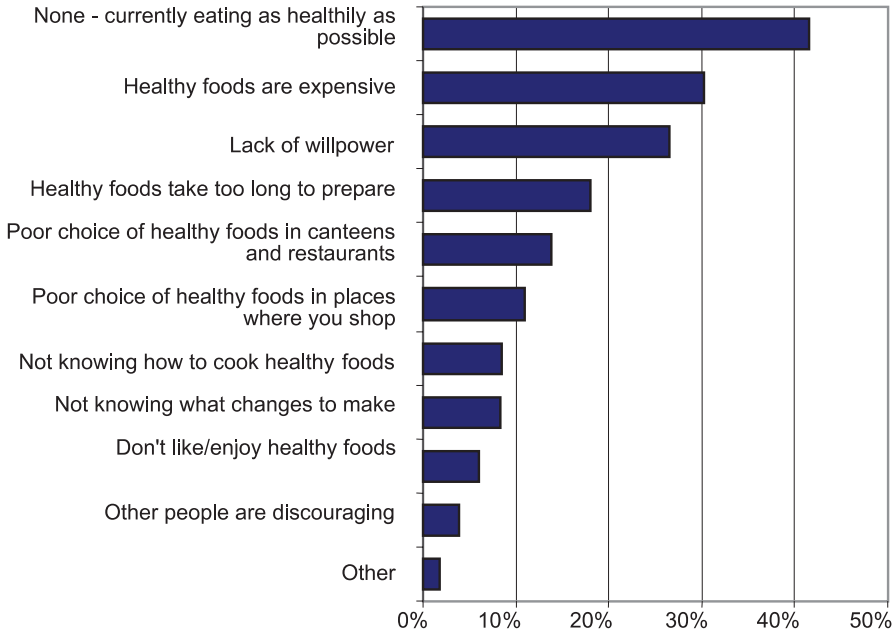
Figure 17 **Barriers to healthy eating in Jersey**



Source: 2007 Jersey Annual Social Survey

Table 2 **Nutritional content of popular sandwiches in Jersey**

Sandwich Type	Calories*	Fat Per 100g	Saturated Fat Per 100g	Salt Per 100g
Chicken, mayonnaise and stuffing	788	21.3	3.9	0.9
Ham, cheese and pickle	497	12.7	6.1	2.1
Tuna and cucumber	543	13.2	2.5	0.76
Chicken, mayonnaise and sweetcorn	442	10.7	1.8	0.78
Coronation chicken	589	18.2	3.4	0.8

Red = HIGH per 100g **Orange** = MEDIUM per 100g **Green** = LOW per 100g

* Guideline daily amounts (GDA) for calories are 2000 for women and 2500 for men

Source: Public Health

Study two - secondary school canteen food

In our second food study, the Public Health Department worked with the Department of Education, Sports and Culture to audit food in secondary schools, to assess whether Jersey school food measured up to the national criteria required to achieve National Healthy Schools Status (NHSS).

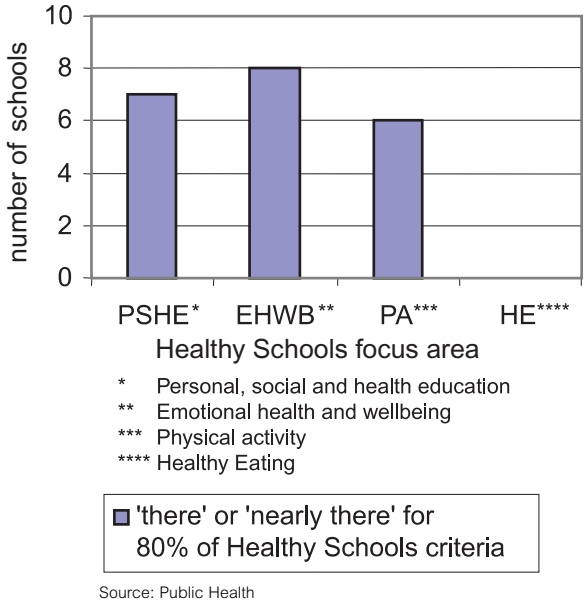
In February and March 2008, eight secondary schools audited their achievements so far against the national healthy schools standards across four key areas:

- Personal, social and health education
- Physical activity
- Emotional health and wellbeing
- Healthy eating

Despite improvements in school food in Jersey over the last few years, no Jersey secondary school currently meets national nutritional standards which apply to schools in England today *(figure 18)*. In 2007 the UK Government introduced a new set of school food standards with the aim of transforming school meals. These standards were designed to promote the consumption of healthy food during the school day while restricting the availability of less healthy choices. Whilst most secondary schools in Jersey would meet many of the UK requirements around the availability of healthy options, such as fruit, vegetables and starchy foods, there is currently little or no restriction locally on the availability of less healthy options such as fried foods, processed meat products, sugary drinks and confectionary sold throughout the school day *(table 3)*.

Clearly, to achieve healthy schools' status Jersey secondary schools need to work on school food as a priority. A fresh approach will be needed if the food served in school canteens is to meet the aspirations of pupils, parents and teachers alike.

Figure 18 **Jersey secondary schools - progress in meeting Healthy Schools' standards**



Source: Public Health

Supporting the majority - leadership required on food

To beat obesity, everyone in Jersey must take action together, now, to improve diet at a population level. The Public Health Department has championed our collective response but we will fail to make headway unless we can convince others - the Government, other States' Departments, food manufacturers, food retailers and the restaurant trade - to take up the leadership baton.

The Island's new 'Health for Life' strategy highlights diet as one of eight priorities for action. The strategy outlines ways to improve the Island's diet and reduce obesity with joined-up solutions to this complex challenge. The actions transcend age groups and settings and include fiscal measures, service provision, policy development and public education *(figure 19)*. Some key first steps are to:

- Explore fiscal measures to remove financial barriers to buying and eating healthy food and reduce the relative cost of healthy food versus unhealthy food. An economic review of local prices and previous trends would help us to understand better the affordability of healthy foods
- Begin a pilot with creative and willing food retailers who want to meet the increasing public demand for healthy food. Equally important is working with local food producers to reduce salt, fat and sugar in locally-produced goods/food such as bread and sandwiches
- Give clear information to consumers, at the point of sale, concerning restaurant menus. A healthy option and traffic-light labelling system against each dish would increase clarity for customers. A Jersey-based awareness scheme, for restaurants and cafes which provide healthy food on their adult and children's menus, could help restaurant-goers to achieve a balanced diet.

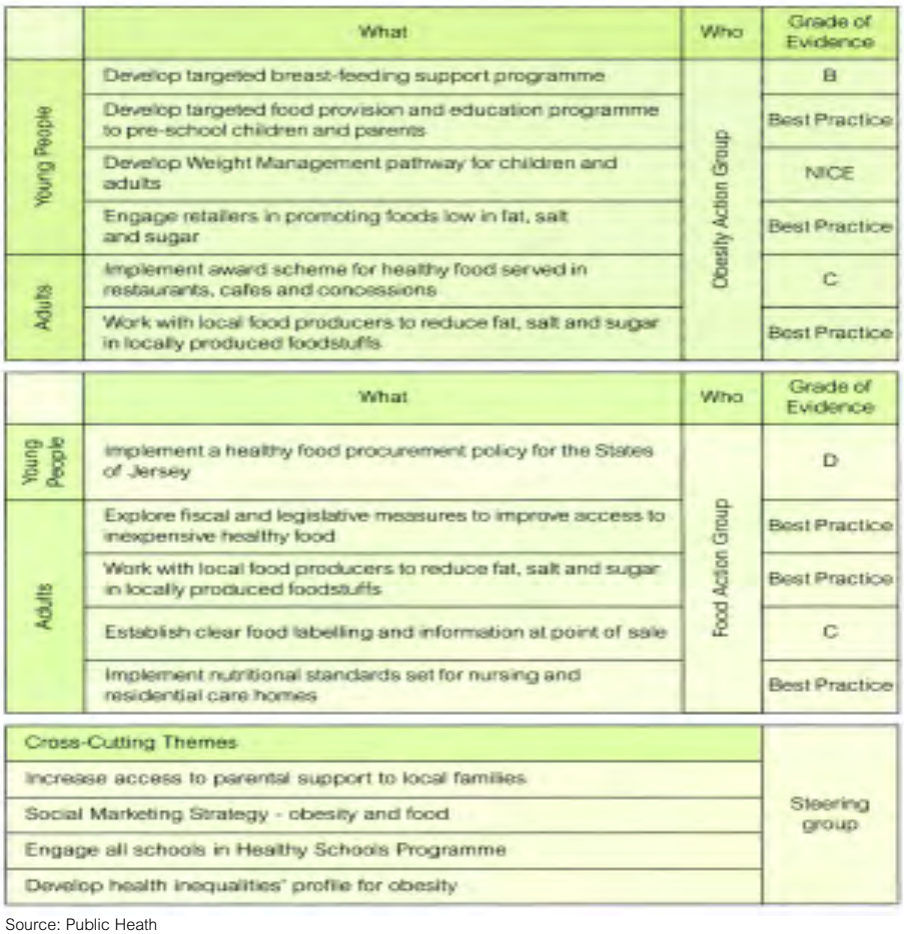
Table 3 **Jersey schools' results for UK food standards**

Currently meeting Healthy Schools 'food-based' standards for school food							
Food Group	**School**						
	A	**B**	**C**	**D**	**E**	**F**	**G**
Fruit and vegetables	✔	✔	✔	✔	✔	✔	✔
Meat, fish and alternatives	✔	✔	✔	✔	✔	✔	✔
Starchy foods	✔	✔	✔	✔	✔	✔	✔
Restricted meat products, i.e. burgers; sausages	✘	✘	✘	✘	✘	✘	✘
Deep-fried food restrictions	✘	✔	✔	✔	✘	✔	✔
Milk and dairy foods	✔	✔	✔	✔	✔	✔	✔
Snacks, i.e. crisps	✘	✘	✘	✔	✘	✘	✘
No confectionary	✘	✘	✘	✘	✘	✘	✘
Healthier drinks only	✘	✘	✘	✘	✘	✘	✘
Free, fresh drinking water	✔	✔	✔	✔	✔	✔	✔

NB One school does not have a canteen

Source: Public Heath

Figure 19 **'Health for Life' action plan to reduce obesity by improving diet**



Source: Public Heath

Recommendation

I recommend:

- implementing the action plan for a healthier diet in the Island's 'Health for Life' strategy.

References

1. Faculty of Public Health Lightening the Load tackling overweight and obesity: (2007).
2. Jersey Adult Social Survey (2008).
3. Health Related Behaviour Survey (2007).
4. Food Standards Agency: The Balance of Good Health (2001).

Chapter 3 Health Protection

Healthcare and infection

Catching an infection, whilst in hospital, is a concern for many patients. MRSA and Clostridium difficile (C. difficile) have hit the headlines during the last few years as infections which can kill or delay a patient's recovery, keeping them in hospital for longer. This causes suffering for the individual and their families and increases the cost of healthcare substantially: 25% of hospital drug costs are for antibiotics to tackle bacterial infections and patients with infections stay in hospital on average eleven days longer than those without an infection.

Islanders can be reassured that the Health and Social Services Department takes infections very seriously, there is a low rate of healthcare-associated infections here in Jersey and we intend to keep it that way.

Healthcare-associated infections - the size of the problem

Healthcare-associated infections (HAI) are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting. Across the developed world, approximately 10% of patients in hospital get such an infection. A further and quite separate 10% of patients come into hospital for treatment of an infection which they have acquired in the community.

In the UK there are at least 300,000 HAIs per annum. HAIs cause an estimated 5,000 deaths and excess healthcare costs of circa £1 billion. In Jersey the figures are much lower due to rigorous infection-control policies.

MRSA

Staphylococcus aureus is a common germ which lives on the skin and in the nostrils of about two thirds of healthy people. This only harms them, or others, when it gets an opportunity to enter the body, usually through a skin wound.

Methicillin-resistant Staphylococcus aureus (MRSA) is simply a variety of Staphylococcus aureus that has developed a resistance to a number of antibiotics, making it difficult to treat. MRSA and other germs cause problems in hospitals because people who are ill are more vulnerable to infections and various medical treatments, including operations and intravenous drips, can let germs enter the body. When this happens, MRSA can cause infections in wounds, the chest or even in the bloodstream.

MRSA is not new. It originated in the 1960s following the widespread use of antibiotics including methicillin. MRSA is found in hospitals across the world and increasingly in people who have left hospital. Indeed half of all new MRSA isolates in Jersey in 2006 were individuals who were neither in the hospital nor had they been in hospital during the preceding month.

MRSA is usually spread by touch. If a person gets MRSA on their hands, they can pass it on to people and things that they touch. It may then be picked up and passed on to others. In this way, MRSA can spread between patients. Hospital staff need to take special precautions with patients who have MRSA in order to stop it spreading:

- everyone should clean their hands before and after touching patients: hands can be cleaned with soap and water or an alcohol gel
- staff should wear gloves and aprons when they care for a patient who has MRSA
- a patient who has MRSA should be moved to a room on their own or into a separate area for people who already have MRSA.

People who get MRSA can be treated. If a patient is at risk of carrying MRSA, a nurse will take swabs to check which parts of the body have MRSA. Treatment with antiseptic gel and cream will help to reduce or remove MRSA from hair, skin and nostrils. A patient who has an MRSA infection inside the body is usually treated with an antibiotic which may have to be given through an intravenous drip.

MRSA in Jersey

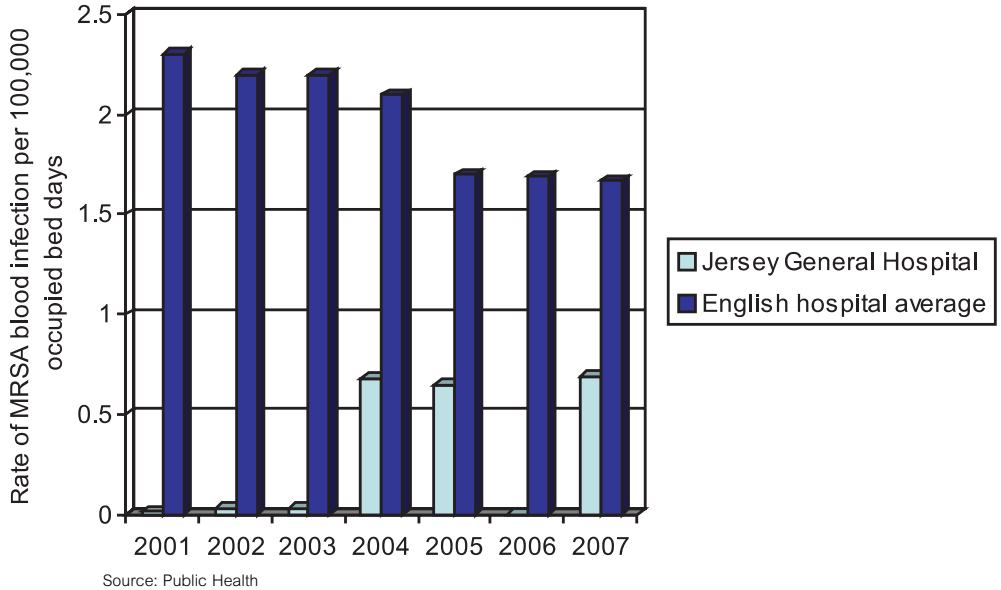
MRSA infection rates in Jersey are low compared with those in England. In England and Jersey we measure bloodstream infections with MRSA and have tracked these for the last fifteen years.

Between 1991 and 2000 the percentage of all Staphylococcus aureus blood infections caused by of MRSA were measured. In Jersey, during that period, this proportion rate increased from 0 to 5% whilst, contemporaneously in England, it rose from 15% to 36%. From 2001 onwards MRSA blood infections have been measured as the rate per 100,000 occupied hospital bed days. Jersey rates remain considerably better than those in England *(figure 20)*. MRSA rates in hospitals in London and the Southeast are particularly high. This means that our hospital staff take particular precaution with patients who return to Jersey after having had specialised treatment and operations on the mainland.

Ruben Costa

Source: Jersey General Hospital

Figure 20 **Comparing MRSA bloodstream infection rates**



Source: Public Health

The relatively low levels of MRSA in Jersey have been achieved by adopting a 'search and destroy' policy where all 'at-risk patients'* admitted to Jersey General Hospital are tested for MRSA carriage and, if necessary, treated.

This type of approach has also been successful in the Netherlands, Scandinavia and Iceland although some of these countries go a step further and screen every patient on admission to hospital.

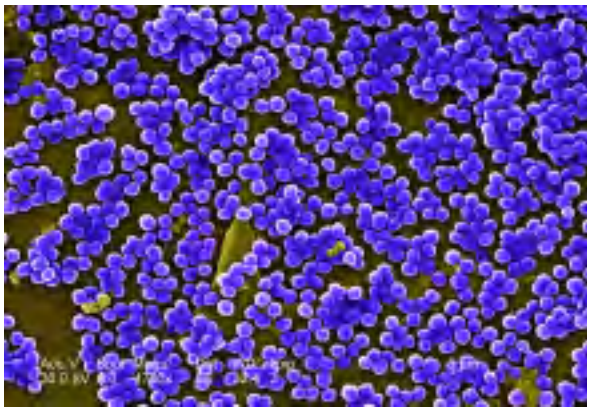
** Patients who come into the Jersey General Hospital from other hospitals or from a nursing home.*

Clearly, reducing the overall number of patients carrying MRSA is an important goal since this reduces the risk of harmful infections. But what of patients who do get infected? Patients who develop a blood or wound infection with MRSA need swift treatment with special antibiotics which would not normally be used. Any delay in using these special antibiotics can mean a poorer prognosis for the patient. Speedy test results diagnosing MRSA are, therefore, essential to save lives and prevent suffering.

Clostridium difficile

Clostridium difficile infection *(C. difficile)* causes diarrhoea, which can be serious, and is the most common cause of hospital-acquired diarrhoea. The bacterium is present in the gut of up to 3% of healthy adults and about 20% of hospital patients. C. difficile rarely causes problems in healthy adults, however, as it is kept in check by the normal intestinal bacteria.

When certain antibiotics disturb the balance of bacteria in the gut, C. difficile multiplies rapidly, producing toxins which can cause serious diarrhoea. C. difficile made the national headlines last year when 90 hospital patients were found to have died from the infection at the Maidstone and Tunbridge Wells Hospital. As a result of their investigation, the Healthcare Commission concluded that C. difficile infections had not been diagnosed, treated and contained with sufficient rigour at the hospital.



Source: PHIL-CDC

C. difficile

The cause of C. difficile diarrhoea

C. difficile diarrhoea is almost always caused as a side effect of antibiotic treatment. It is typically a problem in the elderly, with over 80% of C. difficile infections affecting people aged over 64. C. difficile infection can be spread between hospital or nursing home patients on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. These spores are very resilient and can survive on clothes and surfaces for long periods.

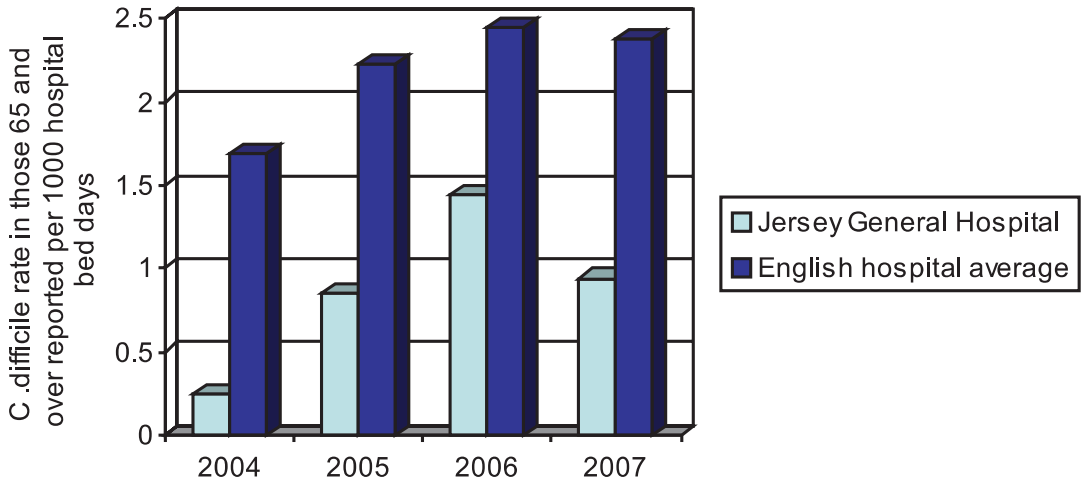
With many frail individuals on antibiotics, hospitals and community-based healthcare settings amplify the risk of C. difficile diarrhoea. With an ever-increasing number of older people within our community, this challenge can only grow.

C. difficile in Jersey

Jersey has a good record for low C. difficile infection rates. It has only been a requirement to monitor this infection for four years, however, and this monitoring is being refined; so while it is early days, we are pleased with Jersey's results so far *(figure 21)*.

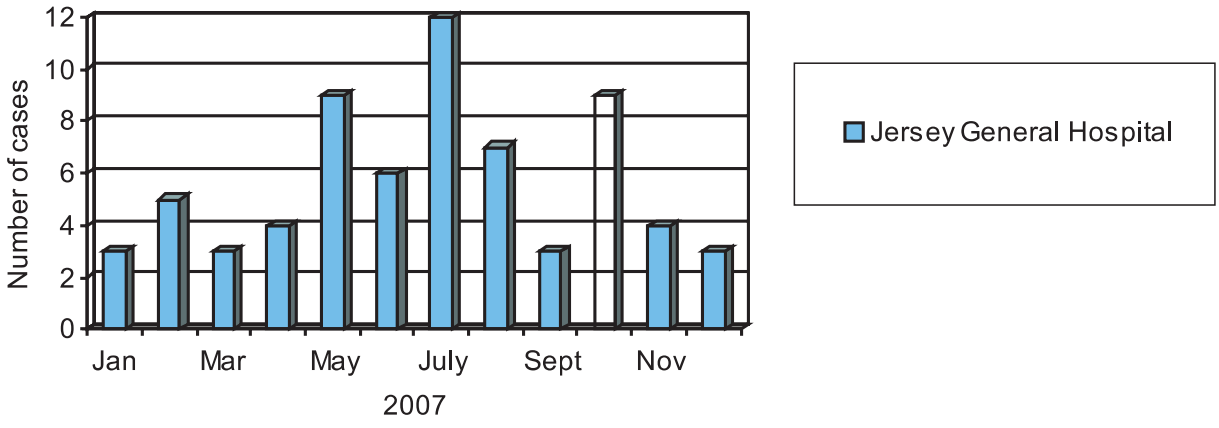
There have been recent outbreaks in England and Jersey because of the more severe 027 C. difficile strain in the USA. In spring and summer 2006 we saw increasing C. difficile infections in our general hospital, with a considerable number being attributable to the 027 strain. As a result two patients in Jersey died from this infection. We introduced infection control measures swiftly and brought the outbreak under control by November *(figure 22)*.

Figure 21 **Comparing C. difficile infection rates**



Source: Public Health

Figure 22 **Jersey outbreak of 027 C. difficile in 2007**



Source: Public Health

Tackling C. difficile infection

Good hospital hygiene is paramount, with an emphasis on hand washing and environmental decontamination. Thorough washing with soap and water is needed as the antiseptic hand scrub solutions don't kill spores. There is also a need to further control antibiotic use to avoid precipitating C. difficile diarrhoea and the evolution of more toxic strains of this bacteria in the future. Patients with diarrhoea need to be diagnosed and treated quickly to help them recover and to prevent any spread to other patients. Infectious patients should be nursed in a separate room with stringent infection-control procedures.

In conclusion

Our community is changing. There is an increasing proportion of elderly people, more chronic illness and an increasing dependency on nursing and residential homes. There is, therefore, an increased likelihood of HAIs. These challenges require us to embrace a broader Islandwide and more rapid response to controlling HAIs, if we are to minimise the ascent of antibiotic resistant organisms in the future.

Jersey rates of infection are low and this is testament to how seriously prevention of infection is taken. We will need, however, to 'raise our game' to keep ahead of these infections as, once they become commonplace, they are much harder to control - as England and other European countries are finding.

Recommendations

I recommend:

- an increased emphasis on infection-control practices and cleanliness, in line with National guidance, in both the hospital and nursing/residential homes
- increasing and modernising infection screening for patients admitted to hospital, both by broadening our screening, in time, to all patients admitted to JGH and by having a more rapid MRSA diagnostic facility
- working towards a maximum of 85% acute-ward bed occupancy and an increase in the number of single rooms
- introducing a pharmacy-supervised antibiotic policy in the hospital and an auditable antibiotic policy in the community.

References

1. Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust Healthcare Commission, October 2007.

Food poisoning

Food poisoning is a common, usually mild, but sometimes serious illness. The sufferer may have a variety of symptoms including fever, nausea, cramps, vomiting and diarrhoea. In severe cases, the person may need to be admitted to intensive care and some may die. Food poisoning is particularly serious for young children and the elderly. Food poisoning results from eating food or drink that is contaminated with bacteria or its toxins. Very occasionally, toxins from chemicals or pesticides can also cause food poisoning. It is hard to tell if a food or drink is contaminated because the look, taste and smell may not be affected. Most food poisoning is caused by the toxins produced by bacteria, or by the amount of bacteria present. Bacteria can multiply from one to millions, given the right conditions of moisture, food, warmth and time. The more bacteria present, the higher the chance of human infection and illness. Food poisoning can affect one person or a group of people if they have all eaten the same contaminated food.

Food poisoning in Jersey

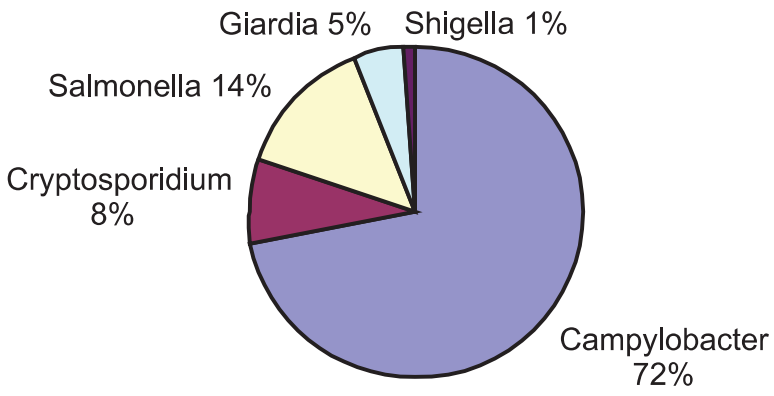
The most common types of bacteria to cause food poisoning are Campylobacter, E.Coli and Salmonella. Campylobacter is the most common bacterial food-borne illness in Jersey *(figure 23)*.

This illness is predominantly associated with poorly cooked food, contamination of cooked food by raw chicken or from mixing the activity of preparing food with handling animals. Recent campaigns on better hand washing and reducing cross contamination - for example on chopping boards - have improved food safety in the home but more still needs to be done to combat this unpleasant infection in Jersey.

Food poisoning is more common in Jersey than on the mainland *(figure 24)*, which may be associated with the lack of a contemporary food hygiene law in Jersey. The English law, for example, makes food hygiene training for catering staff mandatory. Whilst working on a voluntary basis with the catering industry has paid dividends, with reports of food poisoning more than halving since record collection began nine years ago, there is still more progress to be made.

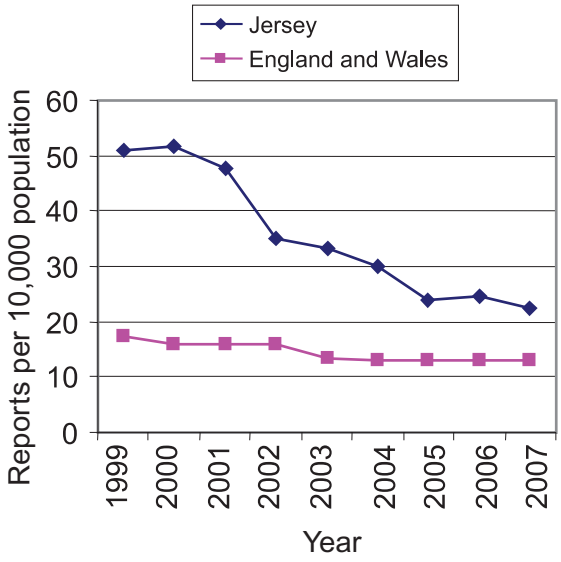
The more severe forms of food-borne illness include dysentery, typhoid and paratyphoid which are often transmitted through drinking water contaminated by sewage or contaminated water used for food preparation. These illnesses are debilitating and can be life threatening. Typhoid and dysentery are usually only a problem when travelling overseas. There have been 40 cases of paratyphoid infection in Jersey since 1995.

Figure 23 **Bacteria causing food poisoning in Jersey 2007**



Source: Public Health

Figure 24 **Comparing food poisoning in Jersey with the national trend**



Source: Public Health

Surveillance

The Public Health Department monitors illnesses in the community caused by food poisoning. This tells us: whether food poisoning is on the increase or on the wane and when an outbreak is occurring and its source - for example a catering event. The data informs the targeting of resources to reduce the risk of infection and contain sources of infection before too many people become ill.

Two major food poisoning outbreaks in Jersey

In 2007 there were two major outbreaks of gastrointestinal illness caused by contaminated food in Jersey.

Outbreak one

On Wednesday 5th September 2007, Haute Vallee School closed because of a sudden illness amongst teaching staff. 20 staff had a severe illness: mostly vomiting and diarrhoea. All the teachers affected had eaten a sandwich lunch at a training day at the school two days previously, on Monday 3rd September. Teachers at

Source: sittingducks.com.au

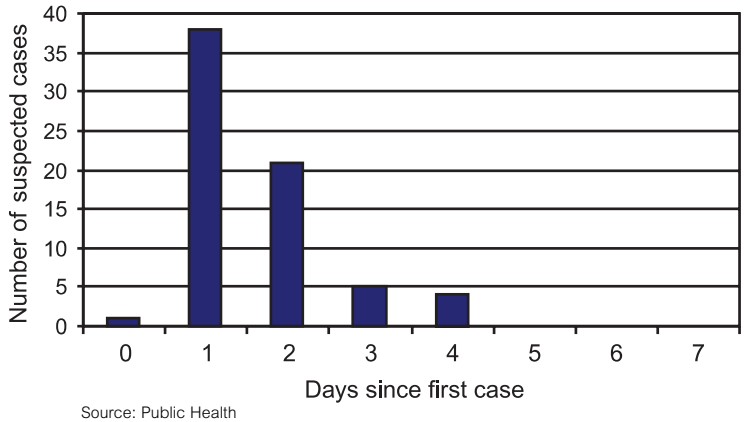
Springfield School and Hautlieu were similarly afflicted, and Springfield School had to close. These teachers had also eaten a sandwich lunch at their training day. A number of people who had worked at 'Jersey Live' held the previous weekend had also become ill.

The results of the stool samples from sufferers proved positive for norovirus. In total 146 staff at the three schools and some workers at the 'Jersey Live' event were ill with norovirus gastroenteritis *(figure 25)*. All had eaten sandwiches from the same sandwich producer within a similar time frame. Because of the large numbers of teachers affected, the schools closed for three days. The impact of the outbreak was felt across the community as the norovirus was passed on within families and at the schools.

Despite a thorough investigation of the sandwich production process and an analysis of the sandwiches which each person had eaten, we were unable to pinpoint the cause of the contamination. The Public Health Department did discover, however, that someone had vomited on the sandwich trays supplied to 'Jersey Live' staff and that these trays had been returned to the sandwich company. This seems a likely explanation for the outbreak.

The virus is in circulation in the community most of the time, so extra care is needed to prevent it from spreading to vulnerable groups. Anyone preparing food commercially must be aware of good food hygiene practices. A strict 48-hour exclusion policy is vital in schools and for staff in residential homes, whereby children/staff remain off work until 48 hours after their symptoms of diarrhoea and vomiting have stopped.

Figure 25 **Cases of norovirus**



Source: Public Health

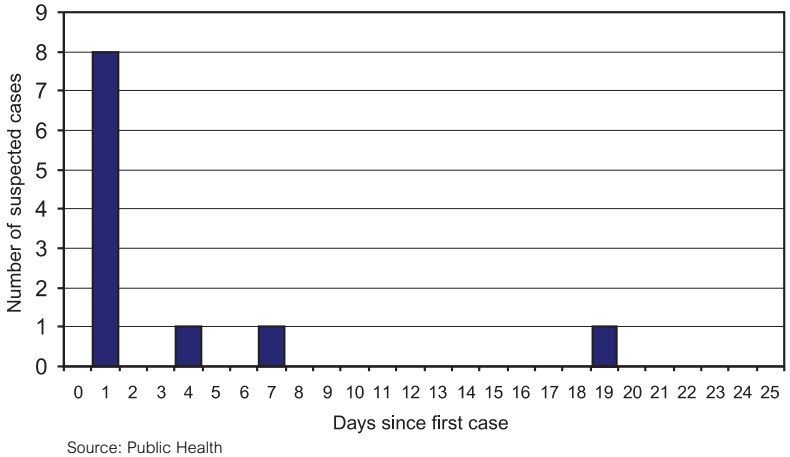
Outbreak two

On 26th October 2007, a GP notified the Public Health Department that one of his patients was suffering from severe diarrhoea and vomiting suggestive of food poisoning. The patient said that five other people he knew had the same symptoms, all of whom had attended a function at a sports club on the previous Sunday. Out of a total of 87 guests at the function, nine people tested positive with Salmonella enteritidis 1e and a further six had symptoms of nausea, vomiting and diarrhoea which persisted for several days *(figure 26)*. One patient was admitted to the Jersey General Hospital Intensive Care Unit and took several weeks to make a full recovery.

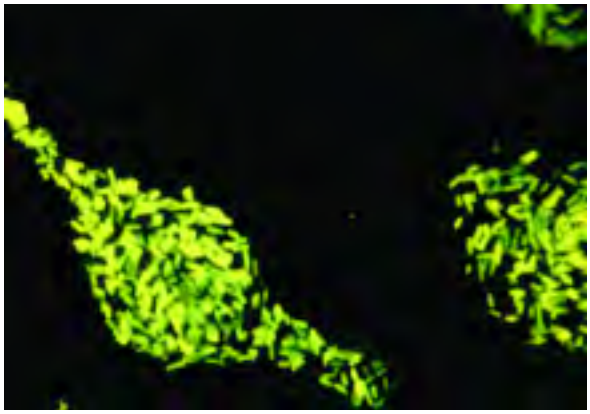
The same bacteria, Salmonella enteritidis 1e, was also found in the pasteurised egg white, imported from France, used to prepare the meringue for a baked Alaska dessert served at the sports club. As soon as the source of the outbreak was confirmed, the egg product was recalled to prevent it being used again in Jersey. As the product had been supplied by a wholesaler in England, the Jersey Public Health Department informed the UK Food Standards Agency and the National Health Protection Agency. They reported the incident to European health agencies as a matter of international concern.

The prompt product recall across Europe undoubtedly saved lives and prevented many outbreaks of food poisoning. Several further outbreaks occurred in UK cities, around the same time as the Jersey outbreak, just before the product had been fully recalled.

Figure 26 **Cases of Salmonella**



Source: Public Health



Source: upload.wikimedia.org

Salmonella bacteria invading human cells

Source: Public Health

Pouches of pasteurised egg white

Several weeks after the Jersey outbreak subsided, a further two cases of Salmonella enteritidis 1e were confirmed by the Jersey hospital laboratory. These cases were family members of those originally infected. People suffering from Salmonella food poisoning can be infectious to others for several months. Salmonella can be passed on when preparing food.

The number of Salmonella outbreaks in Jersey has declined over the last few years. Much of this decline has been attributed to the increased use of eggs from the UK, where flocks of laying fowl are now vaccinated to reduce the incidence of Salmonella. These eggs have the 'lion brand' marking on them to show they are safe from Salmonella contamination.

The new food hygiene law

Outbreaks like this in Jersey remind me that at home, and particularly in businesses and institutions, everyone involved in food preparation needs to be aware of good food-hygiene practices to prevent food poisoning, and in some cases we need to use the law to ensure improvements are made.

The current food law in Jersey has been in existence since 1966. This law will be redrafted to improve the safety of the food we eat. The new law will bring about some important changes. For the first time, all food handlers will be required to be properly trained in food safety practice and all food businesses will need to have written management controls in place. The nutritional quality and health claims made about food will be required to meet new standards and these foods will need to be clearly labelled for consumers.

To prepare for the new law, the Public Health Department has joined forces with Highlands College to deliver accredited food hygiene training. A number of bespoke courses have been provided to ensure training is appropriate for the level of responsibility that each food handler has. Training is also being provided for the hospitality/catering sector on food management systems. Working with businesses in partnership, we are developing information for various sectors of the food industry.

A large number of food business operations are involved with exports e.g. shellfish businesses,

Source: Public Health

Jersey Employment Trust members

where premises' approval and European health marking is essential for continued export and to ensure traceability of these high-risk food products. The new law will formalise these processes.

All these initiatives will improve food safety and help to reduce food poisoning. In addition Islanders will have better information about the food they eat so that everyone can make good choices, eat safely and keep healthy.

Recommendations

I recommend:

- that further work is carried out to improve personal hygiene and to reduce cross-contamination in the home, with particular reference to reducing Campylobacter food poisoning
- that food safety and personal hygiene education is provided to all school children
- that food businesses develop plans to reduce food poisoning risks and, in the event of an outbreak, to enable rapid product recall and to ensure business continuity.

Maintaining the foundations of public health: Island infrastructure

Learning from the past - 'Contagion, dirty water and filth in the streets'

On the mainland

In the nineteenth century, as populations grew, there were serious problems of poor sanitation and lack of drainage, filth in the streets, unclean water and damp, overcrowded and poorly ventilated houses. As a consequence, infectious diseases or 'contagion', as it was called at the time, took many lives, reducing average life expectancy to 19 years in some UK towns.

It is 160 years since the introduction of the first public health legislation in the UK, which instigated the genesis of the drainage, waste and water services and the improvements in housing conditions that have led to contemporary hygiene standards. The improvements in infrastructure were achieved through leaders of the time being outspoken about the problems and championing effective solutions.

These solutions always depended on departments working collaboratively; for example, the aptly named Thomas Fresh, the first Inspector of Nuisances in Liverpool, started *'a daily communication between the town clerk, the medical officer of health, the borough engineer, the head constable and the inspector of nuisances who mutually acted upon each other's reports in carrying out their respective duties.'*

In Jersey

In Jersey the situation was similar. In 1889 Dr Paul Chappuis, the Medical Officer of Health, wrote in his annual report of *"the continuing problems of unhealthy odours shed in various neighbourhoods of the town, appearing to originate from the sewers."* He commissioned a plan of the sewers and 'big and small streams' in the Island. He concluded that these streams, which were in part also used as sewers, were the source of the odours. The systems for the disposal of sewage were insufficient to prevent sewer gas from travelling into the properties close to these streams, through un-trapped pipe-work and poor structural repair of the drainage system. At that time the drainage system did not stretch to all premises in town and was almost nonexistent in the rural parishes.

Although there were a number of laws relating to sanitary regulation of ships and vessels at the time, the 'Loi sur la Sante Publique 1934' or 'Public Health Law' set up the first Public Health Committee on the Island and charged the Committee and the Constables of the Parishes with powers to deal with 'accumulations of manure, or other refuse or filth, insanitary premises, overcrowding and the suppression of workshops, factories or salubrious trades ... a danger to the health of the neighbourhood or of those who work there.' It also, for the first time, made it a requirement for all new premises to be provided with sanitary accommodation and connections to mains drains.

In the 21st century, the Jersey Medical Officers of Health reports will major on deteriorating modern lifestyles which are widening the Island girth, causing cancer, and precipitating an epidemic of chronic diseases such as diabetes.

It would be a mistake, however, to confine our old and overburdened Island infrastructure underground: out of sight and out of mind. Such a lapse in attention could see a return of past public health problems, such as infectious diseases and foul odours, which we thought we had confined to the history books.

Island infrastructure needs today and into the future

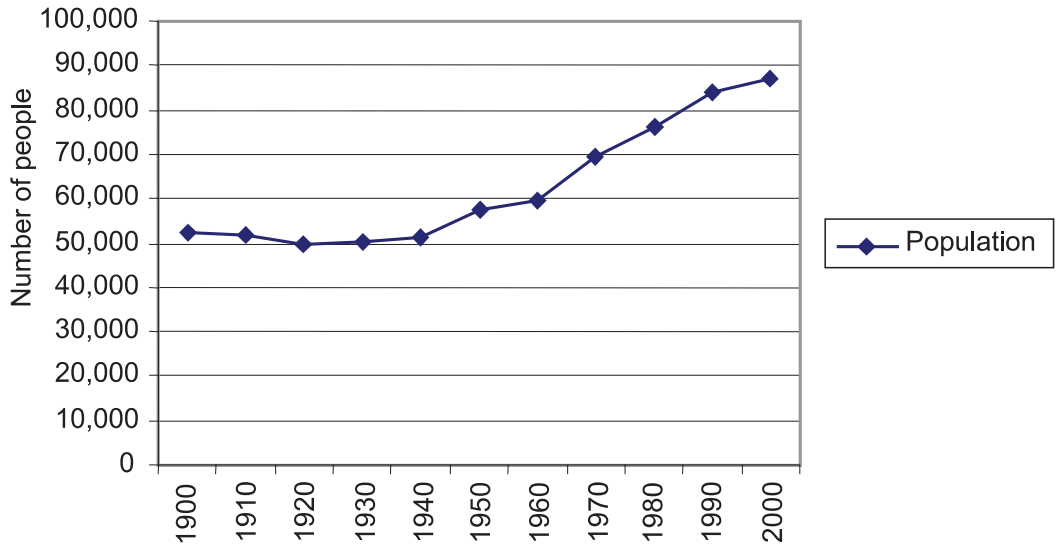
The last forty years have seen a significant increase in the size of the Island population bringing with it unprecedented, increasing demands on the Island's infrastructure *(figure 27)*.

Modern trends in packaging of goods, personal hygiene and washing appliances are adding to the strain for waste disposal. There are increasing volumes of solid waste from packaging which go to the Bellozanne incinerator to be burnt. The greater use of technology in everyday life means increasing volumes of clean water used and waste water produced for disposal and treatment. More people are using more water to run their dishwashers and washing machines and taking daily baths or showers. The sewage plant at Bellozanne is subsequently struggling to cope with demand and meet standards for disposal of liquid effluent.

The transport infrastructure has a significant impact on our lives. Accidents cause disability and wreck lives, and increase the burden on the health service. Traffic is a particularly serious issue for people who live near main roads: exhaust fumes pollute the air and vehicles generate noise and dust from the attrition of roads and the wear on brakes and tyres.

What was once a key feature in improving public health is now more likely to contribute to our problems rather than to solve them. The incinerator at Bellozanne was built to dispose of the Island's solid waste. The incinerator is now thirty years old; designed to deal with volumes of material long since exceeded. When commissioned, the plant achieved a significant improvement in the disposal of the wide variety of the Island's waste. Its tall chimney provides high level discharge of emissions aimed to disperse pollutants and prevent their build-up at ground level and the potential ill effects on health. By today's standards, however, the Bellozanne incinerator is failing. It remains the only non-conforming plant of its type left in Europe, emitting relatively high levels of pollutants into the atmosphere. This failure to meet European standards and failure to cope with the Island's volume of waste, compounded by costly mechanical failures, means that a more appropriate and sustainable waste management solution is long overdue.

Figure 27 **Population growth during the twentieth century**



Source: Public Health

In 2006, the States agreed a new strategy to deal with solid waste which included proposals for increased recycling, a replacement plant for Bellozanne and a new process for composting. There has been a delay in implementing the strategy as political debate has continued about the type of technology to be used and the site and scale of the new plant. This has left us with significant public health concerns, not only about air pollution but also the possibility that the current incinerator will fail, which would result in the stockpiling of municipal solid waste (the most intractable portion of waste). This could have serious consequences, with the risk of contamination of water supplies, attracting pests and vermin and causing infectious diseases.

To address these concerns, officers from Transport and Technical Services and Public Health have joined forces to find temporary solutions to deal with the increasing volumes of material now accumulating as a result of the inadequacies of the current plant.

Source: Public Health

Bellozanne; the twilight years

Composting

The composting plant at La Collette has been the subject of many complaints about smells from people living within the Havre des Pas area. These smells escape into the air as the current process is an open windrow process. Long heaps of green waste are turned periodically to aerate the organic material to optimise its breakdown into compost. During this turning process the material can release odours which, depending on the wind direction, cause a nuisance to local residents.

This open composting process is not the best process for the Island because of the close proximity of residents and the exposure to the vagaries of the climate which prevent continued optimal conditions for breakdown of the waste. Although there are controls to manage the process, there will, nonetheless, always be odour problems as bi-products of the process are vented to the atmosphere whenever the windrows are turned or the material is loaded for removal from site.

There is an urgent need to upgrade the process to a closed process which happens inside a composting vessel which is in turn inside a building. This new system would remove nearly all the odour problems. It would also mean that the plant was no longer at the mercy of the elements such as excessive rain and high winds which hamper the effective operation of the process at the moment.

Source: Public Works

Composting at La Collette

Liquid waste disposal

The sewage treatment plant at Bellozanne is ageing and has been in operation since 1959. Over the years, treatment processes have been updated as the population has grown and as more stringent effluent standards have been required. The plant was initially built to deal with a lower total volume of liquid waste than it does today. It currently receives on average 33,000 cubic metres per day - a 36% increase since 1977.

This increase has occurred despite the many surface water separation schemes undertaken during that time which should have reduced flows.

The mains drainage systems work well in general, although in extended periods of inclement weather, the network becomes overburdened with surface water from combined drainage systems (where foul and surface waters are mixed together) and from ingress through leaking pipe work. The cavern under Fort Regent is designed to take up the excess from the town area and, when flows in the system return to normal, to pump back collected sewage into the works.

Whilst 85% of the Island is connected to mains drainage, properties in many rural areas of the Island rely on septic tanks and soakaways for sewage disposal. Waterlogged ground can result in these private disposal systems flooding, leading to possible contamination of land and nearby private water supplies. This brings with it the risks of infection to those who may be exposed to the untreated effluent. The programme to extend mains drainage to existing rural properties would be costly and at this time is not funded. New connections are being made for new developments as a requirement of planning permissions.

Source: Transport & Technical Services Department

Sewage treatment works at Bellozanne

Water supplies

Jersey Water supplies mains water to the Island. Currently approximately 86% of Island properties have a mains water supply, with the remaining premises having either private bore holes or wells or, in a small number of cases, roof rainwater collection systems.

As an Island with a long history of agriculture both from dairy farming and cropping, inevitably there are problems with runoff into surface and ground water supplies. Nitrates, and to a lesser extent pesticides and herbicides, are regular water contaminants, along with bacterial contamination from animal excrement. These contaminants have the greatest impact on private water supplies where borehole and well owners may not have the appropriate means to ensure that water used for human consumption is always safe and compliant with potable water standards. The contamination of Grands Vaux reservoir by the herbicide Cyanazine in January 2005, which resulted in the reservoir having to be taken out of operation and drained, is a stark reminder of the effect that polluting incidents can have.

Jersey Water draws 96% of its water supplies from the collection and storage of surface waters in reservoirs. It also derives groundwater from extraction from the sand aquifer at St Ouen's Bay and desalinates sea water. The water is purified and treated to transform these Island water sources into safe drinking water.

Ground water sources (or aquifers), which are already polluted to some extent with nitrates, largely from agricultural use, are an important natural reserve in Jersey. Identifying and removing contaminants from an aquifer is a costly and difficult process. In 2007 23% of water samples taken by Jersey Water from aquifers failed the nitrate level. This increase on previous years was attributable to the wet spring that the Island suffered. Currently the nitrates in the mains water supply are diluted by blending different water sources, or in exceptional circumstances by the introduction of desalinated water from the plant at St Brelade. It is important that the sources of nitrate pollution are minimised, or aquifer water may become non-potable, thereby reducing the volume of available water to the Island. Ensuring source protection of water supplies is the most cost-effective and environmentally sustainable way forward.

Traffic and transport

Jersey has one of the highest number of vehicles per head of population in the world and relatively little land area to drive them on. This causes a variety of problems including congestion, air pollution, accidents and an adverse impact on pedestrians and cyclists. Traffic exhaust fumes account for the lion's share of the Island's air pollution today. Through regular air-quality measurements, we have found that there are a number of hotspots of pollution in areas with dense and slow-moving traffic within St Helier town, and particularly inside the tunnel.

Within the Town Plan and the waterfront development proposals, the town area will be the focal point for expanding the built environment into the future. It is paramount that the implications for transport are addressed to avoid further traffic in densely populated areas. Without meaningful planning we could find ourselves exchanging the 'foul odours' and ill health of the 19th century for poor air quality and health problems resulting from traffic fumes in the 21st century.

Source: Transport & Technocal Services

Heavy town traffic

Recommendations

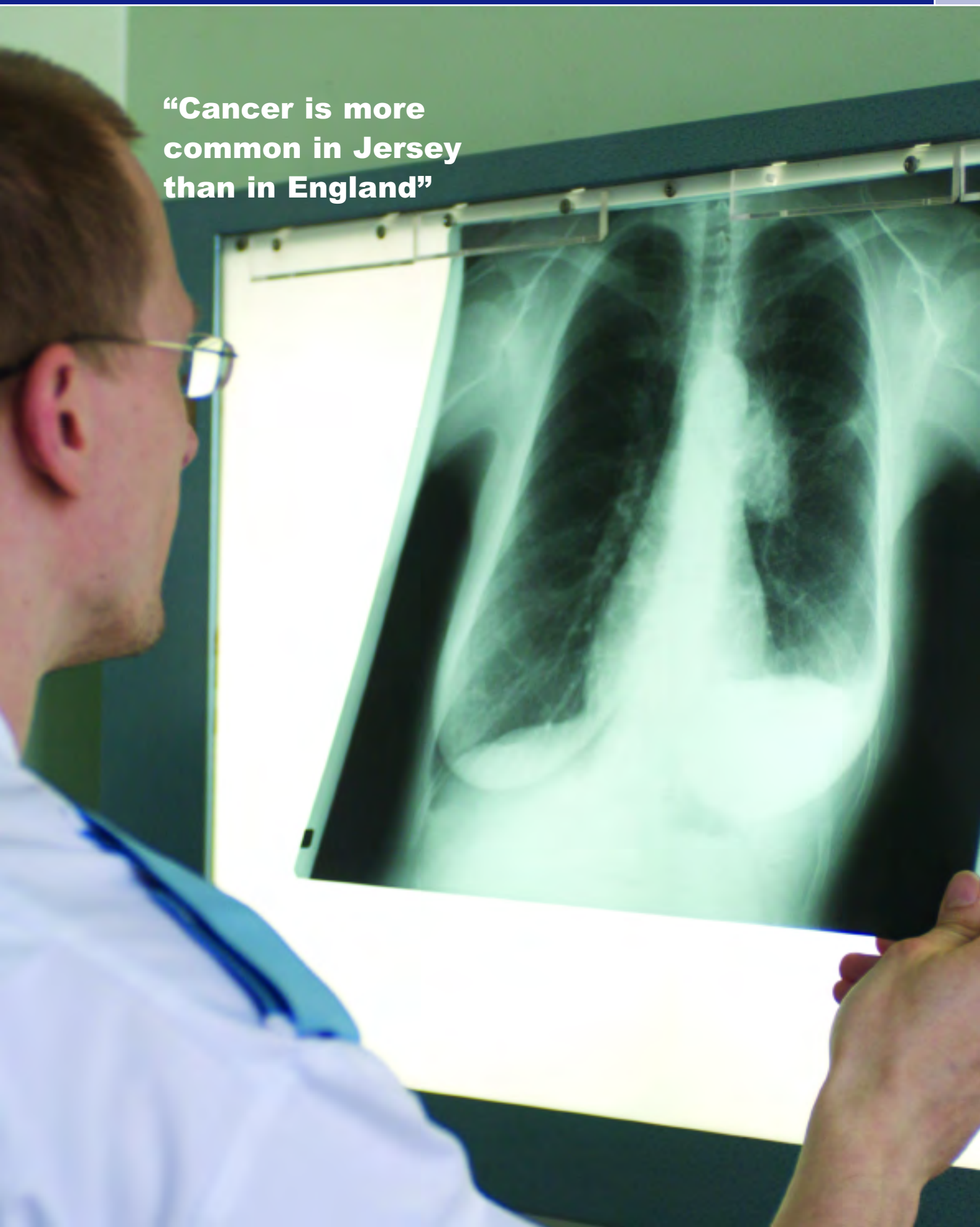
I recommend:

- implementing, at the earliest opportunity, all parts of the agreed States Solid Waste Strategy 2006 with particular regard to the replacement of the non-conforming Bellozanne incinerator plant
- the early formulation of an Islandwide liquid waste strategy to determine the appropriate level of improvement and extension to the mains drainage network, along with an appropriately sized and located replacement for the Bellozanne sewage treatment plant
- introducing Water Catchment Management Areas to ensure the protection and improvement of valuable ground water aquifers and surface watercourses used for public abstraction
- implementing and building on the Sustainable Travel and Transport Plan to address the complementary health aims to reduce traffic pollution and to get Islanders out of their cars and onto their feet and their bicycles.

References

1. For the Common Good - 150 years of Public Health. Environmental Health Journal, CIEH 1998.
2. Medical Officer of Health annual report 2007.
3. Environmental Health Practitioners: Key players in Public Health. CIEH 2007.
4. 1934 Loi sur la Sante Publique States of Jersey.
5. A Solid Waste Strategy for Jersey. Minister for Transport and Technical Services States of Jersey 2006.
6. Sustainable Travel and Transport Plan 2007.

Chapter 4 Health Care



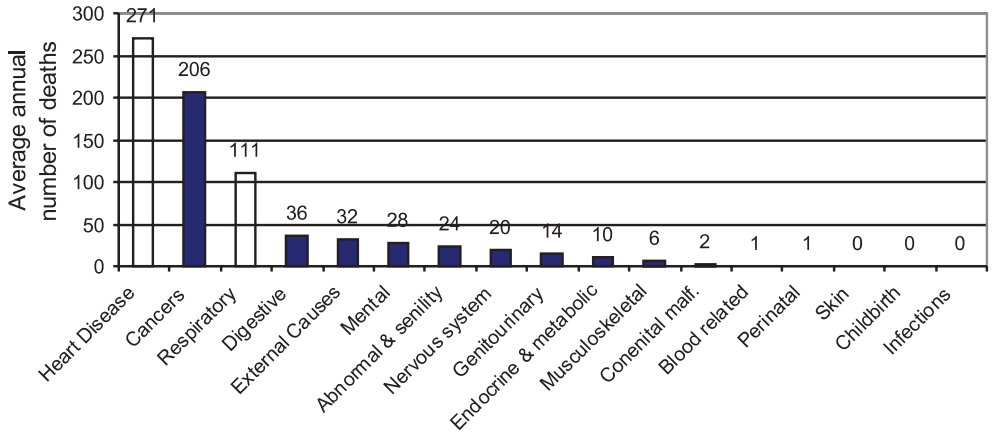
Beating cancer in Jersey

Many families in Jersey will be, or have already been, affected by cancer. On average around 880 new tumours are diagnosed each year; over half of these will be malignant and 206 will die. This makes cancer the second most common cause of death, accounting for over a third of all deaths in Jersey *(figure 28)*. On a more positive note, thanks to increasingly successful treatment, a substantial number of people are living with and beyond cancer.

Tackling cancer is an important public health priority. Some of the biggest killer cancers are almost entirely preventable. Smoking causes around 29% of Jersey cancers - add in a poor diet and too much alcohol and the chances of cancer escalate. Clearly, prevention is better than cure and the old public health mantra of 'lifestyle, lifestyle, lifestyle' has never been more important: we know that more than half of all cancers could be prevented by lifestyle changes.

The chances of surviving some cancers can be improved by effective screening programmes, picking up cancer early when treatment has the best chance of success. Prompt, effective treatment is very important and expected as the norm by 21st century patients. The cost of ever-improving state-of-the-art cancer care is a substantial and increasing burden on our economy. In the light of this we have redoubled our efforts to focus on measures to prevent cancer.

Figure 28 **Causes of death in Jersey**



Source: Public Health Intelligence Unit five-year averages 2002-2006

Patterns for Island cancer

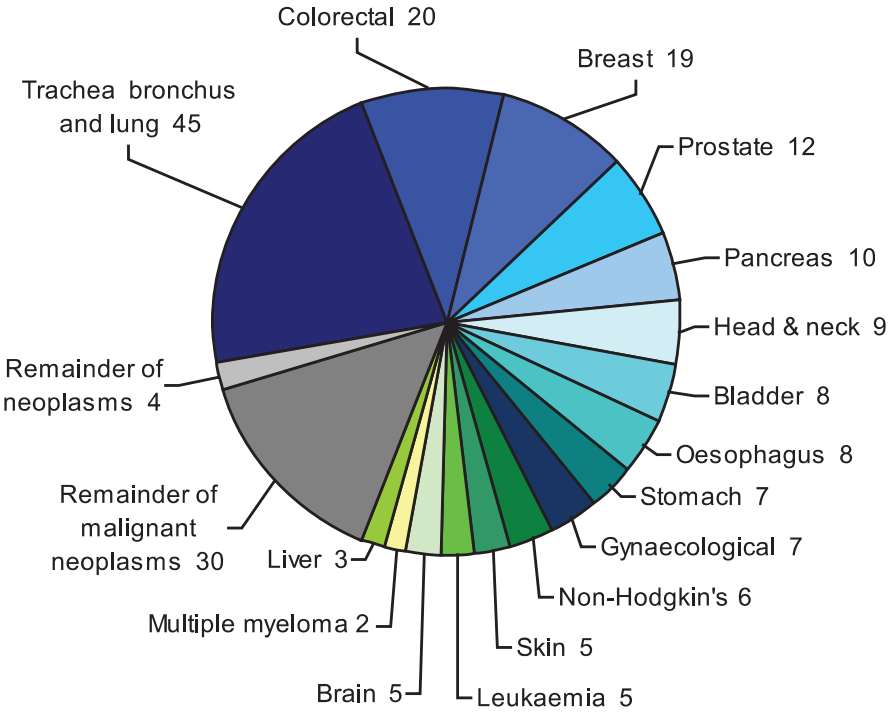
An effective approach on all fronts - prevention, early detection through screening and optimal treatment - requires first an understanding of patterns of cancer in our Island.

Common cancers in Jersey

Cancer is not one illness but many. The term cancer refers to abnormal, malignant cells multiplying out of control and invading and destroying normal body tissues. Cancers can occur in any organ or tissue in the human body and each has different causes, treatments and prognoses.

The commonest fatal cancer is lung cancer (including cancers of the windpipe - trachea and bronchi). It causes on average 45 deaths each

Figure 29 **Deaths from types of cancer in Jersey**



Source: Public Health Intelligence Unit five-year averages 2002 - 2006

year and represents 22% of all cancer deaths here *(figure 29)*. This is especially tragic, as most lung cancers are caused by smoking and so could have been prevented. It is estimated that about a third of ALL cancers - not just lung cancer - could be prevented by stopping smoking.

Bowel (colorectal) cancers are in second place, causing around 20 deaths a year in Jersey. Around 19 women die each year from breast cancer and about 12 men from prostate cancer.

Gender and age

Gender and age determine certain patterns of cancer occurrence. Men are more likely to die from cancer than women (108 men: 98 women per annum). However, breast cancer is still the major cause of early death for women.

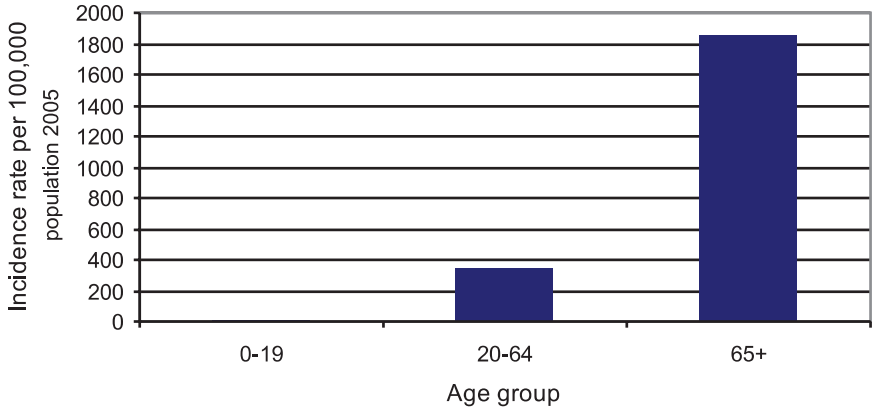
Older people are more likely to develop cancer than younger people *(figure 30)* so, with an ageing population, the challenge of cancer is ever increasing. A few cancers can occasionally affect the young such as leukaemia, lymphomas, sarcomas and brain tumours. For Islanders under the age of 75 years, cancers take the number one spot as the Island's biggest killer - above heart disease *(figure 31)*.

Looking at the types of cancer responsible for shortening life the most (deaths under the age of 75), the top three (lung, colorectal and breast) remain the same as for those over 75. The only difference in the 'top four' is the absence of prostate cancer.

This cancer is often more slow growing than others, and its incidence* increases with age. Four fifths of prostate cancers are diagnosed in men over 65 years old, and because the cancer is usually slow growing, natural life expectancy may not be affected. Many older men die 'with' rather than 'of' prostate cancer.

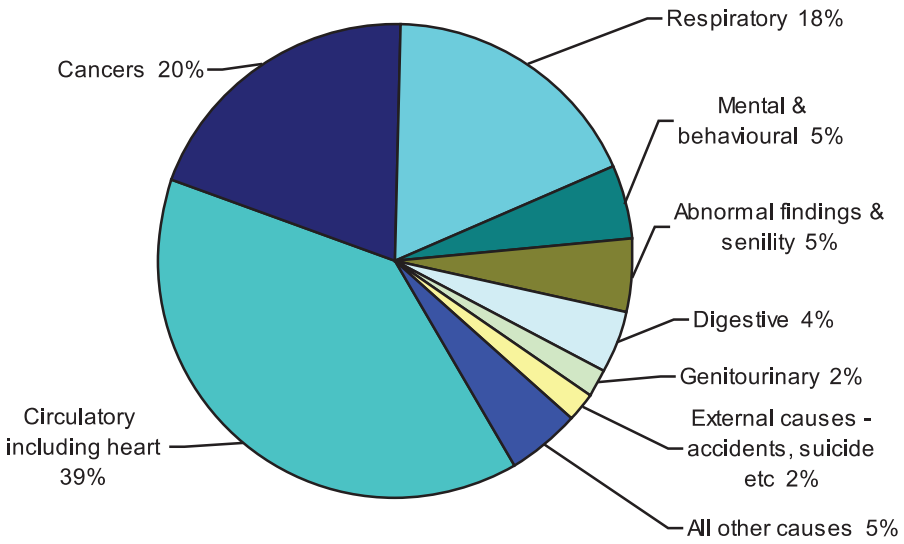
* the number of new cases diagnosed each year

Figure 30 **Cancer by age group**



Source: Public Health Intelligence Unit

Figure 31 **Main causes of premature death in Jersey**



Source: Public Health Intelligence Unit five-year averages 2002 - 2006

Cancer incidence - Jersey statistics compared

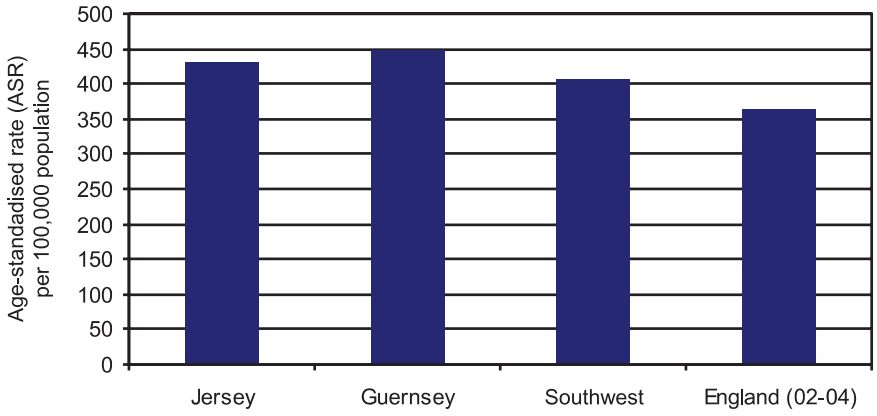
Cancer is clearly an important disease in Jersey, but how do our cancer statistics compare with national figures and with our near neighbours: Guernsey and the Southwest of England? We can answer this question with the help of the South West Region Public Health Observatory which runs a Cancer Intelligence Service (SWCIS). The SWCIS collects and collates cancer incidence data on behalf of Jersey and Guernsey, as well as for the Southwest of England. The figures need to be interpreted with an element of caution as we know that not all Jersey cancers are reported to SWCIS as yet. This means that Jersey cancer statistics may be a little worse than the figures we currently have available. We are working with Jersey hospital staff to improve the data further in the future.

For cancers overall, Jersey's incidence figures are similar to those for Guernsey and the Southwest of England but higher than for England as a whole *(figure 32)*. We have found, however, that there are considerable differences for particular types of cancer *(figure 33)*.

Head, neck and lung cancer

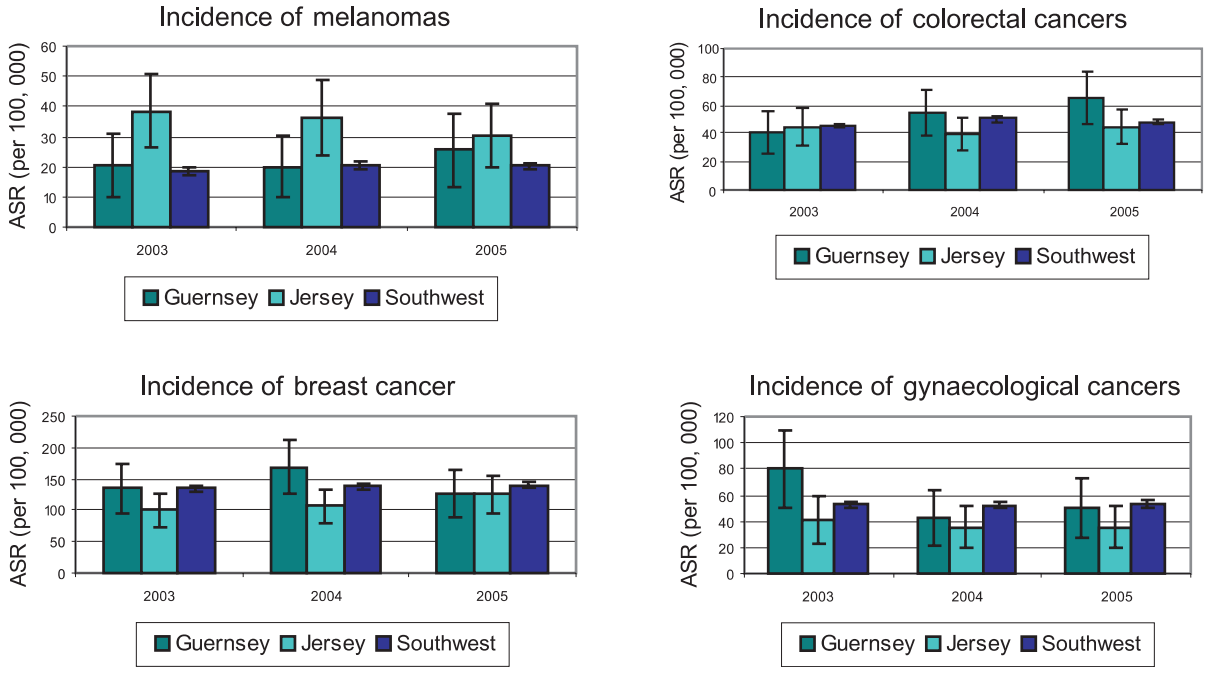
Both lung cancer and cancers of the head and neck are significantly more common in both Jersey and Guernsey compared to the Southwest Region. Our rates are similar to those recorded in the North of England and in Scotland. We share with these areas historically high rates of smoking and continuing extremely high alcohol consumption. Smoking is the leading risk factor for both these cancers. We can hope, therefore, for future reductions in these cancer rates as one of the many important benefits as a result of

Figure 32 **Comparing cancer incidence**



Source: Public Health Intelligence Unit 3-year averages 2003-2005 - all cancers

Figure 33 **Cancer differences for Jersey**



Source SWPHO: Channel Islands Cancer Registration Report 2007

Source: Jersey Evening Post

Smoking and drinking in Jersey, a pub before the smoking ban

less smoking, after the successful introduction of the smoking ban and other measures within Jersey's Tobacco Strategy. Heavy drinking particularly predisposes Islanders to mouth and throat cancers; the more so if they also smoke. Only by taking a wide range of measures to tackle heavy drinking within our society will we see reductions in these cancers. Radon gas is thought to be responsible for a small percentage of lung cancers. Radon is a naturally-occurring gas given off from granite rock, which can accumulate inside buildings. Adequate ventilation prevents the build-up of radon. Smokers are more susceptible to the effects of radon which means they could have a 'double whammy' risk of lung cancer.

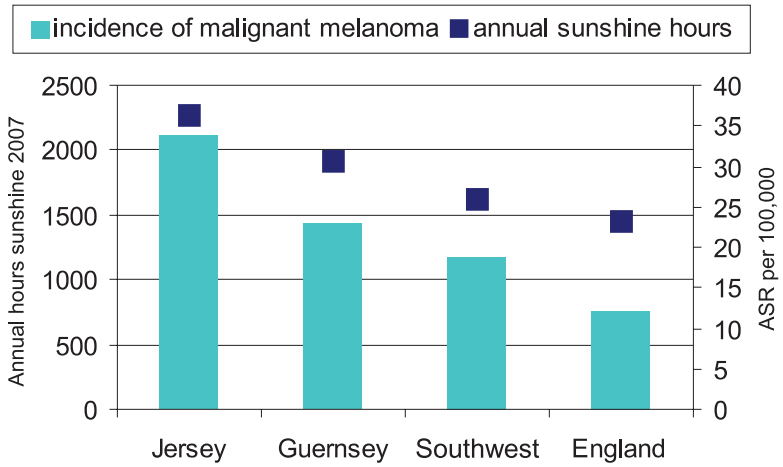
Skin cancer

The Channel Islands and Southwest England have high rates of skin cancer. With more coastline and more hours of sunshine than other parts of mainland Britain, this finding is not a surprise, as skin cancer can be caused by sunlight and sunburn *(figure 34)*.

In Jersey skin cancer rates are even higher than they are in Guernsey and Southwest England. We are particularly worried about malignant melanoma which is the most serious form of skin cancer.

We need a better understanding of why Jersey rates of skin cancer are so high, for example an analysis of the pattern of outdoor activity and sun exposure of people who develop malignant melanoma. This could help us to target prevention advice to those most in need of it. Part of the difference could be that in Jersey we are more assiduous in reporting skin cancers. We are fortunate in Jersey to have a full-time Consultant Dermatologist who makes accurate and prompt diagnoses and reports these cases to the SWCIS.

Figure 34 **Malignant melanomas and hours of sunshine**



Source: Public Health Intelligence Unit

Prostate cancer

Male genital cancer rates, which include prostate cancer, are also significantly higher in Jersey compared to Guernsey, Southwest England and England. Despite this finding, prostate cancer is not a common cause of death in Jersey and does not lead to significant loss of life under 75 years of age. Prostate cancer is more likely to occur in older men, will grow slowly and may not necessarily affect general health. Researchers have found no evidence that picking up lots of cases of early prostate cancer makes any difference to the numbers of men dying of the condition.

Campaigners have sought a screening programme for prostate cancer, which the UK's expert National Screening Committee does not recommend. When considering a new cancer screening programme, the committee evaluates the proposal against well-established criteria. In outline, these are:

- is it an important health problem?
- is there a safe, reliable and acceptable test?
- is the natural history of the condition well understood?
- is there an early or latent phase of the condition?
- does identifying the condition early lead to better treatment outcomes?
- is there a suitable and effective treatment?

For prostate cancer, only the first condition is met i.e. it is an important health problem. With regard to a suitable test, the only one currently available for prostate cancer is the prostate specific antigen (PSA) test. Unfortunately testing for PSA is unreliable and unsuitable as a basis for population screening. It has a high false positive rate which means that if 100 men have a 'positive' PSA level, on further investigation, 75 of them would not be found to have prostate cancer after all. This causes unnecessary anxiety for men and can lead to unnecessary, uncomfortable and intrusive tests and interventions which may not prolong life and may reduce quality of life. Perhaps more importantly, this test cannot be used to rule out prostate cancer as one in five men who have had prostate cancer diagnosed have a normal PSA level.

The question of screening for this cancer remains controversial. Perhaps the most important reason why a population screening programme is not recommended that treatment options are not clear-cut. Major international clinical trials are underway, but it isn't yet clear which type of treatment - radical surgery, radiotherapy or 'watchful waiting' - is the best option. Men considering their risk of prostate cancer and thinking about examinations and tests should first have access to clear information about all the pros and cons. Based on this information, they can make an informed choice.

Breast cancer

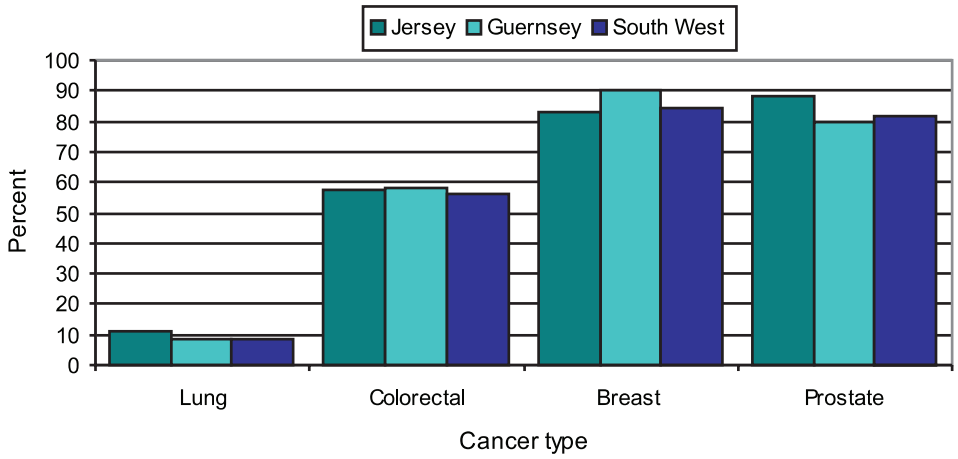
The incidence of breast cancer in Jersey is similar to that in Guernsey and Southwest England, with an increase in breast cancer in each of these areas in recent years. This is partly due to breast-screening programmes diagnosing breast cancer early. Treatment of breast cancer can be very successful and yields the best results when these cancers are detected early through screening. Breast screening meets all the criteria for an effective screening programme. We know, however, that our coverage of women in Jersey who are eligible for breast screening is low. We have been making every effort to improve this; however, there is as yet no robust means of identifying women in Jersey reaching their 50th birthday, so that they can be contacted and invited for their first mammography examination and subsequently be recalled. We have been working on a new health-screening database which has identified some women not yet participating in breast screening. We have contacted these women, invited them for an appointment and many have had their first screen. A small number of cancers, which otherwise might have remained undetected and untreated, have already been diagnosed as a result of this work.

In line with new UK recommendations, we are considering extending the screening programme to start with younger women aged 47 and we already offer screening beyond 70 up to the age of 75. So, for the older age group, Jersey is already ahead of new UK recommendations which are to offer breast screening up to the age of 73.

Surviving cancer

Once diagnosed as having cancer, Islanders survive on average for a similar length of time to residents of Southwest England *(figure 35)*. Five-year survival rates are similar in Jersey to those observed in England, and are: breast cancer (85%); prostate (85%); colon (55%) and lung cancers (9%). This suggests that Islanders receive, on the whole, equally good treatment for cancer as our mainland neighbours. Survival rates can appear artificially prolonged when a diagnosis is made at an early stage of a cancer which may be very slow-growing e.g. for prostate cancer.

Figure 35 **Five-year survival with cancer - Jersey compared**



Source: Public Health Intelligence Unit

In conclusion - key cancers for action

Lung cancer remains one of our biggest cancer challenges, with a relatively high incidence, high mortality and poor survival rate. This is likely to be a legacy of past availability of cheap cigarettes. Our very high rate of head and neck cancers are also likely to be the consequence of smoking; the odds of developing this type of cancer are all the higher when people also drink a lot of alcohol. The continued success of the Jersey Tobacco Strategy plus a new 'higher gear' for the alcohol strategy will be paramount if we are to address these cancers in Jersey.

Survival rates are best, as is the chance of being cured of breast cancer, when it is detected as early as possible by mammography screening. The fact that breast cancer still causes around 100 premature deaths each year in Jersey highlights the need to use every available means to increase the coverage for breast screening through introducing an effective and efficient health-screening database and, in doing so, save lives.

Skin cancer, including malignant melanoma, has a higher incidence than we would expect in Jersey, probably related to outdoor lifestyles and a good diagnosis service. It is a cancer that can be treated effectively if caught in time. We would like to understand more about the pattern of incidence of this cancer to help effective targeting of prevention messages.

Colorectal (bowel) cancer is in the top five cancers causing premature death in Jersey for both men and women. The logistics of setting up a screening programme are currently under consideration.

Recommendations

I recommend:

- pursuing all possible measures to further reduce smoking and harmful drinking in Jersey
- setting up a new Jersey Cancer Strategy Group to improve understanding of local cancer patterns and outcomes, and to agree actions to improve prevention, early diagnosis and access to effective treatment
- redoubling efforts to improve coverage of existing breast and cervical screening programmes through improving the health-screening database
- reviewing the evidence on the most appropriate and effective approach to colorectal (bowel) screening, with a view to introducing a programme for Jersey.

References

1. Cancer Reform Strategy, National Health Service, December 2007.
2. An epidemic of prostate cancer associated with PSA testing, SWPHO, poster presentation, SW region public health scientific meeting 2005.
3. National Institute for Health and Clinical Excellence (NICE) http://www.nice.org.uk/guidance/index.jsp?action=download&o=39527.
4. National Institute for Health and Clinical Excellence (NICE) http://www.nice.org.uk/guidance/index.jsp?action=byID&o=1192.
5. Channel Islands Cancer Registration Report. December 2007. Incorporating 2003-05 data. Cancer Intelligence Service, South West Public Health Observatory, Bristol.
6. Newly diagnosed cases of cancer and directly age standardised incidence rates per 100,000 population: selected sites by sex and country: United Kingdom 2002-2004.
7. www.cancerscreening.nhs.uk/prostate.
8. Cancerbackup.

Depression and anxiety - common problems

Introduction

Mental illness is one of the biggest causes of misery in our society. It is estimated that more than one in six people of working age suffer from mental illness at any one time and mostly with depression and/or anxiety. This can keep people off work for lengthy periods. Given the prevalence and importance of these conditions, we feel they deserve our attention to analyse the nature of the problem in Jersey and to propose evidence-based solutions to help both individuals and the Island's economy.

The financial burden of mental health

In England

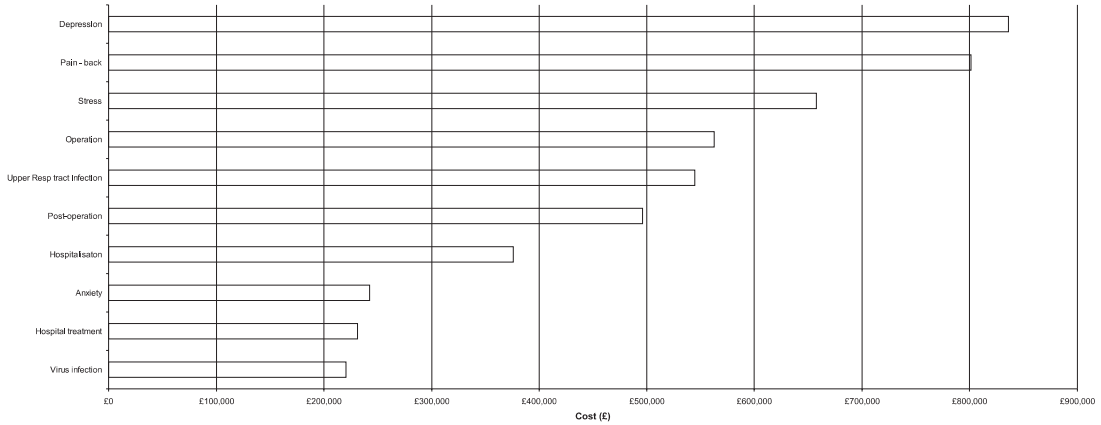
The financial burden of adult mental health problems is immense. In England 33% of new benefit claims are for people with mental health problems, especially among younger people and women. This proportion has tripled in the last two decades. Current English data suggests that:

- the annual cost to society of mental illness is £77.4 billion (2004)
- the cost of mental health problems to the National Health Service (2004/05) is in excess of £4.5 billion
- mental health problems account for around 60 million lost working days per year
- the cost of work-related mental health problems is around £23.1 billion per year
- lost employment accounts for 37% of the total cost of mental health problems in England.

In Jersey

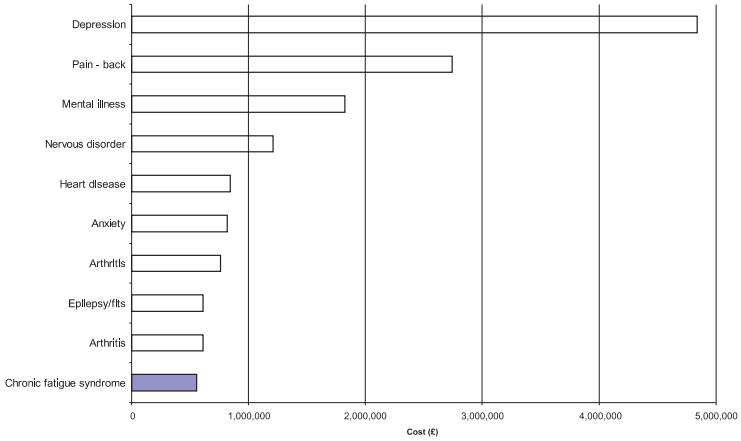
This picture is replicated in Jersey where mental health conditions account for 46.8% of all claims made for both Short-term and Long-term Incapacity Allowance. In total 2,327 claims were made for Short-term Incapacity Allowance which equates to over £2,330,278 and 747 claims for Long-term Incapacity Allowance amounting to over £6,133,210 *(figures 36 & 37)*. Depression and anxiety are the most common mental health problems in Jersey and these are estimated to take up around one third of any GP's time.

Figure 36 **Short-term Incapacity Allowance paid in Jersey in 2007**



Source: Jersey Employment and Social Security Department (E&SS)

Figure 37 **Long-term Incapacity Allowance paid in Jersey in 2007**



Source: Jersey Employment and Social Security Department (E&SS)

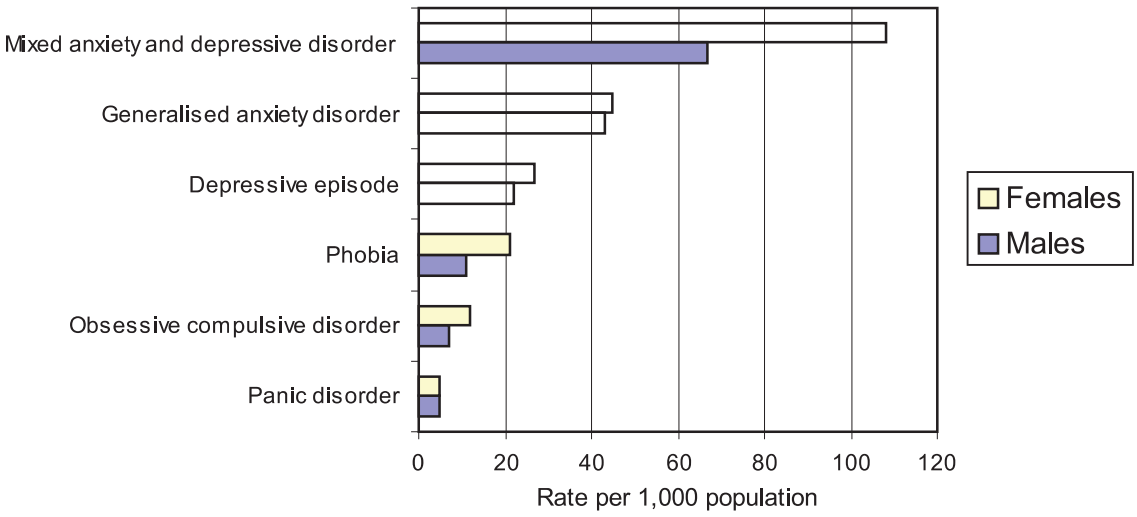
The cost of mental health conditions in providing health care in Jersey is considerable. Taking into account patients' payments, Social Security co-payments, the cost of medicines and the cost of hospital and community care, we estimate that the figure each year could be around £7.9m.

A silent epidemic?

While depression and anxiety are very visible to us through Social Security claimants, these individuals represent the tip of the iceberg of the true number of people who are suffering within the Island community. In the Jersey Annual Social Survey (2005) we asked Islanders to assess their own health using the General Health Questionnaire (GHQ12) which measures a person's health and wellbeing, including quantifying mental health problems. A GHQ12 score of four or more can identify a possible mental disorder. 18% of the Jersey population score more than four, which is a slightly higher percentage than for England (13%).

Depression and anxiety are the most common mental health disorders in Great Britain *(figure 38)*.

Figure 38 **The national prevalence of mental health disorder**



Source: www.issa.int/pdf/GA2004/2howard

People facing socio-economic disadvantage* are more likely to suffer from depression and anxiety. Sufferers who are poor stand a worse chance of making a recovery than more affluent sufferers.

* People with unskilled occupations or who are unemployed, who lack formal qualifications, who are renting accommodation from a local authority or housing association, who are living alone, or are separated or divorced.

What needs to be done?

To combat the high degree of suffering caused by anxiety and depression and the loss of productivity to the Island economy, action is needed by individuals, by service providers and by society as a whole.

Reducing social stigma

The stigma of mental illness can create barriers for sufferers, and previous sufferers, to employment and social interaction. The National Social Exclusion Unit report (2004) suggests that there should be a sustained programme on stigma and discrimination to challenge negative attitudes and promote awareness of people's rights.

A stepping stone to help sufferers return to work could include vocational work schemes, similar to sheltered employment for people with physical disabilities. This could lead to reintegration into the community; giving people with mental health problems a real chance of sustained paid work and an opportunity to take part in the local community, enabling them to lead fulfilling lives. The HSSD are working with local charities such as Jersey Focus on Mental Health to achieve this.

Housing

In last year's report Our Island, Our Health 2007, we highlighted the effect of poor housing on health. Noisy and/or overcrowded homes predisposed their occupants to depression and anxiety. Taking these housing problems seriously, and tackling them, could help reduce depression in the Island.

Treating depression and anxiety

Around 50 years ago there was not much that could be done to help a person with a mental illness beyond improving their social environment. This is no longer the case, however, as anti-depressant drugs and, more recently, the development of psychological (talking) therapies, have transformed the prognosis for sufferers. The National Institute for Clinical Excellence (NICE) have produced guidelines for the best way to treat depression and anxiety. People who receive treatment within 18 months of diagnosis are twice as likely to recover as people not receiving treatment. NICE guidelines also point out that, for many patients, psychological therapy is as effective as drug treatment for many common mental illnesses.

NICE recommends a stepped care model for diagnosing and treating depression *(figure 39)*. This means treating mild depression in the primary care setting and treating patients with more severe depression through specialist mental health services. NICE recommends a similar approach for anxiety. This model of care requires clinical psychologists, specialist mental health practitioners and primary care mental health workers.

The Jersey Psychological Assessment and Therapy Service

The Jersey Psychological Assessment and Therapy Service is based at St Saviour's Hospital and led by Consultant Psychologist Dr Tracey Wade. Dr Wade and her team offer assessment and treatment for people with depression and anxiety. The service aims to promote and maintain the psychological health and wellbeing of the people of Jersey through applying psychological skills.

There are two levels of therapy service for varying degrees of depression:

Level one is a self-help programme which helps clients to learn new skills and to use tools to help them to overcome a variety of difficulties that they may have. The client is empowered to find solutions and make changes that will make a positive impact on their current situation. Clients could be offered computerised cognitive-behavioural therapy*(CCBT) and/or self-help within a group of other clients.

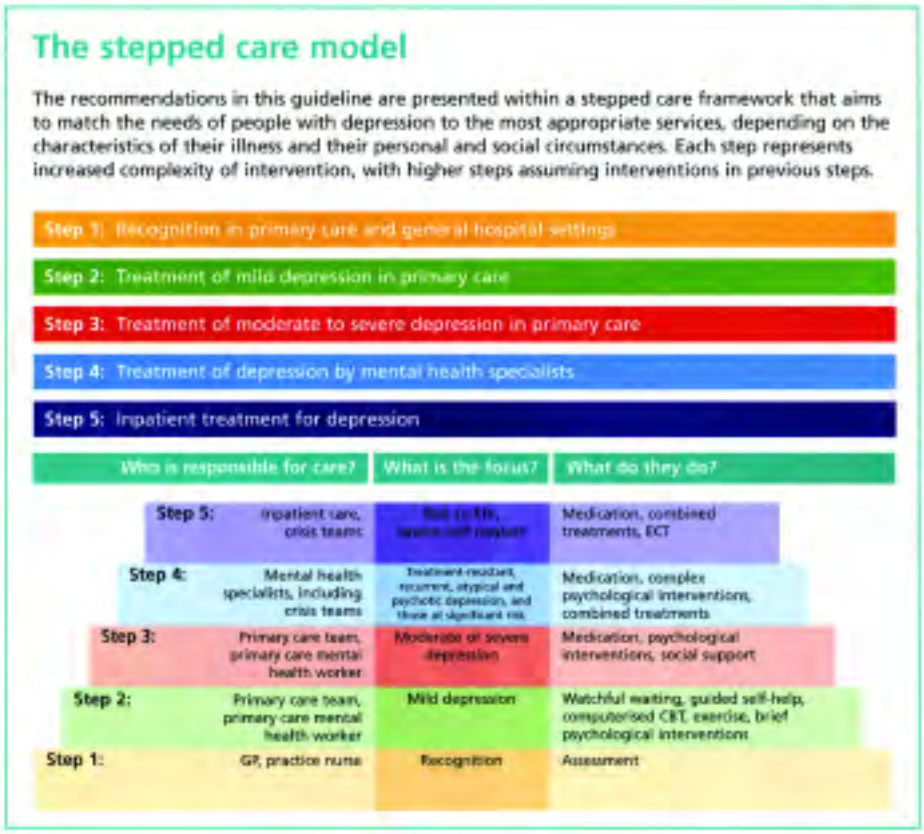
Level two includes one-to-one consultations and cognitive-behavioural therapy**(CBT) and possibly other psychological therapy programmes. Individuals are assessed during a one-hour consultation and treatment, if required, is offered. The emphasis for assessment and treatment is to include the client in the process as much as possible and therefore gain their commitment to realistic goals for their therapy. The number of sessions offered will be agreed with the client at the start of treatment; this usually comprises around six to eight.

Health care professionals, typically GPs (80%), refer patients to both these therapy services via a 'prescription' for the self-help programme (level 1) or a letter of referral to access more intensive therapies (level 2). Demand for these services is high, which is not surprising given the large number of Islanders suffering from depression or anxiety at any one time. Clients have to wait to be assessed and treated. People are currently having to wait for five months, on average, before they receive treatment, and will usually be unable to work during this period.

* Computerised Cognitive-behavioural therapy (CCBT) is cognitive-behavioural therapy delivered using a computer. CCBT may be in addition to or instead of sessions with a therapist. Before someone starts using CCBT it's recommended that they are assessed to make sure the treatment is suitable for them, and they need to be given support in using the programme. CCBT is not suitable for an individual with more severe symptoms of anxiety or depression who needs more intensive treatment and support from healthcare professionals.

** Cognitive-behavioural therapy (CBT) helps a person to recognize his or her own negative thought patterns and behaviours and to replace them with positive ones. Used both with and without medication, cognitive-behavioural therapy is the most popular and commonly used therapy for the treatment of depression. A major aim of CBT is to reduce anxiety and depression by eliminating beliefs or behaviours that help to maintain problematic emotions. CBT generally lasts about 12 weeks and may be conducted individually or in a group. There is evidence that the beneficial effects of CBT last longer than those of medication for people with panic disorder, obsessive-compulsive disorder, post-traumatic stress syndrome and social phobia.

Figure 39 **NICE service model for treating depression**



Source: National Institute for Clinical Excellence

An improved model of care

The current Psychological Assessment and Therapy Service needs to be developed so that it can improve upon its service delivery to primary care. This would help to ensure that people with depression and anxiety receive prompt treatment, recover quickly and get back to work. This branch of the service would need to be coordinated and supervised by a clinical psychologist and delivered by primary mental health care workers attached to GPs' surgeries. From a pilot study carried out in Jersey during 2006/07, it seems that there is demand for this sort of service. We estimate that there could be circa 1,420 patients who might benefit each year. Of these, the majority - 781 (55%) - would require brief interventions, whilst a further 639 (45%) would require medium or longer-term interventions.

For more complex cases specialist therapists would give more in-depth treatment. As a result of the increased input into primary care services these patients could be treated more quickly and without delay.

Recommendations

I recommend:

- developing vocational employment services as a stepping stone back to work for those who have suffered from mental illness
- developing the Psychological Assessment and Therapy Service so that it is able to offer prompt assessment and therapy to those suffering from mild/moderate depression and anxiety, in line with NICE guidelines.

References

1. Layard, R. (2004) Mental Health: Britain's Biggest Social Problem available at http://www.strategy.gov.uk/downloads/files/mh_layard.pdf.
2. Office for National Statistics (2000) 'The Psychiatric Morbidity Survey'.
3. Technical Commission on Social Security Research (2004) Trends in disability benefit recipiency rates in post-industrial societies: Preliminary results of an International Social Security Association research project available at www.issa.int/pdf/GA2004/2howard.
4. Jersey Annual Social Survey (2006).
5. Office of National Statistics (2000) 'Mental Health' available at www.statistics.gov.uk/CCI/nugget.asp?ID=1333&Pos=6&ColRank=2&Rank=576.
6. NICE (2004) Management of Depression in Primary and Secondary Care.
7. The Social Exclusion Unit (2004). 'Mental Health and Social Exclusion'.

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