortality; Sexual Health; Mental Health; Health Protection; Lifestyle and Wider Determinants of Health
2. Guernsey Emotional Wellbeing Survey. Undertaken in collaboration with the Psychological Therapy Service

Future Developments:

1. Joint working with the Greffe to allow access to all appropriate death registration information for epidemiological work
2. A quality audit of local mortality coding with the vital events team at the Office for National Statistics to improve assurance and efficiency of death coding
3. Work with The Chest and Heart Service, using the data they have collected over the last 30 years, initially to investigate secular trends in BMI and smoking status
4. Supporting the Bailiwick Alcohol and Drug Strategy in developing a report on the impact of alcohol in Guernsey and Alderney and developing improved drug monitoring in collaboration with North West Public Health Observatory
5. Reporting on the impact of smoking in Guernsey and Alderney

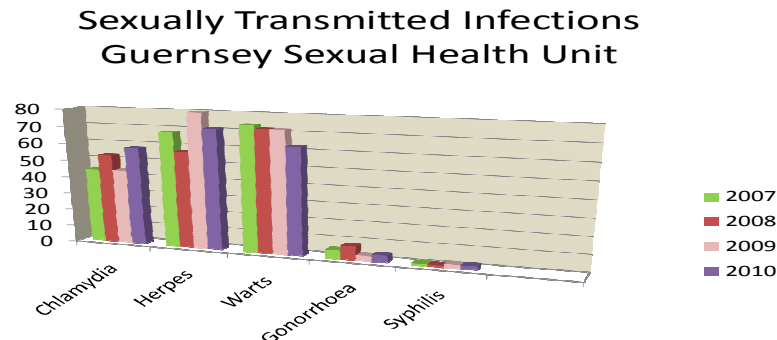
Sexual Health Unit

The Guernsey Sexual Health Unit provides a range of clinical services – including information and advice on sexually transmitted infections, distribution of free condoms, screening for sexually-transmitted infections, HIV and Hepatitis A, B and C testing and management and the treatment of a range of infections.

The three most common infections are *Chlamydia*, genital herpes and warts.

The Sexual Health Unit was formally integrated as a Health and Social Services Department Unit in September 2010.

Figure 16 Sexually Transmitted Infections 2007 – 2010



Achievements:

1. Meeting a wide range of national targets (e.g. there is a national standard that 60% of people at their first sexually transmitted infection screen should have an HIV test and this has increased locally from 48% in 2008 to 80% in 2010 and thereby exceeds that standard).
2. Continued joint working with specialists from national Centres of Excellence in HIV and Hepatitis, to ensure that the standard of care offered to people locally is comparable to the best standards in the UK.
3. Epidemiological identification that when 'Guernsey only' injecting drug users were examined, the majority (86%) were found to be infected with hepatitis C genotype 3a, providing strong supportive evidence that on-island transmission of hepatitis C is occurring in Guernsey; there is also evidence that transmission is not occurring through needle sharing, but through other aspects of the 'works' (e.g. sharing filters, spoons, etc.)

Future Developments:

1. Introduction of the physical removal of genital warts in 2012 to improve user choice.
2. Epidemiological studies in the UK show that one third of HIV infected people remain undiagnosed; we do not have any data in Guernsey for undiagnosed infections, but some recently diagnosed cases have been identified later than we would have wished. Early diagnosis is important, as starting therapy with a low CD4 cell count (below 200 cells/ml) is associated with greater disease progression and death.



3. Empowering people with Human Immunodeficiency Syndrome (HIV)/ Acquired Immunodeficiency Syndrome (AIDS) to challenge HIV-related stigma in a small community is a major challenge. Efforts have been made to provide information to people living with HIV.
4. The World Health Organisation (WHO) estimates that about 170 million people (i.e. 3% of the world's population) are infected with HIV and are at risk of developing liver cirrhosis and/or liver cancer. At present there is no island wide prevalence data.
5. The success of the on-island Hepatitis and HIV viral infection treatment programmes, which are a major cost saving compared to the alternative of sending patients off island, has resulted in a threefold increase in clinic appointments when figures from 2009 are compared to 2010.

To maintain this standard, the service will require additional resources. In 2009, 44 clinic consulting hours were dedicated to the care of individuals infected with hepatitis C; this rose to 136 clinic hours in 2010 and so ensuring that the service is adequately resourced with an appropriate staff skill mix remains an on-going challenge.

6. *Chlamydia* is one of the commonest infections in Guernsey and is the most common curable sexually-transmitted disease in the UK; about 5-10% of sexually active men and women aged 20-24 years may be currently infected. One of the local challenges is to establish a *Chlamydia* Screening Programme, which it is estimated will reduce the prevalence of Chlamydia by 30-90% after 10 years and save significant health-care and tax-payer resources.

Recommendation 27: A *Chlamydia* screening programme is introduced as a spend to save initiative

States Analyst

The laboratories work consists mainly of two main areas – water supplies and environmental contamination; police and customs work also form a small proportion of the workload.

Achievements:

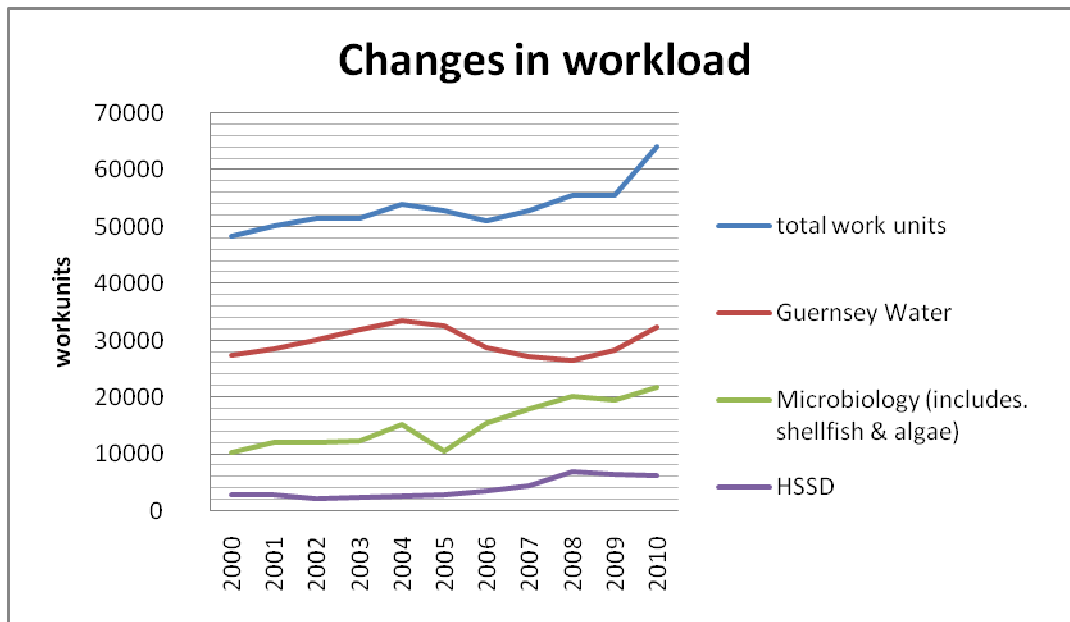
1. The laboratory became accredited for carrying out analyses for *Legionella*.
2. 2010 was easily the busiest year the laboratory has ever experienced.

3. The laboratory ceased undertaking blood alcohol analyses, in view of the high cost of replacement equipment and the low number of blood samples submitted by the police.
4. Successful monitoring of water at bathing beaches, swimming pools and in hospital.
5. The laboratory received accreditation from the UK Accreditation Service.

Future Developments:

1. Appointment of new States Analyst (started April 2011)
2. Gas Chromatograph – mass spectrometer still awaited
3. New information system required

Figure 17 Changes in States Laboratory workload





Guernsey and Alderney Vital Statistic 2010

Guernsey Vital Statistics 2010

BIRTHS AND BIRTH-RELATED DATA

	Guernsey 2010
Estimated mid-year resident population*	62,431
<ul style="list-style-type: none">• Males• Females• M : F	<ul style="list-style-type: none">30,69531,7360.97
Live birth registrations:	
<ul style="list-style-type: none">• Males• Females• M : F	<ul style="list-style-type: none">3183091.03
Stillbirths:	3

*Guernsey Annual Population bulletin 2010,
Policy Council

DEATHS AND DEATH-RELATED DATA

	Guernsey 2010
Total deaths: (number)	486
<ul style="list-style-type: none">• Males• Females• M : F	<ul style="list-style-type: none">2342520.93:1
Infant deaths: (<1 year)	0

Alderney Vital Statistics – 2010

	Males	Females	<u>Total</u>
Population M : F	1094	1100	2194 0.99:1
Births – In Guernsey:	2	1	3
Births – In Alderney:	0	0	0
Total Births to Alderney residents:	2	1	3
Deaths registered in Alderney:	18	8	26

Sark Vital Statistics – 2010

	Males	Females	<u>Total</u>
Births – In Guernsey to Sark residents:	2	4	6
Deaths registered in Sark:	3	2	5



Staff employed within the Public Health Directorate during 2010

Director of Public Health/Medical Officer of Health/Chief Medical Officer

Dr Stephen Bridgman MBCHB MD MPH Dip Biomech FRCS (Ed) FRCS (Glas) FFPH

Deputy Medical Officer of Health (Part-Time)

Dr Brian Parkin MB BS BSc FRCP MRCGP DRCOG

Personal Assistant

Mrs Yvonne Kaill

Clinical Governance Unit:

Clinical Risk Manager/Patient Safety Advisor

Ms Trish De La Mare Reg. PharmTech, PTQA Dip, FDS Sc MM

Risk Support Officer

Mrs Jo McGinn

Clinical Audit Nurse

Acting Clinical Audit and Quality Manager from February 2010

Clinical Audit and Quality Manager from September 2010

Mr Brian O'Connell

Environmental Health Unit:

Director of Environmental Health and Pollution Regulation

Mrs Val Cameron Ch FFPH Ch EHO MREHIS MCIEH MBA

Deputy Chief Environmental Health Officer

Mr Tony Rowe MCIEH

Environmental Health Officers

Mr Tobin Cook MSc CMCIEH

Mrs Jane Cutting GradCIEH

Mr Philip Goodchild MCIEH

Mr Stuart Wiltshire MCIEH

Waste Regulation Officer

Mr Simon Welch BSc(Hons) Cenv MCIWM CMIOSH AIEMA

Pest Control Officers

Mr Paul Tostevin

Mr Michael Brache

Secretary

Mrs Diane Harding

Healthcare Information, Clinical Coding, and Epidemiology:

Health Information Analyst

Mrs Jenny Elliott (until December 2010)

Public Health Analyst/Epidemiologist

Miss Jenny Cataroche MA (Cantab) MSc (from 19th April 2010)

Senior Clinical Coder
Mrs Margaret Cann, ACC

Clinical Coder
Mrs Sue Sheppard

Health Promotion Unit:

Health Promotion Manager
Miss Yvonne Le Page BEd (Hons) PgDip (HealthPromotion) FRSPH

Health Promotion Officer (smoking and heart disease)
Mrs Gerry Le Roy RGN

Health Promotion Officer (cancer)
Mrs Diane Mathews H.Dip

Health Promotion Officer (obesity)
Mrs Lucy Whitman MSc (Conservation Biology) PGDip (Health Promotion)
(until 25th May 2010)
Mrs Lynn Spencer HNC (from 5th July 2010)

Resources Officer
Mrs Stephanie Charlwood

Secretary
Mrs Bella Mahy (until 30th June 2010)

Infection Prevention and Control Unit:

Mrs Elaine Burgess RSCN, ENB329/998, C&G 7307, MSc (Health Sciences)
Mrs Kay Bull RGN, ENB329/998

Sexual Health Unit:
Dr Nikki Brink MBChB MMed FRCPATH
Mrs Stella Vile RN
Mr Mauro Sensi RN
Ms Marianne Duquemin BSc Hons PGDip (CBT)

States Analyst Laboratory

States Analyst
Dr David Mortimer BA BSc(Hons) PhD Cchem FRSC MCIWEM

Mr Laurence Knight BSc (Hons) Cchem MRSC
Mr Michael Hughes BSc (Hons) MIBiol
Mrs Joanne Alder, BSc(Hons)
Mrs C. Joan Le Tissier HNC
Mr John Bullock
Mrs. Julie Perring



Recommendations:

Recommendation 1: Guernsey to adopt internationally agreed definitions for child maltreatment surveillance.
Page 4

Recommendation 2: Further analyses on repeat A&E attendees and improvements in data for comparison with other jurisdictions.
Page 10

Recommendation 3: Further consideration is given to the use of health visiting and school health data for monitoring risk and protective factors in child maltreatment.
Page 10

Recommendation 4: A population based survey using validated tools is carried out in the Bailiwick to measure the prevalence of child maltreatment and the association between past maltreatment, high-risk behaviour, current health status, and socio-economic inequalities.
Page 10

Recommendation 5: The adoption of a population surveillance programme in Guernsey and Alderney along the lines of the Early Development Instrument used in Canada and many other countries. This can then be used to monitor our success in child development for the whole of the islands and also in sub-groups of our population.
Page 11

Recommendation 6: A community development strategy is drawn up which considers both residential and relational communities.
Page 16

Recommendation 7: Guernsey invests in an evidence-based multi-level service for both families and children and the whole population to improve parenting, reduce child maltreatment, and reduce longer-term costs in remedial services.
Page 18

Recommendation 8: There should be a debate on smacking in children.
Page 19

Recommendation 9: Guernsey should aim to formally adopt the UN Convention on the Rights of the Child.
Page 20

Recommendation 10: That child maltreatment is given specific consideration within States strategies.
Page 20

Recommendation 11: Page 20	That the Bailiwick develops a child maltreatment prevention strategy including interventions at all levels of the ecological model of intervention (infant and child, parent and family, community and society (see WHO 2006).
Recommendation 12: Page 21	That it is every citizen's responsibility to help struggling families
Recommendation 13: Page 26	Guernsey and Alderney develop a mental health and well-being promotion strategy at a population level.
Recommendation 14: Page 26	Investment is made in a Mental Health promotion policy officer to assist in the development, and implementation of a mental health promotion strategy at a population level including the support of businesses.
Recommendation 15: Page 26	Health and Social Care staff receive training in evidence-based brief interventions in mental health promotion.
Recommendation 16: Page 26	The emotional wellbeing survey is repeated on a periodic basis, to measure changes in wellbeing of the Guernsey and Alderney population.
Recommendation 17: Page 26	Further research is carried out of population mental health using a face to face survey in addition to the postal survey carried out to date.
Recommendation 18: Page 29	Protection of children from smoke inhalation in homes, motor vehicles, and outdoor areas.
Recommendation 19: Page 29	Protection of adults from smoke inhalation in outdoor areas
Recommendation 20: Page 29	Protection of healthcare and prison staff from smoke inhalation in indoor areas
Recommendation 21: Page 29	Protection of children from marketing of cigarettes at ports and in international waters.
Recommendation 22: Page 29	International work to lobby for outlawing the sale of cigarettes free of tax.



Recommendation 23: Implementation of HSSD policy on smoke-free sites.
Page 29

Recommendation 24: That the States should fund Phase 2 of the Obesity Strategy, given the health and economic impact of the problem.
Page 33

Recommendation 25: The States should introduce systematic Health Impact Assessment for key strategies, developments and investments.
Page 33

Recommendation 26: The States should re-consider commissioning surgical treatment of morbid obesity for selected people.
Page 34

Recommendation 27: A *Chlamydia* screening programme is introduced as a spend to save initiative.
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Table

Table 1:	The rates per 10,000 children aged 18 or less are shown below (unpublished denominator data from Policy Council Research Unit)	5
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If you are concerned about the welfare of a child, please ring the Duty Social worker on 723182 during office hours or the hospital switchboard on 725241 for urgent matters outside of those times. In an emergency, if you are concerned about the safety or protection of a child, please call the Police.

If you require more information on the Quitline service please call 01481 233170.



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REPORT
Bailiwick of Guernsey