STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

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SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Suicide

HANSARD

Douglas, Friday, 8th March 2019

PP2019/0071 **SAPRC-SU, No. 1/2018-19**

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Published by the Office of the Clerk of Tynwald, Legislative Buildings,
Finch Road, Douglas, Isle of Man, IM1 3PW.

Members Present:

Chairman: Mr D C Cretney MLC
Mr M J Perkins MHK

Apologies
Ms J M Edge MHK

Clerk:
Mr J D C King

Assistant Clerk:
Mr B Awkal

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Standing Committee of Tynwald on Social Affairs Policy Review

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The Committee sat in public at 2.45 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas

[MR CRETNEY *in the Chair*]

Procedural

The Chairman (Mr Cretney): Welcome to this public meeting of the Social Affairs Policy Review Committee, a Standing Committee of Tynwald.

I am David Cretney MLC and I chair the Committee. With me is Mr Martyn Perkins MHK.

If we can all ensure our mobile phones are off or on silent so that we do not have any interruptions.

Unfortunately, Ms Julie Edge, who is another Member, is not able to be with us this afternoon.

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but not emergent policies as deemed necessary of the Committee of the Department of Health and Social Care, the Department of Education, Sport and Culture and the Department of Home Affairs.

Today we will be hearing evidence as part of our inquiry into suicide, which follows on from two reports which we have made to Tynwald in relation to mental health issues.

EVIDENCE OF
Mr John Kermode
of Psychology.im

Q1. The Chairman: Today we welcome Mr John Kermode and we would like to invite you to make any opening statement you may wish but also to start off by just setting out what qualifies you to give evidence on the topic.

Mr Kermode: Certainly.

My background is as a psychologist working in education with children and families.

I have got a Bachelor of Science degree awarded by the University of Reading, a Master of Science degree in educational psychology from the University of Newcastle-on-Tyne. I am a qualified teacher, I am a registered practitioner psychologist and can use various restricted titles such as chartered psychologist, educational psychologist, chartered scientist.

I am an associate fellow of the British Psychological Society, I have got a full membership of the Division of Educational and Child Psychology for the British Psychological Society. My father used to say, 'How do you manage to fit through any doors because your head is too big,' sorry about that.

I am a retired civil servant who used to work for Education and I wonder if a declaration of interest might be of help into this as well before we start.

Q2. Mr Perkins: This was Education on the Isle of Man, was it? *(**Mr Kermode:*** Yes.) Yes, okay.

Mr Kermode: I retired some 10 years ago from working for Education when I was managing the Special Needs and Psychology Service and maintained a practice as an educational psychologist. I have maintained in registration the practice as a psychologist since retirement and I have qualified as a family mediator and I practice family mediation with a colleague under the trading name of Logis Family Mediation.

Until 15th February this year when my 10-year appointment came to an end, I held an appointment as a court of protection visitor within the UK. And for the last three years I have been employed as a sessional trainer by LEaD to deliver applied suicide intervention courses that are generally two days each about three times a year. I can track my services as a psychologist and family mediator and trainer through my own company Psychology.im Ltd.

I am also employed as a Cadet Force adult volunteer usually for two to three weeks a year teaching scuba diving to teenagers. I am a volunteer with St John Ambulance and the safeguarding lead for St John Ambulance on the Isle of Man. I am Chair of the Manx Family Mediation Network. I am Chair of the Independent Monitoring Board for secure home Cronk Sollysh on the Island and Deputy Chair of the Parole Committee for the Isle of Man, and recently elected Chair of the national preventative body for the Optional Protocol to the Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment for the Isle of Man. I am a director of the Isle of Man Health and Care Association, a charity registered in the Isle of Man.

I will be talking about programmes from Living Works, particularly Applied Suicide Intervention Skills Training (ASIST), but I have got no financial interest in Living Works other than my employment as a casual trainer for a few days a year through LEaD, but nothing directly with that itself.

You asked about my own background. My own background, particularly into suicide prevention is that as a student I was involved with the emerging student Nightline organisations which were students putting in self-help groups and self-help services themselves for young people that felt very isolated, and inevitably you ran into suicide. I trained and became a counsellor with the Reading Area Youth Counselling Service as a volunteer and I volunteered as what was called Festival Branch, which was a group of people that would rock up at rock festivals and other large events and pick up the distress, the unhappiness. We would run 24-hour shifts through a festival … and many of which were distressed or suicidal.

Coming back, I trained as an educational psychologist and came back to the Island. Before coming back I was a volunteer on a national telephone helpline service appealing to the suicidal and distressed. On the Island I trained volunteers for a time on a local branch.

For a number of years from 1980 on, when I came to the Island I was the only psychologist on the Island working with children and families. As I was approaching my exit routine from working for Government, I attended a suicide prevention workshop billed as the Applied Suicide Intervention Skills, which I was really impressed with as a combination of skills, as a good way of developing skills and I offered to train as a trainer for that. For a number of years I just volunteered as a trainer with the Department of Social Care to deliver that course because I thought it was an absolute cracker and very positive.

I wonder if it will be useful to tell you a little about the Applied Suicide Intervention Training –

The Chairman: Yes, please do.

Mr Kermode: – which is a two-day package and it is pitched very much at the community. It has taken people from the community, volunteers, interested people, those who have been

affected by suicide, as well as pitching at very experienced medical practitioners and staff working in the areas of mental health.

I asked how we were doing. We have trained something like 848 people on the Isle of Man onto this course. I personally have trained on 22 courses over the last 10 years. So we have trained probably about 1% of the population of the Isle of Man on suicide prevention.

The package itself, I describe it … part of my background is I will do regular resuscitation training and I will get out the Resusci Annie in the training and we will practice CPR and rescue breaths and defibrillator – it is partly to do with being a scuba diver and doing stuff in the background – but if I look back and if I ask a group of people in front of me, 'You've all done that. How many times in your life, in your career, have you had to use those skills? Now, how many times in comparison have you been in the situation where you have had to deal with somebody that is potentially suicidal, depressed and very down?' and almost everybody will say that latter one; that group of very depressed people you can encounter in your everyday life is something they encounter much more often than they need to do the full CPR.

So the ASIST is basically saying: well, how do we give people the skills to do first aid interventions at people at risk? How do we recognise which people that we may be dealing with in our everyday life are at risk? And ask the question about: is suicide the issue? If it is, how to help them stay safe for now so that they are engaged with the process of keeping them safe and making arrangements that we are both comfortable with that are going to keep them safe for a bit longer than that.

So that is it. The two-day package, 15 hours, gets very strong crits from the people who attend in terms of the quality of the course in terms of their awareness of people at risk, their preparedness to engage with somebody who might be at risk, and they feel that they have gained in competence to be able to help and support them should they be at risk.

I think it needs to be a community package into here, but it is not without difficulties. So that is the outline of the suicide … which I think I commend to you. I have to say that runs regularly and if it is a topic of suicide you are interested in it is very appropriate for yourselves, if you would be interested in that course. It is available through LEaD without cost, as it is to the community. It is a cracking background to the whole topic.

But it only really is going to work within an overall strategy for suicide prevention on the Isle of Man, and there are a number of difficulties. Over two years ago I was involved in working with a group on the Island's Suicide Strategy for the Isle of Man and that seems to have disappeared into the woodwork. I was trying to even get a copy of the final draft from two years ago and I could not get hold of that … not willing to release that to me, even though I was involved in that. I am not sure what the problem is because I cannot even find out what the problem is.

The Assistant Clerk: Excuse me.

Mr Kermode: But it is crucial. Yes.

Q3. The Assistant Clerk: Could you tell us the name of that strategy if you know it?

Mr Kermode: Yes, it was the Suicide Prevention Strategy for the Isle of Man and it had a number of really important points within it that made, in my mind, a lot of sense. It was looking at the background and trying to make key recommendations for us on the Isle of Man, about the context in terms of academic research of trying to make judgements as to: have we got a particular problem; how do we compare to a bigger population; how do we put together a strategic partnership for the Isle of Man; what would be the priorities for suicide prevention and the action plan?' A lot of the people there were strongly committed to the ASIST model, because we had known that and used it quite a lot.

But there seemed to be a whole range of things needing to happen in terms of: how do we reduce the risk of suicide in high risk groups; how do we try to tailor mental health approaches to high risk groups; how to approach better communication for those at risk; how to provide a background of data as to the effectiveness of what is going on; how to provide support to those left behind that have been badly affected by suicide and whether the support systems were sufficiently effective. All of those seem very strong. I was actually re-reading into some of the stuff from Living Works, which are based in Canada, which are the originators of the ASIST and other programmes and they have got a very good package of exactly what they describe as 10 pillars for a Suicide-Safer Community, and there was about –

Q4. Mr Perkins: Can we just go back to what factors actually commonly cause suicide, for a layman such as myself?

Mr Kermode: Yes, a whole range of stuff into there. One of the difficulties is although you can look at the demographics and say, 'What groups are at higher risk of suicide?' – so for example, veterinary surgeons, doctors, farmers, men of particular ages are at higher risk of suicide – it does not help you an awful lot, because if you have somebody in front of you who is a vet or a farmer it does not necessarily mean that that person is at greater risk of suicide. The key thing is to engage with them and say are they generating the flags, the concerns that would lead you to be worried that their mood seems very poor; that they seem to have difficulty engaging; that they are losing interest in things that they had that were important to them previously; are they having difficulty sleeping; are they obsessed by repeated worries about finances?

I suppose the message is that all of us could be affected by very bad periods in our life and generally, although some people will come out of the blue and will take their own life without any warning, most are known and most have a network around them afterwards that if they have taken their own life would say, 'I knew something was wrong. I wish I had been in the position to do something. I wish I had done something.' Something like ASIST does exactly that; it raises your confidence of asking the questions and of then … time to engage and do something about it.

We are not trying to be a mental health professional forever, we are just trying to do something that is going to keep the person safe for now. I think it works well in the context of an Island community to be able to do exactly that – to engage and see it as part of the things that we would do.

Q5. The Clerk: Do you think 1% of the Island is too small and more people should go through this?

Mr Kermode: Yes, I think we need to do it much more than that. I bet we have got more people with basic first aid skills than that on the Isle of Man and I think we should be doing more of this, quite honestly. Actually, the way it is going, it is not going in a good direction at the moment. When I started 10 years ago we had, I think, about eight or nine trainers drawn from paramedics, from the Isle of Man Prison, through Isle of Man Police, from Mental Health Services, from adult social work.

My phone has decided to go bleep and buzz. Let me just tell it to go away – I hope. Despite putting it on silent! I am sorry about that.

Now it is much more restricted. I am the only professional in to that and we have two other very competent trainers and we are not replacing people as they are being taken away by other exigencies within their own departments or by retirement and natural wastage. We are also not seeing as many people from the community coming into that, I think because they are just not aware of it. It has become much more restricted within there and it feels that it is withering rather than strengthening. Just as you refresh CPR skills periodically to keep them working, these

are skills you need to refresh every couple of years as well, I think, just to dust down and remember the principles, 'Come on, guys, we can do that.'

Q6. Mr Perkins: So what specific local features for the Isle of Man drives people to suicide?

Mr Kermode: Local features? Hard to tell because I am not seeing any of the broad data of that anymore.

One of the practical difficulties we are going to get is that – I do not know if you are aware but Coroner's Courts use very different criteria for a judgment of suicide than they do for most other eventualities. Until this last year the guidance would be that they must use beyond all reasonable doubt, and every other verdict in a Coroner's Court, apart from murder or unlawful killing, is on the balance of probabilities, so that skews the data.

There is also a tendency to be kind in many ways, that as well as that, you have got to be absolutely certain as a Coroner to go to a suicide verdict … you are into a position of saying that if there is any other explanation you are likely to try to protect, 'Perhaps it was an accident. Perhaps they did not intend to,' and the noisiness of the data and the difficulties of definition bedevils any judgment as to what the heck is going on and what the real pattern is.

People would typically say probably there are going to be three to five times as many actual deaths at people's own hands than a recorded suicide verdict because stuff like occasionally you get people driving off the roads or you will get people that have taken overdoses but it was not clear that they intended to, perhaps they made a mistake; and it could be, it is really hard to tell. But each one is a tragedy for them and the people round about, particularly from that. So I would find it really hard to answer that without getting into the detail with the Coroners of what is actually going on in the Island.

Q7. The Chairman: Did you say that the 'beyond reasonable doubt' thing had altered in the last year?

Mr Kermode: It has. There has been a case in the UK which went to the High Court and I think the Appeals Court, that suggested that the criteria ought to be on the balance of probabilities for suicide. I have not had a chance to talk to the Coroners of Inquest here as to know quite where we are up to in adopting that, but we are likely to find that that is going to really confuse data going forward, because you may not be able to rely on just the numbers, which bedevils the whole thing. (**The Chairman:** Yes.)

On the Island, because it is relatively small each year, some of the stats say perhaps we are getting about five to eight suicides a year. As it is so small, what the statisticians say is you get very noisy data, so that one year you might get a number and it looks like it is getting seriously worse, but it may be just part of the natural trend on very small numbers.

You also see strange effects and we saw this in the UK and Wales about four or five years ago, that with young people there was suddenly a whole rash of suicides or attempted suicides amongst girls and it almost became part of the strange freneticism of social media and press reporting that it suddenly … So trying to judge what works is a real wow …

One of things I like about the ASIST package is that it is very well researched, it has got a cracking background in terms of academic research for its content. It is well researched in terms of the effectiveness that it is having in a number of venues. It has got really good quality control. I get my choke chain pulled very regularly over it to say the evaluation said, 'You did not quite stick entirely to that session,' 'Yeah, fair enough.' So they really try to go at that and very strongly in terms of reports from the participants as to the stuff that has happened. So yes, I think it has got a lot going for it as a package that on the Island would fit in well within a strategy for us. But it should only be part of a strategy.

Q8. The Chairman: I got into trouble some years ago with the written media in relation to the reporting of Coroner's inquests, because obviously it is a public court and what is reported is free to be reported; however I was aware at that time that there is this thing where it is described that there can be copycat tendencies.

Any evidence that may –?

Mr Kermode: I was mentioning the Welsh thing from a few years ago and people were feeling very strongly that we were getting into that stuff. But I think that is just probably stuff we are going to have to live with and think about, 'Well, how do we get at groups?' One of the groups I think we really ought to be getting at more for something like ASIST training would be schools, school teachers and even sixth formers. We have had very little uptake into those groups over the 10 years that we have done. I suspect we have had perhaps no more than three or four teachers in that time. I do not control the publicity – that is run by LEaD – but I think we are missing something in terms of trying to get more impact into that.

Q9. The Chairman: It may be that their lives are more pressured than ever before as well.

Mr Kermode: Absolutely. There are lots of demands on people's time now. Everybody has got their own priorities.

Q10. The Chairman: Just following on from what I … do you think the media can influence someone to develop or progress suicidal thoughts, or not?

Mr Kermode: There is some wonderful stuff running at the moment, isn't there, on social media and the influence over young people? (**The Chairman:** Yes.) The latest one everybody was scratching their heads about and then starting to say, 'Well, actually was this real? Was this really happening or is it actually some very deficient advice by well-meaning organisations that has got zizzed up in the into schools, has got taken by everybody, and suddenly I have got friends talking to me about children or grandchildren suddenly getting anxious about that and you go, 'Oh God! How do you persuade the media to report stuff sensibly into here?' There may not have been an issue as of the end of last week at all. 'How do you judge? How do you make sense of this very confusing landscape?'

Q11. The Chairman: There is certain media that obviously is completely outwith the control of the Isle of Man as a jurisdiction where people could receive advice if they choose to. It appears to me that the operators of those social media outlets are being brought to task a little bit and hopefully will be a bit more careful about what is allowed.

Mr Kermode: Yes.

Q12. Mr Perkins: I think the Chief Constable mentioned that, didn't he, in his brief the other day, that they would actually be looking at social media with more of a scrutiny and taking action?

What percentage of people take their own lives that are suffering from a mental illness?

Mr Kermode: I do not have that data to me. I would have to research that. I am very happy to do some research into a background of that.

Q13. Mr Perkins: The reason for the question is if it gradually builds up rather than just comes out of the blue.

Mr Kermode: What can we say sensibly about that? It is getting some fascinating discussions. I am sure this will directly answer the question about is suicide a mental illness.

One of the things we challenge people on the first day of the course is what are their own views about suicide and what are their own attitudes and values about that. A surprising number are saying, 'I am into this because I am trying to prevent suicide; that I do not want people to unnecessarily take their own lives.' You can put in a wonderful challenge: what about then people who are going to things like DIGNITAS to end their own lives? That is suicide. Is that something that you deprecate as well? That produces some interesting stuff because many people would say that they would wish to be in charge of their own end. (**The Chairman:** Yes.) And is that suicide? Yes, I suppose it is, isn't it? But so many people who you would say have got entirely ordinary mental health would think and can contemplate about being in control of their own end.

It is not necessary. Most people with depression do not go on to take their own lives. A very small proportion of people with depression take their own lives. So it is more saying, well, okay, if you are dealing with somebody who is appearing very depressed are they actually thinking about suicide? Have they thought about it in the past? If somebody has made previous attempts of their own life they are at a higher risk of making future attempts. If they have got a history of mental health support there is a greater risk that they may present with suicide in the future. But again it is so individual that you can talk to some people who are very down and say to them … and I am sure you will talk to the Director of Samaritans later on; they will always ask the question about suicide at any contact you make. If you phone up and say, 'Could you pass a message to the Director of Samaritans … giving evidence,' I see in the same response: you will be asked the question, 'Are you feeling suicidal?' They will always ask the question.

Sometimes it is a very difficult question to ask that and sometimes people do not because they worry what the answer would be. I think it is generally a helpful question to ask when the people are presenting with some of the features that make you worried that they may be very down, in a very bad place, that nothing seems to work, when they are talking about everything being bleak and bad, how awful it is.

Often, just in my work still with kids or seeing others or as a family mediator, I will sometimes see people and say 'Everything's going wrong?' … for family mediation context where I am doing perhaps an initial meeting with the person. 'You are telling me that you are feeling very much a failure that this relationship has gone wrong. You feel you are isolated from your children. You see there is no point into trying to even fight back and try to do something about that. You tell me you cannot sleep. You are telling me that your work is seriously, badly affected, that you are living now in digs where you used to live in a house.' And asking that question then, I am really quite worried about this person but I need to ask the question. I say, 'Sometimes when people are saying that to me I worry that they are thinking that things are so bad that they want to take their own life. Is that how you are feeling now?'

A surprising number of the people you ask that will actually say, 'No, that's not what I thought.' But I do not think there is a risk in asking that question to people. I think it is a positive to say, 'Okay, it is not that but at least we are aware that that is a possibility and I need to have some concerns and care for you.'

So that is a very long and not direct answer to your question about mental health. Every one of us at times can have periods – and most of us have had times – when we have been very down that things have not been going well. For some people the concatenation of the various things, of the events and what those events mean to people may coincide into almost the perfect storm.

So going back to … sometimes where people divorce, it may be saying to them that, 'Divorce is absolutely fine. I'm free of the miserable 'b….' that I want … I can go and live my life.' Other people, the same event may say to them that, 'This is awful. I'm a failure. I can't make relationships. I'm useless.'

It is not the events but it is the interpretation of the events and while some people as part of the background may have issues that they find it difficult socially to interact, that has led to them not being able to cope well in a relationship, it is not necessarily the mental health issues, I think, that is part of that. It is just another of the factors one needs to be aware of.

I am going back, I was saying earlier on about the groups that are higher risk, most of us I think would think that the ones at higher risk are actually the ones with more ready access to the means to end their own existence rather than being a feature of the professions itself. (**The Chairman:** Yes.) So in many ways, although the demographics is interesting it is actually very little help when you are looking at the individual in front of you. It is that awareness of the individual and what you can do as a person to help them keep safe for now. 'I am not going to be the mental health worker forever, but I could try and at least do something here and now to help,' and that is one of the skills I think it is useful to give to people.

Q14. The Chairman: How about those that are left behind, because very often they have deep feelings of guilt of, 'Could we have done this? Could we have done that? There was no clue or whatever'? I have been contacted by people who very many years later have been subject or their family has been subject to … and they have still got guilt feelings.

Mr Kermode: Absolutely. I think part of a suicide prevention strategy, a suicide strategy, for the Island should also be about how do we look after those? How do we make it a bit easier for them? At every course one of the first things we do is we actually ask them quietly and they do a form that they give to us and we do not identify but we ask them about: have you been affected by suicide? Have you ever thought about suicide yourself? Have you ever acted on that? Unsurprisingly, in a group of 25-30 people several of those will have had thoughts of suicide or may have made attempts on their lives, or may have been very directly affected by suicide by somebody close to them.

You think, 'Whoa, gosh!' but actually we can do a lot to support them in to courses like that, because you say, 'Okay, that is where we are, but we can help you support other people in the future if that was something you would like to do. But we are never going to put you through an emotional mill on this.' But, yes, we do need as an Island to support people and sometimes we were recognising when we were having the discussions about a suicide strategy for the Island that the support services are not really working that well and how can that be part of the care for people?

Q15. The Chairman: Who was co-ordinating the suicide strategy?

Mr Kermode: It was being co-ordinated by Julie Benyon at Community Wellbeing Services and I know that she has produced … and it has gone into her management structure; I have no idea where it has gone to from there. (**The Chairman:** Okay.) But it has not yet emerged – not even smoke! So I think it would be good to find out what is going on there, (**The Chairman:** Yes, it would be.) because I think a basic strategy is a flipping good plan to me.

Q16. Mr Perkins: So putting aside the health services themselves, is there anything outside that you feel that the Island or the Government could perhaps influence to reduce suicide rates?

Mr Kermode: Yes, I think so. I think there are a number of things that need to pull together. It needs leadership from Government to go for it and say, 'Let's make it happen,' and I think you need always to identify a champion into that to make it go. We need a community needs assessment as to what is going on and accepting that is going to be very noisy data into that, but some of that stuff is being done. There is a general thing that you can see the bits of that is happening in Government in mental health and wellness promotion, which is great stuff.

We need to be doing stuff like assistive suicide prevention awareness, and there are various packages – not just a two-day, there is other lesser stuff that is really quite helpful into bits of the community; of training for people and refreshing training; looking at how well the interface is going with the 'Oh, sugar' services of mental health, of Crisis team – is that working well? About how do you improve some of the clinical services and support services for people who might present at A&E. I think it has changed a lot in my career from taking youngsters of 19 to hospital who have made a go at their wrists and the treatment by A&E was, frankly unsympathetic, was frankly awful. It was. You were seen as a burden. 'Why have you done this to us?' It is almost like the Catholic guilt bit of suicide being an offence against your creator and you should be condemned for that. It is much better, but you still to some extent, unless you are running all the time and looking at that frontline stuff, you will see some people that will see it as, 'Why are you taking up our time? We have got really seriously ill … and you have done this to yourself.' Yes, they have but they are very much in need of care and support and trying to pick up services elsewhere.

You need certainly to pick up on the bereavement stuff because you are not going to succeed all the time … and trying to support people who are left behind and we need decent data. It always worries me about the Island that we seem so adverse to data and really happy to give adjectives. I was listening as a participant at the back and thinking, for the previous sessions, 'I'm hearing a lot of adjectives about, "It's great, it's getting better and we're doing this," but I'm hearing very little on data.' I am a great fan of data, better or worse, of saying, 'How are we actually doing?' It is trying to build capacity and sustainability of the stuff. 'Oh, we had some capacity of this' – it is not sustainable because the numbers of people are going down and it is dependent too much on me as a volunteer doing this, rather than structurally embedded into what we are doing.

Q17. The Chairman: I suppose the good news is the present Health Minister certainly talks about data all the time, doesn't he?

Mr Perkins: He does. You are right there.

Mr Kermode: I love data. Great fan of it.

The Chairman: Oh, I think it has been an area that has been very lacking in the past in certain areas in Government.

Okay. Anything? I think in terms of the questions that we –

Q18. Mr Perkins: It is the bereaved families, I think … How can the Government support the bereaved families? Should we rely on NGOs, Cruse or something like that, or is there anything we can do positively?

Mr Kermode: I think we can use the community stuff. I do not think Government should try to do everything. My view is I am now retired with a Government pension, I think it is important to put something into the community as well, not because I am just paid to do it.

There are some tremendous people in Cruse and we ran one of the packages into their Cruse training the year before last for them. We did one of the short 90-minute Living Works packages. So, yes, I think that is a really valuable support. It is to keep making the links and keep networking with the various people. The relationship with Samaritans is always interesting. We had a wonderful discussion, because the ASIST package is really quite assertive of engaging with a person, 'We are going to try to get an agreed endpoint of we are going to keep you safe and you are happy with that.' 'Sam's' would say they are not in the business of suicide prevention, which at first people go, 'Oh, what? Are you not?' But they say they are much more into non-directive stuff and they will stay there, and that is part of their ethics and values; they will stay

with the person if that is what they want to do. But perhaps they will be more into the non-directive rather than the assertive and directive stuff.

I think both are valuable for different people and it is how you are dealing with different people's views and attitudes under that, which are all useful.

Q19. The Clerk: Can I come back to the question that the Chairman asked or Mr Perkins asked earlier, I forget which: is there anything about the Isle of Man which makes the risk of suicide worse or in any kind of preventable way? And you said, 'Well, we do not know because we have not got the data.' (***Mr Kermode:*** Yes.) But it would be interesting for the Committee if you were able to –

Mr Kermode: What data I have seen would say it is no different from the UK or no different from anywhere else, so we are just a reflection of that. I do not see any higher or lower rates than anything else, but the data is very noisy indeed.

Q20. The Chairman: Yes. The data I have seen in the past confirms what you have said already today, and that is about males of a certain age, particularly in rural areas has been the position in the past. That does line up very often with the Isle of Man because we are not a big city – where you would think actually in a big city some people might be more lonely or whatever.

Mr Kermode: Yes.

Part of the solution to that is, well, okay, if we know we have got a problem with male groups then why don't we start pitching things like ASIST at male groups with a greater awareness and greater willingness to engage with that, because you are into the usual male thing of emotions – you know, blokes don't do that! But it is very possible to give people the skills to do exactly that.

Q21. Mr Perkins: One of the things the Committee has picked up is the large turnover of staff involved in mental health in Noble's Hospital and the Health Service. Have you any comments on that?

Mr Kermode: I worry about the number of people I have worked with in mental health and education that no longer enjoy what they are doing as a job. It really worries the heck out of me. I mean I enjoyed going to work for Education for 28 years. Fine, there were ups and downs and sometimes you were, 'Oh, God, what have you done now?' but I really absolutely enjoyed it and I worry as to how few people I see and talk to that seem to have that enthusiasm, that passion for what they do. Something strange is afoot because unless our professionals enjoy what they are doing and feel that they are doing something worthwhile and useful, then they are going to try to look for ways out – not through suicide but in terms of moving on and getting out of that job. The number of people you talk to who say, 'I'm looking forward to getting out!' Wow, really? That does not feel good so I am worried about that. That is not just in Mental Health –

Q22. Mr Perkins: Is it the pressure of work or a bullying management or the whole ethos of the establishment?

Mr Kermode: I am a great fan of what came out of Harvard Business School of what was called a Balanced Scorecard, where for any service you look at: are you delivering what you set out to deliver? One of the great things about that is if you can give feedback to staff and say, 'Hey guys, we're actually doing it, we're actually doing what we set out to do,' it is a wonderful preventative about this stuff, because problems will come out of the woodwork and you will drop the ball occasionally onto that, that is just the nature of a difficult and varied landscape.

So are we doing what we set out to do? Yes, ideally we should be doing largely, 'Yeah! There's the evidence. We're doing what we set out to do!' It is what your punters think about the service that you get. It is how much does your service cost in comparison with everybody else to deliver that and if you start feeding that stuff back, that you can say to staff, 'Hey guys, you are actually doing what you set out to do. We're doing it at really quite good cost in comparison with everybody else. Look at the positive feedback we're getting from the staff!'

Those are really powerful ones. The last one of the Harvard Business model of the Balanced Scorecard is: have you demonstrated you are getting the engagement of the staff into that? I think in a load of services in the Isle of Man you struggle to extract, 'Have we defined what we are setting out to do?' I was looking at part of the stuff I do for the Isle of Man Health and Care Association and so there is a way but it is digging perhaps at Health and say ... If you looked at the West Midlands Review we are probably achieving about half of the accepted quality standards. That is awful! I mean we should be achieving 90%-ish of quality standards.

If you looked at what is the customer satisfaction looking like, I have seen some stuff on the website about customer satisfaction, but I am not sure that is covering the whole ground. If you look at the cost per procedure or the cost of doing it … virtually no data available publicly. (**The Chairman:** Correct.) But what we are seeing is sort of major increased costs of particular areas like consultants. If you look at the engagement, the Select Committee report that was published yesterday, they were not achieving the engagement into there. (**Mr Perkins:** No.) So on almost all of those measures we are not doing well.

I think that our problem is that staff are going to feel, 'What the heck am I doing? Isn't this awful?' when you are into a system that does that. It is your problem as leaders as to how do we change the culture and say, 'We will celebrate improvement towards that.' Accept that we are not going to jump from where we are to there, but we are going to look for improvement and we are going to celebrate success and movement towards that, rather than only looking at the problems that arise. A wonderful concept. I really liked it when I was working for education and tried to develop a no-blame culture and say, 'As an organisation we need to improve and we are not going to do that by wearing hair shirts and berating ourselves. We are actually going to celebrate the success. Problems will arise and we have got to cop to that and say "Yeah, but let's tell you about the good stuff".' And by Jove, that is sometimes quite difficult with yourselves as politicians to keep on to that, because you will keep coming back to the problems. Of course you should. Of course you should.

So yes, do I think it is a problem? Yes, I think the morale … but it is part of that broader four points within Balanced Scorecard that is our problem and how do we ...? They have got major challenges, not just in Health but I would say in Education as well of talking to teachers about low mood, low morale. We have got to actually say, 'Hey, you are really doing well. Aren't we doing well together?' There is a challenge for you as leaders.

Q23. The Chairman: Okay, I am coming to the end of my period of office, if you like, after a long time, but I have always found that the most difficult area was associated with mental health, because you think you can be helping somebody but they can ring you 20 times a day and they do not think you are, and it is very frustrating.

But I am interested in the course you describe and I think even though I am coming to the end, if you could pass on details of when you are next having it –

Mr Kermode: It is through LEaD. The next one is – I have even got the dates with me here – 1st and 2nd April, 2nd and 3rd July, 5th and 6th November. Applications through LeAD.

The Chairman: Right. I will be certainly doing that.

Mr Kermode: Highly commended and you may unfortunately get me as a tutor! *(Laughter)*

The Chairman: Anything else that anybody wants to –?

Q24. Mr Perkins: I think the only observation I would like to make is I am always intrigued with the Esterlin Paradox. As technology has advanced and people have an easier life they are still no happier than they were say 20 or 30 years ago, *(**Mr Kermode:*** Yes, absolutely.) and that is a paradox, isn't it? Because if people are happy they are obviously not going to contemplate suicide so if we can somehow make people happier, which is very difficult, but that is what we should be aiming at, and I think a smile and a bit of a cheery disposition and all that sort of stuff goes a long way, for the public anyway.

Mr Kermode: Yes, there is a wonderful organisation called Action for Happiness. I do not know if you have spotted it, but it is worth looking at the website of Action for Happiness about how do you actually promote happiness in a society. If you look at some of the strong approaches of … one of the strongest talking therapies is cognitive behavioural therapy and some of that stuff is exactly that: how do you help people adopt a positive mindset? Give them a positive mantra? Because one of the strange things about it, you presume that the thoughts and emotions are leading to depressed behaviour and how other people look down. If you teach people to behave as if they were not depressed actually their mood improves. It is a fascinating interaction between behaviour, between mind, between emotions, between some of the physiology, is where the CBT stuff …

Q25. Mr Perkins: The glass is half full as opposed to half empty.

Mr Kermode: Oh, absolutely. But trying to find ways of giving that … As mentioned, when I came to the Island in 1998 – came back home to the Island – I was the only psychologist working with children and families, and there was one psychiatrist doing an afternoon a week in Ramsey. Now we are tripping over them. The numbers we put into children's stuff are tremendous but it is hard to see any greater satisfaction from the public or greater happiness or better meeting of demands, despite enormous increase. I have not got an answer to that but it is a fascinating question. People's expectations are greater. I think that is so.

Q26. The Chairman: But there is also, it seems to me to be – and I am not criticising people but there seems to be less of a resilience sometimes to dealing with sometimes everyday stuff and people can get more upset and worried and stuff, whereas in the past perhaps we had to get on with things.

Mr Kermode: Yes, there is some correlation in that as well. If you look at the expectations of people for counselling after a traumatic event. There has been a whole industry – and I have been through the training courses here – of putting training in, putting in support after post-traumatic events. Yet the evidence is it makes it worse. Professional intervention straight after an event makes the outcomes worse. The best thing is actually: go and talk to mates; let your family be aware. Of course you are going to be majorly affected, of course you are going to have difficulty sleeping, of course you are going to get recurrent thoughts of that. Why would you expect otherwise? You are human. But if the stuff is going on past about two weeks *then* think about seeking help, but the last thing you do is do counselling for people with professionals like me in the early events.

Part of the stuff to schools in the past has been saying, 'Publicly you need to be saying, "Yes, of course we deployed psychologists and counsellors to X school because there has been a difficulty there for the people that will be there." But you are actually trying to do that almost to stop daft things happening that are going to make it worse in terms of outcomes for the people.' It is exactly that. Some of the things that we did as common sense as, because we cared about each other, because we had families and communities and friends, we sometimes lose to the

experts. But only in time you roll back and say, 'Actually what we used to do was actually pretty good.'

Q27. The Chairman: Okay, anything else anybody?

Can we thank you very much indeed for taking the time to (***Mr Kermode:*** Thank you.) do what you do, but also for coming along today and your written evidence? I am sure it will help us inform whatever we decide to recommend to Tynwald in due course.

Mr Kermode: If I can be any further help … If I may leave you with some stuff about some of the packages I have talked about to give you a bit more detail. I will leave that with Dr King and I hope that will be of some assistance.

The Chairman: Thank you very much.

Mr Perkins: Thank you.

The Chairman: We will now go into private for a moment before our next session.

The Committee adjourned at 3.35 p.m.
and resumed at 3.42 p.m.

Procedural

The Chairman (Mr Cretney): Welcome to this public meeting of the Social Affairs Policy Review Committee, a Standing Committee of Tynwald.

I am David Cretney MLC and I chair the Committee. With me is Mr Martyn Perkins. Unfortunately Ms Edge, the other Member, is not able to be with us today.

If we can all ensure our phones are off or on silent so that we do not have any interruptions. For the purposes of *Hansard* I will be ensuring that we do not have two people speaking at once.

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but not emergent policies as deemed necessary of the Committee of the Department of Health and Social Care, the Department of Education, Sport and Culture and the Department of Home Affairs.

Today we will be continuing to hear evidence as part of our inquiry into suicide. Today we welcome Gill Porter, Director of the Isle of Man Samaritans.

EVIDENCE OF
Ms Gill Porter,
Branch Director of the Isle of Man Samaritans

Q28. The Chairman: We would like to start off by inviting you to set out what qualifies you to give evidence on this topic, which I think is self-explanatory and if you would like to make an opening statement and perhaps give some background on the organisation that you are representing today, which I think, again, is pretty well known to most of us, but welcome.

Ms Porter: Thank you.

I have got my written submission that I sent through to you just with a little bit of statistical information within it, but Isle of Man Samaritans has been here on the Island now for 40 years

this year and obviously has been a bigger organisation for a lot longer. It started in 1953 by Chad Varah. I am not sure whether you know much about that. (**The Chairman:** Yes.)

But really thank you for inviting us to be part of this. We are actually quite honoured to be part of it. As I said in my opening statement, we do not just take calls from the Isle of Man. So although this is an inquiry based on the Isle of Man, we do not just take calls from the Isle of Man. We are a free call national charity and as such we do take calls from callers from the UK, Scotland, Ireland and of course the Isle of Man.

We cannot quantify how many calls we actually take from the Isle of Man because, with it being a national number, callers from here can just call that national number and they will get through to any Samaritan branch. But we do capture generic data. We monitor calls, but anonymously so we do not know where they have called from.

Just to give some sort of basic statistics, in February 2008 we on the Isle of Man answered just short of 1,300 calls – in the month of February; this year in February 2019 we have answered over 1,733 calls.

Also per month we have responded to an average of 126 emails and 154 text messages. Within the organisation we are also looking at instant messaging, trying to roll that out, because we do know that young people are social media beasts and they like to use any sort of mode like that, so we are rolling that out as well.

Regarding the key points of interest here in this inquiry, the first two or three points we are not actually qualified to make much comment really – regarding the adequacy of preventative measures, the response of the public service and indeed the functioning of the Coroner of Inquests. That is all done separately from us.

But a relevant point, I think, is that when we do take calls many of our callers are telling us that NHS services and other services are recommending and referring them to Samaritans. Obviously they are doing that and we are not receiving any funding; we are not asking for funding but we are not receiving any funding. So we become that first line whilst they are waiting for other services, so you can imagine that is why we have got such an increase in calls.

They refer them to us until such time that the professional counselling and support is available. We note that numbers of callers that do experience mental health issues are rising and rising, and we do not assume that somebody is suffering from some mental health issue; we only make note of that if they tell us that they have got a mental health issue.

A lot of our callers regularly mention a lack of support across all mental health services. Again, please remember this is not just on the Isle of Man, it is in general and they note that out-of-hours support, i.e. overnight and weekends, is particularly difficult for them.

We can probably comment a lot more on point 4, which is what support is available. We do offer support for those people that are affected by suicide, but we hope that we can actually touch those people before they get to that point now. We hope that we can reach the people that are experiencing despair, distress and suicidal feelings, in the hope that they get that support before they take the decision to end their own life.

We are a listening organisation, we are totally volunteer-led. I might be the Director but I also do my duties and everybody in the branch is a volunteer. We offer emotional support; we cannot give advice, we are just normal members of the public that are trained to listen but not in anything else particularly.

We believe in self-determination which is akin to some of the services. I think John may have mentioned that there was a strategy taking place and again we were invited to be part of that, but our view on it was quite akin to other people; where Social Services and people like that are there to try and prevent people taking their own life, as are we, our mission is to reduce suicide – but if somebody has really made that decision and that is the only decision for them, we believe in self-determination and we just support them and be with them. I personally would hate any member of my family to be feeling like that and to be on their own at end of life, and I am sure you would feel the same.

That said, we do have a safeguarding policy and this is quite new to Samaritans. A lot of volunteers struggled with it because they see it as a breach of our confidentiality but it has not proven to be so. What we have is safeguarding policy for children and any vulnerable callers. We do not know where they are unless they choose to tell us any identifying information, but if we have that identifying information and we recognise that there is an immediate danger we can refer them to a safeguarding officer within Samaritans and they make the call whether they should take any further action, what they should do, whether they should step in. So that is not our call to make.

We are available 24 hours a day, 365 days a year. I have mentioned some of the stats, but we offer support by the telephone, email, text and face to face, so people can come and see us at Victoria Place and pop in and talk to us. We like to stress that we are not just Isle of Man based because some people have that conception that we are and they would hate to come and meet their neighbour or their friend or whatever at Samaritans, but our confidentiality will assure them that even if that is the case we would never reveal that we had recognised them or we knew them.

Just another point to note: we do go into the Isle of Man Prison on a Saturday morning. We are quite unique, in that we do not have a listening service, we are the listeners. We go to the Prison and we are given the set of keys and we wander the wings and we talk to prisoners and we talk to officers, and we recognise that the prison population are probably amongst the most vulnerable in our society. But we are proud to note that in 20 years we have not had one inmate suicide within the Prison. We know how much they respect and appreciate our support because they constantly tell us. So we are quite proud of that.

Just recently we have been going and meeting with the Education executive and teachers to try and get into secondary schools to see what we can offer there, to try and support the children, do some assemblies, do some roll out of wellbeing and just being kind really. We go to local community events, we are trying to get ourselves out there because it is two-pronged: we can alert people to the fact that we are there if they need us or we can actually try and get some more volunteers, which we are always trying to do. So that would be very helpful.

So hopefully the support we can give here, I am not sure how valuable it is to you, but we are very proud to have been asked to come along and give this evidence and be part of this. We know that it is a service that is much needed – our callers tell us. It is safe, it is confidential and sometimes it is the only place that people can come to in the direst and really difficult times.

We just want people to know that we are here. So thank you.

Q29. The Chairman: No, thank *you*.

Do you think that if there has been somebody who has decided to take their own life do you get family members then contacting you because they are left in a bad place?

Ms Porter: Yes, we do. We get people that may come on the phone and say that the only option they have got is to end their own life and so in a roundabout way we get to the point of, 'What have you thought of? What else have you tried? What do you think you can do?' But if they feel that they have tried absolutely everything and they decide to take their own life then that is what happens.

But we do get callers that come on and say that, 'My brother or my father has taken their own life,' and actually statistics show that family members, and particularly descendants, of someone who has died by suicide are much higher to follow the same way.

And of course they are going through the emotions of anger, shock, upset, blame because they do not know why that has happened; and so we support them in exactly the same way as we support anybody else with any issue that is going on.

Q30. Mr Perkins: Do you think there would be any mileage in having a specific Isle of Man group?

Ms Porter: For people that have lost people through suicide?

Q31. Mr Perkins: On the Island, yes. (***Ms Porter:*** Yes.) There are specific problems on the Island: it is an island and all that sort of stuff.

Ms Porter: Yes, I think we have got Cruse obviously and we have some agencies that we can signpost to, and Cruse is one of them. Yet you hear mixed reports from Cruse because I think there is quite a waiting list and sometimes Cruse advise that it is maybe too soon. But I think somebody losing somebody by suicide is different to somebody just being bereaved through illness or whatever, and I think a support group – I am sure people that have gone through it would say the same – would be something that would be of interest, because when you have got a shared story and a shared experience you realise you are not on your own, you are not the only person that is going through this.

I know when we had the strategy meetings some members of that had lost somebody through suicide. They were quite open to share how they felt and actually shared how difficult it was to get that support. If somebody else had gone through it and could say, 'Well, we did this. Perhaps that would work for you,' maybe that would help, yes. Yes, I think so.

Q32. The Chairman: In terms of the strategy, do you know where it is up to? Have you heard recently?

Ms Porter: I was just having a quick chat with John. No, I used to go to the weekly meetings as well and I met somebody that was sort of overseeing it, and the last I heard was that everything was being written up and everything was being collated; we would then be called back to see what the next steps were. Unfortunately, I have not heard anything else. But we were pleased to be part of that as well.

The Chairman: I am sure that is something to follow up separately to see where that is up to.

Ms Porter: Yes, it would be interesting.

The Chairman: Given your specific and your very helpful response, I am not sure that I have –

Mr Perkins: Yes, we have had a lot.

Q33. The Chairman: Anything else you felt we should ask?

Mr Perkins: Not really. I think that has covered it. I think the Committee acknowledges that the Samaritans is very highly thought of.

Ms Porter: Thank you.

The Chairman: Absolutely.

Mr Perkins: That is why we asked you to come along today.

Ms Porter: We are delighted that we were asked to come along. I am delighted that it is being looked at because I know recent numbers of reported suicides have risen and I know when those figures came out there were a lot of people that voiced concern about that. We made a statement just to say that we are here. Really what we want to do is just remind people we are here, (**The Chairman:** Absolutely.) because lots of schools and places have their own support mechanisms, but we are here as an extra line, should we be required.

So, no, thank *you*.

Q34. The Clerk: Just to make sure that I have understood this correctly, you have said you are a listening organisation – and if we take the UK and the Isle of Man all as one for this purpose – people tell you things, they may choose to tell you where they are, they may choose to tell you maybe what public services they have been engaged with or been kept waiting for, etc. but apart from the safeguarding example which you described as new, you do not pass that on to anybody?

Ms Porter: No.

Q35. The Clerk: You do not collect statistics?

Ms Porter: Totally confidential. The only sort of statistics we do gather is male or female, did they talk about suicidal feelings or is that person experiencing suicidal feelings? That is purely for Samaritans' statistics. So we may make a note of what topics we have discussed just so we can see whether all our callers are experiencing difficulty with mental health or whether there is some bereavement or whatever. But we do not know where they are calling from, we do not trace their telephone number.

Q36. The Clerk: You do not collect statistics and use them to lobby government?

Ms Porter: In the UK our Chief Executive, Ruth, does go to many government meetings and they do lobby over there for more support, more mental health services, but all our calls are not all mental health. So we will go into schools, we do lobby the government for more mental health because mental health services are severely being cut in the UK and when we speak to callers, particularly from the UK – and when I say they do not tell us where they are, they may say, 'I'm in Blackpool,' or they may say, 'I'm in Scotland' – where roughly. They all tell the same story – that mental health support is being cut and they do not have the support they feel they need. Obviously everybody has a feeling of what they need and that is not always the professional view on it, but when they say, 'There is nobody at night. So we can ring a crisis line and the crisis line will refer you to the Police or the crisis line will refer you to A&E. Where do we go? I have tried to cut my wrists, where do I go? A&E?' and the next thing is they are sent home. There is no support. So they do tell us things like that.

Q37. The Clerk: But you have never, as an organisation, got to the stage of hearing enough stories like that from the Isle of Man to step out in public in the Isle of Man and lobby here?

Ms Porter: We would do a lot more. I mean this is probably just the start of it, but historically Samaritans have been sort of quietly getting on with it. We do not want to be out there making lots of noise because of the confidentiality. The worst thing we could do is have somebody on, telling us something dire and we use that story to go out and then that shatters their faith in our confidentiality. Even with safeguarding, we still offer a confidential service so we would not call the Police.

You hear people that are in that most direst of situations. If you flip that you sometimes hear people telling us that they have done something or maybe committed a crime. You do not know whether that is true or not, but we would not make it our business to call the Police or call an ambulance; we are listening to that caller and we encourage *them* to make contact with the Police or make contact with the ambulance. We encourage *them* to do it. We are just there to support them in that moment.

Q38. The Chairman: There are certain documentaries on certain TV channels, usually quite late at night, which describe how the Police and other emergency services are regularly – it is obviously a UK situation but – being contacted. It would be interesting to speak to our own services to see if they have a similar response.

Ms Porter: I went to a meeting, I think Cathy came with me, we went to a meeting here, I think it was the inclusion meeting, but a lot of it was the Police who were there and they did say that a lot of their calls out are to mental health situations and, without going into any of my personal details, I have had a touch on that as well. I think the Police are very good at going and handling mental health issues. But again is that really their role? Where does that lie? Where is that role? Is it for the Police to be dealing with a mental health patient? No, not really. In some cases a mental health patient then gets put in handcuffs and led away. Is that the right thing for him? No. So I think the agencies all work very well together, but where does that responsibility lie and how can we help those people?

Q39. The Chairman: I think there are now two Social Services people.

Ms Porter: That is right. Mental health nurses working with the Police.

Q40. The Chairman: Which is definitely ... because you are right, the Police are not necessarily equipped to deal with those kind of situations, (***Ms Porter:*** No.) or determining whether it is a mental health issue or whether it is something else.

Ms Porter: Absolutely. But, no, just going back to the question, confidentiality is not broken. We do not report things. No.

Q41. The Assistant Clerk: So you do not report any statistics on why people are experiencing suicidal ideation, no?

Ms Porter: No, we have a very generic list of what you talked about, basically. So it can be benefits, bereavement, bereavement by suicide, mental health issues, but we would never assume that somebody had a mental health issue if they did not tell us. So we might tick mental health issues, and that is for exactly the same reason as you suggested, so we can lobby or can talk to the right agencies.

For example, if we did not have any mental health callers we would not be out there talking to anybody involved in mental health. But what our CEO and the actual organisation as a whole does is try to raise awareness that because of the cuts it is causing more people to stress, causing more people to maybe take their own lives, and so what can be done?

So our statistics are very generic, but we can see there is a spike in mental health calls. Sometimes we will take a call and they will tell us that they are on the Isle of Man and, 'I have been to Crisis and they have sent me home,' and so they do mention that. That is quite a common theme even in the UK as well.

Q42. The Assistant Clerk: I think in this inquiry the Committee is not only looking at mental health. (***Ms Porter:*** No, of course not.) We are looking at suicide as an issue that has got myriad antecedent factors. (***Ms Porter:*** Yes, absolutely.) So if you can, what are the common factors that might drive someone to experience suicidal ideation?

Ms Porter: We have finance, unemployment, homelessness, relationship problems, work problems, bereavement, bereavement by suicide, people that have maybe lost their elderly parents and find themselves alone, sexual abuse. Obviously that is a subject that is becoming

more acceptable to talk about now. So sexual abuse. We get calls from abusers. Prison calls. They are the basic sorts of calls we get.

Actually sexual abuse is a high percentage of our calls because people cannot tell people and sometimes they will ring Samaritans and say, 'I have never told anybody else this,' and we hope that by them sharing that with us, it may encourage them to tell the right channels to get some help. We do have agencies that we safeguard too. So if a young person up to the age of 18 calls us, we try and steer them to call Childline, but some have had bad experiences because Childline will take practical help and maybe go into the house or whatever. So we steer them to those places. We have Stop it Now! which is an agency for people that feel that they may go on to sexually abuse; agencies such as financial, gambling, alcohol and drug abuse. It is all the everyday stresses, strains and sometimes horrible things that happen to people that they call for.

Q43. The Assistant Clerk: You talked about signposting; do you think there are adequate services to signpost people to in the Isle of Man or do you struggle to signpost people over here compared to in the neighbouring jurisdictions?

Ms Porter: Yes. Most of our signposting agencies are UK national agencies. I have mentioned Cruse that we have over here. We have got Victim Support, obviously, if they are going through something. But I think for drug and alcohol issues over here I do not think we have got many local agencies that we signpost to. I know there is the Drug and Alcohol team, I know there is Motiv8 and places like that.

My tenure as Director is nearly up. I have only got a few weeks left, but I am hoping that the next Director will carry on the work we have started and perhaps approach those local agencies and say, 'Can we signpost?' But again, Benjamin, the thing is we do not know that they are in the Isle of Man unless they tell us. So when they ask us, 'Do you know of any agencies?' we can only really go to the national one, unless they say, 'We are in the Isle of Man'. So it is quite difficult.

Q44. The Chairman: How long have you been the Director?

Ms Porter: I have been Director for three years. It is a three-year tenure. I have been a Samaritan for five years. My colleague over here has been a Samaritan for 35 years! But the Director is a three-year post – nearly done. They are just starting to look for the next one, but I will stay and hopefully have an active role because I have really enjoyed it and it has got us into places like this, inquiries like this, so I think it is very valuable.

Q45. The Chairman: You say you enjoyed it even though it can be stressful.

Ms Porter: I know it is very –

The Chairman: Just to reflect on what Mr Kermode was saying, the enthusiasm comes over.

Ms Porter: It is hard to say you enjoy something that can be really – (**The Chairman:** That is right.) But the very fact that you are helping somebody is important. Yes.

The Chairman: Anything else?

Mr Perkins: No, that is fine. Thank you.

The Chairman: Then can we thank you as an organisation for being there to listen to people, because it is really important? It is something we in a kind of minimum way do as well and it is

very difficult for lay people to do that. So thank you very much for all you do. Thank you for your presentation and no doubt, again, it will contribute to our findings.

945 ***Ms Porter:*** Thank you.
Thank you for your time and thank you for having us here.

The Committee sat in private at 4.05 p.m.