



Mental Health

Review of Needs and Services

Joint Strategic Needs Assessment (JSNA)
2025 Report

JSNA

Joint Strategic
Needs Assessment

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Executive Summary

Scope and Policy Context

This Joint Strategic Needs Assessment (JSNA) provides a comprehensive overview of mental health need in Jersey across the life course, examining the factors that shape mental health and wellbeing, the level of demand for support, and the pressures across services. It has been developed to inform the new [all age Mental Health Strategy \(2026–2030\)](#) and to ensure that future investment, planning and system improvement are grounded in high quality evidence, lived experience, and an understanding of inequalities.

The JSNA uses a mixed-methods approach to build a shared picture of need across all age groups, triangulating evidence from the following:

- Local population, prevalence and service data, including mapping activity across pathways (e.g. dual diagnosis interfaces)
- Evidence scan of mental health models
- Public, carer and professional engagement, to understand their views and experiences, test findings and identify gaps not visible in routine data

The work is underpinned by equity principles, recognising the diverse ways in which Islanders experience mental health, stigma, barriers to access, and the wider pressures that influence mental health and wellbeing. Limitations and data development priorities are set out in the report.

Wider context

Evidence shows that health and wellbeing services only actually account for 30% of what keeps us healthy.¹ Most of what makes us healthy comes down to **wider protective factors** including money and resources; good housing, work, education and skills, access to good food, and physical activity, the environment where we live and our friends, family and community network.

Jersey has several **protective factors that support good mental health**: a high-quality natural environment, high overall income, strong employment rates, and improving public mental health literacy with gradually declining stigma. These assets should be leveraged.

Despite Jersey being a wealthy island with high overall GDP per capita, **one in five Islanders live in relative low income** after housing costs, including 24% of children and 28% of pensioners.² Furthermore, housing affordability challenges, rapid population ageing, rising screen time, declining social connectedness, low civic engagement, stubbornly high alcohol consumption, increasing diversity without sufficient preparedness for culturally safe services, and global uncertainties continue to be key pressures, leading to worsening mental health and wellbeing and putting continuing pressure on local services.

This needs assessment has shown that there is variation in health outcomes across different groups of islanders. In general, those experiencing systemic inequalities, and those living with multiple disadvantages have a higher risk of poor mental health.

Mental Health Need Across the Life Course

In Jersey an estimated **one in five children and adults**^{3,4} are now struggling with common mental disorders, this is placing sustained pressure on services across the life course. **Most mental health disorders develop early in life**, with 50% of conditions beginning by age 14 and 75% presenting by age 24.⁵ Therefore, it is vital to provide support from early childhood onwards.

Locally, **demand is increasing** across community mental health services and psychological therapies, showing a high level of common mental health need. At the same time, prescribing trends, crisis service use, and statutory interventions indicate an **increase in the complexity of need with more islanders becoming unwell with severe mental illnesses** and requiring more intensive mental health support. Inequalities cut across the system, and data gaps (such as incomplete ethnicity and other equity fields) limit routine monitoring and targeted improvement.

Across the life course:

- Mental health need in the **perinatal period** remains significant. However, following 2022 Government Plan investment, from the Children and Young People Emotional Wellbeing and Mental health Strategy 2022-2025, there has been additional investment leading to an improved perinatal mental health offer to manage the increasing need. The JSNA findings suggest continued focus on the protective role of the family, particularly around **early years attachment**, would be beneficial in Jersey.
- Need amongst **children and young people** is rising, with a pattern similar to the UK; a sharp increase in emotional disorders in adolescence and a **marked deterioration among girls, including higher anxiety, self-harm thoughts and crisis presentations**. Reasons are not fully clear, but data and stakeholder evidence suggest the cumulative impact of bullying and online harms, body image concerns, and schoolwork as a common worry could contribute. The volume and complexity of need is increasing, seen through an increase in Child and Adolescent Mental Health Services (CAMHS) referrals, with high acceptance rates, with repeat/crisis referrals concentrated among adolescent girls. The overlap between the mental health and neurodevelopmental pathways is significant, and need is high in specific groups (e.g., care experienced children and young people). The findings suggest continued **investment in early intervention** and **resilience building** is important for children and young people in Jersey.
- **Young adults** are a cohort with significant need, including the highest prevalence of **loneliness** of any adult age group and substantial presentations to adult services with the CAMHS-to-adult transition remaining a pressure point. Dual need, notably mental health with substance use (alcohol and cannabis), is also prominent amongst this age group. Furthermore, there are **increasing numbers of young people with long term conditions**; 1 in 3 in 2025 up from 1 in 10 in 2017.⁶ Improving the transition pathway, social connectivity and preparing young people for adult hood is especially important in this group.
- Amongst **working-age adults**, pressure is visible across the system, with **rises in primary care prescribing, increasing demand for psychological therapies (with attrition), heavy use of crisis and emergency pathways**, and Mental Health Law activity, with self-harm a major driver of emergency presentations. Community caseloads for mental health support remain high, with nearly half of those across community and specialist services having severe mental illness (SMI) and dual diagnosis. Given the strong links between SMI and dual diagnosis with deprivation, health inequality and increased risk of poor outcomes, strategic prioritisation of **integrating pathways** particularly for this cohort would be beneficial, through **care co-ordination and joint professional training**.
- Amongst **older adults**, anxiety and depression remain present amid **high rates of multimorbidity, frailty, bereavement, cognitive decline, carer strain** and potential social isolation. **Dementia prevalence** is increasing amongst older adults, placing pressure across secondary and inpatient services, and digital exclusion and stoicism can hinder access to support for this group. Points to consider include **strengthening carer support**,

implementing the recommendations of the Dementia Strategy and consolidating rehabilitation pathways.

What Do People Think?

Engagement work revealed that people **recognise progress in improving support** and that **staff are dedicated** across services, they **value voluntary and community sector offers** (e.g., peer support, out-of-hours access) and **strong follow-up post-discharge**. However, they consistently reported:

- **Fragmented and reactive pathways**, with variable continuity and discharge planning.
- **Unclear navigation and thresholds for entry**; with desire for a “no wrong door” approach.
- **Inconsistent crisis response** and patchiness in trauma-informed practice.
- **Cultural and language barriers**, and **limited choice of therapies**.
- Over-reliance on a **medical model** and medication
- **Support** is usually **offered too late**

Groups repeatedly cited as **facing the greatest barriers** include people with severe mental illness, those with dual diagnosis, care-experienced young people and families, unpaid carers, neurodivergent people, migrants, people experiencing homelessness, those struggling on low incomes and those with co-occurring health needs such as mental health and substance-use needs. Members of these groups often face multiple types of disadvantage, further increasing their risk of mental ill health. These groups sometimes **struggled with accessing services** in the first place, suggesting Jersey’s system needs focus on equitable access. It’s important that these groups in particular receive the **right mental health treatment, interventions and rehabilitation services**, with a focus on recovery, independence and quality of life.

In Conclusion

Jersey’s mental health need is significant, rising and increasingly complex; a pattern which we see across similar jurisdictions. While prevalence remains broadly comparable to the UK, demographic change, socioeconomic pressure, service complexity and inequality are increasing demand - especially for adolescents (notably girls), young adults in transition and a smaller cohort with severe, enduring or crisis-driven presentations. The JSNA identifies a number of areas for prioritisation, with further work undertaken in co-production during the strategy design phase to refine these further.

1. Prioritise poor mental health **prevention, early intervention and building resilience**
2. Improve islanders’ **mental health literacy** to reduce stigma
3. Develop **integrated pathways**, continuity of care, and workforce stability
4. Build an **increased range of quality interventions** to support recovery
5. Ensure a dedicated **focus on best start, children, family and transitions**
6. Involve and increase **support for carers and families**
7. Develop the island’s **culture, environments and facilities** to be more inclusive, accessible and sensitive
8. **Improve crisis, urgent care and step-down** support

About the JSNA

This report outlines the findings of Jersey's Joint Strategic Needs Assessment (JSNA) on Mental Health. The core purpose of a JSNA is to understand the current and emerging health and wellbeing needs of Islanders, enabling Government and partners to plan and prioritise improvements in prevention, support and services.

While JSNA is not a legal requirement in Jersey, as it is in the UK, the programme was initiated in response to several strategic drivers, most notably the health minister's prioritisation in the 2022 Ministerial Plan. The Director for Public Health is the accountable officer for JSNA outputs, but the work itself involves a wide range of stakeholders across Government and partner organisations.

This JSNA on mental health draws on local data, service information, stakeholder input, lived experience, and best practice evidence to inform Jersey's new all-age Mental Health Strategy (2026-2030) and ensure that resources are directed where they are most needed. This JSNA considers the mental health of all age groups across the life course, with particular focus on populations at greater risk of poor mental health outcomes, including (but not limited to) people from minority ethnic backgrounds and migrant communities, LGBTQ+ people (including trans and gender-diverse people), women, neurodivergent people and people with a learning disability, unpaid carers (including young carers), people living with long-term conditions and chronic pain, people experiencing homelessness or insecure housing, and older adults who are socially isolated).⁷ Risk is often driven by wider social determinants such as poverty, discrimination, trauma, housing insecurity and isolation. Barriers to access can delay help until needs become more complex. Many individuals sit across more than one of these groups, and this cumulative disadvantage is a key consideration throughout the assessment. **Throughout the rest of the JSNA document, these groups of people will be defined together as those 'experiencing systemic inequalities'.**

Prioritisation process

The focus topic for this JSNA was selected following learning from the previous JSNA on Women's Health and Wellbeing.⁸ Mental health was prioritised for the current JSNA cycle, not only due to its significance across the population, but also to align with the development of Jersey's new all age Mental Health Strategy 2026-2030, ensuring that the JSNA directly informs strategic planning and investment. This approach also enables the JSNA to set out a small number of clear, evidence-led priorities that can be tracked through the Strategy implementation period.

Spotlight on mental health

Good mental health is fundamental to overall wellbeing and daily functioning.⁹ It affects how people think, feel, and act, influencing everything from physical health and relationships to the ability to handle stress and lead productive lives.¹⁰ Like many places, Jersey has experienced growing demand for mental health support in recent years. Prevalence estimates indicate that mental disorders affect approximately 500 children aged 5-10 years old and around 900 young people aged 11-16 years old in Jersey. Among adults aged 25-64, an estimated one in five are experiencing a common mental health condition at any given time,¹¹ and demand for community and specialist support for severe mental illness is rising. This level of need underlines the importance of strengthening prevention and early help, improving access and navigation, ensuring crisis care is reliable, and reducing the gaps experienced by populations at greater risk including those with complex needs.

Equalities statement

This JSNA recognises that mental health is experienced differently across diverse communities, and that inequalities in access, outcomes, and stigma are shaped by factors such as gender, age, ethnicity, migration status, language needs, neurodivergence, disability, sexual orientation, gender identity, socioeconomic status, and lived experience of trauma. Where data allows, we describe differences in need, access and outcomes across groups, and set out key data development priorities to improve inequality monitoring over time.

We are committed to ensuring that this assessment is inclusive of the experiences and needs of groups who may be experiencing systemic inequalities. The JSNA outlines what is known about inequalities in need, access and outcomes for different groups, and where routine data is not available to allow for robust analysis, this is noted.

The JSNA aims to inform strategies that reduce mental health inequalities, strengthen person-centred care, and improve access and outcomes for all.

Aims of the mental health JSNA

The purpose of this JSNA is to inform the development of an integrated, needs-led, and evidence-based all-age Mental Health Strategy (2026-2030). This work aims to ensure that the experiences of underrepresented and at-risk groups are meaningfully reflected in future planning and decision-making. This JSNA aims to provide current understanding of mental health needs in Jersey across age groups by:

- Identifying whether existing provision meets population needs and highlighting key gaps, barriers, and inequalities, particularly for underrepresented and priority groups.
- Identifying key priority areas for development and improvement within Jersey's mental health landscape to inform the integrated all age Mental Health Strategy (2026-2030).

The JSNA addresses the following questions:

- What are the current and emerging mental health needs across all age groups, and to what extent are they being met, especially for those with serious mental illness and other priority groups?
- What are the main strengths and weaknesses in Jersey's mental health system (e.g. offer, access, integration, navigation, service user outcomes)?
- What are the key barriers and enablers affecting mental health outcomes, including wider social and environmental factors?
- What trends, risks, and challenges will shape future needs, and how can Jersey prepare?
- What do people with lived experience, carers, and professionals view as the top priorities for improvement?
- What lessons from past strategies, data, and best practice can inform a more effective and inclusive approach?

Where did the evidence come from?

This JSNA gathers and triangulates evidence about mental health needs from multiple sources, including:

- Engagement with people with lived experience, carers, the public and professional to understand experiences, barriers and priorities for improvement.
- Analysis of local population data, health and wellbeing indicators, and wider societal factors that influence mental health outcomes*.
- Review of service activity and pathways (including transitions, thresholds and key interfaces such as crisis care and dual diagnosis, where data allows).
- Evidence scan of mental health models.

**Local data collection and analysis ended in November 2025. Efforts have been made to incorporate relevant data from more recent publications, where possible.*

Methodology

The methodological process integrates both quantitative and qualitative evidence to develop a shared, system-wide understanding of mental health in Jersey, including inequalities in need, access and outcomes.

The Mental Health JSNA used a mixed-methods approach, combining analysis of existing data and service mapping with a review of service activity and provision, alongside engagement with professional and the public. Stakeholder engagement (people with lived experience, carers, the general public and professionals) was used to test emerging evidence, identify current needs and service gaps, highlighting opportunities for improvement and other issues that may not be visible in administrative data.

The data collation and analysis work was delivered by the Mental Health JSNA Working Group. This working group included analytics and intelligence representatives from several government departments, to ensure topic area experts were involved. Throughout development of the JSNA, the Mental Health Strategy Steering Group were regularly updated, to ensure findings fed directly into strategy development work.

Below details the methods of data collection, engagement and analysis, across 4 stages:

- Stage 1: Review of evidence
- Stage 2: Professional engagement
- Stage 3: Public engagement
- Stage 4: Synthesis and refinement of key findings

Stage 1: Review of evidence

The first stage focused on reviewing existing strategies, datasets, and intelligence to establish a baseline understanding of mental health needs, service provision, and progress since the Adult Mental Health Strategy (2016–2020) and the Children and Young People’s Mental Health Strategy (2022–2025). Actions and outcomes from these strategies were mapped to assess delivery, barriers, and successes. Quantitative and qualitative data from the past five years were analysed to identify key target groups, trends, and evidence gaps. The JSNA Working Group collated data from across Government departments, healthcare providers, and the voluntary and community sector to form a comprehensive picture of mental health in Jersey. Where possible, data were contextualised through comparisons over time and with other jurisdictions.

Stage 2: Professional engagement

Initial professional engagement was carried out between 5th June and 8th July 2025, to complement the data review and capture expert perspectives on system strengths, challenges, and priorities for improvement.

The JSNA Working Group developed a stakeholder list and prioritised it to balance breadth and depth of input. This stage used a dual-method approach: an online survey and semi-structured interviews. The survey and interview guide were designed in parallel to ensure consistency across methods. The survey included 18 questions (closed, scaled, and open-ended), enabling both quantifiable insights and reflective feedback. The semi-structured interview guide followed a similar structure but allowed for greater depth through 14 core questions and flexible prompts, covering six key areas: role, service strengths and gaps, system-wide context, enablers and barriers, strategic priorities, and final reflections. Facilitators adapted the guide as needed, with key questions prioritised when time was limited. Together, the methods enabled collection of broad system-level insights alongside rich, frontline experiences.

In total, 27 professionals were interviewed, and 61 survey responses were received. Participants represented adult and children's mental health services, strategic leadership, and both Government and third-sector roles.

All responses were anonymised and analysed thematically to identify recurring patterns, shared perspectives, and differences. Illustrative quotes were extracted where appropriate to bring professional voices into the findings while maintaining confidentiality.

Stage 3: Public engagement

Targeted public engagement was done through trauma-informed focus groups and a public survey.

Identification of target groups: Following completion of the professional engagement phase, a list of priority population groups was developed. This drew on:

- data and insights provided by the Mental Health JSNA Working Group
- themes emerging from interviews and workshops with professionals
- known areas of unmet need within Jersey's mental health system

The intention was to ensure that people most affected by service gaps or structural barriers were actively included in the next phase of engagement.

Prioritisation and RAG rating: Each identified group was then RAG-rated (Red–Amber–Green) according to two key considerations:

- **Representation to date:** whether the group's views were already well-represented through previous consultations or service feedback mechanisms.
- **Need for additional engagement:** whether the group historically had limited opportunities to share their experiences or was identified by professionals as under-represented or at higher risk of unmet mental health needs.

Groups rated **Green** were prioritised for targeted outreach and tailored engagement sessions. **Amber** groups were invited to participate through open routes such as the public survey, while **Red** groups were considered sufficiently represented through existing evidence.

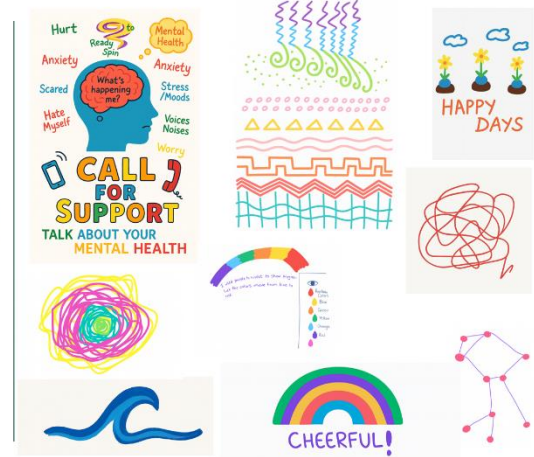
The public engagement phase was designed and delivered in line with Government of Jersey ethical and governance standards. Materials and methods were reviewed by the HCJ Research and Ethics Panel prior to launch, with specific consideration given to participant safety, informed consent, data protection, and appropriate safeguarding and signposting information. All engagement activity followed the Government of Jersey Privacy Policies and the Data Protection (Jersey) Law 2018. No direct identifiers were collected. Free-text quotes were lightly edited to remove identifiable information.

Recruitment for public engagement

As part of the engagement strategy for the 2025 Mental Health JSNA, short, accessible postcards and posters promoted the public survey and routes to take part online, by email, or on paper. Materials were produced in English and Portuguese and used a logo created from artwork by people with lived experience.

To ensure the postcard carried genuine meaning, the artwork was developed in partnership with individuals who have lived experience of mental health challenges. Rather than producing a design in isolation, the objective was to create a logo that authentically reflected the people at the heart of this work. Participants were invited to illustrate what mental health represented to them personally. The resulting artwork was powerful—honest, emotive, and visually compelling. These individual contributions were then carefully digitalised, with key shapes, colours, and themes combined to form a single, unified design.

Artwork



The final logo represents the idea that mental health is complex but connected. Every piece tells part of the story, and together they form something whole, just like the system we're trying to build.



Distribution for public engagement

Approximately 4,000 postcards (around 3,500 English and 500 Portuguese) and 150 posters (around 130 English and 20 Portuguese), plus a small batch of paper surveys in English and Portuguese were printed and distributed to Islanders.

How we targeted distribution: We mapped drops to the RAG-rated priority groups and placed materials where those groups already are, using three routes:

1. **In-person drops** to frontline settings and community venues
2. **Email requests** to host posters or share the survey link/newsletter blurb
3. **Community amplification** via Facebook groups, parish channels, and consulates

Where materials went (illustrative, not exhaustive)

- **Healthcare and clinics:** Adult Mental Health services, CAMHS, Crisis & Home Treatment Team, Listening Lounge, JTT, Dietetics, Pain Clinic, Cardiology, Stroke, Memory Clinic, Long-Term Care, Rehab units (Clarevale), hospital departments, GP surgeries, and pharmacies across all parishes (Boots, Co-op, Reids, Castle Quay, Island Medical Centre Pharmacy, etc.).
- **Community and third sector:** Mind Jersey, Focus on Mental Illness, Carers Support Team, Acorn/JET, Enable Jersey, Beresford Street Kitchen, The Salvation Army, Sanctuary

Trust, Shelter Trust, Age Concern, Meals on Wheels, Phillips Footprints, Tiny Seeds, Macmillan, Grace Trust, Grace Crocker Foundation, ABC/After Breast Cancer Support.

- **Youth and family settings:** YES Project, Jersey Youth Service, school/college contacts routed via CYPES, Youth Parliament, parent and toddler groups, home-education networks (e.g., Jersey Association of Home Educators).
- **General public spaces:** Parish Halls across all twelve parishes, St Helier Town Hall, Jersey Library, GOJ workplaces, courts and civic buildings.
- **Ethnic-minority outreach:** Caritas Welcome Centre, Portuguese and Polish Facebook groups, Friends of Africa, Romanian community groups, Polish and Portuguese consular contacts, faith settings (Freedom Church, JMC Centre, Jersey Jewish Congregation), agricultural employers (e.g., Jersey Royal).
- **Workforce and employers:** Chamber of Commerce, Jersey Business, sector associations (hospitality, construction), ambulance service.

Governance and tracking: Each delivery was logged with organisation, parish, contact route, staff member, language split, and quantity. Notes captured on-the-day issues (e.g., venue closures, moved locations) to maintain an audit trail.

Public survey design

A SmartSurvey questionnaire ran from 19th August 2025 to 21st September 2025, with paper copies available. Individuals could respond in three ways:

- people reporting on their own experiences,
- people reporting for someone they know or care for,
- people sharing general views on the system.

The landing page set out the purpose of the JSNA and how public feedback would shape the All Ages Mental Health Strategy (2026-2030). It explained how to complete and return the survey online, the response deadline (21st September), and provided a contact email for anyone who preferred to send feedback by email.

Before starting, participants confirmed they were aged 13 or over and happy to take part. They were reminded that responses are anonymous, and they could skip any question or stop at any time, and they were informed their feedback would be used to inform the strategy. They were signposted to the Government of Jersey privacy policies and it included a safeguarding statement.

Structure, routing and question types: The questionnaire used simple routing so people could answer only the parts that applied to them.

- **Section 1: For yourself:** Demographics and context questions, then items on crisis experience, what helped in the past 12 months, whether needs are met, experiences of services, waiting and signposting, and barriers to getting help.
- **Section 2: For someone you know or care for:** Parallel structure to Section 1, with carer-aware wording and “don’t know” options where appropriate.
- **Section 3: General views:** Perceptions of system barriers, what is missing, and how services could improve.

Question formats combined multiple-choice items (tick-boxes, single-select scales) and free-text boxes. This allowed us to produce basic descriptive summaries and then dig into lived experience in people’s own words.

In total, the public survey contained 58 questions, including approximately 35 closed (tick-box or multiple-choice) and 23 open-ended items. Of these, around 21 were optional free-text questions that allowed participants to describe experiences in their own words.

Data handling and privacy: All responses were stored in line with Government of Jersey data protection requirements. We aggregated results for reporting. Direct identifiers were not collected. Free-text quotes were lightly edited for readability and to remove potentially identifying details. Small numbers are suppressed where disclosure risk remained

Children's survey design

As part of the engagement activities with children and young people, participants were invited to complete a short survey designed to capture their perspectives on mental health support in Jersey. The survey asked three core questions:

1. what they feel is currently working well for young people's mental health
2. what support they believe is lacking
3. what improvements they would recommend to strengthen existing mental health provision.

Participants were also asked to identify the two improvements they considered most important for the Government to prioritise.

A total of 23 children and young people participated in the survey. Of these, 19 attend the Jersey Youth Assembly, 2 attend Youthful Minds, and 2 had not attended either organised group.

For more details on specific findings from young people please see chapter 5 'What do People Think?'

Focus group sessions

Facilitated, trauma-informed sessions explored what works, what does not, and what could be improved. Locations included, The Diner, Focus on Mental Illness, Jersey Eating Disorder Service, an Older Adults Forum, the prison, Freeda, Shelter Trust, Off-island placements and the learning disability mental health team. A second practitioner or service representative attended each session for safeguarding.

In total, 168 islanders completed the public survey. Additional engagement sessions were conducted with individuals with lived experience, where we spoke to approximately 100 individuals.

For more details on specific analysis on stakeholder and public engagement please see chapter 5 'What do People Think?'

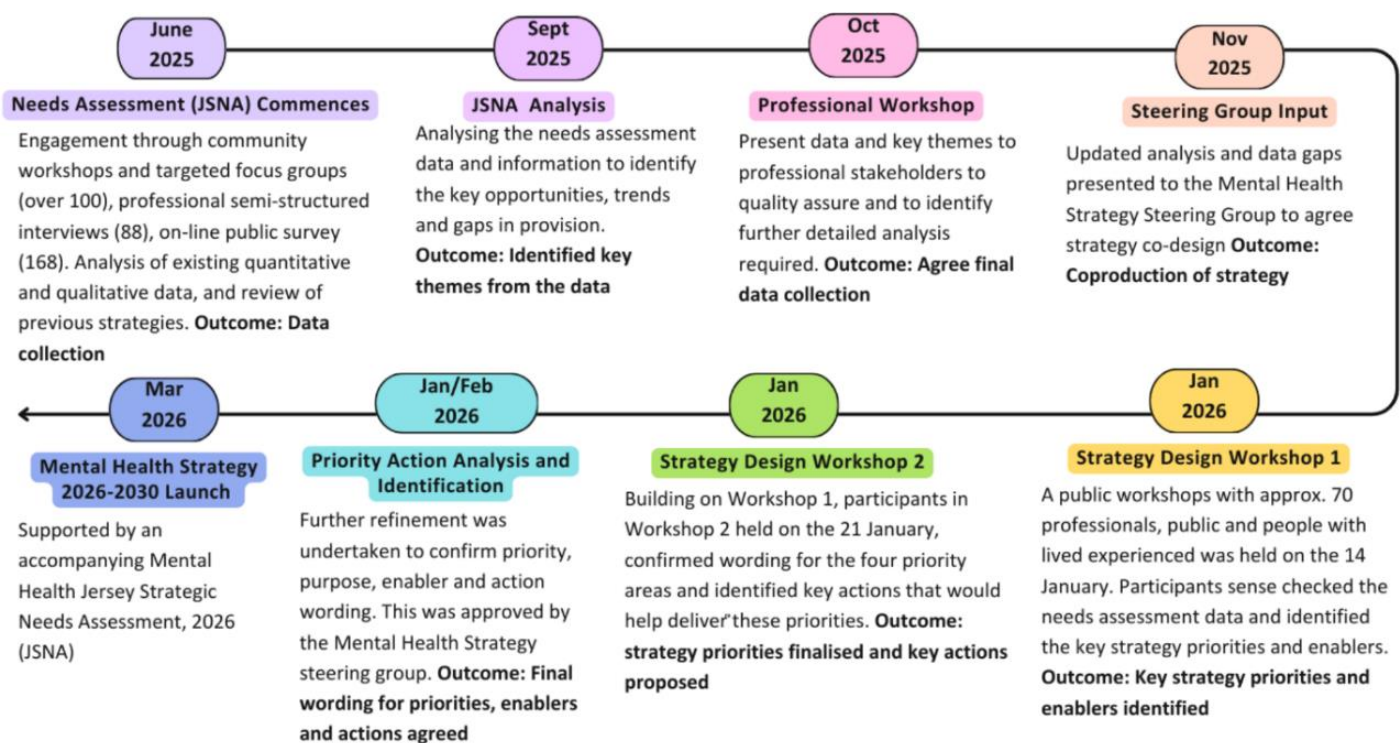
Stage 4: Synthesis and refinement of key findings

All qualitative and quantitative evidence was analysed in parallel, generating initial themes that could then be tested and refined.

At a workshop held in October 2025, the Mental Health Strategy Steering Group, working alongside a wider group of invited professionals, undertook a detailed review of the JSNA's initial findings. The workshop attendees identified any gaps and further areas for consideration. Based on this feedback, the Working Group did further exploration, analysis and development, and presented final findings back to the Mental Health Strategy Steering Group in November 2025.

This process allowed the JSNA work to be synthesised into key findings and themes. The next step was to work with professionals and those with lived experience to develop these key themes into strategy priorities and actions, through a series of workshops with approximately 70 adults and 20 young people (See [Turning JSNA Findings into Priorities for Action](#)).

A summary timeline of the Mental Health JSNA and Jersey All Age Mental Health Strategy (2026–2030) development is shown below:



Reading this report

This report is structured into six main chapters:

1. [Policy context](#)
2. [Demographic overview](#)
3. [Wider context](#)
4. [Level of need across the life course](#) (Perinatal, Children and Young People, Young Adults, Adults, Older adults)
5. [What do people think?](#) (Professional and Public engagement) ⁺
6. [Evidence scan of mental health models](#)
7. [Drawing the evidence together](#)

⁺When interpreting the professional and public engagement findings (chapter 5), it is important to note that:

- *the JSNA engagement findings are not statistically representative of the Jersey population; rather, they represent the views of the individuals that chose to take part in the consultation*
- *the qualitative findings are based on people's self-reported perceptions. While some perceptions may not be factually accurate, they represent respondents' lived realities and are therefore essential for understanding their attitudes and experiences*

Feedback

If you would like to provide feedback, then please contact us at the following address or email us at: jsna@gov.je

Public Health Intelligence & Commissioning
Government of Jersey
Union Street
St. Helier
JE2 3DN

Your feedback will be assigned to the right person so it can be responded to in the right way. All feedback will be handled in line with our [Customer Feedback Policy](#)

1. Policy context and scope

Jersey's previous [Mental Health Strategy \(2016-2020\)](#) set out a broad vision to improve mental health support across the population. It focused on improving service access, integrating care pathways, and reducing stigma, with high-level priorities around prevention, and early intervention. The strategy led to a number of system-level recommendations, some of which have since been implemented, while others remain ongoing or have evolved into separate workstreams.

A key limitation identified in the 2016-2020 strategy was its reduced focus on children and young people. While intended as an all-age framework, it did not provide sufficient emphasis on early years, specific needs of children, young people and families, or transition arrangements between children and adult mental health services. In response, a dedicated [Children and Young People's Mental Health Strategy \(2022-2025\)](#) was developed. This strategy focused specifically on early years attachment and perinatal mental health, the mental health needs of children and young people (CYP), and their families, Child and Adolescent Mental Health Service (CAMHS) improvements, including integrating CAMHS with the front- door- the Children and Families Hub, developing an early intervention service in collaboration with schools, introducing an holistic, multi-agency neurodevelopmental pathway and improving transition arrangements to Adult Mental Health Services (AMHS).

Alongside these developments, AMHS was redesigned in 2022 with the introduction of a Front Door model. This created a single point of access to secondary AMHS for people not previously known to these services. The redesign was informed by community engagement and based on principles of person centred and recovery focused care, strong partnership with service users and carers, and a commitment to safety, dignity, inclusion and continuous improvement.

Following learning from the above strategies and consultations, work was initiated in 2025 to develop an all-age Mental Health Strategy (2026-2030), to follow on from the previous strategies. This JSNA provides a solid evidence foundation for the new strategy and will support continued improvement for Islanders mental health in the years ahead.

Scope and strategic alignment

It is important to note that a number of other strategies and frameworks across government departments also cover aspects of mental health. These include (but are not limited to):

- [Neuroinclusive Strategy Jersey 2025 to 2028](#)
- [A Change of Direction: A Substance Use Strategy for Jersey 2023 to 2033](#)
- [Strong Foundations: A Dementia Strategy for Jersey 2024-2029](#)
- [Connected in Hope: A Strategy for Suicide Prevention in Jersey 2025-2029](#)

While this JSNA acknowledges and complements these documents, it does not duplicate their work. Instead, it focuses on filling identified gaps, highlighting areas of unmet need, and updating evidence where there has been notable change since the last strategic review. The aim is to provide a clear, up-to-date evidence base to directly inform the development of Jersey's new integrated, all-age Mental Health Strategy (2026-2030), ensuring future policy, commissioning and investment decisions are based on population need.

This JSNA focuses on all-age mental health needs across Jersey, including primary, secondary/community and crisis care, and spanning the full pathway from prevention and early intervention through to treatment and recovery. It considers both mental illness and mental

wellbeing, recognising that people may experience poor mental wellbeing and significant distress even without a diagnosed mental illness, and that this can still result in unmet need.

It will also focus on the parts on the systems where gaps and dependencies most affect outcomes, including transitions between children’s and adult services, interfaces between mental and substance use services, dual diagnosis, and access to crisis and recovery support.

The scope includes:

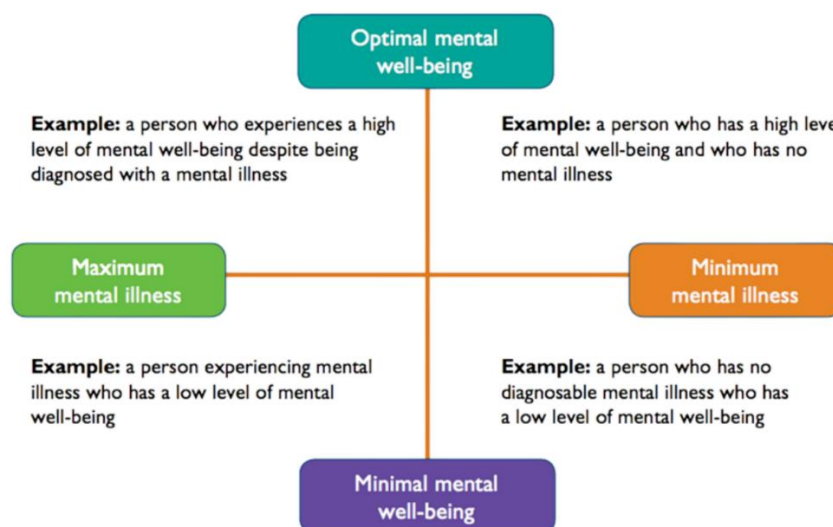
- Common mental health conditions (for example anxiety and depression) and severe mental health conditions (for example schizophrenia and bipolar disorder)
- Dual diagnosis and complexity, including co-occurring substance use and mental illness
- Inequalities in access, experience and outcomes
- Emerging and future needs likely to influence priorities over the strategy period (2026-2030), alongside wider determinants and protective factors

Where other strategies lead on specific populations, conditions or interventions (for example, substance use, neurodivergence, or dementia), this JSNA will signpost and align. It focuses on system-wide interfaces, gaps and dependencies relevant to an integrated, all-age approach. However, dual diagnosis cases involving mental illness remain explicitly within scope for this JSNA, to ensure that needs and gaps at the interface between services are properly understood and addressed.

Definition of mental health

For the purposes of this JSNA, *mental health* refers to a person’s emotional, psychological, and social wellbeing, as well as any diagnosed or undiagnosed mental health conditions they may experience.¹² It’s important to recognise that mental health is not a simple scale from "well" to "unwell". People can experience significant mental health conditions and still lead meaningful, connected lives. Others may not have a formal diagnosis but still experience emotional distress or poor mental wellbeing. Mental health and wellbeing can be described as a continuum, where people can move between different levels of illness and wellbeing, depending on a range of factors.¹³ Figure 1 illustrates this continuum.

Figure 1. The relationship between mental health and wellbeing. Image source: [Cambridgeshire & Peterborough Insight](#)



2. Jersey's population overview

Key insights

A worsening dependency ratio and shrinking "home-grown" workforce

Jersey has an increasingly older population, as births fall and young adults continue to leave. This means more people with higher health and support needs will be relying on a smaller working-age population.

- Population growth is modest and driven by migration rather than births.¹⁴ Jersey had 104,540 residents in 2024, with projections rising to 106,000-114,000 by 2030.¹⁵
- The population is rapidly ageing:
 - People aged 75+ may rise by 75% (8,650 to 15,100) by 2051.
 - The working-age population (16-64 years old) may stay constant or even decline by 2051 without significant inward migration.
- Birth rates are falling,¹⁶ mirroring global trends of delayed parenthood and smaller family sizes.
- Natural change is negative: in 2024 Jersey recorded around 140 more deaths than births, meaning the island is no longer replacing its population through births.
- Young people continue to leave the island, especially those aged 16-24, weakening the future workforce and increasing the dependency ratio.

Reliance on inward migration, alongside rising risk of unmet need and inequality

Migration is essential to maintain the workforce, but changes in who is arriving (and their circumstances) can increase mental health risk and barriers to access, particularly if eligibility/navigation of services is challenging.

Jersey has seen a decline in European workers since Brexit, and sharp rise in residents from non-European countries.

- Migrant workers can face isolation, poor housing, low-paid work, and ineligibility for support, all known mental health risk factors.

Rising social isolation and changing household structures

More people living alone and more pressure in single-parent households can increase loneliness, stress, and demand for support, especially for older adults and families under strain.

- 40% of households are single adult, with almost 5,500 single pensioner households.¹⁷
- Single parents face high cost-of-living pressures and elevated risk of poor mental health.

Persistent inequality

Financial insecurity (especially after housing costs are accounted for) increases the risk of poor mental health and can make recovery harder, while also widening inequalities.

- 1 in 5 Islanders lives in relative low income after housing costs.
- This includes 24% of children and 28% of pensioners.¹⁸

The combination of these trends (ageing, outward migration of young adults, reliance on a changing migrant workforce, rising isolation, and persistent poverty) is increasing the dependency ratio, driving up demand for mental health services and support, while also making needs more complex and harder to meet with a shrinking resident workforce.

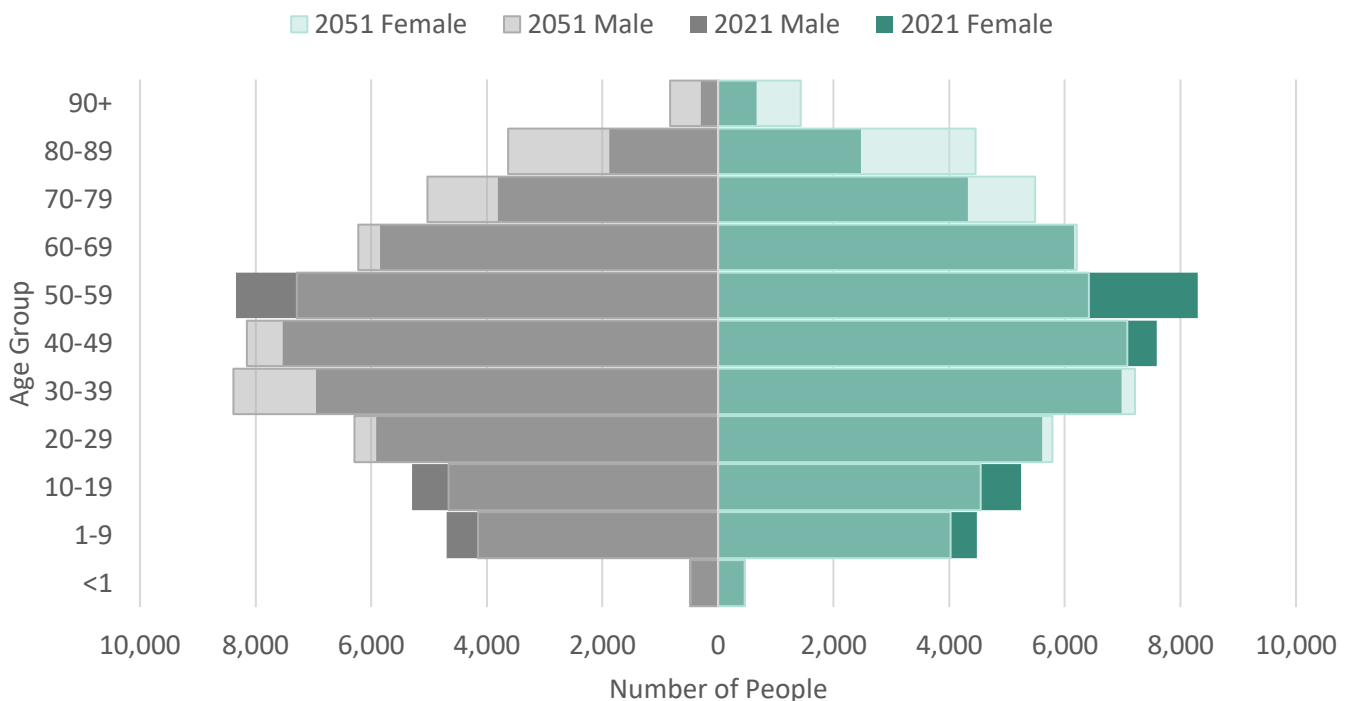
Population size and growth

Jersey is a diverse and vibrant place to live. At the end of 2024, it was estimated that 104,540 people were living in Jersey, around 4,480 more than in 2014. Based on Statistics Jersey’s population projections (published in 2023), this number is expected to rise between 106,000 and 114,000 by 2030, depending on net migration levels.¹⁵ This projected growth is likely to increase demand for services, including mental health provision.

Ageing population and rising dependency

Like much of the Western world, Jersey is facing a demographic shift towards an older population. The population of those aged 75+ is projected to rise by 75%, increasing from 8,650 in 2021 to 15,100 in 2051. In contrast, the working age population (16-64) may decrease by 9%, from 68,055 in 2021 to 62,160 in 2051 (assuming +325 annual net migration).

Figure 2: Age structure of Jersey population (2021 Census population compared to 2051 population projections with net +325 annual migration assumption). Source: Statistics Jersey



Ageing can bring with it increased risk of chronic illness and pain, cognitive decline, loss of independence, bereavement, isolation, financial insecurity and carer strain, all factors which can increase risk of mental ill-health.¹⁹ Around 5,500 older adults live alone (single pensioner households in the 2021 Census¹⁷), many with limited income,² increasing their vulnerability to loneliness, reduced independence and poorer mental health outcomes (see [Wider Context](#)). These trends are expected to accelerate over the next decade, and may shape service demand.

Negative natural change and falling birth rates

In 2024, Jersey recorded around 140 more deaths than births, continuing a pattern of negative natural change. Population growth is now driven primarily by migration rather than births.²²

This accelerates population ageing and increases reliance on inward migration to sustain the workforce. Falling birth rates mirror wider trends across high-income countries, with people choosing to delay or have fewer children.²³

Young adult outmigration and future workforce risk

Jersey continues to experience significant emigration of young adults. Population projections published in 2023 show the Island’s age structure is expected to shift considerably over the coming decades.

Based on the central net migration scenario of +325 per year, between 2021 and 2051

- The number of residents aged under 16 is projected to fall by around 11%, reflecting a shrinking younger population.
- The working-age population is also expected to change; –7% among those aged 16-24, –14% among those aged 50-64, and +7% amongst those aged 25-49.
- The older population is set to increase substantially. Those aged 75-84 are projected to grow by 57%, while the 85+ population is expected to rise by 121%.

This mirrors trends seen elsewhere (e.g. Guernsey, Figure 3), but carries specific implications for Jersey’s workforce, service planning, and long-term demand for health and social care.

Figure 3. Percentage change in population by age group for Jersey (+325 net migrations) and Guernsey (+150 net migrations) (2021 Census to 2051 projections). Source: Statistics Jersey, States of Guernsey



These shifts matter for mental health. Young people report pressures related to housing, higher education options, and uncertainty about career pathways. A declining local young adult population also affects social cohesion and limits the future workforce available to support an increasingly older population, raising the dependency ratio, and adding pressure to health, care and community services, including mental health.

Migration and diversity

Inward migration plays a crucial role in sustaining Jersey’s working-age population and public services. In 2023, the Island recorded net migration of +670 people, largely working-age adults. Temporary work permits have risen from 80 in 2020 to around 1,750 in 2024, creating patterns of cyclical migration.

The Island’s nationality profile has also changed in recent years. Between 2018 and 2023²⁴:

- Residents with “rest-of-world” nationalities increased from 1,720 to 4,300 (+150%)
- European nationals declined from 16,740 to 15,610 (-7%)
- Jersey/British nationals remained broadly stable (approximately 64,000)

Table 1. Population size, aged 20 years or older, by nationality in 2023 compared to 2018 Source: Statistics Jersey

Nationality	Population		Population Change	
	Dec 2018	Dec 2023	Number	Percentage
Jersey or British	64,120	63,890	-230	0%
European	16,740	15,610	-1,130	-7%
Rest of world	1,720	4,300	+2,580	+150%
Total	82,570	83,790	1,220	1%

Jersey now has a growing population from various African nations and the Philippines. These shifts align with employer reports of decreased recruitment from Europe and increased recruitment from non-European countries.²⁴ Growing ethnic and linguistic diversity is also evident among children and young people. In 2024/2025, 29.5% of school pupils were multilingual learners, compared with 21.4% in 2016/17. Within this group, 3% were new to English and 9% were at an early stage of English acquisition. This reinforces the need for culturally informed mental health support in education settings and clear early-identification pathways.

Although the number of “entitled” status residents has grown by 2% over five years, this has been driven mainly by inward migration rather than retention of local young people. Loss of young Islanders may affect social cohesion, belonging and community networks, while migrant workers filling these gaps may face additional stress related to job security, housing conditions, entitlement rules and financial resilience.²⁶ For those relocating from farther afield, separation from family and long-established support networks combined with practical constraints such as high travel costs, limited leave entitlement, or immigration requirements can heighten loneliness, stress and emotional strain. These are known risk factors for poorer mental health and may affect help-seeking and engagement with services.

Despite increasing diversity, data gaps remain in routine collection of ethnicity, country of birth, language needs and length of residence. This limits the ability to identify inequalities, target support and monitor trends.

Implications for mental health and service planning

Taken together, Jersey's demographic and socioeconomic context is likely to increase both the volume and complexity of mental health need across the life course. Population growth will raise overall demand, while rapid demographic ageing and a rising dependency ratio will increase presentations associated with long-term conditions, pain, cognitive decline, bereavement, loneliness and carer strain, often requiring more sustained support.

Continued outmigration of younger adults and a smaller working-age population may further constrain capacity and continuity across the health, care and community services, reducing access to care services. At the same time, high housing costs, relative low income and rising single occupancy will concentrate risk in specific groups and places. Increasing reliance on inward migration also strengthens the need to design services that are accessible and culturally safe, with appropriate language support and clear navigations routes, particularly in light of current gaps in routine data on ethnicity, language and migration-related factors which restrict the ability to monitor inequalities and target support effectively.²⁷ Where barriers such as language needs, stigma, mistrust, or uncertainty about eligibility reduce help-seeking, mental health problems become more severe before diagnosis, treatment and support are obtained.²⁷ As Jersey becomes more ethnically and nationally diverse, service design must prioritise cultural competence, accessible information, and appropriate interpretation or language support.

The JSNA builds on this context by assessing need across the life course, considering inequalities and summarising stakeholder experience of what is working well and where the most important gaps remain.

3. Wider context

Evidence shows that health and wellbeing services only actually account for 30% of what keeps us healthy.¹ Most of what determines our health comes down to **wider risk and protective factors**.

Risk factors increase vulnerability such as financial strain, insecure housing, long-term illness or exposure to violence.

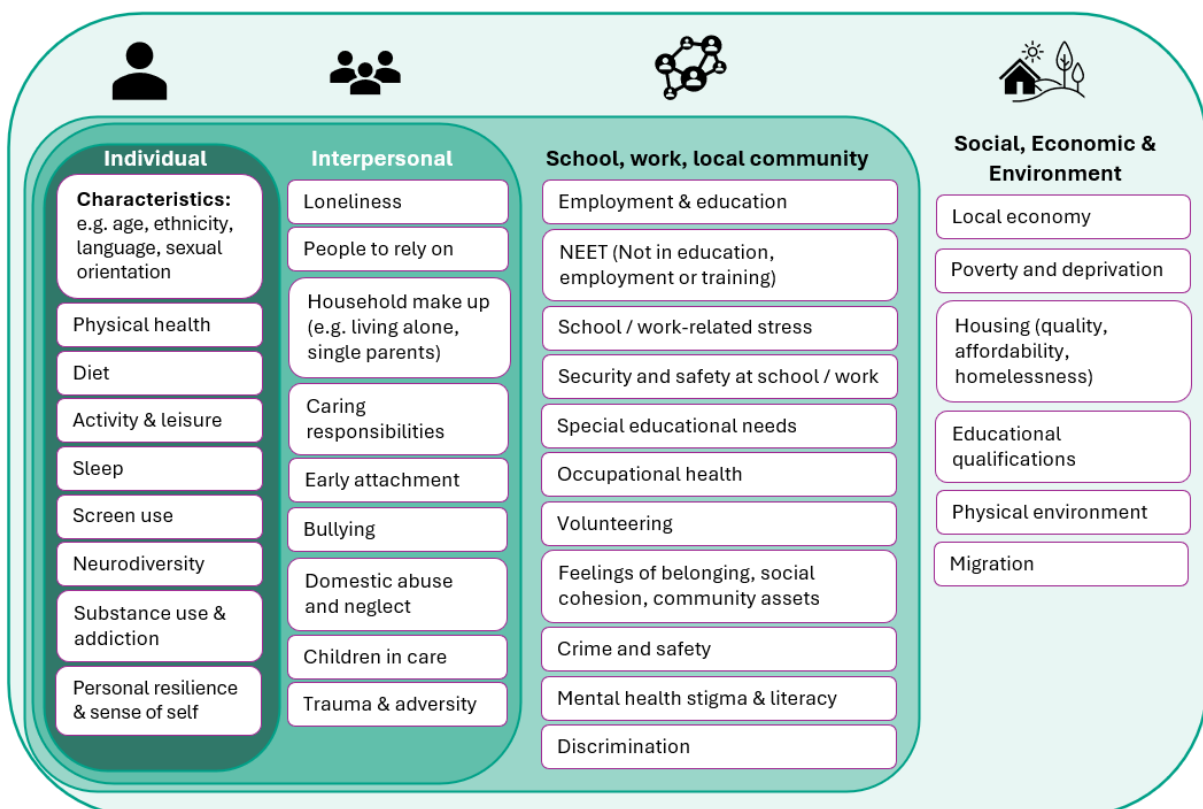
Protective factors support resilience and recovery, including secure relationships, stable housing, good-quality work, regular sleep and physical activity.

Risk and protective factors often operate as opposites (for example stable versus unstable housing), but they rarely exist in isolation. Many factors are interrelated and tend to cluster, meaning that disadvantage in one area can reinforce vulnerabilities in another, while improvements in one domain can create benefits elsewhere. Determinants shape the environments in which these risk and protective factors arise and therefore influence both exposure to risk and access to protection.

Considering these factors is a core part of a needs assessment, as it provides essential context and helps explain the drivers behind the patterns of mental ill health observed locally. Although not all determinants are modifiable, many can be influenced through policy, service design or wider system action.

This section groups the main influences into four domains (as shown in Figure 4) and brings together evidence and local data on each. While the domains provide a useful structure, it is important to recognise that most risk and protective factors are interconnected.

Figure 4. A framework of risk and protective factors, adapted from gov.uk



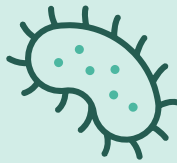
Social and Economic Factors

4% of Jersey households were overcrowded
Rising to **15%** for non-qualified households



Among the **300** people experiencing homelessness, **1 in 7** reported substance use and **1 in 9** reported mental health problems as reasons for their homelessness

1 in 15 children reported black mould at home linked to lower self-esteem



84% of adults said they were satisfied with the greenery in their neighbourhood



73% of children visit parks, beaches or open spaces weekly

82% of lower-income private renters experience rental stress



The proportion of people with higher-education qualifications grew from **33%** (2011) to **42%** (2021)

4 in 5 single-parent families reported difficulty coping financially



The proportion of adults with no qualifications fell from **20%** (2011) to **15%** (2021)

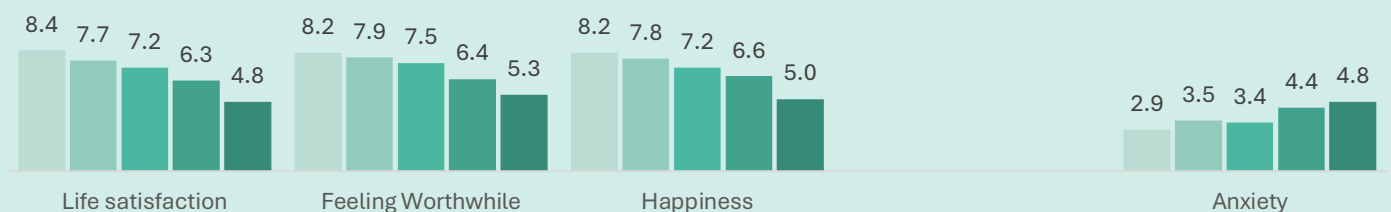


Financial difficulty was linked to lower wellbeing and higher anxiety



How easy or difficult do you find it to cope financially:

Very easy Quite easy Neither Quite difficult Very difficult



Average (mean) scores out of 10

3.1 Social and economic factors

Financial strain and housing affordability

Poverty and material hardship increase chronic stress for families and individuals. International evidence consistently shows that financial strain and high housing costs are associated with worse mental health outcomes, including anxiety and depression.³⁰ In Jersey, average wellbeing scores were lowest for adults who find it difficult to cope financially; they also scored higher for anxiety than those who found it easy to cope financially (Figure 5). Local poverty and the recent cost of living pressures are, therefore, a significant context for mental health on the Island.

Figure 5. Average (mean) scores out of 10 for wellbeing measures, by ability to cope financially. Source: JOLS 2024



Jersey enjoys a high GDP per capita,³¹ but also experiences significant income inequality and pockets of deprivation. Local income data underline the scale of potential pressure: after housing costs, about 24% of households and 21% of individuals are in relative low income.¹⁸ This includes one in four children (24%) and over one in four pensioners (28%) living in relative poverty. In Jersey, more than a third (35%) of households found it difficult to cope financially in 2024, with 82% of single-parent families reporting difficulty coping financially, and around 10% of children reporting their family is “not well off”. At year-end 2024, there were 6,247 adults and around 2,334 children receiving income support.³²

Local people frequently report that inability to meet housing costs and rising living expenses are prominent stressors, and impact people’s ability to lead a healthy life,³³ with single-parent families particularly affected.⁸ In 2021/22, households spent 30% of income on housing, fuel and power. Average weekly expenditure in Jersey was 59% higher than in the UK.

Despite recent incremental improvements in housing affordability, it remains a key pressure.³⁵ The majority (82%) of lower-income private renters experienced “rental stress”, and affordability indexes consistently rank Jersey as very expensive relative to income. In 2024, a household on average income could service a mortgage affordably on a median-priced one-bedroom flat, but not on a median-priced house or a two-bedroom flat.³⁵

Housing suitability and homelessness

Unsuitable housing (such as damp, mould and overcrowding) can undermine both physical and mental health.³⁷ The *English Housing Survey* reports that poor housing conditions (including damp, cold, overcrowding) correlate with higher rates of long-standing health conditions, including mental ill-health.³⁸ In Jersey, 4% of households in Jersey were overcrowded in 2021, but amongst “non-qualified” households the proportion was much higher at 15%, and rates were higher in parts of St Helier. In 2021, around one in fifteen children (6%) said their walls or ceilings had black mould, and this was significantly correlated with lower self-esteem among those young people.³⁹

Homelessness is strongly associated with mental health problems; evidence indicates high prevalence of mental disorders among homeless populations, including young people.⁴⁰ It is linked to trauma exposure, sleep deprivation, victimisation, and barriers to accessing consistent care, making homelessness both a cause and consequence of mental ill health.⁴¹

Data from the Homelessness in Jersey Quarterly Report (Q1 2025) shows that 304 people made 321 service visits for homelessness/housing instability. The majority of people experiencing homelessness are classified as houseless (253 individuals), with smaller numbers recorded as insecure (32), roofless (10) or living in inadequate accommodation (fewer than five).

The reported reasons for homelessness reinforce the close relationship between housing instability and mental health:

- Substance use (alcohol and drugs) is the most commonly recorded reason, accounting for 14% of cases.
- Mental health problems account for 11% of recorded reasons.
- Being aged 18-25 and requiring support to manage independently also accounts for 11%, highlighting a distinct vulnerability linked to developmental stage rather than a single presenting issue.

Family and relationship-related causes are also prominent causes of homelessness, including:

- Parents, family or friends no longer willing or able to accommodate (10%).
- Relationship breakdown (7%).
- Family breakdowns (4%).
- Domestic abuse risk or experience (8%).

Among males recorded as experiencing homelessness, those aged under 25 are one of the largest age groups. Among females, young adults under 25 are also a prominent group, though female homelessness is more evenly distributed across early and mid-adulthood. This pattern suggests that homelessness often emerges early in the life course, coinciding with transitions out of education, care, or the family home, periods already associated with heightened mental health vulnerability.

Economy, Education and Skills

Economic context

Economically, Jersey is heavily reliant on financial services, which comprise roughly 38% of the Island's economy.³¹ This is reflected in the labour market where financial and legal activities are the largest sector, representing around 21% of the workforce jobs (as at June 2025).⁴³ Economic activity (employment rate) is relatively good in Jersey; the economic activity rate of all adults (aged 16 and over) was 63% in 2021, higher than that recorded in the UK at that time (59%). See also [Work and working conditions](#).

Educational attainment and inequalities

A lack of formal qualifications or leaving school early is associated with significant mental health risks.⁴⁴ Evidence shows that lower educational attainment is associated with higher rates of poor mental health, including depression and anxiety^{45,46} and higher risk of social exclusion across the life course. Education can serve as a gateway to well-paid, stable employment and upward social mobility, which in turn provides financial security and life stability that protect mental health.⁴⁷ Attaining formal qualifications (e.g. GCSEs, A-levels, degrees) can promote resilience and mental wellbeing by opening opportunities for a secure and fulfilling life.⁴⁸

Over the last decade, the qualification profile of adults aged 16-64 has improved. The 2021 Census shows that the proportion holding a higher-education qualifications increased from 33% in 2011 to 42% in 2021, while the share with no formal qualifications fell from 20% to 15%. However, educational attainment is not evenly distributed. Levels of qualification varies by place of birth with just over half (54%) of adults aged 16-64 born in Portugal or Madeira reporting no formal qualifications, substantially higher than any other group.¹⁷ There are also geographic differences; in St Helier, around 25% of adults had no formal qualifications (slightly higher than the Jersey average of 21%).

Children and young people's educational outcomes

Data for educational performance in Jersey shows that in the early development space, three-fifths of Jersey pupils met the expected level of development at the end of reception in 2024, leaving around 300 pupils below expected levels.⁵⁰ Note that legacy effects of the COVID pandemic affected children's development, especially communication and language, but assessments at the end of Key Stage 1 show children's prime areas of learning have either remained the same or increased slightly due to the quality and focus of early years teaching.⁵¹

At GCSE level, in 2023/24 73.2% of pupils achieved English and Maths at grades 4 or above, broadly comparable to English rates.⁵² In 2023/24 17.5% of pupils has inconsistent attendance (attended school less than 90% of the time) similar to the English figure (18%). There were also just over 1,000 fixed-term exclusions from Government schools overall in 2023/24, indicating a significant cohort of children (8.8% of pupils) with challenges and interruptions in their school education.

In a labour market with a large high-skill sector, unequal educational attainment can translate into unequal access to secure employment, income, and progression, all of which are established social determinants of health.⁵³ This is particularly relevant for the 16-25 group, where transitions from school to work or further training can be fragile. Young people leaving education with few or no qualifications are more likely to experience insecure or precarious work or a period of labour market detachment, which are linked to poorer mental health outcomes.⁵⁴ See also [Work and working conditions](#).

Physical environment

Access to high quality outdoor spaces supports activity and wellbeing. In children and young people, access to safe outdoor spaces, parks and recreation areas encourages physical activity and social interaction, both of which support wellbeing,^{55,56} and adults who spend time doing activities in the natural environment also reap psychological benefits.^{57,58}

The quality and accessibility of green and blue spaces is generally good in Jersey; Jersey has 2,145 hectares of Coastal National Park, approximately 200 km of public access routes, and environmental quality is judged to be comparatively strong.⁵⁹ Jersey's natural spaces are well used and accessible; 73% of children visit parks, beaches or open spaces weekly, for example. In 2023, 91% of households have access to at least one type of green space, and 84% of adults said they were satisfied with the greenery in their neighbourhood.⁶⁰ There are some inequalities in Islander's experience of the local environment, however. For example, in 2024 just a quarter (25%) of St Helier residents were very satisfied with their neighbourhood compared to two-thirds (68%) of adults living in rural parishes.⁶¹

Individual Factors

1 in 7 adults reported having a neurodiverse condition



By Year 12, about **3 in 4** students spend 3+ hours on screens daily, and around **2 in 5** spend 5+ hours



Fewer than half children slept 8+ hours; heavy screen use correlated with poorer sleep



Around half of adults get the recommended 7+ hours of sleep



6% working-age adults in Jersey receive medicinal cannabis, compared with **<1%** in England

1 in 5 children and **1 in 2** adults meet activity recommendations



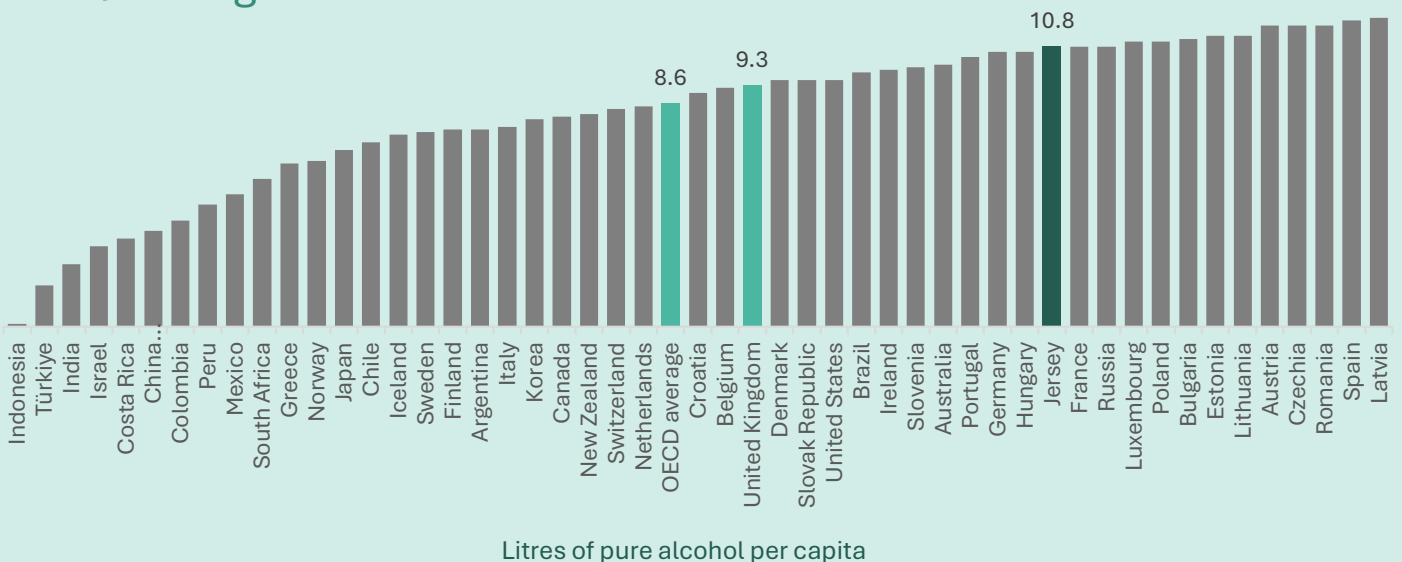
Just 8% of females in Years 10-12 meet activity recommendations



1 in 7 households report going without fresh fruit and vegetable due to shortage of money



On average, each person in Jersey consumed **10.8L** of alcohol in 2024, higher than the UK average (9.3L)



Litres of pure alcohol per capita

3.2 Individual factors

Personal characteristics: ethnicity, language, sexual orientation, gender identity

Personal characteristics such as ethnicity, language, sexual orientation and gender identity can mean some groups face a higher risk of poor mental health. These increased risks are usually not due to the characteristic itself, but to the experiences that often accompany it, such as barriers to accessing services, structural inequity, stigma or discrimination.⁶²

As described in the [population overview section](#), Jersey has an increasingly ethnically diverse population. Perceived or actual discrimination, language barriers and the absence of culturally appropriate services can elevate risk among minority groups. In 2024, around 20% of pupils surveyed said they used English at home only some of the time, and a further 5% said they hardly ever/never used English at home,⁶³ indicating a significant number of families in Jersey using different languages in everyday life. In 2025, 1 in 12 adults reported experiencing discrimination because of their race or nationality, including 35% of Portuguese adults.⁶⁴ There is local evidence that some health outcomes vary with ethnicity; for example, people identifying as Portuguese or Madeiran were the most likely of all ethnic groups to report poor health.⁶⁵

The 2021 Census recorded 189 adults whose gender was different from that registered at birth, representing around 0.2% of the adult population, compared with 0.5% in the UK.

Local data on mental health outcomes by ethnicity, sexual orientation and gender identity remain very limited, which restricts the ability to undertake meaningful equity analysis. Strengthening routine data collection in these areas is a key priority highlighted for [data development](#). For example, in 2024, over half of mothers in perinatal services were recorded as White, while almost half had no stated ethnicity, limiting understanding of need and potential inequalities.

Neurodevelopmental needs can increase vulnerability to mental health difficulties, not because of neurodivergence itself, but because of factors such as social exclusion, bullying, school or work related stress, co-occurring difficulties and limited access to timely support. The national autistic society estimates up to half of autistic people also experience depression at some point in their lives.⁶⁶ In 2025, around 1 in 7 adults reported having a neurodiverse condition including autism, attention deficit hyperactivity disorder (ADHD), dyslexia, or other condition. Young adults were more likely to report having a condition than older adults, with 21% of 16-34 year olds compared to 8% of those aged 65 and over. People with neurodiverse conditions identified flexible work or study hours and improved access to support services as the most helpful forms of support.⁶⁴

Physical health

Physical and mental health are closely interlinked, and they influence each other in both directions. Poor physical health increases mental health risk, and mental ill health can also worsen physical illness and reduce healthy behaviours. Long term conditions such as diabetes, heart disease and stroke, as well as serious injury, can increase the risk of depression, anxiety and post-traumatic stress disorder,⁶⁸ and serious injury can cause mental health problems including depression, anxiety and post-traumatic stress disorder (PTSD).⁶⁹ Ill health or living with a chronic condition is a major risk factor for poor mental health because it can disrupt nearly every part of a person's life, including physical functioning, emotional wellbeing, social participation and financial stability. In 2025, adults in Jersey who reported bad or very bad health had significantly lower wellbeing scores than adults who rated their health as good or very good.⁶⁴ For example, only 19% of those in bad or very bad health rated life satisfaction as high, compared to 81% of those with very good health.

Over 33,000 Islanders are living with a long-term health condition, and over 14,200 have 2 or more conditions (multi-morbidity).⁷¹ Self-rated good health decreases with age, and the prevalence of chronic health conditions such as hypertension, heart disease, chronic kidney disease, stroke and dementia increases with age, along with the likelihood of multi morbidity. For example, by age 80, Jersey residents are more likely than not to have at least 2 health conditions.⁷¹ Concerningly, increasing numbers of younger people (16-34 year olds) report having a long-term health condition (physical or mental); 1 in 3 in 2025 up from 1 in 10 in 2017.⁶⁴ About 15% of Jersey schoolchildren report a disability or long-term illness.⁶³ Pain appears to be an emerging issue among young people, reflected in increasing referrals to [pain clinic](#). In Jersey in 2024 there were just under 25,000 short term incapacity allowance claims for “back/neck pain/injury” or “other injury”.⁷⁵

Health-related challenges such as experiencing infertility are associated with poorer mental health. Some women experience depression or anxiety related to fertility challenges, and some men report reduced quality of life.⁷⁶ International estimates suggest up to 1 in 6 couples experience infertility.⁷⁷ As the average age of mothers in Jersey continues to rise,¹⁶ a larger proportion of local people may be affected. To understand local need, service activity provides important context. Jersey’s assisted reproduction unit sees more than 400 patients each year,⁷⁸ which indicates a substantial number of individuals and couples seeking support for fertility issues. In 2024, the unit facilitated 42 in vitro fertilisation cycles, 70 embryo transfers and 15 inseminations. In the context of known mental health risks associated with fertility, this level of service use highlights the importance of access to psychological support within reproductive health pathways.

Diet and physical activity

Poor diet quality is increasingly recognised as a contributor to mental ill health. Diets high in ultra-processed foods and low in fruits, vegetables, and essential nutrients are associated with increased depressive and anxiety symptoms.⁷⁹ In Jersey, only 31% of adults meet “5 a day” fruit and vegetable intake recommendations in 2025,⁶⁴ whilst the other 69% fall short.

Regular physical activity is associated with reduced incidence of depression and improved wellbeing, mediated through neurobiological, psychological, and social mechanisms.⁸¹ In 2025 in Jersey, just 54% of adults meet physical activity recommendations of 150 minutes per week, and this drops to just 48% of adults aged 65+.⁶⁴ Wellbeing was higher among those who were active. Three-quarters (76%) of adults who met the recommended activity levels reported high happiness and life satisfaction, compared with 60% of those who did not meet the recommendations.

Physical activity recommendations for children are higher, yet only one in five children in Jersey meet the expected level. The gap is even wider for older girls. By Years 10 and 12, only 8% of females met the recommended level of activity.⁶³

Local evidence points to clear inequalities in the ability to engage in healthy behaviours. Survey data shows that adults who struggled to cope financially were less likely to meet fruit and vegetable intake recommendations. Fifteen percent of households reported going without fresh fruit and vegetables because of a shortage of money. Adults facing financial strain were also less likely to meet physical activity recommendations, and similar patterns were seen among those who described themselves as “very time poor”.⁶⁴

Sleep

Good-quality sleep helps regulate emotional processing, memory consolidation, and stress response. Poor or insufficient sleep can disrupt the brain’s ability to manage mood, making people more prone to irritability, low mood, and even clinical depression or anxiety.⁸⁵ English data shows young people with frequent sleep difficulties are more likely to meet the criteria for a possible or

probable mental health disorder using a screening tool.³ In Jersey, the children and young people’s survey in 2023 found that fewer than half of children (45%) reported sleeping more than 8 hours the previous night. Heavy screen use correlated with poorer sleep amongst children. Amongst adults in Jersey, 56% get the recommended 7 hours or more; whilst 34% report that poor sleep affects daily activities weekly in 2025.⁶⁴

Screen use and social media

As of early 2025, there were 131,000 mobile cellular connections on island, roughly 126% of the total population indicating that many individuals use multiple devices or services. Internet use was similarly widespread, with 96,700 residents online (93% penetration), and over half the population overall (54%) actively maintaining social media accounts.⁸⁸ In 2025, more than four-fifths (83%) of adults used Facebook in the last week, and amongst young people, around 90% of Year 12 pupils have at least one social media account.⁶⁴

This high level of connectivity can support access to information, communication, and social inclusion. However, access and use of digital media are not uniform across the population. Around half of those aged 65+ (46%) “rarely” or “never” used social media, and this group tended to rely on newspapers, TV and radio as their main media sources.

The rise of digital technology and social media also brings challenges. Screen use is increasing across the population, and children may be particularly vulnerable to harm. International evidence shows that high digital exposure and problematic social media use can contribute to anxiety, stress, social comparison and sleep disruption.⁹⁰ Local evidence shows that high screen usage is linked to poorer sleep amongst Jersey teens; and more than 1 in 5 report receiving threatening or scary messages online. A quarter of Year 12 pupils report lying to parents or caregivers about who they speak to online. By Year 12, nearly three quarters of students report daily screen-time of over 3 hours, and around two-fifths report over 5 hours per day.⁶³ Two thirds of Year 12 students (66%) were socialising online for 2 or more hours per day. Young people who have experienced bullying are particularly affected. Among those who had been bullied, 49% reported more than five hours on screens daily, compared to just 34% of their non-bullied peers.

Additionally, constant exposure to news (often negative global issues such as war, pandemic and climate breakdown) through the 24-hour news cycle and social media contributes to increased stress, anxiety, and emotional strain, with experts describing this as “media saturation overload,” or “doomscrolling”.⁹² There are also safety concerns associated with the shift to digital, as crimes can occur in online and digital spaces. See also section on [crime, safety and exposure to violence](#).

Substance use and addiction

Alcohol and tobacco

Harmful alcohol use is associated with increased risk of depression, anxiety disorders, and suicidal behaviour, with evidence supporting a bidirectional relationship.⁹³ Tobacco use is also associated with poorer mental health outcomes, including increased depressive symptoms and psychological distress.⁹⁴ Alcohol consumption rates remain stubbornly high in Jersey. In 2024, per-capita alcohol consumption was 10.8 litres,⁹⁵ higher than the UK and many other countries.

The 2024 Jersey Opinions and Lifestyle Survey (JOLS) survey found that the most common place people drank alcohol was at home (either socially or alone), and 25% of drinkers in Jersey scored 3 or above on the fast alcohol screening test (FAST), indicating hazardous or harmful drinking. Adults in mid-life drink frequently; 20% exceed weekly limits; and two thirds (66%) of adults report at least one binge episode in the past year (74% of men; 59% of women). The proportion of young

people who do not drink alcohol at all has risen in recent years, but among 16-34 year olds, binge drinking patterns remain relatively common with 25% report binge drinking at least monthly.

The health and wellbeing impacts of Jersey's high alcohol consumption culture are significant. Alcohol-specific hospitalisations in Jersey remain higher than England, especially for males. The Social Security Department spent £633,000 on approximately 120 claims related to alcohol-related sickness and ailments in 2024, and a significant burden of crime and road traffic collisions are linked to alcohol.⁹⁵

Adult smoking prevalence in Jersey has declined overall, from 19% in 2009 to 13% in 2024. The long-term decline in smoking rates aligns with strengthened tobacco control measures and broader public health efforts. Smoking prevalence is also correlated with socio-economic factors; for example, 1 in 5 people (20%) in routine and technical roles are current smokers, which is higher than Jersey's overall average (13%). Smoking prevalence remains a significant health concern, partly due to its strong association with poorer mental health outcomes.⁹⁴

Drugs and cannabis

There are important mental health risk concerns associated with cannabis use, including an increased risk of psychosis. Research shows a clear dose-response relationship, with heavy or frequent cannabis use (especially of high-potency strains) significantly raising the risk of psychosis.⁹⁷ Beyond psychosis, evidence suggests cannabis use in adolescence can contribute to mood disorders and suicidality. One large review reported that cannabis users were 1.4 times more likely to become depressed, and significantly more likely to have suicidal ideation or attempt suicide later on, compared to non-users.⁹⁸ Adolescents are markedly more vulnerable to cannabis addiction than adults.⁹⁹ Regular cannabis use during adolescence can impair neurocognitive functions and derail educational progress, which in turn affects mental and social wellbeing.¹⁰⁰ In Jersey, around 1 in 5 Year 12 pupils said they had taken cannabis at some point.⁶³

Medicinal cannabis prescribing in Jersey is substantially higher than in England relative to population size. During the nine-month period from January to September 2022, approximately 4% of Jersey's total population received a medicinal cannabis prescription, compared with <1% of the population in England. When looking at prescription rate amongst the working age group (adults aged 16-64 years), this difference is even more pronounced, with around 6% of Jersey's working-age population receiving medicinal cannabis, compared with <1% in England.¹⁰²

With respect to drugs other than cannabis, data for adult usage is limited, as the topic is not included in Jersey's Opinion and Lifestyle Survey. Amongst young people in Years 8, 10 and 12, 11% of secondary school students reported having ever taken drugs (of any kind), with similar proportions of males and females reported having ever taken drugs.⁶³ After cannabis, MDMA and LSD or magic mushrooms were the most commonly used drugs. Of those in years 10 and 12 who reported taking drugs, around 1 in 4 admitted using more than one type on the same occasion, and 27% said they'd had a bad reaction after taking drugs, with "paranoia" cited as the most common type, underscoring the direct impact drug taking can have on mental wellbeing.

More on drug-related mental health need can be found in the service usage sections of Chapter 4.

Gambling harms

Gambling can be associated with poorer mental health outcomes, particularly when it is used as a coping strategy in the absence of appropriate support.¹⁰⁴ While many people gamble casually without experiencing harm, gambling is a complex behaviour that, for some individuals, can contribute to significant mental health risks. This is especially the case for those experiencing

financial stress, social isolation, or pre-existing mental health conditions, where gambling may exacerbate existing vulnerabilities. Problem gambling is associated with increased rates of anxiety, depression, substance misuse, and suicidal ideation.¹⁰⁵ In Jersey, while many gamble without significant harm, recent data shows that around 7% of adults who gamble are considered 'at risk' for problem gambling, whether low, moderate, or high. Of particular concern, approximately 2% of adults fall into the moderate to high-risk category, equating to roughly 1,200 Islanders. Men are significantly more affected than women, with 11% of male gamblers identified as at risk compared to just 3% of female gamblers.⁶¹

Personal resilience and sense of self

Personal resilience and a strong sense of self are well-established protective factors against poor mental health. They help individuals maintain psychological stability when facing stress or adversity. Resilience is usually framed as a process of positive adaptation that enables people to recover or sustain wellbeing, despite significant stressors, thereby reducing vulnerability to anxiety and depression.¹⁰⁷ Studies demonstrate that higher resilience scores are associated with lower psychological distress, and that internal psychological factors such as self-esteem, emotional regulation, and optimism confer protective effects against later mental-health difficulties.¹⁰⁸

In Jersey in 2025, 40% of adults said they always or often "felt optimistic about the future", whilst 19% said they rarely or never felt optimistic.⁶⁴ Just over half of adults (53%) felt they often or always dealt with problems well, 39% said they did some of the time, and 7% said they rarely or never dealt with problems well. Low self-esteem/worth was the 3rd most common presenting issue amongst Islanders seeking counselling support from the "Listening Lounge".

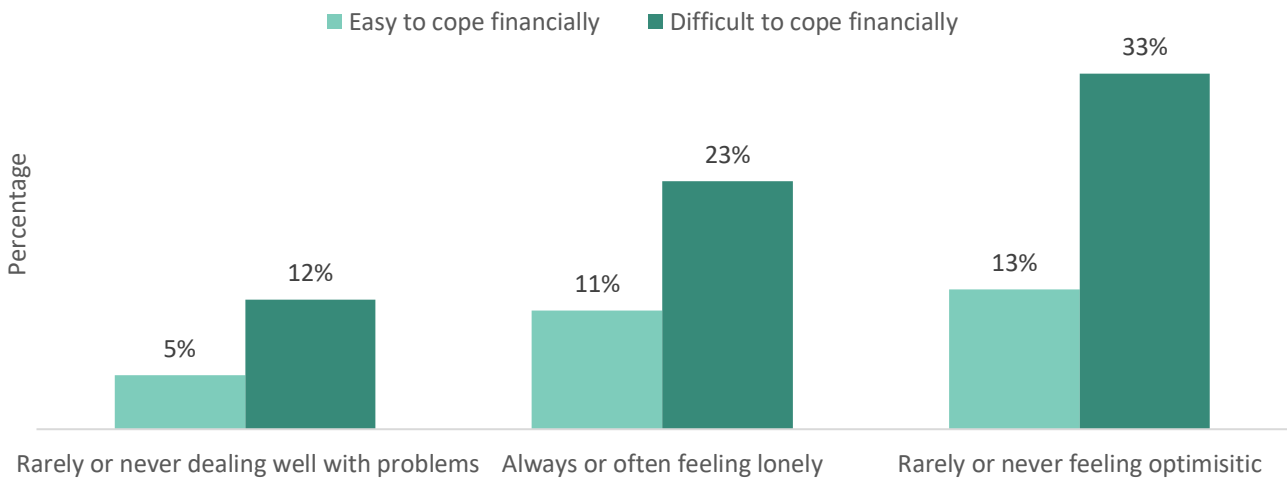
Amongst children, strong emotional regulation skills, such as the ability to recognise, understand and safely express feelings,¹¹⁰ alongside positive self-esteem, confidence, and a sense of personal competence play a crucial role in helping children and young people manage stress and maintain positive mental health.^{111,112} Effective problem-solving and coping strategies, including seeking help when needed or using healthy methods to manage stress, further strengthens resilience.¹¹³ Survey data for Jersey shows the proportion of pupils with low or medium-low self-esteem has shown a gradual increase over the years, rising from 21% in 2018 to 27% in 2024.⁶³

Crucially, resilience is modifiable. Individuals can cultivate greater resilience through practice, like a skill, and behavioural and activity factors (like sleep and exercise) as well as interpersonal factors (like friendship and social support) which all contribute to resilience. Resilience can also be linked to wider socioeconomic factors, and we see evidence of this in Jersey's population.

In 2025:

- Islanders who found it difficult to cope financially were more than twice as likely to report rarely or never dealing with problems well, always or often feeling lonely, and rarely or never feeling optimistic, compared to those who found it easy to cope financially (Figure 6).
- Just 1 in 3 Islanders living in urban parishes said they always or often felt optimistic, compared to 1 in 2 of those in rural parishes Those in urban parishes were almost twice as likely to report rarely or never dealing with problems well compared to those in rural parishes.⁶⁴
- Amongst children, those in fee paying schools were more likely to report high self-esteem (41%) than those in non-fee paying schools (32%).⁶³ Pupils living in housing with black mould were more likely to have low self-esteem.¹¹⁷

Figure 6. Responses to wellbeing questions on dealing with problems, feeling lonely and feeling optimistic, split by how respondents cope financially, JOLS 2025. Source: Statistics Jersey



The interconnected nature of resilience and other determinants shows that protective factors rarely operate alone. Instead, they work together, and strengthening one area can reinforce others and help protect people from the development of mental health difficulties.

Interpersonal Factors

The number of older adults living alone rose from **4,115** in 2001 to **5,463** in 2021



Up to **8,000** Islanders give unpaid care and around **1%** of households have a young carer

82% of single parents in Jersey are women, and Single parents are more likely to report poor health



29% of UK adults had experienced abuse before age 18. Applied to Jersey, this would be nearly 25,000 local adults



Around **400-450** domestic abuse crimes are recorded in Jersey each year

An estimated **175** children live in high-risk domestic abuse households, and **225** in medium-risk households

Two thirds of care experienced children were receiving mental health support (in 2025)

Migrants and ethnic minorities are less likely to have support networks on-Island



1 in 5 adults who socialised daily outside their household feel lonely often or some of the time, whilst



1 in 2 adults who rarely socialised outside their household feel lonely often or some of the time



66% of Year 12 pupils spent 2 or more hours socialising online the previous day

16-34 year olds were the age group most likely to report often or always feeling lonely



1 in 4 adults overall feel lonely some of the time
1 in 6 adults feel lonely often or all of the time



3.3 Interpersonal factors

Household structure and living arrangements

Household composition and living arrangements influence exposure to important mental health risk factors. Living with others can be protective because it can enhance social connection and the availability of informal support and buffer against loneliness. Studies consistently demonstrate that people who live alone are more likely to experience mental illness,¹¹⁸ including higher rates of self-harm and suicide.¹¹⁹ Living alone does not necessarily mean being lonely, but evidence consistently links social isolation with higher levels of depression and poorer overall health outcomes in later life. Studies show that things like meaningful social connection and remaining physically active are important, particularly for older adults living alone.¹²⁰ The number of older adults living alone has increased over time. In 2001 there were 4,115 single pensioner households, rising to 5,463 in 2021.¹⁷ Jersey will therefore need to ensure accessible community and lifestyle support is available for this growing group.

Household and family structures have also changed. The proportion of married adults has declined over several decades with 45% of adults married in 2021 compared with 54% in 1971. The proportions never married or divorced has increased.¹⁷ These trends reinforce the need to consider how changes in household and family structures may affect the availability of protective social networks, particularly during periods of stress or ill health.

Single-parent households

Single parent households can face compounded pressures because the demands of parenting sit alongside greater exposure to financial strain and reduced time for social connection or self-care. A report on the 2021 census in Jersey showed that being a single parent was one variable associated with poorer health generally,⁶⁵ and a survey carried out in 2024 for the women’s health needs assessment showed single parents were more likely to report poor or very poor mental health (28% compared to 11% of those parenting as a couple).¹²³

Most single parents with dependent children (82%) in Jersey are female. Census data also indicates that single parents with dependent children are more likely to be living in social housing, reflecting higher housing vulnerability.**Error! Bookmark not defined.** International evidence shows higher rates of depression and anxiety among single parents compared with partnered parents, with economic stress and reduced support acting as key factors.¹²⁵ Around a quarter of children in Jersey do not live continuously with both parents.⁶³ Socioeconomic disadvantage and family instability can create sustained stress for these young people too. See also the section on [Domestic abuse and household dysfunction](#).

Table 2: Household types, Jersey (Census 2021). Source Statistics Jersey

Composition	Number	Percentage
Single adults	8,603	19.3
Adult couples	6,884	15.4
Single parents	3,686	8.3
Couples with children	11,501	25.8
Pensioner couples	5,466	12.3
Single pensioner	5,463	12.3
Other	2,980	6.7
Total	44,583	100

Caring responsibilities

Becoming a carer is a significant life transition that carries substantial mental health risks. Research consistently links unpaid caregiving to elevated levels of stress, depression, and anxiety compared to non-carers, particularly when caring is intensive or sustained, and this can be worsened by financial and time pressures.^{127,128}

Among adults in Jersey, it is estimated between 5,000 - 8,000 Islanders are providing unpaid care to a family member, relative or friend, but only 206 are in receipt of carers allowance. Locally, an estimated 1% of households include young carers.¹²⁹ In 2021, 2% of children and young people said they were the main carer for a family member or friend. Of these, 5% spent more than 5 hours per week carrying out caring responsibilities.¹³⁰ A 2022 survey conducted by the Carers Partnership Group¹³¹ revealed the intensity and emotional toll of this roll, 92% of respondents reported that caregiving was stressful, and three-quarters (76%) said their health had been considerably affected. More than half of carers were providing over 72 hours of care each week, with limited formal support. Mental health was itself the primary reason for care in nearly a quarter (23%) of cases, underscoring the complex emotional dynamics involved.

With the right support, the burden of care can be mitigated. Mind Jersey, for instance, has expanded one-to-one support for carers, growing its caseload from 30 in early 2024 to around 85 by mid-2025.¹³² Encouragingly, 80-90% of supported carers report feeling better able to cope, with increased confidence in their role. This suggests that while caregiving can be a major risk factor for psychological distress, timely and sustained emotional support offers a strong protective buffer.

Early attachment and nurturing

Secure early attachment provides an essential foundation, supporting emotional stability, social development, and the capacity to cope with adversity later in life.^{133,134} Family and caregiver protective factors are central to children's healthy development, as supportive home environments provide the emotional and practical foundations for wellbeing. Warm, responsive, and nurturing parenting fosters secure attachment and emotional stability,¹³⁵ while consistent boundaries and predictable routines help children feel safe and grounded.¹³⁶ Early childhood social and emotional learning interventions have long-term protective effects by strengthening emotional regulation, interpersonal skills, and resilience. Evidence on positive childhood experiences demonstrates that early relational and competence-building inputs are associated with reduced risk of depression, anxiety, and suicidal behaviour later in life, and adaptive coping during key life transitions, even among those exposed to adversity.^{137,138} Supportive relationships with siblings and extended family members offer extra sources of comfort, guidance, and role modelling, and for young adults, at least one stable, supportive relationship (family, partner, peer, trusted professional) is among the strongest protective factors, promoting help-seeking and recovery.

The state of parental mental health and wellbeing can affect their ability to provide stable support for their dependents, and there is some evidence that it can affect secure attachment.^{139,140} The perinatal period can be a particularly vulnerable time for parents. Perinatal mental health conditions are common and can affect a pregnant or birthing parent, as well as their partner and wider family.¹⁴¹ UK data suggests 1 in 4 expectant and new mums experience mental health problems,¹⁴³ demonstrating the importance of supporting good wellbeing in the perinatal period, to protect the mental health of both parents and children. See also [Perinatal mental health section](#).

Domestic abuse and household dysfunction

Domestic conflict or domestic abuse can be damaging to mental health. It can induce chronic stress, affect self-esteem and physical health, and can isolate victims from support outside the home. Domestic abuse exposure has serious mental health implications for adult victims and for children who witness or experience it.¹⁴⁴ Living in a family with inter-parental violence in childhood is a strong predictor of adult mental illness,¹⁴⁵ and relationship conflict or domestic abuse during pregnancy elevates risk of perinatal mental health challenges.

States of Jersey Police data shows around 400 to 450 domestic abuse crimes are committed every year in Jersey, and estimates suggest around 11,000 women in Jersey may have experienced domestic abuse at some point in their lives.¹⁴⁶ An estimated 175 children live in households with high-risk domestic abuse, and a further 225 with medium risk abuse visible to services. These estimates were based on Jersey's 2011 population, so the true need is likely higher now.

Adverse Childhood Experiences (ACE) are potentially traumatic events that occur in childhood. ACEs can have a profound and lasting impact on mental and physical health.¹⁴⁷ These experiences include various forms of abuse (physical, emotional, or sexual), neglect, and household dysfunction, such as witnessing domestic violence, living with a caregiver who has a substance use disorder or mental illness, or experiencing parental separation or imprisonment. The cumulative impact of ACEs is well documented. Individuals with multiple ACEs are at significantly higher risk for mental health conditions like anxiety, depression, and post-traumatic stress disorder, as well as harmful health behaviours such as substance misuse.¹⁴⁸ Early exposure to chronic stress can also affect neurodevelopment and emotional regulation, increasing vulnerability throughout life. Jersey currently lacks an official estimate of ACE prevalence. Data for England and Wales estimates that 29% of adults experienced at least one form of abuse before age 18;¹⁴⁹ applied to Jersey's population this would equate to just under 25,000 adults.

Care-experienced children are an especially vulnerable group. International evidence and UK data show children with experience of the care system, including foster care and residential homes, have much higher rates of emotional and behavioural disorders than the general population.¹⁵⁰ In Jersey, this group is small but particularly vulnerable. As at October 2025 there were 53 children looked after and 102 with child protection plans. Two thirds (66%) of children in care, and just over a third (35%) of those with child protection plans, were receiving support from CAMHS, much higher rates than for their peers without care needs. The transition from care around ages 18-25 coincides with withdrawal of structured support. For young people lacking traditional family support, mental health risks can be amplified at this important life transition. As at June 2025 there were 87 care leavers up to age 25 receiving ongoing support from personal advisers.

Wider social support, loneliness and isolation

Social connection and supportive relationships are known protective factors against mental health; they are known to buffer stress and are consistently linked with better mental health outcomes. Conversely, social isolation and loneliness are associated with poorer mental health outcomes and increased risk of common mental disorders. Evidence from local loneliness data suggests that while feelings of loneliness decrease for many people with age, a small but consistent proportion (at least 1 in 10) of adults experience persistent loneliness across mid and later life.⁶⁴

In the 2025 Jersey Opinions and Lifestyle Survey, respondents were asked to self-report on feelings of loneliness. Overall around 1 in 4 people said they felt lonely some of the time, and a

further 16% said they felt lonely often or all of the time. The proportion of respondents who reported rarely or never feeling lonely increased with age, rising from 47% among adults aged 16-34 years to 65% among those aged 65+. Despite being one of the age groups most likely to socialise with people outside of their household, the group most likely to report often or always feeling lonely were 16-34 year olds (22%), showing that frequency of social contact and quality of connection do not always align.

As children move into adolescence, patterns of social interaction change. In 2024 two thirds (66%) of Year 12 pupils spent 2 or more hours socialising online the previous day, a massive social change for the current generation of young people compared to those that went before them. Some young adults may be socially active but still experiencing loneliness. The elevated levels of loneliness reported by young adults are particularly important when considered alongside other indicators of vulnerability during this life stage. The 16-25 age range is characterised by major social transitions, including leaving school, entering higher education or work, changing friendship groups, and often moving away from the family home. While these transitions can create opportunities, they can also weaken existing social networks and increase isolation, particularly for those who are not in education, employment or training, or who are in insecure work.

Across all age groups at least 1 in 10 people reported often feeling lonely.⁶⁴ Although overall loneliness appears to decrease with age, the persistence of this “often lonely” group suggests the presence of a small but consistent cohort experiencing chronic loneliness across mid- and later life. Persistent loneliness is strongly associated with poorer mental health outcomes, including higher risk of depression and anxiety.

Social connection and physical health were strongly associated with reported loneliness. One in five adults (19%) who socialised daily outside their household reported feeling lonely often or some of the time, compared with almost half (48%) of those who rarely socialised outside their household. Similarly, 34% of adults with a longstanding illness reported feeling lonely often or some of the time, compared with 20% of those without a longstanding illness. Migrants and minority ethnic groups also report being less likely to have relatives or friends on the Island whom they can rely on when needed.⁶¹

These findings highlight the interaction between social isolation, physical health and mental wellbeing, and suggest that loneliness risk in Jersey is shaped not only by age, but also by wider factors including health status and opportunities for regular social contact.

Further discussion of social connectedness in [Belonging, inclusion and meaningful activity](#) section.

School, Work and Local Community

1 in 7 Jersey employees worked long hours (50+ hours per week) higher than the UK (1 in 9) and OECD (1 in 8)



over **two-fifths** of working adults said they felt they were spending “too much time” at work

1 in 6 short-term sickness claims were for mental health related (for stress, anxiety or depression)



20% of females vs **5%** of males were worried about being a victim of sexual crime

4 in 5 people agreed (slightly or strongly) that “Jersey is a safe place for everyone”



1 in 13 young people reported having been a victim of crime in the last 12 months

Over half of adults were worried about being a victim of digital crime, the highest of all crime types



In 2025 the average daily prison population in Jersey increased to **175**, a rise of 13% compared with 2024

Young people who were bullied were over **twice as likely**

to self-harm (27%) compared to those who had not been bullied (11%)



1 in 5 primary school pupils experienced mobile or online bullying

8% of pupils said they did not do any out of school activities



Around half of adults feel comfortable talking to friends or family about a mental health problem



3.4. School, work and local community factors

Work and working conditions

Employment plays a central role in shaping mental health across the lifespan. It provides income, identity, structure and social connection, all of which support positive wellbeing.¹⁵⁴ However, insecure, unstable or poor-quality employment can undermine mental health, increase stress, anxiety and long-term health inequalities.¹⁵⁵ For those unable to work, unemployment or economic inactivity can contribute to lower life satisfaction, and concerns about job security can have a detrimental effect on mental health.¹⁵⁶

Economic activity (employment rate) is generally high in Jersey, but a small minority of adults are unemployed, some persistently. At the 2021 census the economic activity rate of all adults (aged 16 and over) was 63%, higher than that recorded in the UK at that time (59%). Around 2,000 individuals were unemployed and looking for work at this point. The number of people registered as “actively seeking work” peaked during the COVID pandemic and has since declined. At the end of 2025, 870 people were registered as actively seeking work, of whom 240 were classed as “long-term unemployed”.¹⁵⁷

Jersey’s rate of young people (aged 16-24 years) not in education, employment or training improved from 12.3 percent in 2011 to 8.2 percent in 2021 and remains lower than the United Kingdom. However, there are still a cohort of around 800 young people exposed to risk at this critical transition. For these young people, disengagement remains a risk for anxiety, depression and long-term social exclusion.

Quality of employment also matters. Long working hours, poor work life balance and low job satisfaction can be a risk to mental health. Jersey’s OECD Better Life Index ranking was relatively low for work-life balance, with 14% of employees in Jersey working 50 or more hours in a usual week during 2022, a higher proportion than in the UK (11%) and the OECD average (12%).⁵⁹ Additionally, in 2024, over two-fifths of working adults said they felt they were spending “too much time” at work.⁶¹ About 75% of workers reported high or very high job satisfaction, but the other 25% had medium or low job satisfaction scores. There were disparities across employment sectors. Job satisfaction was strongest in education and health (93% high or very high) and weakest in hospitality and transport or storage (around 62%).⁶¹ A rise in the number of mental health-related sickness claims may also indicate a sign of stress at work. In 2024, 16% of short-term incapacity claims were for stress, anxiety or depression, up from 10% in 2016.¹⁶¹

Evidence indicates that workers on unstable contracts, such as short-term, temporary, or zero-hour agreements, are more likely to experience poorer mental health, compared to those in secure employment.¹⁵⁶ In June 2025 about 10% of all jobs filled in Jersey had “zero-hours” status (6,710 zero-hours jobs out of 65,320 total jobs filled). At this time, full-time jobs were 75% and part-time roles accounted for 14%.¹⁶³ The use of temporary work permits has also increased significantly since 2020, with around 1,750 people employed on permits that require mandated periods away from the Island. See also [Migration and diversity](#).

Crime, safety and exposure to violence

Being a victim of crime can have a profound impact on a person’s life, affecting emotions, relationships and sense of safety.¹⁶⁴ Victimisation, particularly violent crime, is a known risk factor for mental illness, including post-traumatic stress disorder (PTSD) and depression.¹⁶⁵ Evidence shows that people with mental health problems are three times more likely to be victims of crime than the general population.¹⁶⁶

Jersey is generally considered a safe place. In 2025, 4 out of 5 responders to the Jersey Opinion and Lifestyle survey agreed (slightly or strongly) that “Jersey is a safe place for everyone”.⁶⁴ Feelings of safety are subjective though, and there are differences amongst Jersey’s population. Adults who found it difficult to cope financially, for example, were much less likely to strongly agree that Jersey is safe for everyone (28%) than those who find it easy to cope financially (46%). There are also stark differences between gender. For example, 47% of males feel very safe after dark on a quiet street compared with just 19% of females, and 20% of females were fairly or very worried about being a victim of sexual crime compared to 5% of males.

Around one in ten Islanders were very or fairly worried about being a victim of violent crime, and 1 in 13 young people reported having been a victim of crime in the last 12 months.⁶³ Jersey has relatively low levels of violent crime (13.7 to 18.3 per 1000 people)¹⁷⁰ compared to England (28.2 to 35.0 per 1,000 people¹⁷¹). However, recorded violent crime has risen steadily over time in Jersey, from 1,519 in 2018 to 1,911 incidents in 2024. While the number of first-time adult offenders has fallen since 2019, reoffending among adults has increased from 32% in 2018 to 40% in 2025. This suggests a cohort of adults cycling repeatedly through the criminal justice system. Youth offending continues to fluctuate but remains relatively low. These patterns have implications for mental-health need, both for victims and for those at risk of offending or reoffending.

There has been an upward trend in reporting of sexual crimes in Jersey; 217 crimes of this type were reported in 2024, with some of these relating to sexual crimes that happened in previous years. Experiencing a sexual assault is a known risk factor to mental health.¹⁷² A meta-analytic review of the prevalence of various mental disorders in survivors of adult sexual assault found that 17% to 65% of people with a history of sexual assault develop PTSD, 13% to 51% meet diagnostic criteria for depression, 12 to 40% experience symptoms of anxiety, 13 to 49% develop alcohol use disorders, 28 to 61% develop drug use disorders, 23 to 44% experience suicidal ideation, and 2-19% attempt suicide.¹⁷³ See also [Domestic abuse](#)

Digital crime is a growing concern for Islanders. In 2025, over half of adults said they were worried about being a victim of digital crime in the next 12 months, higher than any of the other crime categories.⁶⁴ The rise of online scams, catfishing, so-called “deep fakes” and “revenge porn” can all cause intense distress, trauma and emotional damage for victims. See also [Screen use and social media](#)

Imprisonment

Although how people react to imprisonment varies from person to person, imprisonment is associated with poor mental health outcomes.¹⁷⁵ UK data shows high rates of mental health and learning disability in the prison population, with 71% of women and 47% of men in prison report having mental health problems.¹⁷⁶ In 2025, the average daily prison population in Jersey increased to 175, a rise of 27% compared with 2023. Much of this change reflects growth in the average male prison population, which went from 131 in 2023 to 164 in 2025, an increase of 25%. The number of women in custody increased from 7 to 11 over the same period.

Imprisonment can intensify existing mental health problems and create new vulnerabilities, particularly through isolation, loss of autonomy, separation from family and exposure to stressful or traumatic environments. These factors increase the need for accessible and responsive mental health assessment and support within the prison system and during transition back into the community.

School stress and bullying

Academic pressure and school-related stress can be associated with anxiety and depressive symptoms.¹⁷⁷ In Jersey's 2024 Children and Young People's Survey, older pupils repeatedly cited schoolwork among their top worries, with nearly half of secondary school pupils worrying often or most days about workload (46%) and school tests (45%),⁶³ with the percentages even higher among girls (59% and 58% respectively).

Peer relationships are also a critical influence for pupils. Bullying (including cyberbullying) is a well-established risk factor for poor mental health. It has been consistently linked to increased depressive symptoms, lower self-esteem, and heightened anxiety when compared to children who are not bullied.¹⁷⁸ Research consistently finds bullying victims (and even perpetrators) have much higher rates of depression, anxiety, substance misuse and suicidal ideation.¹⁷⁹ Children who feel socially excluded or who lack peer support are at greater risk, whereas a sense of belonging at school can buffer stress.

Findings from the 2024 Children and Young People's Survey in Jersey illustrate the scope and emotional toll of bullying locally. Jersey data show that about 22% of children reported being bullied at school in the past year and roughly one in five young children admitted to either experiencing or engaging in bullying behaviour during a school term.⁶³ Reported experiences were highest among Year 4 students, with around one in four children in Years 4, 6, and 8 saying they had been bullied at or near school in the past year. The prevalence dropped slightly in older year groups, with 19% of Year 10 and 13% of Year 12 students reporting bullying in the same time frame. Importantly, bullying was strongly associated with poorer wellbeing: approximately a third of those with low levels of life satisfaction, feelings of worth, or happiness reported being bullied, compared to only one in ten among peers with higher wellbeing scores. Gender differences also emerged, with 38% of girls and 26% of boys saying they felt worried about going to school at least sometimes due to bullying. Young people bullied in the last 12 months were more than twice as likely to self-harm, with 27% doing so compared to 11% of those who had not been bullied. These findings reinforce that bullying remains a significant mental health risk for young people, influencing not just their emotional wellbeing but also their sense of safety and school engagement.

Cyberbullying is an extension of peer bullying, with World Health Organisation experts warning this "potentially damaging" use of social media can lead to depression, bullying, anxiety and poor academic performance.¹⁸⁰ Jersey survey data show one in five primary children were involved in bullying via mobile or online devices in recent months, revealing that from a young age, local children are exposed to both online harassment and its mental health consequences.⁶³

Special educational needs and inclusion

The holistic needs of those with neurodiversity is out of scope for this JSNA, as a [neuroinclusive strategy for Jersey](#) sits in parallel with this mental health work. However, neurodiversity and other educational needs are relevant as key risk factors for overall mental health, as inadequate inclusion increases stress and disengagement for children with different needs. These pressures can affect emotional wellbeing, self-esteem and the ability to fully participate in school life.

In Jersey, pupils with additional needs are categorised in administrative systems using "Record of Need" (RON) or "Special Educational Needs and Disabilities" (SEN/D), to ensure pupils have the right support in place to successfully access education. The overall numbers of pupils with needs have been rising steadily year on year. In the 2024/25 academic year, there were 1,536 pupils with

SEN/D and 559 with a RON. A significant portion of these pupils (1 in 4 pupils with RON and over half of those with SEN) have social, emotional and mental health needs (SEMH) as their primary need (this category includes ADHD). In the past 5 years there has been a 60% increase in secondary school pupils with SEN/D support for SEMH. Inclusive education practices are crucial to ensure that neurodiverse learners feel understood, supported, and able to engage fully in school life. Effective inclusion promotes resilience, reduces stress and supports positive mental health outcomes.¹⁸¹

Belonging, trust and meaningful activity

Schools play a central role in supporting children's wellbeing and can serve as powerful protective environments when they provide safety, connection, and meaningful support.¹⁸² A strong sense of belonging and connection to school, where pupils feel valued, included and part of the community, is a key buffer against stress and emotional difficulties.¹⁸³ Positive and trusting relationships with teachers further strengthen this protection, as teachers often act as early identifiers of concern and as reliable adults, young people can turn to.¹⁸⁴ Reassuringly in Jersey, trust in school adults is high in younger pupils. In 2021, 91% of Year 4 and 6 pupils agreed or strongly agreed that they trust adults in their school to act quickly to solve their worries.¹¹⁷ Trust declines in older year groups however; among Years 8, 10 and 12, agreement fell to 65%, indicating lower levels of confidence in adult responses as pupils get older.

Belonging in the workplace and in the community remains important for wellbeing and mental health throughout life. Participation in sport, arts, and culture fosters confidence and resilience. The perceived availability of leisure and recreation is generally positive. In 2024, around two-thirds of adults rated the range of sporting activities and events (68%) and social and recreational activities (71%) in Jersey as good or very good, although satisfaction ratings have declined over time. Amongst children, just under half (48%) reported doing sports with a club or team, and 29% in sports organised by friends. Music, art, drama or dance (27%) and clubs, community or church groups (21%) were also common activities for young people, although concerningly 8% of pupils said they did not do any out of school activities. Overall, 58% of young people in Years 8, 10 and 12 felt they belonged to Jersey 'a great deal' or 'quite a lot'.

Volunteering can also provide structure, purpose and social networks, all key protective elements. Community engagement through volunteering is fairly common in Jersey. In 2025, 44% of adults said they had volunteered in the last 12 months, with sports, recreation and local community groups being the most common areas.⁶⁴ However, civic engagement for Jersey remains relatively low. Turnout for the most recent states assembly elections was 41.6%, lower than all other OECD countries included in the Better Life Index.⁵⁹ There are signs this might improve, however, with the most recent JOLS survey indicating two thirds of adults (66%) planned to vote in the 2026 election, and a further 19% are not sure. In 2025, adults reported trust in government departments at 5.9 out of 10 on average (higher than in 2022 when it was 5.1) and trust in the police and in charities were also relatively good, at 6.9 and 7.1 out of 10 respectively.

Stigma and mental health literacy

Positive community attitudes towards mental health and lower stigma act as protective factors by supporting early recognition, disclosure and help-seeking behaviours. Conversely negative attitudes and high stigma associated with mental health can delay access to support.¹⁸⁷

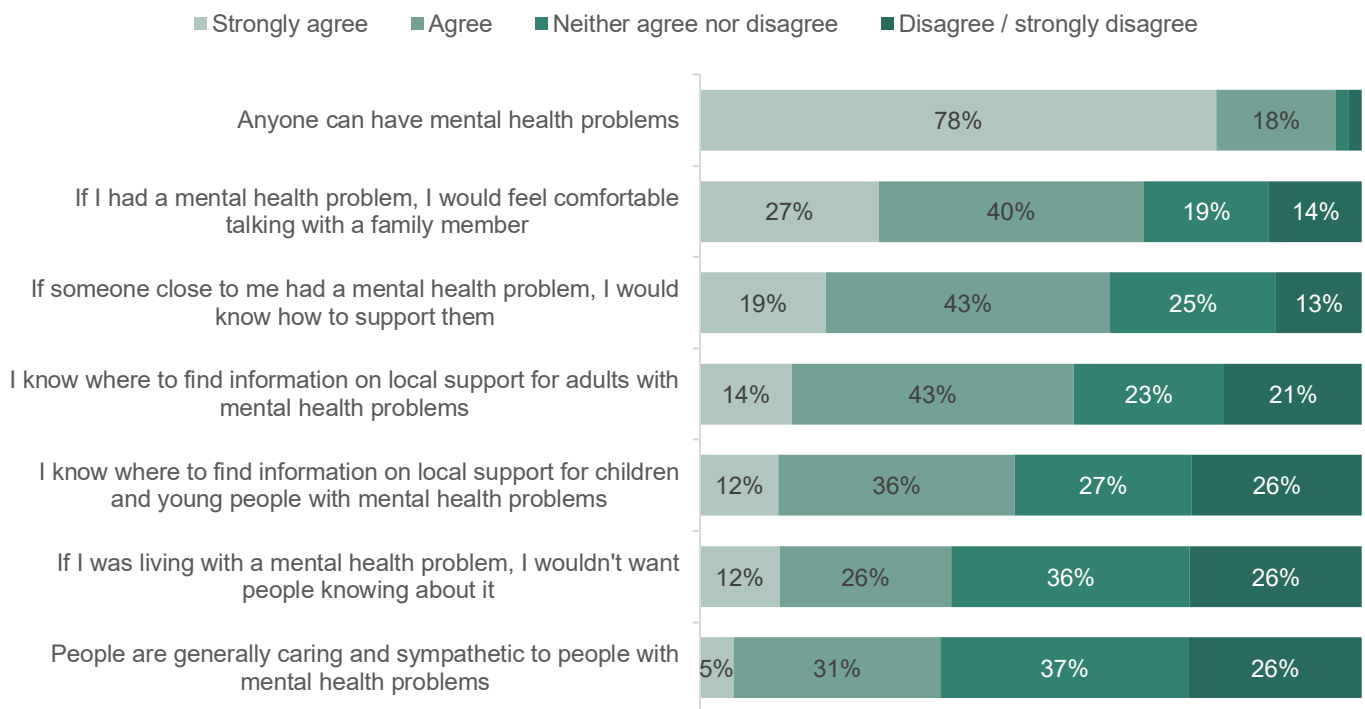
Data from the JOLS show improving levels of understanding and supportive attitudes towards mental health across the community, alongside areas where stigma and awareness gaps

remain.⁶¹ Almost all adults (96%) in 2024 agreed or strongly agreed that anyone can have mental health problems, indicating widespread recognition that mental health issues are common and not confined to particular groups.

The mental health attitudes questions were first asked in the survey in 2016. While agreement with most statements has remained broadly stable over the last decade, two key indicators show improvement, suggesting strengthening community-level protective factors: The proportion of adults who agreed they would know how to support someone close to them with a mental health problem increased from 46% in 2016 to 61% in 2024. Whilst agreement that people are generally caring and sympathetic towards those with mental health problems increased from 26% in 2016 to 37% in 2024.

Despite these positive trends, important challenges remain. Only two thirds of adults feel comfortable talking to a friend or family member if they had a mental health problem. Knowledge of where to find local mental health support is limited, particularly for children and young people. Over a third of adults neither agree nor disagree that people are caring and sympathetic, and a substantial minority (1 in 8) would prefer to keep a mental health problem private, indicating ongoing stigma.

Figure 7: Responses to questions on perceptions of mental health and mental health support (JOLS 2024). Source: Jersey Opinions and Lifestyles Survey

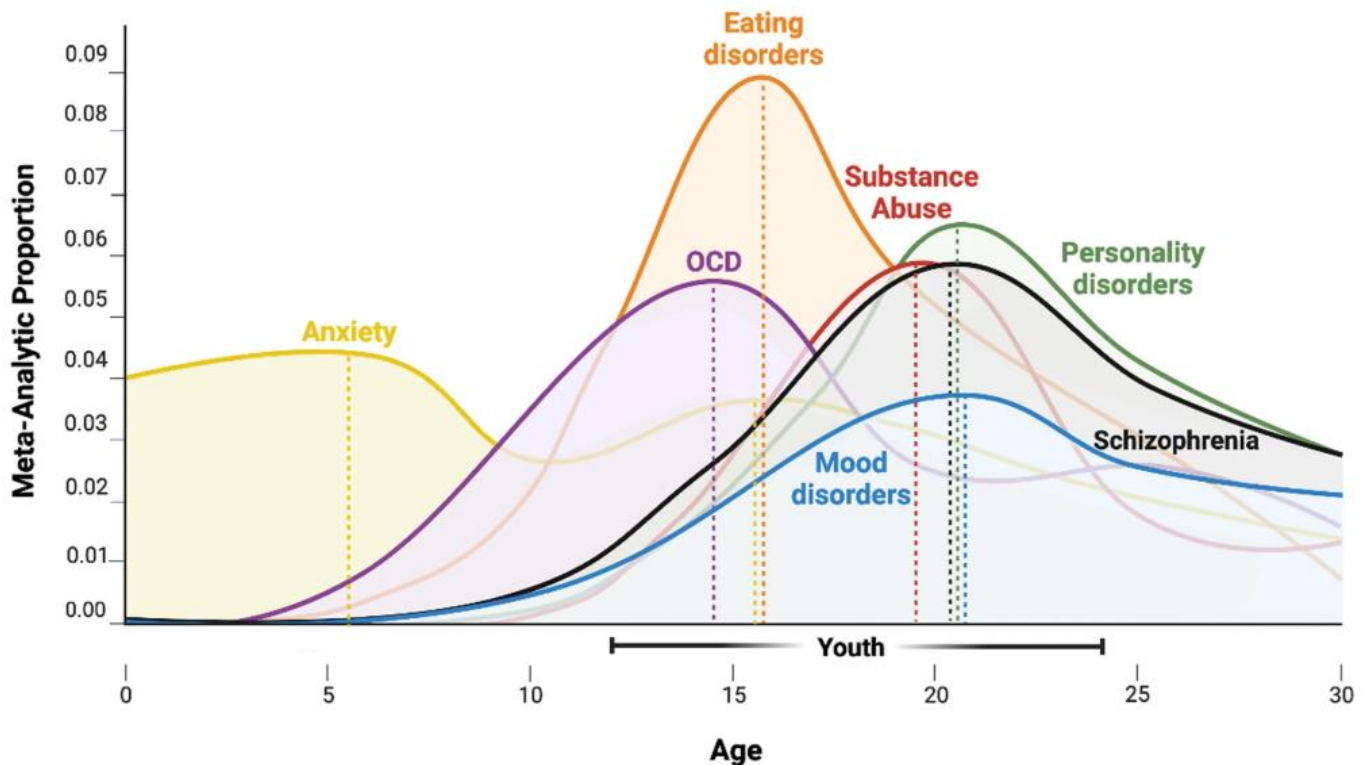


One area not well captured in the current Jersey data is people’s understanding of the difference between mental health and wellbeing. Generally, these concepts are considered distinct but closely inter-related,^{188,189} and the relationship between them can be described as a continuum¹⁹⁰ (see [Figure 1](#)). Literacy (people’s knowledge and understanding of) the differences between mental wellbeing, common mental health difficulties and severe mental illness is a known protective factor, as it increases the chances of the right support being sought at the right time, and reduction of self-stigma.¹⁹¹

4. Level of need across the life course

Mental health is important for everyone, at every stage of life - from birth, through childhood and adolescence and into adulthood. Evidence shows that **most mental health disorders develop early in life**, with 50% of conditions beginning by age 14 and 75% presenting by age 24.⁵ Figure 8 shows the typical age of onset for various common and severe mental illnesses, noting that the majority have peak onset in the adolescent period. Therefore, it is vital to look at prevention, resilience building, and support for emerging mental health need from early childhood onwards.

Figure 8. Distribution of age of onset of mental disorders in the general population, taken from meta-analysis by Solmi et al.¹⁹² The dotted horizontal lines represent the peak age of onset for each diagnostic category. OCD = Obsessive Compulsive Disorder



The following chapter sets out the level of mental health need in Jersey across the life course, combining prevalence estimates, survey findings, and service activity to describe both the scale and the changing nature of the demand. It highlights how need differs by age and circumstance, from the perinatal period and early years through childhood and adolescence, and into adulthood and older age. Alongside conditions that are clinically significant, it also considers how wider pressures such as trauma, deprivation, neurodevelopment needs, isolation, and life transitions shape risk, complexity, and help-seeking. Where possible, it compares expected needs with service usage to indicate where support is reaching people effectively and where unmet or hidden need is likely to persist.

4.1. Perinatal mental health

Perinatal mental health refers to the emotional and psychological wellbeing of women/birthing people during pregnancy and in the first years after giving birth.¹⁹³ Mental health conditions may already exist before pregnancy, or they can emerge during pregnancy or after childbirth, and can range from mild to severe. Perinatal mental health conditions are common and can affect a pregnant or birthing parent, as well as their partner and wider family.¹⁴¹ UK data suggests 1 in 4 expectant and new mums experience mental health problems.¹⁴³ Perinatal mental health problems may require different types of support, care, or treatment depending on their nature and impact. Untreated perinatal mental ill health can affect the parent’s wellbeing, family functioning, and the developing parent-infant relationship, with long term effects on children’s emotional cognitive and physical development.⁷

Note: Infant attachment support (parent infant psychotherapist) is covered in the [Children and Young People](#) section

Key insights

Perinatal mental health need in Jersey remains significant and persistent

despite declining birth rate, and traditional perinatal risk factors being low (e.g. teenage pregnancy, infant mortality, stillbirths).

The specialist caseload is incrementally rising

reaching almost 100 individuals in 2024, and 120 at points in 2025. This is likely driven by complexity and wider determinants (e.g. high C-section rates, mothers lacking adequate social support, substance use among a minority of mothers), rather than birth volume alone.

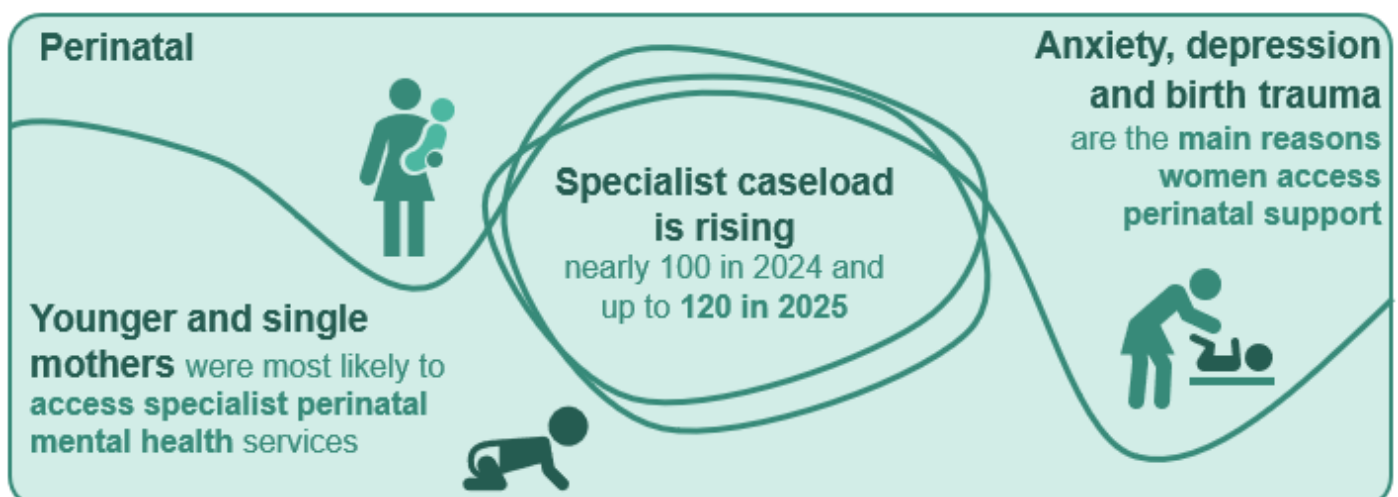
Specialist service use broadly aligns with expected need

suggesting the Specialist Perinatal Mental Health Service is effectively identifying those in need. Early-intervention pathways such as MESCH show positive outcomes. However, unmet need cannot be ruled out, especially among vulnerable groups.

Assessment of equity access is limited

Ethnicity data is not routinely recorded, limiting the ability to assess equity of access and outcomes across population groups. Routine reporting would be strengthened by improved completeness of demographic field (for example, including ethnicity, language need, migration/residency markers where appropriate).

Overall, findings support maintaining specialist capacity while strengthening early identification and trauma-informed follow-up, alongside improved monitoring of things like equity and long-term outcomes, to ensure inclusive, effective perinatal mental health care.



Determinants, risk factors and local context

Important overarching determinants for perinatal mental health are [socioeconomic adversity](#), [domestic abuse or household dysfunction](#), and [social support](#). Table 3 summarises determinants and risk factors for perinatal mental health and highlights the local context for each.

Table 3 Determinants and Risk Factors for Perinatal Mental Health with Local Jersey Context

Determinant/Risk factors	Local context
Younger maternal age (under 20) ¹⁹⁴	<ul style="list-style-type: none"> Jersey conception and birth rates for under-18s¹⁶ remain low compared with England and the Southwest¹⁹⁵ Jersey records fewer than 10 births to teenage mothers a year, with an age-specific fertility rate of 3 per 1,000 women aged 15-19 (2022-2024) A high proportion of under 18 conceptions lead to abortion (most years >80%) in Jersey
Low social support ^{196,197} See wider social support, loneliness and isolation	The 2024 Women's Health Needs Assessment found that many local mothers report that lack of support adds to mental strain and affects their health and wellbeing, particularly for single parents, those with low income or long working hours, and those without on-Island family. ⁸
Relationship conflict or domestic abuse ^{198 199} See domestic abuse and household dysfunction	In Jersey there are around 400-450 domestic abuse crimes per year. At present, local data is not disaggregated to show rates in the perinatal period, but international evidence shows domestic abuse risk can increase during pregnancy, with up to 20% of pregnant women experiencing intimate partner violence. ²⁰⁰
Financial hardship, housing insecurity, and low income See financial strain and housing affordability	The birth rate for mothers in receipt of income support is 50 births per 1,000 women aged 15-49 in 2023, compared to 35 per 1,000 women not receiving income support. ²⁰¹
Unplanned or unwanted pregnancies ²⁰²	In 2024, around 280 abortions took place in Jersey, a rate of 14.9 per 1,000, a marked increase from 9.7 in 2020. ²⁰³ Referrals for counselling support are offered through the hospital service; 40 patients received counselling support during 2025.
Complications during birth or neonatal health concerns, such as emergency caesarean sections or infant mortality ²⁰⁴	Jersey has consistently lower infant mortality and still birth rates than the English average. ¹⁶ In the 10-year period 2015-2024 there were: <ul style="list-style-type: none"> less than 20 infant deaths 25 stillbirths Regarding potential birth trauma, each year: <ul style="list-style-type: none"> around 200 Jersey births (approximately 1 in 4) births were emergency caesareans in 2024 a small number of women (7) experienced a 3rd or 4th degree tear during birth²⁰⁵
Substance use, including smoking, alcohol, or illicit drug use ²⁰⁶ See substance use and addiction	In 2024: <ul style="list-style-type: none"> around 4 to 5% of pregnant women were current smokers²⁰⁵ around 10% of women reported drinking more than 5 units of alcohol per week <i>before</i> pregnancy⁹⁵
Lifestyle factors; Maternal nutrition, physical activity and sleep ^{207,208,209} See diet and physical activity and sleep	Disaggregated data for diet, physical activity and sleep amongst perinatal women specifically is lacking in Jersey. The 2024 Women's Health JSNA found many local mothers report finding it difficult to prioritise their own healthy lifestyle due to time and financial constraints. ⁸

Prevalence and service use

Jersey's birth rate has declined from around 1,000 births per year in previous years to just 720 births in 2024. Applying national UK prevalence²¹⁰ estimates to the Jersey birth rate suggests that each year:

- 70 to 105 mothers may experience mild to moderate anxiety or depression
- Around 20 may experience PTSD
- Around 20 may experience severe depressive illness, but fewer than 5 cases of chronic serious mental illness or postpartum psychosis

Population projections for 2025-2030 indicate a relatively stable, or slightly declining number of mothers likely to require mental health support in the near future (depending on the migration and fertility rate assumptions used).¹⁵

Perinatal Mental Health Care

Quality antenatal and postnatal care enables early identification of mental health symptoms, reinforces social support, ensures safe birth experiences, and reduces stress from medical uncertainty.²¹¹ Following a 2021 review, maternity services in Jersey committed to an ongoing improvement plan, and 3-year maternity services strategy, to address key areas for improvement, including support for mental health.²¹² A Jersey midwife was awarded the perinatal mental health prize at the 2026 Royal College of Midwives awards,²¹³ demonstrating excellence in this area.

In Jersey, the Perinatal Mental Health Team are trained professionals who provide support before, during and after pregnancy. The service primarily supports individuals with perinatal anxiety, depression, and complex mood disorders, and the small number who also experience severe psychotic symptoms. They support up to 2 years postnatally.

The specialist perinatal mental health service caseload has steadily increased, rising from just below 80 at the beginning of 2023 to just under 100 by the end of 2024 (and up to 120 at points in 2025) despite a declining birth rate.²¹⁴ Between 2021 and 2023, six women were diagnosed with severe perinatal mental illness.²¹⁵ Younger and single mothers were most likely to access specialist perinatal mental health services; over half on the caseload were single women (54%),²¹⁴ and 21% were aged under 25 (compared to just 7% of mothers overall being aged under 25 in 2024). Ethnicity information is not consistently recorded in maternity data; nearly half of the mothers have no stated ethnicity recorded, limiting the ability to assess equity of access and outcomes across population groups. The three most common reasons for women accessing support through the perinatal pathway in Jersey are anxiety, depression and birth trauma.²¹⁵ Around 200 births per year in Jersey are by emergency c-section, and Jersey has a high overall c-section rate compared to England, birth trauma could be contributing to the sustained demand for specialist perinatal mental health support.

Prevalence estimates are slightly higher than the perinatal mental health caseload (just under 100 at year end 2024), suggesting that the service is reaching most of the population likely to need this level of input. While unmet need can never be entirely ruled out, there is no evidence from current prevalence or activity data to suggest large-scale unmet need at the specialist level.

Family Nursing and Homecare

Family Nursing and Home Care (FNHC) delivers mental health screening and early intervention through the Maternal Early Screening and Care Hub (MESCH), supporting mothers and families during the perinatal period.

Data from Q1 2023 to Q1 2025 show consistently high levels of engagement, with between 67 and 87 families supported per quarter, indicating sustained demand for early family and perinatal mental health support. Each quarter, a subset of mothers on the MESCH caseload were screened specifically for perinatal mental health difficulties, typically between 10 and 18 mothers, and a proportion of these families were either signposted to early identification pathways or referred on to additional services.²¹⁶

4.2. Children and young people's (up to 16 years) mental health

Childhood and adolescence are critical periods for mental health. Most mental health disorders develop early in life, with an estimated 50% of conditions beginning by age 14 and 75% presenting by age 24.²¹⁷ This makes it essential to provide effective support from early childhood onwards. A child's early experiences and the quality of attachment to caregivers shape the brain's architecture. Responsive caregiving, nurturing interaction and opportunities for safe exploration strengthen healthy development, while chronic stress or neglect can disrupt it and leave lasting effects on mental health, learning and behaviour.

Adolescence presents challenges, with rapid biological, social and emotional changes. Other issues can emerge during this time, such as autism-related needs and eating disorders, highlighting the need for holistic, coordinated support throughout childhood and adolescence.

Key insights

Need increases steadily with age, and peaks in adolescence

- Prevalence rises from early childhood into the teenage years, with a clear increase in both the *level* and *complexity* of mental health difficulties as children get older.

Support for healthy attachment in early years is crucial

- Around 30 local families⁵¹ are currently being supported by the Parent Infant Psychotherapy Service.
- There may be unmet need in this area; as at October 2025 less than 5 of the 65 children aged 0 to 4 who were either on a protection plan, a child looked after or a child in need were being seen by the Parent Infant Psychotherapist.

Adolescence brings a sharp rise in emotional distress

- Emotional disorders more than double between 11 and 16 years of age, marking adolescence as the point where anxiety and low mood become the dominant pattern of need.
- Worries about schoolwork become very common around adolescence (46% of secondary pupils worry about workload).
- A substantial minority of pupils in Year 10 and Year 12 report thoughts of self-harm and self-harming behaviour, indicating significant levels of distress.

Marked deterioration for girls as they progress through the teenage years

- From around age 11 onwards, average wellbeing among girls declines. Emotional distress, anxiety and the proportion reporting thoughts of self-harm all increase.
- Girls become the larger group in CAMHS demand and crisis presentations.
- There is no single agreed explanation for this shift. International evidence and local survey data highlights the cumulative impact of academic pressure, peer relationships, bullying, body image concerns, social media exposure and gendered expectations, all of which disproportionately affect adolescent girls.²¹⁹

Investing in early intervention and resilience building for young people is crucial

- Wellbeing indicators are worsening over time; the proportion of pupils reporting low or medium low self-esteem has increased between 2018 and 2024

- Deteriorating self-perceived wellbeing across the school age population suggests a need to support young people develop resilience building skills and invest in early intervention services.

Socioeconomic disadvantage strongly compounds risk

- Material deprivation is consistently associated with poorer wellbeing, including lower life satisfaction, feelings of worth and happiness.
- Children with care related needs, for example children looked after or those on protection plans, are far more likely to require support from CAMHS.

Service demand is rising and is driven by complexity and duration of care

- CAMHS referrals have continued to increase since 2018, with a high acceptance rate.
- Pressure is driven not only by higher referral numbers but also by sustained involvement, referrals for individuals already open to CAMHS, crisis presentations, and the need for ongoing specialist care for children and young people with complex needs.

Two different demand profiles: neurodevelopmental assessment vs. adolescent crisis

- New referrals are often for generic or neurodevelopmental assessment, which drives overall volume.
- Referrals for those already open to CAMHS are predominantly **crisis-related**, including self-harm, suicidal ideation and behaviours that challenge. This reflects increasing acuity and risk.

Key transition points are visible in the data

- Referral peaks around ages **7** and **13** suggest vulnerable transition stages, including early primary identification, early adolescence and emotional escalation.
- The transition from children's to adult mental health services remains a known vulnerability point.

Hidden need is likely substantial

- Survey findings indicate far more distress, particularly relating to self-harm ideation, anxiety and eating concerns, than is reflected in specialist referral data.
- Stigma, non-disclosure, cultural barriers, confidentiality concerns and practical access issues can delay help seeking. Many children may only present once difficulties have escalated.

Digital support is being used, but doesn't replace face-to-face

- Engagement with Kooth remains strong and indicates ongoing demand for low threshold support.
- Young people continue to express a preference for face-to-face support where possible.



Determinants, risk factors and local context

Mental health risks in children and young people are closely linked to the circumstances and environments they grow up in. Children have limited control over their environment, and risk factors are, therefore, more likely to arise from family circumstances, early experiences, school and peer relationships, and exposure to adversity.

Important overarching risk factors for children and young people’s mental health are [early attachment and nurturing](#), [socioeconomic adversity](#), [domestic abuse or household dysfunction](#), [screen use and social media](#), [school stress and bullying](#) and [special educational needs and inclusion](#).

Table 4. key determinants and risk factors that shape children and young people’s mental health and highlights the local context for each.

Determinant/Risk factors	Local context
<p>Poverty and material hardship¹⁵⁰ See financial strain and housing affordability</p>	<ul style="list-style-type: none"> Roughly 10% of children report that their family is “not well off” (an indication of poverty/deprivation)⁶³ One in four children (24%) live in relative low-income households, a lower proportion than UK²
<p>Childhood trauma and children looked after^{220,150} See domestic abuse and household dysfunction, early attachment and nurturing</p>	<ul style="list-style-type: none"> SafeLives estimate approximately 175 children are living in households with high-risk domestic abuse and 225 with medium-risk abuse already visible to services¹⁴⁶ As at October 2025, there were 53 children looked after, 102 with child protection plans, and 239 “children in need”⁵¹
<p>Young carers and parental illness^{222,150,223,224,225} See caring responsibilities</p>	<ul style="list-style-type: none"> Young carers represent approximately 1% of households in Jersey¹²⁹ In 2021, nearly two-fifths (38%) of young people reported having a family member or friend with a health-related condition. Two percent said they were the main carer for a family member or friend, slightly higher amongst girls than boys.¹³⁰ Of these, 5% spent more than five hours a week carrying out caring responsibilities In 2018, 1 in 10 young carers said they did not receive the help and support they needed (approximately 20 young people in each year group)²²⁷
<p>School readiness and attainment⁴⁴ See Economy, education and skills</p>	<ul style="list-style-type: none"> In 2024, three-fifths of pupils (464 out of 762 pupils) achieved the expected level of development at the end of reception, whilst approximately 300 pupils did not⁵⁰ At GCSE level, in 2023/2024, 73.2% of pupils achieved English and Maths at grades 4 or above, broadly comparable to English rates⁵²
<p>Educational needs and inclusion See special educational needs and inclusion</p>	<ul style="list-style-type: none"> 29.5% of pupils are multilingual learners. Of these, 3% were new to English and 9% were in early acquisition stages In the past 5 years there has been a 60% increase in secondary school pupils with Special Educational Needs (SEN/D) support for “Social, Emotional and Mental Health” reasons⁵¹ The number of electively home-educated pupils more than doubled from 41 in 2019/2020 to 86 in 2024/2025⁵¹

Table 4. Continued

Determinant/Risk factors	Local context
<p>Social media and screen time^{90,180} See screen use and social media</p>	<ul style="list-style-type: none"> • 90% of Year 12 pupils have at least one social media account⁶⁴ • Time online is rising. In 2024, nearly three quarters of Year 12 students report daily screen-time of over 3 hours, and two thirds (66%) were socialising online for 2+ hours per day • 1 in 5 pupils report receiving threatening or scary messages online, and 28% of Year 12s had lied to a parent or carer about who they'd spoken to online • Over a third of girls feel social media pressure around appearance
<p>Bullying and cyber bullying¹⁷⁹ See school stress and bullying</p>	<ul style="list-style-type: none"> • In 2024, 22% of children reported being bullied at school in the past year • 49% of those bullied spend more than five hours on screens daily, compared to just 34% of their non-bullied peers • One in five primary children were involved in bullying via mobile or online devices in recent months • Bullying was strongly associated with poorer wellbeing. Approximately a third of those with low levels of life satisfaction, feelings of worth, or happiness reported being bullied, compared to only one in ten among peers with higher wellbeing scores
<p>Resilience, self-esteem¹⁰⁸ See Personal resilience and sense of self</p>	<ul style="list-style-type: none"> • The proportion of pupils with low or medium-low self-esteem has shown a gradual increase over the years, rising from 21% in 2018 to 27% in 2024^{Error! Bookmark not defined.} • Pupils in fee paying schools were more likely to report high self-esteem (41%) than those in non-fee paying schools⁶³ (32%)
<p>School attendance, exclusion and offending^{232,233,234}</p>	<ul style="list-style-type: none"> • In the 2024/2025 academic year there were 830 fixed-term exclusions, affecting 7.2% of pupils • Overall school attendance showed that around one in six pupils (17%) attended less than 90% of the time, slightly lower than England (18%) • There were 64 first-time youth offenders in 2024, the lowest number since 2018¹⁷⁰

Table 4. Continued

Determinant/Risk factors	Local context
<p>Lifestyle factors; diet, sleep, substance use, physical activity and time outdoors²³⁶ See Diet and Physical Activity and Sleep</p>	<ul style="list-style-type: none"> • In 2023, nine in ten (91%) households had access to at least one form of green space⁶⁰ • 75% of children visit parks, beaches or open spaces weekly • Fewer than half (45%) of young people slept eight hours or more the previous night⁶³ • Sleep is linked to screen time: Among those who slept three hours or less, 55% reported more than five hours of screen time the day before, compared with 28% of those who slept eight hours or more • Only 1 in 5 young people in Jersey meet recommended activity levels, and this declines with age. Just 8% of Year 10 and 12 females met the recommended level in 2024 • In 2024, over half of secondary pupils (55%) reported never having consumed alcohol, a proportion that's growing over time • In 2024, 11% of pupils had ever tried drugs, and this proportion has decreased since 2018, but by Year 12, 21% had used cannabis
<p>Meaningful activity²³⁹ See belonging, trust and meaningful activity</p>	<ul style="list-style-type: none"> • In 2024, around half (48%) of pupils reported doing sports with a club or team, and 29% in sports organised by friends. Music, art, drama or dance (27%) and clubs, community or church groups (21%) were also common activities for young people • Concerningly, 8% of pupils said they did not do any out of school activities in 2024 • Just under half (49%) of young people hadn't done any volunteering in the last 12 months, a decrease since 2021 (58%) • Overall, 58% of young people in Years 8, 10 and 12 felt they belonged to Jersey 'a great deal' or 'quite a lot'

Prevalence and incidence

Early childhood (aged up to 4)

Using prevalence rate data for England²⁴⁰ applied to the Jersey population, there are an estimated:

- 150 children aged 2-4 years affected by mental disorders, with higher levels observed among boys than girls (approximately 95 boys compared with around 50 girls)
- Behavioural disorders (e.g. oppositional defiant disorder) were the most frequently identified condition in early childhood, while emotional disorders (e.g. depression, anxiety) and hyperactivity disorders (e.g. hyperkinetic disorder) were less common

Middle childhood and adolescence (school age)

Mental disorders tend to become more common with increasing age. Using prevalence rate data for England³ applied to the Jersey population, there are an estimated:

- 570 children aged 5-10 years affected by mental disorders
- 925 young people aged 11-16 years affected by mental disorders
- Boys may be more likely than girls to be affected in the younger age group, but among adolescents the estimated numbers for boys and girls were broadly similar

Emotional disorders (e.g. depression, anxiety) showed the most marked increase across age groups. Estimates rise from around 250 cases among children aged 5-10 years to approximately 575 cases among those aged 11-16 years. Amongst 11-16 year olds, emotional disorders were more common amongst girls, whilst behavioural and hyperactivity disorders were more common amongst boys.

In addition, English survey data also estimates prevalence of

- **probable mental disorders**, giving a broader sense for the burden of mental health difficulties amongst children. An estimated 20.3% of 8-16 year olds have a probable mental disorder, this would equate to 1,940 children in Jersey
- **eating disorders**, an estimated 2.6% of 11-16 year olds had eating disorders (including anorexia nervosa, bulimia nervosa, and others). Rates are 4 times higher amongst girls (4.3%) than boys (1.0%), this would equate to 165 children in Jersey
- **sleep difficulties**, an estimated 37.8% of children aged 8-16 years had a problem with sleep 3 or more times over the previous 7 nights. The rate was much higher among those with a probable mental disorder (76.5%), highlighting the strong relationship between sleep quality and mental health

For comparison of estimated prevalence to service demand, see the [service usage](#) section.

Self-reported wellbeing (JCYP Survey)

The Jersey Children and Young Peoples Survey⁶³ found proportion of pupils overall reporting low or medium-low self-esteem has increased steadily, rising from 21% in 2018 to 27% in 2024. Socioeconomic factors were strongly associated with wellbeing outcomes; children experiencing material deprivation were more likely to report low life satisfaction, lower feelings of worth, and reduced happiness.

Among Year 12 pupils there are clear gender differences in wellbeing. Around 37% of females reporting low happiness, compared with 17% of males. Survey data indicate a marked

deterioration in mental health among females as they progress through adolescence, with over two-fifths of girls in Year 12 reporting high levels of anxiety. Concerns related to eating are also significantly more common among females, with 38% worrying about the amount they eat, compared with 15% of males.

The survey also asked children about worries. For primary school students, the top four worries they reported worrying about 'often' or 'most days' were school tests (26%), school work (24%), what people think of them (22%) and friendships (19%). For secondary school students, the top four worries they reported worrying about 'often' or 'most days' were workload (46%), school tests (45%), what people thought of them (39%) and the way they look (36%). Females worried more frequently than males, and those who had been bullied reported much higher rates of worry about emotional health and what people thought of them.

More severe indicators of distress are evident among older adolescents: across Year 10 and Year 12 pupils, around 22% reported thoughts of self-harm in the past year, and approximately one in seven reported having self-harmed. Rates were higher among females and those identifying as 'other' gender or preferring not to disclose their gender. When asked about support, young people most commonly expressed a preference for face-to-face support, either from a professional or through school-based groups.

Overall, prevalence estimates and the local survey data indicate a clear progression in mental health need from early childhood into adolescence, with both the level and complexity of difficulties increasing with age. While mental disorders in early childhood are more commonly behavioural and more prevalent among boys, adolescence is characterised by a marked rise in emotional distress, particularly among females, alongside increasing rates of anxiety, low wellbeing, and self-harm. Socioeconomic disadvantage further compounds risk across all ages.

Together, these findings highlight the importance of early identification and intervention in childhood, alongside sustained, age- and gender-responsive support through adolescence, with a continued emphasis on accessible, face-to-face mental health provision.

These prevalence and survey findings provide important context for understanding patterns of CAMHS referrals, caseload growth, and service pressure described below.

Service usage

Children and young people may access support for mental health through many different routes. This includes voluntary sector provision (e.g. MIND Jersey), the youth enquiry service (a counselling service forms part of their offer), or more informal support through community organisations. Here we focus on the main services accessed by children and young people for formal mental health support and treatment.

Early support and attachment

The Children and Families Hub in Jersey provide advice and support to parents and families. They can work directly with families or co-ordinate other children and family organisations to provide the right help at the right time. Help can include support for those with disabilities and special needs, speech and language therapy, educational needs, behaviour support or support with finances and housing. In 2025, the team were supporting 311 children and 197 families.

Around 30 local families⁵¹ are currently being supported by the Parent Infant Psychotherapy Service, a service providing infant attachment support for parents who struggle to relate to, or

have any positive feelings about, their babies.²⁴³ There is some indication that there may be unmet need in this area. As at October 2025 there were 65 children aged 0-4 who were either on a protection plan, a child looked after or a child in need. Fewer than five of these children were being seen by the Parent Infant Psychotherapist.

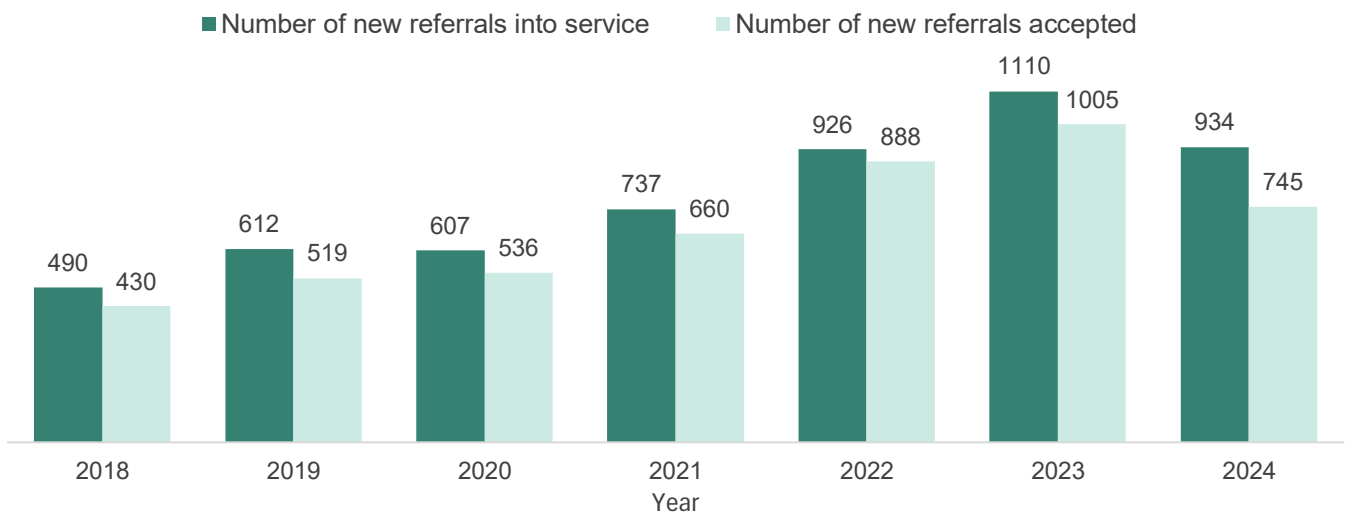
CAMHS referrals and caseload

Children in Jersey access mental health support through a mix of services, including the public CAMHS, school-based supports, primary care, and voluntary sector programs. This analysis is based on under 18’s referred to CAMHS in Jersey. However, it is important to note that some young people remain on the caseload past 18 years old until they are transferred to adult services.

CAMHS Referrals

In 2024, CAMHS received 1,146 referrals; 934 new referrals and 211 referrals for young people already open to the service. The 80% acceptance rate indicates that many referrals are appropriate and reflect genuine clinical need. However, this does not rule out the possibility that for some of these children and young people, better access to universal or preventative support could alleviate the need for a CAMHS referral. The continued increase in referrals since 2018 suggests sustained and rising demand rather than short-term fluctuation (Figure 9). Referrals for a relatively small number of young people already open to CAMHS highlight increasing complexity and acuity of need, with some individuals requiring repeated or crisis-based intervention (consistent with prevalence and survey data showing rising emotional distress, anxiety, and self-harm among older children and adolescents).

Figure 9: Number of new referrals and accepted referrals into CAMHS (2018 to 2024). Source CYPES Informatics



In 2024, most new CAMHS referrals were for children aged 5-16, with relatively few referrals for under 5s and those aged over 16. Referral peaks at ages 7 and 13 highlighting key developmental transition points, likely reflecting increased identification of neurodevelopmental needs in early primary school and rising emotional distress during early adolescence.

Gender patterns vary by age, with more boys referred in younger age groups and more girls referred from age 11 onwards. This is consistent with the earlier detection of neurodevelopmental differences in boys and the later emergence of emotional and internalising difficulties among adolescent girls. The high proportion of neurodevelopmental referrals has a significant impact on overall CAMHS demand and helps explain age- and gender-related referral patterns.

CAMHS referrals demand profiles

Referrals for young people already open to CAMHS are rare in early childhood but increase markedly with age. In 2024, fewer than five referrals were generated by children aged 0-4 already open to CAMHS, compared with 178 referrals among those aged 5-16 and 30 referrals among 17-year olds. Referrals for existing CAMHS service users are dominated by teenage girls and most commonly arise from emergency department (ED) presentations requiring urgent or emergency support. This pattern reflects increasing acuity and complexity of need during adolescence and aligns with prevalence and survey data showing higher rates of emotional distress and self-harm among adolescent females. The concentration of referrals to young people already open to CAMHS in crisis settings highlights sustained pressure on CAMHS crisis response pathways and underscores the importance of timely, preventative, and continuity-focused support for high-risk young people.

Referral patterns indicate a distinction between pathways for new and existing CAMHS service users. New referrals are most commonly for generic assessment or neurodevelopmental assessment, with gender differences reflecting earlier identification of neurodiversity in males and higher rates of emotional and eating-related difficulties among females. In contrast, referrals for young people already open to CAMHS are predominantly for crisis response, accounting for 59% of such referrals. Presenting issues for these referrals are dominated by self-harm, suicidal ideation, and behaviours that challenge, highlighting the acute and high-risk nature of need in this group.

CAMHS Caseload

The CAMHS caseload has increased year on year since 2018, with a particularly sharp rise of 35% between 2021 and 2022, and now stands at 1,959 young people, including 1,357 active cases. Neurodevelopmental pathways account for a substantial proportion of this demand; however, even when these pathways are excluded, the active caseload remains both large and clinically complex. As at 29 May 2025, a third of the non-neurodevelopmental active caseload is open to CAMHS Specialist teams, and nearly one in five are open to the CAMHS Psychiatry Clinic, indicating a high level of severity and need for ongoing specialist input.

Notably, 39% (251) of young people on the active non-neurodevelopmental caseload are also open to the neurodevelopmental pathway, either actively or awaiting assessment, highlighting significant overlap and complexity of need across pathways rather than discrete, single-issue presentations. Across the total CAMHS caseload, neurodevelopmental diagnoses remain common, with 735 young people diagnosed with ADHD and 381 with Autism, alongside a smaller but clinically significant cohort with eating disorders, further illustrating the breadth and complexity of need being supported. 19 young people are receiving care through the CAMHS Eating Disorders pathway. This is significantly less than prevalence estimates (approximately 165 children age 11-16) indicating possible unmet need in this area.

There was a high level of demand for mental health support amongst children with care experience; as at October 2025, two thirds (66%) of children in care, and just over a third (35%) of those with child protection plans, were receiving support from CAMHS, much higher rates than for their peers without care needs.

Gender patterns differ by level of care. While roughly equal numbers of males and females are open to Early Intervention services, females make up a clear majority of those open to Specialist teams and Duty and Assessment teams, reflecting the higher prevalence, acuity and persistence

of emotional and mental health difficulties among adolescent girls. There is no single agreed explanation for this shift, but it is important to emphasise that this gendered pattern is not simply biological, nor an inevitable consequence of female “emotionality” or hormones.²⁴⁴ UK and international evidence highlights the cumulative impact of academic pressure, peer relationships, bullying, body image concerns, social media exposure and gendered expectations, all of which disproportionately affect adolescent girls.²¹⁹ Previous JSNA work on women’s health also identified stigma around attributing mental health difficulties to hormones,⁸ reinforcing the need to avoid oversimplified or gender-stereotyped explanations.

Caseloads increase steadily with age, reaching their highest levels in early to mid-adolescence, with the largest non-neurodevelopmental caseload observed among 14 year olds (as at 29 May 2025). These patterns may suggest that CAMHS demand is driven not only by rising referral volumes, but could also be driven by sustained involvement with specialist and psychiatry services for a cohort of young people, predominantly adolescent females, with complex, overlapping and long-term mental health and neurodevelopmental needs.

In 2024, the average waiting time from referral to initial routine assessment was 31 days, reflecting continued improvement in access since 2019. However, assessment timeliness has not translated into reduced service pressure. Of the 729 young people whose referrals were accepted in 2024, 76% were either on an active caseload, waiting for further assessment, or had gone straight onto a neurodevelopmental assessment pathway by May 2025, indicating a significant level of ongoing need following assessment.

Transition to adult services

As of 29 May 2025, CAMHS continues to support a small number of young people aged 18+, with 34 individuals remaining open to the service, excluding those on neurodevelopmental pathways. The majority are female, and most are receiving specialist-level input, reflecting the persistence and complexity of need among some young people as they move into adulthood. Transition remains a key pressure point requiring coordinated planning to ensure continuity of care and reduce the risk of disengagement. As at May 2025, just ten individuals were on the transition pathway to ADMH services.

CAMHS Service Feedback

One proxy for outcomes is user satisfaction and experience. In 2024, Jersey CAMHS gathered 218 responses to an *Experience of Service Questionnaire* from 121 young people and 97 parents/carers. Feedback was overwhelmingly positive in all categories.²⁴⁵ This suggests that many of those receiving care and their families felt it was helpful and positive.

Children mental health inpatient

To give an idea of the level of inpatient activity for children and young people, since April 2024, there has been an average of around six discharges per month of CAMHS patients from Robin Ward (children’s ward at the General hospital), accounting for approximately 16 inpatient bed nights per month. In addition, six admissions of CAMHS patients to Orchard Ward (adult mental health unit) were recorded during 2024.

Kooth usage

The digital service “Kooth”²⁴⁶ had over 1,000 cumulative new registrations between 2022 and 2024, and an average of 620 returning users per quarter. Between 2022 and 2024, Kooth recorded consistently high levels of repeat engagement, with return user log-ins fluctuating

quarter-to-quarter but remaining substantially higher than new registrations throughout the period. New registrations showed a modest increase toward late 2024, indicating ongoing demand for accessible, low-threshold mental health support among children and young people.

Ambulance data under 18

Ambulance service data trends suggest a persistent level of high-acuity mental health distress among young people, with ambulance services increasingly acting as a first point of contact during crises. Between 2015 and 2025, the number of ambulance incidents involving under-18s triaged as overdose or poisoning increased overall, rising from around 20 incidents in 2015 to a peak of 76 in 2022, before reducing in subsequent years (but remaining above pre-pandemic levels). A similar pattern is seen for incidents triaged as psychiatric/abnormal behaviour/suicide attempt, which increased markedly from single-digit figures in 2015 to consistently higher levels from 2020 onwards. Incidents peaked during the pandemic period and have remained high, with over 30 incidents recorded in both 2024 and 2025.

Mental Health Act episodes and detentions

For information on types of mental health act episodes and detentions, please see the adult section. Of relevance for children and young people; the number of detentions under article 36 among under-18s was relatively small, but not insignificant; increasing to 16 in 2024 (from 8 in 2023).

Barriers to Accessing Mental Health Support

Although referral and caseload data provide insights into the demand for CAMHS, they may not capture the full extent of mental health need among CYP in Jersey. A number of children experiencing distress never reach specialist services. Referral statistics can underestimate true need: UK data suggest only approximately 25% of children with mental health problems access specialist care.²⁴⁷

Barriers exist at individual, family, community and system levels, creating “hidden need” that is not reflected in referral figures.²⁴⁸ This is hard to determine as there is no recorded data on those with hidden need, but research shows key factors and demographics can impact access into mental health support. Without consistently recorded demographic data like ethnicity, sexual orientation and gender identity in service data, it is challenging to access equity of access or highlight where there might be barriers for particular groups.

A significant proportion of young people may not disclose distress to adults.²⁴⁹ Local survey data suggests far more young people think about or engage in self-harm than are known to services, for example. Signs of eating difficulties may be managed “in secret” due to shame or fear of consequences.²⁵⁰ Anxiety and low mood are also frequently internalised, particularly among girls, high-achieving students, and those from cultural groups with strong norms around emotional privacy. These young people often only reach services when difficulties have escalated.²⁵¹

Stigma remains a significant barrier to seeking help. Research has shown that norms around masculinity can discourage emotional disclosure, leading many to minimise distress or present instead with behavioural problems.²⁵² Young people of all genders report concerns about being judged, labelled, or misunderstood, and fear that speaking to professionals may affect school experiences or relationships with peers.²⁵³ Practical obstacles also can also limit access such as, limited appointment flexibility, transport challenges for some families, and lack of clarity about referral routes.²⁴⁸

4.3. Young adults (age 16-24) mental health

Young adulthood is a critical consolidation period for mental health, marking the transition from dependence to independence at a time when brain development, identity formation and social roles are still evolving.^{254,255} Major life transitions during this period (leaving school, entering higher education or employment, forming intimate relationships, and moving away from the family home) can support growth and resilience, but they can also introduce instability, uncertainty and pressure.^{256,254} For young adults with pre-existing vulnerabilities, unmet needs or adverse childhood experiences, these changes can trigger the emergence, recurrence or worsening of mental health problems.^{148,257} Protective structures associated with childhood, such as school-based support, safeguarding systems and routine family oversight, often reduce or fall away, placing greater responsibility on individuals to recognise distress and seek help.²⁵⁸ Supporting mental wellbeing in early adulthood therefore has important implications for both immediate outcomes and long-term mental health trajectories.²⁵⁹

Overall, the evidence indicates a substantial level of mental health need in young adults in Jersey, with increasing complexity linked to loneliness, gendered risk (particularly among young women), and overlap with substance use, pain, housing instability and work incapacity. Young adults making up a significant share of demand across talking therapies and secondary care access routes. Planning should protect secondary care capacity while strengthening prevention and early intervention, improving continuity and data linkage from CAMHS into adult pathways, and routinely monitoring outcomes, waiting times and equity to ensure access remains aligned with need.

Key Insights

Mental health need among young adults is significant

- An estimated 1 in 4 Islanders aged 16-24 are experiencing a common mental health disorder (CMD).

High rates of loneliness persist amongst young adults

- Survey data shows that young adults aged 16-34 report the highest levels of loneliness of any age group, despite being the most likely to socialise frequently outside their households. Over half (56%) of people aged 16-34 experience loneliness at least some of the time.

Higher presentation in young females than males

- A higher proportion of “front door” referrals for young adults were for females (58%) than males (42%).
- The majority of eating disorder diagnoses occurred among girls and young women, particularly among those aged 17-19.
- Mental health-related short term incapacity allowance claims are higher among young females (20-24 year olds) than males.

Young people are over-represented in mental health caseloads

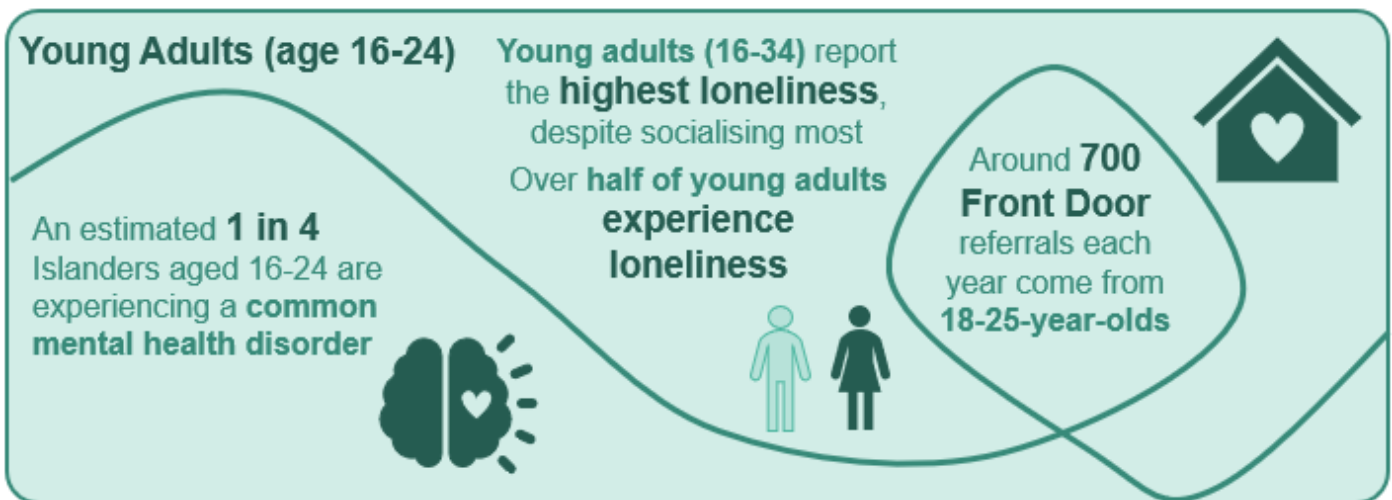
- 16% of Jersey Talking Therapies referrals are for young adults aged 18-25 years old.
- Around 700 referrals to the Front Door service come from 18-25 year olds per year.
- The outpatient and community mental health teams are seeing growing demand from young adults, raising concerns about sustainability.

Pain and musculoskeletal referrals are rising among young adults, with potential mental health overlap

- Referrals to pain-related services have increased notably (especially since changes to the referral system in 2023), with 155 in total in 2024.

Substance use is a major risk factor in young adulthood

- Young adults aged 16-34 have the highest rates of hazardous/harmful drinking: 35% score in the hazardous/harmful range, compared to 30% of those aged 35-44 and 15% aged 65+. Risk is driven by binge patterns.
- 28% of young people on the Drug and Alcohol Service caseload recorded secondary diagnoses (including ADHD and anxiety disorders), reinforcing dual-need patterns. Cannabis is also a prominent substance used by this cohort.



Determinants, risk factors and local context

Mental health risks in young adults are closely shaped by the social and economic conditions they experience during the transition from adolescence into adulthood. This is a life stage marked by major changes in education, employment, relationships, independence and identity. Young adults often have greater autonomy than children, but still face substantial structural pressures, including financial strain, housing challenges, insecure work, lifestyle stressors and increased exposure to substance use and social media. These factors can interact with broader determinants such as socioeconomic disadvantage, limited social support, care experience, and barriers to meaningful participation in community life.

Important overarching determinants for young adults' mental health include [diet and physical activity](#), [sleep](#), [substance use and addiction](#), [screen use and social media](#), [financial strain and housing affordability](#), [wider social support, loneliness and isolation](#), [belonging, trust and meaningful activity](#), and [personal resilience and sense of self](#).

Table 5. Determinants and Risk Factors for Children and Young People's Mental Health with Local Jersey Context

Determinant/Risk Factors	Local context
<p>Not in Education, Employment or Training (NEET)^{260,261} See economy, education and skills</p>	<ul style="list-style-type: none"> The proportion 16-24 year olds who were NEET, fell from 12.3% in 2011 (approximately 1,250 individuals) to 8.2% in 2021 (approximately 800 individuals); NEET rates are slightly lower among females (7.2%) than males (9.1%). Jersey reports a lower proportion of NEET young people than the UK (8.2% in Jersey compared with 9.9% in UK). The number of under 25's "actively seeking work" has declined from approximately 290 in 2021 to 70 in 2024.
<p>Lifestyle factors; diet, sleep, physical activity^{262,81,263,79,264} See Diet and physical activity, Sleep</p>	<ul style="list-style-type: none"> Only a quarter (26%) of people aged 16-34 years consume the recommended fruit or vegetables,²⁶⁵ and in 2025 1 in 5 had gone without fresh fruit or veg, and home cooked meals due to lack of money (the highest of any age group). In 2025, over half (52%) of 16-34 year olds reported getting an average of 7+ hours of sleep per night (the highest of any age group), but 39% were getting 5 to 6 hours, and 1 in 10 (9%) were getting less than 5 hours. 16-34 year olds were the age group most likely to report poor sleep affecting day to day activity (19%, or 1 in 5). In 2025, young adults (16-34 year olds) were the age group most likely to meet physical activity guidelines, but 2 in 5 (39%) still weren't meeting the 150 minutes per week recommendations.
<p>Substance use^{93,94,97,98,99} See Substance use and addiction</p>	<ul style="list-style-type: none"> Young adults aged 16-34 are the most likely of all age groups to drink at harmful or hazardous levels, as measured by the FAST alcohol screening tool (35% in 2024) and report binge drinking (25% binge drink at least monthly). Error! Bookmark not defined. 17% of 16-34 year olds report failing to meet responsibilities due to alcohol at least once in the past year, and 34% report being unable to remember what happened the night before at least once in the past year. Increasing minority are choosing not to consume alcohol (23% of 16-34 year olds, the highest proportion of any adult age group). After alcohol, cannabis was the second most common primary substance cited in alcohol and drug service referrals for young people (aged under 25).

Table 5. Continued

Determinant/Risk Factors	Local context
Social media and screen time? See <i>screen use and social media</i>	<ul style="list-style-type: none"> Social media use is widespread amongst young adults; in 2025 16-34 year olds were the age group most likely to report weekly use of social media platforms like Instagram, X, YouTube and TikTok compared to other age groups.⁶⁴ The majority of 16-34 year olds use social media several times per week or month at least (86%), much higher than older Islanders (55% for those aged 65+, for example). Young adults were the age group most comfortable with doing activities online, like booking appointments and filling in Government forms.
Physical health and pain See physical health	<ul style="list-style-type: none"> In 2025, most 16-34 year olds (80%) report being in good or very good health generally, but 30% reported having a long-term health condition (physical or mental). Indication that referrals for musculoskeletal and pain related assessments for young people age 16-25 are rising, from 66 in 2021 to 155 in 2024 (although there have been changes to referrals system).
Socioeconomic disadvantage ^{267,268,269} See financial strain and housing affordability	<ul style="list-style-type: none"> In 2025, 2 out of 5 16-34 year olds said their household found it quite or very difficult to cope financially, and only half (53%) said they could afford an unexpected but necessary expense of £1,400 (this proportion was higher for older adults).
Homelessness See housing suitability and homelessness	<ul style="list-style-type: none"> In Q1 of 2025 there were almost 60 people under age 25 experiencing homelessness²⁷⁰ (about 1 in 5 of those experiencing homelessness overall).
Care leavers ^{271,272,273}	<ul style="list-style-type: none"> As of June 2025, 87 care leavers up to the age of 25 were being supported by personal advisers.
Social support and loneliness ^{274,275,276,277} See Wider social support, loneliness and isolation	<ul style="list-style-type: none"> Despite being one of the age groups most likely to socialise with people outside of their household (82% at least weekly), 16-34 year olds were the group most likely to report often or always feeling lonely (22%).⁶⁴
Meaningful activity ^{239,278} See belonging, trust and meaningful activity	<ul style="list-style-type: none"> In 2025, just over half (55%) of young adults reported high satisfaction with what they did in their leisure time. 39% (2 in 5) of 16-34 year olds had volunteered in the last 12 months, the lowest of any adult age group. Young adults were the age group least likely to say they planned to vote in the 2026 general election (51%).
Resilience ^{279, 280} See Personal resilience and sense of self	<ul style="list-style-type: none"> In 2025, young adults (16-34 year olds) were the age group most likely to report always or often being optimistic about the future (47%), but were most likely to report high anxiety (37% high anxiety compared to 24% in those aged 55+)⁶⁴

Prevalence and incidence

The recently published Adult Psychiatric Morbidity Survey 2023/24 in England⁴ provides estimates of the prevalence of common mental health disorder (CMD) and eating disorders in the UK population. Applying these prevalence estimates to the 2024 Jersey population gives an approximation of local numbers:

- around 26% of people (1 in 4) aged 16 to 24 in Jersey are estimated to be experiencing a CMD, equivalent to approximately 2,365 individuals
- generalised anxiety disorder was the most prevalent condition in this age group, affecting around 8% of young people (estimated 700 individuals), followed by obsessive compulsive disorder, which affected around 6% (estimated 520 individuals)
- girls and young women were more likely than boys and young men to be classified as having a probable disorder in this age group
- an estimated 750 17 to 25 year olds have an eating disorder including anorexia and bulimia, with more than three quarters being female

These estimates suggest that although most older adolescents and young adults do not meet the threshold for a mental disorder, a significant proportion, particularly young women, may be experiencing mental health difficulties and eating disorder.

Loneliness and social isolation

Loneliness is a significant factor in understanding mental health among young adults in Jersey. Since at least 2018, young adults (aged 16-34) have been the age group to report the highest levels of loneliness of any age group. In 2025, 22% reported often or always feeling lonely (compared to 17% or lower in all other adults age groups). Survey data also shows that most people aged 16-34 report regular face-to-face social contact, with 88% indicating that they socialise with people outside their household daily or weekly, suggesting that frequency of social contact and quality of connection do not always align.

Mental health related incapacity allowance

Between 2014 and 2021, the number of mental health related Short Term Incapacity Allowance claims among under 25s increased steadily. Claims rose from approximately 250 per year in 2014 to a peak of around 360 claims in 2021, indicating growing numbers of young adults experiencing mental health difficulties severe enough to disrupt their capacity to work. Stress, anxiety and depression account for the majority of claims. Short Term Incapacity Allowance claims are substantially higher among females than males in the 20 to 24 age group.

Service Usage

Note that age breakdown of users is unavailable for some adult services (e.g. some community and voluntary services). Please also see the [adult's mental health](#) service use section for a more comprehensive review of adult services (many of which serve young adults).

Jersey Talking Therapies referrals

Jersey Talking Therapies (JTT), part of Health and Care Jersey, offers a free and confidential self-referral therapy service for Islanders aged 18 and over. They provide a range of therapeutic options both face-to-face and over the phone. The service accepts self-referrals, ensuring accessible support for those experiencing common mental health difficulties. Young adults can

seek help directly. In 2024, 16% of JTT referrals were for young adults aged 18-25 years old, a slight reduction since 2021 when 21% of JTT referrals were for 18-25 year olds.

Transition

The transition from CAMHS to AMHS can be a point of vulnerability for young people aged 16-25. This transition does not simply reflect a change in service provider, but a shift between fundamentally different service models, thresholds and expectations, at a time which can coincide with many major life changes (starting work, working or moving away from home, etc).

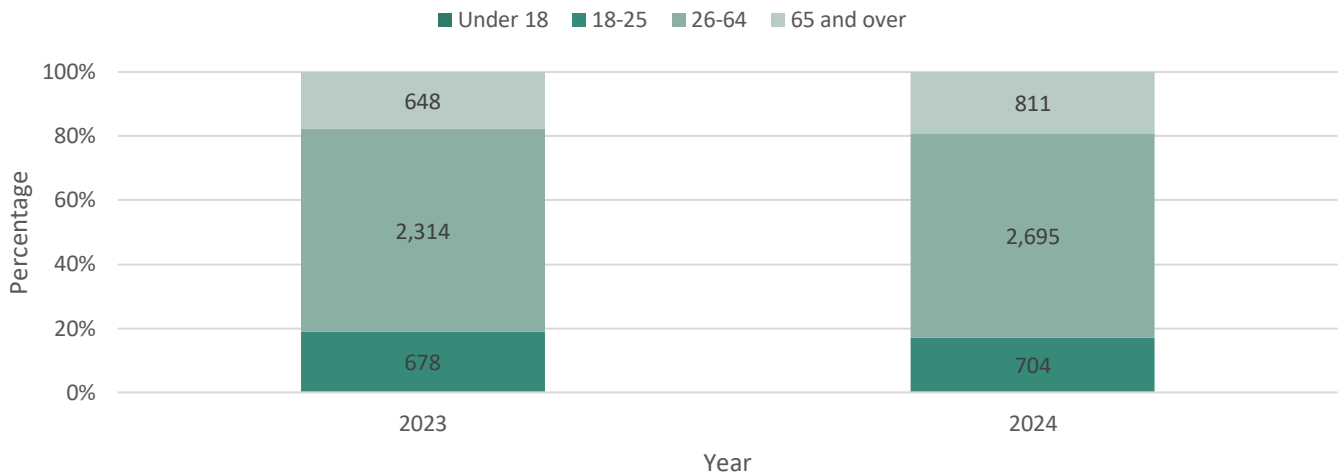
The 2022 Child and Adolescent mental health audit identified that some young people transitioning from CAMHS had not been involved sufficiently, did not feel they had ownership of their care plans and felt they had inadequate support during the transition process.²⁸² Subsequently a transition scheme was created which follows a series of protocols to ensure a smooth transition when there is a high likelihood of requiring services as an adult. This includes:

- ensuring adult referrals occur in good time (when the patient is no older than 17 years and 6 months)
- a support plan is developed and at least one face to face meeting will be held for a young person with their CAMHS key worker
- a lead practitioner and transition co-ordinator should also ensure a seamless transition²⁸²

As at May 2025, there were 10 young people aged 18 and over open to the formal transition pathway to AMHS.

In 2022, AMHS in Jersey were redesigned with the introduction of a 'Front Door' model, creating a single point of access to secondary AMHS for individuals not previously known to those services. The redesign was informed by community engagement and underpinned by principles of person centred, recovery focused care, partnership with service users and carers, and a commitment to safety, dignity, inclusion and continuous improvement. Since implementation, referral volumes to the Front Door have shown a consistent upward trend. This may reflect increasing demand for mental health support, improved public awareness, or clearer access pathways into services. Young adults aged 18-25 account for approximately 700 referrals per year (about 17% of all referrals), with referrals slightly more common among females (58%) than males (42%) (Figure 10). The relatively large number of Front Door referrals in this age group suggests that some young people may be re-entering services at the point of crisis. Current data do not routinely capture whether young adults aged 18-25 referred through the Front Door were previously known to CAMHS, limiting the ability to fully understand patterns of transition and continuity of care. Further analysis should be undertaken to understand how to better support transition or those who may cross over between CAMHS and adult services.

Figure 10: Front Door Referrals by age group (2023 and 2024). Source: Health and Care Jersey, Adult Mental Health informatics team



Alcohol and Drug Referrals

In 2024, just under 50 referrals to Jersey’s Drug and Alcohol Service were recorded for young people under the age of 25, with an approximately even gender split. Over half of these referrals (56%) represented first contacts with the service, suggesting that for many young people, engagement with specialist substance misuse support is occurring for the first time in early adulthood. Mental health comorbidity was common. Over a quarter of referrals (28%) had a recorded secondary mental health diagnosis, including conditions such as ADHD and anxiety disorders.

Just over a quarter of under-25s referred (27%) had recorded criminal justice involvement, including offences related to violence or driving. The same proportion (27%) were NEET (not in education, employment, or training). Health service utilisation among this group was high. A substantial majority (84%) had experienced at least one hospital admission in the previous 12 months, and almost half of these admissions (49%) were substance related. This reinforces evidence that substance use in young adults frequently co-occurs with underlying or emerging mental health difficulties, and that substance misuse services are often engaging with young people whose needs extend beyond substance use alone. The complex presentation in this cohort of young people indicates there may be opportunities for earlier intervention and better coordination between acute services and community-based support.

Alcohol was the most commonly identified primary substance, accounting for 55% of referrals, followed by cannabis at 28%. Among those whose primary substance was alcohol, 45% also had cannabis recorded as a secondary substance. This pattern indicates that cannabis use is highly prevalent within this cohort, even when not identified as the primary presenting issue. There are key mental health concerns associated with adolescent cannabis use, including increased risk of psychosis. Research shows a clear dose-response relationship, with heavy or frequent cannabis use (especially of high-potency strains) significantly raising the risk of psychosis, mood disorders and suicidality.⁹⁹ For young people who already have underlying psychiatric conditions, cannabis use often worsens clinical outcomes, suggesting that youths with vulnerabilities should be provided with clear, informed guidance to support safer decision-making.

Pain clinic service referrals

Referrals of young people to the pain service show a notable increase in recent years, particularly since the introduction of the new referral system in 2023. The overall pattern indicates a rise in referrals among older adolescents and young adults. In 2024, there were 155 referrals for 16 to 25 year olds overall, up from 66 in 2021. Those running the service have observed that some young patients are presenting with negative views of their own health and future potential, and challenges in finding/sustaining employment, underscoring potential co-occurrence with poorer wellbeing and compromised resilience in this cohort.

Adult Outpatients (OPD) and Community Mental Health Team (CMHT)

The overall rate of referral (OPD and CMHT) increased by 18% between 2023 and 2024, with those aged under 30 over-represented (relative to population size), indicating significant demand at the transition point between adolescence to adulthood. Feedback from professionals working in the community mental health space suggest this demand could become unsustainable, with the demand for psychiatrists in the OPD/CMHT growing by approximately one full time employee equivalent psychiatrist per year. Professionals suggest the increasing demand could be driven by a combination of factors including growing numbers of younger people with mental health problems, increasing identification of need (through things like specialist services for ADHD), patients remaining on the caseload for a long time, and challenges with coordination/access to secondary care.

Recovery and Outcomes

Ultimately, the aim of mental health services is to help young people recover or manage their conditions so they can lead fulfilling lives. Jersey has a Residential Recovery unit (Clairvale) as part of adult services, which provides a step-down for individuals (including young adults) who are coming out of acute inpatient care or who need intensive support in the community.²⁸³ While we do not have published statistics on returning to education or employment post-treatment in Jersey, it is important to note that emphasis is on enabling individuals to build resilience and continue with their lives post treatment, regaining social and vocational functioning.

4.4. Adults (age 25-64) mental health

Adulthood represents the longest and most diverse phase of the life course. For many adults aged 25-64, mental health is shaped less by developmental change and more by the cumulative impact of work, relationships, caregiving responsibilities, physical health and wider socioeconomic conditions.^{284 285 286} This stage of life is characterised by competing demands; employment, parenting, caring for ageing relatives, financial commitments and housing pressures, often alongside managing long-term physical conditions.^{287 288} Chronic stressors of this kind can erode resilience over time and increase vulnerability to anxiety, depression and burnout.²⁸⁹ Experiences of trauma, violence, bereavement and relationship breakdown continue to influence mental health during adulthood, and substance use can emerge or escalate as a maladaptive coping strategy in response to stress or emotional distress.²⁹⁰

Adult mental health is not only a clinical issue but a key determinant of workforce participation, family stability and social cohesion.²⁹¹ Supporting mental wellbeing in working-age adults requires services that can respond to both high-volume common mental health needs and a smaller cohort with severe, enduring or crisis-driven presentations, while also addressing the wider social and economic drivers of poor mental health.

Overall, the evidence in Jersey shows a sustained level of mental health need among adults aged 25-64 in Jersey, with an estimated one in five living with a common mental health disorder. The data also reveals an increasingly unwell cohort (some with serious mental illness) driving demand for crisis, statutory and inpatient care. While outcomes such as suicide rates have improved, pressures across primary care, psychological therapies and secondary services indicate rising complexity, longer durations of illness and heavy reliance on medication. Mental ill health in this age group is closely linked to wider determinants including work stress, long-term physical illness, caring responsibilities, housing insecurity, trauma and substance use. Planning should therefore protect community and primary care capacity, support timely access to psychological and crisis services, and strengthen prevention and early intervention to address both clinical need and its underlying social drivers.

Note that not all data for adult prevalence, incidence and service use is disaggregated by age. Therefore, some of the analysis in this section includes data for all adults (not just working age).

Key Insights

Need for support for common mental disorders (CMD) is high and rising among working-age adults

- An estimated 20-25% of adults aged 25-64 in Jersey are living with a CMD, with the proportion of adults estimated to be experiencing any CMD rising from 15.5% in 1993 to 22.6% in 2023/2024, with generalised anxiety disorder estimated to be the most common CMD across all ages.
- While loneliness generally decreases with age, a small but persistent group (approximately 15% of 35 to 64 year olds) report often feeling lonely, indicating a small cohort with chronic loneliness.

Gender differences persist

- CMD prevalence is consistently higher among females, particularly for anxiety and depression.

- Females account for around two-thirds of referrals to psychological therapies and a higher proportion of Mental Health Act detentions under legal powers than males.
- Jersey's suicide rate has fallen significantly since 2018-2020 and is now lower than England, but men remain significantly over-represented in suicide deaths, being around 2.5 times more likely than women to die by suicide, highlighting different patterns of risk and help-seeking.

Medication use indicates high and complex demand in primary care

- 13% of the population are prescribed antidepressants, broadly in line with England.
- Prescribing of hypnotics and anxiolytics (8%) and antipsychotics (3%) is notably higher than England, suggesting both a greater burden of severe mental illness and heavier reliance on pharmacological management.
- Primary care is acting as a critical pressure point, supporting both high volumes of CMD and people with complex, enduring conditions.

Demand for psychological therapies continues to grow, with attrition evident

- Referrals to Jersey Talking Therapies have increased steadily since 2020.
- Not all referrals progress to treatment or completion, reflecting capacity constraints, waiting times and disengagement.
- Recovery and improvement rates are close to national targets but not yet consistently meeting them, indicating both effectiveness and system strain.

Increasing severity and complexity in secondary and crisis services

- Crisis, Front Door, Emergency Department, ambulance and Mental Health Act data all point to an increasingly unwell cohort driving demand.
- Self-harm accounts for nearly half of mental health-related emergency department attendances, and crisis referrals have risen steadily.
- Statutory activity has declined overall, but shifted toward more emergency detentions and longer compulsory treatment.

Inpatient care is dominated by severe mental illness

- Inpatient demand remains elevated. Admissions are primarily for psychotic, mood and organic mental disorders, with most patients aged 25-64. Length of stay is highly variable, reflecting complex needs and a small number of long-stay patients.
- Post-discharge follow-up performance is strong, acting as an important protective factor.

Community and specialist services carry sustained pressure

- Community caseloads remain high (1,100-1,350 cases), with serious mental illnesses such as mood disorders, psychosis and organic disorders accounting for 65% of need. The ACMH Team supports the largest share, underscoring the importance of community-based, multidisciplinary care.

Voluntary and community sector services are critical

- Services such as Listening Lounge, Mind Jersey, Togetherall and Jersey Hospice provide early intervention, peer support, out-of-hours access and bereavement care, often reaching people not engaged with statutory services.
- High engagement, strong outcome measures and low re-referral rates suggest these services reduce escalation into crisis and statutory pathways.

Mental ill health has a substantial economic and workforce impact

- Mental health conditions remain a major driver of short-term incapacity, particularly among 25 to 49 year olds, with depression, stress and anxiety most common.
- Women account for more claims across most age groups, but men also experience significant work-related impact, particularly in core working ages.
- Over two-fifths of workers report spending too much time at work, increasing risk of anxiety and burnout.

Long-term physical illness is common and strongly linked to poorer wellbeing

- Around 3 in 10 adults aged 35 to 64 had a long-standing health condition. Of these, around two thirds said it impacted their day-to-day activities a little or a lot
- Adults who reported bad or very bad health had significantly lower wellbeing scores than adults who rated their health as good or very good.⁶⁴

Unpaid carers are a high-risk group for poor mental health

- There are an estimated 5,000 to 8,000 carers in Jersey (of any age), with only 206 receiving Carers Allowance (a working age benefit). 92% report caregiving is stressful and 76% say their health is considerably affected. Mental health is the primary reason for care in 23% of cases.

Housing insecurity and affordability are major mental health stressors

- By 2024, around one in three households struggled with housing costs; 82% of low-income private renters were in rental stress. Housing instability services recorded 321 visits in Q1 2025, with mental health, domestic abuse and substance use key drivers.

Trauma and violence remain significant drivers of mental ill health

- Jersey records 400 to 450 domestic abuse crimes per year, rising violent crime, and over 300 sexual offences annually, all strongly associated with depression, PTSD and suicidality.

Substance use is a major population-level risk factor

- 25% of drinkers consume alcohol at hazardous or harmful levels; 66% binge drink annually. Alcohol-related hospital admissions remain high, especially among men.
- Dual mental health and substance-use need is increasing, with over 80 clients open to both mental health and alcohol and drug pathways in October 2025
- Around 6% of working-age adults have received medicinal cannabis prescriptions. One in five acute inpatient admissions flagged cannabis use as a risk factor.

Protective factors are improving but uneven

- Mental health awareness is high (96% agree anyone can have mental health problems), but only two thirds feel comfortable discussing their own mental health, indicating persistent stigma.
- Improving physical activity and quality sleep remain under-achieved prevention opportunities in Jersey's population.



Determinants, risk factors and local context

Mental health in adulthood is shaped by a complex interaction of social, economic, relational and behavioural determinants. Adults aged 25-64 often balance multiple pressures, including employment, caring responsibilities, financial commitments and changes in physical health. These years can bring stability and opportunity, but also significant stress, particularly for those facing insecure employment, rising living costs, poor housing conditions or limited social support. Patterns of health behaviour established earlier in life, such as diet, sleep, physical activity and substance use, can become increasingly important as adults age. Structural inequalities, socioeconomic adversity and exposure to chronic stress can accumulate over time, increasing vulnerability to mental health difficulties. There is also a small cohort with serious mental illness, who have lifelong conditions and need ongoing support through adulthood.

Important overarching determinants for adults' mental health include [financial strain and housing affordability](#), [substance use and addiction](#), [diet and physical activity](#), [sleep](#), [screen use and social media](#), [wider social support](#), [loneliness and isolation](#), [belonging, trust and meaningful activity](#), and [personal resilience and sense of self](#).

Table 6. Determinants and Risk Factors for adults' mental health with Local Jersey Context

Determinant/Risk factors	Local context
Physical health ⁶⁸ See Physical health	<ul style="list-style-type: none"> Over 33,000 Islanders are living with a diagnosed long-term health condition, and over 14,200 have 2 or more conditions (multi-morbidity).⁷¹ In 2025, around 3 in 10 adults aged 35 to 64 had a long-standing health condition. Of these, around two thirds said it impacted their day to day activities a little or a lot. Adults who reported bad or very bad health had significantly lower wellbeing scores than adults who rated their health as good or very good.⁶⁴
Caring responsibilities ¹²⁷ See caring responsibilities	<ul style="list-style-type: none"> Among adults in Jersey, it is estimated between 5,000 and 8,000 Islanders are providing unpaid care to a family member, relative or friend, but only 206 are in receipt of carers allowance.
Housing ^{294,37,295} See housing suitability and homelessness	<ul style="list-style-type: none"> In 2021, 4% of households in Jersey were overcrowded overall, but amongst "non-qualified" households the proportion was much higher at 15%. In Jersey, 321 service visits were made by 304 adults in just the first quarter of 2025 seeking support related to housing instability or homelessness, mental health itself was a direct factor in 12% of male and 7% of female cases.
Socioeconomic disadvantage ^{37,296,297} See financial strain and housing affordability	<ul style="list-style-type: none"> After housing costs, about 24% of households and 21% of individuals are in relative low income. In 2021/2022, 82% of lower-income households renting privately were classed as living in "rental stress". 82% of single-parent families reported difficulty coping financially. In Jersey, average wellbeing scores were lowest and anxiety scores were highest for adults who find it difficult to cope financially.

Table 6. Continued

Determinant/Risk Factors	Local context
<p>Employment and skills^{154,155,156} See work and working conditions, and economy, education and skills</p>	<ul style="list-style-type: none"> • Economic activity (employment rates) is relatively good in Jersey; the economic activity rate of all adults was 63% in 2021, higher than that recorded in the UK at that time (59%). • The proportion holding a higher-education qualifications has grown from 33% in 2011 to 42% in 2021. There are disparities however; just over half (54%) of adults aged 16-64 born in Portugal or Madeira reported no formal qualifications, substantially higher than any other group. • Jersey’s OECD Better Life Index ranking was relatively low for work-life balance, with 14% of employees in Jersey working 50 or more hours in a usual week during 2022, a higher proportion than in the UK (11%) and the OECD average (12%).⁵⁹ • In 2024, 25% of Jersey workers had medium or low job satisfaction scores,⁶¹ dissatisfaction was highest in the hospitality sector. • About 10% of all Jersey jobs are on zero-hours contracts, and the use of temporary work permits has increased considerably, from 80 in 2020, to 1,750 at year end 2024.³⁰⁰ • Data from the Jersey Annual Social Survey 2010³⁰¹ showed a quarter (24%) of workers said that they had personally experienced bullying in the workplace at least once in the previous twelve months.
<p>Adulthood trauma^{172,173,164,165,166} See domestic abuse and household dysfunction, and crime safety and exposure to violence</p>	<ul style="list-style-type: none"> • Jersey has relatively low levels of violent crime (13.7-18.3 per 1000 people¹⁷⁰) compared to England (28.2-35 per 1,000 people¹⁷¹). However, recorded violent crime has risen steadily over time in Jersey, from 1,519 in 2018 to 1,911 incidents in 2024. • Around 400-450 domestic abuse crimes are committed every year in Jersey, and estimates suggest around 11,000 women in Jersey may have experienced domestic abuse at some point in their lives. • In 2024, the average daily prison population increased to 175 (a rise of 27% compared with 2023). Adult re-offending within 12 months has increased from 32% in 2018 to 39% in 2024, indicating a cohort of adults cycling repeatedly through the criminal justice system.
<p>Substance use and addiction^{303,105} See substance use and addiction</p>	<ul style="list-style-type: none"> • Alcohol consumption rates remain stubbornly high in Jersey. In 2024, per-capita alcohol consumption was 10.8 litres Error! Bookmark not defined. (higher than the UK and many other countries). • Adults in mid-life drink alcohol frequently; 20% exceed weekly recommended limits. • Adult men (33%) were nearly twice as likely as women (17%) to drink at harmful/hazardous levels. • 6.1% of Jersey’s working-age population receive medicinal cannabis, compared with 0.05% in England. • Around 7% of adults who gamble are considered ‘at risk’ for problem gambling overall (11% of male gamblers, 3% of female gamblers), with approximately 1,200 Islanders are considered moderate to high risk.

Table 6. Continued

Determinant/Risk Factors	Local context
<p>Lifestyle factors; diet, sleep and physical activity ^{304,305} See Diet and physical activity</p>	<ul style="list-style-type: none"> • In Jersey, only 31% of adults meet “5 a day” fruit and vegetable intake recommendations in 2025. • In 2025 in Jersey, just 54% of adults meet physical activity recommendations of 150 minutes per week; those who met recommendations were more likely to report high happiness and life satisfaction than those who didn’t. • Amongst adults in Jersey, 56% get the recommended 7 hours or more; whilst 34% report that poor sleep affects daily activities weekly in 2025.
<p>Bereavement^{306, 307}</p>	<ul style="list-style-type: none"> • There are roughly 900 deaths per year in Jersey, with around 1 in 3 deaths occur before 75 years of age; around 900 families are therefore impacted by bereavement, several hundred of whom face losing a loved one relatively young.³⁰⁸
<p>Social support and loneliness See Wider social support, loneliness and isolation</p>	<ul style="list-style-type: none"> • In 2025 overall around 1 in 4 adults said they felt lonely some of the time. Across 35 to 64 year olds, around 15% report feeling persistently lonely (often or all of the time). • Almost all adults (96%) in 2024 agreed or strongly agreed that anyone can have mental health problems. • Migrants and ethnic minorities report being less likely to have relatives or friends on-Island that they can count on when they need them.
<p>Meaningful activity See belonging, trust and meaningful activity</p>	<ul style="list-style-type: none"> • In 2025, 44% of adults said they had volunteered in the last 12 months, with sports, recreation and local community groups being the most common areas.⁶⁴ • Civic engagement for Jersey remains relatively poor. Turnout for the most recent states assembly elections was 41.6%, lower than all other OECD countries.

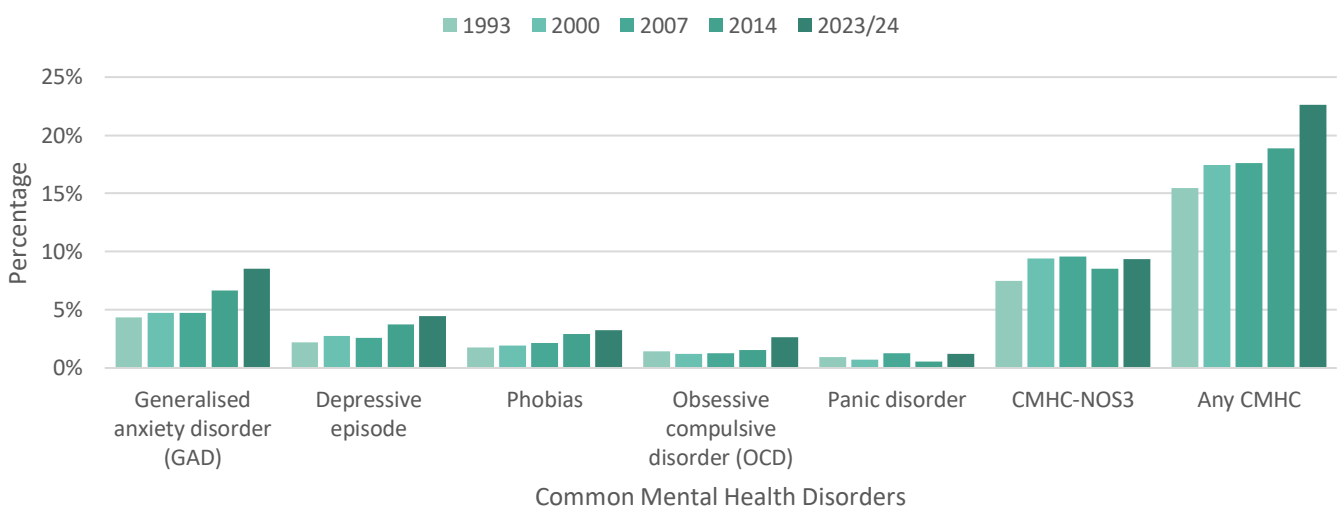
Prevalence and incidence

The recently published Adult Psychiatric Morbidity Survey 2023/2024 in England⁴ provides estimates of the prevalence of CMD in the UK population. Across all adult age groups, generalised anxiety disorder was the most common condition, affecting around 7-10% of adults. Depressive episodes were also common, affecting around 4-5% of adults, while other conditions such as phobias, obsessive compulsive disorder and panic disorder were less prevalent but still present. Prevalence data show a sustained increase in common mental health conditions over the past three decades, with the proportion of people experiencing any common mental health condition rising from 15.5% in 1993 to 22.6% in 2023/2024. Rates have remained consistently higher among females, particularly for anxiety and depression, but notably obsessive-compulsive disorder has more than doubled among males.

Applying these English prevalence estimates to the 2024 Jersey population gives an approximation of local numbers (Figure 11):

- between one in five and one in four adults aged 25-64 in Jersey are estimated to be living with a CMD. Prevalence varies by age, highest among adults aged 25-34 and 45-54 (around 23%) and lowest among 55-64 year olds (around 19%).
- These prevalence estimates equate to around 12,800 local people aged 25-64 years living with a common mental disorder

Figure 11. Estimated CMD prevalence over time amongst 16-64 year olds, England (1993 to 2023/24)



The mental health disease register (JQIF)

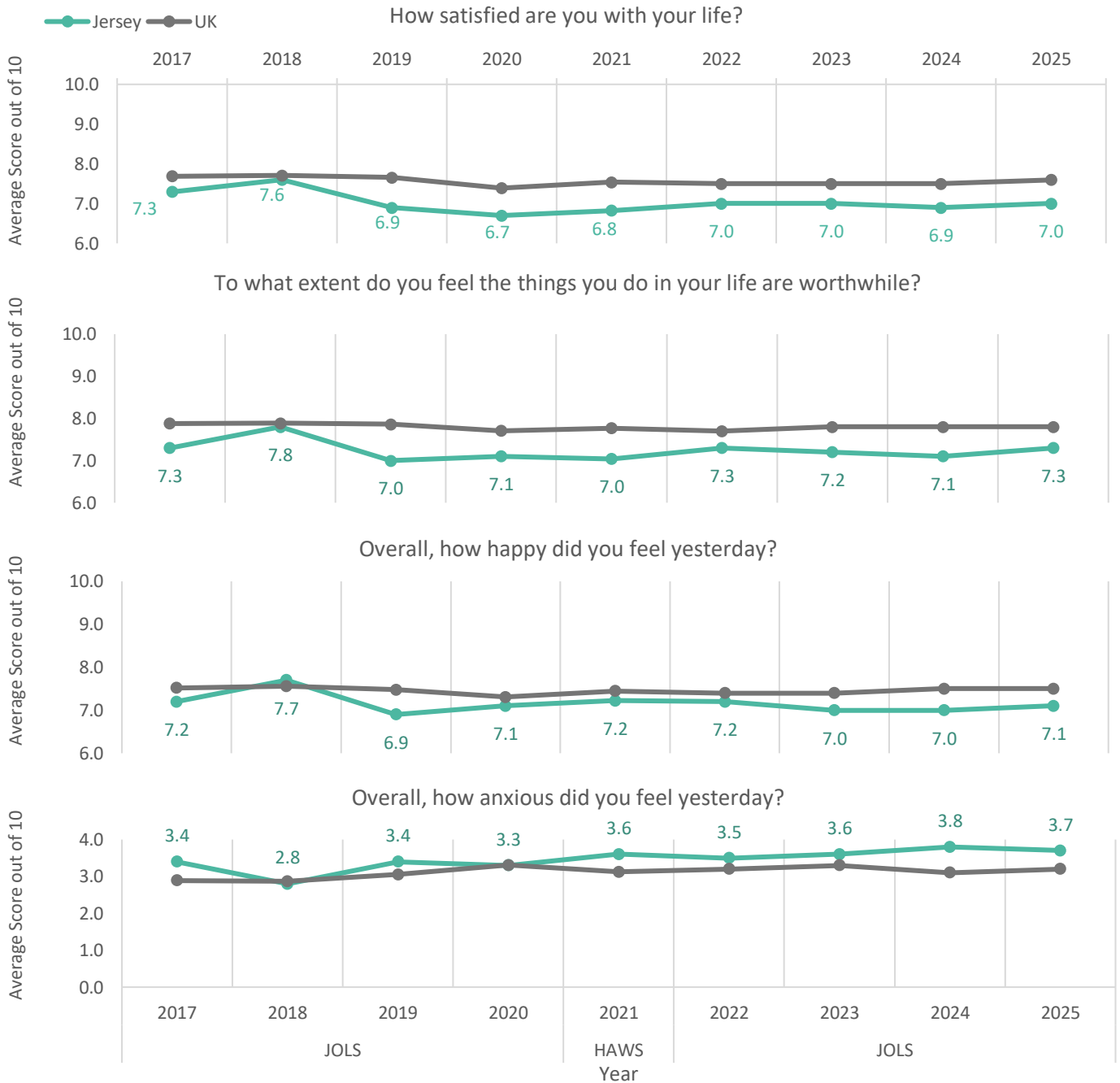
In 2024, there were 880 people on the mental health register, around 1% of Jersey’s population. This register includes diagnoses of mental health conditions on the more severe end of the spectrum (such as schizophrenia and bipolar disorder).

Wellbeing

The proportion of males and females reporting low levels of life satisfaction, feeling worthwhile and happiness have remained essentially stable over the past 4 years, with only minor year on year fluctuations. The proportion of adults aged 35 to 64 reporting high anxiety in 2025 was around 27%, Females have consistently shown higher anxiety levels than men. Compared to England,

Jersey has a higher proportion of the population reporting low levels of life satisfaction, feeling worthwhile and happiness, whilst having higher proportions reporting high levels of anxiety.⁶⁴

Figure 12. Happiness, life satisfaction feeling worthwhile, and anxiety scores between 2017 and 2025 from annual social surveys in Jersey, and in the United Kingdom. Source: Jersey Opinion and lifestyles Survey and Health, Activity and Wellbeing Survey 2021



Suicide rates

Detailed analysis of suicide is not included in this JSNA, as this is covered separately within the Suicide Prevention Strategy (2025-2029). However, it is important to highlight key contextual data. Jersey's suicide rate was 7.0 per 100,000 population in 2021-2023, which is significantly lower than both England (10.7) and the Southwest region (12.2). Important inequalities remain; between 2014 and 2023, approximately seven in ten suicides involved men (70%), meaning men were around 2.5 times more likely to die by suicide than women. Suicide was most common among people aged 40 to 54, who accounted for 38% of deaths during this period. These patterns highlight the continued importance of targeted prevention efforts, particularly for middle-aged men, alongside broader mental health and wellbeing initiatives.

Prescriptions and medication

Data sourced from the General Practitioner Central Server (GPCS) in Jersey shows the number of patients prescribed at least one antidepressant item has risen by 22% over the past 9 years. The number of patients prescribed at least one hypnotic, and anxiolytic item has risen by 23% over the past 9 years. The number of patients prescribed an antipsychotic has fallen by 6% over the past 9 years.

In 2024, 13% of Jersey's population were prescribed antidepressants, a level broadly comparable with England (15% in 2022), suggesting a similar prevalence of treated depression and anxiety-related conditions. However, Jersey shows notably higher prescribing of hypnotics and anxiolytics, with 8% of the population receiving these medicines, compared with 3% in England. This points to a heavier reliance on pharmacological management of anxiety, sleep disturbance, and acute distress within primary care patients.

In addition, 3% of Jersey's population were prescribed drugs used in psychoses and related disorders, three times the proportion observed in England (1%). Although this represents a smaller absolute group, it signals a relatively higher burden of severe and enduring mental illness being managed in the community. Taken together, these patterns suggest that primary care in Jersey is supporting both a large volume of people with common mental health conditions and a non-trivial cohort with more complex or severe needs, often through medication.

Mental health related incapacity allowance

Mental health conditions contribute to a growing proportion of short-term incapacity allowance claims in Jersey, rising from around 2,800 claims in 2014 to over 3,500 claims by 2024.⁷⁵ The proportion of all STIA claims linked to mental health remains high at around 15%. Depression and stress account for the largest share of claims each year, with anxiety also a persistent component.

STIA claims in 2024 were concentrated among working-age adults, with the highest volumes seen between ages 25-49. Claim numbers peak in the 30-39 and 40-44 age groups, reflecting the ages at which common mental health disorders are most prevalent and where work, caring responsibilities, and financial pressures are greatest. Across almost all age groups, women accounted for more claims than men, mirroring higher prevalence of anxiety and depression among females and their greater use of health services.

Service Usage

Note that regrettably age breakdown is not available for all services. Unless otherwise stated the data in this section refers to all adults (including 25-64 year olds).

Jersey Talking Therapies

In 2024, there were around 1,540 referrals to JTT, and around 5,210 contacts with the service in total over the year. JTT has seen an increase in referrals since 2020, with more than 350 per quarter in 2024.

Between 2021 and 2024, the majority of JTT referrals were from adults aged 26-64, who consistently accounted for around three-quarters of referrals (approximately 76 to 78%) each year. Across all age approximately two-thirds of referrals were from females, indicating either a higher need/demand amongst females or a higher willingness to seek therapy through this route.

Understanding how adults move through JTT from referral to entering treatment and completing a course of therapy is essential to assessing service effectiveness, capacity and pressure points within the adult mental health system. Between 2020 and 2024, JTT received a total of 5,949 referrals. Of these, 2,682 individuals entered treatment, and 1,050 completed a full course of treatment. This indicates that not all referrals progress to treatment, and that a further proportion of those who begin therapy do not complete a full course. This pattern reflects the reality of adult psychological therapy services, where attrition can occur at multiple stages (including pre-treatment assessment, waiting periods, once treatment has begun), and for multiple reasons (including changes in individual circumstances, personal choice, disengagement, or potential step up to another service).

NHS Talking Therapies targets are to reach 53% reliable recovery and 71% reliable improvement by 2028/2029. The data for Jersey shows recovery rate in 2024 was just over 50% and at 60% for the first part of 2025.

Psychological Assessment and Therapy Service (PATS)

PATS is a free therapy service that provides confidential psychological support for adults aged 18+ with complex psychological needs. Referral data from 2020 to 2024 shows an increase in demand for PATS over time, with just over 250 referrals in total in 2024. Alongside this increase in referral volume the average waiting time has crept up (median wait time stood at 251 days at year end 2024), showing keeping up with the increase in demand is challenging. This pattern aligns with wider adult mental health service data showing increasing pressure across psychological therapies and secondary mental health services.³¹⁰

Home Treatment Team

The Home Treatment Team (HTT) caseload data for 2023-2024 indicate a consistently utilised, high-acuity community service that plays a central role in managing mental health crisis outside of hospital settings. Across the two-year period, the HTT caseload was typically between around 14 and 26 individuals.

Adult mental health inpatient care

Between January 2023 and December 2024, monthly admissions into inpatient care averaged around 15 to 20 people per month. There was a slight increase in overall admissions in 2024 compared with 2023. Adults aged 25-64 made up around two thirds (67%) of all admissions in

2024, with approximately equal numbers of males and females. Inpatient admissions are most commonly related to psychotic disorders (e.g. schizophrenia, psychotic disorders), which account for over one-third of all cases, followed by mood disorders (e.g. bipolar affective disorder, recurrent depressive disorder) and organic mental disorders (e.g. dementia). These three categories of serious mental illness reflect the core pressure of very unwell patients on inpatient services; managing acute psychosis, stabilizing severe mood episodes, and addressing complex needs in older adults. Personality disorders also feature prominently, requiring trauma-informed care approaches, while anxiety, substance use, and developmental disorders highlight gaps in crisis pathways and community-based alternatives.

This diagnostic profile underlines the need for targeted resource planning, particularly around psychosis, mood disorders, and dementia care, while also investing in community-based alternatives to avoidable admissions for complex or neurodiverse individuals.

Cannabis use, including prescribed medicinal cannabis, is a clinically relevant factor within acute mental health presentations in Jersey. Of the 100 admissions to the working age adult acute mental health ward between January and July 2025, cannabis use was identified in the initial assessment as a risk factor in 20 admissions (1 in 5 admissions), 6 of which included the reported use of prescribed medicinal cannabis.

Despite this clinical complexity seen amongst inpatient care, post-discharge follow-up performance is strong. In 2024, 93% of adult acute discharges received face-to-face follow-up within three days. Providing a follow-up within 72 hours of discharge from a mental health hospital acts as a harm reduction measure, it bridges the vulnerable transition from inpatient to community care, reduces the likelihood of suicide and self-harm, and strengthens engagement with ongoing support.

Front door and crisis

In 2022, mental health services in Jersey were re-designed to introduce a 'front door' model, creating a single, streamlined point of access to secondary services.

The Crisis and Assessment Team aims to provide an initial assessment to all those referred to AMHS with the exception of those transitioning from the CAMHS and those referred who are inpatients of the General Hospital, who will be seen by the Liaison service.

The Front Door service tracks key performance indicators, including targets to respond to crisis referrals within 4 hours and complete assessment referrals within 10 working days. The team has consistently met both targets, indicating effective triage processes and strong operational performance. Data shows that on average around 90% of referrals are assessed within 4 hours.

Referrals by the crisis, assessment and liaison teams:

- Assessment Team referrals typically ranged between 200 and 260 per month
- Crisis Team referrals were lower but showed growth over time, increasing from around 80 to 100 per month in early 2023 to approximately 127 referrals by the end of 2024
- Liaison Team referrals remained the smallest volume but increased steadily following implementation of the Front Door, reaching approximately 33 referrals per month by the end of 2024

These figures illustrate that while most demand enters through assessment pathways (planned and urgent), there is also a notable and growing volume of crisis presentations, alongside sustained demand for hospital-based mental health input via Liaison services.

Since the introduction of the Front Door model, referral volumes have increased consistently, suggesting:

- rising levels of mental health need in the adult population, and/or
- increased visibility and accessibility of mental health services

Monitoring Front Door activity is therefore critical for understanding demand across the entire adult mental health system, as pressures at this entry point directly influence capacity, waiting times and workload across secondary services.

Emergency Department Attendances

Emergency Department (ED) data indicate that acute mental health presentations remain a significant component of urgent care demand in Jersey. In 2024, there were 550 ED attendances for mental health-related problems, reflecting substantial ongoing pressure on emergency services. Almost half (45%) of all mental health-related ED presentations involved self-harm (245). This highlights self-harm as a major driver of mental health-related emergency activity and underscores the importance of effective crisis prevention, timely community-based support, and post-ED follow-up to reduce repeat attendances and escalation to crisis.

Ambulance Data

Ambulance service data provide an important indicator of acute mental health crisis and severe distress within the community, capturing presentations that may not be visible within routine primary care or planned mental health services. Between 2015 and 2024, the number of ambulance incidents triaged as overdose/poisoning and as psychiatric/abnormal behaviour/suicide attempt among adults aged 18-64 has remained consistently high (just over 370 incidents in 2024 for example), indicating sustained pressure on emergency response services.

Sometimes mental health services were unavailable to support mental-health related ambulance callouts; in the September 2024 to August 2025 period, mental health services were unavailable to support around 14% of mental-health related incidents attended by the ambulance service. Of these:

- The most frequent attendances were due to overdose/intentional overdose, suicidal thoughts or intent, and mental health crises. Alcohol and drug intoxication, self-harm, anxiety/depression, and acute behavioural or psychotic episodes were also common
- Calls peaked around 5pm, particularly for presentations such as intoxication, mental health crisis, psychosis, intentional overdose, and self-harm
- Calls were highest on Saturdays, with frequent presentations including overdose with suicidal intent, intoxication with mental health crisis, self-harm, psychotic episodes, and suicidal thoughts

This data suggests that more mental health service support may be required particularly around the end-of-day and weekend time periods, to support individuals in crisis.

Fire Service data

Over the past 15 years, there has been a marginal rise in the frequency of incidents where mental health was noted. A spike was observed in 2022, with 15 recorded incidents. Of these, 10 involved known or suspected mental illness and 10 resulted in Single Point of Referral submissions. While causality is unknown, this increase may reflect a combination of factors, such as coming out of the COVID-19 pandemic, increased reporting, or broader system pressures.

Mental Health Act episodes and detentions

Overall, use of the Mental Health (Jersey) Law has reduced since the peak during the pandemic. In 2024 there were 253 Mental Health Law assessments, down from 361 in 2021 to 2022. However, statutory activity remains significant for a relatively small cohort with high levels of need, who are more likely to be female, younger or of working age.

Short term emergency detentions appear to be increasing. Article 15, which enables emergency assessment in situations where someone appears to have a mental disorder and immediate action is needed, rose from 12 detentions in 2023 to 30 in 2024. Planned assessment detentions under Article 17, which provides a route for non-emergency compulsory assessment when statutory criteria are met, also increased in 2024.

Conversely, detentions under Article 36, which allows the police to remove a person from a public place to a place of safety if they appear mentally disordered and in need of immediate care or control, have declined from 163 in 2021 to 54 in 2024. Most Article 36 detentions last less than 24 hours, and about one in three results in admission following assessment.

Detentions for assessment under Article 21, which allows compulsory hospital admission for a time-limited period when specific criteria are met, decreased from 91 in 2023 to 73 in 2024. However, the need for longer term compulsory treatment appears to be increasing. Renewals under Article 22, which relates to compulsory treatment after detention once safeguards are met, increased from 9 in 2023 to 23 in 2024, suggesting that more people require extended periods of care.

Taken together, these patterns indicate that although the total number of assessments has fallen from pandemic levels, statutory activity remains high. There is evidence of more frequent emergency presentations and a rising number of individuals who require longer periods of compulsory treatment. Need is concentrated among young adults and people of working age, with a slightly higher proportion of cases involving females.

Dialectical behaviour therapy (DBT)

DBT therapy has been available in Jersey since 2010. DBT is a mindfulness-based therapy, comprised of a weekly skills training group and regular one to one sessions for problem solving, skills coaching, and phone coaching, with the ultimate aim of building 'a life worth living'. The DBT caseload data show an increase since 2020, with the caseload sitting at 45 in 2024, indicating that DBT has become a well-established component of adult secondary mental health provision in Jersey.

Clairevale

Caseloads in the Clairevale mental health rehab service have remained between 9 and 14 in the 2023/2024 period. This service has a fixed bed capacity, and professionals working in the service report at times provision does not meet demand. Rehabilitation service redesign work is

underway, to ensure provision meets demand (including more specialist provision for patients with complex needs and forensic backgrounds), so that patients have appropriate on-Island support.

Off-Island Placements

At the end of 2025 there were 18 adults placed off Island for specialist mental health care; the majority in forensic mental health (secure) settings, with a very small number in specialist rehabilitation services (including locked placements) and an eating disorder unit. Public and professional views on the Off-Island placements and reintegration post-treatment can be found in [Section 6: What do people think.](#)

Community and specialist services caseload

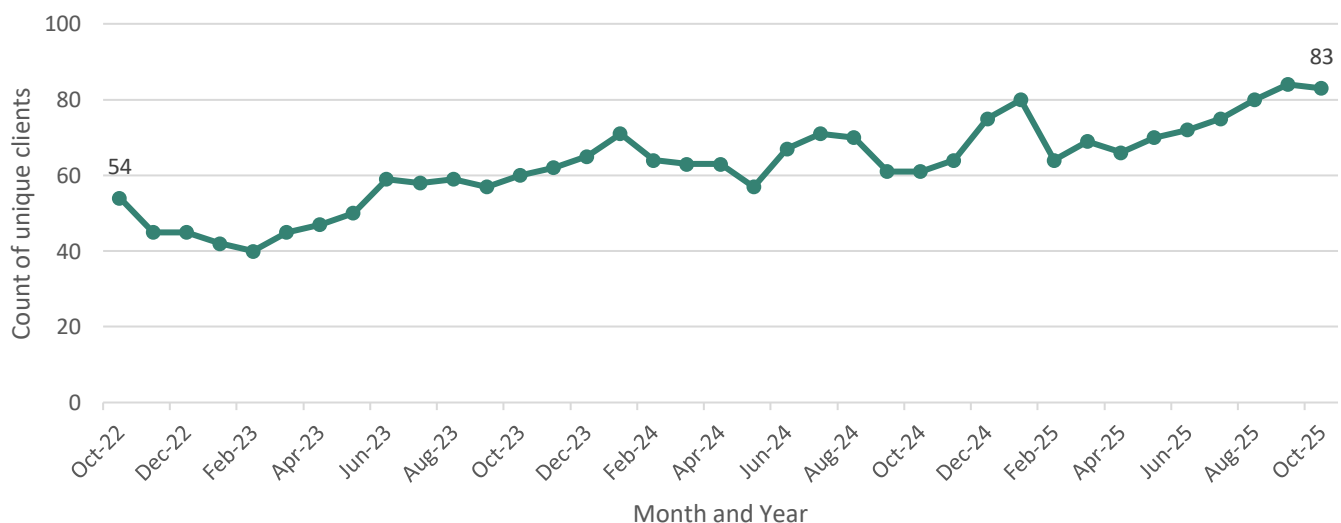
Over 2023 and 2024 the caseload for community and specialist services varied from around 1,100 cases to over 1,350 cases. 1 in 3 cases on the caseload were for the Adult Community Team. 1 in 4 (24%) were for Adult Mental Health Outpatients only, and a further 16% for Older Adult Mental Health Outpatients. A small proportion of cases were for forensics, eating disorders and transition (2-3%). Across 2023 and 2024, there was a higher proportion of females accessing the service than males. The majority of individuals fell within the 26-64 age range. Mood disorders, schizophrenia and other psychotic disorders, and organic mental disorders (e.g. dementia) were the three diagnostic groups with the highest combined prevalence (65%). These serious mental illnesses are typically long-term, complex conditions requiring sustained, multidisciplinary care.

Alcohol and Drug

The high and sustained level of alcohol consumption among adults in Jersey is reflected in continued demand for specialist alcohol and drug support services, including a growing number of individuals whose substance use is intertwined with mental health needs.

Throughout 2024, demand for alcohol and drug services remained consistently high, ranging from approximately 395 to 435 individuals per month. The count of clients who are open to both Alcohol and Drug services and a secondary mental health pathway has been increasing since 2022, with the most recent data showing approximately 83 clients in October 2025 (Figure 13).

Figure 13. Count of clients who are open to both Alcohol and Drug services and a secondary mental health pathway (October 2022 to October 2025). Source: Adult Mental Health Informatics



Voluntary and Community Sector Support

Listening Lounge

The Listening Lounge in Jersey is a free mental health and wellbeing service for adults aged 18 and over, offering early support to prevent issues from escalating into a crisis. Located at Charles House on Charles Street in St Helier, it provides walk-in access without the need for a referral.

The Listening Lounge has provided over 300 assessment appointments in the 12 months between July 2024 and June 2025, varying from 35 to 70 in any one month. A total of 1,205 treatment appointments have been provided in the July 2024 and June 2025 period. On average, clients wait around 18 days for an assessment and around 44 days for treatment once assessed. Around 4 in 5 clients show improvements on discharge across the clinical measurement tools used to assess mental health outcomes. A very small proportion, (close to 0%) of clients re-refer within 6 months of discharge. Anxiety and stress account for the largest proportion of presenting issues. A number of clients present with issues related to relationships with others, whether the result of breakdown of familial relationships (249 clients), relationship issues (171 clients) or divorce or breakdown of relationship (143) or bereavement (88 clients). 188 clients were seen in the past 12 months for feelings of isolation or loneliness and 331 for low self-esteem or self-worth.

Mind Jersey

Mind Jersey is an independent local charity based in Jersey that supports people living with mental illness. Demand for peer and drop-in support has grown significantly, with over 4,000 individuals accessing the drop-in service over the January 2025 to September 2025 period and a steady rise in people receiving one-to-one and peer support. The number of individuals engaging in peer support has increased notably, with over 800 participants giving and receiving support, showing a strong community network. Most carers and peer support users now report feeling less isolated (around 90%), highlighting the social and emotional benefits of the service. Peer support workers have maintained consistent participation in supervision, helping sustain service quality and wellbeing, although reported wellbeing improvements remain lower and could be an area for further focus.

The number of carers approaching the service has remained steady, with consistent demand throughout 2024 and 2025. The service has grown in capacity, with caseloads increasing from around 30 carers in early 2024 to around 85 by mid-2025. One-to-one support has expanded significantly, resulting in strong engagement and positive outcomes for carers. Most carers (around 80-90%) report feeling more able to cope and more confident in their caring role, showing a sustained positive impact.

Togetherall

Togetherall is an online, peer-to-peer mental health support community that operates 24/7 and is completely anonymous, allowing members to share their feelings openly without fear of judgment. Togetherall provides a safe space monitored by licensed mental health professionals, known as Wall Guides, who ensure member safety and offer crisis support when needed.

Data from August 2024 to July 2025 show monthly new registrations ranging from 12 to 43 and typically between 28 and 49 active members per month. Engagement is predominantly self-directed, with high volumes of completed activities such as courses, creative expression and self-assessments, ranging from 254 to 1,483 activities per month, while use of 1:1 support from licensed clinicians remained low, at between 2 and 11 sessions per month.

Access patterns indicate that Togetherall is primarily used outside of standard service hours, with 57% to 85% of access occurring between 5pm and 9am, highlighting its role in providing support when traditional services are unavailable. A substantial proportion of users were not engaged with any other mental health service, with 39% to 81% of active members reporting no concurrent mental health support, suggesting that Togetherall is reaching individuals who may otherwise not access formal services.

Escalation to crisis support was rare, with 0 to 2 escalations per month across the period, despite high levels of activity, indicating that the platform largely supports people with needs that can be managed within a digital, preventative framework. Overall, the data suggest that Togetherall is an important adjunct to adult mental health provision in Jersey, offering accessible, out-of-hours support and potentially mitigating pressure on primary care, crisis services and secondary mental health pathways.

Jersey Hospice

Jersey Hospice provides a significant component of emotional and bereavement support for adults, operating alongside statutory mental health services and addressing needs that are closely linked to mental wellbeing.

The service received around 100 bereavement referrals in the 12-month period July 2024 to June 2025, with smaller numbers of emotional support and group referrals. Caseload in this period was stable, between 105 and 128 cases. Referral sources are dominated by Hospice, with community and "other" sources contributing; self-referrals remain low, highlighting an opportunity to improve direct access. Specialist support for death of a baby/CYP remains essential, with 1 to 9 clients supported monthly.

Jersey Hospice also provides structured support to families and carers of patients, recognising the significant emotional and psychological impact of caring and bereavement. Almost all carers/families of hospice patients receive this bereavement pack, reflecting a high level of consistency in early bereavement support for carers and families, which is a key protective factor for mental wellbeing during periods of loss and transition.

4.5. Older adults (65+ years) mental health

Ageing brings with it a host of mental health risk factors including, chronic physical conditions and pain, reduced mobility and independence, cognitive decline, bereavement, loneliness and social isolation, and financial insecurity, carer strain, and barriers to accessing support in an increasingly digital world.³¹¹ A growing number of pensioners now live alone, often in poverty, which can increase risk of social isolation and present barriers to engagement in protective activities. As described in [section 3 Jersey's population overview](#), the overall number of elderly Islanders is increasing, meaning a higher volume of need from the older demographic is expected. These trends are already shaping service demand and will accelerate over the next decade.

Key Insights

A growing number of elderly Islanders means the overall level of need for the older demographic will increase in coming decades

- The number of Islanders aged 75+ is expected to increase by 75% in the next 30 years.¹⁵
- An increasing number of older adults live alone (nearly 5,500 households were single pensioners in 2021, up from 4,115 in 2001).¹⁷

Several age-related factors mean older adults are at increasing risk of poor mental health

- Unpaid care responsibilities, including for loved ones with emotionally distressing conditions like dementia and cognitive decline.
- Reduced mobility and independence limiting ability to participate in protective activities (e.g. physical activity, socialisation, civic engagement).

Islanders are living longer, but in poorer health (on average), especially women

- An estimated 2,415 Islanders aged 65+ years are already living with a common mental health condition.
- Although overall life expectancy is longer for females, they can expect to live longer in “poor” health than their male counterparts (an average of 23.5 years for females, 15.9 years for males).

Stoicism and generational patterns of attitude to mental health may present barriers for older adults needing support

- Many people in older generations hold different views about mental health compared with younger adults, which can affect recognition of difficulties and willingness to seek help.

A general shift to digital or remote services may present an access barrier for older adults needing support

- Older adults are least likely to regularly use or feel comfortable using digital tools.
- Public and healthcare services increasingly shifting online (bookings, appointments, and virtual consultations) can unintentionally create barriers for older adults with low digital literacy or limited internet access.
- Low digital confidence can also limit informal social contact, particularly for those with mobility issues or dispersed family networks, compounding feelings of loneliness and disconnection.

Determinants, risk factors and local context

Mental health in later life is shaped by a combination of social, economic, relational and health related determinants that accumulate across the life course. Adults aged 65+ often experience major changes that can influence mental wellbeing, including retirement, bereavement, changes to income, increasing health needs and shrinking social networks. Although many older adults maintain good mental health, rising levels of social isolation, loss of community connections, reduced mobility and the increasing prevalence of long-term physical conditions all contribute to greater vulnerability. The experience of chronic illness, pain or cognitive decline can also compound risk, particularly when combined with limited support or difficulties accessing age-appropriate services.

Important overarching determinants for older adults include [physical health](#), [caring responsibilities](#), [housing suitability and homelessness](#) and [household structure and living arrangements](#), [financial strain and housing affordability](#), [diet and physical activity](#), [substance use and addiction](#), [screen use and social media](#), [stigma and mental health literacy](#), [wider social support, loneliness and isolation](#), and [belonging, trust and meaningful activity](#).

Table 7. Determinants and Risk Factors for older adults' mental health with Local Jersey Context

Determinant/Risk factor	Local context
Physical health³¹³ See physical health	<ul style="list-style-type: none"> overall healthy life expectancy in Jersey is just over 64 years, suggesting that on average people aged 65+ are likely to live the majority of the rest of their life in “poor” health. Although overall life expectancy is longer for females, they can expect to live longer in poor health than their male counterparts (an average of 23.5 years for females, 15.9 years for males). In 2021, around 40% of residents aged 65+ stated that they had a longstanding condition, the highest of any age group, and the prevalence of chronic health conditions (e.g. hypertension, heart disease, chronic kidney disease, stroke and dementia) increases with age, and so does the likelihood of living with “multi-morbidity” (living with two or more long-term conditions)⁶³ self-reported health amongst over 65's is comparatively good in Jersey (63% of males and 65% females consider themselves to be in good or very good health, ranking third highest in Europe³¹⁵)
Frailty and cognitive decline	<ul style="list-style-type: none"> The 2025 JOLS survey found that almost half (48%) of Islanders age 65+ had “been hearing less well in the last 2 years”, much higher than younger adults. Around half (49%) also said they had “been seeing less well in the last 2 years” UK NHS data^{316,317} suggests approximately 35% of people aged 65+ live with some degree of frailty, equating to approximately 6,560 people in Jersey in 2021, rising to 9,200 people by 2051, and approximately 3% are living with severe frailty (equating to 560 people in Jersey, rising to 790 people by 2051)

Table 7. Continued

Determinant	Local context
<p>Caring responsibilities Error! Bookmark not defined. See caring responsibilities</p>	<ul style="list-style-type: none"> An estimated 5,000 - 8,000 Islanders are providing unpaid care. Regrettably, age breakdown information is not available, but it is likely a substantial proportion of these carers are older people caring for their partner or spouse as their health declines
<p>Housing and living alone ^{294,37,295} See housing suitability and homelessness and Household structure and living arrangements</p>	<ul style="list-style-type: none"> The 2021 census found that nearly 5,500 households in Jersey were single pensioners (up from 4,850 in 2011, and 4,115 in 2001) Only a small proportion of individuals recorded as homeless in 2025 were aged 65+³¹⁸
<p>Socioeconomic disadvantage ^{37,296,297} See financial strain and housing affordability</p>	<ul style="list-style-type: none"> In 2021/22 28% of pensioners in Jersey were living in a household in “relative low income, higher than the UK (18%)
<p>Lifestyle factors; diet, sleep and physical activity ^{304,305} See Diet and physical activity</p>	<ul style="list-style-type: none"> In 2025 just under half of over 65’s surveyed met the weekly recommendations for physical activity, the lowest of any adult age group In 2025 the vast majority (90% or more) of over 65’s feel safe in public spaces (during the day) Those aged 65+ were the age group most likely to report meeting the “5-a-day” fruit and vegetable recommendations (43% met the recommendations)
<p>Substance use Error! Bookmark not defined. See substance use and addiction</p>	<ul style="list-style-type: none"> although binge drinking is less prevalent amongst older adults in Jersey, the proportion of adults who drank frequently (4 or more times per week) increased with age with around half of adults aged 65+ drinking 2 or more times per week.⁶⁴
<p>Digital skills ³²⁰ See screen use and social media</p>	<ul style="list-style-type: none"> In 2025 around half (46%) of those aged 65+ “rarely” or “never” used social media, with this group indicating they preferred newspaper, TV and radio as media sources.⁶⁴ In 2025, adults aged 65+ were consistently less likely to feel very comfortable completing activities like booking appointments online or via an app; only 22% of over 65’s were very comfortable filling in government forms, for example, compared to 57% of 16-34 year olds.
<p>Ageism, stigma and mental health literacy ³²² See Stigma and mental health literacy</p>	<ul style="list-style-type: none"> In 2024, older adults were the age group least likely to strongly agree with the statement “anyone can have mental health problems”; just 61% of over 65’s compared to over 80% amongst all other adult age groups In 2024, only half of those aged 65+ agreed they “know where to find information on local support for adults with mental health problems”, the lowest proportion of any age group Concerningly, adults aged 65+ were found the age group most likely to agree with the statement “There is nothing anyone can do to reduce their risk of getting dementia”, with 38% agreeing to some extent. This compares to 15-20% among younger adults.

Table 7. Continued

Determinant	Local context
<p>Social support and loneliness See Wider social support, loneliness and isolation</p>	<ul style="list-style-type: none"> • In 2025, just under half of people aged 65+ in Jersey do socialise with people outside of their households daily, and just 8% socialise rarely or never)⁶⁴ • Adults aged 65+ were also least likely to report feeling lonely; 65% said they felt lonely rarely or never, compared to 47% of 16-34 year olds. The majority (88%) of Islanders aged 65+ also reported having friend or relatives on-Island to help them when needed (similar to other age groups)
<p>Meaningful activity See belonging, trust and meaningful activity</p>	<ul style="list-style-type: none"> • In 2025, 43% of adults aged 65+ reported having volunteered in the past 12 months • Those aged 65+ were the age group most likely to intend to vote in the 2026 election (73%) • Those aged 65+ rated trust in their local parish the highest of any age group • Those aged 65+ were the age group most likely to be satisfied with how they spent their time; the majority thought they spent about the right amount of time with family, with social contacts, doing hobbies/interests or at work • 2025 survey data shows those aged 65+ were the age group most likely to be considered “time rich” (54%)

Prevalence and incidence

The mental health disease register (JQIF)

As at year end 2024, there were around 215 people aged 65+ years on the mental health disease register[†] in Jersey. The register includes patients with diagnosed mental health disorders on the more severe end of the spectrum; schizophrenia, bipolar disorder, psychosis and other patients on lithium therapy.

On average, there were more females on the register (130 females compared to 85 males), possibly as a result of longer life expectancy for females.

Common mental health disorder (CMD) estimates

The recently published Adult Psychiatric Morbidity Survey 2023/2024⁴ provides estimates of the prevalence of CMD in the UK population. Applying these prevalence estimates to the Jersey population gives an approximation of local numbers.

- An estimated 13.7% of adults aged 65 to 74 and 10.2% of those aged 75 and over were experiencing a CMD, equating to approximately 2,415 individuals across the 65+ population in Jersey.
- Generalised anxiety disorder was the most prevalent condition, affecting 4.9% of 65 to 74 year olds (approximately 510 people in Jersey) and 3.5% of those aged 75 and over (approximately 335 people in Jersey).
- Depressive episodes were also present, though at lower levels, with 1.8% of the 65 to 74 year olds (approximately 185 people) and 1.7% of the 75+ group (approximately 165 people) affected. Other CMDs, including phobias, OCD, and panic disorder, were reported at low levels across both age groups.

While the English survey data shows prevalence of CMD is lower in older adults compared to younger age groups, these figures still highlight a need for age-appropriate mental health support, particularly for anxiety and mood-related conditions.

Dementia / Alzheimer's disease

Dementia / Alzheimer's disease is a neurological disorder affecting the brain. Whilst it is not in itself a mental illness, progression of the disease can significantly impact mental health, and some symptoms can overlap with psychiatric conditions.

An overview of dementia prevalence in Jersey is included here, but please note that the subject is covered more comprehensively in a dedicated dementia strategy covering the 2024-2029 period.³²⁴ Work on the commitments and priorities within the strategy is already in motion.

As at year end 2024, there were 840 people overall on the dementia register, the vast majority of whom were aged 65 or over. The average age of those with dementia was 84 years.

Trends and future state

Data from the UK Adult Psychiatric Morbidity Survey 2023/2024 suggests the overall prevalence of common mental health conditions has increased in older adults over the last decade.

[†] This register is extracted from Jersey GP practices and includes active patients with a diagnosed mental health disorder as defined in the Jersey Quality Improvement Framework.

- Males have seen a notable rise in generalised anxiety disorder, while depressive episodes have remained relatively stable
- OCD has more than doubled in both males and females
- Panic disorder remains relatively uncommon and has changed little over time
- Females continue to experience higher rates of mental health conditions overall, particularly for depression and unspecified CMDs

As discussed in Chapter 2, Jersey's population overall is ageing. Population projections show the 65+ population will increase by the greatest proportion over the coming decades. This means the overall number of older adults with mental conditions is likely to rise:

- The number of 65+ year olds living with a CMD could rise to 2,635 by 2030.
- The number of people on the mental health register living with schizophrenia, bipolar disorder, psychosis and other patients on lithium therapy, may also rise in the coming decades, reaching around 270 overall by the 2030's.

Dementia and other cognitive impairments, while not mental illnesses, are strongly associated with changes in memory, thinking and daily functioning and can significantly affect mental health. These conditions create complex care needs that often require coordinated support across mental health, primary care and social care. With an ageing population, the number of people on the dementia register is expected to increase by around 50 percent over next 20 years.¹⁵ This will place additional pressure on services and reinforces the need for integrated, age-appropriate pathways that support both older adults and their carers.

Service Usage

Age breakdowns are not available for all mental health services in Jersey (e.g. voluntary sector). Please see also the [adults mental health service use](#) section for a more comprehensive overview of service activity, noting that some of this will include older adults where not age disaggregated.

Jersey Talking Therapies

Referrals to JTT from those aged 65+ remain relatively low, accounting for 2 to 5% of referrals across the 2021-2024 period.

Adult mental health inpatient care

The inpatient mental health service provides care for individuals whose mental health needs are acute, severe, or complex, and cannot be safely or effectively managed in the community. In 2023 and 2024, around 1 in 5 inpatient admissions for mental health were for those aged 65+, around 90 over the two-year period.

Post-discharge follow-up performance is strong. In 2024, 100% of older adult discharges received face-to-face follow-up within three days, exceeding the historical mean of 84%. Providing a follow-up within 72 hours of discharge from a mental health hospital acts as a harm reduction measure, it bridges the vulnerable transition from inpatient to community care, reduces the likelihood of suicide and self-harm, and strengthens engagement with ongoing support.

Community based mental health services for older adults

Timely diagnosis of memory problems amongst older adults is crucial for enabling early intervention, supporting individuals and their families to access an appropriate treatment plan for the future and potentially slow the progression of cognitive decline. Early identification also

improves opportunities for non-pharmacological support and helps reduce crisis presentations later in the care pathway. In Jersey, waiting times for the memory assessment service increased during 2023, reaching 170 days by 2024. In response, improvements to streamline the assessment pathway in 2025 have improved efficiency and reduced waiting times back down to around 100 days in 2025.

In the two year period 2023-2024 those aged 65+ over accounted for a significant proportion (30%) of the community and specialist services caseload period. Split by specialist team, 16% of the overall community and specialist service caseload were under the adult mental health outpatients team, and 11% were under the older adult community mental health team. Organic mental disorders, such as dementia and other cognitive impairments, primarily affect this cohort of older adults and are associated with progressive decline in memory, thinking, and functioning. These conditions present complex care needs and often require coordination across mental health, primary care, and social care services. With an ageing population, the prevalence of these disorders is expected to rise, placing increasing pressure on services and highlighting the need for integrated, age-appropriate pathways that support both individuals and their carers.

5. What do people think?

This chapter explores the findings of a Government of Jersey consultation that gathered insights from the public and professional stakeholders. It covers views on whether islanders' mental health needs are being met, harmful factors, barriers that prevent access to services, and priority areas for improvement.

Key insights

- Professionals and the public share a consistent view: progress is visible, but services remain stretched, fragmented, and reactive.
- Continuity of care is the strongest driver of positive experience; turnover, poor handovers, and inconsistent follow-up erode trust and safety.
- Crisis care and discharge pathways are believed to be unreliable. People want predictable 24/7 options, accessible crisis spaces, and planned reintegration after hospital or off-island care.
- The system relies too heavily on medication. Broader, evidence-based psychological and social recovery offers are needed, alongside specialist pathways for complex needs.
- Prevention, early help, and equitable access remain weak points, particularly for carers, older adults, people experiencing homelessness, and minority or neurodivergent groups.

5.1. Consultation data analysis methodology

Qualitative data from professional and public engagement were analysed using a multi-stage thematic approach to capture both shared and distinct perspectives across Jersey's mental health system.

Professional survey and interview responses were combined and coded inductively to identify strengths, challenges, and opportunities for improvement, followed by secondary analysis by life stage and service area.

Public feedback,[‡] gathered through surveys and engagement sessions, underwent question-level coding and thematic analysis to identify recurring patterns, followed by separate analysis across key population groups. The two datasets were then integrated to highlight areas of alignment and divergence between professional and public perspectives.

As part of the public engagement, respondents could complete the survey in one of three ways: on behalf of themselves, on behalf of someone they know or care for in Jersey, and/or to share general opinions about mental health services as a whole.

Analysis was conducted across all three routes and revealed very similar responses and key themes. For this reason, findings have not been separated by response route. Feedback specifically related to caring for someone (route two) has been incorporated into the findings for the target group carers, please see table 8.

[‡] **Note:** Because the survey was open to the public, findings are not statistically representative. They are best understood as qualitative insight that adds depth to routine data and stakeholder interviews. We treated themes as signals of lived experience and service perception, not as prevalence estimates. Qualitative analysis was quality assured by a second reviewer who spot-checked a sample of coded responses for consistency and clarity.

Combined analysis

Finally, the two strands (professional and public) were integrated to identify shared and contrasting perspectives across the system. This aimed to highlight areas of alignment, where professionals and the public described similar challenges or priorities, as well as points of divergence that may indicate communication or delivery gaps.

5.2. Consultation findings

The perspectives of professionals and the public reveal a broadly consistent picture: Jersey's mental health system has made meaningful progress in recent years, but remains stretched, uneven, and reactive. Both groups described committed staff and promising service improvements, yet felt these strengths are undermined by fragmentation, limited capacity, and persistent inequities in access and experience.

Across both groups, seven overarching themes emerged, each linked to practical areas for improvement.

Quality of services: A system improving, but still inconsistent

Both professionals and service users recognised that crisis care, referral processes, and frontline responsiveness have improved compared to previous years. However, these gains are not yet universal. People described a "postcode lottery" within the same Island: excellent care in some areas, transactional or unsafe care in others.

"I no longer engage with services... treated me as a box ticking exercise"
(Member of the public)

"I think we are better than we were three years ago. We're less good than we'll be in three years' time"
(Professional stakeholder)

Professionals spoke of pockets of excellence but not consistency, while the public called it "luck of who you get."

Suggested areas for improvements:

- View the patient as a whole, incorporating more holistic views
- The model should recognise the broader determinants of health such as housing, employment, education, social inclusion and builds support around the whole person
- Consistent, timely and high-quality rather than crisis driven or "stop-start"
- Need for permanent staff
- Improve broader, evidence-based psychological offers
- Right-first-time triage
- Joined-up care that is coordinated, consistent and helps service users to feel connected
- Services should be acting as one, not operating in silos
- Clinicians should read notes
- Improve transition between services

Resourcing: Staff are dedicated, but the system is under strain

There was a majority who agreed that frontline staff are the system's greatest strength, they were described as compassionate, skilled, and motivated. Yet both professionals and the public highlighted chronic under-resourcing, high turnover, and limited supervision or training as major risks. Professionals said morale suffers when staff "firefight" rather than deliver therapeutic care; the public described burnout, long waits, and "tired faces behind the desks."

"Staff are amazing but generally over worked and there is not enough staff"
(Member of the public)

Suggested areas for improvements:

- Importance of continuity with clinical relationships
- Named professionals, consistent teams, collaborative care plans
- Warm clinical handovers

Communication and collaboration: Fragmented pathways and poor coordination

Professionals and the public repeatedly described weak communication and disjointed handovers between services. From CAMHS to AMHS, hospital to community, and mental to physical health, transitions were seen as fragile. People need to retell their story, they experience gaps in follow-up, and struggle to know who is responsible for what.

"Emails were ignored, and I was passed on to different people like a problem no one wanted to deal with"
(Member of the public)

Suggested areas for improvements:

- Shared care records, joint tools and whole-person partnerships to reduce duplication and deliver seamless, person-centred care across the system
- Warm clinical handovers, better public-facing navigation, visible service map and what to expect guidelines
- Routine, transparent communications including, realistic timeframes, proactive updates on referrals, and public education
- Monthly myth-busting posts with simple access/outcome stats, a co-produced "You said, we did" page across the whole of government, and an annual public report setting out targets, misses, and next steps

"Reducing the need for patients to repeat their stories and improving communication between services would make care feel more joined-up"
(Member of the public)

Variety of care: sometimes limited choice and inconsistent access

The breadth of mental health support in Jersey has grown, particularly through community and third-sector services.

Peer support roles are expanding, offering lived-experience perspectives that help people feel understood and less alone. GPs and trusted practitioners remain a vital point of contact, especially when they take time to listen and follow up. Despite this, choice and consistency often remains limited.

"So, I would imagine the two things; one is making sure we've got the clinical expertise, and then making sure that we've got consistency"
(Professional stakeholder)

"Too quick to throw pills at the problem, less interest in getting to root cause"
(Member of the public)

For many, medication is still the only reliably available option, and therapeutic offers are narrow in scope or short in duration. There were concerns around the suspected reliance on medication as the first form of treatment. Carers and families often feel excluded from care planning, despite playing a central role in daily support. Provision for people with complex or co-occurring needs, such as serious mental illness, eating disorders, adult ADHD or autism, remains patchy and under-resourced.

Suggested areas for improvement:

- Increase therapy capacity and range, moving beyond short-term CBT models
- Strengthen peer and community support networks through sustainable funding and formal partnerships
- Develop specialist pathways for complex needs including SMI, eating disorders, personality disorders, adult ADHD, and autism
- Involve carers and families in planning and reviews by default, with consent
- Expand carer-specific support such as family therapy, carer groups, and proactive check-ins
- Embed lived experience within service design and evaluation to ensure care reflects real-world needs

“Support for the parents or caregivers immediately on how to support their child. Don’t waste peoples time sending them on generic parenting courses!” (Member of the public)

Crisis, off-Island support, inpatient integration and step-down support: Inconsistent experiences and fragile reintegration

The redesign of crisis care and creation of a single point of access has improved triage, reduced unnecessary emergency attendances, and enabled more consistent care planning. However, experiences still vary widely. Some described fast, compassionate crisis responses; others reported dismissive or procedural encounters and repeated retelling of traumatic stories when presenting. Inpatient settings and off-Island placements continue to raise concern. While necessary for complex or high-risk cases, being separated from family and community was described as distressing, and reintegration on return often lacks coordination. People need practical and emotional support alongside clinical follow-up to prevent relapse.

“There wasn’t a really clear crisis pathway or framework. We changed all of that. So, the fact that we now have a single point of entry [for crisis]” (Professional stakeholder)

Suggested areas for improvement:

- Provide fast, humane crisis responses outside ED, with 24/7 triage options such as walk-in hubs or safe spaces
- Guarantee consistent follow-up and proactive aftercare following every crisis episode
- Create a clear reintegration and step-down pathway linking clinical, housing, social, and employment support
- Ensure every off-Island placement has a reintegration plan written in plain language and shared early
- Offer interim help while waiting for specialist or follow-up support, rather than only at points of crisis

Prevention: A reactive system missing early help

Both professionals and the public agreed that prevention remains the weakest part of the system. Early intervention and community-based support are still not embedded as core practice.

Many people only access help once they are already in crisis, reflecting a system that remains reactive rather than proactive.

Building mental health literacy, tackling stigma, and offering timely early help were all identified as essential to long-term improvement. Schools, workplaces, and community spaces were seen as key arenas for normalising mental health discussions and providing accessible, low-level support before problems escalate.

“If the hospital kept getting children coming in with broken legs, and we saw more every year, you wouldn’t just keep hiring more radiographers. You’d ask: why are they breaking their legs? We need to step back [and] look upstream.” (Professional stakeholder)

Suggested areas for improvement:

- Invest in upstream prevention and early-help services, including peer groups, psychoeducation and social prescribing
- Strengthen community mental health literacy so people recognise early signs and know where to turn
- Integrate prevention into schools and workplaces, offering in-house mental health support, staff training, and protected time for appointments
- Improve public understanding of wellbeing versus illness to reduce misdirected referrals and demand on specialist services
- Target outreach and education to reduce stigma and promote help-seeking across all age groups

Cultural competence and accessibility: Persistent barriers and unmet needs

Jersey is becoming more open in how it talks about mental health, yet not everyone can access support equally. Structural and cultural barriers persist.

Costs, transport, and clinic-only models exclude lower-income households, those with disabilities or caring responsibilities, and people experiencing anxiety or not wanting to leave the house.

Neurodivergent Islanders and those with overlapping conditions often sit in a “missing middle,” where their needs are too complex for low-level services but not acute enough for specialist care.

Some LGBTQ+ and minority ethnic participants also reported poor experiences and cultural insensitivity.

“Sometimes there are people that may be seen in children’s services that don’t meet the threshold for adult services, and they fall down the middle” (Professional stakeholder)

“I think there needs to be a “no wrong door” policy to avoid people falling through the cracks” (Member of the public)

Suggested areas for improvement:

- Create flexible, inclusive access routes, including walk-ins, outreach clinics, evening/weekend options, and hybrid appointments
- Provide interpretation, translated materials, and culturally safe practice across all services
- Reduce financial barriers by exploring low-cost or subsidised therapy, transport support, and partnerships with private providers
- Embed trauma-informed, neurodiversity-affirming practice and make reasonable adjustments standard (alternative formats, sensory-friendly spaces, flexible communication)
- Develop a dedicated neurodiversity and ADHD pathway with clear timelines and shared-care prescribing arrangements.
- Produce a learning disabilities strategy to address unmet need and inclusion

“I think there’s probably quite a big social inadequacy across [access/quality of mental healthcare services]. Language and culture is a big [social inadequacy]”
(Professional stakeholder)

Target group findings

While these overarching themes reflect the system-wide picture, distinct experiences and priorities also emerged within specific population groups. While these overarching themes reflect the system-wide picture, distinct experiences and priorities also emerged within specific population groups (Table 8).

When analysing the findings for these groups separately, the same overarching themes continued to appear and are therefore not repeated here. However, where a group provided a distinct perspective or additional detail, for example, people with serious mental illness sharing more specific experiences of crisis services, these have been highlighted in the relevant section. Each target group summary focuses on the themes most relevant to that population.

First, key themes for children and young people are discussed, then themes for adult groups (in Table 8).

Key themes for children and young people

As part of the public and professional engagement, key findings were pulled out specifically related to children and young people and families. The following areas were perceived as working well, school-based support for low level mental health need, in particular ELSAs (Emotional Literacy Support Assistants) were mentioned. The wide range of free charity, community and youth services of particular note were the YES project, Kooth and School Counsellors. Data available from within CAMHS shows service users have reported improvements in staff making them feel comfortable; being taken seriously; communication; and the range of support available.

Specifically, young people and families told us:

- **Crisis support** often felt hard to access, with support not always available when needed, for example the current 24/7 crisis helpline is just for adults and it was felt support was often offered too late.
- **Transitions from CAMHS to adult mental health services** felt abrupt and poorly supported, losing continuity at a time when stability was most needed
- Services need to be **consistent, needs led and inclusive, with clear pathways** and information about what will happen

- **More drop-in services, youth friendly options** and support whilst waiting for treatment or a diagnosis
- **Exam stress and assessment pressures are a key concern**, schools should consider how to measure success differently
- Services need to **communicate** and **work together more effectively** to ensure a smoother coordinated experience
- More **activity based / outdoor activities** were needed
- The need to **strengthen a multi-agency offer for children looked-after** and those with the most complex needs
- Young people often want to help and **support each other** but need the right tools, their **own mental wellbeing needs to be taken care of** and they weren't sure how to do this
- Recovery can be seen as **small manageable steps** rather than big leaps; feeling in control and having choices around care makes it feel more achievable
- They recognised the **negative impact of social media on self-esteem and mental health**
- Young people would like **more online access to mental health support**
- There appears to be gaps in **specialist support and pathways**, especially after an **ASD or ADHD diagnosis**, for **eating disorders beyond anorexia**, and for those with **complex or long-lasting needs**
- **Clearer guidance** on how to **access the right help** for example videos and social media showing young people 'what to expect' how long their treatment can last, what sort of professional they would see, what the room looks like

Two distinct themes clearly appeared most frequently across the thematic analysis. The strongest collective priorities identified by young people were:

Theme 1 - Access and waiting times: Young people are concerned about long CAMHS waiting lists, delays in getting therapy, lack of specialists, difficulties accessing services quickly and stretched workforce capacity. They want faster access, more staff, and reduced queuing times.

Theme 2 – information, communication & awareness: young people frequently cited not knowing where to get help, inadequate publicity about services, lack of awareness of charities and support and difficulty navigating the system. They want clear information, better signposting and proactive communication.

Within the **professional engagement**, the fragmentation of children, young people and family support pathways creating unintended barriers was also identified. There was a strong call for clearer access criteria for not only CAMHS services but other services supporting the wellbeing of children, young people and families. When thinking about service design and improvement the importance of health inequalities were noted. Engagement from services was described as variable, and some concerns remained in relation to the care of young people who require inpatient admission. There were also consistent concerns regarding the capacity of the education system to meet the needs of children and young people with Social Emotional and Mental Health (SEMH) needs, and those who are neurodivergent or experiencing trauma. A recurring theme was the lack of adequate support for carers / families, which was echoed by carers themselves

Key themes for adult groups

Table 8. Key themes for adult target group

Target group	Key issues raised	What would help
People with serious mental illness (SMI)	People felt that... Crisis care inconsistent; medication-led care; staff turnover; mixed inpatient/support housing; unsafe discharge; weak continuity on return from off-island; environments felt punitive	Participants would like... 24/7 predictable crisis space; wider therapy and social recovery offers; stable care coordination; recovery-oriented inpatient settings; planned step-down; trauma-informed culture
Off-island placements	Participants felt that... Emotional harm due to separation, feelings of rejection, loss of belonging and identity erosion. They felt they were institutionalised and had restricted development, there is unsafe or poorly planned discharge and weak continuity on return, Inconsistent or absent independent advocacy. Neurodiversity, sensory needs and trauma often misunderstood or mislabelled as “challenging behaviour”. Physical health needs neglected alongside mental health care. Over-medication and limited access to psychological therapies. Family relationships strained by distance, cost and lack of involvement.	Participants would like... Planned, timely and supported repatriation, with clear-step down pathways; trauma-informed, psychological led care rather than medication; strong consistent care coordination; Independent advocacy embedded throughout placement and discharge planning; Peer support from people with lived experience of recovery and repatriation; Family-inclusive models of care and support to maintain island connections; Neuroinclusive, sensory-aware environments and personalised support; Integrated physical and mental health care, including monitoring of medication side effects; Clear communication, involvement in decisions (“Nothing about me without me”), and predictable planning for transitions
Eating disorders	Participants felt that... Late access; high thresholds; unsafe generic advice; gaps after intensive care; weak care coordination; carers unsupported	Participants would like... Early intervention; specialist workforce; step-down recovery house; multi-disciplinary team input; carer education and inclusion; single 24/7 crisis line and safe spaces
Prison population	Participants felt that... Long waits; lost applications; inconsistent quality; stigma; privacy limits; weak post-release links	Participants would like... Consistent clinicians; trauma training for officers; confidential spaces; peer listeners; work-linked rehab; joint prison-community pathways

Target group	Key issues raised	What would help
Long-term physical health conditions	Participants felt that... “Too complex” label; mental and physical care siloed; accessibility barriers; missing allied health and step-down	Participants would like... Joint care plans and reviews; flexible access; home/quiet options; occupational therapists, dietetics, community rehab
People experiencing homelessness	Participants felt that... Unreliable crisis response; unsafe discharges; medication errors; no shared risk plans; low trauma-informed practice; housing barriers	Participants would like... Real-time crisis access; shared care and risk plans; planned discharges; trauma-informed in-reach; housing and income support as part of care
Women accessing support through Freeda	Participants felt that... Long waits for therapy; services not shaped around refugee reality; mixed crisis responses; limited peer options; cultural barriers	Participants would like... Prioritised triage in refuge; in-reach trauma programmes; arts therapies; consent-based information sharing; culturally competent practice
Male Islanders and fathers	Participants felt that... Cost and scheduling barriers; disengagement after poor experiences; exclusion from care planning	Participants would like... Evening/weekend slots; mixed online and in-person routes; clear Triangle of Care use; named family contact
Older adults	Participants felt that... Digital exclusion; fragmented care; carer strain; fear and stigma; age bias; emotional needs overlooked in hospital	Participants would like... Non-digital signposting; advocacy/case coordination; respite and carer support; age-aware, trauma-informed practice; mental health in hospital pathways
Perinatal	Participants felt that... Overall positive, but gaps during pregnancy complications; appointments hard to attend	Participants would like... Proactive trauma-informed outreach in pregnancy; flexible and home-based options
Recently bereaved	Participants felt that... Patchy trauma-informed practice; little grief counselling; repeated retelling	Participants would like... Timely, paced trauma support; consistent practitioner; clear consent and safety planning; access to grief counselling
Carers	Participants felt that... Excluded from planning; burnout; fragmented services; limited peer support; closure of JRC	Participants would like... Recognise carers as partners with consent; named contact; crisis plans; proactive check-ins; family therapy; structured skills and education; rebuild peer offers
Women with hormonal or reproductive needs	Participants felt that... Fragmented pathways; poor continuity; limited understanding of health-mental health links	Participants would like... Named clinician; integrated women’s health, pain, and psychology pathways; trauma-informed approach

Target group	Key issues raised	What would help
Gender identity and LGBTQ+	Participants felt that... Unsupportive environments; discrimination; slow, confusing gender care	Participants would like... Inclusive practice; clear coordinated pathways; reduce waits and lost referrals; safe school spaces
Ethnic minorities	Participants felt that... Costs, unclear routes, limited translation; cultural stigma	Participants would like... Translated and plain-English info; interpreters; culturally aware staff; trusted-community outreach

Notes: Only group-specific findings are listed here. Overlapping issues with the seven system themes are not repeated

6. Evidence scan of mental health models

Introduction

This chapter summarises evidence on mental health service models that help support prevention, early access to support, safety, recovery and continuity of care. It draws on a pragmatic review of national and international evidence published between 2019 and February 2026. The review identifies approaches that have been consistently linked with better access to services, fewer restrictive practices, stronger continuity of care and improved long-term outcomes.

The review has some limits. It is not intended to be a full systematic review. It did not include formal quality ratings for individual studies, and some of the evidence comes from routinely collected service data. Despite these limits, the findings provide a clear and coherent picture of the approaches most consistently associated with positive outcomes, including better access, improved safety, stronger therapeutic relationships and higher overall effectiveness.

This chapter presents the key evidence for children and young people, adults, people with complex needs and people who need acute, inpatient or perinatal support.

Early help, primary care and navigation

For CYP, needs-led frameworks such as i-THRIVE are associated with shorter waits for triage, assessment and treatment, and with higher levels of clinical activity and face-to-face work. Improvements are largest where cross-sector working is strong.³²⁵

For adults in primary care, collaborative care improves depression outcomes. An individual-participant meta-analysis highlights 2 components most linked to better outcomes: structured psychotherapy and active involvement of family or other supporters within a measurement-based plan.³²⁶ Collaborative care also improves primary-care-professional knowledge, confidence and inter-professional working. Implementation usually needs some workflow adaptation.³²⁷

Crisis response and post-crisis follow-up

Crisis Resolution and Home Treatment Teams provide rapid assessment and intensive home support as an alternative to admission, with core features such as 24-hour availability and frequent contact during acute phases.³²⁸ People who use these services consistently value swift access, therapeutic relationships and shared decision-making, while also reporting unmet needs around timeliness, tailoring and continuity across transitions.³²⁹

Evidence from Europe shows that transitional interventions with structured contact soon after discharge reduce readmission rates and improve continuity of care.³³⁰ A UK randomised trial similarly found that early supportive contact following discharge from crisis teams lowered the risk of acute readmission.³³¹

Integrated models such as Bristol's Mental Health Integrated Access Partnership demonstrate how reducing service silos and coordinating crisis, community, ambulance, police and voluntary-sector pathways can further strengthen transitions and reduce avoidable crisis escalation.³³² Establishing follow-up contact within the first few days after discharge is therefore a practical and evidence-based standard that can be adopted in local systems seeking to improve post-crisis outcomes.

Inpatient safety, trauma-informed practice and de-escalation

The Safewards intervention reduced conflict events by about 15% and containment events by about 24% in a cluster randomised trial across 31 wards.³³³

Recovery-oriented and trauma-informed care approaches are linked to fewer restraints and seclusions and better experience when implemented as organisational change with policies, supervision and leadership, rather than training alone.^{334,335}

Rehabilitation, housing and longer-term recovery

Housing First and high-quality supported accommodation are associated with sustained housing stability and more appropriate service use over several years. Quality assurance and oversight influence outcomes.^{336,337}

Individual Placement and Support (IPS) increase competitive employment for people with severe mental illness. Evidence shows stronger employment outcomes when fidelity to the IPS model is high, and employment itself is associated with improved functioning and quality of life.^{338,339}

Perinatal mental health

Integrated perinatal mental health models that combine screening and triage, specialist perinatal teams and stepped psychosocial or psychological care are associated with better accessibility, continuity and quality. Clear transition planning and timely access to mother-and-baby admission, when indicated, are important features.³⁴⁰

Community teams for severe mental illness

Flexible Assertive Community Treatment (FACT) blends lower-intensity case management with the ability to step up to assertive outreach when needs increase. Outcomes vary with implementation quality, team configuration and local system relationships, particularly in services that convert from ACT to FACT.³⁴¹

Mental health in general hospitals

Where acute hospitals invest in liaison psychiatry (RAID/Core-24-like models), evaluated programmes report faster assessments, shorter length of stay and reduced readmissions, with emerging signals of cost saving.³⁴²

Discussion

Across care settings, the strongest improvements relate to timeliness, continuity and the reduction of restrictive practice. Needs-led access models for children and young people help systems understand demand, direct people to appropriate support and reduce delays. In primary care, collaborative care links psychological therapies, physical health management and social support.

Crisis and inpatient settings benefit most when approaches focus on relationships and safety. Trauma-informed organisational change and structured early follow-up after crisis events improve experience and reduce risk.

Longer-term recovery depends on secure housing, meaningful activity and participation. Supported accommodation and IPS provide structured ways to address these needs. Specialist pathways, such as perinatal mental health and liaison psychiatry, strengthen safety and continuity at key transition points.

Implementation quality affects outcomes in all models. Fidelity, supervision and clear outcome monitoring are important for consistent results.

Conclusion

The evidence identifies a shared set of characteristics for effective mental health systems. These include early and needs-based access, collaborative and measurement-based care in primary care, rapid and least restrictive crisis responses with early follow-up, trauma-informed inpatient environments, strong rehabilitation pathways linked to housing and employment, and specialist capacity at key transition points. Taken together, these approaches provide a practical framework for improving outcomes, safety and experience in Jersey.

7. Drawing the evidence together

This section shows how findings from Chapters 1 to 6 were synthesised. The qualitative and quantitative evidence was brought together, and cross-cutting themes were identified.

At workshops in October and November 2025, the Mental Health Strategy Steering Group, working alongside a wider group of invited professionals, reviewed findings of the JSNA, and helped test and refine the themes. This synthesis and refinement work produced **8 key areas for prioritisation**. Table 9 shows the 8 priority areas and maps the key supporting evidence for each, from across the JSNA chapters. Please note that the table includes key evidence only, and more detail on the evidence supporting these themes is found throughout the document.

Table 9. Priority areas from the JSNA with mapping of key supporting evidence

Priority area	Key supporting evidence
<p>1. Prioritise poor mental health prevention, early intervention and building resilience</p>	<ul style="list-style-type: none"> • Poor mental wellbeing and low resilience is widespread amongst adults and children, e.g. 19% of adults rarely or never feel optimistic about the future, average life satisfaction scores for adults are lower than in the UK, and amongst children, the proportion of pupils with low or medium-low self-esteem has increased from 21% in 2018 to 27% in 2024 - Chapter 4 • Around 1 in 5 adults and children in Jersey is estimated to have a common mental disorder; access to early intervention services for this cohort is essential to prevent development of more serious mental illness - Chapter 4 • Key findings from engagement work show that both the public and professionals consistently cite need for early intervention work to be a top priority - Chapter 5 • Jersey faces key demographic changes; an ageing population and rising cultural and ethnic diversity. Preparation for these changes (through prevention and early intervention work) is essential to tackle anticipated increase in need – Chapter 2 • Wider factors are important for people’s mental health; prevention and early intervention work in key risk factor areas (such as financial strain, substance use, loneliness, screen use) will work as upstream protection for mental health in Jersey’s population – Chapter 3
<p>2. Improve Islanders’ mental health literacy to reduce stigma</p>	<ul style="list-style-type: none"> • Gaps remain in the mental health literacy of Jersey’s population; only 61% of adults report knowing how to support someone, and only half know where to find information on local support - Chapter 3 • Whilst there have been improvements in attitudes towards mental health (e.g. 96% of adults agree anyone can have a mental health problem), stigma persists; 1 in 8 adults say they wouldn’t want people knowing about it if they had a mental health problem - Chapter 3 • Young people want to see reduced stigma (through greater publicity of mental health and wellbeing need, and more open

Priority area	Key supporting evidence
	<p>discussion of mental health topics) and increased awareness of what support is available - <i>Chapter 5</i></p> <ul style="list-style-type: none"> Both the public and professionals agree that Jersey is becoming more open in how it talks about mental health, yet not everyone can access support equally. Structural and cultural barriers persist. Stakeholders called for strengthened community mental health literacy so people recognise early signs and know where to turn - <i>Chapter 5</i>
<p>3. Develop integrated pathways, continuity of care, and workforce stability</p>	<ul style="list-style-type: none"> Dual-diagnosis and complex need is high (e.g. nearly half of adult community/specialist caseload has SMI or dual diagnosis), showing need for well-coordinated care - <i>Chapter 4</i> Mental health need often presents combined with other needs (substance use need, neurodevelopmental challenges, involvement in criminal justice system) showing the importance of integrated pathways and person-centred care – <i>Chapters 3 & 4</i> Both the public and professionals report sometimes there are fragmented and reactive pathways, inconsistent discharge planning, and unclear thresholds across Jersey mental health services - <i>Chapter 5</i> Children to adult transition remains a key pressure point – <i>Chapter 4</i>, and some young people experienced abrupt and poorly supported transition, losing continuity at a time when stability was most needed. They call for services to be consistent, needs led and inclusive, with clear pathways and information about what will happen – <i>Chapter 5</i> Stakeholders agreed that frontline staff are the system’s greatest strength, (described as compassionate, skilled, and motivated) but highlighted workforce shortages, temporary staffing, inconsistent continuity as areas for improvement – <i>Chapter 5</i>
<p>4. Build an increased range of quality interventions to support recovery</p>	<ul style="list-style-type: none"> There is high demand in specialist areas; perinatal support, eating-disorder care, neurodevelopmental assessment, and recovery/rehab pathways for SMI – <i>Chapter 4</i> The public and professionals reported concerns about overreliance on medication, limited access to psychological therapies and inconsistent availability of specialist pathways. People expressed a desire for greater choice, including trauma informed therapies, peer support, group interventions and culturally safe services – <i>Chapter 5</i> High numbers of carers and individuals with chronic conditions (with numbers expected to rise in coming years as the population ages) indicate need for holistic biopsychosocial support – <i>Chapters 2, 3 & 4</i>
<p>5. Ensure a dedicated focus on best start, children, family and transitions</p>	<ul style="list-style-type: none"> Nurturing and healthy attachment are key for building a strong foundation of resilience and good mental health across life – <i>Chapter 3</i> There may be unmet need in the early years attachment space, with some vulnerable families not receiving

Priority area	Key supporting evidence
	<p>psychological support (e.g. less than 5 of the ~65 children in need/on protection plans are being seen by the parent infant psychotherapist) – <i>Chapter 4</i></p> <ul style="list-style-type: none"> • Support in childhood is critical as international evidence shows 50% of mental health conditions begin by age 14, and 75% by age 24. Amongst children in Jersey, mental health need peaks in adolescence, with high crisis presentation particularly amongst girls – <i>Chapter 4</i> • Common worries amongst children include school pressures, bullying, online harms, and body image concerns, showing the complex risk landscape for children – <i>Chapters 3 & 4</i> • Peaks in CAMHS referrals occur at ages 7 and 13 (suggesting vulnerable transition stages: early primary identification and early adolescence) and the children to adult service transition remains a key pressure point (see also priority 3) – <i>Chapter 4</i> • Support should be targeted as some families are more at risk; socio-economic inequality persists in Jersey, with single-parent families and those in poverty often experiencing elevated strain (housing stress, financial struggle, time paucity) and poorer wellbeing – <i>Chapter 3</i>
<p>6. Involve and increase support for carers and families</p>	<ul style="list-style-type: none"> • Unpaid carers experience strain; 92% report feeling stress and 76% say their health is affected, with many carers lacking structured support. Carer strain is particularly significant for older adults, parents of children with SEN/D, care experienced youth, dual diagnosis cases – <i>Chapter 3 & 4</i> • Some families report exclusion from care planning and inconsistent communication. They call for carers and families to be involved in planning and reviews by default, with consent, and for carer-specific support (such as family therapy, carer groups) to be expanded – <i>Chapter 5</i> • International evidence shows active involvement of family or other supporters within a measurement-based care plan leads to better outcomes – <i>Chapter 6</i>
<p>7. Develop the Island’s culture, environments and facilities to be more inclusive, accessible and sensitive</p>	<ul style="list-style-type: none"> • Social isolation is widespread: 16-34 year olds were the age group most likely to report feeling lonely (22% often/always), whilst older adults are also vulnerable due to bereavement, frailty, digital exclusion, and increasing numbers of pensioners living alone – <i>Chapter 2 & 3</i> • Minority groups can face cultural/language barriers, insensitivity, and may have lower trust in services. People on temporary work visas lack eligibility for care – <i>Chapter 3 & 5</i> • People suggested reasonable adjustments should be made standard, to make services accessible and appropriate for those who need them, e.g. trauma-informed services, neurodiversity-affirming practice (alternative formats, sensory-friendly spaces, flexible communication), online options for those unable to easily leave the house, and more - <i>Chapter 5</i>

Priority area	Key supporting evidence
	<ul style="list-style-type: none"> • Satisfaction with the Island’s natural and built environment is relatively good (e.g. 84% of adults were satisfied with the greenery in their neighbourhood) but there are disparities; just 25% of St Helier residents were very satisfied with their neighbourhood compared to 68% in rural parishes – <i>Chapter 3</i> • Just over half (58%) of young people in Years 8, 10 and 12 felt they belonged to Jersey ‘a great deal’ or ‘quite a lot’, showing there is room for improvement in making Jersey an inclusive and supportive place, where everyone feels they belong – <i>Chapter 3</i>
<p>8. Improve crisis, urgent care and step-down support</p>	<ul style="list-style-type: none"> • Mental health crisis presentations are increasing: self-harm is a major driver of ED attendance, and there has been a sharp rise among adolescent girls. Short term emergency detentions under the Mental Health Act also appear to be increasing – <i>Chapter 4</i> • There may be gaps in mental health support for crisis: e.g. mental health services were unavailable to support around 14% of mental-health related incidents attended by the ambulance service – <i>Chapter 4</i> • The redesign of crisis care (2022 “front door” model) has improved triage, unnecessary emergency attendances and care planning. However, experiences still vary widely. People experience inconsistent crisis response, unclear routes, and trauma insensitive care – <i>Chapter 5</i> • Better data capture is needed to fully understand the scale of crisis presentations amongst those already known to services. This would reveal whether there is sufficient stabilisation between crises or periods of need – <i>Chapter 4</i> • Stakeholders called for predictable 24/7 crisis offer, safe alternatives to ED, and robust follow up/step down care. This includes support reintegrating into normal life after returning from off-Island care – <i>Chapter 5</i> • International evidence suggests that using integrated models for crisis response can reduce service silos, coordinate pathways, strengthen transitions and reduce avoidable crisis escalation, and that establishing follow-up contact within the first few days after discharge improves post-crisis outcomes – <i>Chapter 6</i>

Conclusion

The Mental Health JSNA set out to build a comprehensive, evidence-based understanding of mental health need in Jersey, across all ages, communities and services. Its purpose was to map the scale and nature of need, identify gaps, highlight inequalities, and identify key priority areas to be further developed through an all-age Mental Health Strategy. The JSNA has been informed by the experiences of Islanders with lived experience, data, and wider partnership insights to create a shared picture of what is working well and what challenges remain for those experiencing poor mental health.

To develop this JSNA, between June and November 2025, we undertook an extensive programme of evidence gathering and engagement. We began with a detailed quantitative review of population data, survey findings, service use, and risk and protective factors, supported by further analysis after early gaps were identified. Alongside this, we carried out large-scale engagement with professionals and the public. More than 100 professionals contributed through interviews and surveys across children's services, adult mental health, emergency services, primary care and the voluntary sector. Public engagement included a survey completed by 168 Islanders and over 100 participants in trauma-informed focus groups and discussion sessions across a wide range of settings.

The JSNA has evidenced that much progress has been made since the implementation of the previous adult's strategy (2016-2020) and children's strategy (2022-2025), nonetheless there is more work to do. One professional stakeholder noted, 'I think we are better than we were three years ago [but] we're less good than we'll be in three years' time.' Primarily, mental health need is significant, rising, and increasing in complexity across the life course. Around one in five children and adults^{3,4} in Jersey are now experiencing common mental health difficulties, contributing to sustained pressure across all services (those provided by both Government and community partners). Most mental health conditions begin early in life; 50 % by age 14 and continue throughout adulthood,⁵ evidencing the importance of supporting children and young people and families at an early stage and developing integrated life-course support pathways. This also explains the significance of undertaking an all-age mental health JSNA and subsequent strategy.

While overall prevalence remains broadly comparable to the UK, the Island's unique demographic, socioeconomic and service pressures are intensifying demand. These pressures sit within wider demographic and socioeconomic trends. An ageing population, declining birth rates, outward migration of young adults and persistent income and housing pressures are shaping both the volume and complexity of mental health presentations. At the same time, improvements in community mental health literacy and strong voluntary-sector provision offer important assets to build upon.

Across the life course, distinct but interconnected patterns of need emerge. In the perinatal period, demand remains significant despite recent investment improving capacity and the support available to families. The findings highlight the ongoing importance of strengthening early relationships and prioritising early attachment as a protective factor.

Among children and young people, levels of emotional distress continue to rise, particularly during adolescence, which shows similar patterns to the UK. Girls experience the steepest deterioration, with higher rates of anxiety, self-harm thoughts and crisis presentations. While the drivers of this

trend are complex, the evidence suggests that multiple pressures including bullying, online harms, body-image concerns and school-related stress are contributing factors. The volume and complexity of presentations continue to grow, reflected in rising CAMHS referrals, consistently high acceptance rates and repeated or crisis-related contacts, particularly among adolescent girls. Significant overlap between mental health and neurodevelopmental need, particularly for care-experienced children and young people, further underscores the need for early intervention

Young adults also face substantial pressures. They report the highest levels of loneliness of any adult age group, experience high levels of dual need involving mental health and substance use, and are heavily represented across secondary mental health pathways. The transition from CAMHS to adult services remains a vulnerable point. The number of young people living with long-term health conditions has also increased sharply, rising from one in ten a decade ago to one in three today.⁶⁴

Among working-age adults, one in five live with a common mental health disorder, and statutory, crisis and prescribing data all point to a smaller cohort with increasingly severe and enduring needs. Community caseloads for mental health support remain high, with nearly half of those across community and specialist services having severe mental illness (SMI) and dual diagnosis.

Amongst older adults' anxiety and depression remain present amid high rates of multimorbidity, dementia, bereavement, frailty and social isolation, with projected demographic changes likely to intensify pressures on community, crisis and inpatient care.

Throughout the system, inequalities are visible and persistent. People with severe mental illness, care-experienced young people, unpaid carers, neurodivergent Islanders, migrants, people experiencing homelessness, and those with co-occurring mental health and substance use needs face the greatest barriers to access and the most severe consequences of unmet need. Crucially, major data gaps in ethnicity, migration status, disability, language need and other equity indicators mean that many inequalities remain insufficiently visible and cannot be routinely monitored.

The findings can be drawn together into 8 key priority areas, that feed into strategic development:

1. Prioritise poor mental health **prevention, early intervention and building resilience**
2. Improve islanders' **mental health literacy** to reduce stigma
3. Develop **integrated pathways**, continuity of care, and workforce stability
4. Build an **increased range of quality interventions** to support recovery
5. Ensure a dedicated **focus on best start, children, family and transitions**
6. Involve and increase **support for carers and families**
7. Develop the island's **culture, environments and facilities** to be more inclusive, accessible and sensitive
8. **Improve crisis, urgent care** and **step-down** support

Turning JSNA Findings into Priorities for Action

In January 2025 work began developing the All Age Mental Health Strategy (2026-2030).

Four workshops were held, with professionals from Government, third sector and charities along with people with lived experience and their carers, and dedicated workshops for young people. The purpose of these workshops was to present the key findings of the JSNA, discuss feedback, and refine the findings down to a smaller number of priorities for action, to be addressed in the All Age Mental Health Strategy (2026-2030).

At workshop 1:

Key findings from the JSNA were presented, and stakeholders scored each area using a traffic-light system:

- Green sticker: Non-negotiable priorities
- Post-it notes: Missing elements
- Red sticker: Items to remove
- Yellow sticker: Top four priorities

Analysis took place to identify which areas stakeholders considered to be the top priorities.

At workshop 2:

The refined priorities were shared back to the stakeholders. Stakeholders were asked a series of questions for each priority:

- What does this priority mean to you?
- How would you like this to look by 2030 and for future generations? What does 'good' look like?
- What needs to be true in order to achieve this vision? What are the blockers to achieving this and how can these be overcome?
- What can happen now? What can be done to make a difference on a daily basis?
- How do we know when we have achieved this vision? How can this be measured?

The answers to these questions were thematically analysed, combined with previous engagement work where individuals identified areas of improvement, and together they formed the strategy actions under each priority. These detailed actions can be found in the All Age Mental Health Strategy (2026-2030).

At workshop 3 & 4 (young people):

Two in-person workshops took place in February 2026, with participants from the Youth Assembly and Youthful Minds. The purpose of this engagement was to explore what the four draft priorities of the Mental Health Strategy (2026–2030) meant to children and young people, and to ensure their perspectives informed the development of the final strategy.

Young people were asked to discuss what each priority meant to them and their feedback was noted down. They were then asked to identify the key actions they felt were needed to achieve each priority based on their views as a young person. These findings were combined with workshop 2 outputs to develop the strategy actions, for a full breakdown of the strategy actions they can be found in the All Age Mental Health Strategy (2026-2030).

Finalised priority themes for the All Age Mental Health Strategy (2026-2030)

Following the analysis of the JSNA, combined with findings from the four workshops, the four finalised strategy priorities are:

1. Prevention, early intervention and building resilience
2. Integrated pathways and quality interventions
3. Crisis and urgent care response
4. Recovery, rehabilitation and transitions

Detailed actions and next steps can be found in the [All Age Mental Health Strategy \(2026-2030\)](#).

Data development

The development of this JSNA highlighted significant challenges in the availability, completeness and accessibility of mental health data in Jersey. While a range of information is held across Government of Jersey systems, limited analytical capacity and legislative constraints have affected the ability to extract, link and analyse these datasets in a way that fully reflects population need and service use. As a result, some datasets that could have been valuable could not be included in this JSNA.

A central limitation is the difficulty in assessing inequalities within many datasets. Unlike other jurisdictions such as the United Kingdom, Jersey does not yet routinely collect detailed data on deprivation, ethnicity, disability or other key demographic characteristics across major datasets. This restricts the ability to examine differences in access, outcomes and need between population sub-groups. This gap is particularly important given the JSNA's findings on higher risk among groups such as young women, people living in poverty, migrant communities, neurodiverse people, care experienced young people and older adults who live alone.

The Public Health Intelligence team currently operates under the Loi (1934) sur la Santé Publique, which provides limited authority to access health and social care datasets for public health assessment. As a result, analysts have relied on support from other teams to obtain and interpret data but are unable to link datasets themselves. This limits the ability to assess whether needs are being met, for example by examining whether people recorded with mental health conditions in primary care are accessing specialist services, or whether services are reaching individuals with the greatest level of need. Although work to modernise the public health law has begun, these limitations continue to restrict the scope of intelligence.

During the development of this JSNA a number of important data gaps were identified. Addressing these gaps would significantly strengthen future assessments and support more equitable planning and commissioning. Priority areas for data development include

- an index of multiple deprivation
- consistent, high-quality recording of disability and ethnicity across all major datasets
- improved data on veterans with mental health needs
- expanded mental health statistics with breakdowns for vulnerable groups such as young adults, care experienced young people and the LGBTQ plus community
- data on housing quality and fuel poverty
- data on children in absolute low-income households
- access to the Healthy Assets and Hazards Index or a Jersey equivalent
- previous mental health history for perinatal women, including prior depression, anxiety, bipolar disorder or other psychiatric conditions³⁴⁶
- structured data on trauma history among perinatal women, including childhood abuse, sexual violence and traumatic previous births, given these are well established predictors of perinatal mental health difficulties³⁴⁶

Strengthening data quality, building analytical capacity, updating data-sharing legislation and improving cross government collaboration will be essential to ensure future JSNAs provide a fuller and more accurate understanding of mental health need and support targeted action to reduce inequalities.

Glossary

Key Terms

Adverse Childhood Experiences (ACEs): Potentially traumatic childhood events increasing long-term mental and physical health risks.

All-age approach: System considering mental health needs across the entire lifespan.

Crisis care: Emergency mental health support for acute distress.

Determinants of mental health: Influences across individual, interpersonal, community, and socioeconomic domains.

Dual diagnosis: Co-occurring mental illness and other health and wellbeing need (such as substance use).

Inequalities / systemic inequalities: Groups facing greater risk due to discrimination or structural disadvantage.

Life course approach: Understanding mental health needs across each developmental stage.

Mental health: A continuum of emotional, psychological, and social wellbeing.

Mental health literacy: Knowledge that enables recognition, prevention, and management of mental health needs.

Neurodivergence / Neurodevelopmental need: Atypical neurological development including autism and ADHD.

Perinatal mental health: Mental health during pregnancy and up to two years postpartum.

Protective factors: Conditions that strengthen resilience and support good mental health

Resilience: The ability to recover from adversity.

Risk factors: Conditions increasing likelihood of poor mental health.

Severe Mental Illness (SMI): Conditions such as schizophrenia or bipolar disorder.

Substance use: Use of alcohol, tobacco, or drugs.

Warm clinical handover: a real-time handover where the current clinician personally introduces the service user to the next clinician to ensure continuity, safety and a supported transition.

Abbreviations

- ACE** – Adverse Childhood Experience
- AMHS** – Adult Mental Health Services
- CAMHS** – Child and Adolescent Mental Health Services
- CBT** – Cognitive Behavioural Therapy
- CMD** – Common Mental Disorder
- CYPES** – Children, Young People, Education and Skills
- DBT** – Dialectical Behaviour Therapy
- ED** – Emergency Department (also known as Accident and Emergency; A&E)
- ELSA** – Emotional Literacy Support Assistant
- FNHC** – Family Nursing & Home Care
- FAST** – Fast Alcohol Screening Test
- FOI** – Freedom of Information
- GDP** – Gross Domestic Product
- HCJ** – Health and Care Jersey
- IMD** – Index of Multiple Deprivation
- JCYPS** – Jersey Children and Young People’s Survey
- JOLS** – Jersey Opinions and Lifestyle Survey
- JSNA** – Joint Strategic Needs Assessment
- JTT** – Jersey Talking Therapies
- MESCH** – Maternal Early Screening & Care Hub
- MHL** – Mental Health Law
- NEET** – Not in Education, Employment or Training
- OCD** – Obsessive Compulsive Disorder
- OECD** – Organisation for Economic Co-operation and Development
- PATS** – Psychological Assessment and Treatment Service
- PIP** – Parent Infant Psychotherapy
- PTSD** – Post-Traumatic Stress Disorder
- RON** – Record of Need
- SEN/D** – Special Educational Needs and/or Disability
- SMI** – Severe Mental Illness
- STIA** – Short-Term Incapacity Allowance
- WHO** – World Health Organization

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