HEALTH AND SOCIAL SERVICES
A STATES OF GUERNSEY GOVERNMENT DEPARTMENT

Mental Health and Wellbeing in Guernsey and Alderney

A Research Report

2012

Health & Social Services 2020 vision

Mental Health and Wellbeing in Guernsey and Alderney

a Research Report, 2012

This report was prepared in order to inform the Mental Health and Wellbeing Strategy for the States of Guernsey. The report draws on UK and international research, as well as the outcomes of consultations held in Guernsey during 2012. It provides guidance on the overall strategic direction which should be followed in Guernsey and Alderney, and makes recommendations for specific developments in some areas. The first Mental Health and Wellbeing Strategy States Report will be available separately.

Acknowledgements

Special thanks are expressed to all the people who engaged with the development of this strategy to ensure that it provides an informed and sound foundation upon which to build.

Thank you to the 250 people who participated in the consultation and feedback workshops and who ensured the strategy was rooted and grounded within the Guernsey context. Thank you to the Chief Officers and their staff at all levels who supported this work. Thank you to the service users who contributed in many ways and to Emily Litten from Guernsey Mind.

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Executive Summary

What is this research report about?

The mental health and wellbeing strategy explores the impact of every element of life on a person's emotional wellbeing and the positive effects of improved wellbeing on physical health and chronic disease. It sets out the issues that all members of the community need to consider, including The States of Guernsey, families and individuals, local community groups, and the business sector. It summarises the international evidence base on the determinants of health and wellbeing, and how we can achieve improvements through mental health promotion, targeted support and proven effective actions. These will enable people to understand that emotional wellbeing is important, to develop the resilience to manage their lives and reduce the negative reactions to life events. Where treatment for a mental health condition is required, this will be provided in ways that are evidence based, make access easy, reduce stigma and discrimination and promote recovery and rehabilitation. In addition, it will explain the impact of the New Mental Health Law and the replacement of the Castel hospital. Finally, the strategy will suggest ways in which we will be able to monitor and evaluate progress on an ongoing basis to ensure service continue to be responsive rather than reactive.

Why do we need it?

In 'The Future 2020 Vision of the Health and Social Services System', 2010, the Health and Social Services Department (HSSD) set a direction of travel to improve the wellbeing of the population and to promote self care and independence. In doing so it set a new direction for the Health and Social Services system that will enable and support every islander – irrespective of age or ability – to live as independently as possible and to make choices that support healthy lifestyles.

Mental wellbeing is related to, but not the same as, the absence of mental ill health. It has been defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, both as individuals and collectively. It is independent of mental health status: people with mental health problems can enjoy good wellbeing, while some people without a diagnosed mental health problem may find it difficult to cope with life's problems. However, fewer people are likely to develop mental health problems in populations with high levels of mental wellbeing.

The presence or absence of positive mental health or "wellbeing[ii]" can have wide impact including 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.

There are a number of factors that contribute to someone's state of mental wellbeing. These include having somewhere to live, access to education, a job and income, having a feeling of self worth, having friends and family and access to leisure.

It is clear that all States Departments and every part of our community can, by their actions, not only promote and improve wellbeing, but can take action to provide solutions to some of the challenges that affect emotional health and wellbeing.

In short, mental health and wellbeing is everyone's business. It is essential that programmes for improvement are developed across all sectors and include multi agency and departmental cross cutting action plans including expertise from, and meaningful partnerships with, the third sector and business community. It is vital to acknowledge that a person does not need a clinical diagnosis of mental illness to suffer from poor mental wellbeing. The economic and social cost of poor mental wellbeing is huge and affects every part of our lives, every day of the year.

The 2020 vision estimated that the annual cost of mental health problems to the Guernsey economy is of the order of £100m per annum, (based on "No health without mental health" – published by UK Department of Health– February 2011), and determined that an early priority would be the development of a mental health and wellbeing strategy as the basis for enabling people to live healthy, independent lives.

The 2020 vision also suggested that demographic trends show that there will be an increase in the numbers of people over 65 in the coming years and that increasing numbers of people will live longer. Even if there is a reduction in preventable early death from cancer, circulatory disease and respiratory disease, there will be an increase in the diseases of older age, such as dementia. More people will need to access greater levels of care and support for longer. Future trends and predictions based on Hospital data alone suggests that admissions will increase by 15 to 20%. This indicates the current model of health and social care is not sustainable and the demand on services and therefore expenditure will outstrip the Islands' ability to pay for them. Being more efficient will not be sufficient to contain expenditure within allocated levels. The ageing population and the potential for an overall decline in tax revenue may exacerbate this problem. Improving wellbeing across the whole population will have a beneficial impact on demand.

How did we go about it?

Process

The strategy was developed through a process of consultation and workshops with service users, professionals and representatives of the voluntary sector the following strategic vision was identified.

The vision for the future is to promote good mental health and wellbeing; provide accessible and acceptable support for people as they live their lives and timely, respectful and effective intervention, in partnership, when needed. There is an expectation of recovery and rehabilitation and a recognition that a focus on early intervention is crucial in giving people the best chance to recover from an episode of mental illness, improve outcomes and reduce the incidence of long term mental health problems.

This will be achieved by ensuring that

- People are made aware of the importance of mental well being and the need to develop and maintain resilience, in order for there to be a reduction of mental distress and illness.
- The wellbeing of parents and children is protected by facilitating social, cultural and economic support for all aspects of family life.
- The wellbeing of young people is increased by providing education and training opportunities that optimise the chance of good quality employment.
- The mental health of adults and children is improved by protecting and enhancing social, physical and natural environments.
- Advice on wellbeing, reduction of stressors and information on reduction of harmful behaviours is readily accessible and available in non-stigmatizing settings.
- Mental health is improved and suicide rates are reduced.
- Active ageing is accompanied by good mental wellbeing.
- People with mental health problems are treated with the same respect and courtesy that is offered to all without discrimination by virtue of their mental condition.
- People can access services that are user, recovery and outcome focused, reflect evidence based best practice and are made available in a variety of settings.

The strategy identifies what is available on Guernsey to promote and support wellbeing, compares that to the best evidence from international sources, and proposes strategic priorities for improvement.

Links were identified with other existing and emerging strategies.

Proposed strategic priorities were then subjected to a further consultation process.

Format

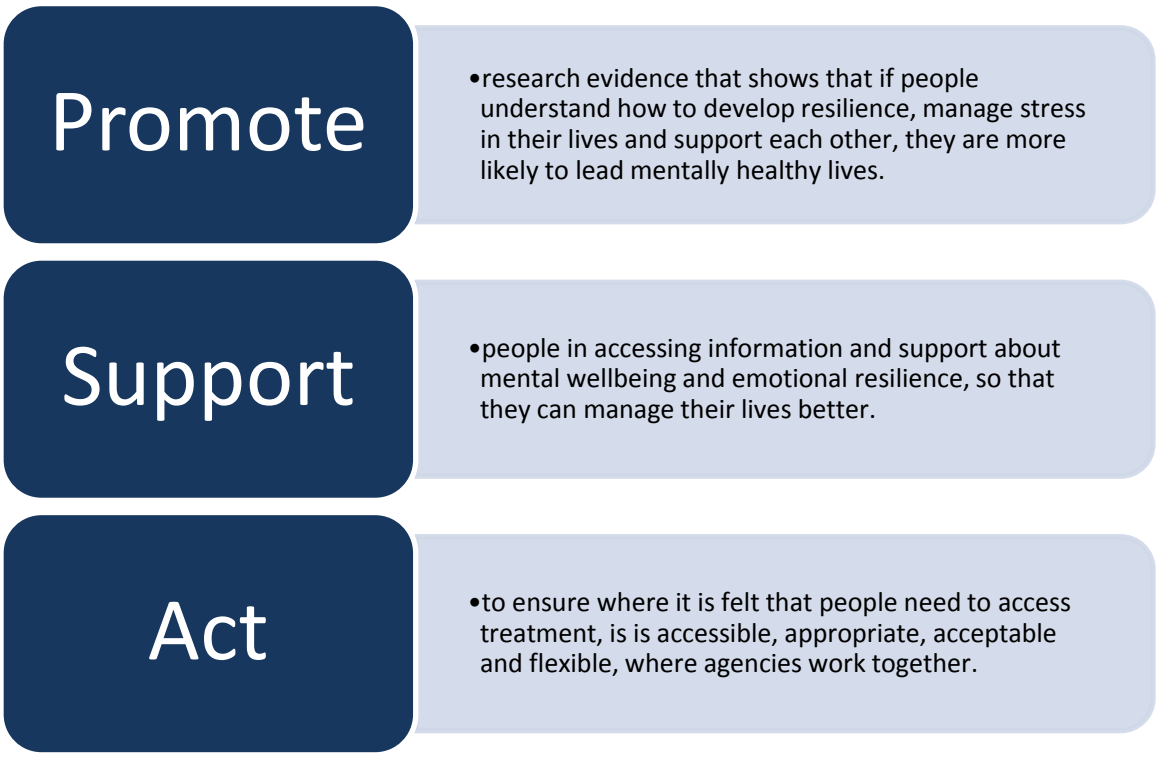
The evidence shows that ways of improving wellbeing can change at different stages in life. Because of this, it was decided to adopt a chronological life-span format and develop sections that focused on:-

- Starting, growing and developing well
- Living well
- Working well
- Ageing well

The benefit of this is that multi- agency working groups can be established to focus on a particular section of the population, drawing together the right people to make cross sector plans to bring about change.

This strategy will be delivered through a 'Three Strand Approach' to Mental Health and Wellbeing.

This approach is being adopted because it will ensure equal focus on three interrelated themes of equal importance. These are:



In addition there are a number of key areas:

- Challenging stigma and discrimination.
- Providing safe and effective mental health services.
- Addressing the needs of carers.
- Consideration of the new mental health law.
- Consideration of the replacement of the Castel Hospital.

How did we identify priorities for action?

The key findings were derived from the initial workshops, subsequent discussions and a review of international research and guidance. In all focus group and workshop sessions, there were a number of recurrent and overarching themes that were seen as presenting barriers to accessing support and treatment. Tackling some of the overarching issues early will be essential, in order that mental health and wellbeing can be improved.

In addition, each age-related workshop identified a number of specific strategic priorities.

How will improvement be delivered?

The improvement of wellbeing, the strengthening of emotional resilience and the reduction of mental health distress and illness is a challenge for everyone in Guernsey.

The States will need to promote, support and act to ensure that the need for mental health services is appropriate and affordable for the years to come.

As has been shown, whilst HSSD has a significant role in the design and delivery of mental health services, much of the prevention and reduction of factors that contribute to mental distress will be the responsibility of other States Departments, employers and the voluntary sector.

How will this be achieved?

The implementation of this strategy does not require additional resources. It does need those resources to be employed differently and for there to be joined-up government that reinforces inter-agency partnership and collaboration. This will address the sometimes perverse incentives to work in isolation. In order for this to be successful, this strategy must be relevant at political, strategic, managerial and operational levels. This can be viewed as providing a clear governance structure but which effectiveness can be monitored, evaluated and measured.

Summary of Strategic vision

The vision for the future is to:

- promote good mental health and wellbeing;
- provide accessible and acceptable support for people as they live their lives and timely, respectful and effective intervention, in partnership, when needed, with an expectation of recovery and rehabilitation;
- recognise that a focus on prevention and early intervention is crucial in giving people the best chance to recover from an episode of mental illness; and
- improve outcomes and reduce the incidence of long term mental health problems.

This will be achieved by ensuring that

- People are aware of the importance of mental wellbeing and the need to develop and maintain resilience, in order for there to be a reduction in mental distress and illness.
- The wellbeing of parents and children is protected by facilitating social, cultural and economic support for all aspects of family life.
- Wellbeing for young people is enhanced by providing education and training opportunities that optimise the chance of good quality employment.
- The mental health of adults and children is improved by protecting and enhancing social, physical and natural environments.
- Advice on wellbeing, reduction of stressors, and information on reduction of harmful behaviours is readily available and accessible and available in non-stigmatising settings.
- Mental health is improved and suicide rates reduced.
- Active ageing is accompanied by good mental wellbeing.
- People with mental health problems are treated with the same respect and courtesy that is offered to all without discrimination by virtue of their mental condition.
- People can access services that are: user, recovery and outcome focused; reflect evidence based best practice; and are made available in a variety of settings.

1. Introduction

This strategy will explore the impact of every element of life on a persons' wellbeing. It sets out the responsibilities which all aspects of the community need to consider, including the Business Sector, local community groups, families and individuals, and of course, the States of Guernsey. It will provide the evidence base of international research on determinants of health and wellbeing and of what can be achieved through health promotion and preventative approaches, targeted support and proven effective actions that will enable people to understand that emotional wellbeing is important, develop the resilience to manage their lives, and reduce negative reactions to life events. Where treatment for a mental health condition is required, this will be provided in ways that make access easy, reduce stigma and discrimination and promote recovery and rehabilitation.

Background

In 'The Future 2020 Vision of the Health and Social Services System', 2010, the HSSD Department set out to:

a. describe the current health and social care system in the Bailiwick and the estimated costs;
b. establish the key principles within which State's Departments can plan, develop and deliver health and social care services and other related activities in the Bailiwick;
c. seek States of Guernsey approval further to develop this framework and the constituent plans to review the services, funding, infrastructure and organisational structure of the health and social care system.

The report also identified a number of essential key points that will need to be addressed to support the States in its future identification of resources to meet the future needs of the health and social care system.

Key Point 9 highlighted the need for the development of a specific strategy for mental health that would improve service provision and enable people to live as productive and independent lives as possible.

Key Point 12 suggested that the health and social care system should promote self-care and independence with the support of a social care and prevention model rather than a health care model.

A key element of the vision is the development of a mental health and wellbeing strategy that will contribute to the achievements of these objectives.

The strategy is a comprehensive document when viewed as a whole. However, a chronological, multi-agency, lifespan approach has been adopted in order that each chapter can be viewed as a 'standalone' document, addressing issues specific to a group. Actions needed to bring about the whole population improvement anticipated cannot be delivered by a single agency, but will be achieved by the multi-agency forums that already exist and can incorporate this strategy in their working groups.

Developing the Wellbeing Strategy

This Mental Health and Wellbeing Strategy is not just about the way we will provide the systems and care to support people who have developed mental health problems.

Developing the ability to cope with life events and withstand the negative impact of these begins in childhood and is a crucial part of effective parenting. Where this is not well developed, the strategy will explore how the current services that are provided can be promoted and further developed.

As children grow, their education and developing emotional resilience are essential in ensuring that, as young people leave education, they are equipped intellectually and emotionally to secure employment and build meaningful relationships. Where this does not happen, young people are more likely to be unemployed, unhappy, more exposed to the risk of alcohol and drug misuse, and more likely to be in contact with the criminal justice system.

In adult life, work, home and family relationships continue to be the keystones for wellbeing. Negative events can lead to domestic violence, drug and alcohol problems, crime and dependence on the benefits system.

As people reach older age, the maintenance of independence is vital in ensuring that they have a happy, enjoyable and satisfying retirement that can help reduce avoidable dependency.

When people do have mental health problems, they need to be able to access effective services, provided in a non-stigmatising way that provides support and treatment that will aid recovery. Much work has already been done to improve Guernsey's mental health services and the new mental health unit, due for completion in 2015, will provide the much needed improvement to the accommodation.

The Mental Health Law that has now received the Royal Assent and will be implemented in April 2013 will also require changes in the way we detain people under this act and uphold their rights.

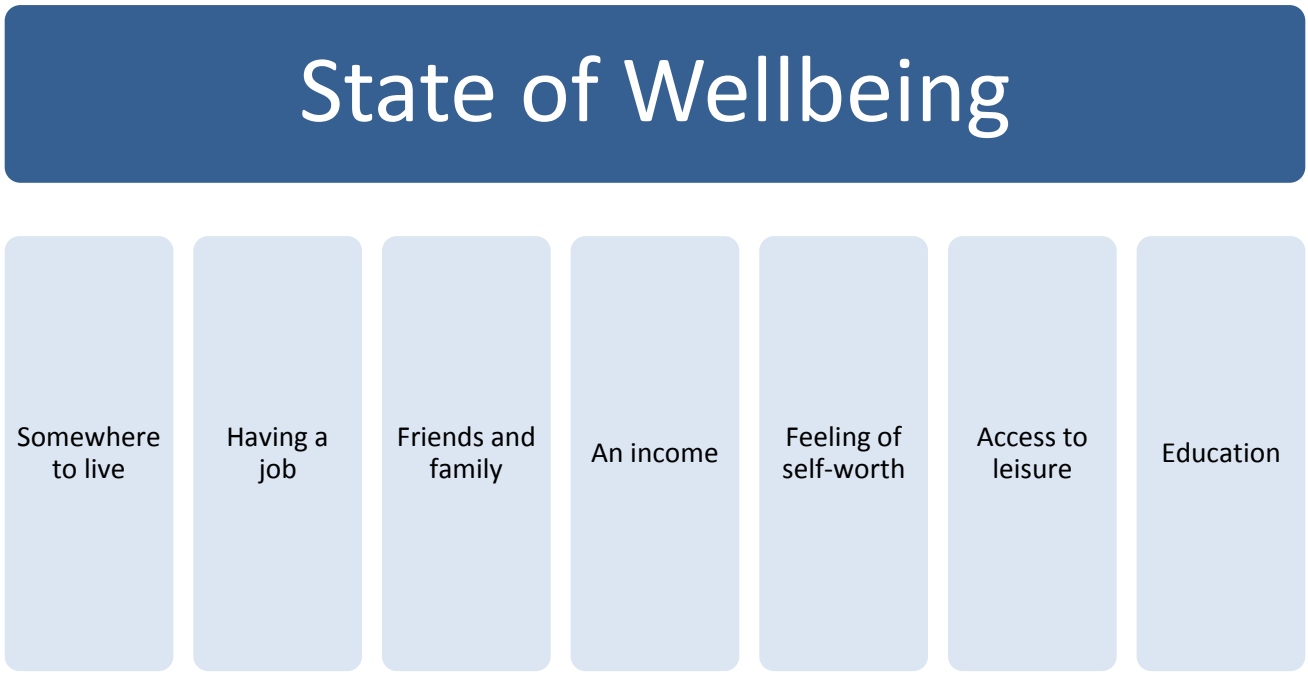
As can be seen, mental wellbeing is not just the responsibility of the Health and Social Care Services. Every aspect of life can benefit, maintain, or have a negative impact on wellbeing.

The strategy will consider this research in a 'Guernsey' context, identify what is already available and prioritise actions for improvement.

It is really important to acknowledge that you do not need a clinical diagnosis of mental illness to suffer from poor mental wellbeing. The economic and social cost of poor mental wellbeing is huge and affects every part of our lives, every day of the year.

There are a number of factors that can contribute to someone's state of mental wellbeing. Generally these can be viewed as:

Factors that impact on mental wellbeing



From this it is clear that all States Departments and every part of our community can, by their actions, not only promote and improve wellbeing, but can take action to provide solutions to some of the challenges that affect wellbeing.

People vary in their ability to withstand the negative impact of life events. Everyone will have their own 'ups and downs' that will affect how they feel. Some will be able to manage these with relative ease; others may find that significant events will have such impact that their ability to function normally will be affected, perhaps with family members or with employment. For some people, their needs can be met within primary care and others will have periods of contact with specialist mental health services. For a very small number, this contact may extend to the need for highly specialist services on or off-island.

We need to make sure that agencies work together to ensure that the vulnerable and other risk groups have the specific attention that ensures that care is co-ordinated and risk reduced.

This strategy will set out how good mental health can be supported by us all, and how, when they are needed, mental health services can be provided to meet these differing needs in a way that gives a hope and expectation of recovery, rather than life-long dependence.

Developing the Strategy

The Vision

The vision for the future is to promote good mental health and wellbeing; provide accessible and acceptable support for people as they live their lives, and timely, respectful and effective intervention, in partnership, when needed. There is an expectation of recovery and rehabilitation and a recognition that a focus on early intervention is crucial in giving people the best chance to recover from an episode of mental illness, improve outcomes and reduce the incidence of long term mental health problems.

This will be delivered through a 'Three Strand Approach' to Mental Health and Wellbeing.

This approach is being adopted because it will ensure equal focus on three interrelated themes of equal importance. These are:

Promote

- research evidence that shows that if people understand how to develop resilience, manage stress in their lives and support each other, they are more likely to lead mentally healthy lives.

Support

- people in accessing information and support about mental wellbeing and emotional resilience, so that they can manage their lives better.

Act

- to ensure where it is felt that people need to access treatment, is is accessible, appropriate, acceptable and flexible, where agencies work together.

It was decided to follow a lifespan developmental framework for the strategy to ensure that specific consideration is given to each of these age groups:

- Starting developing and growing well.
- Living well.
- Working well.
- Ageing well.

In addition, there are a number of cross-cutting themes that will be explored. These are:

- Challenging stigma and discrimination.
- Providing safe and effective mental health services.
- Addressing the needs of specific vulnerable groups, including:
    - Prison mental health care.
    - Those who have behaviours that challenge.
    - Those with complex needs
    - People on low incomes
    - Small volume highly specialist services.
    - Off-island provision.
- Addressing the needs of carers.
- Inter-agency working.

2. Wellbeing and Good Mental Health

Strategic Vision

People will be aware of the importance of mental wellbeing and the need to develop and maintain resilience, in order for there to be a reduction of mental distress and illness and reliance on statutory services.

Mental wellbeing is related to, but not the same as, the absence of mental ill health. It has been defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, both as individuals and collectively. It is independent of mental health status: people with mental health problems can enjoy good wellbeing, while some people without a diagnosed mental health problem may find it difficult to cope with life's problems. However, fewer people are likely to develop mental health problems in populations with high levels of mental wellbeing.

Mental health and wellbeing

According to the World Health Organization's constitution (1946), health is 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. This early definition shows an appreciation for mental health as a fundamental part of an individual's overall health. A second tenet drawn from this definition is that good mental health is more than just the absence of mental illness and indeed can coexist with illness. That is, individuals who may fit the criteria for a DSM IV or ICD-10 mental disorder may also have positive mental health; conversely, someone without a recognised diagnosis may not necessarily have positive mental health.

"Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of wellbeing whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities." (WHO 2003, p.7)

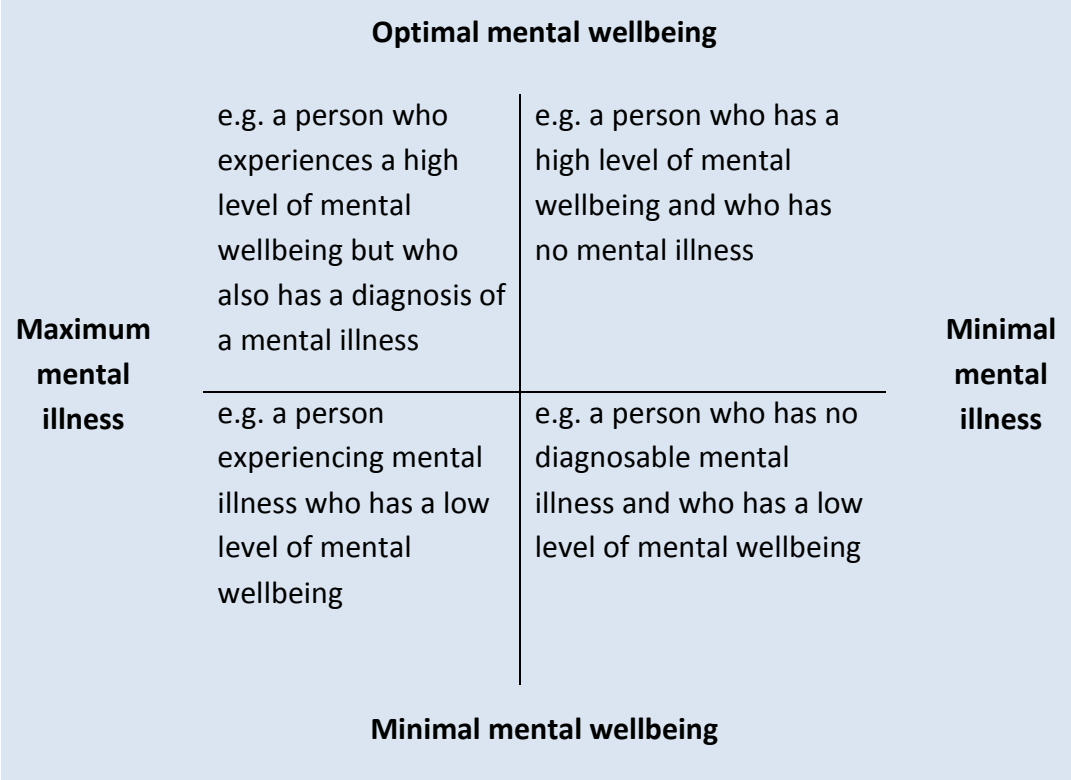
Though definitions of mental health vary, it includes the following components (Friedli, 2009):

- Emotion (affect/feeling).
- Cognition (perception, thinking, reasoning).
- Social functioning (relations with others and society).
- Coherence (sense of meaning and purpose in life).

In the past, models of mental health presented mental wellness (good mental health) to mental illness along a continuum, from which all mental health 'states' could be plotted. However, modern research and understanding shows mental health and mental illness as

being on a 'dual continuum', with optimal mental health or wellbeing on one axis and diagnosis of mental illness on the other. This 'dual continuum' can be seen in Figure 1 below, which was used in the consultation for Towards a Mentally Flourishing Scotland (Tudor, 1996; Keyes, 2002; Scottish Government, 2007). It follows that one person may have no mental health problems but might have a low level of mental wellbeing, whilst another may have a diagnosis of mental illness but has high level of mental wellbeing as a result of effective support and intervention.

Figure 1: A model of mental health (Towards a Mentally Flourishing Scotland; Scottish Government 2007)



Mental wellbeing

A variety of terms have been used interchangeably in the literature, positive mental health, good mental health, mental wellbeing, and wellbeing: often the term used depends on the context. There are also a number of concepts of general wellbeing. One prominent model comes from Keyes (2002) who proposes that mental wellbeing comprises three major components: emotional wellbeing (i.e. positive feelings or subjective wellbeing); psychological wellbeing (i.e. self-esteem, resilience) and social wellbeing (i.e. supportive relationships, trust, a sense of belonging). These three components interact with one

another and are the foundations for individual wellbeing and community functioning. Other concepts of wellbeing focus on an individual's capability and what a person is capable of doing (Sen, 1993) relates wellbeing to the interactions between a person's circumstances, their behaviours and their psychological resources ('mental capital').

Having positive mental health or high levels of mental wellbeing has far-reaching benefits; healthier lifestyles, better physical health, improved recovery from illness, greater educational achievement, greater productivity, employment and earnings, better relationships, greater social cohesion and participation as well as improved quality of life (WHO, 2004b; Barry & Jenkins, 2007; Jane-Llopis et al., 2004).

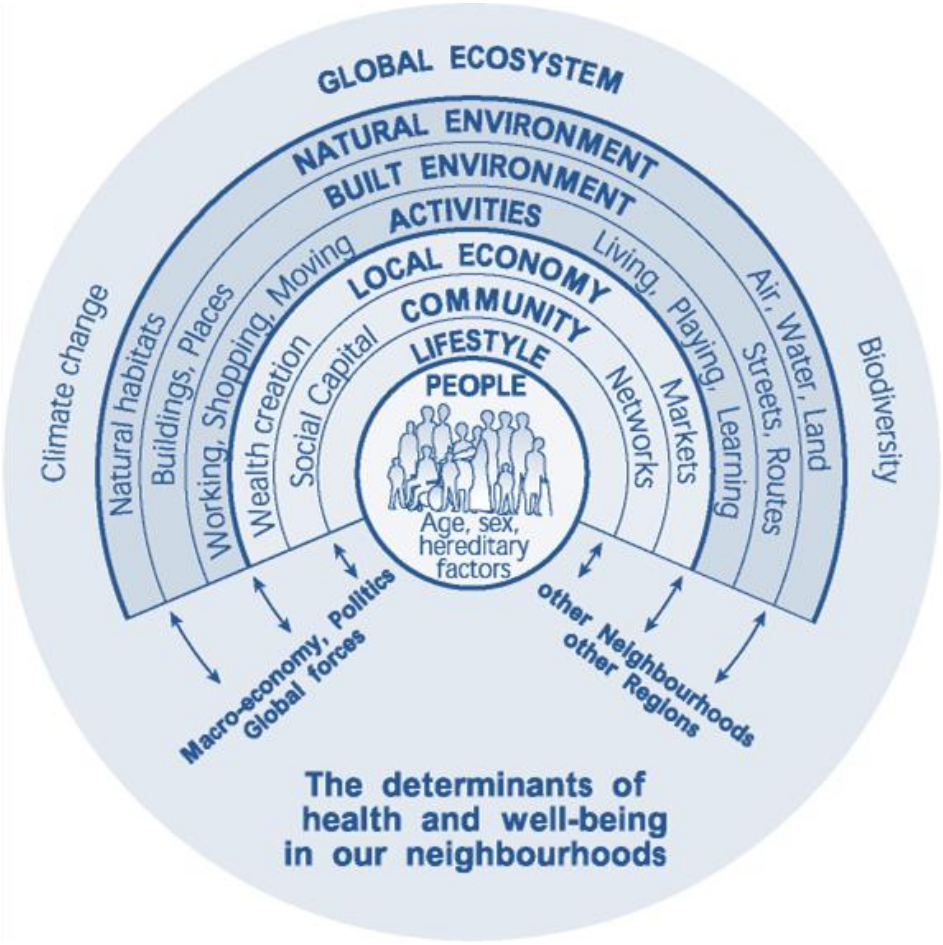
Quality of life is a measure that is can be used to evaluate the wellbeing of individuals and populations. It is a general term applied to the entirety of an individuals' physical, psychological, and social functioning. Indicators of quality of life include: built environment, physical and mental health, education, recreation and leisure time, and social belonging. Quality of life is difficult to measure because it covers so many aspects of functioning, thus rating scales can be either very long, or if brief, focused quite broadly (Fitzpatrick et al., 1992). One measure of quality of life is the Warwick-Edinburgh Mental Well-being scale (WEMWBS; Tennant et al., 2007). The WEMWBS is a 14 item scale, widely used for the assessment of population mental wellbeing.

Determinants of health

Social, psychological and biological factors determine mental health status. There is no simple answer as to why some individuals become mentally unwell or develop mental illness, and others do not. Many factors impact upon an individual's mental health and wellbeing. For example, a person may inherit certain genes from their family, or lifestyle factors and past experiences may influence mental health. These factors operate at many levels; personal (e.g. genetic factors, diet, exercise, relationships, how a person may perceive events), social and community (e.g. family structure, friends, isolation, area of deprivation) and larger societal and environmental conditions (e.g. education, social connectedness, health care provision, unemployment levels, equality).

An individual's overall health is determined by complex interactions between social and economic factors, the physical environment, and individual biology and behaviour. These are referred to as 'determinants of health'. The combined influence of these factors determines an individual's health status. As individuals, we have more control over some of these factors than others. For instance, good nutrition protects our mental health and we can choose to eat a healthier diet, however we cannot control hereditary factors that make us vulnerable to mental illness although we might be able to mitigate their impact. This is graphically represented in the Figure 2 below.

Figure 2: The Health and Wellbeing Map showing the relationship between health and the physical/social/economic environment with people at the heart of the map (after Barton and Grant, 2006)



There a number of challenges when we begin to explore these determinants. The first challenge is that the determinants or causes of many mental illnesses are frequently distant in time from the effects that they produce. For instance, mental health problems in adult life might be partially attributed to negative childhood experiences. A second problem is that a single cause or determinant can have several effects and it is difficult to determine the extent to which a particular factor contributes towards the development of mental illness. For example, severe deprivation of parental affection in childhood has been linked to antisocial behaviour, depression, and suicide. On the other hand, mental illness may arise from several causes. Depressive disorder for instance, may occur for one individual through a combination of genetic factors, adverse childhood experiences and stressful life events in adult life, in another it might be related mostly to very recent events such as bereavement or trauma.

Another challenge when examining the causes of mental illness is that rarely do these factors

exert their effects directly; for example, an individual may have the genetic predisposition to depression which is mediated by psychological factors, another may experience depression which is secondary to an alcohol misuse problem which has its own determinants. In the first example, the depressed person may perceive a negative event as their fault and not likely to change, in the second they may cope with their depression by drinking, leading also to a negative cycle.

> *"…It is likely that parenting, genetics, life events (and how they are interpreted), and inequality /poverty are all major determinants of many mental illnesses as well as general mental health."* (Goldie and McCulloch 2010, p.24).

Any attempt at understanding how these factors interact and impact the health of individuals and communities needs to be understood in their sociocultural and environmental setting. Examples of mental health determinants are shown in Table 1:

Table 1. Examples of determinants of mental health (Goldie and McCulloch, 2010)

Society	Community	Family	Individual
Equality versus discrimination	Personal Safety	Family Structure	Lifestyle factors (diet, exercise, alcohol intake)
Unemployment Levels	Housing and access to open space	Family dynamics (eg. High/low expressed emotion)	Attributional style (ie. How events are understood)
Social Coherence	Economic status of the community	Genetic Makeup	Debt versus financial security
Education	Isolation	Intergenerational Contact	Physical Health
Health Care Provision	Neighbourliness	Parenting	Individual relationships and responses to these

Demographic factors play a role in mental health. Gender, for example, is a critical determinant of mental health and mental illness. There are gender-specific mechanisms that promote and protect mental health and foster resilience to stress and adversity. Gender determines the power and control men and women have over socioeconomic determinants of their mental health, their social position, status and treatment in society as well as susceptibility and exposure to specific mental health risks (WHO Department of Mental

Health and Substance Dependence, 2002). Overall rates of mental health problems are comparable for men and women but gender differences are found in the patterns of mental illness. Gender differences are seen in the rates of common mental disorders, such as depression and anxiety; where women predominate (Piccinelli & Homen, 1997).

Depression is more common and more persistent in women. Gender specific risk factors for women include gender-based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate status and rank and unremitting responsibility for the care of others. Alcohol dependence, on the other hand, is more than twice as common in men. Men are three times more likely to be diagnosed with antisocial personality disorder than women. Gender differences can also be seen in reported age of onset of symptoms, frequency for psychotic symptoms, the course of these disorders, social adjustment and long term outcomes (Piccinelli & Homen, 1997; Leibenluft, 1997).

> *"Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination."* (WHO, 1998:6)

Some ethnic groups appear to have higher prevalence of specific mental health problems. It has been suggested that schizophrenia occurs at higher rates in African Caribbean communities compared to the White population (Kirkbride et al., 2006) but this is likely to be determined by patterns of immigration and acculturation, and the social consequences, rather than genetics. The 'Count Me In' census was introduced in England in 2005 and was designed to support the Department of Health's five year plan; 'Delivering Race Equality in Mental Health Care'. Data from the census showed men from Black and White/Black mixed groups had the highest rates of admission to psychiatric hospitals. They were three or more times likely than the general population to be admitted. Women from Black and mixed White/Black groups were two or more times likely to be admitted than the general population. These figures have remained the same in later years (CQC, 2009). Stigma and discrimination within minority ethnic communities may influence help-seeking patterns leading to over representation at crisis point (Glasgow Anti-stigma Partnership, 2007). However, it has been suggested that there may be a diagnostic and coercion bias in dealing with certain mental health problems in some specific population groups (Metzl, 2010).This is a good example of the fact that the *experience* of mental illness differs and this is also the result of social and psychological determinants.

Socioeconomic status

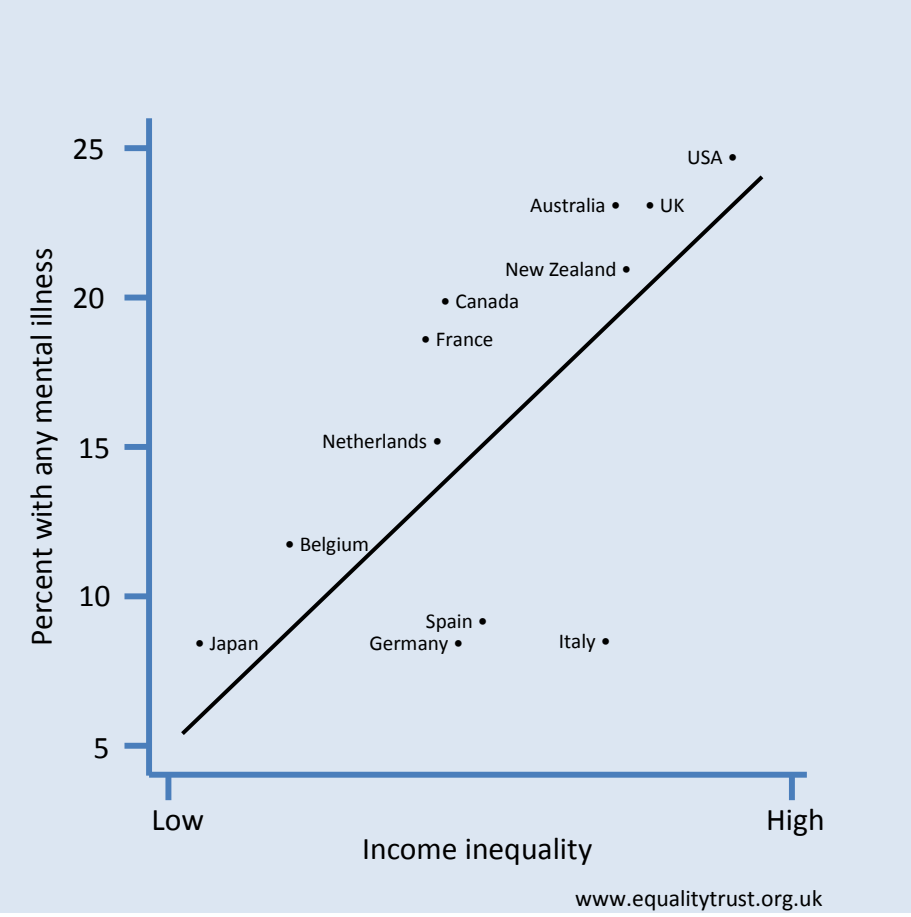
There is a social gradient in health. Adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social disadvantage compared to those experiencing least disadvantage (Kessler et al., 1994; Macran et al., 1996; Gilbert & Allan 1998). Higher income and social status is associated with better health. Socio-economic pressures such as poverty and low levels of education are recognised risks to mental health for individuals and communities. The greater the gap between

the rich and the poor, the greater differences are observed in health (Marmot, 2010).

Many problems associated with relative deprivation are more prevalent in more unequal societies. A review of the evidence suggested that this may be true of morbidity and mortality, obesity, teenage birth rates, mental illness, homicide, low trust, low social capital, hostility, racism, poor educational performance among school children, the proportion of the population imprisoned, drug overdose mortality and low social mobility (Wilkinson and Pickett 2007). Arguably these are all part of the same pattern of social problems in which mental illness is a (large) player.

The surveys by the World Health Organisation show that different societies have different levels of mental illness. In some countries, only 5–10% of the adult population has suffered from any mental illness in the past year, but for example in the USA it is more than 25%. The Equality Trust demonstrated a relationship between mental illness and income inequality in developed countries. Mental illness appears to be much more common in more unequal countries, and is also more common in the richer countries (Figure 3; Picket et al., 2006).

Figure 3. Relationship between income inequality and prevalence of mental illness in developed countries (The Equality Trust)



One reason for this phenomenon may be that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequality. That is, levels of inequality have a strong impact on how people feel, how people feel (emotional wellbeing) is a powerful indicator of their mental health (Friedli, 2009). Socioeconomic position shapes access to resources, aspects of experience in the home, neighbourhood and workplace (Krieger 2001a; Graham 2004; Regidor 2006). In addition, aspects of socioeconomic position such as education, income, and occupation prestige may influence health. Additional dimensions of rural deprivation, such as opportunity deprivation (access to services) and mobility deprivation (transport costs and inaccessibility of jobs) may also be worth considering in terms of their potential impact on mental health and wellbeing (Nicholson, 2008).

Social relationships

Social support networks, support from families, friends and communities is linked to better health. Culture, customs and traditions, as well as family and community beliefs, all affect health. Social capital is a term used to describe the value of social networks, bonding similar people and bridging between diverse people, with norms of reciprocity (Dekker and Uslaner, 2001).

> *"Social capital can be defined simply as the existence of a certain set of informal values or norms shared among members of a group that permit co-operation among them."* (Fukuyama 1999)

Social capital is a measure of social cohesion; it defines social relations that have productive benefits: the features of social life such as how involved we are in our community, how much we trust each other and our governments and institutions, how connected we are to our communities and families and how much we help each other. The link between social isolation and poor health has been well-established (Berkman and Kawachi, 2000). People who participate in their community, have strong and supportive family and cultural and community relationships have better health outcomes than people who are socially isolated.

> *"Social capital refers to the institutions, relationships, and norms that shape the quality and quantity of a society's social interactions… Social capital is not just the sum of the institutions which underpin a society - it is the glue that holds them together."* (The World Bank, 2008).

Presence of social capital through social networks and communities has a protective quality on health. Social capital affects health risk behaviour: individuals who are embedded in a network or community rich in support, social trust, information, and norms, have resources that help achieve health goals (Lin, 2001). For example, a person who is ill may receive information, money, or moral support he or she needs to endure treatment and recover. Social capital also encourages social trust and membership. These factors can discourage individuals from engaging in risky health behaviours, such as smoking and binge drinking (Bolin et al., 2003).

Personal resources

The interactions of risk and protective factors influence people's metal health and wellbeing. Many mental health problems appear to have some form of biological origin, probably including complex inheritance patterns involving many genes and environmental factors. Hereditary factors play a part in determining lifespan, health outcomes, and the likelihood of developing certain health problems. An individual's psychological make-up, their personal behaviour and coping skills – such as eating a balanced diet, keeping active, abstaining from smoking and drinking – all can influence an individual's mental health and wellbeing. How people perceive and manage an event, if they make inappropriate attributions or have negative thought patterns, and how we deal with stressful life situations all affect mental health (World Health Organization 2012, 'The Determinants of Health www.who.int/hia/evidence/doh/en/index.html). Being resilient, able to deal with life stress and having positive attitude are all attributes that enable an individual to deal with adversity. These attributes serve as protective factors for individuals when exposed to poor circumstances. Some individuals are fortunate and will have more of these personal attributes that will serve to protect them from developing mental illness.

Application to the Bailiwick of Guernsey

It is clear that any intervention targeting the mental wellbeing of people in Guernsey will need to take into account a range of factors, such as socioeconomic position, large disparity in income levels, social cohesion, and sense of belonging. From the Guernsey Emotional and Wellbeing Survey undertaken in 2010, overall general mental wellbeing measured from the Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007). The mean WEMWBS scores were not dissimilar to that of other regions in the UK, such as Scotland and the North West of England. However, significant variations were found in the WEMWBS score and the Hospital Anxiety and Depression Scale scores (HADS; Snaith and Zigmond, 1983) among certain subsets of respondents. There was a greater likelihood of poor mental wellbeing and anxiety/depression symptoms for those with low incomes and those unemployed for instance. This association between mental wellbeing, work status and household income highlights the potential approaches and interventions that could be utilised in Guernsey. For example, targeted interventions could be directed towards the poorest communities in Guernsey using techniques such as peer support, helplines, drop ins etc. as support for such groups needs to be offered in non-stigmatising settings. And whilst there may be significant levels of inequality within Guernsey it has the advantage of being a small, identifiable community, within which simple interventions to further build communities and social capital could work without massive resources or recourse to politically more sensitive "social engineering" approaches.

Resilience

Resilience is the capacity of individuals and communities to deal effectively with stress and adversity. Wellbeing, resilience and the prevention of mental health problems are thus distinct but linked, and many of the successful interventions affect all three.

At a personal level, a person's mood will vary from day to day, affected and influenced by factors in their lives and relationships. For some people negative wellbeing can lead to depression.

Factors that help to support and maintain good wellbeing include:	Factors that can help to improve wellbeing:
• Happy intimate relationship with a partner.	• Developing and maintaining strong relationships with family and friends.
• A network of close friends.	• Making regular time available for social contact.
• An enjoyable and fulfilling career.	• Trying to find work that is enjoyable and rewarding, rather than just working for the best pay.
• Having enough money.	• Eating wholesome, nutritious foods.
• Taking regular exercise.	• Taking regular physical activity.
• Maintaining a nutritious diet.	• Joining local organisations or clubs that appeal to the individual.
• Having sufficient sleep.	• Becoming involved in activities that interest the individual.
• Having spiritual or religious beliefs.	• Setting achievable goals and working towards them.
• Enjoying hobbies and leisure pursuits.	• Trying to be optimistic and enjoy each day.
• A healthy self-esteem.	
• Having an optimistic outlook.	
• Having realistic and achievable goals.	
• Having a sense of purpose and meaning.	
• Having a sense of belonging.	
• Having the ability to adapt to change.	
• Living in a fair and democratic society.	

Poor mental health and reduced wellbeing is linked not only to disorders such as depression, psychosis and increased risk of self-harm and suicide, but also impact on physical health as a result of increased risk behaviours including smoking, increased dependence on alcohol, poor diet and low levels of exercise.

The benefits of preventing mental illness

The essence of the case for prevention is that, on any standard of measurement, mental illness imposes an enormous burden, both on individuals and on the wider community. Mental health problems have very high rates of prevalence; they are often of long duration and are even lifelong in some cases. They have adverse effects on many aspects of people's lives, including educational performance, employment, income, personal and family relationships and some forms of social participation.

Long-term limiting illness and disability, such as chronic pain, also have significant, detrimental effects on mental capital and wellbeing. Chronic conditions are expected to become the main cause of death and disability in the world by 2020, contributing around two thirds of the global burden of disease with enormous healthcare costs for societies and governments. In the UK, every week, nearly 3,000 people enter long term incapacity due to ill-health (www.gutherie.org).

Economic Impact

Effects on mental wellbeing include stigmatisation, feelings of shame, hopelessness, victim mentality, stress, lack of control, loss of self-confidence, and low expectations. Social marginalisation can be a dynamic state, changing at different life stages. For example, children and young people may be less marginalised as they become older, and older people more marginalised as they age.

In addition to its effects on individuals, depression brings substantial economic costs to society, where the direct health care costs are dwarfed by the indirect costs. For example, in a study of depression in Manchester, total service costs during six months were about £425 per person, but lost productivity costs due to morbidity were, on average, £2,575 per person. Days lost from work due to depression exceed all other disorders and on average individuals reporting depression are estimated to lose 22 workdays per annum compared with 4-6 days for non-depressed individuals plus impaired performance even when attending work.

When taken as a whole, the UK Health and Safety Executive has estimated that 5-6 million days are lost because of depression.

The King's Fund has estimated that costs arising from mental ill health in the UK reached £48.6 billion in 2007. This figure includes 'service costs' – both direct and indirect – and the costs of lost employment. Other estimates have put the costs of mental illness to be higher than the total costs associated with crime. In Northern Ireland, work commissioned by the Northern Ireland Association for Mental Health (NIAMH) indicated that mental illness costs about £2.7 billion per year.

The economic and social cost of poor mental wellbeing is significant in Guernsey as much as elsewhere. In a snapshot on a day in June 2011, the Social Security Department reported that, of the 900 people receiving invalidity benefit, 30% had a mental health-related illness as the primary cause of disability. 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'État XIII, July 2011).

3. The Guernsey Picture

Guernsey mental health

Historically, the data collection systems available have been unable to collect accurate and meaningful data. With recent organisational and information system changes, it will be possible for future data collection to be more robust and meaningful. This will be vital to the evaluation process.

We do have some data and comparisons that strongly indicate that the incidence of mental distress and mental health problems in Guernsey is similar to the United Kingdom. Broadly, prevalence for mental health conditions are similar in countries with similar social and economic profiles although with particular variation in common mental disorders. It is safe, therefore to draw upon UK and other international data when developing the strategic direction.

Prevalence of Mental Health Conditions.

In February 2010, a report by the Director of Public Health estimated the number of people with mental health problems for a variety of conditions. All England estimates of prevalence were used and the demographic composition of the population of the States of Guernsey were taken into account. The report also considered the particular challenges presented in moving to a modern mental service that reflects the changes and increasing sophistication over the last 20 years.

Data sources and methods:

Ideally, prevalence estimates are derived by direct measurement of sample populations but this is particularly difficult for mental health as each condition requires its own screening tool and an accurate assessment requires a very large sample population. The cost of such an exercise would be prohibitive so estimates for the States of Guernsey have been derived using the data from national surveys from England. The most relevant and most recent of these is, Adult psychiatric morbidity in England, 2007[i]. It needs to be emphasised that these estimates are therefore only an approximate guide and are given to illustrate the relative scale of each mental health issue rather than to give a precise estimate of the resources needed to treat each condition. Furthermore, nearly all mental health conditions have huge variations in severity so that the estimates of common mental health problems range from moderate distress that will resolve without treatment, through to severe depression and anxiety that needs urgent treatment. Resources needed to treat mental health conditions are far more difficult to define and far more elastic than say a diagnosis of myocardial infarction (heart attack) where all patients follow strict protocols. What these estimates do show is just how common mental health problems are and the potential distress that they can cause.

Demographic adjustments:

It is recognised that the local population differs markedly from some parts of England and it is noted that the local Annual Public Health report uses South Western SHA as a comparator. Data from the 2001 Guernsey census is not directly comparable to the UK census but it does give some indication of the adjustments that need to be made. As a result the estimates have been amended on the assumption that the States of Guernsey has a more affluent population than that of England and that there are lower numbers of people of South Asian and Black Afro-Caribbean extraction. Increased affluence generally has the effect of lowering the predicted numbers as people who have incomes in the lowest quintile have substantially more mental health issues than those in the highest quintile. The effects of ethnicity on Guernsey estimates are less clear cut but may reduce the expected numbers of people with depression but increase estimates for alcoholism, drug misuse and problematic gambling.

Provision of service:

Mental health provision has become increasingly sophisticated over the past 20 years with services being tiered. Tiers 1 and 2 are relatively unspecialised and based in primary care, being designed to deal with moderate levels of problems and refer on more severe problems. Tier 3 is provided at mental health trusts and provides a full range of services including in-patient beds; in England there will generally be 6+ consultants each having their own special interests. Tier 4 are highly-specialist services, such as eating disorder units, provided at (sub)regional level designed to cater for populations of 2 million plus.

This model is not sustainable in Guernsey given its population: the challenge for the health service locally is to provide good quality primary care mental health services and sustainable quality services in secondary care, given the potential for professional isolation on the islands. What we need to be able to do is ensure that the widest range of conditions can be treated on island, with professionals working together.

One would expect only sporadic cases of the severest mental health problems that require Tier 4 intervention. However, there is a danger that these cases will be sent off-island and admitted to expensive private units without adequate assessment and monitoring. Once placed in an off-island treatment centre, repatriation may be extremely difficult as each one will require a bespoke package of care. Over a period of time this could become a major financial burden to local health services. Ideally, the island needs to make an arrangement with a mainland mental health trust that could handle sporadic complex cases.

Common mental disorders (CMD):

This group of conditions are also known as neurotic disorders and affect substantial numbers of people. The English survey counted all people with clinically significant illness as assessed using the Clinical Interview Schedule (Revised)[ii] with a score of 12 or more. People with a score of 18 or more are thought to be in need of clinical treatment. In the findings

roughly half of all people with a score of 12 or more actually were above a score of 18.

In England it was estimated that 16.2% of all people aged 16+ had experienced one or more of these disorders in the previous week. It is likely that the prevalence in Guernsey is slightly lower and this prevalence has been revised downwards to 15%; however most of the reduction is attributable to lower rates of CMD in males.

Table 2 sets out the estimated prevalence in the past week of CMD by age and sex in adults aged 16 or more; it can be seen that a large section of the population have clinically significant symptoms at any given time with as many as 8000 people affected. Note the figures for individual conditions are greater than the totals as many people have more than one problem. If the population has similar behaviour to that in England then only 20% will be seeking treatment for their problems when 50% may be deemed as needing clinical intervention.

There are major issues in providing services to people suffering with neurotic disorders in that demand is potentially beyond anything that can realistically be provided. At the same time there is a need to ensure that severely affected individuals, especially men, are identified and treated early as a small percentage may contemplate suicide.

Primary care has several challenges in treating this group including:

- Distinguishing demand from need so that the more severely affected are offered therapy and/or medication rather than those who are more vocally demanding;
- Ensuring that brief interventions are kept brief so that the maximum number of people can be effectively treated;
- Early identification of the most severely affected;
- Controlling demand for hypnotics and tranquillising medication so that patients do not become psychologically dependent on, for example, benzodiazepines.

The vast majority of morbidity is anxiety and depression much of which is self-limiting and will resolve without treatment. The smaller but still substantial numbers with phobic, obsessive and panic disorders are likely to have more persistent symptoms and a greater need for treatment. In particular these people are more likely to need more complex interventions such as Cognitive Behavioural Therapy and targeted courses of anxiolytics and antidepressants.

Table 2: Estimated number of persons with common mental disorders in the States of Guernsey

Age	Males	Corrected Prevalence	Number CMD	Females	Corrected Prevalence	Number CMD	Total	Corrected Prevalence	Number CMD
16-24	3303	11.2	381	3151	21.6	704	6454	16.2	1085
25-34	3694	12.6	486	3745	22.4	861	7439	17.4	1347
35-44	4468	13.0	599	4761	19.0	930	9229	16.0	1529
45-54	4380	12.5	569	4408	24.6	1113	8788	18.4	1682
55-64	4165	9.2	391	4176	17.2	736	8341	13.1	1127
65-74	2858	6.5	195	2859	13.1	395	5717	9.8	590
75+	3009	5.4	174	4433	11.9	547	7442	9.2	721
Total Numbers	25877	10.8	2795	27533	19.2	5286	53410	15.0	8081

Table 3: Individual prevalence of specific CMDs

	%	Number
Males		
Mixed anxiety and depressive disorder	6.0	1543
Generalised anxiety disorder	2.9	760
Depressive episode	1.6	425
All phobias	0.7	179
Obsessive compulsive disorder	0.8	201
Panic disorder	0.9	224
Any CMD	10.8	2795
Females		
Mixed anxiety and depressive disorder	10.7	2952
Generalised anxiety disorder	5.2	1422
Depressive episode	2.7	751
All phobias	1.9	537
Obsessive compulsive disorder	1.3	349
Panic disorder	1.2	322
Any CMD	19.2	5286
All adults		
Mixed anxiety and depressive disorder	8.3	4494
Generalised anxiety disorder	4.1	2182
Depressive episode	2.1	1176
All phobias	1.3	716
Obsessive compulsive disorder	1.0	530
Panic disorder	1.0	546
Any CMD	15.0	8081

Self-harm

Self-harm is most common in younger people but a proportion of attempts do end fatally even when there was no suicidal intention. Table 4 highlights predicted lifetime self-harm behaviour based on English data. Correction for demography is less of an issue as black and ethnic minorities have lower rates of self-harm than the English white population which mitigate the lower rates expected from the differences in deprivation.

The issue of note is the increasing rate of self-harm in younger people. Attempts at self-harm result in increased attendances at accident and emergency, with a proportion having long-term sequelae, which range in severity from minor scarring to permanent brain injury.

Table 4: Lifetime prevalence of self-harm

Age	Males	Self-harm (lifetime)	Number	Females	Self-harm (lifetime)	Number	Persons	All Self-Harm
		%			%			
16-24	3303	6.3	208	3151	11.7	368	6454	576
25-34	3694	5.4	199	3745	3.9	146	7439	345
35-44	4468	5.5	245	4761	3.9	185	9229	430
45-54	4380	2	87	4408	2.2	96	8788	183
55-64	4165	1.1	45	4176	0.8	33	8341	78
65-74	2858		0	2859	0.2	5	5717	5
75+	3009		0	4433		0	7442	0
Totals	25877	3.0	784	27533	3.0	833	3.0	1617

Probable psychosis:

In the survey probable psychosis was assessed using the Schedule for Clinical Assessment in neuropsychiatry (SCAN)[iii]. This was after being screened positive for psychosis in the general interview.

Psychosis is one of the most problematic mental health disorders given its severity and the long term effects it has on both the individual and the family. A minority (about 20%) will suffer only one attack and make a good recovery; the remainder have recurrent episodes of varying severity although a subset of these patients will suffer no lasting cognitive damage.

Table 5: Prevalence of probable psychosis in previous year

Age	Males	Probable Psychosis	Number with Psychosis	Females	Probable Psychosis	Number with Psychosis	Persons	Probable Psychosis Number
		%			%			%
16-24	3303	0.4	13	3151	0.3	9	6454	22
25-34	3694	0.4	14	3745	0.3	11	7439	25
35-44	4468	0.7	31	4761	1.1	52	9229	83
45-54	4380	0.3	13	4408	0.3	13	8788	26
55-64	4165	0.2	8	4176	0.6	25	8341	33
65-74	2858	0.1	2	2859	0.1	2	5717	4
Total	22868	0.4	81	23100	0.6	112	45968	193

There is, as yet, insufficient evidence as to the best method of treatment for psychosis but it is thought that early intervention and aggressive treatment can be beneficial although evidence so far is limited[iv].

Psychosis itself has two elements:

- Positive symptoms such as delusions and hallucinations, for example: belief that one is being controlled by others, and the hearing of voices.
- Negative symptoms such as lack of energy, passivity, flattening of mood and emotion, and social withdrawal.

In the short term it is important to control the positive symptoms using anti-psychotic medication, control of substance misuse and talking therapies, but it is just as important in the longer term to minimise the negative symptoms which seriously impede the individual's ability to lead a normal life.

Better outcomes can be achieved where there is strong carer support, opportunities for educational and employment, appropriate help in socialising, and rigorous monitoring so that there is early identification and intervention in the event of an acute relapse. Poorer outcomes are associated with severe disease that is treatment resistant, continued misuse of illicit drugs and the inverse of the factors associated with good outcome.

Anti-social and borderline personality disorders

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

Antisocial personality disorder (ASPD)

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. It is associated

with increased rates of assaults, suicidal behaviour, road accidents, and sexually transmitted infections. Presence of ASPD may complicate treatment of comorbid conditions.

People with ASPD have often grown up in families where parenting was characterised by conflict and inconsistency, and care sometimes transferred to outside agencies. Resultant truancy, delinquent peer groups and substance misuse contribute to low educational attainment, and to unemployment, unstable housing and inconsistency in relationships in adulthood. The APMS prisoners' survey[v] identified ASPD in a very high proportion of inmates: 63% of male remand prisoners and 49% of male sentenced prisoners. People with the disorder account for a disproportionately large proportion of crime and violence committed.

Borderline personality disorder (BPD)

BPD is characterised by high levels of personal and emotional instability. People with BPD have severe difficulties in sustaining relationships, and self-harm and suicidal behaviour is common. Most people with the disorder first show symptoms in late adolescence or early adult life. The symptoms fluctuate but generally improve over time. Among those receiving treatment, as many as half improve sufficiently so as not to meet the criteria for BPD five to ten years after first diagnosis.

Table 6: Persons with antisocial personality and borderline personality disorders

Age	Males	Antisocial personality %	Number with ASPD	Borderline personality %	Number with BPD	Females	Antisocial personality %	Number with ASPD	Borderline personality %	Number with BPD	Persons	Number with ASPD	Number with BPD
16-24	3303	1.7	56	0.3	9	3151	0.4	12	1.4	44	6454	68	53
25-34	3694	1.7	62	0.3	11	3745	0.4	14	1.4	52	7439	76	63
35-44	4468	0.2	8	0.2	8	4761			0.5	23	9229	8	31
45-54	4380	0.2	8	0.2	8	4408			0.5	22	8788	8	30
55-64	4165			0.4	16	4176					8341		16
65-74	2858			0.4	11	2859					5717		11
Total	22868		134		63	23100		26		141	45968	160	204

These estimates are around 100 times greater than the forensic cases that health services encounter. This is because less severely affected people will be leading normal lives with occasional periods of difficulty. Moderate ASPD may include people with petty criminality and criminal records for drunkenness, criminal damage and violence; most will never come into contact with health services but a small number will bounce between health, social care and the prison service.

The handling of the most severe forms of ASPD remains controversial; technically people diagnosed with ASPD are not mentally ill although many have other mental health problems. Longer term a proportion will improve and may be helped by lifestyle counselling and behavioural therapy. It is important that anti-social activity is not medicalised and is dealt with through the justice system.

Dementia

"The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which cause problems in themselves, which complicate care, and which can occur at any stage of the illness.

"The causes of these illnesses are not well understood to date but they all result in structural and chemical changes in the brain leading to the death of brain tissue. The main sub-types of dementia are: Alzheimer's disease, vascular dementia, mixtures of these two pathologies ('mixed dementia') and rarer types such as Lewy body dementia.

"In the UK there are estimated to be 700,000 people with dementia[1]." (from Living well with dementia: A National Strategy Dept of Health)

Table 7: Prevalence of Dementia

Age	Males	Dementia	Females	Dementia	Total	Dementia
65-69	1485	20	1472	22	2957	42
70-74	1373	42	1387	30	2760	72
75-79	1116	62	1296	92	2412	154
80-84	851	86	1167	164	2018	250
85+	1042	204	1970	541	3012	745
Total	5867	414	7292	849	13159	1263

It needs to be stressed that the label of dementia says nothing about any individual's capabilities or long term prognosis. Two thirds of the numbers above will have mild dementia and can live in the community with the minimal support especially if aided by family carers, with support from a variety of sources, including the voluntary and statutory sectors. The rate of decline can also be highly variable depending on the cause of the illness; some will have a slow decline over many years while other will deteriorate over a few months. Services should aim to support people in their own homes as long as possible as transfer to a residential placement will increase confusion and reduce independence.

Eating disorders:

Mild to moderate eating disorders are very common in the population and the 2007 survey noted that 3.5% of men and 9.3% of women were screened positive for eating disorders using the SCOFF tool[vi]. Prevalence is not affected by income or ethnicity, and estimates for England are likely to be similar to those in Guernsey. Eating disorders have serious adverse effects on quality of life with alternate dieting and bingeing. More serious cases may develop bulimia or anorexia nervosa; in its most serious forms anorexia nervosa can seriously affect a person's health and may be fatal. Although the focus of anorexia nervosa is on young women over one quarter of cases occur in men. Early detection and intervention is the most effective treatment.

Table 8: People who have screened positive for eating disorder where there is a significant clinical impact

Age	Males	Screen Positive	Number	Females	Screen positive	Number	Persons	Screen Positive
		%			%			
16-24	3303	1.7	56	3151	5.4	170	6454	226
25-34	3694	0.7	25	3745	3.6	134	7439	159
35-44	4468	0.3	13	4761	2.5	119	9229	132
45-54	4380	0.8	35	4408	3.1	136	8788	171
55-64	4165	0.1	4	4176	0.9	37	8341	41
65-74	2858	0.3	8	2859	0.6	17	5717	25
75+	3009		0	4433	0.1	4	7442	4
Totals	25877	0.6	141	27531	2.5	617	53410	758

Services for eating disorders follow a classical tier pattern with levels 1 and 2 provided in primary care for detection and treatment of milder cases and tier 3 being consultant level hospital services. In a population the size of Guernsey it will be difficult to provide even tier 3 services let alone the specialist services at Tier 4 as only a handful of people will be very severely affected.

Data from primary care:

Data from Morbidity Statistics from General Practice Fourth national study 1991-1992 would predict about 2200 people visiting their GP for a neurotic disorder with about 4700 consultations a year relating to neurotic disorders.

Table 9: Consultation rate in primary care for neurotic disorders

Age	Males	Consultation rate/10000	Predicted Number	Females	Consultation rate/10000	Predicted Number	Persons	Total Consultations
16-24	3303	325	107	3151	761	239	6454	346
25-34	3694	524	193	3745	1313	491	7439	684
35-44	4468	524	234	4761	1313	625	9229	859
45-54	4380	656	287	4408	1431	630	8788	917
55-64	4165	656	273	4176	1431	597	8341	870
65-74	2858	577	164	2859	1178	336	5717	500
75-84	1967	499	98	2463	1023	251	4430	349
85+	1042	440	45	1970	804	158	3012	203
Totals	25877		1401	27533		3327	53410	4728

Data on depressive illness shows a lower level of prevalence with nearly 1900 consultations but the likelihood is that overall severity will be greater.

The combined data illustrate the importance of managing neurotic and depressive disease in the community. If even 50% were to be seen in secondary care the services would be swamped. There are massive advantages to managing people in primary care; apart from cost, GPs will often have known their patients for a considerable period of time and are much better placed to judge severity of illness given their long term knowledge of the patient. There are compelling arguments for taking an integrated approach to healthcare based on the prevalence of common mental health problems amongst people with long-term conditions, and the impact on physical health of depression and anxiety.

Table 10: Consultation rate in primary care for depressive disorders

Age	Males	Consultation rate/10000	Predicted Number	Females	Consultation rate/10000	Predicted Number	Persons	Total Consultations
16-24	3303	84	27	3151	283	89	6454	116
25-34	3694	170	62	3745	536	200	7439	262
35-44	4468	170	75	4761	595	283	9229	358
45-54	4380	300	131	4408	595	262	8788	393
55-64	4165	300	124	4176	451	188	8341	312
65-74	2858	240	68	2859	451	128	5717	196
75-84	1967	239	47	2463	462	113	4430	160
85+	1042	315	32	1970	329	64	3012	96
Totals	25877		566	27533		1327	53410	1893

Although incidence and prevalence rates for affective psychosis are much lower than for neurotic and depressive disorders each individual generates far more consultations given the serious nature of the diagnosis. Consultations are also likely to take longer especially during an acute exacerbation of illness.

Table 11: Consultation rate in primary care for affective psychoses

Age	Males	Consultation rate/10000	Predicted Number	Females	Consultation rate/10000	Predicted Number	Persons	Total Consultations
16-24	3303	57	18	3151	100	31	6454	49
25-34	3694	95	35	3745	272	101	7439	136
35-44	4468	95	42	4761	272	129	9229	171
45-54	4380	187	81	4408	379	167	8788	248
55-64	4165	187	77	4176	379	158	8341	235
65-74	2858	148	42	2859	359	102	5717	144
75-84	1967	239	47	2463	342	84	4430	131
85+	1042	273	28	1970	278	54	3012	82
Totals	25877		370	27533		826	53410	1196

There was a further publication on primary care morbidity in 2003 entitled, 'Key statistics from General Practice 1998 covering prevalence data from 1994-1998[vii]. However, these data are not comparable to previous publications, and the quoted prevalence rates for both anxiety and depression show rapidly increasing levels over the 5 years which are likely to be more related to the adoption of registers and coding changes rather than to real increases in prevalence. The quoted prevalence for schizophrenia was stable and is reproduced in table 12.

Table 12: Prevalence of treated schizophrenia

Age	Males	Probable Psychosis	Number with Psychosis	Females	Probable Psychosis	Number with Psychosis	Persons	Probable Psychosis Number
		%			%			%
16-24	3303	0.12	3	3151	0.03	0	6454	3
25-34	3694	0.24	8	3745	0.1	3	7439	11
35-44	4468	0.33	14	4761	0.21	9	9229	23
45-54	4380	0.35	15	4408	0.29	12	8788	27
55-64	4165	0.27	11	4176	0.35	14	8341	25
65-74	2858	0.27	7	2859	0.39	11	5717	18
Total	22868	0.21	58	23100	0.19	49	45968	107

This table illustrates just how difficult it is to compare data from different studies as this is for treated schizophrenia rather than all psychosis. The differences can be explained by some people having psychosis due to depression/anxiety, bipolar disorder, drug misuse or other causes. In addition there will be a group with a diagnosed psychotic disorder who will eventually be diagnosed as having schizophrenia but who have not yet shown all the features necessary to make such a diagnosis.

Off-Island use of services:

In the 2008 summary of off-island placements[viii] it was identified that there were 104 placements costing in excess of £9 million; these placements were in 19 different categories and covered the full spectrum of health and social care. An anecdotal conversation with the Director of Public Health suggested that Jersey had a much lower level of placements. It is possible that some of this difference is due to chance and that Guernsey has been 'unlucky' in having an unusually high need for such placements, but it is more likely that most of the difference is due to different commissioning policies.

Off-Island placements represent a substantial opportunity cost as these resources, in many cases could be used to develop local infrastructure which should enable a better, or cheaper, service locally. It is recognised that the sheer diversity of the placements makes this difficult but there may well be potential for developing some local services.

It is not possible to say anything specific about the placements without an individual clinical review but commissioners should be mindful of the following issues when considering any off-island placement:

- Any consideration of a placement needs to be made following a skilled independent assessment of the individual's needs which considers the best interests of the client.
- There may very well be a number of people, especially children, who could be managed locally with the provision of a range of generic services such as physiotherapy, OT and psychology. There would need to be an initial investment followed by a staged repatriation but once completed this could result in substantial savings and better quality.
- When sending off-island, wherever possible, health services should be commissioned with an NHS provider to ensure compliance with clinical governance and that admission and discharge thresholds conform to acceptable standards. Any off-island placement fractures the normal processes that deal with people so that repatriation can be a very protracted process. Any placement needs to ensure continuity with local service providers from the start.
- Individual high cost placements should be rigorously monitored especially around the need for 1:1 and 2:1 staffing. A persistent requirement for additional staffing suggests that the patient is not appropriately placed.
- Goal orientated criteria should be set where a patient is undergoing rehabilitation so that discharge is

triggered when goals have been met, or where the patient has plateaued.

- The use of in-patient beds should be avoided for conditions where the evidence suggests that community treatment is equally effective such as alcohol and drug misuse services.
- Commissioners should be wary of medicalising conditions such as conduct disorder and personality disorder. For example, sending a child off-island with conduct disorder neglects the issues of parental responsibility and the need to set boundaries for the child within the normal living environment.

In Future, we will ensure that:

A skilled independent assessment will be provided to establish the need for off island placements. Placements will be made when they are in the best interests of the service user and where there are no other least disruptive alternatives and will be monitored carefully ensuring timely discharge and repatriation to the island.

Extract from DPH report 2011

Mental ill health is emerging as one of the most important causes of preventable ill health in the world. In addition to improving outcomes for people with mental health problems, 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. Depression is the third largest contributor to the global burden of disease and is the first in middle and high income countries (WHO, 2004) 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.

According to NICE treatment such as antidepressant medication and brief structured psychotherapy can be effective in 60-80% of people with depression although fewer than half receive treatment (NICE, 2009). Barriers relate to availability and structure of services but also include stigma and discrimination which hinders help-seeking and early diagnosis (Lasalvia A et al., 2012).

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 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 problem becomes enduring (Billet d'Etat XV, June 2010).

The Director of Public Health considers that, whilst the model as implemented in larger countries is not sustainable in Guernsey given its population size; the principles of increased community provision, using the intensive support described in the National Service Frameworks and service specifications for England can be adapted to ensure that the essential functions are provided.

The challenge for the health service locally has been to provide good quality primary care mental health services, and sustainable quality services in secondary care, given the potential for professional isolation on the islands.

Following a number of critical reports, the last year has seen significant changes in the way adult mental health services are configured. These changes reflect international views and evidence on modern practice:

- A number of recommendations, made in the last review, (2010), have been implemented, as far as is possible in the current in-patient facilities. Improved in-patient facilities will not be available until the replacement hospital is available in 2015.
- Community teams have been reconfigured to provide crisis, intensive support and recovery focused services.
- The development of Primary care based Psychological Therapies has enabled GPs to refer patients for Tier 2 services, provided in primary care, meeting a previously unmet need.
- Plans have been agreed for the construction of a new inpatient unit to be built on the Princess Elizabeth hospital site, replacing The Castel hospital.
- Service users and carers have been involved in the planning of services and the new build.
- The Mental Health Law has received Royal Assent and will be enacted in 2013

Whilst it is still early days, there is some evidence that the changes are resulting in people being able to access an acceptable and beneficial service, located in primary and community settings. In addition, the referral process has been streamlined, resulting in an accelerated and improved assessment process and rapid access to intensive support where needed. It is anticipated that reliance on in-patient beds will be reduced. This has been reflected in a reduction of the number of beds now being planned for the new build.

There is also improved pre assessment for those who may be in need of a service that cannot be provided on-island. It is anticipated that this, together with increased expertise this will reduce, but not totally eliminate, off-island placements.

For the future, we need to

Maintain the commitment to further develop community provision, including primary care.

Guernsey Emotional and Wellbeing Survey (GEWS)

The Guernsey Emotional Wellbeing Survey (GEWS) was undertaken in 2010 in response to a growing need to understand more about the mental and emotional wellbeing and the mental health of the people of Guernsey and Alderney, and to aid planning and development of Adult Mental Health Services.

It consisted of a cross-sectional postal survey which was mailed out to a quasi-randomised sample of 5% of the Guernsey and Alderney adult population.

722 completed surveys were returned (26% return rate).

Aims of the Guernsey Emotional Well-being Survey 2010

1. To establish a baseline level of mental wellbeing in the population of Guernsey and Alderney.
2. To estimate the prevalence of mild to moderate anxiety and depression disorders in Guernsey and Alderney.
3. To gain consultation from Bailiwick residents on how Primary Care services should be developed.

Measures

The measures used were:

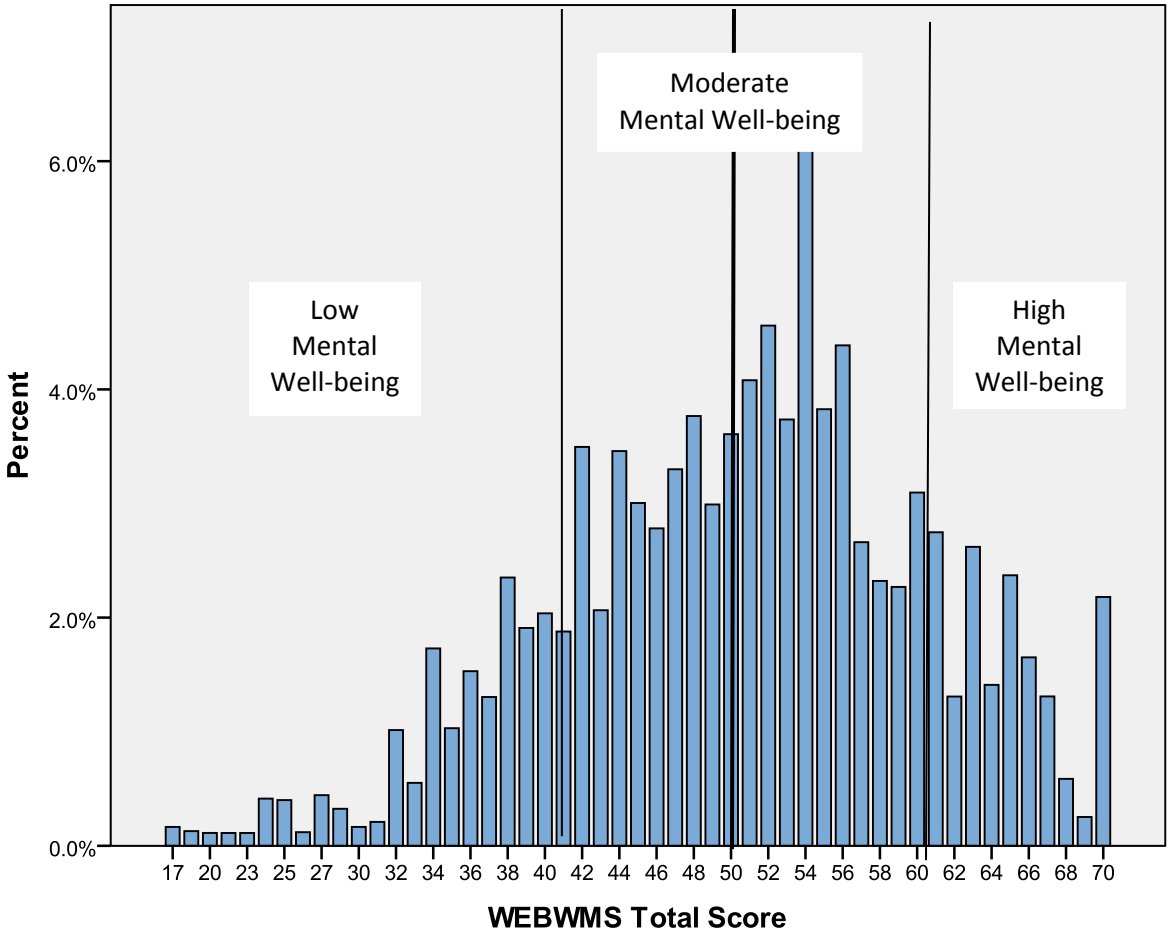
- The 14-Item *Warwick Edinburgh Mental Wellbeing Scale* (WEMWBS; Tennant et al., 2007). A self-report scale which focuses entirely on positive aspects of mental health, permitting an evaluation of low, moderate or high mental wellbeing.
- The *Hospital and Anxiety Depression Scale (HADS; Snaith and Zigm*ond 1983*).* A 14-item self-report scale designed to assess anxiety and depression symptomatology.

Together these measures give an indication both of general mental wellbeing, positive or negative (WEMWBS), and the number and proportion of surveyed individuals who are symptomatic of either depression or anxiety (HADS).

Self-Perceived Health

All respondents were asked to rate their health in general as either 'very good', 'good', 'fair, 'poor' or 'very poor'. Self-assessed health is a useful measure of how an individual regards their own condition generally and is known to be related to the incidence of disease and has been found to predict both hospital admission and mortality (Idler and Benyamini 1997; Hanlon et al., 2007). The Scottish Health surveys in 2008 and 2009 used a similar scale, allowing broad comparisons to be made.

Overall 78% of respondents in Guernsey and Alderney rated their health as 'very good' or 'good'. This was similar to Scottish figures of 76% (2008) and 77% (2009). Almost twice as many Scottish respondents (7%), however, reported their health as being 'very poor' or 'poor' as compared with only 4% of Guernsey and Alderney residents. As in the Scottish Health surveys, self-perceived health varied little with gender but did decrease with age, with 2% of those in the 16–24 age group reporting 'poor' or 'very poor' health as compared with 10% of the 75 year or over group.



Whilst in the 16–24 year age group there were very few individuals who recorded a high wellbeing score, this result must be interpreted with caution. The number of respondents in this group was small (n= 47) and it is unclear whether they accurately represent other people in their age group.

Of note was the association between being unemployed, having a low income and Low Mental Wellbeing. Overall, 53% of the unemployed group versus 18% of those in work were classified as having Low Mental Wellbeing. This equates to a relative risk of 3.01 (three times greater risk) for those who are unemployed. It is not possible to infer the direction of causation. In other words it may be that people who are unemployed are out of work because of their low mental wellbeing, or, alternatively, it could be that low mental wellbeing developed as a consequence of being unemployed. No person in the lowest income group was classified as having High Mental Wellbeing.

However, the results presented in this survey provide a first stage analysis that, in keeping with the aims of the survey, gives a baseline for the level of mental wellbeing among Guernsey and Alderney residents, and provides an estimate, made for the first time from local data, of the prevalence of mild to moderate anxiety and depression disorders within the Bailiwick.

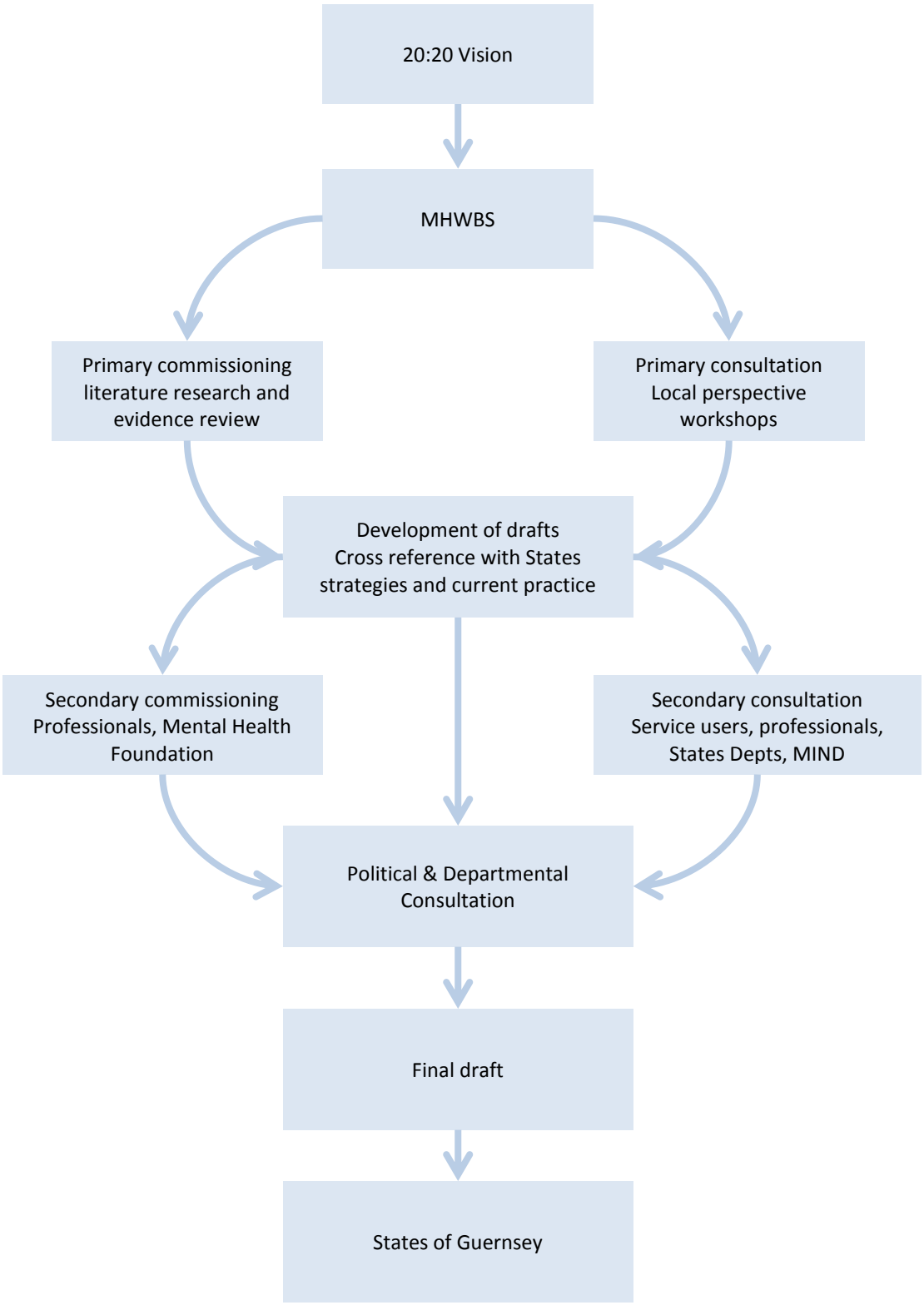
Results revealed a mean WEMWBS score of 50.53 and a distribution of wellbeing scores that saw 16% of respondents being classified as having low mental wellbeing, 67% as having moderate wellbeing and 17% as having high wellbeing. Although these results are similar to those found for other regions, such as the North West of England, and Scotland, results from the second measure, the HADS, used here to gauge symptomatology for anxiety and/or depression to clinical levels, suggests that mental ill-health is experienced at least as frequently in the Bailiwick.

The proportion of respondents whose HADS scores put them above the clinical cut-offs for anxiety and or depression was 21%, or one in five, which is slightly higher relative to recent estimates for Jersey and the UK. Moreover, significant variations in both HADS and WEMWBS scores were detected among certain subsets of the survey respondents. Increased likelihood of low mental wellbeing and anxiety/depression symptomatology was found for those with low incomes and those who were unemployed, for example. The youngest respondents, those aged 16–24, though relatively few in number in this survey, also emerged as possibly a vulnerable group, who could be particularly at risk of experiencing mental ill-health and low mental wellbeing, on account of their having a lower mean WEMWBS score and an increased propensity for anxiety and depression symptoms.

The strong associations noted above, between mental wellbeing and age, work status and household income, merit further investigation and highlight the potential for investigating the GEWS data in greater depth, using, for example, multivariate analyses which are beyond the scope of this report.

These findings support the case for the local development of specific mental health services which are able to provide a full range of evidence-based therapies for mild to moderate anxiety and depression. Adopting such an early intervention approach as an integral part of the emerging Mental Health Strategy, would serve an important preventative function, potentially providing savings from Social Security sickness and incapacity budgets, and Health and Social Services spending on long-term mental health care. Most importantly, however, the provision of such services would enable people in distress to access services aimed not only at reducing mental ill-health but also at promoting positive mental wellbeing.

4. Methodology



A broad overview of the evidence base, including literature and international policy review informed the semi-structured focus group workshops which facilitated sufficient focus on the issues relating to a particular age group and enabled the guidance to be applied in a Bailiwick of Guernsey context.

20 workshops / listening exercises were held using the themes of the proposed chapter headings, using a common agenda and presentation. These were:

Starting and developing well	4 sessions
Growing well	4 sessions
Living well	4 sessions
Working well	3 sessions
Ageing well	3 sessions
Child and Adolescent Services	2 sessions

There were over 200 participants at these workshops from a variety of professional and agency backgrounds and they included services users, relatives and third sector providers.

Each workshop considered the same topics:-

- What do we (HSSD) do now to ensure/ preserve emotional wellbeing?
- What do we (HSSD) do that has a negative impact?
- What could we (HSSD) do better/differently?
- What could other departments/organisations do differently?

The outputs from these workshops have been collated into a number of findings, both overarching and workshop specific.

Other States strategies have been considered and incorporated into this strategy.

Following this, the strategic priorities for each age group have been identified. These sections can be used as 'standalone' for focused work in specific areas.

Overarching Themes

In all focus group sessions, there were a number of recurrent and overarching themes that were seen as presenting barriers to accessing support and treatment. Tackling some of the overarching issues early will be essential, in order that the mental health and wellbeing strategy can be achieved.

These were:

- Professionals and serve users indicated that non-mental health staff do not have sufficient basic knowledge about mental illness.
- Public awareness of mental distress and mental illness is poor. In-patient care is the expectation and off-island transfer for challenging behaviour is preferred. The public perception of mental health services and Castel hospital in particular is one of apprehension and negativity.
- The concept of recovery, re-ablement and rehabilitation has been poorly understood and championed. Whilst this is changing within the mental health service there remains a perception that mental illness is life-long , with no hope of recovery.

- Multi agency and integrated care and care planning is poorly developed, leading to fragmentation of care and the possibility of both duplication and omissions. This is despite anecdotal evidence that the most vulnerable families are known to and engaged with more than one statutory agency.
- Mental wellbeing and the improvement of outcomes for mental health service users is not regarded as 'everyone's business'.
- Service users perceive that they suffer discrimination from health staff when seeking access to care for general medical conditions. In particular, the Princess Elizabeth Hospital was cited by some as being unhelpful and discriminatory.
- Service users consider that there is a stigma to accessing services that are made available in 'mental health only' settings.
- Transition planning from Child to Adult and Older Adult services within mental health needs to be improved. The fixed age of transition needs to be revisited, with improved overlap. In particular the automatic transfer from adult to Older Adult at 65 may not now be as relevant with the increased retirement age.
- Guernsey is a small island. This presents challenges for confidentiality and local access to specialist care.
- Clinical staff within mental health find it very difficult to obtain advice from physicians when treating patients. This presents significant difficulties with conditions such as Eating Disorder in Adults and may precipitate the request for off-island placements.
- The charging system for accessing primary care and A&E is perceived as a barrier to seeking early advice and support. It is also seen as a barrier to discharge from secondary care, where Psychiatrists are concerned that service users are more likely to disengage from medication when charges are applied. This is despite the systems in place that support low paid and unemployed.
- There is a lack of formal evaluation processes for interventions that have been developed and their acceptability.

5. Starting, Developing and Growing Well

Strategic vision

The wellbeing of parents and children is protected by facilitating social, cultural and economic support for family life (e.g. family friendly workplaces, maternity leave, safe play areas for children), including parenting skills, tackling violence/abuse in the home, reducing child poverty and work organisation/reward that is compatible with family life.

Wellbeing for young people is promoted by providing education and training opportunities that point to a hopeful future and optimise the chance of good quality employment. Improving literacy, numeracy and basic skills protects against depression, notably for women.

The Evidence

Mental health in children and young people is more than the absence of mental illness, it has been defined as "the strength and capacity of our minds to grow and develop, to overcome difficulties and make the most of our abilities and opportunities." (Young Minds, 2006). A more comprehensive outline was set out in the Mental Health Foundation's report "Bright Futures." (1999), an enquiry into promoting children and young people's mental health:

Mentally healthy children will have the ability to:

- Develop psychologically, emotionally, intellectually and spiritually.
- Initiate, develop and sustain mutually satisfying personal relationships.
- Use and enjoy solitude.
- Become aware of others and empathise with them.
- Play and learn.
- Develop a sense of right and wrong.
- Resolve (face) problems and setbacks and learn from them.

Good mental health is associated with improved academic achievement and physical health (NICE, 2008; 2009) and enhanced psychosocial functioning (Keyes, 2006). Good mental health protects children against violence, crime, teenage pregnancy, drug and alcohol misuse (Adi et al., 2007; Colman et al., 2009; NICE 2009).

Mental health and child development

The exceptionally strong influence of early experience on the brain architecture makes the early years of life a period of both great opportunity and great vulnerability for brain development (Harvard Centre for the Developing Child).

Therefore, it is important to recognise that child development begins before birth, so maternal health and wellbeing affects babies, even before they are born.

The brain undergoes another development stage during adolescence, during which the brain cells reorganise, and the brain develops more complex processes such as multi-tasking. However, the general consensus among neuroscientists used to be that following childhood the brain has a more fixed structure and cannot grow or change as easily. This view has been challenged by recent findings, demonstrating that neuroplasticity of some aspects of the brain remains even into adulthood (Rakic, 2002).

Specifically emotional development, particularly emotional regulation, takes place throughout childhood and there is a further period of opportunity during early adolescence (Allen 2011).

Nevertheless, the foundation for adult mental health lies in child and adolescent mental health. Most adult and adolescent mental health problems begin in childhood (Smith, 2006); half of adults with mental health problems first experience symptoms before they are14. Preventing mental health problems during childhood reduces the challenges and costs associated with treating them in adulthood. This view is echoed in the English Mental Health Strategy (HM Government, 2011):

"Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences."

Risk and resilience

There is a complex relationship between the range of risk factors in a child's life, their interaction, and any protective factors. The risk factors are cumulative, and can be summarised as follows:

Individual: biological and psychological make-up, developmental delay, communication problems, long-term physical illness, low self-esteem.

Familial: parental mental health problems, family breakdown, physical, sexual or emotional abuse, hostile relationships, criminality, alcoholism, neglect, laissez faire or authoritarian parenting.

Communal: socioeconomic disadvantage (poverty, homelessness), isolation, discrimination.

There are associations between poverty and disadvantage and mental health problems, such as depression, suicide, drug abuse, and schizophrenia (e.g. much of the high rate of diagnosis among young black men can be explained in this way; Metzl , 2010). Nevertheless, there are children who despite the odds grow up without any mental health issues and thrive despite adversity. The protective factors that reduce the impact of risk include:

Individual: easy infant temperament, secure attachment, higher intelligence, positive

personality, problem solving attitude, good communications skills.

Familial: close bond with a carer in first year, affection, small number of children in a family, positive role models, parental employment.

Communal: friendships and social support, good standard of living, opportunities at school, positive leisure activities.

Mental illness in childhood

Research has shown that children suffer from a surprisingly high level of mental health problems, many more than had been suspected in the past. Estimates suggest that approximately 10% of children have a mental health problem (Green, 2005). This may be an under estimate when dual disabilities are addressed (there are strong links with learning disabilities, physical disabilities and learning difficulties), and considering that about half of children with problems do not access any services. In deprived communities, this figure is likely to be significantly higher. Conduct disorder, a commonly reported childhood behavioural problem, affects around 6% of 5–16 year olds, emotional problems such as anxiety and depression affect around 4% of 5–16 year olds, attention deficit disorders affect approximately 2% of 5–16 year, and eating disorders affect 1–2% of young people between the ages of 15 and 30. There are gender differences across the various diagnostic categories; for example, conduct disorder is more common in males and eating disorders and self-harm more common in females. In addition, between 1 in every 12 and 1 in every 15 children and young people deliberately self-harm (Mental Health Foundation, 2006) and around 25,000 are admitted to hospital every year due to the severity of their injuries (Fox & Hawton, 2004). Yet only 12.6% of young people who self-harm go to hospital (Hawton, et al., 2002).

There are clear links between mental health and other health and social outcomes for children. For example, longitudinal studies show that children with emotional and behavioural problems are at an increased risk of mental illness and other problems; these include school exclusion, anti-social behaviour, offending, marital breakdown, drug misuse, alcoholism, and mental illness in adolescence and adulthood (Buchanan, 2000). Although in pre-school years children can be expected to display challenging and highly emotional behaviour, for most behaviour will become more pro-social by the time they have started school; but for around 10% this is not the case and a pattern can develop into and throughout adulthood presenting a strong argument for early intervention ("Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school" Paul Bradshaw and Sarah Tipping, Scottish Centre for Social Research[ix]).

It is also possible to identify risk factors at an early stage that can lead to social problems later in life, for instance, one study of boys assessed by nurses at age 3 as being at risk found that they had two and a half times as many criminal convictions at aged 21 than those deemed not at risk. Moreover, in the at-risk group, 55% of the convictions were for

violent offences, compared to 18% for those who were deemed not to be at risk (Graham Allen Review, 2011).

Supporting the emotional wellbeing of children and young people can reduce mental health problems, including depression, anxiety, suicide, eating disorders, and stress (Buchanan, 2000). There is evidence that programmes which promote emotional and social competence can contribute substantially to this emotional wellbeing, and directly and indirectly to positive outcomes including mental health, improved school performance, and reduced high risk behaviours (Caplan et al., 2002; Wells et al., 2003; Greenberg et al., 2003; Zins et al., 2004).

Young people today are under a lot of stress (Pugh, McHugh & McKinstrie, 2006). A study by UNICEF found that the well-being of young people in the UK was poorer than in 20 other industrialised countries (UNICEF, 2007). A further study of young people carried out by the Prince's Trust (2009) showed that 47% of young people aged between 16 and 25 felt regularly stressed and more than a quarter (27%) stated that they were always or often depressed. This presents still greater risk to their mental health and wellbeing (Youth Access, 2010) and therefore highlights the importance of starting and developing well in life. More than 95% of major depressive episodes in young people arise in those that experience long-standing psychosocial problems, such as family breakdown, domestic violence, physical and sexual abuse and school difficulties including bullying (Rueter et al., 1999). This is not surprising given that young people develop in the context of their families, their schools and their peer group. When compared with young people who live with both parents, children who have experienced family breakdown experience higher levels of mental health and behavioural problems which persists into adult life (Amato and Soboleski, 2001). Guernsey has a disproportionately high level of family break-up.

Early years

A number of interventions can be offered during the period from birth to school age. It is more effective to intervene early in the cycle that generates mental health problems and early in life. Social and family characteristics, such as the risk factors mentioned above, contribute to the risk for mental health problems later. In addition, children from families with low socioeconomic status are exposed to risk factors more frequently and also experience more serious consequences (Fonagy et al., 2002). Interventions for children at risk should be available at key transition points in the life of a family, such as around birth, pre-school, and transitions to and from school.

Early intervention is an approach which offers Guernsey an opportunity to make lasting improvements to the lives of children, to intervene in many persistent social problems, and to prevent their transmission from one generation to the next, and in doing so make long term saving in public spending.

Perinatal mental health problems affect not only the lives of mothers themselves, but also

can have a huge impact upon the development of babies and the functioning of the family (Blackburn et al., 2009). Studies have demonstrated significant adverse effects on cognitive, behavioural and social development of children whose mothers have postnatal depression (Murray and Cooper, 2003). Between 10% and 15% of women develop postnatal depression in the first year after having a baby (Department of Health, 2004). Antenatal mental health problems have also been found to have an impact upon the developing baby and are the largest single predictor of emotional status in the postnatal period (Heron et al., 2004). In view of these multiple adverse effects, guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE, 2007) which recommend a holistic package of care for all women during pregnancy and following childbirth, which includes early identification of any mental health problems, targeted support offered by trained Midwives and Health Visitors who have been given the time and training to discuss emotional issues, and quick referral to specialist services for further professional intervention when required. However, in practice front line professionals may not have sufficient training and confidence in their knowledge and understanding of mental health and have caseloads which are too large to be able to fulfil this role (Children and Young People's Mental Health Coalition, 2010).

Between infancy and school age, most children will attend some form of group day care activity such as preschool. These activities allow children the opportunity to play with other children, and develop self-esteem and competencies in a range of emotional and social skills. In the UK formal preschool education is offered to every child over the age of 3 for 15 hours per week. This preschool education follows the early years foundation stage curriculum which is implemented in all nursery schools in England.

Sure Start Centres have been advised to implement programmes such as Webster Stratton, Incredible Years Parenting Programme and Triple P in their work, (Graham Allen Review, 2012) as the combination of parent training and high quality preschool education is likely to produce the best outcomes for children.

Role of school

One in ten children and young people are estimated to have a mental disorder (Green, et al., 2005) at any time, which makes it about 3 children in every class. In an average classroom, 10 children will have witnessed their parents separate; 8 will have experienced physical violence, sexual abuse or neglect; 1 will have experienced the death of a parent; and 7 will have been bullied – all these experience are potential risk factors for mental health problems later in life (Faulkner, 2011).

Children are at school for at least eleven years, therefore the school environment has a huge potential to influence their health and wellbeing. At school, children can interact with peers, learn, participate in activities, and achieve academically. During their time at school, there are unique opportunities to support children to learn how to manage and

improve their emotional wellbeing in a way that it would be impossible to achieve in a home environment.

However, time at school can also be difficult for children and affect their mental health negatively. A recent national survey (100 children, aged 6–16; Chamberlain et al., 2010) suggested that 51% were worried about exams; 43% worried about the future; 31% worried about friendships, 30% by their appearance, 26% by money and 25% by bullying. Another study suggests that 35% of students in mainstream secondary schools fear being bullied and 23% report having been bullied (MORI 2004). One study in England found that 7–10% of pupils suffered from low levels of wellbeing (Rees et al., 2010); lower levels of wellbeing were associated with family relationships, disability, and increasing age. In addition, some emotional states such as sadness or anger, can hinder learning, while others, such as a sense of wellbeing, feeling safe and valued, have been found to promote learning. Learning to manage emotions early on can enable children to achieve better outcomes (Greenhalgh, 1994).

"Children must be provided with experiences and support which will help them to develop a positive sense of themselves and of others; respect for others; social skills; and a positive disposition to learn. Providers must ensure support for children's emotional wellbeing to help them to know themselves and what they can do" (DfES, Early Years Foundation Stage Framework, 2008).

The transition from primary to secondary school has been noted as a source of particular stress. Also, it has been reported that teachers in secondary schools may be more uncomfortable with notions of emotional wellbeing than primary schools (Weare and Gray, 2003). Nevertheless, a number of secondary schools in England are implementing work in relation to whole school behaviour policies, anti-bullying strategies, peer support and young people's participation – all of which are essential elements of a more comprehensive approach to promoting mental wellbeing. The developmental phase which occurs at secondary school is particularly important in young people's lives, as this is the time when (a) many mental health problems begin to surface, and (b) young people experiment with drugs and alcohol.

Caring and supportive relationships are crucial factors in contributing not only to mental wellbeing but also to staff and children's performance; for example, experiencing greater enjoyment of school, motivation, attainment, and attendance levels. There is a particular need for children who are having emotional difficulties to experience caring environments so they can learn to trust, as the relationship with their teacher may be the most stable relationship some children have.

However, despite the potential gains only a small minority of teachers appear to be in favour of work promoting wellbeing and the majority are reluctant to get involved, in part because they are not trained sufficiently (Weare and Gray, 2003) or because they do not understand the relevance to their job and desired outcomes.

School interventions

Schools have a vital role to play in the development of all children's wellbeing, as well as being involved in or facilitating early intervention for children experiencing mental health problems. Positive school experience can have a beneficial effect, while negative experiences can increase the risk. Interventions to improve mental health and wellbeing in schools can be either generic or targeted. Frequently, both types of intervention are required; generic programmes tend to be implemented across the whole school, and are relevant to all pupils and teachers, whereas targeted interventions work with specific individuals who are considered to be at greater risk of developing mental health problems. For example, children at risk of exclusion from school usually suffer multiple stresses in their lives. The additional negative impact of school exclusion has been shown to increase the risk of antisocial behaviour and involvement in crime, and in turn put the children at even greater risk of developing mental health problems (Hayden, 1997). Focusing interventions on these children should improve their outcomes significantly.

It is essential to start to work on children's wellbeing early, both with whole school and targeted approaches, and to take a long-term view. The evidence on early intervention highlights that many emotional issues are best addressed in primary school, when children are most open to help (McGinnis, 1990). The ability to change negative behaviour appears to decrease with age (Loeber, 1990), and as the signs of difficulty can be seen very early, they are best addressed when they are still mild (Rutter et al., 1998).

An increasing body of evidence demonstrates the importance of a multidisciplinary approach to the understanding and support of wellbeing and mental health of children. Theory and research from across the world highlight the importance of taking a holistic approach in schools, which includes several aspects of school life, as well as the underlying determinants of wellbeing, not just learning or behavioural outcomes. A systematic review concluded that whole school approaches can be powerful ways of tackling a whole range of health-related issues, including mental health and social issues (Lister-Sharpe et al., 2000). These approaches are effective not only for changing the behaviour and attitudes amongst pupils as a whole , but are especially helpful for those with emotional and behavioural problems. Another systematic review of approaches which were designed to promote mental wellbeing in schools concluded that "the most robustly positive evidence was obtained for programmes that adopted a whole school approach, were implemented continuously for more than a year, and were aimed at the promotion of mental health as opposed to the prevention of mental illness" (Wells et al., 2003). These approaches were more effective than those limited to classroom approaches alone; and this included outcomes for children with emotional and behavioural problems.

An example of an intervention that employs both generic and targeted elements is the Place2be. This is a national charity working with

172 schools across the UK, which aims to improve the wellbeing of children, their families and school community. They use tried and tested techniques such as one-to-one support, group work, circles of support, and training for teachers. They aim to "give children the chance to explore their problems through talking, creative work and play, in order to help them cope with current stresses and distress and help prevent more serious mental health and behavioural problems in later life" (The Place2be, 2010).

Another example is Achievement for All – a two-year pilot project (2009–2011) of a national charity supporting 450 primary, secondary, mainstream and special schools to improve the aspirations, access and achievement of children and young people. It aims to improve children's progress, parental engagement, children's attendance and behaviour, peer relationships, participation in extra-curricular activities, and access to future opportunities. It has been shown to have a significant impact on the outcomes of pupils with special educational needs and/or disabilities (SEND) and on school improvement.

Mental health and wellbeing are part of Personal Social Health and Economic (PSHE) education, although PSHE is often not taught by teachers with expertise in the subject. One well-known whole school education intervention is the Social and Emotional Aspects of Learning (SEAL) programme, existing in the majority of primary and minority of secondary schools. SEAL aims to promote "the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools" (DCSF, 2007), and there is some evidence to suggest that it has been useful (Hallam, 2009), although effectiveness is dependent upon how it is implemented (Humphrey et al., 2010).

There needs to be good links between generic children's services such as schools and specialist mental health support, such as Child and Adolescent Mental Health Services (CAMHS) to ensure that children who are experiencing difficulties with their mental health are able to receive appropriate support at the earliest point. One example of a specific mental health programme is Targeted Mental Health in Schools (TAMHS), an ongoing three-year programme in England which is aimed at intervening with children and young people aged 5-13 who are at risk of mental health problems, or who are experiencing mental health problems. The core aims of the TAMHS programme is the strategic integration of all agencies involved in the delivery of child and adolescent mental health services (including schools) so that they can work together to deliver flexible, responsive early intervention mental health services . The delivery of mental health interventions are grounded in the available evidence about "what works " in helping children and families with or at risk of developing problems. The programme is in the process of being evaluated.

Nevertheless, it is important to keep in mind that the processes which help some children may help all because they are addressing issues which are in fact common to all e.g. attribution,

anxiety management (e.g. Rutter et al., 1998). Also, it is less stigmatising to work with everyone, which means that those with problems are more likely to use the services offered and feel positive about them than if they feel they are being singled out. The inclusion of "difficult" children can be made easier by teaching skills to enable them to fit into classrooms more easily and manage their own behaviour, while helping their classmates to learn tolerance and positively support their efforts to become part of the mainstream. A study of this approach found that there was no detriment to the learning of other pupils (Epstein and Elias, 1996).

Effective schools work closely with parents and there is evidence that effective programmes of wellbeing need to involve parents. The involvement of parents is especially important for children with emotional and behavioural problems; this can involve teaching parents the competencies their children need to acquire (Wilkin et al., 2003). For example, a combination of parenting programmes and problem-solving skills training and communication skills has been found to be "the intervention of choice for effectively addressing behavioural problems in children below the age of 13" (Carr, 2000; Fonagy et al., 2002), while the involvement of parents through specific family therapies has been effective with teenagers (Brosnan & Carr, 2002). The extended schools approach also has a positive impact on parents by increasing their involvement with the school and with their child's learning.

Family and parenting

Studies consistently suggest that attentive, warm and stimulating parenting significantly enhance children's emotional, social and psychological development. Children and adolescence needs sensitive and responsive care in order to secure attachments and ultimately to achieve mental wellbeing as adults.

Children and adolescents need positive role models in order to achieve mental wellbeing. The interaction between a child and a primary caregiver, usually the parent(s), is among the fundamental cornerstones of child wellbeing (Sinclair, 2007; Barlow and Svanbery, 2009), and interaction with at least one trusted adult helps the child build resilience (O'Dougherty et al., 2006). This is one of the single most important influences on lifetime mental health, arguably it is the most important modifiable determinant of mental health.

Approximately 13% of children have suffered abuse and 2% have been affected by neglect (Cawson et al., 2000). Neglectful or abusive parenting negatively impacts on development:

> *"When the environment is impoverished, neglectful or abusive, this often results in a child who doesn't develop empathy, learn how to regulate their emotions or develop social skills, and this can lead to an increased risk of mental health problems, relationship difficulties, antisocial behaviour and aggression"* (Graham Allen Review, 2012).

Parental mental health influences child mental health: maternal mental illness increases fivefold the risk of child mental illness (Meltzer, 2003; Parry-Langdon et al., 2008). Children of parents with severe mental illness, such as schizophrenia and bipolar disorder, experience greater emotional, psychological and behavioural disturbance than their peers (Mowbray et al., 2006).

Parenting style influences the child's mental health and wellbeing; styles include authoritative, authoritarian, permissive or neglectful (Baumrind, 1991). Authoritative and authoritarian styles emphasise discipline, establishing rules for the child to follow. Authoritative parenting is supportive; for example, punishment never occurs without explanation of why the child is being punished. Permissive and neglectful parents are more lenient and make fewer demands of their children; these styles rely less on discipline. Permissive parents are more involved than neglectful parents, as the latter are inattentive to their children's needs. Authoritative parenting appears to lead to the best outcomes for children (Maccoby, 1992).

Parenting Style

Managing Misbehaviour	
Authoritative **High control** Reciprocal, Democratic (allows child to lead but establishes safe limits and boundaries. Likely to use encouragement, choices and consequences, positive reinforcement, time-out). **High Acceptance**	**Authoritarian** Powerful, Assertive/Aggressive (Adult leads makes all decisions which are imposed on child. May be highly critical. Likely to use shouting and smacking. Danger of physical abuse). **Low Acceptance**
Permissive Indulgent (Parent may ignore misbehaviour but set no limits or boundaries for inappropriate behaviour) **Low control**	**Neglecting** Uninvolved. Parent has no input to relationship with child. Abusive.

Outcomes of Discipline Styles

- These four parenting styles can be understood in terms of two dimensions: warmth or acceptance and control or demand.
- These styles seem to relate to outcomes:
    - Children from authoritarian parents may be lower in self-esteem and less socially skilled.
    - Children from authoritative parents develop most positively (e.g. high self-esteem, more independent, more compliant and fewer problems)
    - Children from permissive families may be more immature and take less responsibility.
    - Children from neglecting families have most negative outcomes (e.g. disturbed relationships with peers and adults).

Good parenting encourages children to play, which is defined as an activity which is enjoyable, non-prescriptive, spontaneous, engaging and imaginative. Play stimulates the brain and is vital for child development. Play also allows children to simulate and experiment within a safe environment; it can help them develop experience and understanding of risk (Jennings, 2005) and can produce a range of positive outcomes including: enhanced self-esteem, development of social skills and emotional regulation and acceptance of boundaries.

Parenting is not necessarily an innate skill and can be improved through practice. Some interventions for families with children showing early signs of behavioural problems (e.g. conduct disorder) combine improving parenting skills with family support and education. Many of these interventions are very cost-effective (Knapp et al., 2011). New parents may benefit from parenting programmes; for example the widespread Triple P (Positive Parenting Programme®) model, which is one of a number of parenting programmes, which can improve behavioural outcomes and reduce conduct disorder in children (De Graaf et al., 2008). Parenting programmes offer support according to severity of need; for example, universal education and information for those with the lowest need, followed by brief, medium and intensive interventions. The introduction of such initiatives is potentially one of the most effective ways to improve the mental health of a population in the long term.

Specialist support

Child and adolescent mental health services (CAMHS) aim to promote the mental health and psychological wellbeing of children and young people. They deliver multidisciplinary mental health services to all children and young people with mental health problems. CAMHS may include nurses, psychotherapists, speech and language therapists, psychologists, occupational therapists, and social workers . There are approximately 450 teams working in England, and more than 200,000 children and young people accessed CAMHS during 2008–2009 (Robotham et al., 2010). The CAMHS Review UK (CAMHS

Review UK, 2008) suggested that CAMHS may not be as child-centred as they could be, and that services may be difficult to access for some children.

In the 1990s, a four-tiered model was used to describe the CAMHS system. Since then, this model has been used as a framework for commissioning and delivering services. As highlighted in the CAMHS Review there are variations in the interpretation of this model between services and local areas:

- **Tier 1:** Services such as schools, youth clubs and GP surgeries where staff are generally not trained mental health specialists. These services offer general support and advice and mental health promotion. They will refer families requiring further support up to the higher Tiers.
- **Tier 2:** Services provided by staff who generally are trained mental health specialists and who work in community and primary care settings such as schools and GP practices. These services offer assessment, consultation and more specialist support for children and young people.
- **Tier 3:** Multi-disciplinary mental health services such as community mental health clinics or psychiatry outpatient services. These services support children and young people with more severe and complex difficulties than lower tier services.
- **Tier 4:** Highly specialist services such as psychiatric inpatient units or day units. These provide support to children and young people with the most serious difficulties.

More recently, some areas have been working with the definitions of 'universal', 'targeted' and 'specialist' services. These have been used in children's services more generally and have been applied to CAMHS. CAMHS has been restructured several times in recent history and there is considerable regional variation around how services are organised and delivered. Either way there is a constant need for the more specialist services (higher tiers) to be linked with generic services (lower tiers).

An example of an innovative approach to mental health services for young people is the 'Right Here' programme, which is using a model of youth participation to help design young people friendly services for those aged 16-25. The project brings young people together with a range of services and organisations to help raise awareness of mental health issues, and also supports them in deciding what to do and where to go if they experience difficulties. Right Here provides both general and targeted mental health support. Its target groups are young people not in education, employment or training (NEET), Black and Minority Ethnic groups, and young parents – groups most at risk of developing mental health problems. The project is currently being evaluated; early results are promising.

Transition into adulthood

Transition from adolescence to adulthood is one of the most important times in a young person's life. At 18 years of age, the transition to adult services coincides with other legal boundaries, such as the right to vote. This corresponds with a number of life changes,

such as moving from a family home or a foster home into independent living, or moving from education into employment, unemployment, or further education. For young people with complex needs who are using health and social services, this may coincide with the transition from young people's services into adult services. Transitions between child and adult services are often poorly managed. If a young person has been poorly prepared for the transition, and lacks emotional resilience and external support networks, then they may struggle to cope with the transition (Children and Young People's Mental Health Coalition, 2010).

The CAMHS Review UK (2008) highlighted transition as an area of concern for children and young people, their families and service providers. Voluntary sector provision can help to ease the transition; for example, the Mental Health Foundation's 'Right Here' programme, in partnership with the Paul Hamlyn Foundation, is using a model of youth participation to help redesign mental health services for young people. Transition should be flexible as young people adjust to adulthood, which may happen over a number of years.

Mental health promotion

It is vital to be aware of the stigma attached to mental ill-health amongst children and young people. It has been shown repeatedly that stigma is an important issue for young people (Woolfson et al., 2008; NCSS, 2010; YoungMinds 2010) and it may prevent them from accessing the support they need. Evidence suggests that teenagers hold the most stigmatised views about mental health; younger people aged 16–34 have more negative attitudes to mental illness than the 35+ age group (TNS, 2009). Stigma is an important issue that needs to be addressed, otherwise children and young people are less likely to identify and seek support for their mental health needs, and the opportunities for early intervention and promotion of positive mental health may be lost.

Consequently, children and young people enter the mental health system to receive more specialist and intensive – and more expensive – support.

Experiential approaches are most effective in reducing stigma; media campaigns alone have shown limited effectiveness. One option that incorporates both a focus on the early years and an experiential approach, is mental health service users coming into schools to help educate children, using films and peer-support work. In addition, anti-stigma work would need to involve parents as evidence suggests that stigmatising views about mental health are picked up by children from their parents and that all adults, such as teachers, should model behaviours related to attitudes about mental health (Children and Young People's Mental Health Coalition, 2010).

The Local Picture

The Child and Adolescent Mental Health Service (CAMHS) in Guernsey was established in 1993 on the appointment of a Child & Adolescent Psychiatrist. Prior to this, children with mental health difficulties were seen either by an Adult

Psychiatrist or a Psychiatrist with some child experience employed by the Education Department. Over the last 18 years, CAMHS has gradually employed more clinicians and now has a well-established multidisciplinary team. From this generic Tier 3 team, sub-specialties have arisen; for example an ADHD clinic; a Community Clinic dealing with Tier 2 difficulties and participation in the Autism Spectrum Disorder Assessment Team.

The CAMHS Outreach Team was set up in 2011 to provide intensive and rapid interventions for young people presenting with severe mental health difficulties, including eating disorders, with the specific aim of reducing the number of young people requiring off-island hospital care.

The Outreach Team saw 91 clients during the period 1st January – 31st December 2011. Total face to face contacts with young people and families was 1905 contacts. To measure outcomes the CGAS outcome measure was used. An increase in the CGAS score represents an improvement in everyday functioning. Clients received a CGAS score upon referral to the Outreach team, and a CGAS score upon discharge. The average initial CGAS for Outreach clients seen during 2011 was 43. The average CGAS score for clients discharged in 2011 was 69. Clients seen by the Outreach team thus had a significant improvement in their everyday functioning.

An additional outcome measure for the Outreach Team is the off-island bed days and cost of off-island placements for children and young people with complex mental health needs and eating disorders. The average annual cost of off-island placements over the last three years (2008, 2009, and 2010) has been £922, 376. The average annual number of off-island bed days over the same period has been 1508 bed days. For the year 2011 the cost of off-island placements was £376,683. The total off-island bed days was 615. There has thus been a significant reduction in the cost of off-island placements and a significant reduction in bed days. For a more detailed analysis of the Outreach team's first year of activity please see the separate CAMHS Outreach annual report.

Unlike most UK services, CAMHS in Guernsey has no primary mental health workers working alongside primary care to offer early support. The development of such a service as has recently been established for adult mental health as a strategic priority.

Workshop Feedback

Findings

From the discussion it was clear that there are a number of initiatives in place to support vulnerable families and children. In the main these are small and demand exceeds need. It would appear that some schemes have been started by enthusiastic clinicians, in isolation from each other and often with non-recurrent funding.

There was general agreement that the most pressing current needs are:

- To improve parenting skills and support for family life.
- To raise the importance of emotional development in children, with more

multi agency awareness of this need and a joint commitment to address this in an integrated manner across agencies.

- To raise awareness in parents of importance of play, home learning, family meals etc. and how parenting is not necessarily automatic and can be learnt and improved as any other skill. Also, to recognise the need for support is not a sign of failure but can be a healthy coping strategy.
- To reduce adverse experience such as domestic violence, drug and alcohol abuse, and neglect. Many participants said how they could, with a high degree of accuracy, identify the children who would experience considerable emotional difficulties both in adolescence and later life.
- To determine the accessibility, acceptability and effectiveness of a number of established processes, currently available, either through identified teachers or through school nurses where young people can access confidential advice and support and understand the relevance and importance of developing emotional resilience.
- To address a concern that young people are leaving school without the necessary skills for employment.

Strategic Priorities

That all professionals who work with children and families have the skills actively to support mental health and wellbeing throughout the lifecycle. This will include:-

- Promoting the need for nurturing from pre-birth into adulthood.
- Understanding mental wellbeing from a very young age, and being taught in environments that promote wellbeing.
- Work on the emotional wellbeing of children and young people will be high profile, the approach and strategy explicit, and shared with all the agencies involved.

This will be delivered by through:

1. All staff who have a caring duty for children and parents should have access to knowledge about mental health and wellbeing; this includes midwives, health visitors, teachers and support staff.
2. Midwives and health visitors will be trained in mental health issues, and be able to:
    - screen new mothers for post-partum depression;
    - offer short-term interventions and structured programmes for families at risk;
    - identify mothers with previous mental health problems who are at higher risk post-birth.
    - Refer these for additional support and intervention if required.
3. Schools will continue to prioritise work on mental wellbeing, and link it with their organisation, policies, practice and curriculum.

4. Teachers will have access to guidance and training in child development, including mental health issues, and be able to link to more specialist areas of support if needed, such as clinical expertise.
5. Teachers, children and parents will be made aware of the importance of mental wellbeing.
6. Children spend many hours every day at school therefore schools play an important role in children's development. Generic whole school interventions for mental health education and emotional literacy show good evidence of effectiveness.
7. Early identification of children with particular problems to maximise the chances of success. Early interventions will begin early, be long term, and be directed at risk factors. The interventions will have long term commitment and funding.
8. Schools will be encouraged to engage with or signpost early interventions for children and families experiencing mental health problems.
9. Targeted mental health promotion for those at high risk will be used, with the appropriate language and means (e.g. use of new technologies to reach young people).
10. Universal and targeted parenting programmes which can be delivered through a variety of mechanisms or settings can have a significant impact on the mental health of future generations.

Mental health services for children

The CAMHS provides assessment and treatment for children with more serious mental health problems.

Strategic priorities

- Tier 2: Increased access to trained mental health professionals using evidence-based interventions in community settings.
- Tier 3: Targets its work on more complex mental health problems and use evidence-based interventions. Ensure staff are trained to deliver.
- Tier 4: Develop service within Tier 3 to reduce off-island placements.

In summary

What does the research say?

Parenting and Early Years

- Investing in a healthy start in life influences development in childhood, adolescence and adulthood.
- Effective preparation for parenthood should include a focus on emotional wellbeing.
- It is important to develop good parenting skills and support for parents, together with early recognition and extra, targeted support for the vulnerable.
- A number of studies from the U.S.A. have shown that parenting and early intervention strategies are cost-effective and lead to increases in employment, literacy and social responsibility, as well as decreases in teenage pregnancy, crime and arrests.
- Multi-agency working is essential in providing help and support to families.
- Emotional as well as physical development should be monitored.

School years and adolescence

- Good mental health is associated with improved academic achievement, physical health, and enhanced psychosocial functioning.
- Good mental health helps to protect children against involvement with violence or crime, teenage pregnancy, drug and alcohol misuse.
- It is important to develop and build emotional resilience, and provide easily accessible advice and support in a variety of non-stigmatising settings.
- Healthy living advice and guidance on harmful behaviours should include advice on emotional resilience.

Problem identification

- Access to confidential advice in non-stigmatising settings, and early referral to mental health services, are key.

The Guernsey picture

Parenting and Early Years

- A number of initiatives support pregnant women and children who are known or believed to be at risk:
    - Family Partnership Team.
    - Children and Young People's Plan.
    - Islands Child Protection Committee (ICPC).
    - Early Intervention and Emotional Wellbeing Network (EIEWN).
    - Guernsey Young Parent Partnership Project (GYPPP).

School years and adolescence

- Wellbeing is taught in schools as part of PSHE.
- School nurses provide 'drop in' sessions in school.
- Professionals believe they could, with a high degree of accuracy, identify children who would experience considerable emotional difficulties in adolescence and later life.
- Professionals believe that improving multi-agency collaboration would lead to better outcomes. Apparent 'silo' functioning across agencies leads to duplication and omissions.
- There is a lack of primary care psychological therapy services for young people.
- There is some confusion over the interpretation and application of 'confidentiality policies'.
- Some employers believe that some children leave school without the necessary maturity or personal skills for employment.

Problem identification

- A Guernsey Young People's Survey is carried out on a regular basis, to identify any emerging issues.

What will we do?

In conjunction with the Children and Young People's Plan:

- Improve parenting skills and support for family life.
- Raise the importance of emotional development in children, with more multi-agency awareness.
- Raise awareness in parents of importance of play, home learning, family meals etc.
- Improve inter-agency working.
- Determine the accessibility, acceptability and effectiveness of services that are currently available.

In conjunction with the Domestic Abuse Strategy:

- Reduce adverse experience such as domestic violence, drug and alcohol abuse, neglect.

In conjunction with the Skills Strategy:

- Address a concern that young people are leaving school without the necessary level of emotional maturity for employment.

The three strand approach for starting, developing and growing well

6. Living well

Strategic Vision

The mental health of adults and children is improved by protecting and enhancing social, physical and natural environments including physical security, good housing, limited exposure to socio/environmental hazards (e.g. motor traffic density and noise), and providing opportunities for outdoor play and contact with nature for the emotional wellbeing and development of children.

Advice on wellbeing, reduction of stressors and information on reduction of harmful behaviours is readily available and accessible.

Support and interventions are available in non-stigmatising settings.

The Evidence

Public health

Public health is concerned with the health and wellbeing of populations rather than individuals; it involves improving health, maintaining good health, and discouraging behaviours that contribute negatively to health. Public health is focused less on condition or disease management and treatment and more on working with people to reduce their chances of becoming ill in the future. It has been described as:

> *"The science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organisations, public and private, communities and individuals."* (Winslow, 1920).

Almost everyone will have encountered public health messages, consciously or not. Most people will be aware of ways in which they can live 'more healthily': taking exercise, avoiding excessive drinking, quitting smoking. Public health messages adorn schools and workplaces; the five-a-day fruit and vegetable campaign is a well-known example. Good public health equates to a population that is 'living well'.

However, the mental health element of public health is often underplayed and this creates two problems:

1. Mental health is a major public health issue in its own right.
2. Good mental health (resilience, empowerment, and agency) is a major factor in determining whether public health messages can be acted upon.

Public mental health

Public health should encompass both physical and mental health; the term 'public mental health' is sometimes used to describe the mental health of a society or nation. Good public mental health contributes to improving health, recovery rates, productivity and

educational attainment (Friedli, 2009). The economic implications of poor mental health cost the UK society an estimated £67bn each year (New Philanthropy Capital, 2012).

Public mental health highlights the promotion of mentally healthy living, the prevention of mental illness, and early intervention, recognising the signs and symptoms of mental ill health before they become serious and/or long term and tackling them, often with low level, accessible, interventions. The English Mental Health Strategy (HM Government, 2011) emphasises the importance of public mental health as one of its four foci:

> *"By focusing on the prevention of mental health problems and the promotion of mental wellbeing, we can significantly improve outcomes for individuals and increase the resilience of the population, while reducing costs."*

Public mental health depends on exposure to risk factors and protective factors (Nurse and Campion, 2006). Experiencing high/significant risk factors and few/insignificant protective factors will be likely to lead to a decline in mental health. Risk and protective factors operate at both community and individual levels. Risk factors include social deprivation, debt, poor housing, unemployment and low income. Protective factors include community cohesion, safe and affordable housing, social networks, employment, security, access to leisure activities, access to green spaces, and individuals' and communities' resilience in the face of adversity.

The term 'wellbeing' has become synonymous with public mental health. The Coalition Government's Public Health White Paper (2010) defines wellbeing as a "positive physical, social and mental state".

Mentally healthy communities

Considering the mental health dimension of communities is a vital component of any mental health strategy. Most people live in a community, work in a community and may belong to one or more communities of interest. Our mental health is 'profoundly effected by the quality of these communities and the behaviour of others within them' (Tannahill et al., 2010).

> *"Communities are important for physical and mental health and well-being. The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution"* (Marmot review, 2010).

Mental health promotion is at its most effective in community or institutional (e.g. workplaces) settings where there is an ability to target and engage members in the change process and to develop approaches that are acceptable and meaningful within the specific community context. Early intervention in the community has been implemented In England through the Improved Access to Psychological Therapy (IAPT) programme. At a community level, mental health improvement activities can be practiced by anybody:

"The development of community-based services and the widespread integration of health and social care has meant that fewer people need inpatient care" (Department of Health, 2011).

Mental health problems can be treated through community based initiatives such as for example, through social prescription; or prescribing a service instead (or in addition to) a course of medication. Social prescribing is about linking people to local sources of support. It benefits individuals experiencing mental health problems alongside benefiting local communities by increasing activities available to the local population, enabling voluntary organisations to promote positive wellbeing, and therefore potentially reducing waiting lists for psychological interventions within primary care.

For the majority of people with lower level mental health needs, community-based interventions are most appropriate. Community interventions can promote mental health and support recovery for people with mental health problems in non-stigmatising environments. This distinguishes them from traditional mental health services which treat mental health problems in clinical settings. For example, community interventions for mental health problems could include 'buddying' or mentoring schemes, exercise or arts programmes, or self-help and peer support groups – all of which can be run at a relatively low cost. It has been shown that promoting mental health in the community can help to reduce the stigma of mental illness and of seeking treatment, and be cost effective (Mental Health Foundation, MHF, 2011).

Understanding of mental health

The level of mental health literacy of a population can improve public mental health. Understanding of illness can improve recovery rates, and people experiencing mental ill health usually benefit from understanding their illness, its triggers and symptoms. Access to user-friendly information can be given on 'prescription'; for example a GP may give patients access to a library of information (bibliotherapy). A book prescription scheme has been established in Guernsey for 10 years.

There are various information services for people with mental health problems, such as online information, telephone helplines and IMS chat. These kinds of information have the benefit of being anonymous, especially useful for people who may otherwise not seek help (Christogiorgos et al., 2010).

Treating mental health in a community improves the community's understanding of mental health problems. Negative perceptions of mental illness affect public mental health, preventing people with mental health problems from seeking help and/or treatment. Stigma can also make mental health problems worse and increase the isolation of people who experience them. Recent public campaigns in England and Scotland have targeted stigma and discrimination. In Scotland, the 'See Me' public campaign attempted to reduce the stigma about mental health in society. The recent Time to Change campaign has also aimed to do this.

The three way of reducing stigma are protest, contact and education; the most promising approach is the 'contact' method (Corrigan et al., 2001; Corrigan and Gelb, 2006). Having experienced mental health problems, or knowing someone suffering with mental health problems, seems to achieve meaningful changes in attitude and behaviour. Therefore using 'contact' to expose members of the public to the reality of the lives of people with mental health problems can help to dispel myths and challenge stereotypes although this process needs to be thoughtfully managed.

Suicide prevention

Although research indicates that there are high levels of mental health problems among those who have attempted or completed suicide, there are also many who do not have a diagnosed mental illness, and their actions are a result of other social causes (RCP, 2010). For this reason, the Royal College of Psychiatrists have argued that suicide prevention should be a priority within public health policy and addressed not only within mental health services, but also within a range of other sectors including education, social work, prisons, police, third sector and community organisations (RCP, 2010).

In Scotland, the national suicide prevention strategy and action plan 'Choose Life' prioritised training frontline staff in suicide prevention, to increase the ability of organisations and communities to recognise and intervene to prevent the immediate risk of suicide. Established courses such as ASIST and safeTALK could be rolled out across Guernsey to similarly increase local capacity to respond to suicide risk.

Self-management and empowerment

Studies show that people suffering from mental health problems often do not seek professional help (Bebbington et al., 2000); men are less likely to seek help than women, with young men being particularly vulnerable (Oliver et al., 2005). Self-management of mental health is a way in which people can learn to manage and take responsibility for their mental health and wellbeing. Improvement in mental health should be led by people who wish to make such improvements. It also means that they should be empowered to seek external help and support when needed. An empowered population is more receptive to learning new skills and capabilities. This can increase mental capital and wellbeing (Foresight Mental Capital and Wellbeing Project, 2008) and improve resilience against mental health problems. However, self-management implies that a person must engage with help-seeking behaviour.

The principles of self-management extend to people who may be suffering from diagnosable mental health problems. Many chronic conditions are self-managed within the community; for example, diabetes and hypertension. Mental health problems can be managed in a similar way. There is evidence to suggest that self-management and peer support can help people with long term mental health problems too (Crepaz-Keay & Cyhlarova, in press). People can support each other through patient and carer groups. This kind of mentoring and advocacy service, using experts

by experience, can be applied in primary mental health settings (Joint Commissioning Panel for Mental Health, 2012). Self-management techniques such as mindfulness can be useful; they can help people become more aware and accepting of their negative thoughts, rather than dwelling on them. Trials show that mindfulness-based therapies can reduce stress and mood disturbance. In a study of people with long-term anxiety problems, participants had less anxiety during and after completing the course, with improvements maintained at three-year follow-up (Kabat-Zinn et al., 1992). People who practice mindfulness are less likely to experience depression and anxiety, and report greater well-being and life satisfaction (Mental Health Foundation, 2010).

Physical health

There is a bi-directional relationship between physical health and mental health; people who experience severe mental health problems have lower life expectancy, and may find it more difficult to recover from physical illnesses (Chang et al., 2001). Improvements in physical health are often linked to improvements in mental health. Good physical health is a protective factor which protects people against the effects of mental ill health, just as poor physical health exacerbates mental ill health. Individuals with long term conditions, such as diabetes or coronary heart disease, are two to three times as likely to experience depression than the general population (Fenton & Stover, 2006) Factors that influence physical health also affect mental health, such as diet, exercise and substance misuse. The brain needs optimal amounts of certain nutrients to remain healthy (Cyhlarova & Hart, 2011), and the importance of exercise for mental health is strong (Fox, 1999). Interventions that are effective in improving physical health will have subsequent beneficial effects on mental health. Structured exercise programmes, for example, can be given on prescription by health professionals such as GPs, with positive results on mental health and wellbeing (MHF, 2009; Scottish Development Centre, 2007). Incorporating mental health awareness raising, screening and self-help guidance within routine physical health checks for people with long term conditions may also support the prevention of common mental health problems in this population and assist with early intervention and recovery (Maxwell et al, 2011).

Social support

Social support is a protective factor against mental ill health, helping to reduce psychological distress. Low levels of social support increase the risk of someone developing mental health problems (WHO, 2004), and make it more difficult to recover from mental health problems (Hendryx et al., 2009). Research shows that social networks are good for physical and mental wellbeing, and that better integrated societies have lower rates of crime and mortality and better quality of life (Wilkinson & Pickett, 2009). Any kind of community activity that encourages social support potentially improves mental health and wellbeing, such as community engagement activities (NICE, 2008).

Social inclusion is seen to be particularly important in reducing the likelihood of developing mental health problems. Loneliness and a lack of social relationships can negatively affect our mental health (Mental Health Foundation, 2010), and being part of a social network makes people feel valued. Interventions to reduce loneliness can play a role; these can establish satisfying personal relationships; prevent loneliness from becoming chronic; and prevent loneliness in risk populations (Rook, 1984). Befriending schemes, for example, may help to ease the worst effects of isolation in vulnerable people and could prevent loneliness becoming chronic (Dean & Goodlad, 1998). Initiatives that bridge the gap between generations are believed to create more cohesive communities, helping to reduce social isolation. Some schemes that bring together different age groups can have a positive effect, with older people providing younger people with positive role models, both of engaged citizenship and active ageing (The Centre for Intergenerational Practice).

Individual, cultural, environmental and economic factors all have an impact on our capacity to build and maintain social relationships. The quality of relationships is a key factor in individual and collective resilience in the face of adversity (Friedli, 2009). The availability of couple counselling services can be an important factor in whether relationship breakdown impacts more or less strongly on the mental health of couples going through difficulties.

Volunteering

Volunteering is a way in which people can increase social support networks, but it may have other positive effects on mental health. It can introduce people to new communities, improve employment prospects, and help people to feel connected to the world around them. Volunteering has been shown to be beneficial to the mental health of individuals. It can improve overall mental health and also help to protect from mental health problems. The Brighter Futures project (Mental Health Foundation, 2011) showed that volunteering played an important role in promoting wellbeing and preventing mental health problems amongst a pool of older people who were volunteers. The principle of 'giving something' each day has been highlighted in 'Five Ways to Wellbeing' (New Economics Foundation, 2011).

Volunteering, and being part of a social network, has been found to contribute significantly to the recovery of people who have mental health problems. A London-based project, Capital Volunteering, found that volunteering aided recovery by improving self-confidence, and providing the opportunity to meet new people. Volunteering gave structure to people's lives, equipped them with new skills, and people also enjoyed helping others. Volunteers reported higher levels of self-esteem and wellbeing. Volunteer work improves access to social and psychological resources, which are known to counter negative moods, such as depression and anxiety (Musick and Wilson, 2003).

Workplaces

The majority of the working age population spends at least 35 hours a week at work, so creating mentally healthy workplaces has important implications for public mental health (Shaw Trust, 2010). The following factors can support healthy workplaces: promoting autonomy, minimising work pressure, having clear expectations, and most of all the support of a manager (Grove et al., 2005). Supportive workplace environments are good for mental health, helping build resilience, socialising opportunities, and development of confidence and self-esteem (Department of Health, 2011). Unsupportive workplace environments negatively affect mental health, and factors such as prolonged stress, overwork or harassment increase the likelihood of developing mental health problems. Poor wellbeing at work may result in absenteeism or presenteeism, which contribute significantly to the cost of decreased performance and productivity (Sainsbury Centre for Mental Health, 2007). There is therefore a strong economic case to be made to employers for funding wellbeing at work programmes which tend to show a Return on Investment of 2.5 to 1.

Schools

This area has been extensively covered in the Starting Well Chapter.

Debt

Financial hardship is linked to poor mental health (Rogers and Pilgrim, 2003).. This relationship can be understood as resulting from:

- Social Divisions – where mental health problems both reflect deprivation and contribute to it.
- Social drift – where the social and ecological impact of adversity, including the impact of physical health problems and the cycle of invisible barriers prevent or inhibit people from taking up opportunities to improve their financial status.
- Social injuries – with mental distress an outcome of demoralisation and despair.

In addition, in societies where there are higher levels of income inequality a resulting higher prevalence of mental health problems can be found (Pickett et al., 2006). People with mental health problems are less likely to be in employment and even when working find it more difficult to keep. . Low income is associated with mental health problems, and debt is a major contributing factor in making mental ill-health worse (Jenkins et al., 2008). Similarly, people experiencing financial hardship may experience greater social exclusion, for example not having enough money to socialise or speak to friends over the phone, further increasing the risk of developing mental health problems. People may not seek advice for problem debt until after it has become a problem, often due to embarrassment (Mind, 2008). Independent monetary advice needs to be made available. In England, the Financial Services Authority has linked with Mind to provide training for staff in mental health drop-in centres on how to assess for financial difficulty and the Mental Health Foundation has

advised the major debt counselling charity on linking its work with depression interventions.

Housing

Housing is critical for people to work and to take part in society (NHS Confederation, 2011). Good quality, affordable, safe housing is essential to mental health and wellbeing (NMHDU, 2010). There are also relationships between factors such as damp, multiple-occupancy and overcrowding and a risk of developing mental health problems (Page, 2002). Guite et al., (2006) found that people living in cold and damp conditions were 1.88 times more likely to be in the lowest quartile for mental health. In addition to the physical discomfort the stigma associated with living in damp conditions and time lost at work or in education due to cold related illnesses were highlighted as impacting negatively on mental health.

Research by the National Housing Federation (NHS Confederation, 2011) highlights the importance of a settled home for good mental health. People with mental health problems are less likely to be homeowners and are more likely to live in unstable environments. The lack of appropriate housing impedes recovery and access to community facilities and treatment, many of which can only be accessed once a person has a fixed abode. Support with housing can improve the health of individuals and help reduce overall demand for health and social care services. Ensuring service users have a suitable and settled place to live can aid recovery from mental health problems. By working in partnership, mental health providers and housing associations, statutory housing and social housing can deliver better outcomes for service users. Poor mental health, poor housing, worklessness and income poverty are all seen to be indicators of 'multiple disadvantage' (Cabinet Office, 2010). One review reported that housing quality was positively correlated with psychological wellbeing (NMHDU, 2010) and that improving housing maintenance could contribute to mental health improvement.

Feeling safe within neighbourhoods is also important with fear of crime leading to isolation and poor mental health (Guite et al., 2006).

Green spaces

There is increasing evidence that access to green spaces has a significant impact on mental health, and proximity to green space can affect physical and mental health of communities (Maas et al., 2009). Access to green space improves the health and wellbeing of communities. The WHO now incorporates the natural environment as a determinant of community health and wellbeing (Barton and Grant, 2006). Access to green spaces is unequally distributed across socio-economic groups, with poorer social groups having lower access (Sustainable Development Commission, 2010), hence individuals and communities who could benefit most from contact with nature are often least able to access it. For example, people in hospitals, mental health wards, prisons, and older people are often unable to get to green space.

There is an association between good mental health and physical activity, and access to green space can encourage people to take exercise (Department of Health, 2009). Green space

could have positive influence on other health conditions such as obesity, heart disease and asthma, which are significant factors in relation to health inequality. A relationship between lack of green space in urban areas and levels of stress has also been reported (Mind, 2007).

In addition, walking and cycling in a country park as opposed to in an urban area seems to bring enhanced benefits: being near nature had a more positive effect on mood and self-esteem (Mind, 2007). The Green Gym Scheme run by the British Trust for Conservation Volunteers helps people to take exercise outdoors while participating in activities that improve the environment. A vast majority of participants with poor mental or physical health show an improvement within a few months (Sustainable Development Commission, 2007).

More equal access to green space could be key to reducing health inequalities between socio-economic groups, and provide a preventative and synergistic approach that has social, environmental and economic benefits. In Guernsey there is easy access to pleasant outdoor space so it might be particularly relevant to encourage or facilitate excluded groups to use this facility.

The Local Picture

In many respects, The Bailiwick of Guernsey is very fortunate, in that it is a beautiful island with a plethora of beaches and coastal walks that encourage physical activity at low cost.

Islanders are very protective of their heritage. Housing is expensive with a two tier system that protects house availability for the local market.

The island is relatively affluent, although there are pockets of deprivation. Unemployment is very low at 0.9%.

Workshop Feedback

From the discussions, it was clear that there is a need for two incomes to maintain a reasonable standard of living. This presents challenges for family life and particular difficulties for single parents.

Social workers in contact with vulnerable families reported that transport, both in terms of cost and availability, presented challenges when accessing leisure services.

It was stated that the primary care charging system acts as a deterrent to people seeking both early advice and ‘stepping down’ from secondary care. This is despite the systems that are currently in place.

For people with mental health problems, the lack of good quality rented accommodation is a particular issue, together with few opportunities for return to work or to find new employment. The lack of employment opportunities for people needing part time work or with mental health problems is seen as a particular difficulty.

The stigmatising effect of attending the Castel Hospital and its history of not always providing the best service deters people from accessing appropriate specialist help.

Strategic Priorities

That everyone is aware of the need to improve and maintain mental and physical health and knows how this can be achieved.

This will be achieved by:

- The promotion of healthy lifestyle.
- Improving access to advice in non-stigmatising settings.
- Providing mental health awareness and suicide prevention training to community based organisations, to support their understanding of their role as promoters of good mental health and wellbeing.
- Incorporating mental health awareness raising, screening and self-help guidance within routine physical health checks for people with long term conditions.

In Summary

What does the research say?

Poor mental health impacts on every aspect of life. There are a number of factors that help to support and maintain good wellbeing including:

- Close relationships with family and friends
- Somewhere to live
- Fulfilling work
- Exercise
- Diet
- Sensible use of alcohol
- Avoidance of harmful substances
- Income
- Hobbies
- A sense of purpose
- A fair democracy

The Guernsey picture

Positive influences

- Public Health promotion, including advice on potentially harmful behaviours (including alcohol, drugs and smoking), sexual health, diet and exercise, is clear and available.
- There is public advice on the sensible use of alcohol due to the substance misuse strategy.
- A pilot scheme was commenced in 2011 to provide access to psychological therapies in primary care.

Poor influences

- Mental Health promotion has not had the same high profile as other health promotion areas, such as smoking cessation.
- Mental health promotion is focused on those with mental health issues, and included as part of an individual recovery plan.
- From the workshops leading to this Strategy, it was clear that there is a need for two incomes to maintain a reasonable standard of living. This presents challenges for family life and particular difficulties for single parents.
- Social workers in contact with vulnerable families report that transport, both in terms of cost and availability, presents challenges when accessing leisure services.
- The primary care charging system appears to act as a deterrent to people seeking early advice and to 'stepping down' from secondary care. This is despite the systems that are currently in place.
- For people with mental health problems, the lack of good quality rented accommodation is a particular issue, together with few opportunities for return to work or find new employment. The lack of employment opportunities for people needing part time work or with mental health problems is seen as a particular difficulty.
- People are deterred from seeking appropriate help due to the stigma attached to the Castel Hospital and to its history of not always providing the best service.

What will we do?

- Provide more information for people as they live their lives.
- Evaluate the benefits of primary care mental health and wellbeing pilot scheme.
- Provide access to advice and support in non-stigmatising settings.

A Three Strand Approach to Living Well

7. Working well

Strategic Vision

Mental health will be improved and suicide rates reduced by improving the availability, quality, security and rewards of employment, including workplace mental health promotion, stress management, health protection, employee retention, rehabilitation and reintegration.

The Evidence

The workplace has a powerful effect on everyone's health – the employer, employee and the customer. How healthy a person feels affects his or her productivity and how they relate to others. How satisfied they are with their job affects their own mental and physical wellbeing. How people are treated has a profound effect on their ability to express their views and access services. There is also considerable cost to individuals, businesses and society with an estimated 80 million work days being lost each year to stress, depression and anxiety[2]. It has been estimated that not addressing mental health problems in the work place costs business and the public sector £9 billion each year.

Employment is a key factor influencing individual fulfilment, bringing autonomy, pride and confidence to individuals, families and communities across the life course. In childhood living in a workless household increases our risk of material poverty (Unicef, 2007), and a poor start in early years can influence our early ambitions and motivation (McDaid and Park, 2011). As adults employment is not only a main source of income, but a determinant of social status and a key route to vital social networks (DWP, 2008). Previous working life also often determines access to financial and social support in retirement. The overall annual estimate of the total cost of working age ill-health is estimated to be £100bn for the UK, equating to a figure of £100m for Guernsey (States of Guernsey, 2011).

In the Guernsey Emotional Wellbeing Survey (GEWS) (Johnson et al., 2010) the effect of unemployment on both mental wellbeing and anxiety and depression were clear. Unemployed people had the lowest overall mean WEMWBS score for wellbeing, with 53% of those out of work classified as having low wellbeing compared to 18% of those in work. This equated to a relative risk of poor mental wellbeing three times greater than the general Guernsey and Alderney population sample. This result was replicated in the application of the HADS screening tool for anxiety and depression within the same population. Some 21% of the unemployed group had a HADS score suggestive of depression, compared to only 5% for those in work. This indicates a risk of depression, which is four times higher for those who are not in employment.

However, no directionality could be determined in this study (it was not known if unemployment caused low wellbeing or if poor mental health caused unemployment).

Low wellbeing in WEMWBS is indicated by scores at least 1 Standard Deviation lower than population mean.

Actions to improve mental health therefore need to recognise the role of employment and in doing so key benefits may include:

- Increases in productivity as good mental health has consistently been shown to improve the quality of working life, and the productivity of enterprise and services (Dewe and Kompier 2008).
- Greater workforce resilience, reducing absenteeism (and presenteeism) associated with stress and mental health related illnesses. Improved quality of life and a reduction in benefits dependency for people furthest from the labour market, including people with long-term mental health problems.

Context

Work has an important role to play in promoting mental wellbeing. Mental wellbeing at work is determined by the interaction between the working environment, the nature of the work and the individual. It is an important determinant of self-esteem and identity. It can provide a sense of fulfilment and opportunities for social interaction. For most people, work provides their main source of income (NICE, 2009).

As the population gets older and individuals work longer hours and for more years, working life demands greater mobility, increasing adaptability (in changing jobs and potentially careers), and greater technical expertise and competitiveness in a globalised world (O'Sullivan, 2006). The economic challenges of recent years, the prospect of further years of austerity, and the risks presented by increasing youth unemployment mean that safeguarding and promoting the benefits associated with employment and of other meaningful activity may be more important than ever (WHO, 2010; RCP, 2010).

There is a clear link between workplace stress and poor wellbeing, and advice on stress at work, encourages organisations to measure as well as tackle stress. Stress can be viewed as an interaction between individuals and their environment, and therefore measures for overcoming the negative effects of stress should focus on both the workplace and the employee (McDaid, 2008).

It is accepted that factors outside the workplace such as changing patterns of family relationships and social networks impact on performance. The benefits of regarding the workplace as a positive environment for improving staff health, including provision of support for non-workplace related problems, are now clearer in terms of health outcomes but also of bottom line cost benefit (increased productivity and reduced sickness absence) (Jane Llopis et al., 2011;Price Waterhouse Coopers, 2008; Tiexeira, 2010).

The case for action

Costs associated with poor employee mental health and wellbeing can be considerable, involving: sickness absence; early retirement; employee turnover (recruitment, training and development costs); grievances and compensation; damage to equipment; loss of reputation for the company; and decreased performance and productivity. As public sector employees are at particular risk from stress and poor mental health (HSE, 2009), there can be a double burden placed on the public purse of paying for absenteeism and healthcare.

Most often, the cost of poor wellbeing at work is measured in terms of the burden attached to absenteeism, but the cost of decreased performance and productivity - presenteeism, is becoming a particular concern (Brun, 2008).

Estimates of prevalence of mental illness in the population vary. However, according to the 2000 survey of psychiatric morbidity 1 in 6 workers will experience mental ill health at some point in their working life (Sainsbury Centre for Mental Health, 2007) rising to 1 in 5 if drug and alcohol misuse is included. Despite this high prevalence, a major research study with UK employers in 2010 (Shaw Trust, 2010) found that 11% of employers still agree that none of their staff will be affected by mental ill health although promisingly, this was down from 41% in 2006. The same study also showed that 72% of workplaces still have no formal mental health policy although best practice now focuses on integrated wellbeing and healthy workplace policies.

A compelling argument for addressing mental health in the workplace is that the majority of people who experience common mental health problems are in work. The UK Psychiatric Morbidity Survey of 2000 found that 63% of people with mental health problems are in work (47% working full-time and 16% part time) demonstrating a need to ensure that workplaces are able to manage mental health successfully (Meltzer et al., 2002).

The rates of employment for people with significant and ongoing mental health problems can be as low as 20%, compared with a rate of around 50% for disabled people in general and 80% for the population as a whole (ONS Labour Force Survey, 2009) Yet there is evidence that indicates that people can and do lead successful careers following serious mental ill health and that most people out of work with mental health problems express a desire to work (Perkins et al., 2009).

Stigma and discrimination

The workplace is a critical setting where mental health stigma and discrimination can have a serious impact on people's lives. Employers may be reluctant to recruit individuals with known mental health problems believing that they are likely to be less productive or more disruptive in the workplace (Rinaldi and Hill, 2000; Manning and While, 1995). Within Ireland, surveys have shown that more than a quarter of employers feel that employing people with mental illness may adversely impact on other employees. 54% of employers think that organisations take a significant risk when employing people experiencing mental

health problems, 34% of employers think that people with mental ill-health are less reliable and 39% of employees also agreed with this statement (NESF, 2007).

The Shaw Trust found in its recent survey of 500 employers that 1 in 3 employers think that people with any form of mental health problem are less reliable than other employees. A similar number say that negative attitudes from workplace colleagues are a major barrier to employing people with mental health problems. In the same study 40% of employers viewed workers with mental health problems as a 'significant risk' (Shaw Trust, 2010).

People with mental health problems may also be reluctant to enter employment due to fear of having to disclose their condition even though the majority express a desire to work. In a survey for 'See Me', Scotland's anti-stigma campaign 57% of those who had experienced mental health problems had concealed the fact when applying for a job and 43% had not gone ahead with a job application due to concerns about how their mental health history might be perceived ('See Me', 2006).

In a 1998 study 200 HR professionals in UK companies were asked to consider vignettes of candidates disclosing diabetes and depression (Glozier et al., 1998). This study found that the mention of depression significantly reduced the chances of employment, compared with a history of diabetes. On exploration it was found that this differential treatment was based upon perceptions of potential poor work performance, rather than expectations of future absenteeism (Glozier, 1998). While disclosure may reduce chances of employment, without disclosure an individual cannot request support and modifications to help them maintain employment and it may be difficult to explain gaps in employment history to any prospective employer (McDaid, 2010).

In addition, the growing diversity of the workforce, including the significant increase in women working part-time, migrant workers and older employees, has increased the potential for stress associated with discrimination and perceived injustice (Foresight Mental Capital and Wellbeing Project, 2008).

Absenteeism and presenteeism

In the UK, poor mental health is a major reason for workplace illness and absence. According to the UK Labour Force Survey an estimated 13.5 million working days (full-day equivalent) were lost in 2007/08 through self-reported stress, depression or anxiety caused or made worse by work. On average, each person suffering took an estimated 30.6 days off in that 12-month period (HSE, 2009). This equates to 0.56 days absence per worker in the UK workforce. The Royal College of Psychiatrists estimate 21 days as the average length of absence for a mental health problem (per time/episode) and that a high proportion of long-term absences are due to mental health problems (RCP, 2008).

The Centre for Mental Health found that mental health problems account for 40% of all days lost through sickness absence (Centre for Mental Health, 2008). This equates to an approximate cost to Guernsey of £40m per year

from sickness absence arising from poor mental health (based on a total cost of absence) through sick leave (States of Guernsey, 2011)).

Long-term absences can lead to long-term disability benefits claims and retirement for medical reasons, which can be a considerable expense for employers but also society as a whole.

Mental health problems increase the risk of people leaving the workplace, with mental illness overtaking musculoskeletal problems as the leading cause of health related early retirement (RCP, 2008).

In recent years research has strongly linked long term health conditions with greatly increased risk of common mental health problems (Naylor et al., 2012). Review level evidence suggests that those with co-morbid mental health problems and long term conditions are less likely to be employed, less productive in work, and more likely to take greater sick leave than those without a co-morbid mental health problem (Hutter et al., 2010; Von Korff et al., 2005; Druss et al., 2000).

Presenteeism is defined in terms of lost productivity arising from attendance at work whilst unwell, leading to sub-optimal performance (Cooper and Dewe, 2008). Poor mental wellbeing is a major cause of presenteeism, whether or not this arises from a mental health problem or from the need to contend with work or non-work related stressors. Australian data suggest that there is variation in presenteeism according to job role, with higher paid males experiencing less absenteeism but more presenteeism, and the mix of presenteeism and absenteeism more canted to presenteeism in clerical, technical and executive jobs, and to absenteeism in trades, labour, and in sales (Hilton, 2007; NICE, 2009).

As instruments for measuring productivity improve, the scale of the potential problem is becoming clearer (Cooper and Dewe, 2008). Although there is a scarce amount of data from Europe, data from the USA, Canada and Australia suggest the problem is significant. Nevertheless care should be taken in interpretation, due to differences in social protection in terms of sick pay between the UK and US (NICE, 2009). However, it is now being suggested that the effect of presenteeism on output and productivity has a greater associated cost than that of absenteeism (Brun, 2008; Cooper and Dewe, 2008). This is borne out by a study by the Sainsbury Centre for Mental Health that estimated that presenteeism costs 1.8 times as much as absenteeism (Sainsbury Centre for Mental Health, 2007). This research estimates the cost of mental health problems to individual employers at £335 per person because of absenteeism, £605 per person because of presenteeism and £95 per person because of staff turnover. This is a total of £1,035 a year for every employee in the workforce.

The conclusion is that whilst absenteeism is important, and easily measured at an employer and a national level, the cost of presenteeism is likely to be greater, and particularly relevant in relation to mental health.

Recession and economic downturn

High quality employment has been shown to contribute to mental health and wellbeing and unemployment to poor mental health (Dorling, 2009). Strong evidence indicates that loss of employment and the risk of unemployment are associated with an increased rate of harmful stress, anxiety, depression and psychotic disorders. Unemployment causes significant deterioration of mental health for people of all ages and especially for middle-aged men (WHO, 2010). Recent statistical studies show that rising unemployment is also associated with small but significant short-term increases in premature deaths from suicide (Stuckler et al., 2009).

The recent financial downturn is being blamed for creating an unstable employment environment, and as a result is negatively impacting on mental health through direct job losses and in terms of lifestyle changes and healthcare access (Royal College of Psychiatrists, 2009; WHO, 2010).

Stability within workplaces is also an emerging issue with at least 20% of people in work experiencing substantial restructuring or reorganisation at work in the last 3 years (Keisselbach et al., 2010). It has been argued that if managed badly, restructuring can increase the risk of stress and poor mental health (European Foundation for the Improvement of Living and Working Conditions, 2010).

Effective strategies for consideration

In the past few years, increasing attention has been paid to developing an evidence base for mental health in the workplace. In 2006/7 the European Commission funded two major three-year projects under the Sixth Research Framework to provide scientific support to policy in mental health. ProMenPol2, which later developed into a European Network for Mental Health Promotion, concentrated on supporting implementation of mental health improvement into practice in three settings including the workplace. One component of this work was the collation of workplace health promotion tools, which were made available online within a database. The ProMenPol team worked closely with the European Network for Workplace Health Promotion3, a highly effective network of practitioners delivering workplace health initiatives, including four successive programmes of transnational mental health at work initiatives. The DataPrev4 project brought together several research groups to conduct rigorous reviews of evidence based mental health improvement measures, one example of which was a review of psycho-social interventions in workplaces (Czabala et al., 2011). The concluding paper 'Reducing the Silent Burden of Impaired Mental Health' (Jane Llopis et al., 2011) identified the workplace as one of the most important settings for mental health promotion.
(http://www.mentalhealthpromotion.net
http://www.enwhp.org
http://dataprevproject.net).

Studies such as the Foresight report on Wellbeing and Work (Brun, 2008) have begun to assess what influences wellbeing at work. One factor is considered to be employees' satisfaction with their work experience, which has a significant impact on motivation and performance. Developing job satisfaction, for example, through promoting challenge, identity, control, creativity, and positive relationships can lead to improved wellbeing at work and increased productivity.

At an organisational level, approaches that appear to be successful in creating a positive and mentally healthy environment for all are very similar to what would be regarded as the best practice in management more widely, and it has been suggested that this may be a way to mainstream productivity and wellbeing in workplaces (Cooper, 2011, World Economic Forum, 2011). Activities that promote awareness among managers of the importance of mental health and wellbeing at work, and aim to improve their skills in risk management for stress and poor mental health, have been associated with positive outcomes. These activities often concentrate on mainstream business productivity as opposed to mental health specifically, and have included: reviewing job content, working conditions and terms of employment; addressing the built environment; introducing flexible working hours; improving internal communication; and offering opportunities for career development (Jane Llopis et al., 2011).

At an individual level a range of activities have shown promise including: modifying workloads; providing cognitive behavioural therapy, relaxation and meditation training (including the mindfulness based approach); time management training; exercise programmes; goal setting; and creating time for group and social activities (Czabala et al., 2011; Teixeira et al., 2010). Comprehensive programs that promote training in resilience development and stress management have been shown to be effective (Robertson & Cooper, 2011).

A strategic approach to employee wellbeing should include supporting those employees who experience mental health problems. In keeping with the actions that promote positive mental health at work, best practice in relation to supporting people who experience mental health problems at work is based on sound management principles. However, this should be combined with a clear approach to addressing stigma and discrimination in the workplace (McDaid, 2010). To reduce stigma it is important that a mentally healthy workplace approach includes everyone, involving: those entering the workforce for the first time; people that have experienced long periods of absence; people currently in work requiring support; and the general work force that have the ability to flourish in mental health promoting workplaces. Overall, the promotion of mental wellbeing should be integrated into all policies and practices concerned with managing people, including those related to employment rights and working conditions. (NICE, 2009).

For several years the World Economic Forum and other business bodies such as Business Europe and CSR Europe have tracked mental health activities in large, multi-national

organisations and it appears that there are more examples of successful practice than the published evidence indicates. This may be related to issues of commercial sensitivity, or it could be because there aren't enough incentives to publish evaluations (Jane Llopis et al., 2011). Regardless of the rationale some promising practice has been kept out of the public domain. However, this situation is improving with large corporations such as British Telecom and Electricite de France (EDF) presenting their activities in business and policy forums. For example, BT has reported that its mental wellbeing strategy has led to a reduction of 30 per cent in mental health-related sickness absence and a return-to-work rate of 75 per cent for people absent for more than six months with mental health problems (Wilson, 2007).

Despite some emerging research NICE (2009) point out that evidence on the effectiveness and cost effectiveness of organisation-wide approaches for promoting the mental wellbeing of employees is 'limited in nature and quality'. Further, they state that such organisation-wide approaches do not lend themselves readily to traditional experimental evaluations or systematic reviews. Consequently in developing guidance on mental health promotion in workplaces, NICE adopted a more flexible review process that drew on a wider range of methodologies.

NICE estimates that effective management of mental health in a UK organisation with 100 employees could save £250,000 per year overall (National Institute for Health and Clinical Excellence, 2009). They concur that in addition to benefits for the employee and the company, there are collateral benefits for friends and family, in addition to improving mental health awareness and reducing stigma across society.

In the NICE Public Health Guideline 22, Promoting Mental Wellbeing at Work (NICE, 2009) key recommendations for action included:

- Create an awareness and understanding of mental wellbeing and reduce the potential for discrimination and stigma related to mental health problems.
- Ensure processes for job design, selection, recruitment, training, development and appraisal promote mental wellbeing and reduce the potential for stigma and discrimination.
- Employees should have the necessary skills and support to meet the demands of a job that is worthwhile and offers opportunities for development and progression.
- Employees should be fully supported throughout organisational change and situations of uncertainty.
- Ensure that groups of employees who might be exposed to stress but might be less likely to be included in the various approaches for promoting mental wellbeing have equality of opportunity to participate. These groups include part-time workers, shift workers and migrant workers.

NICE (2009) also identify a key challenge for mental health at work, which is commonly encountered, in that much activity in this field is centred on large companies and organisations that have HR and occupational health resources at their disposal to assist with

evidence based interventions such as employee assistance, and absence management. NICE recommend collaboration with micro-, small- and medium-sized businesses to offer advice and a range of support and services. This could include access to occupational health services (including counselling support and stress management training). They also recommend establishing mechanisms for providing support and advice on developing and implementing organisation wide approaches to promoting mental wellbeing. They suggest that these could include tools and approaches for: risk assessment; human resource management; and management training and development (NICE, 2009). In Scotland an interesting approach adopted by the Scottish Centre for Healthy Working Lives5 is the coordination of a national award scheme for all
types of organisations (Glass et al., 5 http://www.healthyworkinglives.com/ 2010) which gives employers an opportunity to work towards a Commendation Award in mental health if they choose.

As part of the Black review of workplace health in the UK (DWP, 2008) management consultancy company Price Waterhouse Coopers were asked to review 55 wellbeing programmes in a variety of companies. They found that in general these programmes had a major positive effect on reducing sickness absence, staff turnover, accidents and injuries, and in improving productivity. In addition, seven organisations that were reviewed and used as case studies reported a return on investment for their wellness programmes, in terms of a benefit–cost ratio.

Access to employment for people with mental health problems

In 2009 Rachel Perkins was invited by the Secretary of State of Work and Pensions to lead an independent review of support for people with mental health problems in work. Her work was predicated on three principles: that appropriate employment activities improve mental health; that people with mental health problems can and do pursue successful careers; and that most people with mental health problems who are out of work would like to be in paid employment (Perkins et al., 2009).

The case for supporting people with mental health problems into work appears clear. Firstly, and most importantly, people with mental health problems are as able as anybody else to enjoy the mental health benefits of good work, and most of them want to do so. Secondly, our ability to provide social protection in terms of welfare benefits is challenged, and if people can be supported into work by a flexible benefits system that works with the established evidence for employment support, a cost saving to the public purse is possible (McDaid, 2010).

Activities to reduce stigma and discrimination in the workplace are important in ensuring that the experience of working and seeking work is positive (Perkins et al., 2009; McDaid, 2010).

Health, education and social services and welfare support should be coordinated as much and as early as possible to ensure that employment is discussed early in the course of health treatment. This may require integration

of services and support for workforce development. It is likely that many of those people experiencing mild to moderate mental health problems who are out of work, or at risk of unemployment, would be enabled to return to work quickly through this approach (Perkins et al., 2009; SAMH, 2011).

For many years, supported employment has been a key mechanism for supporting those with mental health problems to find work both in sheltered employment and the mainstream labour market, and it has been shown that these active labour market approaches have the potential to be successful (McDaid, 2010). However, Perkins et al. (2009) call for substantially more support to be offered to those with long term and severe mental health problems to enable their return to work. They recommend tailored support with employment specialists co-located within health and social care services. Across Europe such case management approaches have been shown to be effective in practice (McDaid, 2010).

In recent years a substantial and high quality evidence base has developed for supported employment based on the Individualised Placement and Support (IPS) Model (Burns et al., 2008). IPS is based on a US model of supported employment, predicated on rapid job search and on-the- job support. The single most important factor in the success of IPS is a desire to work on the part of the client. The EQOLISE project (Burns et al., 2008) adapted and imported IPS from the US to a number of European centres and conducted an RCT, which showed that IPS was effective for clients with mental health problems. It found that IPS clients were: twice as likely to gain employment (55% v. 28%); worked for significantly longer thereafter; that the total costs for IPS were generally lower than standard employability services over the first 6 months; and that those individuals who gained employment had reduced hospitalisation rates.

The principles of evidence based supported employment are (Bond, 2008):

- Focus on competitive employment as a primary goal.
- Eligibility should be based on the individual's choice.
- Rapid job search and minimal pre-vocational training.
- Integrated into the work of the clinical team.
- Attention to client preferences is important.
- Availability of time unlimited support
- Benefits counselling should be provided to help people maximise their welfare benefits.
- Employer engagement and job development helps secure job opportunities for clients.

A comprehensive tool for measuring the 'fidelity' to these principles has been developed and provides a consistent quantitative method of assessing progress (Secker et al., 2011). This fidelity scale is used in practice in several areas of the UK.

Whilst IPS is the method of intensive employment support with the strongest empirical evidence to support it, other methods of support such as Clubhouse and social firms have been shown to be effective, particularly as they provide more than simply employment (New Philanthropy Capital, 2012).

Implementing a working well approach.

In 2008 the European Pact for Mental Health and Wellbeing (European Commission, 2008) invited policy makers, social partners and further stakeholders across Europe to take action on mental health in the workplace. The Pact recommended the following broad actions:

1. Improve work organisation, organisational cultures and leadership practices to promote mental wellbeing at work, including the reconciliation of work and family life;
2. Implement mental health and wellbeing programmes with risk assessment and prevention programmes for situations that can cause adverse effects on the mental health of workers (stress, abusive behaviour such as violence or harassment at work, alcohol, drugs) and early intervention schemes at workplaces;
3. Provide measures to support the recruitment, retention or rehabilitation and return to work of people with mental health problems or disorders.

Four years on, these areas of action are still the cornerstones of a successful approach to workplace mental health. Given the current economic climate there is an even stronger case than ever before for prioritising workplace mental health initiatives. Stress is even more relevant, as job security has become a luxury for many and employers struggle to keep businesses afloat. Redundancies may increase the workload of the employees still in their jobs, but the anxiety of job insecurity prevails (Law Society, 2012). In addition, there are growing concerns amongst mental health charities in relation to work capability assessments and the number of people with mental health problems being declared fit for work (RCP, 2011). Although welfare reform is not within the domain of a mental health strategy, there is a compelling ethical argument that a principle of reciprocity should be adopted in ensuring that good quality evidence based employability services are available to support people with mental health problems into employment. This will be challenging in the current economic climate, as stigma continues to prevail and may increase and employment opportunities contract. It is therefore crucial that any approach to employability adopted has a strong alignment with Guernsey's stigma reduction activities.

Mental health and wellbeing in workplaces

There is a strong case for developing a mental health at work programme that acts to support and encourage employers to promote wellbeing and address poor mental health in the workplace. Successful interventions to promote wellbeing, and prevent and manage mental health problems in the workplace require a multi-level approach, involving a combination of actions at an organisation wide and team level as well as measures targeted at individuals (Robertson and Cooper, 2011; Teixeira et al., 2010; Sahler et al., 2009).

Large employers with strong HR support will find this less of a challenge, whereas small to medium sized employers will require additional assistance to enable them to undertake the systemic and cultural changes that may be required. A range of well tested tools are available to support integrated, multi-level programmes (OSHA, 2011).

The ProMenPol database6 provides a range of reviewed tools and support for implementation. (www.mentalhealthpromotion.net) Adopting a whole workplace approach, which starts with promotion of wellbeing for all staff, will assist in promoting resilience but will also create an environment in which support and preventive measures for people experiencing stress or mental health problems at work is possible. Creating a positive and open environment can help to reduce stigma as well as enabling early intervention. A workplace with these systems and approaches in place will be welcoming to those with lived experience of mental health problems, and may provide an opportunity for those moving from employment support to join the mainstream labour market (O'Sullivan and McCollam, 2006).

Making the business case for employers and creating incentives

In addition to communicating the economic arguments for improving mental health in the workplace, it is also important to support employers to recognise that there are strong health and safety imperatives, with the European Agency for Occupational Safety and Health identifying a number of key components of successful workplace interventions such as: a whole workplace approach; strong management commitment; meaningful employee involvement; a designated lead; ongoing evaluation; and effective internal communication. Award schemes have also been found to provide effective incentives in some countries (OSHA, 2011).

Linking organisations and promoting the sharing of resources may assist with provision of support for small and medium sized enterprises that lack HR or access to occupational health services (NICE, 2009).

Supporting people with mental health problems into work

Stigma and discrimination act as major barriers to employment and workplace mental health. As such the workplace should be considered as a critical setting for coordinated stigma reduction programmes (Krupa, 2009; McDaid, 2010).

Anti-discrimination legislation should be applied appropriately to safeguard the rights of those with mental health problems in employment (McDaid, 2010). Organisations may need support to understand the application and relevance of anti-discrimination legislation for mental health and in embedding this within their policies and procedures. Guernsey's stigma reduction programmes should also ensure that a core aim is to support the appropriate awareness

and application of anti-discrimination legislation.

Supported employment programmes should be developed as alongside flexible welfare benefits and enforcement of anti-discrimination legislation these can increase the participation of people with mental health problems in the labour market (McDaid, 2010).

Individualised Placement and Support (IPS) has the strongest evidence base of the supported employment approaches, and to be implemented effectively requires that health, employment support, social care and welfare benefits are closely aligned (Perkins et al., 2009).

A case management approach should be promoted as providing consistent support from a designated professional for the duration of the employability journey enables a client to have continuity of contact, even though other agencies and professionals may be required to provide input over time. This applies both to people with long term mental health problems in supporting their entry to the labour market, and to those newly unemployed and at risk of or already experiencing poor mental health (Rinaldi and Perkins, 2010; Perkins et al., 2009).

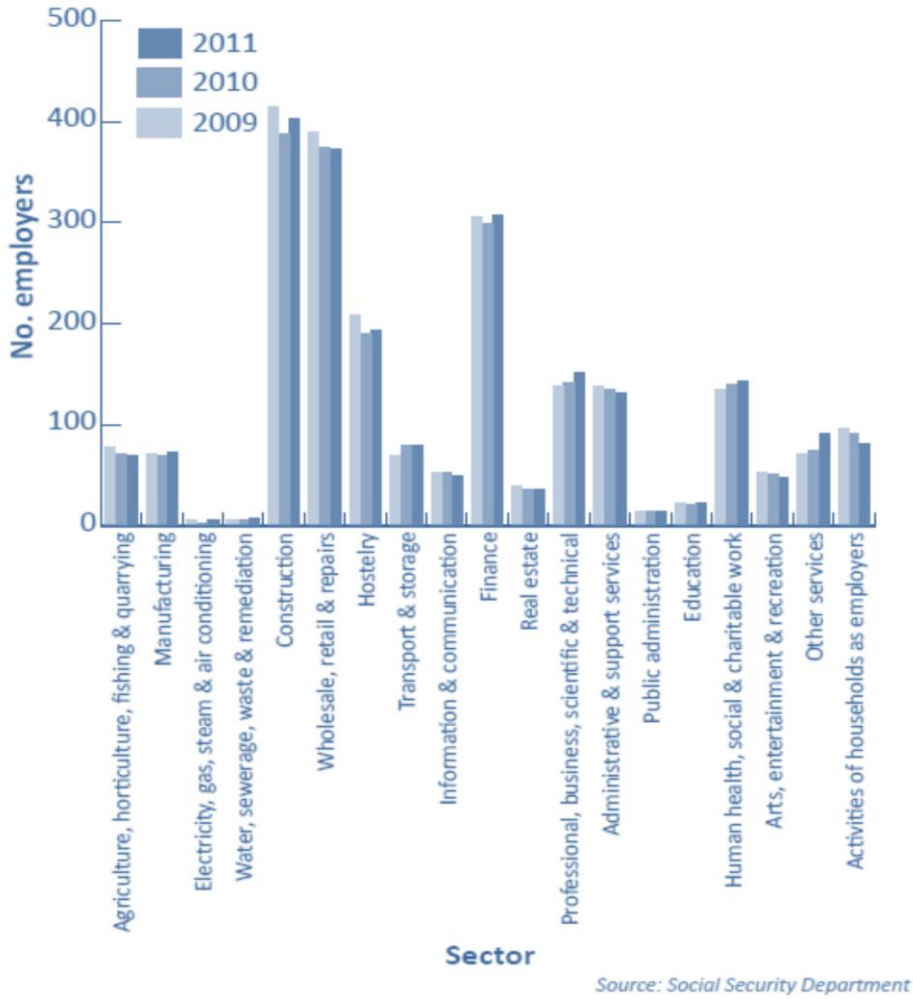
The Local Picture

Employment

The current unemployment rate is around 1%.

Since the 1980s traditional employment in agriculture and horticulture has decreased markedly with very few commercial growing businesses left on the Island. There is considerable reliance upon the finance sector and service based industries. Employment practices and experiences are changing dramatically. It is no longer the expected norm that individuals can expect a “job for life” and are more likely to have a series of careers.

Employing organisations by sector at March each year



Source: Social Security Department

Workshop findings

Employers who attended the workshops indicated that they do not know enough about how employment impacts on wellbeing and mental distress.

Employers commented that some young people seeking employment after leaving fulltime education do not have the necessary literacy skills or attitude required.

Employees and service users commented that employers want to know how to support employees with mental health problems – if they are valuable to the organisation. Some service users felt that some employers had little interest in supporting non-essential staff who have mental health problems.

The changes in occupation and industry base present a challenge for return to work schemes. Historically it has been possible to secure practical work experience, but this is proving more difficult with the changing picture of employment and the current economic climate.

The Guernsey Mind Employment Project

The Guernsey Mind Employment Project aims to promote best practice to support both employers and employees locally. Beginning in March 2011, it is a two year project during which employers and employees/potential employees from a range of sectors will be able to access information, support, seminars and intensive training on issues of common concern related to mental health in the workplace. It will identify inexpensive, simple measures to support staff wellbeing that have been shown to save up to 30% of possible costs. It will highlight the adoption of a mental health policy as a key factor in preventing people taking time off work because of their mental health and in getting existing staff back to work smoothly.

In Guernsey in 2010, 33% of the people receiving Invalidity Benefit were people with mental health issues so this is a big issue locally. Also, with no Disability Discrimination employers have to act on their own initiative to adopt reasonable adjustments to help individuals stay in work. This project aims to help them do this.

In 2011 a core organising group was established for the network, and the project developed example policies for mental health and wellbeing, and produced a leaflet signposting local services and supportive websites. It held the first seminar in September 2011 on 'The Business Case for Mental Wellbeing in the Workplace'. This seminar for over 30 employers explored the financial benefits of adopting a mental health and wellbeing policy, identified how to make business more mentally healthy and offered practical advice on services that are available locally. . As a result of the seminar Guernsey Post adopted one of our mental health policies.

In 2012 the project will create a bespoke training package for 'Mental Health in the Workplace, which will be delivered in-house to local employers. This training is being piloted in February and April 2012 to The Guernsey Post and will be more widely disseminated after this. There will be two seminars for local employers with expert speakers on mental health in the workplace work will start on the development of the Guernsey Employment Network for Mental Health in 2013.

In the long term the project aims to develop a **Guernsey Employment Network for Mental Health** where employers can meet regularly to share experiences and ideas, have access to information and advice, and meet with local employment support agencies. It will also continue to offer bespoke training for employers and encourage the development of a training and support network for people experiencing mental health issues. This shouldl make it easier for people with mental health issues to stay in or return to work and for employers to develop practices that support and make the best use of experienced individuals who also happen to have a mental health issue.

Guernsey mental health strategy: implications for social welfare

Mental health and social welfare policy and practice are inextricably linked. The way either topic is approached will inevitably affect the other. Strategies aimed to promote mental wellbeing, prevent mental illness and support recovery for people with mental health problems will have an impact on welfare systems. Likewise changes to welfare policies have a direct impact on population mental health and the lives of people with mental health problems.

The draft strategy recognises these connections. It notes that in 2011 almost one-third of people receiving invalidity benefit on Guernsey had a mental health related primary cause of disability, and it recognises that unemployment is a major risk factor for both mental and physical ill health. Thus the health, welfare and employment systems are inter-dependent and integrating these systems to meet people's needs will be beneficial to them all (as well as the people they serve).

This short paper looks at the potential impact of the draft strategy on the welfare system based on what we know to date about the links between the two issues from experience in the UK and internationally.

Overarching themes

Three of the proposed overarching themes in the draft strategy have particular resonance for this issue:

Ensuring that all States staff have a basic understanding of mental illness is critical. Many people with mental health problems, and the parents of younger children, approach non-mental health professionals to seek help. These often include GPs and teachers.

Understanding of mental health issues in workplaces can also have a significant impact; particularly in enabling line managers to respond positively and supportively when people become unwell. States employers can lead by example by demonstrating the business benefits of responding well to mental ill health, and reducing the risk of employees drifting towards unemployment and long-term sickness through a lack of workplace response early on.

Developing **a model of recovery and re-ablement** for people using mental health services should generate major benefits for the welfare system. Ensuring that people who wish to take up opportunities for paid work are offered the best possible support to fulfil their potential will over time generate financial benefits both for the welfare system, and within the health service (as demand for clinical services gradually falls).

Building recognition that **mental health is everyone's business** is vital for the success of any modern mental health strategy. Health and social care services cannot act alone in improving the mental health of the workforce

and enabling more people with mental health problems to gain and retain paid work. They need to work alongside and in close collaboration with employment services, employers, housing providers and other key services to achieve better outcomes.

Working well

The strategy sets out six key actions, grouped under three headings, to support 'working well' in Guernsey. The potential implications of these are discussed briefly below.

1. **Promote** a mentally healthy workplace.

As the draft strategy notes, the cost of mental ill health in UK workplaces is about £1,000 for every employee in the workforce. Effective efforts to promote wellbeing and prevent illness may therefore reduce this cost to business and its consequent exchequer cost in long-term sickness and lost work. The evidence base for interventions to promote mentally healthy workplaces is still emerging but many of the most effective means of promoting wellbeing are relatively low-cost or involve changes to routines and practices in the workplace. Such measures can improve productivity by reducing absenteeism, presenteeism and staff turnover; all of these reduce the risk of long-term sickness absence and job loss and consequent spending on welfare benefits.

2. **Support** employers through information, help and advice, and training.

While efforts to promote healthier workplaces are important, it will be impossible to eradicate mental ill health from the workplace. Only 15% of mental ill health in the workforce is caused by work-related stresses. It is therefore crucial that employers are aware of how to respond effectively when staff become unwell for whatever reason: mental ill health in the workplace is equally damaging economically and socially whatever the cause. The role of the supervisor or line manager is especially important: managers who respond sensitively, confidently and helpfully when people seek help or show signs of distress can reduce the costs to their employer by encouraging the individual to seek treatment; by keeping them at work if possible, with adjustments where necessary; and by enabling a successful return to work if they need to take time off. Centre for Mental Health's workplace training programme has demonstrated that line manager training can improve their understanding of mental health at work and help them to respond appropriately when this is required. Again, this should reduce later costs in welfare benefits.

3. **Act** to support a return to work.

People using specialist mental health services have an employment rate in England of about 12%. Yet there is evidence that a much larger proportion would like the chance to do paid work. This should be seen as a key pillar of

supporting recovery for people with a mental illness – while not all service users will want or be able to work at any given time, no one should be denied the opportunity to try. The most important indicators of employability among people with a mental illness are not diagnosis or severity of their condition but their motivation and belief in themselves.

There is now clear evidence that with the right support up to two-thirds of people using mental health services can take up employment. The Individual Placement and Support (IPS) approach is able to achieve these rates of employment outcomes but only where it is implemented faithfully. Among the key elements of fidelity to IPS are that clinical and employment support are integrated, and preferably co-located. This has major implications for both health and employment services: working together to support the individual on their journey to work is vital to achieve the best results. Where the two systems do not work together, or work at cross-purposes, they will not achieve improvements in either health or employment outcomes.

The IPS approach also emphasises rapid job search, based on the person's preferences, followed by time-unlimited support for them and their employer when they get work. Again, this has implications for health and employment services: it requires a shift from a focus on pre-employment training and sheltered work activities, to helping people find and keep real work opportunities for as long as it takes.

Research by Centre for Mental Health has found that IPS costs no more than traditional day and vocational services but by achieving better employment outcomes it reduces the costs of health care over time as well as creating new taxpayers. Many people's journey to employment starts with working for a few hours a week or intermittently. This reduces the immediate impact on welfare spending; however the overall benefits of employment will be considerable.

For people who are not using specialist mental health services but facing job loss or long-term sickness, timely access to psychological therapy can be an important part of their recovery journey. Psychological therapies alone, however, have not been found to facilitate a return to work; they need to be provided alongside specialist employment advice and support, for example to enable the individual to manage their condition and negotiate any adjustments with their employer.

Strategic Priorities

To improve the knowledge of the benefits of wellbeing in the workplace with employers.

To increase the work opportunities for people recovering from mental illness.

This will be achieved by:

- The provision of information and advice to employers.
- Providing targeted support to people in long term unemployment.
- Continued dialogue with employers.
- The identification of 'workplace champions'.

In Summary

What does the research say?

There is a clear link between workplace stress and poor wellbeing, and advice on stress at work encourages organisations to measure as well as tackle stress.
Actions to improve mental health therefore need to recognise the role of employment and in doing so key benefits may include:

- Increases in productivity.
- Improved workforce resilience, reducing the absenteeism (and presenteeism) associated with stress and mental health-related illnesses.
- Improved quality of life and reduction in benefit dependency for people furthest from the labour market, including people with long-term mental health problems.

In 2008 the European Pact for Mental Health and Wellbeing invited policy makers, social partners and further stakeholders across Europe to take action on mental health in the workplace. The Pact recommended the following broad actions:

- Improve work organisation, organisational cultures and leadership practices to promote mental wellbeing at work, including the reconciliation of work and family life.
- Implement mental health and wellbeing programmes with risk assessment and prevention programmes for situations that can cause adverse effects on the mental health of workers (stress, abusive behaviour such as violence or harassment at work, alcohol, drugs) and early intervention schemes at workplaces.
- Provide measures to support the recruitment, retention or rehabilitation and return to work of people with mental health problems or disorders.

Stigma and discrimination act as major barriers to employment and workplace mental health. As such the workplace should be considered as a critical setting for coordinated stigma reduction programmes.

The Guernsey picture

Guernsey has a very low unemployment rate, which is usually around 1%.

Employers have acknowledged that they know little about mental wellbeing, or the impacts of employment on wellbeing and mental distress, but want to know more. Employers recognise that sickness absence and turnover rates can be measured to indicate levels of stress in the workplace.

Employers commented that some young people seeking employment after leaving fulltime education do not have the necessary literacy skills or attitudes required.

Employees and service users commented that employers want to know how to support employees with mental health problems – if they are valuable to the organization. Some service users felt that some employers had little interest in supporting "non-essential" staff who have mental health problems.

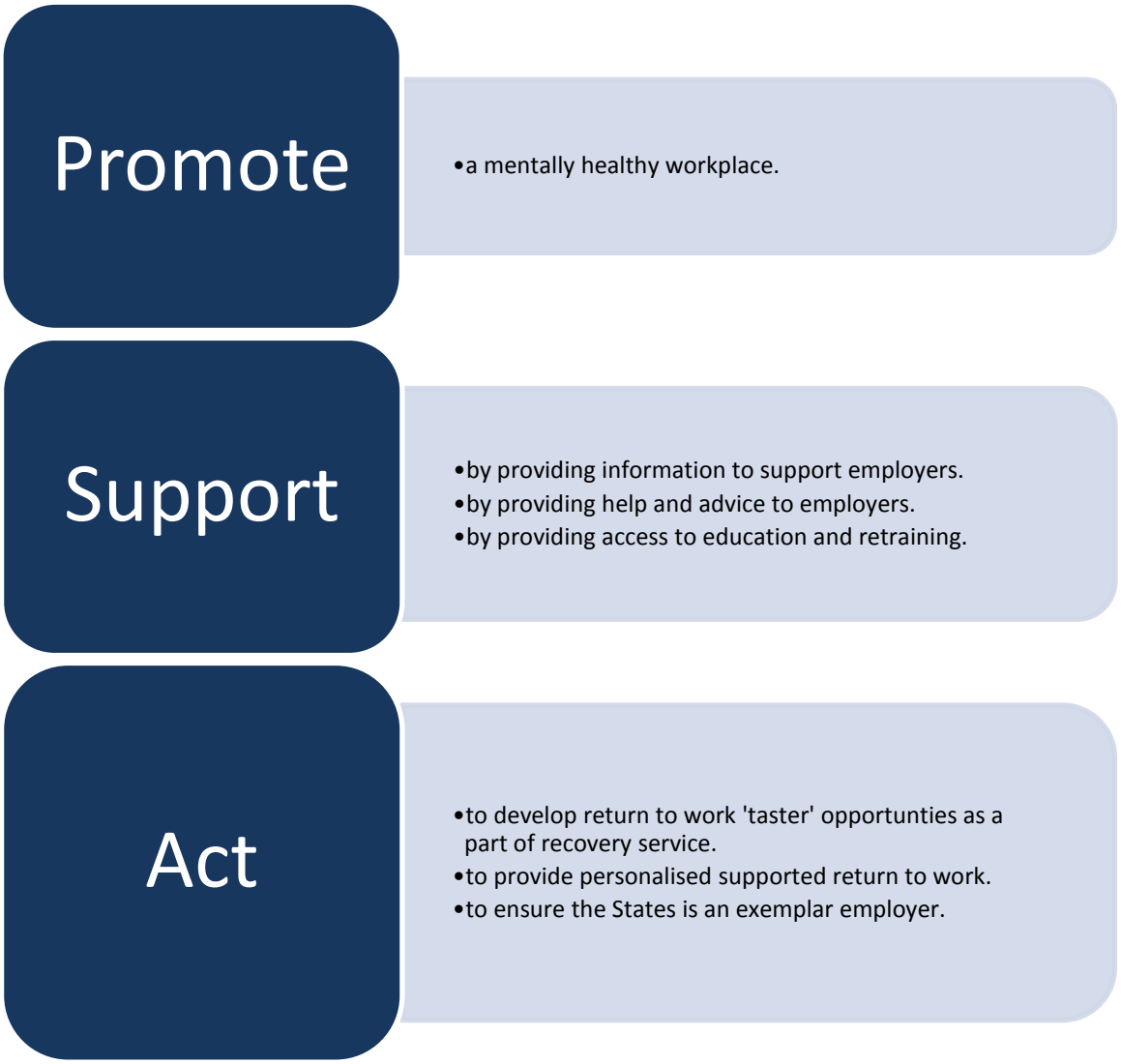
Interwork Services and the Social Security Department both provide supported employment and training opportunities for people with mental conditions. However, it is proving more difficult to find workplace supported employment schemes.

The Guernsey Mind Employment Project aims to promote best practice to support both employers and employees locally, through mental health awareness training and the Guernsey Wellbeing in Employment Network, among other initiatives.

What will we do?

- Promote the benefits of a healthy workplace.
- Provide opportunities for employers to improve knowledge and understanding that will break down stigma and provide a wider scope for supported employment.
- Identify opportunities to present a positive view of people who have mental health problems.
- Encourage the States to promote mental wellbeing as an exemplary employer.
- Providing targeted support to people in long term unemployment.
- Maintaining an open dialogue with employers.
- Identifying 'workplace champions' for mental wellbeing.

A three strand approach to working well



8. Ageing Well

Strategic Vision

Active ageing with good mental wellbeing is supported by enhancing independence including protecting income, reducing the risk of poverty in old age, supporting workplace retention and preventing early retirement due to ill health. One of the most powerful strategies to promote mental health and wellbeing in old age is the prevention of loneliness and isolation in which support from families and peers and the wider community plays a key role. The risk of depression is reduced and the protection of cognitive function in old age enhanced by encouraging regular physical activity in social settings.

Ageing and mental health and wellbeing

Growing older is the development process that people experience from conception. It is a multi-dimensional process, encompassing physical, psychological and social dimensions. It is important to keep in mind that "…older people are exactly that – people who have grown older." (McCulloch, 2009, p.9).

However, frequently held views of ageing see it entirely as a negative process of physical and mental decline, even if later life can also be a time for growth and development. As the Guernsey Emotional Wellbeing Survey illustrates, older people may experience improved life satisfaction. Moreover, symptoms experienced by people who have been living with mental illness may also improve. Other advantages of ageing include increased self-acceptance and confidence and more time to focus on personal priorities.

Older people are part of the solution to the "problem" of an ageing society. Acknowledging the skills and contribution of people over 65 and supporting opportunities for their active engagement is a major aspect of maintaining wellbeing in later life.

Mental health and the life course

Mental health in later life is affected by people's life experiences and the advantages and disadvantages they accrue (McCulloch, 2009). Good mental health is important for a successful old age, as it enables older people to enjoy old age, and also to cope with bereavement, physical illness and other difficulties; enables them to continue to make a contribution economically and socially; may help reduce the impacts of long term physical conditions such as cardiovascular disease and diabetes; and can help people protect their mental functioning and capacities.

Risk factors

Later life creates challenges, as people experience physical disability, illness, loss of loved ones and loss of wider relationships (Godfrey et al., 2005). Risk factors for

experiencing mental health problems, such as depression and anxiety, include:

- **Chronic ill health and disability** are consistent risk factors. Prevalence rates of mental ill health are around double for people suffering ill health and disability compared to healthy people: chronic ill health is an age-related risk. Pain and the loss of functional ability are key factors. This in turn, may link to increasing **isolation,** which is itself a significant risk factor. Depressive symptoms may in turn, lead to increased disability.
- **Physical inactivity**. A low level of physical activity is a risk factor for depression and depressive symptoms.
- **Daily stressors** may be significant. For example, dealing with daily tasks that become more difficult because of disability, or were previously done by a deceased spouse.

There is evidence that such cumulative and on-going stressors may be more significant than major life events and that people in lower socio-economic groups may be more vulnerable.

Caregiving

For some older people caregiving (the provision of regular assistance with daily living) may be a risk factor. In particular, there is evidence of depression and anxiety in caregivers to people with dementia and chronic illnesses. Some key factors differentiating those at risk were role overload (being physically or emotionally depleted by caregiving), role captivity (feeling trapped by responsibilities) and higher levels of behaviour problems. Subjective burdenor perceived strain, is the most significant risk.

Life events

This includes recent negative events, such as the loss of close social relationships, severe illness of self or other, and being a victim of crime or sudden unexpected events. It also encompasses the accumulation of negative events over life that give rise to stress and increases the risk of depression.

Bereavement: most older people who experience the death of a close relative are able to manage the stress and adjust to a different life. However, a significant minority suffer complicated grief reactions which may lead them to become chronically ill, with impairments in general health.

Social, relational and contextual factors are significant in explaining different experiences.

Retirement and other transitions: retirement brings opportunities but can also lead to loss of a valued role and status, as well as anxieties about managing on a reduced income (including the actual experience of poverty, especially for women). Patterns around retirement are changing and becoming more transitional. Evidence indicates that depressive symptoms are greatest when retirement is abrupt or forced.

Age: epidemiological evidence suggests that while major depression declines with age, depressive symptoms increase – the result of age-related changes in risk factors rather than ageing itself. These factors include

deterioration in health and activities of daily living, poor current health, poor social support, and low current activity levels.

Loneliness in older age is linked to the depletion of relationships and is a risk factor for emotional and physical health problems.

Gender: women are more likely to experience depression and anxiety disorders than men.

Ethnicity: it is likely that older people from minority ethnic communities are at greater risk. In addition to the stresses experienced by older people generally, they have additional life experiences that may increase the risk for common mental health problems.

Socio-economic situation: while ill health and disability have been identified as risk factors for depression and anxiety in older age, people from poorer socio-economic backgrounds are at much greater risk of experiencing poor health, and therefore more likely to suffer from these mental conditions.

There is also evidence that some of these factors may be linked to the development of dementia.

Protective factors

Factors protecting people against experiencing depression and anxiety that may buffer the risk or mediate its impact include:

- Factors internal to the individual: self-esteem, self-efficacy and mastery in managing stress are important internal resources. Low self-esteem is a predictor of stress. The effects of illness and disability are mediated by how people master them. There is evidence that maintaining a positive sense of self is rooted in people's relationships, activities, interests and social responsibilities and their continuing ability to control their lives and see meaning in them. As people get older a broad interest in other people seems to protect self-esteem.
- Social relationships and support, and participation in life. People's access to social ties and the support they provide can moderate stress and maintain life satisfaction. The availability of close confiding relationships is associated with higher morale and lower levels of loneliness and social isolation. Life satisfaction, satisfaction with ageing and feeling good about oneself, particularly linked to social relationships and social participation, are preventive factors. Evidence indicates that perceived social support rather than its actual level, closeness, shared confidence and mutual support are important in preventing depressive symptoms. Engagement in social activities has been shown to have an impact in preserving functional ability and mental health. Friends are essential for support; it is the interaction with friends rather than contact with family that best sustains wellbeing in older age. Reciprocal help and interdependence give a sense of purpose and meaning to people's lives. This includes the benefits of volunteering and befriending by older people.
- Neighbourhood and community. Neighbours are an important community resource for older people, and the neighbourhood is a context in which socially supportive relationships can be established. Physical and social

environment are both important. The design of houses and accessibility of shops, services and transport may affect the opportunities for social interaction. Lack of maintenance of buildings and public spaces, and environmental problems such as traffic noise and pollution can be daily stressors. The concept of social capital is used to define the characteristics of neighbourhoods'. The resource offered by older people in developing a sense of community in a local area, including building intergenerational links, can be an important element in creating strong neighbourhoods.

Mental health and mental wellbeing

Mental health seems to be closely bound to peoples' self-perception, how they feel they are coping with daily life, and with their physical health. Quality of life, or mental wellbeing, bears a strong relationship to the issues that contribute to good mental health. Mental wellbeing broadly summarises how good a person's life is overall. Factors that promote mental wellbeing in later life include meaningful activity, relationships, physical health, and financial security. Some aspects of life can reduce older people's wellbeing (Campion, 2010).

- Work: there is evidence that people experience leaving work in different ways. Employment after retirement age is associated with positive mental wellbeing; however, positive wellbeing is also experienced by many people as they leave employment. Unemployment is linked to lowest levels of wellbeing. Issues raised here concern choice and flexibility.
- Poverty: low socio-economic status is associated with poor quality of life.
- Living environment: housing quality, transport, access to facilities including shops, leisure services, health services, community safety, and local community affect quality of life and wellbeing.
- Families and relationships: people living with partners usually express greater satisfaction with life.
- Natural environment: parks, open spaces and clean environments have a positive impact on wellbeing.

Mental illness in later life

The three mental health problems with greatest significance for older people are depression, delirium, and dementia. The prevalence and thus the importance of these conditions is not captured by the Guernsey Emotional Wellbeing Survey, either because of the measures used or the coverage of the survey. The Royal College of Psychiatrists have produced a mental illness prevalence assessment for the UK (Anderson et al., 2009). For a population of 10,000 people aged 65+, 2500 will have diagnosable mental illness of which 1350 will have depression, 500 will have dementia (333 not diagnosed), and 650 people other mental illness. Guernsey's population aged over 65 is slightly higher than 10,000, therefore these figures are likely to provide a good indication of prevalence of these conditions on Guernsey in this age group.

Depression

Depressive illness, comprising both major depression and sub-threshold depression, is now widely acknowledged to be the most common mental health problem among older people; estimated prevalence rates are three times those of dementia. The exact prevalence is a subject of debate with variability in estimates reflecting many factors, including definitions and diagnostic instruments used (Wilson, 2008). The estimated prevalence of major depression in older people across six international community-based studies was reported at 1.8%; the average for major-plus-minor drawn from 28 studies was 13.3% (Beekmann, 1999). A more recent review of sub-threshold depression in 181 studies of adults aged over 55 found a prevalence of 10% in community settings, 25% in primary care, 30% in hospital inpatients and 45–50% in long term institutional care settings (Meeks, 2011).

The Central European Ageing Study (Geiselmann, 2001) concluded that although sub-threshold depression may be milder than specified forms of depression, its high prevalence makes it a health care problem. The following prevalence levels were identified in people aged 70–100+:

- Major depression: 4.5%
- Sub-threshold depression: 16.5%
- At least one depressive symptom experienced at least once in four weeks: 9%

While the degree of impairment in sub-threshold depression is less severe than that associated with major depression (Chew-Graham, 2008a), it is quite comparable to that of other medical conditions (Wells et al., 1992). Sub-threshold depression may represent early manifestations of major depression or partial remission of unrecognised major depression; it presents a risk for development of major depression (Broad et al., 1987).

Many studies provide evidence that later life depression is under-diagnosed and under-treated. A large number of older people are defined as sub-threshold, which may result in an insufficient detection rates both in surveys and in primary care. The symptoms of depression experienced in older people differ from those seen in younger people. Compared with younger people, older people with depression are less likely to complain of low mood and reduced enjoyment, and more likely to have disturbed sleep and appetite and also to be experiencing anxiety (Chew-Graham, 2008b).

The Health Survey for England found that 40% of older people who visited their GP had a mental health problem. Longitudinal studies have suggested that the age gradient for depression is steepest beyond age 70 (Green and Benzeval, 2011). Apart from suffering, family disruption and disability, depression in older people worsens the outcomes of many physical illnesses and increases mortality (Alexopulos, 2005).

Most older people with depression are treated in primary care settings (Alexopoulos 2005). However, primary care doctors rarely diagnose depression and, when they do, may provide inappropriate treatment. Some of the barriers

to successful treatment include doctors' reluctance to discuss emotional problems, time constraints, and medical co-morbidity. From the patient's perspective the perceived stigma of mental health problems may lead to reluctance to initiate treatment.

Anxiety

Estimating anxiety prevalence poses a number of difficulties, in particular the frequent co-existence of anxiety with depression, especially in later life. Incidence that meets diagnostic criteria is around 2–4% of people over 65 (Godfrey, 2009), but about half of older people with depression suffer with anxiety. The interactive effect of these two conditions increases the distress and the likelihood of poor outcomes.

Suicide

Suicide is a significant risk of non-treatment of depressive illness. The suicide rate of people over age 65 is double that of people under 25 in the UK. Most older people who succeed in killing themselves have consulted a GP in the previous month. Self-harm in the over 65 age group represents failed attempts at suicide (Dennis, 2009) and may include self-neglect, for example, dietary self-neglect. 70-90% of people who self-harm suffer from depression, are often socially isolated, and have poor physical health. There are high rates of subsequent completed suicide amongst them.

Psychoses

Psychotic symptoms are seen in older people in many conditions. Prevalence in the community has been found to range from 0.2–4.7% and in nursing homes from 10– 63%. A three-year study of very old people without dementia found a prevalence of 7.4%, including hallucinations (6.7%) and delusions (0.6%) (Ostling, 2007). A number of factors have been considered to contribute to increased risk including social isolation, sensory deficits, cognitive decline, polypharmacy and age related pharmacodynamic changes. As with dementia, there are concerns about the safety of using antipsychotic drugs in this group and the focus is on other interventions including CBT and psychosocial therapies (Karim & Byrne, 2005).

Schizophrenia is more common in early adulthood than in later life. Around 0.5% of people over 65 have schizophrenia and around three quarters of them developed it in their teens or twenties; about 10% develop the condition after age 65. Women are more likely than men to develop schizophrenia late in life, and at older ages around two thirds of people with schizophrenia are women (McNulty, 2003). This reflects both preponderance of late onset among women and also the poorer outcomes, including high incidence of comorbid conditions for men with schizophrenia. Schizophrenia and bipolar disorder often occur with other mental health problems, including depression, alcohol and drug problems. Mortality rates are higher for people with schizophrenia, with links to physical health problems, such as cardiovascular disease and diabetes.

Delirium

Delirium (acute confusion) affects up to 50% of older people admitted to hospital and is significantly more common in people over 65 and people with dementia. Causes are usually physical in nature, including infection and dehydration. The risk of developing delirium is three times higher over age 65, rises rapidly with increasing age, and is five times more common in older people who have dementia. It is associated with increased cognitive decline and increased risk of medical complications including infection, falls, and incontinence. The condition increases mortality, disability and length of hospital stays. Like many mental health conditions of older people, delirium is often undetected and untreated. It is however both preventable and treatable. The British Geriatric Society and the Royal College of Physicians have produced guidelines for the prevention, diagnosis and management of delirium.

Drugs and alcohol misuse

Alcohol and benzodiazepines are the most common substances misused by older people; over-the-counter drugs, such as analgesics and cough medicines, may also be misused. Some later life symptoms, such as falls, confusion, incontinence and failure to cope, may be attributable to such misuse; however, the UK experience is that questions about alcohol and drugs are not often asked. The Adult Psychiatric Morbidity Survey in England (2007) found that 1.7% of men and 0.5% of women aged 65-74, and 1% of men over 75 were harmful drinkers. In terms of drug use in the past year, 0.3% of people aged 65-74 and 0.5% aged over 75 had used cannabis; 0.6% and 0.3%, respectively, had used tranquillisers. Figures for other drug use are less easily available.

Cognitive health

Three types of cognitive change are recognised in late life: normative cognitive ageing, cognitive impairment, and dementia (Hughes and Ganguli, 2009).

Normative cognitive ageing

Psychological changes occur throughout life. The brain decreases in weight and volume by two per cent per decade. In the same way that people experience age-related changes in physical functioning they may also experience changes in cognitive functioning. Verbal, numerical and general knowledge abilities are generally well retained as people grow older, and well-practised skills show little decline. Aspects of memory, reasoning, speed of information processing and executive function may decline. Such declines are not of the same order as dementia or mild cognitive impairment, and are better considered as characteristics of ageing. There is a large variation in cognitive changes between people indicating that decline is not inevitable (Deary and Gow, 2008). Variation between individuals and the factors affecting cognitive ageing are the focus of current research, with the aim of promoting successful cognitive ageing.

Cognitive skills and mental health are intertwined (Richards & Hatch, 2011). Cognitive decline and depression often coexist and cognitive capability and mental wellbeing can

be mutually self- supportive. The concept of 'mastery' describes the development over the life course of a belief in the ability to manage important life circumstances and a sense of personal control. Mastery can be undermined by factors such as serious illness, and it declines in old age. In later life people channel cognitive resources away from goals, such as making a living or supporting a family, towards maintaining emotional stability in the face of negative events.

Mild cognitive impairment

Mild cognitive impairment and cognitive impairment without dementia are considered intermediate states between normal cognitive ageing and dementia, where individuals experience cognitive deficits greater than expected for their age (Hughes and Ganguli, 2009). There is a risk of progression to dementia with both these conditions.

Dementia

Dementia is qualitatively and quantitatively different to normal cognitive decline in the pattern of decline across cognitive abilities (Deary, 2009). People with dementia often exhibit changes in behaviour and other aspects of mental state, decline in carrying out daily living activities and loss of episodic memory. There are, nevertheless, difficulties in distinguishing between normative and non-normative ageing in advanced old age.

The most common subtype of dementia is Alzheimer's disease (62%), followed by vascular dementia (17%), and mixed dementia with both degenerative and vascular pathology (10%), and others (11%). Dementia can affect people of any age but is most common in older people. The way each person experiences dementia, and their rate of decline, will depend on many factors, including their physical make-up, emotional resilience, and the support that is available to them. It is estimated that only around a third of people with some form of dementia in the UK are clinically diagnosed (National Audit Office, 2007).

Dementia prevalence increases with age (Knapp, 2007); it is found in

- 1% of people aged 65-69
- 3% of people aged 70-74
- 6% of people aged 75-79
- 12% of people aged 80-84
- 20% of people aged 85-89
- 29% of people aged 90-94
- 33% of people aged 95+

The risk of Alzheimer's disease evolves throughout life, and the risk factors include childhood poverty with inadequate nutrition, overcrowding and poor housing, poor schooling, risky lifestyles, and chronic stress (Richards and Brayne, 2010). The life course is also associated with exposure to physical diseases. Evidence is growing that cerebrovascular disease plays a causal role. Thus the accumulation of cardiovascular risk factors, such as obesity, hypertension and hypercholesterolaemia also builds a risk for Alzheimer's. Low physical activity, smoking, poor diet and heavy drinking are lifestyle-related risk factors. There is little evidence that depression is a risk factor for dementia (Tsopelas, 2011).

Developing effective interventions

Emerging evidence indicates that depressive symptoms and depression in older people can be treated and prevented by psychosocial interventions (Rodda, 2011). The design of care services for older people needs to recognise the importance of providing access to meaningful social activities and possibilities for peer group support. Depression in older adults can be prevented by addressing risk factors and strengthening protective factors.

Psychosocial interventions often include group discussions and exchanges of experiences. Social support has been identified as the most effective intervention in reducing depressive symptoms among older adults (Jané-Llopis et al., 2003). Studies also show that psychosocial interventions aiming to increase the social contacts of the older participants tend to improve mental wellbeing as the feelings of loneliness are reduced (Stevens and Tilburg, 2000). These friendship programmes often attract older women living alone and are therefore targeting a major risk group for depression.

Studies have demonstrated that time-limited, small group-based, psychoeducational and skill training interventions have an impact on depressive symptoms and quality of life (Coon et al., 2003). These can have a focus on emotional problem management, e.g. depression or anger management, and lead to a significant increases in self-efficacy in negative thought management among the older adults. The interventions need to be customised for older adults possibly suffering from various functional limitations. For example, offering information about available professional aids, support and promotion of personal resources and advice on coping strategies (Wahl et al., 2006).

Cognitive-behavioural therapy can be an effective treatment of depression in older people, but is rarely prescribed. CBT has been shown to be equally effective with older people as with younger people (Cuijpers, 2007). Evans (2007) identifies the need to challenge myths about ageing as part of therapy.

Depression worsens the course of chronic physical illness. The efficacy of both pharmacological and psychosocial treatments for depression across a range of chronic medical conditions has been demonstrated (Simon, 2001).

Integrated care for chronic physical illness and depression in reducing disability and improving quality of life has shown positive results (Von Korff, 2011).

Collaborative care: In the UK 90% of older people with depression do not see a specialist. The best results for managing later life depression come from multi-faceted interventions and collaborative care (Chew-Graham, 2004).

Models for older people's services

The Royal College of Psychiatrists (Anderson et al., 2009) has identified approaches that work in services for older people, based on an evaluation of good practice.

Liaison psychiatry services for older peoplebased in a general hospital lead to reduced admissions, faster assessment and fewer inappropriate admissions to hospital.

Crisis resolution home treatment: to manage people in crisis without hospitalisation. This approach can be effective in retaining people at home, and carers are overwhelmingly positive.

Care home liaison: specialist older people's care home liaison to deliver person-centred care and training to registered care homes. There is evidence that this results in reduced admission to hospital and better quality of care.

Mental health promotion

Mental health promotion refers to any activity or action that strengthens the mental health and wellbeing of individuals, families, and communities (Milne, 2009). Mental health promotion activities tend to be effective when targeted either at a specific population group (e.g. all older people), individuals at risk (e.g. disadvantaged older people, bereaved people), or people with existing mental health problems (people with dementia).

Maintaining a positive sense of self, maintaining physical function, engagement in physical activities, and participation as valued members of family or social networks are essential to older people's mental wellbeing. The losses that accompany old age present a risk by stunting people's opportunities to fulfil these needs. Interventions geared towards reducing the impact of such losses are likely to support or promote wellbeing, in particular those linked to bereavement or acute illness, including the first diagnosis of dementia.

The National Institute for Clinical Excellence (NICE, 2008) public health guidance 16 recommends:

Interventions to provide support and care services for older people in community or residential settings with the aim of increasing older people's knowledge and awareness of where to get reliable information and advice on a broad range of topics. These may include: meeting or maintaining healthcare needs (e.g. eye, hearing and foot care); nutrition (e.g. healthy eating on a budget); personal care (e.g. shopping, laundry, keeping warm); staying active and increasing daily mobility; getting information on accessing services and benefits; home and community safety; and using local transport schemes. The aim should be to deliver regular sessions that involve older people as experts in maintaining their own quality of life.

Physical activity through tailored exercise and physical activity programmes including dancing, walking and swimming; strength and resistance exercises, and toning and stretching exercises, reflecting the preferences of participants.

Walking schemes: It is recommended to offer a range of walking schemes of low to moderate intensity with sessions lasting about an hour and including 30-40 minutes of walking; and to promote regular participation.

Training health and social care professionals, domiciliary and residential care staff and support workers, including the voluntary

sector, in the principles and methods of occupational therapy and health and wellbeing promotion. Developing effective communication skills to engage with older people and their carers is also important.

The Mental Health Foundation (MHF, 2011) has produced a 10-point action list to help people protect their mental health in later life:

- Be prepared for changes
- Talk about problems and concerns
- Ask for help
- Think ahead and have a plan
- Care for others
- Keep in touch
- Be active and sleep well
- Eat and drink sensibly
- Do things you enjoy
- Relax and have a break

Long-term carers are at particular risk of mental ill health. Proactive help for carers, particularly when the cared-for person dies or enters residential care, can help prevent them feeling emotionally and socially adrift (Milne, 2009).

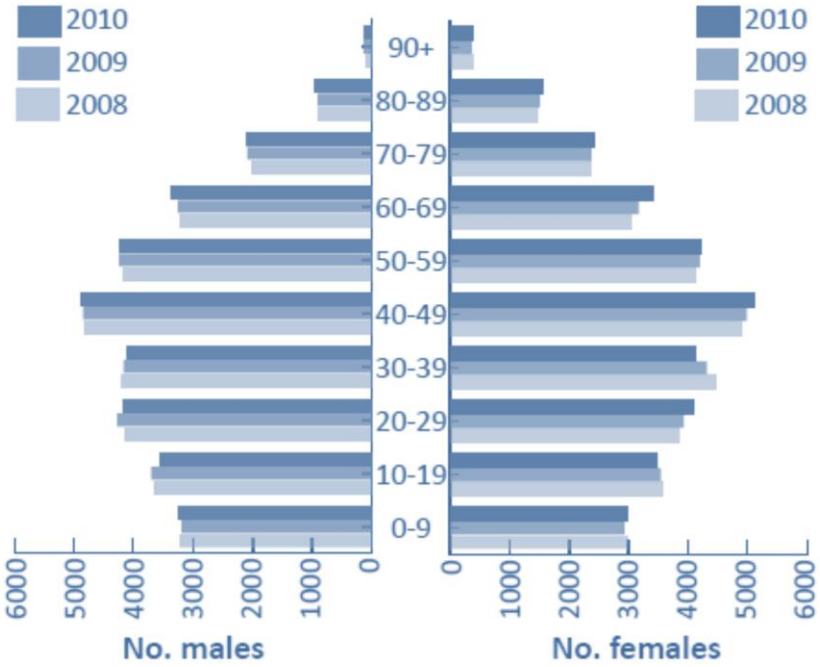
Older men are also often less likely to engage in activities to protect their mental wellbeing. An MHF project, (Grouchy Old Men 2010) has identified some points to be considered in engaging with men.

A review of the impact of participatory arts on older people (2010) identified increased confidence and self-esteem amongst participants, with added value gained from performing to an audience in terms of feelings of accomplishment. Community arts initiatives may be particularly important in counterbalancing the mental wellbeing difficulties associated with periods of loss. For people with dementia, participatory art can help improve cognitive functioning, communication, self-esteem, musical skills, pleasure, enjoyment of life and memory.

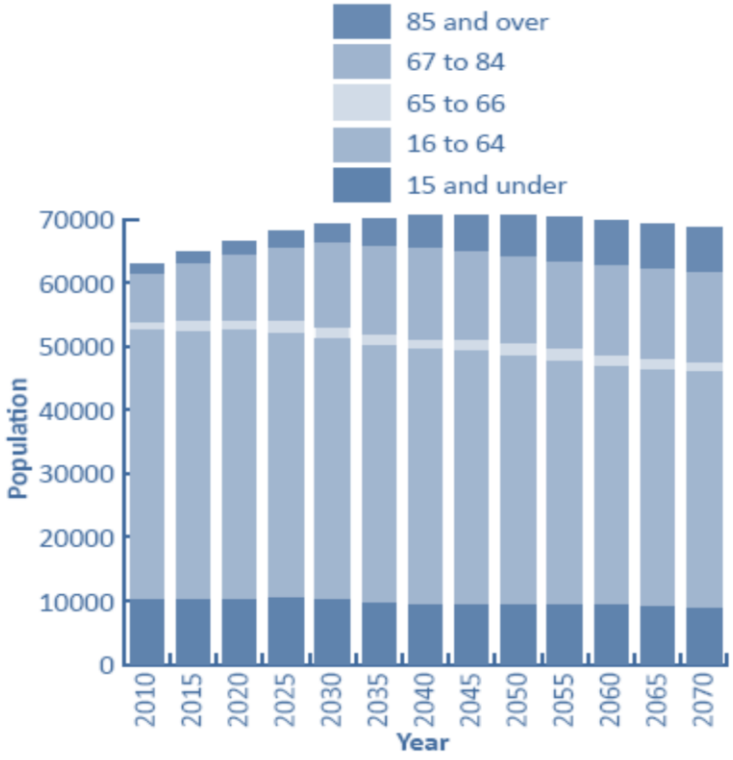
Peer mentoring has been used in Scotland to support isolated older people (MHF, 2011). This involved recruiting older people to be trained as volunteer peer mentors and allocating them to support isolated older people, to engage with a wide range of community resources including universities, arts, music and cultural groups, social clubs, sports clubs and classes, church and faith groups and community organisations. Participants attributed a range of improvements in their lives to the project.

The Local Picture

Population (Source Guernsey Annual Population Bulletin 2011)



Projected population by age group



The number of males and females in five out of six age bands from seventy years upwards increased between 2006 and 2009. The 'bulge' in the pyramids due to the 'baby boom' between the 1950's and early 1970's can be seen moving up out of the 35-39 age group into the 60-64 group. This bulge will move progressively further up the pyramid as the 'baby boom' generation get older.

Like other Western countries, there is a growing ageing population that presents significant challenges to health and social delivery especially with respect to dementia and community based services. There has hitherto been a societal expectation the States will be responsible for providing and funding the majority of care needs for this population group. The 2020 Vision demonstrates that this is unsustainable and such an approach arguably leads to an institutional model of care.

As the older population increases, there are many who will continue to lead active, independent lives, although there will be others who will experience significant physical and economic challenges. The demographic age-shift in the population means that older people will become an increasingly critical sector of the population in the future. There are two principal challenges. The first is how to ensure that the greatest numbers of older people maintain the best possible mental capital, and so preserve their independence and wellbeing – both for their own benefit, and also to minimise their need for support as they age. The second challenge is how to ensure that the considerable resource which older people offer is not wasted.

Workshop findings

In discussion, the greatest difficulty was reported as the lack of community support to maintain people with dementia in their own homes. This lack may result in earlier admission to residential or nursing home care and loss of independence than might otherwise be the case.

Attendees commented that elderly people often required a number of interventions, both for their physical and mental health. It was suggested that the lack of an integrated community service not only fragments care and impacts on quality, but also may be reduce efficiency and be more costly.

There is a perception that the cost and availability of residential care has led to a 'reliance' on HSSD provision in the Lighthouse wards, which have long lengths of stay and an expectation that patients have a 'bed for life.' This is very different from provision elsewhere in the UK.

The 'automatic' transfer of people to the older Adult service at 65 years was questioned. This is particularly relevant as the retirement age rises.

Strategic Priority

To improve care and treatment of older people and develop integrated care for people with Dementia.

This will be achieved by:

- Promoting factors that maintain good mental health in older people.
- Providing access to assessment and diagnosis.
- Expanding community services to enable more people to remain in independent living for longer.
- Working with other agencies to provide access to leisure, education, exercise, volunteering and social activities for older people.
- To consider the development of locality focused integrated support teams.
- To engage with clinical staff to explore the development of 'ageless' services, where appropriate.
- To seek opportunities to encourage development of alternatives to the Lighthouse wards for long term care.
- To increase the capacity of older adult services to identify those at risk of suicide and intervene appropriately, through the roll out of validated suicide prevention training courses such as ASIST or STORM.

In Summary

What does the research say?

Maintaining a positive sense of self, maintaining physical function, engagement in physical activities and participation as valued members of family or social networks, are essential to older people's mental wellbeing.

The losses that accompany old age present a risk by stunting people's opportunities to fulfil these needs. Interventions geared towards reducing the impact of such losses are likely to support or promote wellbeing, in particular those linked to bereavement and to acute illness, including first diagnosis of dementia.

The Mental Health Foundation recommends a 10 point plan for mental wellbeing in old age:

- Be prepared for changes.
- Talk about problems and concerns.
- Ask for help.
- Think ahead and have a plan.
- Care for others.
- Keep in touch.

- Be active and sleep well.
- Eat and drink sensibly.
- Do things you enjoy.
- Relax and have a break.

The NICE Public Health Guidance 16 recommends:

- Interventions by Occupational Therapists or people who provide support and care services for older people in community or residential settings, with the aim of increasing older people's knowledge and awareness of where to get reliable information and advice on a broad range of topics and involving older people as experts in maintaining their own quality of life.
- Physical activity through tailored exercise and physical activity programmes which reflect the preferences of participants. These might include: dancing or swimming; strength and resistance exercises and toning and stretching exercises; or low to moderate intensity walking schemes on a regular basis.
- Training professionals, care staff and support workers (including in the voluntary sector) in the principles and methods of occupational therapy and health and wellbeing promotion.
- Develop effective communication skills to engage with older people and their carers.

The Guernsey picture

There is a small mental health community service available for dementia care, with limited access to a memory clinic. There are also numerous voluntary, community-based social activities for older people.

The greatest local challenge was reported as the lack of community support to maintain people with dementia in their own homes. This lack may result in earlier admission to residential or nursing home care and loss of independence than might otherwise be the case.

There is no integrated community service, intended to meet both physical, mental health, and social care needs. This may fragment care and impact on quality, and also may reduce efficiency and be more costly. In addition, there is a poor understanding of dementia among healthcare professionals.

There is a perception that the cost and limited availability of suitable residential care has led to a reliance on HSSD provision in the Lighthouse wards, which have long lengths of stay and an expectation that patients have a 'bed for life.' This, as well as the use of assessment beds and of care planning, needs to be reviewed in the light of best practice elsewhere.

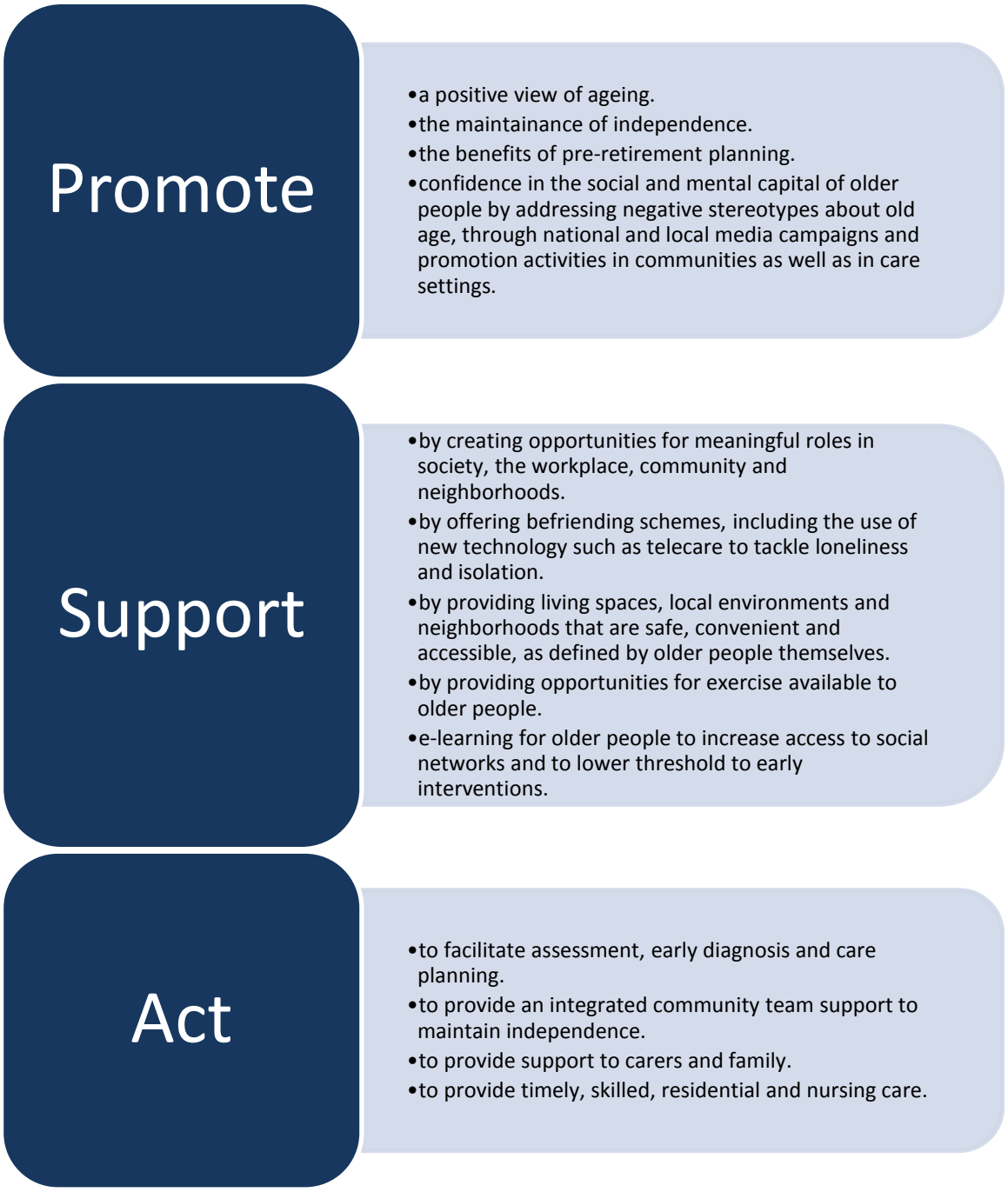
The 'automatic' transfer of people to the older adult service at 65 years was questioned. This is particularly relevant as the retirement age rises.

What will we do?

In conjunction with the Supported Living and Ageing Well Strategy, we will improve the care and treatment of older people and develop integrated care for people with dementia by:

- Improving knowledge and understanding of dementia.
- Promoting factors that maintain good mental health in older people.
- Providing access to assessment diagnosis and care planning.
- Expanding community services to enable more people to remain in independent living for longer.
- Establishing inter-agency work to provide access to leisure, education, exercise volunteering and social activities for older people.
- Considering the development of locality-focused integrated support teams.
- Engaging with clinical staff to explore the development of 'ageless' services, where appropriate.

A three strand approach to ageing well



9. Tackling Stigma and Discrimination

Strategic Vision

People with mental health problems are treated with the same respect and courtesy that is offered to all and can access health and other services, secure employment, engage in education and enjoy leisure pastimes without discrimination by virtue of their mental condition.

The Evidence

The history of stigma research spans more than 5 decades, much of which has been dominated by considering the experiences of people with schizophrenia and other severe mental health problems. This research has helped to influence and inform the development of stigma reduction programmes across Europe and internationally. More recently evaluation studies have emerged, which are beginning to consider common mental health problems such as depression and provide some evidence of the effectiveness of current stigma reduction programmes. However, few of these studies have been longitudinal and there is more to do to fully understand what works in practice to achieve long-term behavioural change. Key themes from the current evidence indicate:

- The need to adopt multi-level approaches that take account of the different types of stigma and the context of people's lives.
- The importance of a level of targeted activity as dominant whole population approaches can be expensive and difficult to sustain, and messages need to be targeted to specific audiences to maximise impact.
- That programmes that adopt a mixed methodology of contact alongside mental health literacy appear to show most promise.
- That discrimination encountered by people who experience mental health problems is a human rights issue that acts to prevent help seeking and reduces life chances, therefore programmes should aim to empower people with a lived experience whether they adopt a service user identity or not.

Introduction

Stigma and discrimination encountered by people with mental health problems offers a key public health challenge (Thornicroft et al., 2009). Stigma in a mental health context has been described as an undesirable attribute in terms of social normality (Goffman, 1963). Research indicates that mental health problems are more stigmatising than experiencing physical illness (Corrigan et al., 2000; Scrambler, 1998). In recognition of the challenge associated with addressing mental health stigma, Link and Phelan (2001) have produced a model which is commonly applied. For stigma to take place they state that 4 conditions need to occur:

- Labelling – in which personal characteristics are signalled or noticed as conveying an important difference.

- Separation – the categorical distinction between the mainstream or normal group and the labelled group as in some respects fundamentally different.
- Stereotyping – the linkage of difference to undesirable characteristics.
- Status loss and discrimination – devaluing, rejecting and excluding the labelled group.

More recently Link et al. (2004) have revised this model and added the emotional reactions that accompany each of these stages in recognition of the powerful impact of emotions in this process. They also acknowledge that power differences enable discrimination to occur and outline a number of levels in which stigma and discrimination can operate including: family, the community or society as a whole, and institutional discrimination. In attempting to understand Stigma Thornicroft (2007) has described it as containing a combination of ignorance, prejudice and discrimination. Research indicates that the most stigmatising conditions are schizophrenia (Mann & Hemelein, 2004) and eating disorders (Corrigan et al., 2004). However, stigma has been shown to still have a strong impact on people with common mental health problems such as depression (Priest, 1991). This has been more recently evidenced within the European wide ASPEN study (available at: http://www.antistigma.eu/).

Stigma and help-seeking

Despite the prevalence of mental health problems in society only a proportion of people experiencing these actually seek professional help (Lepine et al., 1997). According to health behaviour theory a person will seek help for a problem if they believe that: the problem is severe enough to interfere with their daily lives; treatment will reduce symptoms; and that there are no major barriers to help seeking (Hensaw & Freedman-Doan, 2009). For many years the stigma associated with a mental health diagnosis has been viewed as a major barrier to help-seeking (Corrigan, 2004; Link & Phelan, 2006; Sherwood et al., 2007) along with the associated embarrassment of consulting relevant professionals (Barney et al., 2006) and the consequences individuals envisage within, for example, employment and relationships. Individuals believe that seeking help is akin to admitting that they cannot cope; the likelihood of seeking help for a physical problem is higher than for a mental health problem, suggesting that seeking support for a mental health problem is particularly stigmatising. However, the problem extends beyond experienced stigma as research has shown that self-stigma or anticipated discrimination of the person affected is a key barrier to help-seeking, but also wider inclusion and acts to prevent those with mental health difficulties from accomplishing their life goals (Corrigan, 2003; Thornicroft et al., 2009). It has been argued that the consequences of failure to seek help include a continuation stigma and perhaps worsening of symptoms (Thornicroft, 2008).

Report of a Case Study – The European Study of Epidemiology of Mental Disorders (ESEMeD) - France

This representative population survey was conducted in 6 European countries, including France (France n=1436 respondents). While this study was designed to investigate the epidemiology of a range of mental disorders, it included 5 items exploring attitudes towards help-seeking for mental health problems. Within the French experience, 40% of respondents would not seek professional help for a serious emotional problem, and 38% would not feel comfortable talking about personal problems with a professional.

UK programmes

Time to Change – England (and Time to Change Wales)

Time to Change is a major country wide anti-stigma campaign run by mental health charities Mind and Rethink. The campaign is funded by the Big Lottery Fund and Comic Relief and is being evaluated by the Institute of Psychiatry at King's College London. Time to Change is the first anti-stigma initiative that aims to change behaviour as well as attitudes. Key aims include:

- Creating a 5% positive shift in public attitudes towards mental health problems.
- Achieving a 5% reduction in discrimination by 2012.
- Increasing the ability of 100,000 people with mental health problems to address discrimination.
- Providing opportunities for 274,500 people with a range of mental health experiences to come together.
- Producing a powerful evidence base of what works.

Progress to date includes:

A 4% reduction in the discrimination experienced by people with mental health problems. This was measured by asking 1,000 people who are being treated for a defined mental illness and are living in the community about the discrimination they face in their day to day lives and comparing this annually. The 4% reduction in discrimination was evidenced in the survey that was carried out in 2010 and remained consistent in 2011.

A 0.8% improvement in public attitudes towards people with mental health problems has been seen since the launch of Time to Change according to the Department of Health's annual 'Attitudes to Mental Illness' survey which asks a representative sample of the general public questions about their attitudes. Between 2008 and 2010 there was a 2.2% improvement in public attitudes. However, in 2011 this dropped back to a 0.8% improvement overall since the launch of the campaign. This dip may concur with international research into public attitudes, which suggests that attitudes towards 'vulnerable groups', including people with mental health problems, can harden during periods of recession and higher unemployment.

‘See Me’ Campaign - Scotland

‘See Me’ is Scotland’s national campaign to end stigma and discrimination in relation to mental ill-health. ‘See Me’ is managed by an alliance of five mental health organisations and has been fully funded by the Scottish Government since 2002. See Me has 4 main aims:

- To change public understanding, attitudes and behaviours so that the stigma and discrimination associated with mental ill-health is eliminated.
- To enhance the ability of people to challenge stigma and discrimination.
- To ensure that all organisations value and include people with mental health problems and those who support them.
- To improve media reporting of mental ill-health.

See Me have outlined 8 Objectives which are to:

- Deliver a social marketing campaign which uses a range of media and approaches to deliver improved general public attitudes and behaviours towards those of us with mental health problems and those who support them.
- Deliver social marketing campaigns to specific target audiences in order to tackle inequality and address multiple stigma and discrimination.
- Engage the participation of people with experience of mental ill-health and those who support them as a benefit to the campaign, and in order to encourage individual and collective stands against stigma.
- Improve the standard of media reporting of mental ill-health.
- Run a specific social marketing campaign to challenge stigma in public services, and particularly in health services.
- Encourage the take up of anti-stigma initiatives in local areas across Scotland, building local capacity to take effective action.
- Develop and strengthen relationships between individuals across Scotland and the campaign, to encourage wider involvement in campaign action.
- Add significantly to the body of public knowledge about stigma, its impact and how best to tackle it.

Key Strategies for consideration

Although most of the published research on stigma is from the USA and Canada this evidence has relevance for Guernsey as reviews between countries have highlighted that there is much common ground on themes that emerge around the experience of stigma and discrimination (de Toledo Piza & Blay, 2004; Kurumantani et al., 2004; Thornicroft et al., 2009).

Themes in relation to stigma include:

- The conditions most often rated as mental illnesses were psychotic disorders, particularly schizophrenia.
- People with higher levels of education tended to have more favourable attitudes to people with mental health problems.
- Alcohol abuse was considered to be the most common type of mental disorder.
- Most people thought that a health professional needs to be consulted by people with mental illnesses.

Commonly reported negative experiences of discrimination for people diagnosed with schizophrenia include: making and keeping friends (47%); discrimination by family members (43%); keeping a job (29%); finding a job (29%); and intimate or sexual relationships (29%). The most commonly reported anticipated discrimination areas include: applying for work/training/education (64%); looking for a close relationship (55%); and feeling the need to conceal the diagnosis (72%). (Thornicroft et al., 2009).

As reducing stigma and discrimination is context dependent then it can reasonably be considered that institutional and structural actions are needed to address this such as equality legislation, progressive mental health services, community based care and service user/consumer empowerment. Much of this is within the gift of the new mental health strategy; however, it is clear in relation to wider equality issues that some cross-departmental work will be required.

In terms of more specific approaches to reducing public stigma, three main methods of anti-stigma intervention are most often considered to be most effective within the literature. These are: protest, contact and education. Contact has been shown to have the most consistent results in reducing stigma, whilst protest has more mixed effects (Corrigan et al., 2001; Corrigan and Gelb, 2006). Corrigan and Penn (1999) found that contact with a person with mental illness produced greater improvements in attitudes than protest and education. In a subsequent study, contact again produced the greatest improvements in attitudes and participants' willingness to donate money to a mental health advocacy group (Penn & Corrigan, 2002). In Corrigan's study (2001) the effects of 3 strategies for changing stigmatising attitudes – education (which replaces myths with more accurate information), contact (which challenges public attitudes about mental health problems through interaction with people with mental health problems) and protest (which seeks to suppress stigmatising attitudes about mental illness) were examined using attribution theory about schizophrenia and other severe mental illness. Community college students (n=152) were randomly assigned to one of the three strategies or a control condition. They completed a questionnaire about attributions toward 6 groups of people: depression; psychosis; cocaine addiction; learning disability; cancer; and AIDS. Results showed that education had no effect on attributions about physical disabilities but led to improved attributions in all 4 mental health groups. Protest yielded no significant changes in attributions about any group. Contact produced positive changes that exceeded education effects in attributions with regard to depression and psychosis.

Education

This term encompasses a set of approaches that are essentially about giving information such as mental health literacy (Jorm, 2000) and social marketing. Davidson (2002) describes the basis of educational campaigns on mental health stigma as providing correct information about mental health and emphasising the social unacceptability of holding stigmatising views.

There is evidence that suggests educational campaigns may increase tolerance and understanding of mental illness (Corrigan et al., 2004) and can reduce stigma amongst school age pupils who displayed negative baseline attitudes (Watson et al., 2004). However, there is a counter argument that education campaigns can be ineffective or have only a partial role to play in addressing stigma (Davidson, 2002; McDaid, 2008). The model upon which educational programmes are built is important as they may for example over-emphasise the role of individual agency versus structural determinants of stigma, or they may use bio-medical explanations whose effectiveness is uncertain (Mann & Heimlein, 2008; Corrigan & Watson, 2004; Watson et al., 2004).

Educational campaigns appear to be most effective when they target specific anxieties of particular groups rather than mental health generally and the public as a whole (Byrne, 2000; Byrne, 2001). There is support for targeting at community level, for example through a local awareness campaign such as we have seen happen within the UK (Evans-Lacko et al., 2010). Such programmes can encourage participation and stimulate interest by preparing educational interventions on subjects familiar to specific audiences (Tanaka et al., 2003). Interventions should be sensitive to cultural beliefs and literacy levels in communities (Mubbashaar & Farooq, 2001). Within Guernsey it is recognised that there is some diversity although on a different scale to England. However, it will still be important to explore cultural relevance within these communities as concepts of mental illness have been built around western disease models and within Scotland, for example, stigma has shown to be greater within minority ethnic communities (Newbigging & Bola, 2011). This will have relevance for stigma reduction programmes in terms of the messages that are presented to these communities but also in with regard to the methods used at present. Many cultures have a more collectivist view of the world whereas within western cultures more individualistic approaches often dominate (Triandis, 1995). In general, audience's/participant's beliefs, level of understanding and concerns need to be taken into consideration (Smith, 2002).

Overall, there is support for multi-level strategies which include education. Research suggests that the most effective approach is to employ a social marketing strategy that includes key elements that aim to: raise awareness and increase positive attitudes (Scheffer, 2003); emotionally involve learners and encourage them to learn actively rather than be passive recipients of imparted knowledge (Finkelstein et al., 2008); create champions or role models; and where possible capture interest at a young age and through work in schools (Kakuma et al., 2010).

Contact

The potential for positive contact, between those with mental health problems and target audiences, to reduce stigma shows promise in a range of contexts including with police officers in the UK (Pinfold et al., 2003a), schools (Pinfold et al., 2003b) and universities (Mann & Heimlein, 2008). Quinn et al. (2010) go further

in espousing the idea that not only should service users and target audiences mix during mental health programmes, service users should be meaningfully involved in all areas of developing and evaluating such events. Contact has been said to be most effective when there is equal status between both parties and when work is one-to-one (Estroff et al., 2004; Mann & Himelein, 2008). Estroff et al (2004) argue that not only do contact programmes have benefits for the audience, but also for those presenting, as they can be empowered and contribute to the wellbeing of those sharing their stories. Most of the research in relation to contact has like stigma research in general predominantly been related to schizophrenia.

In relation to initiatives specifically designed to tackle stigma associated with depression there is much less evidence, however, international studies suggest certain factors can be effective. Parslow and Jorm (2002) found contact to be the most effective strategy (from the three main strategies outlined earlier) in tackling stigma against people with depression. Again they found that this impact is maximised when audience and participants have equal status; when programmes offer real-world, rather than contrived, interaction opportunities; when contact is sponsored by a well-regarded organisation and when the person speaking is seen as typical of a person with depression. This is supported further by Scheffer (2003) who argues that contact with people who fill "normal" social roles has a positive influence on attitudes.

Particular targeting of stigma reduction programmes is indicated to reach older people, those on lower incomes and men, given that previous data suggests women may be easier to reach (Quinn et al., 2010). Young people may be a priority target group for anti-stigma campaigns and Mann and Heimlein (2008) say the classroom is an ideal place for these campaigns to take place and with less cost. It may also be useful to involve parents, since previous research suggests children and their parents may share similar stigmatising attitudes (Jorm & Wright, 2008).

Limitations of the evidence

Much of the evidence to date has been specifically related to schizophrenia and other major psychotic disorders, therefore more research is required to gain a fuller picture in relation to more prevalent mental health problems. Equally research has focused predominantly on understanding the problem and has only more recently shifted focus to begin to gain some ground on what works to affect change. Commonly attitude surveys have been a key measure, however, there is more to do to understand impact on behaviour and what actions achieve sustained behavioural change. Indeed, the need for more research to identify evidence based approaches that are effective in reducing mental illness stigma has been identified by many authors (Angermeyer, 2002; McNulty, 2004) including for depression (Griffiths et al., 2004). These views are supported by Lauber who criticises the common sense lay approaches often currently in use (Lauber et al., 2005). It is important to acknowledge that assessing the effectiveness of stigma reduction strategies can be challenging, given that the public's attitudes are neither

logical nor clear-cut, compounded by issues such as socio-cultural health beliefs, researcher effects, and the many intervening variables in real life social research. Below we have provided a summary of the evidence in relation to education and contact as two of the three methods that have an emerging helpful evidence base. I It should be noted that we are at an early stage in understanding how you scale up activities focused on contact as much of the research has been within controlled environments. Protest has not been included as the evidence is more mixed and in its purest form this is an area that is not usually within the domain of a mental health strategy, as much effective protest emerges from within social movements and activist groups. Although it is worth noting that grassroots protest can support the efforts of a stigma reduction activity, for example, by campaigning on equal rights for people with mental health problems. In turn a strategy can help to create an environment and create enabling structures that support effective human rights campaigns.

Within smaller communities there is evidence that indicates that stigma is often a greater challenge and a major barrier to help-seeking (Mulder & Chang, 1997). Added to the previous evidence this sets out a compelling case for investing in stigma and discrimination reduction activities within Guernsey.

The following recommendations are based on the existing evidence base from the ASPEN pan-Europe literature reviews, best practice in stigma reduction programmes across Europe, and consensus on best practice developed by the Mental Health Foundation with our 27 ASPEN partners.

A stigma reduction programme should:

- Be based on sound theoretical principles. Much of the work to date has focused on social interactionism theories around labelling and stereotyping and as a result has prioritised information provision activities. This approach assumes that providing information will lead to behavioural change. However, recent theorists have challenged this and have instead focused on structural stigma and discrimination. This places a spotlight upon legislation and empowering those who experience mental health problems. Link and Phelan (2001) reconcile these different approaches in their modified labelling theory and identify stigma as a process involving labelling, stereotyping, separation, status loss and discrimination. Thornicroft (2006) provides a clear framework for stigma programmes that can be translated to the work in Guernsey, that programmes should contain 3 key elements for focus: knowledge, attitudes and behaviour.
- Operate on different levels recognising different forms of stigma including self-stigma, associated stigma, social stigma in the community and structural discrimination, for example, within the media, employment, health services or the legal system. Entering agreements with the media on reporting of mental health problems and suicide would be a good example of one way in which structural discrimination can be

challenged. It is likely that instant feedback using online social media may assist with snowballing responses from people with mental health problems to episodes of stigma. Creating opportunities for online responses/discussion and debate may be useful to consider within an island community where more anonymous ways of responding could be helpful. Examples such as Stigma stop-watch in Scotland are useful ways of supporting service users and other champions to tackle episodes of stigmatising media reporting.

- Be targeted on areas of need, as a focus on the general public is a very ambitious goal and often programmes aimed at the whole population do not reach marginalised social groups, and may be financially difficult to sustain in the current economic climate. There is therefore a strong economic as well as a moral imperative to focus where the most damage is located and where it is possible to achieve the greatest impact. Stigma and discrimination in relation to employment is still seen as being a significant barrier in attempting to gain employment for people with mental health problems, and a key component is anticipated discrimination. Therefore a targeted approach that includes employers, including the harder to reach small to medium sized employers, could have a significant impact on the quality of life of people with mental health problems. Using a mixed approach of contact and education may be most effective as there is good practice to be shared in employability success stories. The evidence also indicates that targeting school children can be effective but also that older people often experience higher levels of stigma and multiple discrimination (ageism alongside mental health stigma). Therefore school based programmes and specific approaches developed alongside older people may be particularly effective.
- Have specific strands that are focused on different diagnoses to ensure that messages are specific enough to challenge attitudes and stereotypes (as beliefs around depression differs from stigma related to psychotic illnesses with ideas of blame being more dominant rather than concerns around violence). People's own stories may have the greatest impact although in an island community anonymity may be a barrier in gaining narrative volunteers. Although there is evidence that proxy contact through film, radio, posters and leaflets etc. can be useful, and stories can be presented anonymously or using well known public figures who feel able to come out about their mental health problem. This may help to capture unique individual experience and dispel ideas of homogeniety as well as providing a story that may resonate on a personal and emotional level with the audience.
- Use methods that are evidence based/known to be effective, including a combination of protest (supporting rather than leading), education and contact (Corrigan et al., 2007). Positive personal contact has the most promising evidence-base; including proxy contact for example narrative through film (Quinn et al., 2011). Indeed proxy contact may help to overcome concerns about scaling up

contact approaches. Within the Scottish Mental Health Arts and Film Festival contact has been used with large audiences to good effect, including well known musicians talking to audiences at gigs and the press about their own experiences. It is important to note that contact works best when people do not feel compelled to take part and messages must be carefully targeted for different audiences (Byrne, 2000).

- Be rights based so rather than mainly aiming to change beliefs and attitudes, programme messages should consider how to tackle discrimination and be clear that stigma is a human rights issue. Although protest would not usually be considered to be within the domain of a mental health strategy supporting the development of the service user movement and a strong voluntary sector voice is a clear area where the strategy can help support human rights focused campaigns.
- Use positive recovery messages by focusing on promoting positive messages and strengths rather than dispelling negative beliefs. Being clear that people recover and make positive social contributions. There are examples within the UK of the use of media volunteers/speakers bureaus where there are people willing to share their recovery stories and of the emergence in Scotland of recovery networks. These can support people to put positive messages into the public domain. The Mental Health Foundation hosts the Scottish Mental Health Arts and Film Festival which aims in part to reduce stigma by exploring mental health with the public. An early evaluation of the impact of festival events indicated that the most promising approach was to promote positive images of people with mental health problems rather than challenging negative stereotypes.
- Ensure full user involvement as stigma is a “rights.” issue and work to address this has the potential to empower and enable people to regain control. People who have experienced mental health problems should be meaningfully involved in programme leadership, planning, implementation and evaluation. People should be involved with different diagnoses, experiences, age groups, gender, and sexual orientation and from ethnic and income backgrounds. Due to stigma many people do not seek help or use treatment services. Therefore, although it is important to involve people who are service users, it is also vital to engage those that do not take on this identity. This can often be the case for people experiencing common mental health problems such as anxiety and depression. Particularly when stigma may affect people who make use of self-help and lower tier interventions, and who may never associate themselves with the service user movement. Best practice would indicate that the initial development of a Guernsey stigma reduction programme should be built around the views of service users and feel owned by people with mental health problems. More than any other programme stigma reduction work needs to ensure that meaningful service user involvement is the key operating principle.

- Focus on equity as mental health problems are unequally distributed within communities. Stigma programmes across Europe have to date been in general most often directed at the whole population although there has been some examples of useful targeting (such as towards health professionals, workplaces and schools). However, it will be important to ensure that work within Guernsey has a focus on disadvantaged communities or there is a risk of increasing inequalities in stigma and mental health (Petticrew et al., 2004). General anti-stigma activity such as a population wide media campaigns should be combined with actions targeted towards those at highest risk or who encounter multiple layers of discrimination, including older people, people in low-income communities, people with long-term conditions and disabilities, and ethnic minority communities. To do this effectively it will be important to work alongside different communities to develop approaches to fully understand their experience.

Case Study – Netherlands Older Persons Cross-sectional study

This research project aimed to investigate whether the type of residential institution older people live in or type of disorder they have is related to their experiences of stigma and the impact on their quality of life. A cross-sectional methodology was adopted (n=131) and older adults with severe mental illness were recruited across 18 elder care homes, supported living programmes and psychiatric hospitals throughout Netherlands. Stigmatisation was measured using an 11 item questionnaire (an adjusted version of the Consumer Experiences of Stigma Questionnaire – CESQ) and quality of life was measured using the Manchester Short Assessment of Quality of Life (MANSA). To better ascertain the role of stigma, the relationship of social participation to quality of life was comparatively measure. The results indicated that 57% of the respondents had experienced stigma. No association emerged in relation to disorder or type of accommodation arrangements. Stigmatisation did show a negative association with quality of life, which importantly was a stronger connection than between social participation and quality of life.

Effective approaches to reducing stigma include:

Use messages and methods that are accessible and meaningful to people who use different languages, have a learning disability, low literacy, visual or hearing impairment. Using communication methods and resources that reach different groups e.g. community centres in low-income areas or media which are accessed by children and young people or people from minority ethnic communities.

Work more closely with specific communities to consider the different cultural contexts of mental health problems. Different sections of society may hold different beliefs about mental health problems and its causes. For example, some people see depression as a social construct that relates to power in society. Others hold cultural explanations linked to faith or traditional beliefs. It is important that as demography changes in Guernsey in relation to age, but also where future changes to ethnic mix are expected or likely, that a programme is developed that has messages and uses methods that are based on an understanding of meaning attached to mental health. The limited but useful work of the Mosaics programme in Glasgow is a good starting point.

Develop collaborative partnerships that are wider than our mental health world. Developing partnerships with non-mental health organisations will help to make mental health everyone's business. One example of how this can be approached would be by developing a wider stigma advisory network comprised of representatives from workplaces, schools and universities, community and civil society groups, as well as people with a lived experience of mental health problems. Aim for sustainability as large media campaigns can be expensive. Stigma is a deep-seated issue that will take a long time to reduce and it is therefore very important to develop programmes and approaches that can be sustainable. For example, it may be easier to deliver mental health awareness sessions in employment by building capacity for HR managers to take on this role as this will be more sustainable long term. Placing mental health on the curriculum within schools is a more sustainable approach than providing mental health sessions directly. A key consideration and aim of any stigma reduction programme should be to grow capacity within universal settings for others to take on the responsibility for improving mental health. Evaluate independently the effect on behaviour as well as attitude. Evaluation can be expensive but it is essential to understand which stigma and discrimination reduction activities affect sustained behaviour change. Within Scotland the main measure of change has been recorded through the social attitudes survey and although this provides a crude measure of changes in society but it does not provide information on behavioural change and can be subject to reporting bias.

The Local Picture

As the Guernsey Emotional and Wellbeing Survey revealed, Castel hospital was seen as very stigmatising.

Service users report that they have difficulty in accessing services to meet other health care needs, particularly A&E and hospital services.

There was a general consensus that the Guernsey population and politicians are more risk averse than the mainland and that this leads to greater pressure to find ways of addressing challenging behaviours,

As small islands, there is a difficulty with confidentiality.

Strategic Priority

To provide information that changes the knowledge, behaviour and attitudes of people, in order to improve the experience of mental health service users.

This will be achieved through

- Engaging with the media to provide 'positive messages' about mental health
- Improving knowledge and understanding in the general public.
- Using World Mental Health Day (October 10) as an opportunity to engage with public
- The identification of a high profile Guernsey 'champion'

10. Provision of Safe Effective Services

Strategic vision

People can access services that are acceptable, recovery and outcome focused, reflect evidence based best practice, and are made available in a variety of settings.

Wherever Guernsey people access services, there are quality standards that they, and The States should expect.

	Quality statements
1	People using mental health services, and their families or carers, feel optimistic that care will be effective.
2	People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.
3	People using mental health services are actively involved in shared decision-making and supported in self-management.
4	People using community mental health services are normally supported by staff from a multidisciplinary community team, familiar to them and with whom they have a continuous relationship.
5	People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6	People can access mental health services when they need them.
7	People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8	People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9	People using mental health services who may be at risk of crisis are offered a crisis plan.
10	People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
11	People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making.
12	People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team.
13	People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.
14	People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force.
15	People using mental health services feel less stigmatised in the community and health service, including within mental health services

The changing picture of mental health provision

Mental health problems are common and vary in their nature and severity. Some people experience long-term and severely disabling effects, but many people recover fully, including from severe mental health problems. There are many social and other determinants and consequences of mental health problems so we need approaches covering a broad range of outcomes – whether 'psychological', such as reduced distress, or 'social', such as employment and improved relationships and physical health.

Mental health problems – the statistics

- At least one in four people will experience a mental health problem at each year and one in six adults has a mental health problem at any one time.
- One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14,and three-quarters before their mid-20s.
- Self-harming in young people is not uncommon (10-13% of 15-16-year olds have self-harmed).
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.
- About one in 100 people has a severe mental health problem.
- Some 60% of adults living in hostels have a personality disorder.
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

The last 10 years have seen major changes in the way in which mental health services are delivered. The publication of the National Service Framework for Adults in England (1999) and similar strategies for Older Adults and Children, introduced specialist community teams, including Crisis Resolution and Assertive Outreach that supported people in their own homes, rather than as an inpatient.

The objective of each of these strategies has been to reduce the number of admissions to hospital by improving out of hospital care and emphasising an expectation of recovery and re-ablement.

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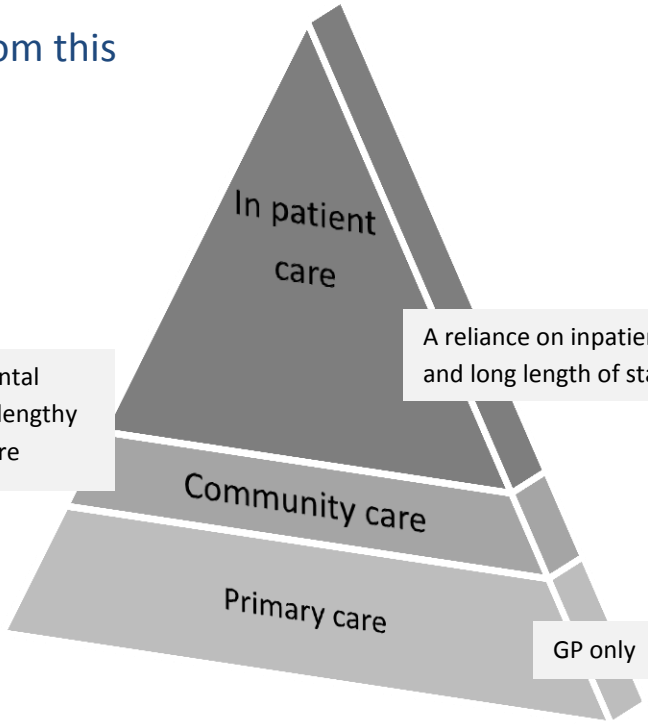
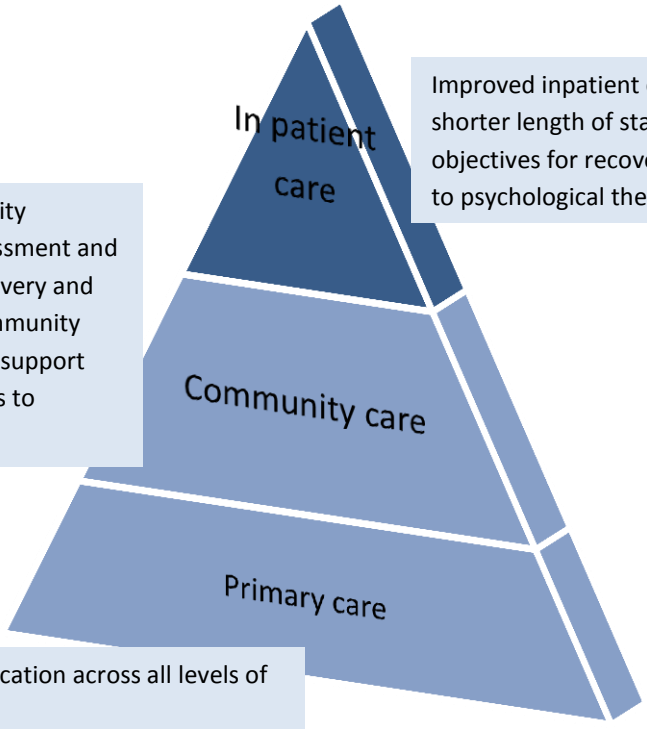


Generic community Mental health Teams maintain lengthy contact in secondary care

A reliance on inpatient beds and long length of stay

GP only

To this



Improved inpatient care, shorter length of stay, clear objectives for recovery, access to psychological therapies

Access to a range of community services, including rapid assessment and signposting, focussed on recovery and rehabilitation. A range of community functions providing intensive support and crisis intervention. Access to psychological therapies

Improved communication across all levels of care

In addition, Early Intervention in Psychosis services have been established intended to reduce the risk of young people developing serious and long term problems.

More recently, increased access to talking therapies particularly within primary care settings, has signalled further changes in how services are planned and provided.

At the same time, services have become more recovery and rehabilitation focused, reducing the sense of hopelessness that has prevailed amongst service users.

One of the many concerns that service users have is that very few staff working in mental health services have the time to spend with them to talk about their needs, what they want from services and how to put their lives back on track. Service users say professional and other staff always seem too busy to support them in the way they want. Service users value the whole-person, whole-life support which they can receive from workers with a specific remit to take a flexible approach based on their individual needs.

The final report of the Workforce Action Team (DOH, 2001) identified the need for a new type of worker, a Support, Time and Recovery Worker (STR), who could support service users in:

- Managing the practicalities and realities of everyday life – including accommodation, finance and budgeting;
- Making daily life meaningful;
- Achieving rehabilitation and social reintegration – including personal and interpersonal skills.

An STR worker is someone who works as part of a team which provides mental health services and focuses directly on the needs of service users, working across boundaries of care, organisation and role.

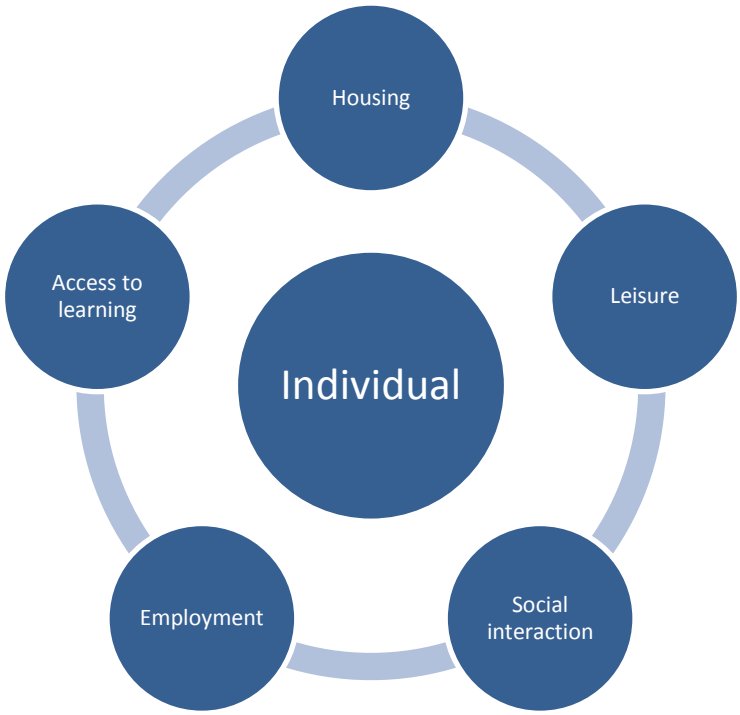
The principles of the recovery approach, that emphasises the equal importance of good relationships, education, employment and purpose, alongside reduction in clinical symptoms, apply equally to adults, children and young people. It is designed to:

- Support people in maintaining good mental health and wellbeing
- Give people the maximum support to live full, positive lives when they are dealing with mental health problems
- Help people to recover as quickly as possible.

Recovery from mental illness and improving wellbeing are not only reliant on medical treatment and psychological interventions. Finding a place in society, employment, friends, income, a home, and access to learning and opportunities to regain self-esteem are also key factors in the recovery process.

It follows from this that wellbeing and recovery are not just the responsibility of health services, but of everyone, including all ‘statutory bodies’.

Factors that impact on recovery



This strategy recognises the need to shift the balance of care from institutional settings to community based services, and ensuring community services are available and responsive to the needs of the residents of the bailiwick. The central planks to delivering a successful strategy from 2010 to 2020 include:

- Improved outcomes for people with mental health problems;
- Improved access to rehabilitation and recovery;
- Improved access to education and employment through remodelled day opportunities and access to mainstream education services;
- Less reliance on residential and nursing care, with improved access to supported and general needs housing.

The impact of stigma and discrimination affects significant numbers of people with mental health problems and their families. The Stigma Shout survey 2008 found that people were most likely to be discriminated against by family, employers, neighbours and friends. In addition, fear of discrimination can deter people from accessing other health services, including primary care, A&E and acute hospitals. Seeking advice for the physical health needs of people with mental illness can be difficult.

People with mental health problems have worse life chances than other people. Whilst this can be a direct effect of their condition, a large part is due to stigma, ignorance, fear and prejudice which can:

- Affect the attitudes of clinicians
- Deter people from seeking help
- Keep people isolated
- Stop people working, being educated and taking their place in society.

Different approaches are required for children, young people and adults, although some interventions are effective in reducing distress and improving functioning across all age groups. Stigma and discrimination create barriers for people with mental health problems of all ages and their families and carers.

There are a growing number of effective approaches. National Institute for Health and Clinical Excellence (NICE) guidelines (UK) have outlined evidence-based interventions that cover the majority of mental health conditions and problems that people may experience over their lives. These include guidelines on schizophrenia (2009), and borderline personality disorder (2008), with others in development.

The structure of individual mental health services will vary, influenced by the population demographics and density. Consideration will need to be given as to how the increased specialisation described in guidelines can be met within a small island population and it is likely that there will need to be increased collaboration with other providers to ensure that residents of the bailiwick can access high quality services that reflect international quality standards.

Service users

People who need to use mental health services need to feel that they are involved in decisions about how their needs will be met and, where appropriate offered a degree of choice.

At the same time, there is increasing emphasis that service users should understand that they have a responsibility to comply with care plans that they have agreed.

Service user views should be at the heart of service planning and redesign.

Carers and relatives

The experience of a family member having a mental health problem can have a significant impact on carers. In recent years this has been acknowledged, and there is a growing expectation that carers are involved in care planning and their needs are assessed as part of this process.

Principles that govern the provision of safe, effective care (adapted from 'No health without mental health, DOH).

These apply at all stages of care and support and there is an established consensus about what these are:

- Putting the person at the centre and sharing decision-making – 'No decision about me without me' should be a governing principle in service design and delivery.
- Early recognition of and intervention in problems in early year settings, schools, workplaces, primary care, acute health and social care settings and the criminal justice system.
- Where appropriate, adopting a whole-family approach with involvement of family, friends and other carers, together with an assessment of their needs.
- Equal and timely access to appropriate services and evidence-based interventions.
- Proactive, assertive engagement, particularly with young people at higher risk (e.g. young people at risk of offending/offenders).
- Single assessments that underpin continuity of care – using the principle of 'ask once'.
- Co-ordinated interventions planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a recovery-based focus on building individual strengths and improving quality of life, including improvements in employment, accommodation and social relationships.
- Co-ordination of care and support – using tools such as the Care Programme Approach.
- Care in the least restrictive setting.
- Sometimes treatment has to be delivered under the Mental Health Law without a person's consent. Where that happens, it is important that the guiding principles in the Code of Practice be applied. That includes the least restriction principle: people taking action without a person's consent must attempt to keep to a minimum the restrictions they impose on the person's liberty.
- Age and developmentally appropriate settings and approaches for children and young people, and adults of all ages, and the need for a life course approach based on needs rather than an age-defined approach based on available services.
- Culturally appropriate integrated approaches that recognise mental health problems may often be complex and may co-exist with alcohol and illicit drug use.
- Early intervention and other evidence-based interventions, including diversion delivered by high-quality services that reflect good practice guidance, along a stepped pathway of care from primary to secondary services.
- Good, clear information to inform people's choices and decision-making.

Mental health service provision is described in terms of tiers, from 1 to 4.

A challenge for Guernsey is to provide a modern mental health service, including all of the functions described in the National Service frameworks, on an island with a population of 63,000. Whilst services must reflect best practice, they will need to adapted, as fidelity to the model described in National Service Framework Guidelines is not only impractical, but inefficient and unaffordable in a Guernsey context.

A number of patients each year are accommodated in off-island placements for the purpose of containment and therapy. Placements are both costly and, historically, have had limited success in long term outcomes. In particular, patients reach their potential in placement, but may return to high risk on return, often because of the limited support available within current resources. The current in-patient ward does not have a high dependency area, nor staffing levels and skills that would be required to support some challenging individuals. A recent report into the adult mental health service (2010), recommended that alternatives should be considered that could be more beneficial and reduce long term risk.

Level	Service	Provision within the Bailiwick	Provision off-island
Tier 4	Specialist		Access to specialist advice and treatment off-island for individual packages of care and across sectors. Forensic and secure services Specialist Adult In-patient services CAMHS in-patient
Tier 3	In patient services Specialist	Adult In-patients Older adult in-patients Substance misuse and alcohol detox and support. Shared care with off-island centres CAMHS	
Tier 2	Community Services	Adult and Older Adult Crisis and priority assessment and treatment service Routine assessment and treatment Assertive support Therapeutic services Recovery and rehabilitation	
Tier 1	Primary care services	GP Shared care Psychological therapies Voluntary sector	

11. Mental Health Services for Guernsey and Alderney in 2012

Child and Adolescent Services (CAMHS)

Services for children and young people up to the age of 18yrs and above, if still in full time education, are provided by the CAMHS team, based at Bell House. The service has expanded in the last year, with the establishment of an Outreach team, In order to provide rapid assessment and intensive treatment to young people at high risk and /or who may need hospital admission.

Current challenges

- A perceived lack of collaboration and joint working across Health, Education and Maternity services.
- Each agency involved with children in education has developed their own response to the identification and support of children with mental health problems and a number of interventions have been developed. This could be improved by a formal joint approach, where the most vulnerable children and families can be supported in collaboration.
- Transition arrangements for children as they become adults lack consistent preparation and planning.
- In-patient facilities for children are not provided in Guernsey, except on the general acute hospital paediatric ward.
- Planning for the return of a child from an episode of care is not always well co-ordinated. This is particularly difficult where a child returns to the care of the adult psychiatrists.

Adult Mental Health Services

Following a number of critical reports, the last 2 years have seen significant change:

- A number of recommendations, made in the last review Deuchar and Hunt, (2010) have been implemented, as far as is possible in the current in-patient facilities. Improved in-patient facilities will not be available until the replacement hospital is available in 2015.
- Community teams have been reconfigured to provide crisis, intensive support and recovery focused services.
- The development of primary care based Psychological Therapies has enabled GPs to refer patients for Tier 2 services, provided in primary care, meeting a previously unmet need.
- Plans have been agreed for the construction of a new inpatient unit to be built on the Princess Elizabeth hospital site, replacing The Castel hospital and Bell House.
- Service users and carers have been involved in the planning of services and the new build.
- The Mental Health Law has received Royal Assent and will be enacted in 2013.

Historically, mental health services for adults have been mainly psychiatrist dependent and in-patient focused, with less well developed community provision. Patients tended to remain in contact with their doctor for long periods and attend the 'maintenance' model day services.

Following the implementation of the 2010 review and the re-focusing of community services, day services have been redesigned to provide a recovery and re-ablement service, involving a multi-disciplinary team, that has improved connections to the education, employment and housing departments.

Whilst progress is slow, there are clear indications that people who need mental health services in the bailiwick are, more and more, able to access a service that reflects modern practice.

That is not to say that more progress is not needed and this strategy will require that the progress to date is maintained and further developed, so that:

- More people can access advice and support in primary care.
- The presumption will be that care will be provided in the community.
- Inpatient care will be provided in modern, purpose built facilities that reflect the current relevant guidance.
- Specialist services will be provided through shared care, joint working and off-island placements where this is the best option.
- Adults are treated in age appropriate, rather than age defined, services.

Current challenges

- Arranging shared and joint care with physicians on island presents difficulties when treating conditions that have an impact on physical health e.g. eating disorders in adults. This has led to patients needing to be transferred to specialist units on the mainland.
- Attitudes of staff, particularly in A&E and PEH to mental health service users.
- Providing adequate care for people in extreme distress in the Castel facilities.
- Discharge from secondary care services to primary care, because of concerns over service user confidence or engagement.
- Discharge from in-patient care to supported accommodation.
- Employment opportunities for people recovering.

Older Adult Services

The Health & Social Services Department's 2020 Vision for the Future of the Health and Social Care System, approved by the States in May 2011, emphasised the need for a focus on preventive services and early intervention, before people reach crisis point and require high levels of support. The principles which have shaped the Extra-Care Housing development, and which will inform the Strategy outlined in this Paper, reflect the need to prioritise independence and self-care, to promote healthy living and provide early support, so that the demand for intensive and expensive bed-based or round-the-clock services is reduced.

The Supported Living and Ageing Well Strategy green paper, currently being developed jointly

by Guernsey States Housing Department and Guernsey Health and Social Services Department, sets out the work that will need to be undertaken to produce the Strategy itself.

Early intervention, prevention, independence and choice will be at the heart of the strategy. The Supported Living and Ageing Well Strategy is intended to tackle these issues and will provide the framework for the States, the voluntary and third sector, and older people and people with supported living needs themselves to work together.

The people of the Bailiwick of Guernsey are living much longer. The time spent leading up to, and after retirement, can now be as long as the time spent in paid or unpaid work. Because of this it is important that we plan for the future by working together to provide opportunities and services that meet the needs of an ageing population and people with supported living needs. It is imperative that a full and comprehensive strategy is produced and this paper shows how we will get there.

Mental Health services for Older People need to provide not only care and treatment for the functional conditions, such as anxiety and depression and the mental health problems treated within adult services, that an older person may have experienced in earlier life, but also the care and support needed for organic conditions, including dementia.

Current challenges

- Lack of access to comprehensive, integrated, multiagency assessment and care planning.
- Lack of integrated home support
- Lack of alternatives to admission, leading to admission earlier than necessary.
- An expectation by families that older person will be cared for long term following assessment.

Strategic Priorities

	Timescale
Implementation of the Mental Health law.	2013
New build to replace Castel Hospital.	2015
Early intervention for mental health problems, for both children and adults, improving outcomes and reducing the impact of long term distress and suicide.	
People to access age appropriate services, rather than be transferred at a pre-defined age.	
Effective planning and preparation for transition between services.	
Early assessment, diagnosis and care planning for people with dementia.	
More people with mental health problems to receive effective, evidence based services that have good outcomes.	
Processes for audit and evaluation of services will be established.	
More people will be supported in their own homes, rather than residential or nursing home care.	
More people will be able to access psychological therapies in primary care.	
More people to be able to access services in their locality, in non-stigmatising settings.	
More people to have their care needs met on island through collaboration between physical and mental health staff.	
More people will be able to access specialist mental health services through partnership and shared care arrangements with mainland providers.	

This will be achieved by

- Establishing multi-agency forums for joint planning, to improve effectiveness and efficiency.
- Improving arrangements for collaborative and joint working between agencies, including health and social care, education, probation, employment services and housing.
- Improving the skills of non-mental health staff to recognise and manage mild mental health problems in primary care and to refer promptly for advice and consultation.
- Ensuring that the physical health needs of mental health service users are assessed and met.
- Developing improved care pathways that enable people to receive high quality specialist care on island.

People with Learning Disabilities and their health needs

"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity."
(WHO)

Definition

The definition of learning disabilities utilised in England is:

- A significantly reduced ability to understand new or complex information, and to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- Onset before adulthood, with a lasting effect on development.

Background: prevalence

People with learning disabilities face many barriers when they have a dual diagnosis such as a learning disability and a mental health problem. It is currently recognised that people with learning disabilities can develop poor mental health in the same way as any other person in the wider population. People with learning disabilities demonstrate the complete spectrum of mental health problems, with a higher prevalence than found in those without learning disabilities (Cooper et al., 2007).

Between 25 and 40% of people with learning disabilities have mental health problems at any one time. A summary of research evidence, compiled by the Public Health Observatory for learning disability, cites prevalence rates of:

- 3% for schizophrenia (three times greater than for the general population), with higher rates for people of South Asian origin;
- Same as the general population for anxiety and depression (though higher in people with Down's syndrome).

For children and young people, (Emerson and Hatton, 2007) demonstrated that the prevalence rate of a diagnosable psychiatric disorder is 36% in children and adolescents with learning disabilities, compared with 8% of those who did not have a learning disability. These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders. Children and young people with learning disabilities are much more likely than others to live in poverty, to have few friends and to have concomitant long term health problems and disabilities such as epilepsy and sensory impairments. All these factors are positively associated with mental health problems. Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are some important differences. People with a learning disability are at greater risk of developing dementia at a younger age - particularly those with Down's syndrome.

The increased prevalence of mental health problems in those with learning disabilities has been attributed to biological, psychological and social risk factors that may predispose to,

precipitate and perpetuate mental health problems (Deb et al., 2001). While anyone in the wider population can be affected, people with learning disabilities confront them at a higher rate and may be less able to deal with the consequences: together this leads to increased mental health problems.

Due to the high prevalence of people with learning disabilities also having mental health problems in their life, the following material addresses some of the wider issues that people with learning disabilities are faced with as well as how these can be considered in providing better treatment.

Risk factors for mental health problems

Many people with learning disabilities have led a life of rejection by society due to stigma and discrimination. This has a great impact on a person's self-esteem, self-confidence and self-image. People with learning disabilities may not be aware of their rights as citizens, or may not be able to understand the systems that they have been placed in by others. They frequently rely on others to advocate on their behalf to meet their physical and emotional needs because many people with learning disabilities do not have long term relationships with people who look after their best interests. They are often at the mercy of what others feel is best for them and thus are at a higher risk of being taken advantage of and not having recourse when treated unfairly.

People with learning disabilities often encounter discrimination by not being given opportunities, so they develop low expectations of themselves. Current evidence from a partnership between the Foundation for People with Learning Disabilities and Lemos and Crane (2012) showed that people with learning disabilities living independently in the community experience a disturbing range of harassment, abuse and related crime. The perpetrators in the main are local people, neighbours, and often young people and schoolchildren. Incidents happen when people are out and about in the community, but also in and around their homes. Above all, these incidents are straightforward cruelty. The loneliness of some people with learning disabilities – one in four people interviewed for the research said they didn't have any friends – is putting them at particular risk, leaving them with little choice but to visit hostile public spaces and spend time with exploitative and cruel people.

People with learning disabilities are more likely to be born into and live in lower socio-economic classes (Royal College of Nursing, 2010). They frequently have smaller social networks, and as a result are deprived of the support of a wide circle of friends and other relationships. This is because they may not have been given the information, support and skills needed to develop meaningful social networks. Many people form relationships which are artificial and short term such as with paid support staff. Some may get involved in destructive and abusive relationships in their attempts to 'fit in'. Typically they do not have the support or other positive relationships to help them get out of these situations.

In the UK the majority of people with learning disabilities live with their families, while others, especially older people, may have lived in large institutional settings or other segregated settings where they had little or no choice in what happened in their lives. The experience of having no control or choice can cause people with learning disabilities to lack "real" world experiences or have lower expectations than others of their same age and gender.

We are told by people with learning disabilities and their families that the transition to adulthood is particularly stressful. This is due to a lack of support and information, and poor communication between children's, education and adult services. This leaves the young person feeling frightened and anxious about their life after school.

People with learning disabilities are one of the most vulnerable groups in society (Royal College of Nursing, 2012). People with learning disabilities have often been abused and/or neglected by individuals or their services, which may go unrecognised as they are seen as unreliable informants. People with learning disabilities are more likely to have communication needs that make it difficult for them to report abuse. Also, they may not realise that what they have experienced constitutes abuse.

Cognitive impairment

Cognitive impairment can make it difficult for people to think through the consequences of their actions or decisions. Although many people with learning disabilities can understand and manage under difficult conditions, not everyone has the same ability to handle their situation especially if this is complicated, requiring different levels of decision making.

People with learning disabilities have had a history of low expectations by others and have lacked opportunities due to discrimination, thus they see themselves as not being capable and competent. This has caused overreliance by people with learning disabilities on others, regardless of their abilities. It is a vicious feedback loop of low expectations from others reinforced by self-stigma and low self-esteem. People with learning disabilities who have had these experiences of vulnerability will also be more apt to defer to people who appear to be in authority. They are more willing to answer "yes" or "no" questions or try to give you an answer rather than say 'I don't know'. This is a dangerous situation for the person with a learning disability as it increases their risk of victimisation. Some people with learning disabilities may say they are okay as they are fearful that the "professional" won't like it if they say they are not feeling well. The presence of a low intelligence quotient, e.g. an IQ below 70, should not be used as a sole reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining how to offer supports, diagnosis, assessment and treatment.

There are many barriers that get in the way of receiving early identification and diagnosis of mental health issues in people with learning disabilities; they include:

- Diagnostic overshadowing where presenting symptoms are considered as challenging behaviours or part of the learning disability;
- Communication - the way people with learning disabilities communicate;
- The language used to describe mental health can be abstract but it needs to be far more concrete in working with this client group;
- Stigma can be a major barrier to families who may loath for another label to be given to their son/daughter. With some families from black and minority ethnic communities this would add to the already heavy stigma that may be felt with the label of learning disability;
- Sometimes mental health professionals do not want to take responsibility for the presenting symptoms and often send patients back to learning disability services (Foundation for People with Learning Disabilities, 2002).

Communication

Communication can be an area that many people with learning disabilities, and other associated disabilities such as autism, will struggle with when trying to communicate their needs and emotions. It is estimated that at least 50% of people with learning disabilities have significant communication difficulties (Mansell, 1992).

Some people with learning disabilities have learned to use verbal, visual and social "cues" to try and fit in, and thus will answer questions based on what they think the other person wants them to say. Some people with learning disabilities may use a word without knowing what it means. For example, they may be asked if they are depressed, and say "no" when they actually are "feeling sad". Advances in therapeutic thinking have led to an increased recognition of the importance of non-verbal processes and communication. Therefore, lack of verbal ability need not preclude engagement in therapy. The Department of Health published advice on making the "Improving Access to Psychological Therapies" programme accessible to people with learning disabilities. The "Do Once and Share" (Department of Health, 2009), care pathway for children and adolescents with learning disabilities who have mental health problems advises practitioners to consider the full range of interventions that they would normally apply, with adaptations according to the communication needs and cognitive development of the young person.

Challenging behaviour

The term "challenging behaviour" was introduced with the intention of highlighting that many of the "aggressive" problems people with learning disabilities experience are caused as much by the way in which a person is supported as by their own characteristics. In the ensuing years, there has been a drift towards using it as a label for people.

Mental health issues may become apparent because of a change in behaviour. They can be a seen as a cause, especially if the person has not previously had this type of behaviour in the

past. It is important to take into consideration that there could be physical causes to the behaviours, or that they are serving as a means to communicate a need or emotion. A very high proportion of people with learning disabilities are prescribed psychotropic medication (most commonly anti-psychotics, often older brands) – published papers report rates of between 9% (people living with their families) to 32% in some residential settings. Anti-psychotics are most commonly prescribed for challenging behaviour, despite lack of evidence of their effectiveness and considerable evidence of harmful side-effects (Royal College of Nursing, 2010).

Case study

Andy had a diagnosis of a severe learning disability and autistic spectrum disorder. Andy was 60 years old and had been living with his 85 year old father who had died. It was determined by the social care staff that Andy lacked the capacity, using the Mental Capacity Act 2005, to make a decision about where was the best place for him to live. A decision was made that Andy would be placed in a local residential care home. Andy was taken to the home where he knew no one, on the day that his father passed away. There were no other family members in the area, and only two distant cousins who had no contact with Andy. Andy was not allowed to attend the funeral as it was felt it would just upset him and he might become aggressive. For the first week at the home, Andy refused to eat and drink, and stayed in his room. When asked what the problem was he became aggressive, lashing out at staff and other residents who came near him. When staff tried to get him to do things, he would try and hit them and throw things at them. A locum psychiatrist was called to the home. Andy was given psychotropic medication to calm him down. While on the medication staff were able to get Andy to go to the day centre where he had been going up until his father died. At the day centre, his keyworker who had returned from holiday to find Andy in his current state (listless, not talking, his appearance dishevelled), was shocked. She contacted the social worker and insisted a meeting be held to look into the situation that Andy had been placed. She also contacted the local GP who knew Andy and his father. Andy went with her to see the GP who assessed Andy to be in a severe depressive state, with additional anxiety. The support worker identified the reasons for this as Andy being removed from his home against his will, not being able to have closure with his father's death, and a clear breach in his daily routines. Andy was able to tell the support worker and the GP that he was scared and felt bad. A best interests meeting was held and an emergency care plan was developed. Andy's medication was changed, and Andy began receiving grief therapy. Andy was allowed to go back home with supports paid for by social services and health.

Physical health

People with learning disabilities have increased health needs compared to the wider population. Although mortality rates have significantly decreased over recent decades, they are still likely to die younger than other people. The RCN has produced guidance on this – Meeting the health needs of people with learning disabilities (Royal College of Nursing 2010).

- They may develop physical health problems, e.g. due to self-neglect, poor dental hygiene, and poor health care;
- Medication may be over utilised that may cause other physical ailments and other interventions limited or not used such as psychological interventions. They may have less choice and have fewer opportunities to express their views and opinions (Adapted from Hardy et al., 2006).

The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2008) followed the Mencap report Death by Indifference (2007) looking at the deaths of six people with learning disabilities in general hospitals. They found that one man died as a result of failings in his care, while a second death could have been avoided. It also found that failings in the care of two others was partly due to their learning disability. The enquiry concluded that:

> *"The evidence from the literature, from the consultation and from witnesses suggests very clearly that high levels of health need are not currently being met and that there are risks inherent in the care system. People with learning disabilities appear to receive less effective care than they are entitled to receive, especially as they move from children's to adult services and discrimination is evident in access to and outcomes from services. Many of these problems concern basic shortcomings in the way that treatment is delivered that would be simple to remedy. However, there is also evidence of a significant level of avoidable suffering due to untreated ill health, and a high likelihood that avoidable deaths are occurring. All these areas require urgent attention."* The Independent Inquiry into Access to Healthcare for People with Learning Disabilities (2008).

Problems often arise when people with learning disabilities and mental health problems are admitted to generic mental health wards. Vulnerable clients can be put at risk of abuse from other clients. (Bouras et al., 2003)

The frequency of epilepsy occurring in people with a learning disability is higher than in the population as a whole. About 30% of people with a learning disability also have some form of epilepsy (Foundation for People with Learning Disabilities, 2009). People with Down's syndrome have higher rates of congenital heart disease and a higher risk of gastrointestinal

disorders and cancer (Michael, 2008). We find that higher rates of obesity in people with learning disabilities and these are even higher for women. This can be due to poor diet, isolation and lack of opportunities to get good health advice and support, lack of physical exercise, or medications that cause weight gain.

Conclusions and implications

It is evident that despite information on prevalence and on good practice relating to learning disability and mental health; it appears that there is little done to promote mental health amongst people with learning disabilities, their families and frontline staff. Identification of early signs of common mental health problems are not readily spotted and very few people with learning disabilities get an annual health check in primary care and there is little evidence as to whether mental health issues are considered if a check is done.

Awareness of overshadowing and understanding of the prevalence of mental health in people with learning disabilities, their families and staff is key to the early detection of mental health problems. The diagnosis of mental health problems in people with learning disabilities needs special attention in order for good support and treatment to be offered. The improvement of practice requires the inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems, and the development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities. Improvement in the development of diagnostic services and pathways to care and support alone will not create the necessary changes to good practice. There is a need for greater awareness among healthcare and social care professionals on the issues relating to presentation and diagnosis, and a requirement for adjustments in meeting individual needs.

Strategies for the provision of good mental health services for people with learning disabilities should consider the following issues:

- Implementation of policies that reinforce entitlements to health and mental health services for people with learning disabilities. This would include methods to monitor that policies are effective. See example below.
- Ensure that people with learning disabilities, including those from minority ethnic communities, have the same right of access to mainstream health services as the rest of the population. Mandatory annual health checks could be implemented for this group that include a mental health check.
- Assessments need to consider mental health issues as a cause – particularly if the person has not previously displayed any/ this particular type of challenging behaviour.
- Inclusivity of mainstream mental health services needs to be delivered for people with learning disabilities who have mental health problems.
- Development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism.

- Development of diagnostic services and pathways to care and support for people with learning disabilities and mental health problems.
- Health checks on an annual basis to be a requirement that includes mental health. Clinical coding should be improving for people who are having health checks and this may improve the availability of data in future on access to and uptake of the full range of interventions in primary and secondary care. A register of people with learning disabilities may be a useful tool.
- Clear pathways to care to avoid "boundary‟ problems between secondary mental health and learning disability services.
- Early Intervention in Psychosis services for young people aged 14–35 with the first onset of psychosis have been shown to benefit individuals, reduce relapse, improve employment and educational outcomes, and reduce risk of suicide and homicide (Deb, S., et al., 2001).
- Commissioners and service providers will need to ensure that mental health services are accessible to all people with disabilities.

12. Mental health and criminal justice

Mental health in prison

Up to 90% of prisoners have some form of mental health problem (including addictions and personality disorder - Singleton et al., 1998) and 10% of male and 30% of female prisoners have previously experienced a psychiatric acute admission to hospital (DH, 2007).

Most prisoners with mental health problems have common conditions, such as depression or anxiety. A smaller number have more severe conditions such as psychosis. The table below shows the prevalence of mental health problems in prisons compared to the general population.

Rates of self harm and attempted suicide in prison are high. A total of 58 prison suicides[1] and 24,114 self-harm incidents[2] were recorded in 2010. Women represent 5% of the prison population, but account for nearly half of all reported self-harm incidents[3].

Not everyone enters prison with a mental health problem: for some, being in prison will lead them to develop depression or anxiety (JCHR, 2004).

Table 13: Mental health problems in prisons and the general population

	Prevalence among prisoners (16 years+)	Prevalence in general population (16-64 years)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Depression, anxiety etc	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%
	Source: Singleton et al. (1998)	Source: Singleton et al. (2000)

Ethnicity

People from Black and minority ethnic (BME) communities represent about 10% of the UK population but in prison this rises to 26%, a significant proportion of whom are foreign[4]. There are high rates of suicide among foreign nationals: 25% of all prison suicides in 2007/8 (HMIP, 2009). Some Black communities are also overrepresented in secure mental health hospitals (Rutherford & Duggan, 2007). While the rate of diagnosed mental health problems in prison is lower in BME people than among the white population, this may reflect lower levels of identification and referral (Durcan & Knowles, 2006).

[1] http://www.justice.gov.uk/news/press-releases/moj/press-release-020111a.htm

[2] http://www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/safety-in-custody.htm

[3] According to official figures in 2010, 13,688 of people involved in self-harm incidents were male and 10,426 were female.

[4] http://www.prisonreformtrust.org.uk/Portals/0/Documents/Fact%20File%20June%202011%20web.pdf

Women

Women comprise a small proportion of the prison population: at any one time in England and Wales there are about 4,000 women prisoners. A study of 500 women prisoners found that "women in custody are five times more likely to have a mental health concern than women in the general population" (University of Oxford, cited in Prison Reform Trust, 2008).

Women serve shorter sentences, but during that time their children may be taken into the care of the local authority, and they may lose both their job and their home, increasing the likelihood of re-offending and mental illness. The Corston Review commissioned by the Home Office recommended completely replacing the women's prison estate and creating better alternatives (Home Office, 2007).

Children and young people

Children who end up in the youth justice system are three times more likely to have diagnosable mental health difficulties compared with those who do not (Hagell, 2002).

Many also have histories characterised by trauma or abuse and neglect as well as a range of other difficulties which further hamper their ability to achieve their potential. Three quarters have significant speech and communication impairments (Bryan 2004 and Bryan et al. 2007) and 1 in 5 has a learning disability (Chitsabesan et al. 2006). These difficulties all too often remain undiagnosed throughout school careers and even by the time they move into secure custodial settings:

- 75% of young people in custody have lived with someone other than a parent at points in their lives, compared with 1.5% of children in the general population (YJB, 2007).
- 2 out of 5 girls and young women, and a quarter of boys, in custody report suffering violence at home (YJB, 2007).
- 45% of young people in custody have been permanently excluded from school (PRT, 2008).

Probation services

A 2011 report into the prevalence of mental health disorders in the probation population found that more than a quarter of offenders in contact with probation said they currently had a mental illness (Brooker et al 2011). One in seven had a mood disorder and one in five had an anxiety disorder. Some eight per cent had a psychotic illness: about eight times the national average. About half had the symptoms of a personality disorder; more than half had the signs of hazardous or harmful alcohol consumption; and 12 per cent had the signs of serious drug misuse.

Unemployment and social exclusion

Prisoners are disadvantaged in many ways before coming into contact with the criminal justice system:

- 67% were unemployed before going to prison (SEU, 2002).
- 70% will have no employment or placement in training / education on release (Niven & Stewart, 2005).
- 42% of released prisoners have no fixed abode (cited in Williamson, 2006).
- 65% of prisoners have numeracy skills at or below the level of an 11-year-old and 48% have reading skills at or below this level (SEU, 2002).

It is estimated that being in work reduces the risk of re-offending by between a third and a half (SEU, 2002). But a criminal record, low educational attainment, health problems and a lack of stable housing can make it very difficult for prisoners to find employment on release.

Identifying mental health problems

Any prisoner thought to be in need of a mental health service will undergo an assessment process. Because agencies in prisons all tend to work independently of each other, prisoners with mental health problems may undergo multiple assessments, with considerable overlap between each.

Most inreach teams are not involved in the medical screening of new arrivals to prison. In some prisons a mental health nurse carries out this screening but in many cases it is done by staff who do not have mental health training (Edgar & Rickford, 2009).

Reception itself can be a chaotic process in which large numbers of people arrive at one time. Records of previous mental health care often do not accompany prisoners when they are transferred from other prisons. As a result, prisoners with mental health problems have often not been identified at this crucial time (Durcan, 2008).

Primary mental health care

Primary care for prisoners with common mental health problems such as depression, anxiety, emotional distress and adjustment problems is variable. Many prisoners have experienced trauma and abuse (Durcan, 2008) and need psychological therapy.

Some prisons are served by prison doctors and others by a local GP practice. While a majority of prison doctors work with prisoners with mental health problems, most do not receive any training in psychiatry (Pearce et al., 2004). Prison nurses provide a significant proportion of the primary care service. Many prison nurses, including those with mental health training, are employed in a generic health role. Those that have tried to provide primary mental health care have often found this difficult due to staff shortages and the broader demands of the generic role.

Some prisons have developed dedicated specialist primary mental health care teams which are able to deliver some crisis intervention and psychological interventions or psychological therapy services.

Specialist mental health services

Specialist mental health 'inreach' teams have been introduced to work with prisoners with severe and enduring mental illnesses. This has led to an improvement in mental health care in some prisons (Durcan, 2008) but the picture is mixed. Some inreach teams have made a positive contribution – for example a study of five prisons in the West Midlands found that prisoners using inreach services felt better prepared for their release than on previous occasions (Durcan, 2008).

Many prisoners with common mental health problems are also referred to inreach teams. This is because they are given little or no treatment or support from other health services in prison. This puts added pressure on inreach teams and restricts the time they can give to each person.

There has been no implementation guidance for inreach teams or for those commissioning them. Therefore their role and function is different from prison to prison. While inreach teams should include a mixture of staff such as psychiatrists, social workers, mental health nurses and allied health professionals, most teams are mainly made up of nurses, with varying degrees of medical support.

The range of interventions offered by inreach teams can often be very limited. There has been a strong tendency for the various teams and agencies in prisons to work separately rather than together. This is a real challenge for a client group that typically has complex and multiple needs of which poor mental health is just one. Siloed working has made it difficult to provide an integrated approach for those who require support across a range of areas. However, there are some prisons that have achieved good practice in this area and particularly so in the young people's estate.

Transfers to hospital

Some prisons have 24-hour health care facilities which include inpatient units. These can be used for any medical need, but their use tends to be dominated by prisoners with mental health problems. There is also evidence that some prisoners with serious mental health problems are placed in segregation units, because an 'ordinary location' is considered to be too stressful (Edgar & Rickford, 2009; Durcan, 2008).

For the purposes of compulsory care, prisons are not recognised as hospitals under the Mental Health Act 1983. People must be transferred to an NHS hospital for treatment if compulsion is required, usually to secure mental health services.

The population in secure adult psychiatric hospitals is approximately 7,000. Transfer from prison to a secure hospital is often a very slow process. The Department of Health (England) has previously instigated a pilot project to bring waiting times down to 14 days, but often it takes several months for a transfer to take place. The Bradley Review, commissioned by the previous Government, called for this waiting time limit to be applied nationally.

Centre for Mental Health conducted a review of secure services in 2009/10 and found that secure mental health provision varied across the country. While some areas were able to manage timely transfers into such provision, the general picture was one of considerable delay both in admitting prisoners to hospital and in discharging patients from secure units to step-down and community services (Centre for Mental Health,2011b).

Dual diagnosis and multiple need

It is estimated that a large proportion of offenders have both mental health and substance misuse problems (Brooker et al., 2002 and Brooker et al., 2011). However, there is big gap in 'dual diagnosis' services in prisons. Up to 70% of inreach team clients have substance misuse needs, but only around one in ten teams has a specialist dual diagnosis service (HMIP, 2009).

During the year before prison, 63% of male sentenced prisoners and 39% of female sentenced prisoners were hazardous drinkers (Singleton et al, 1998). Many more prisoners have less severe problems with alcohol which would still benefit from treatment. But the provision of alcohol services in adult prisons is variable: some have appointed dedicated alcohol workers, but most prison substance misuse teams do not work with prisoners who have alcohol problems unless they also use street drugs (HMIP, 2009).

Across the criminal justice pathway, alcohol interventions are under-resourced (Centre for ces (Bather, Fitzpatrick & Rutherford, 2008).

Mental Health, 2011a). There is inadequate support for offenders who misuse alcohol at all levels, from basic screening and advice to specialist counselling and treatment programmes. This inadequate provision at all stages is further exacerbated by misalignment between health and criminal justice agencies and a lack of equivalence between alcohol and drug service commissioning.

Personality disorders

It is estimated that 66% of prisoners have a personality disorder (Singleton et al., 1998). Personality disorders are not classed as mental illness by some authorities but are described by psychiatrists as aspects of an individual's personality that make it difficult for them to live with themselves or other people. The majority of prisoners with personality disorder receive little in the way of support targeted to their needs (Durcan, 2008). There is huge geographical variability in practice in the transfer of people with personality disorder to secure mental health care for treatment (Centre for Mental Health, 2011a)

Liaison and diversion

Around 15% of incidents with which the police deal have some kind of mental health dimension. Yet police officers rarely have mental health training and there are few opportunities to divert people from police stations to health and social care services.

Police and court liaison and diversion schemes were introduced to ensure that people with mental health problems who come into contact with the police and courts are identified and directed towards more appropriate care. There is evidence that where such services are working well they can be cost-effective (Sainsbury Centre, 2009), but too often they have been unable to have a major impact on the system. It is estimated that just one-fifth of the potential national caseload is seen, and even cases of severe mental illness are often missed, because many schemes rely on police or court staff to identify individuals who may need support (Sainsbury Centre, 2009).

The Bradley Report called for criminal justice mental health teams to be set up across England to divert people from police stations and courts to more appropriate care (Bradley, 2009). The Coalition Government has committed to developing diversion services to identify people with mental health difficulties in police stations and courts and to make available treatment-based alternatives to imprisonment for offenders with mental health and drug problems.

Community sentences

For people with mental health problems who cannot be entirely diverted away from a criminal justice sanction, a community sentence with a Mental Health Treatment Requirement (MHTR) can be a viable alternative to a short prison sentence. At present it is little used by the courts because it is poorly understood, subject to lengthy delays and there is no procedure for ensuring that support is available from local community mental health services (Sainsbury Centre, 2009b).

There is a particularly strong case for diverting offenders away from short sentences in prison towards effective treatment in the community. It is estimated that this will lead to savings in crime-related costs of over £20,000 per case (Sainsbury Centre, 2009a).

Care after release

The resettlement experience of most prisoners is poor with most receiving little meaningful help on leaving prison. Prisoners with mental health problems are particularly vulnerable. Many have no permanent residence arranged on release which makes it harder for them to keep in touch with services (Sainsbury Centre, 2008c) and few receive support to find and keep paid work (Centre for Mental Health, 2010).

Men recently released from prison are eight times more likely than the general population to commit suicide. Women released from prison are 36 times more likely to kill themselves than women in the general community (Pratt et al., 2006). Some individuals may be in distress because they are being released from prison into the same situation that led them to crime in the first place.

Research from Peninsula Medical School in Plymouth (Byng et al, 2012) indicates that where probation and health services work closely together, offering released prisoners integrated support and ensuring probation staff understand mental health issues, rehabilitation services work more effectively in improving health and reducing the risk of reoffending.

13. Summary of New Mental Health Law

Background

Guernsey's current Mental Health Law dates from 1939. The new law is modelled very much on the UK's 1983 Mental Health Act, as amended in 2007, whilst maintaining the simplicity of Guernsey's current Law. The Law received Privy Council Approval and was registered by the Royal Court in December 2011. It is currently anticipated that the law will be introduced at the end of 2012.

The implementation of the new legislation will be supported by a separate **Code of Practice,** and there will be an extensive training and information programme. The new law makes significant changes to the way in which people can be detained, the processes that govern this and the people who have powers of detention.

Compulsory orders available under the new law:

- **Assessment**
  - Compulsory admission for up to 28 days (replaces current 7 day Urgency Order, and equivalent to Section 2 of the UK 1983 Mental Health Act).
- **Treatment**
  - Will allow compulsory detention for up to 6 months. It can be renewed, in the first instance for 6 months, then subsequently, for periods of 12 months. (Replaces current Certification Order).
- **Medical Holding**
- **Nurse Holding**
  - Will allow a Registered Nurse to detain any voluntary inpatient, for up to 8 hours whilst waiting for a doctor to attend.
- **Community Treatment**
  - The new Law introduces a new community treatment power for patients who have been detained on a treatment order. It allows for a comprehensive care plan to be put in place which will provide services to a person to support their safe living in suitable accommodation in the community, within the boundaries of the legislative framework.
- **Criminal Justice Orders**
  - The Law will allow the Courts a number of options when considering the disposal of persons concerned in criminal proceedings. These include:
    - Remand to Hospital for Psychiatric Report or Treatment.
    - Hospital Treatment Order.
    - Hospital Transfer Order.

New Roles created by the New Law

Approved Social Worker

A Social Worker who has undertaken further intensive training in mental health who will be able to:

- Make applications for compulsory admission to hospital. (This is currently undertaken by a Parish Constable or relative).
- Make applications for Community Treatment Orders
- Apply for a court warrant to enable a police officer to enter premises to search for and remove persons to a place of safety.

Nominated Representative

An individual over the age eighteen years has the right to appoint a person whom they wish to act in their interests and with whom they give consent for information about their care and treatment to be shared. This person may be a family member, carer, friend, neighbour, clergyman etc. The Nominated Representative shall also be deemed to be that person's Nearest Relative and has a number of rights and powers, some of which are detailed below, in order to fulfil this duty.

Mental Health Law Administrator

Will provide a comprehensive, accurate and professional administration of detained clients and will:

- Ensure documentation is scrutinised and maintained within statutory guidelines.
- Co-ordinate Mental Health Review Panel process, liaising between RMO, ASW, legal representative, panel members, ward managers and client's nearest relative.
- Take minutes of MHRP.
- Report breaches of the law to the Governance Committee

Second Opinion Appointed Doctor (SOAD)

In certain circumstances, there will be a requirement for detained patients who are not consenting to medication to be reviewed by an independent doctor (SOAD).

Mental Health Review Tribunal

People detained under the law, who wish to appeal against their detention, can apply to a Mental Health Review Tribunal.

This will consist of 3 persons: the Chair (a qualified legal practitioner), an independent Consultant Psychiatrist and one lay member. The MHRT can:

- Discharge patients from Assessment, Treatment or Community Treatment Orders.
- The Tribunal Chair will personally communicate the decision to the patient, and the Mental Health Administrator will ensure communication within a 5 day period.

Glossary

A&E	Accident & Emergency Department
ASW	Approved Social Worker
CMHN	Community Mental Health Nurse (CPN)
HSSD	Health & Social Services Department
MHRP	Mental Health Review Panel
MHRT	Mental Health Review Tribunal
OT	Occupational Therapist
RMN	Registered Mental Health Nurse
RMO	Responsible Medical Officer
SW	Social Worker

14. Replacement of Castel Hospital

The main focus for mental health service provision for adults is currently centred on the Castel Hospital, where all out-patient services are sited, together with the base for all community services and the single inpatient 21 bed ward which also provides inpatient facilities for alcohol detoxification. The accommodation is not suitable for a modern service and has contributed to the need for off-island placements because the configuration of the beds does not allow for separate female only areas, the lack of separate high dependency facilities and lack of flexibility to accommodate a varied case-mix.

Castel Hospital is also the location for Adult Day services, secondary care Psychological Therapies and the Older Adult Community Team.

Plans have been developed to replace the Castel Hospital and have been given a Priority 1 status. It is anticipated that this will be completed by 2015.

The new hospital will be sited on the Princess Elizabeth Hospital site. The new build has been designed to deliver a modern mental health service and will have:

- 18 adult beds, configured in small groups that will provide opportunities for flexible use, with separate male and female areas and an area for higher intensity of care.
- Day services for recovery and rehabilitation.
- 8 Bed older adult assessment and respite facility, replacing Divette Ward, currently at PEH.
- Child and Adolescent Mental Health Services out patients, currently at Bell House.
- A 2 bed adolescent secure unit, currently at Perrouque House.
- Office accommodation for Mental Health support services.

The improvement in accommodation is expected to deliver a number of benefits:

- Improve the therapeutic milieu, leading to shorter lengths of stay and improved outcomes.
- Provide a high intensity area, where people in acute distress can be accommodated, reducing the tension that might be felt elsewhere in the ward.
- Allow for the separate accommodation for an adolescent, or mother and baby, prior to transfer.
- Improve the opportunities for assessment and treatment instead of off-island transfer.
- Facilitate improved planning for off-island specialist care.
- Assist in providing accommodation for early transfer back from mainland.
- Reduce the stigma and discrimination currently attributed to the Castel Hospital.

15. Evaluating the Effectiveness and Impact of the Guernsey Mental Health Strategy

Introduction: Summary of key tasks and challenges

To measure the effectiveness and impact of a national strategy, it is necessary to understand its purpose, both as explicitly stated and implicit or assumed, and build measures around this understanding. This chapter outlines possible ways of assessing the effectiveness of the strategy, and identifies some of the challenges, as well as potential assessment tools, and the steps needed to achieve a reliable assessment.

Aims of a mental health strategy:

1. Improve national wellbeing.
2. Reduce impact of mental ill-health.
3. Deliver services effectively.
4. Reduce inequalities faced by people who experience mental ill-health.

In order to measure the impact of the strategy, the following challenges will need to be overcome:

Data challenges:

- Developing a standardised way of collecting baseline data.
- Collecting data from whole population at regular intervals.
- Identifying specific groups of interest.
- Collecting data from these groups at regular intervals.

People challenges:

- Health service commitment to delivery and impact assessment, in particular understanding at all staff levels – may require incentives.
- Commitment from staff beyond health, particularly where delivery requires contributions from social care and broader public services.
- Collecting reliable data from service users and carers.

Impact challenges:

- Attributing any change to the strategy
- Applying learning from impact. assessment to future practice.

Background

Evaluating the impact of a mental health policy is challenging. Very few countries have completed comprehensive assessments of the impact of national mental health strategies (Petrea & McCulloch, 2012). A number of countries have introduced strategies or legislation for specific purposes; for example policies or strategies to reduce suicides or repeat hospital admissions. These focused policies clearly lend themselves to simple

impact assessment: they either do or do not have the desired effect in simple countable terms.

In the past decade, mental health care policy in England has moved from a directive approach, aimed at the development of a sophisticated community care structure, towards the promotion of social inclusion and recovery goals (Trimbos Institute, 2011). In the early 1990s, an acknowledgement of the importance of impact assessment and a review of available measures led to the development of the Health of the Nation Outcome Scale (HoNOS, Wing et al., 1998). HoNOS was developed as a measure of the health and social functioning of people with severe mental illness. Its key purpose was to enable recording of progress towards the targets set within the Health of the Nation (DoH, 1988), the key health strategy document of the time.

In 2004, NHS Health Scotland was commissioned to establish a core set of national, sustainable mental health indicators of mental health improvement. A new scale was developed to obtain an assessment of the overall positive mental health of the adult population: the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007). Wales is currently in the process of developing an implementation plan for its new mental health strategy which makes a strong commitment to assessing the impact of the strategy, particularly "through the lens of the service user". The Welsh Government is using a range of population and groups-specific tools; others are currently being developed.

In addition, a number of countries with anti-stigma or discrimination programmes have accompanied them with evaluation strategies, such as Germany. The key challenge these face has been to attribute any measured change to the strategy, particularly where the evaluation has relied primarily on measuring public attitudes.

The relatively small scale of Guernsey compared to countries where some work of this type has already been undertaken makes some aspects of this work easier, and some more difficult. The mechanics of data collection and the task of analysis are much more straightforward. The ability to identify impact and trends is reduced (annual fluctuations in suicide rates, for example, are unlikely to be significant and long timescales will be required), though the ability to link change to strategy will be easier and local key informants will be able to help understand likely causality.

National wellbeing

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007) has been used in Guernsey and is widely used as an indicator of wellbeing. It can be employed for the general population as well as for people in touch with specialist services, and has also been validated for use with children from the age of 13. In addition, there are a number of more sophisticated "capabilities-based" audit approaches that would help establish the impact of measures designed to increase resilience, either in the general population, or

in specific groups at a greater risk, or already experiencing mental ill-health.

It is well known that some groups are at increased risk of developing mental ill-health, have less healthy lifestyles, or are less likely to benefit from mental health promotion interventions. Particular attention needs to be paid to these groups and the framework needs to ensure impact amongst these sub-populations (Murali & Oyebode, 2004).

There has been growing interest in monitoring the wellbeing of children and young people as an important element of national wellbeing. To assess the benefits of preventative policy and service initiatives, children and young people's experiences have to be captured from their perspectives (Deighton & Wolpert, 2009). The Children's Society developed a short index of children's subjective wellbeing, building on the Students' Life Satisfaction Scale (Huebner, 1991), as well as the questions from the British Households Panel Survey and the Families and Children Study, which have asked about children's wellbeing (Rees et al., 2010). There any many group specific scales for assessing mental health outcomes for children and young people (see review by Deighton & Wolpert, 2009).

Glossary

Acute care	A branch of secondary health care where a patient receives active but short-term treatment for a severe episode of mental illness.
Assertive outreach	A system of intensive client centred community support, including health and social care support, for people with severe mental illness who have difficulty in engaging with services. It is characterised by low caseloads and a high regular and persistent contact with clients.
Care	Health and social care by both formal and informal carers.
Carers	People who informally care for someone with mental illness, e.g. family, neighbours and friends.
Care planning	This consists of needs assessment, followed by the formulation on an agreed plan as to how those needs are to be met. The plan is usually developed in a multidisciplinary way, involving the relevant professionals, patient and carer. The concept has evolved in specialist care but could also be used in primary care.
Case management	This term refers to a patient-centred system of care, with a strong emphasis on the co-ordination of care in the community. Its goals are continuity of care and individualised support through assessment, care planning, intervention, monitoring and review.
Commissioner	Someone, often an administrator, who requests a specific service infrastructure from a health provider.
Common mental health problem	Psychological distress usually connected with various life situations, events and problems (e.g. depression, anxiety disorders).
Dementia	Progressive organic disorder of the brain.
Early Intervention	The overall aim of early intervention is to allow early identification and treatment of mental illness. This includes those who are experiencing their first experience of mental illness and can also include people who may be at risk of developing mental health problems.
Evidence based	Practice designed and delivered in accordance with the best available research evidence.
Forensic	The branch of mental health services that is concerned with the legal aspects of mental illness.
Incidence	The number of cases of a disease or condition whose onset occurs during a specific time.
Mental health	Includes a positive sense of wellbeing; individual resources include self-esteem, optimism, a sense of mastery and coherence; the ability to initiate, develop and sustain mututally satisfying personal relationships and the ability to cope with adversities.
Mental health promotion	An interdisciplinary and socio-cultural endeavor geared to enhancing the wellbeing of individuals, groups and communities. It implies the creation of individual, social, societal, and environmental conditions

	which enable optimal psychological development and reduction in mental health problems.
Mental illness	Include psychological distress usually connected with various life situations, events and problems; common mental disorders (e.g. depression, anxiety disorders); severe mental disorders with disturbances in perception, beliefs and thought processes (psychoses); substance abuse disorders (excess consumption and dependency on alcohol, drugs, tobacco); abnormal personality traits which are handicapping to the individual and / or to others; and progressive organic disorders of the brain (dementias).
Morbidity	The incidence of a particular disease. Co-morbidity describes the presence of one or more disorders (or diseases) in addition to a primary disease or disorder. Multi-morbidity is as the co-existence of two or more long-term conditions in an individual.
Personality disorders	Include anti-social personality disorder / borderline personality disorder.
Prevalence	Total number of cases of a disease within a population.
Prevention	Measures to prevent the onset of mental illness (primary prevention), limit the severity of the illness (secondary prevention) and measures to reduce disability after a mental (tertiary prevention).
Primary care	The first point of contact with the patient, user or client, providing non-specialist care and an overview of health and social care needs. Primary care is sometimes provided by specialist services working in more general mode (e.g. A&E departments, assertive outreach teams) but is usually provided by general practitioners and primary care nurses.
Protective factor	Any factor whose presence is associated with an increased protection from a disease or condition.
Psychosis	A mental illness in which a person's thoughts, affective response, ability to recognise reality and ability to communicate and relate to others are sufficiently impaired to grossly interfere with an individual's capacity to cope with life.
Quality of life	A measure that is can be used to evaluate the wellbeing of individuals and populations.
Recovery	Being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.
Rehabilitation	The physical, mental, social and vocational preparation of a patient for the fullest possible life compatible with their abilities and disabilities.
Resilience	The capacity of individuals and communities to deal effectively with stress and adversity.
Risk assessment	Prediction of likelihood that an individual will commit violence directed

	to self or others.
Risk factor	A variable associated with an increased risk of illness or condition.
Risk group	An assessment of a sub population's likelihood for development of a condition.
Secondary care	A service provided by medical specialists who generally do not have first contact with patients.
Severe and enduring mental health problem	Mental illness where the individual experiences severe disturbances in perception, beliefs and thought processes (see also psychosis).
Social capital	The existence of a certain set of informal values or norms shared among members of a group that permit co-operation among them.
Stakeholder	Someone with a specific and legitimate interest in mental health services who should therefore be consulted.
Stigma	An attempt to label a particular group of people as less worthy of respect than others.
User	A consumer of services, client, patient. It is not used in this strategy in the sense of someone who uses illicit drugs.
Wellbeing	Concept that comprises three major components: emotional wellbeing (i.e. positive feelings or subjective wellbeing); psychological wellbeing (i.e. self-esteem, resilience) and social wellbeing (i.e. supportive relationships, trust, a sense of belonging).

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Annex: Useful resources

Good practice guidance

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- Practice guidelines for the assessment and diagnosis of mental health problems in adults with intellectual disability. ***http://www.estiacentre.org/freepub.html***

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Down's syndrome and dementia resource

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British Institute of Learning Disabilities

www.bild.org.uk Mental health in learning disabilities: A training resource

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OLM-Pavilion **www.pavpub.com** Understanding depression in people with learning disabilities

Hollins S and Curran J (1997)

OLM-Pavilion **www.pavpub.com** Supporting Complex Needs - A practical guide for support staff working with people with a learning disability who have mental health needs.

http://www.estiacentre.org/freepub.html

Websites

www.communicationmatters.org www.easyinfo.org refer back to previous information on adapting communication.

Books beyond words – published by the Royal College of Psychiatry

www.booksbeyondwords.co.uk Easy to understand leaflets about medication **www.elfrida.com** / **www.easyhealth.org** more accessible written material.

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