STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

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PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Suicide

HANSARD

Douglas, Friday, 22nd March 2019

PP2019/0081 **SAPRC-SU, No. 3/2018-19**

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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

Clerk:
Mr J D C King

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Standing Committee of Tynwald on Social Affairs Policy Review

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The Committee sat in public at 3 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 and for the purposes of *Hansard* I will be ensuring that we do not have two people speaking at once – and that is principally Martyn and I, generally!

The remit of the Social Affairs Policy Review Committee is to scrutinise the established but not emergent policies as deemed necessary by 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 further evidence as part of our inquiry into suicide, and today we welcome Mr Bill Henderson, Member of the Legislative Council. So welcome, Bill.

EVIDENCE OF
Mr Bill Henderson MLC

Q128. The Chairman: Perhaps you would like to set out what qualifies you to give evidence on this topic and, if you would like to, any opening statement; and thank you for your extensive correspondence which you have submitted.

Mr Henderson: Thank you very much, Mr Chairman, members of the Committee, Clerk.

You asked what qualifies me to give any evidence and, as I have submitted in my document to you, I have 20 years', or nearly 20 years', experience working in the Isle of Man psychiatric services as a registered mental nurse and several of those years, prior to my leaving, as the psychiatric hospital night manager.

Over that period of time I have had considerable training in recognising, shall we say, depressive episodes, people in distress, people suffering from stress and indicators that would possibly mean that somebody was feeling suicidal or intending on committing suicide.

Indeed, my 20 years hence working in Tynwald as a Member of Tynwald and continual contact with constituents and assisting in personal matters, and indeed, continual contact with my colleagues, or former colleagues, in the Mental Health Service on and off over the years, has given me some insight – I do not claim to be an expert and I put that on record but certainly it

gives me an awful lot of experiential learning to be able to produce the paper I did and certainly answer any questions you might wish to put to me.

The Chairman: Thank you very much.

Q129. Mr Perkins: Can I just ask, presumably you were in Ballamona Hospital when it was fully operational?

Mr Henderson: Yes, that is correct.

Q130. Mr Perkins: How many wards did it have?

Mr Henderson: Twelve or thirteen – a rough estimate. It was fairly large, well laid out, spaced out across a considerable ground that the new Hospital now resides on.

Q131. Mr Perkins: It was an old Victorian building and a bit depressing in itself, was it?

Mr Henderson: Some of it. It depends which way you looked at that. Odd visitors to the place who had never seen it before would say that the centre block was an old depressing Victorian building. However, there were plenty of new satellite units around the main block which were quite modern and airy and spacious, and so on – maybe not to our satisfaction, seeing what moneys were being spent in general health, but certainly there was plenty of modern satellite buildings around.

If you talk to the patients, however – and certainly the ones who lived at Ballamona, long-stay patients – that was their home, it was their territory and where they felt safe and they did not feel depressed or down by the fact that in the middle of the hospital complex was this Victorian centre block.

In 1933, the point you raised was certainly in the forefront of the mental health board's mind in those days and that was where our Ard Aalin was built – a new acute psychiatric unit some distance away from the main block. Although dated in design now, it is still there. But that fact was recognised, that really we need to try and destigmatise and uplift the atmosphere and get away from the old custodial image that was still in the public psyche of the day.

Q132. Mr Perkins: One last question on this while we are on the subject. How many outpatients? A lot of outpatients? Do you know any numbers at all?

Mr Henderson: We did operate a day patient unit and you could get as many … I am just thinking, possibly 20, 30, 40 at any particular week. (**Mr Perkins:** Yes.) There could well have been patients who would also turn up to … We had a section of what we called day patients who turned up and stayed on the campus for the day. They came from residential homes, other residential areas, where they lived, but came to us for the day for their activities or they had occupational therapy or industrial therapy, as was, as part of their daily routine therapy. It gave them a sense of purpose and they joined in with others and had friendship and socialisation, which I thought was very good.

But then you did have other kinds of appointments, certainly on the acute side of things, where there could be doctor's appointments and outpatients would turn up for those, yes, certainly.

Mr Perkins: Okay. Thank you.

Q133. The Chairman: We will just continue on that. I guess part the reason that that changed was this philosophy of ordinary people in ordinary streets trying to accommodate those former residents in accommodation in society. Do you think, looking back, that that was the best policy?

Also, just while you are thinking about that, have you had the opportunity to look at Manannan Court and see whether that is meeting today's needs?

Mr Henderson: We are talking about a completely different subject matter there, if I may, Mr Chairman.

The idea of the ordinary house in the ordinary street came from UK initiatives and further afield kind of thinking. It was specifically targeted here at folk with learning difficulties, not with depressive psychiatric disorders. These were folk who lived in Ballamona for most of their lives really and it was decided pretty rapidly on the appointment of a new Director of Mental Health at the time that we should be aiming for this. Certainly new houses were purchased by the DHSD, as was then, and quite a few folk with learning difficulties subsequently moved out.

It was also a move to residential homes for some of them as well. The policy or the philosophy sounds good – why should people be living in a mental health campus when they have got enough skills to live in an ordinary residential area with ordinary people? Why should they be treated extraordinarily when they can in fact …? The trouble with some of that was that then they lost the campus that they felt safe in and where they had activities they loved to do, jobs, paid work they looked to do as well. Many patients would team up with our mechanics and learn on the engines on our buses and so on; some would follow the porters around, some the painters and decorators, and because of the parkland setting of the area – on a nice day it was a beautiful park as well ...

So just to answer Mr Perkins, the impact of the Victorian structure actually was lost in the vista of the grounds, to be quite honest. It was a joy to walk around there on a sunny day, which many patients did and they knew they could be at ease there and not be picked on or victimised or the usual insults.

We regularly brought them – when I say 'them' I mean the long-stay patients … We had long-stay patients who had long and chronic psychotic disorders, medically managed and behaviourally managed by ourselves. So those folk used to enjoy going to town on Saturdays and we would organise their shopping list, so they would help, for new clothes, have a meal out in a café, or Cannell's Café, as it was then, and that was an absolute major highlight for them. But you could see the looks and the odd name-calling and so on, whereas in our area it was quite safe for them, so it was really good.

The ordinary man in the street was more targeted for folk with learning difficulties, though at that point. Later on there was a discharging policy where the longer-term patient who had suffered from chronic psychosis was *put* – and I use that word deliberately – into residential homes and that, to me, was wrong. What should have been done was a slow transition to hospital closure and, if necessary, move more patients together in a family setting as they were used to, down from three wards down to one ward as time went on. But I have seen them following that and regularly do; they wander the streets of Douglas which I do not think –

Q134. Mr Perkins: Just going back to your comment, were there people with dementia?

Mr Henderson: Because it was an island hospital we treated every kind of psychological disorder you can think of, to be quite honest – except for a severe criminal case, which we have had to look after too, but then ultimately they would be transferred to the UK.

The Chairman: Excuse us for taking advantage of your experience. It is just interesting to have that bit of background before we –

Mr Perkins: It sets a scene, doesn't it?

The Chairman: I think so.

Mr Henderson: That was hospital inpatients of course, gentlemen, as was up to 1998 upon my departure of Ballamona.

I would say we tried our very best and produced a family atmosphere that we aimed for. It was sadly neglected though and it was sadly underfunded by Government at that time. There was a Professor Symes who came here and assessed the place in the late 1990s before I left and he really did condemn the issue of underfunding and how we saw some of the wards still covered in 1950s lino and things like that, 1960s chairs in lounges and no hoists in areas for care of the elderly and so on. So in one way it was very antiquated and not up to scratch, which immensely frustrated the staff because we could see how Noble's was being funded, how general health was being funded, how things were moving elsewhere, yet we were taking the hit for what can only be described as Government penny pinching of the day to try and balance other budgets elsewhere and cover other deficiencies.

Q135. The Chairman: Okay.

What factors do you think might commonly cause a person to begin thinking of taking their own life?

Mr Henderson: That is a huge question, Chairman.

The range of issues that could cause that to occur are immense, but there are some main themes.

Chronic pain and illness such as cancer, which determines the person's lifespan. Then we have partnership crises. A split up of a partnership – that can have devastating consequences. It could be a short-term relationship or a long-term relationship. I recall one description from a police officer who attended a domestic disturbance in Pulrose. Following a huge matrimonial row and possible split-up, the male partner just grabbed a shotgun in the house and went to the rear of the house and just blew his brains out on the spur of the moment. Police had to attend that and the obvious consequential duties involved.

Even the most minor things that we would see as minor. That is our personal view; to somebody else's personal view who has been bullied or victimised because they did not do well at a certain physical activity in school or a certain activity outside, those remarks can reverberate through that person's mind for a long time and have a major effect. That has been the causative factor in many suicide cases too: 'What others think of me.' 'I am a failure.'

You also have isolationism. Somebody who is lonely or unable to make friends; that has been seen as a major cause or I know it to be a major cause. Social media is coming to the forefront now as a major causative factor. It did not exist when I was in the psychiatric services as such, although I was well acquainted with the rumour machine, if I can put it like that, of a person's social circle and the effect that could have on the person.

I have supplied evidence where it was quite obvious that, certainly in one case, a young woman killed herself as a result of continual bombardment of negative commentaries on social media through her social circle. Social media seems to, in some cases I have observed and through a lot of constituency work from personal experience, hold huge sway on that person's thinking, how they function and indeed how they go on about their daily lives, to the point where every few minutes the phone has been checked to see what has been said next or, 'Should I comment on that?'

I have seen it to the extent in some households where comments have escalated or been misread to the point where the Police have been involved and the whole social network group has become upset or outraged, and the poor person in the middle of it might be innocent but the huge effect that has had on them is quite dramatic and unbelievable.

Q136. Mr Perkins: Do you think that is because it is the Isle of Man factor that is in that, that it would not perhaps happen in the UK?

Mr Henderson: You could be forgiven for saying that, Mr Perkins, but generally speaking this seems to be happening elsewhere too. You have got small communities in the UK, outside the main urban areas and we see the same reports in the UK press as well, where ongoing commentaries of bullying have been a factor in somebody taking their own life.

I have looked at Isle of Man factors here, as you probably noticed in my paper, and I cannot discover, through trawling through the evidence myself, any highlighted Isle of Man factor of such that would be causing people to take their own lives. But I have identified areas that might not help if somebody is feeling depressed. I specifically asked the Committee to look at the incidences of alcohol abuse here, drug abuse and drug and alcohol dependency, because people who move into that area are also moving into high risk suicide and potentially suicidal risk. It has always been said here about the amount of people who drink and take drugs … social attitudes point of view.

The other factor is isolation here or loneliness by virtue of being an island and the fact that it is very difficult for many people. You cannot just hop off. If you are living across you can drive from one town to the next or there is a bus service or train to take you. Here, if you want to visit family, loved ones, friends it becomes incredibly difficult, especially if you are on the low income scale of earnings, whereby, yes, it is cheap to get a boat trip across and back, comparatively, but to somebody on low wages it is not that cheap. Plus the time involved and all the rest of it with regard to a ferry journey.

Or a family holiday, a break away from the place, from seeing the same old faces and work. You have to add on almost another holiday in expenses then to get to the UK, a possible overnight stay somewhere, to catch a flight to take you; and it only might be Mallorca or somewhere like that, not a posh holiday. But the positive effect a break away can give some people is quite immense and if you cannot do that you feel trapped here or you are feeling lonely and you cannot directly see family or friends. I think that does have an effect.

This is a secondary point, as opposed to the main causative factors of suicide. But I have identified those because they will become exacerbated if you are feeling depressed or down or stressed over any particular issue.

Q137. The Chairman: One of the things you have referred to in your commentary, and we found it very interesting, was in relation to the number of people at the time who were actually engaged with the mental health services. Do you want to comment further about what percentage of people actually were engaged at that time and whether you think it is a wider issue than that?

Mr Henderson: I am not sure if I have given a figure.

Q138. The Chairman: I do not think you have given a figure, but I think what you said was – and I am using my words rather than your words – it would be wrong to assume that everybody who took their own life was engaged at that time with the mental health services.

Mr Henderson: Yes, sure.

When they look back on things and certainly the Fee and Heggs Report, for instance, 50% of people who have taken their own lives have been involved, roughly, with the Mental Health Service, which I think gives us a whole new level of observation to this really, because usually when somebody commits suicide there is always a finger of blame, it is always who did what wrong. Mental health services are always planted firmly in the middle of it, yet in 50% or so of cases of people taking their own lives they have had no contact with the Mental Health Service, which is very interesting; which drives my point then that really suicide is an Island wide

community issue that should be picked up in the Public Health arena, supported by agencies such as Mental Health, the Police and whatever.

Q139. Mr Perkins: How do you think we can improve that? Regarding the people that do not present with mental health issues, how can we find those people out?

Mr Henderson: That is a hugely difficult question. (**Mr Perkins:** I know.) It is monstrous, because I am not saying it is impossible but the likes of males who commit suicide – and it is well known and demonstrated – they tend not to talk about it. It is an inherent, almost genetic, thing, if you like. So it is a difficult barrier to overcome, but I think – as I have laid out in my paper – that there is plenty we could do to make help obvious, where and as much as we can.

We can do that with notices, little bulletins, social media. Although I have just passed negative comment on social media I can see the good side of it as well, where we can get messages out there, such as the American psychiatric services do and the self-help for social media users that they offer.

However, it has been highlighted to me – it is not my point but I have put it in the papers – such as advocates who are managing separation and divorce cases, they could make it tactfully known, 'If you feel stressed or pressurised with this, look, here are some people that are great to talk to.' Samaritans or our own Mental Health. Some way of highlighting it. Post offices are another area, even shops or community centres. There is a lot of highlighting we could do so that people know there is help available if someone is feeling stressed or overwhelmed with the situation, not possibly moved into feeling suicidal, but for those people too, but even before you get to that point in your life with regard to a situation. There is quite a lot.

Mr Perkins: Yes, thank you.

Q140. The Chairman: One of the things you referred to in your paper was in relation to, you remembered that I raised this matter in Tynwald, I think in 1992 or 1993, I cannot remember exactly. (***Mr Henderson:*** In 1992.) Thank you. One of the things I had raised at that time was in relation to the press reporting of Coroner's inquests and the detail that the press went into. Did you have a view about that, whether that is …?

Mr Henderson: It is still pertinent today because suicide still makes major headlines and in the Manx press. They may not go into detail, but certainly the virtue of printing somebody's picture and putting a monstrous headline under it and the effects that has on the family and everything else, I do not think does our modern community any justice at all, to be quite frank.

Yes, the press could argue it is newsworthy, people need to know what is going on, but I think something like that could be condensed or left to a family obituary notice to be put in some time after, which they would do.

It is difficult to describe because I have done quite a bit of research on the fact. It sort of immortalises that person in one way. They are free. They have got away from it all. Haven't they done well? That then has a knock-on effect to their social circle, peers, colleagues, friends. It gives the idea to them then. We have seen this happen before.

We cannot just blame the press entirely on this but it has been a contributory factor. I think in general terms the way suicide is reported, from the articles I have seen, we could be a lot more sensitive.

Q141. The Chairman: I think the point I would make back to you and publicly is, yes, Coroner's inquests are a public open court, but it is the extent to which the detail is gone in to as to whether that is actually in the public interest, is my view for what it is worth.

Mr Henderson: My view, Chairman, is that it is not in the public interest.

Another point, if I may, around the Coroner's inquest is the fact of the circumstances of somebody's death – and I am thinking of a particular male who committed suicide last year in particularly gruesome circumstances which included bodily mutilation as well – and yet the Coroner has to assess all the factors in an open court situation and come to a conclusion, but then the family are listening to that and the children that were involved; and I think there has got to be some way of managing a private, closed session to a lot of detail. Yes, the press should know that somebody has killed themselves, but how far they get to know or how far the family or the effects … and I am talking young children here, the effects on those will be monumental.

Q142. The Chairman: In your professional life have you ever had to deal with the family of …? Has there been a consequence of somebody taking their own life and then repercussions on the family? Again, we have had evidence that people are still affected 20-30 years following the situation.

Mr Henderson: Without a doubt, that is true, Chairman.

Indirect contact with family from such sad cases. But, yes, it is the total shock that causes the situation you describe. I have outlined some cases in the paper. Quite often – not just in some cases – quite often somebody who takes their own life nobody else will know what is going to happen. They have not a clue that anything is out of the ordinary until they go into the garage the next day or they go into the bedroom in the evening to see where on earth their partner or child is. Or in one of the cases I have outlined, used a hosepipe on a car in Kewaigue School carpark and the school was closed the next day because of that.

There are some extraordinary circumstances. One of our own students blew his brains out at Blue Point. I am not speaking out of turn because it was reported at the time, but that kind of shock tactic and the effect that has then on mums, dads, wives, husbands, children, relatives. It is not as if it was an expected death to some prolonged illness or anything of that nature. It really is an out-of-the-blue bolt.

I have put post-traumatic syndrome down actually – or post-traumatic stress – as a result and we need to look at support in the background. Is it adequate? I am sure in lots of cases it is, but it is something worth bearing in mind if we are making any recommendations.

Q143. The Chairman: Thank you.

Just on to that, do you think the current mental health care provision is adequate?

Mr Henderson: That is a very leading question, Chair.

I would say, to answer this in a political way, the funding is not adequate and I certainly believe that knowing what I do, and I do not criticise the current – and I want to make it clear for *Hansard* – administration because they, more than ever I have seen in this place in my 20 years, have pushed for improvements to mental health. So I want to make that clear. But there is still a funding gap and if you measure the Mental Health Service's provision compared to the physical health service, general health service provision, you will see a very wide and noticeable gap as to where Mental Health should be and why is it still not on the same footing as general health in that regard? That puts great stress on the service and obviously if you are underfunded in the ability to provide a service or have enough specialists to provide counselling for young people then it is not as good as it could be in that regard.

The staff, however, who were supplying the service – nurses, doctors and my colleagues – and I *would* say this but I try to say it as impartially as I can – supply, by and large, an excellent service and put their heart and soul into their job every day. So it is a double edged question really, because, yes, what they do with people is great. Could they do better if they had more? Yes, they could – and if it was matched to general health.

Q144. Mr Perkins: There is a huge turnover in staff with psychiatrists and psychologists. What do you put that down to?

Mr Henderson: Is that a local figure you are quoting, Martyn?

Q145. Mr Perkins: We always seem to be … the reason the waiting list is 19 weeks or whatever is we have not got the staff to actually cater for it.

Mr Henderson: There have been longstanding vacancies and the use of locums in various specialist positions. I do not know what the answer to that is, because at times the service is almost under pressure not just to prove somebody's appointment but … Or there may be little by way of choice to pick from, who are candidates who are adequate but there is not a big field. And/or the candidates arrive here – the same as in any other area – 'I was expecting … Island life is not all that it's cracked up to be.' It is not a training area, as such, here. Your career progression is quite stalled when you get here. It is not like working in a big teaching hospital, for instance. So somebody might come here for some experience or between jobs.

Gone are the days, unfortunately, that we had our continuing psychiatrists that I remember that did 20-30 years at our hospital and the continuation was there.

Q146. Mr Perkins: Dr Costain, for example, he was there for years and years, wasn't he?

Mr Henderson: Dr Costain, being one, yes. Drs Khan, Balakrishna, Ellias and Dr Vanyan. We had newer psychiatrists and psychologists too, but it was an era where people were more likely to stay in post. Now, certainly specialist roles are more mobile and people are looking towards career progression, earnings progression as well. And we are not in the same league as some other areas. Probably there is a case there to argue to Enterprise on recruitment packages working with the Department of Health on how can we make it more attractive to achieve what we need to. I think I have put that in my paper, that certainly mental health need to talk to Enterprise to see what kind of relocation packages could ...

Q147. Mr Perkins: Do you think there is any scope in training a lower level of counsellor, because what I am feeling from this is that early intervention will save a lot of trouble down the road? If we can get people early and if we are having trouble getting the qualified staff – I do not know the business myself but – do you think there may be a possibility of being able to train low level counsellors?

Mr Henderson: The Mental Health Service is trying to institute that now as we speak. (**Mr Perkins:** Oh, right.) So to provide additional training to already registered nurses to get that therapy – if I can call it that, whatever; it could be some sort of behavioural therapy qualification or counselling – qualification or whatever, it is required so that they can then act as a specialist in their own right as far as that goes. That is an idea being progressed at the minute to try and plug the gaps, as it were.

Mr Perkins: Thank you.

Q148. The Clerk: Thanks, Mr Cretney.

Can I ask about the statement, 'Mental health should be on a par with physical health,' because we hear this quite a lot? What does it really mean? There are lots of different specialisms within what you might call physical health and they are all in competition as well with one another.

Are you saying that mental health should have its fair share like any other specialism or are you actually saying that mental health is equivalent to all of physical health and that half of the health budget should be on mental health?

Mr Henderson: The former.

Q149. The Clerk: What is the situation at the moment? When people say that Mental Health is underfunded, how do you know that it is doing worse than cardiology or cancer treatment or whatever, because they also say that they are underfunded?

Mr Henderson: They do, but not to the same extent Mental Health can demonstrate at times and certainly in areas such as adolescent care and specialist intervention therapies required there through the likes of CAMHS and so on. The waiting lists there are unacceptably huge, as Angela Murray, the Director of Mental Health and Social Care, I think has told the Committee (**The Chairman:** Yes.) before now; I am not covering anything new here, Mr King. I think the same is true in other areas of Mental Health, where if you measured it off against general health, although they have got waiting lists I think the Mental Health is still the second cousin.

Q150. Mr Perkins: One of the reasons I asked you about Ballamona was the different wards actually catered for, one would be schizophrenia, one would be different aspects of mental health; do you think there is a problem that with Manannan Court we have just got one place and all the patients are in one?

Mr Henderson: If I was the Treasury Minister with a burgeoning budget and coffers I would not – and I am not degrading Manannan Court, but in the ideal situation you would want to have separate specialist units for the type of mental illness you are dealing with and you would certainly have a separate unit to deal with alcohol and drug addiction.

There is the perfect answer to your question, Mr King, inasmuch as mental health is the poor cousin: put in an acute psychiatric unit as a catchall for every mental health issue and substance misuse issue where you have elderly depressed clients, as they call them now, who are in the same vicinity as withdrawing drug addicts with behavioural issues who may be causing aggressive episodes, with somebody who suffers from schizophrenia, and it is still not an ideal situation. You do not see that in Noble's Hospital; it is plotted out in the specialist areas.

Ballamona, when I worked there certainly had long-term psychiatric wards for chronic psychotic episodes and so on. We did have an alcohol unit specifically designated with designated staff to treat substance addiction at one point. At the point in time when I was there it had one of the highest success rates in the British Isles. Certainly, when you look at things now I think that would be a highly desirable facility to have.

You are right, Mr Perkins, in an ideal world we would have more specialisms to nurse different categories of mental health.

Q151. The Chairman: For me one of the positive things about this year's Budget was not only the financing of additional physical infrastructure with the £500,000 additional money towards Mental Health Services, but then at this month's sitting of the Court the Minister indicated that there was I think £360,000, around that, overspend on the Mental Health Services in the last financial year.

Do you think we are just catching up – that the £500,000 is the actual amount that they should have had really before?

Mr Henderson: You could argue that. I think what has happened there is possibly what is called a spot placement, whereby there has been admission to Manannan Court of such a nature

that the patient requires to be transferred across for specialist treatment, where we just cannot cater, (**The Chairman:** Yes.) if I can put it like that, or supply the services needed.

Q152. The Chairman: Yes, he did speak about those individual cases as well. Mrs Murray, amongst others, has spoken to us about that.

Okay, let's get back to the script. Outside of improved medical care, any idea how the number of suicides could possibly be reduced?

Mr Henderson: Again, when you say 'improved medical care' we know that somewhere in the region of 50% of people who take their own lives have been in contact with Mental Health Services and something like 30% of those have been in contact within the last seven days – in the last review anyway. So with regard to that 30%, certainly there is no harm in undertaking a review of procedures, practices and risk assessments that are currently in use.

I have advocated that as a recommendation in my paper, more so on the fact that it does not appear that any recommendations seem to have ever been followed up from any report I have highlighted in my paper. If they have, no one has made any mention of it, or if they have been superseded, and that needs to be assessed. Where did we go from these three reports? Currently, there is a Mental Health Strategy Assessment 2017 that was undertaken. A monster amount of work was put into that. I have spoken to the staff involved and I know it has not become a public department document and I am not sure it has departmental ramifications, and I want to know why.

Q153. The Chairman: So you do not know why at the moment?

Mr Henderson: No.

The Chairman: No, we do not either.

Mr Henderson: No, staff do not.

A huge amount of work was put into that and there was another paper after that done on suicide strategy/mental health strategy and that is still in the melting pot somewhere. I mentioned those in my submission as well.

So I would like to know what the Department … not Mental Health because they have made the effort, they have had the joint working, (**The Chairman:** Yes.) interdepartmental workshops and all the rest of it to come up with. So in answer to how do we stop incidences of folk committing suicide who are in touch with Mental Health, as part of the answer what has happened to all that work? What has happened to the passion of the staff who produced that, who really want to bring figures down, who were in contact with them and so on?

Q154. The Chairman: From my point of view I was thinking whether we as a society or as a community are doing enough for people who may be lonely or whatever.

Mr Henderson: Yes, moving into that sphere, David, certainly I do not think we are. The amount of loneliness in larger states around the Island ... There is this new 21st century attitude that is well known and noticed by myself too, where a family comes home at night time and the kids are picked up from school, mum or dad brings them in, the tea is put on, the other partner comes in at six or whatever it is, it is usually a 'doors closed' job. They want to get on with their own business. The telly is on and the computers are on and they do not want to be disturbed. It is kind of a very insular social lifestyle. It has become more prevalent over the years, that is for sure.

Certainly as consumerism has taken hold of people's lives we are more concerned about what we want, where we are going and we are losing sight of our neighbours. There is a social

disintegration as far as that goes. It is less common now for neighbours to call round on a neighbour, 'Oh, I haven't see you for a day or two.' I noticed that with my constituency work and my work as an MHK, canvassing, calling round and seeing people. You can get a sense in the areas where there is a lot of support and community interaction and you can certainly get a sense of the cold areas. (**The Chairman:** Yes, definitely.) There are elderly or physically disabled folk living within those areas and they are particularly vulnerable to loneliness or isolation.

Q155. The Chairman: Thank you.

Do you have any comments on how Government services respond when a person has taken or attempts to take their own life?

Mr Henderson: That is the bit I am out of touch on, Mr Chairman, and I have to hold my hands up in ignorance on that one, not being in the clinical field anymore. But from anecdotal evidence and talking to colleagues as well, I would say the response normally … Well, if somebody is threatening to take their own life the response is pretty rapid, whether it be from the Police or the Crisis Intervention team, or whatever.

Q156. The Chairman: We have had good meetings with both the Chief Constable and Mrs Murray in relation to the way they are working more closely together and the Police in the past would go to a situation and they might not be adequately equipped in terms of assessing the situation.

Mr Henderson: That particular point, I thought you meant if somebody was seen or going to kill themselves, how quick was the response time. It can be very quick, but in relation to inappropriate placement of police officers I can only say that I find what has been happening ultimately appalling, degrading and so Victorian an outlook – discriminatory to the point where it has turned my stomach at times. I will put that on the record.

I especially think, as I often quote, the female who was lifted off Douglas Prom a few years ago who had two young children with her, who was not displaying behaviour that was a danger to herself or others – obviously, behaviour to the point where somebody called the Police; however, the Police – and I think a social worker may well have turned up – but what happened was the social worker grabbed the kids off her in the end – and I mean *grabbed* the kids off her. And that person became extremely frightened and confused, as anyone would do, and in the end they were bound hands and feet and bundled in the back of a police van and taken to Noble's A&E first and then Grianagh Court, as it was then. The effect on that person again was monumental. What a way to treat somebody in the 21st century in our modern society! That will stay with me forever. But there are other instances.

Yes, there are two nurses now working with the Police, but unfortunately, and as I put in my paper, I want that built on because we still have in last year's Chief Constable's Report something like 23-27 instances a week where Police are the first responder to a mental health incident. So we still have not got it right. That answers your question again, Mr King: why do I see mental health as lesser to physical health? Here is another good example: in general health you would not send a policeman to somebody who has collapsed in Strand Street. The ambulance would turn up. Obviously if a policeman was present he would probably try CPR, but I think you get the point. So yes, utterly disgusted with that, but utterly pleased with the development. It is something I have highlighted in Tynwald for years, as you obviously heard me, Mr Cretney.

The Chairman: Yes.

Q157. Mr Perkins: Do you think the surviving relatives receive enough assistance from Government?

Mr Henderson: I know the support is there. When you say 'assistance' do you mean psychological assistance or Social Security assistance? (**Mr Perkins:** Both.)

Psychological assistance is timely and adequate. I have asked the question here and that needs to be assessed or the service needs to assess itself to ensure it is doing all it can on that front.

Social Security support, my knowledge is not that great. They would be entitled to bereavement support, but I do not think there is any specific payment or monetary support in relation to somebody taking their own lives. So again, certainly I would say that the Committee needs to make a point of that.

The Chairman: I think we are getting to ... Anything?

Q158. The Clerk: Can I just ask Bill my other question reflecting on this topic more generally. We were talking about the Victorians before in quite negative terms, but here we are in a Victorian Chamber built at a time of optimism and occupied by the legislature in an optimistic way and maintained over 130 years, and when we go back to the pages of our *Hansard* that we are so proud of and we flick through what were they talking about in the 1880s when they moved into this building – our predecessors, your predecessors as Members – mental health is there. It is there in the earliest pages that we have got. This legislature was concerned with this issue and always has been.

Mr Henderson: This institute was concerned with that issue in the 1870s because there was such an outcry, if I can put it like that, or public pressure over 'lunatics' being placed in chains in Castle Rushen and tethered down in other places of Victoriana, that they had to do something and the upshot of Ballamona Hospital, funnily enough, is that in 1868 it was opened, prior money was raised by public subscription to the Asylum Fund. (**The Clerk:** Indeed –) It did not come from taxes or a vote from Tynwald; I have to say there is a little bit of 'they were pushed into it' as well.

Q159. The Clerk: Right. But it is not a new issue and every generation has tried to find a better way of dealing with it. But why have we got into the state that you have described, that we see mental health as a health issue but we do not fund it in the way that we fund other health issues?

Mr Henderson: It is a social legacy that hangs 50-100 years ago that has persisted right through to today, is the honest answer to that. There is still a stigma around it and you will notice in the reports that I have supplied to the Committee that certainly the 2005 one by Dr King, she specifically noted a medical record from Noble's Hospital where a general nurse describes a depressive patient as not being depressed, it is dismissed as a dramatic kind of thing. It is worth a read, that report, to see that there, that came out of the Coroner's inquest and subsequently that person did kill themselves. The way it was dismissed with the social attitude and stigma, that is the kind of thing that is ... The grip is lessening, is the answer, but by golly it has taken a long time to lessen, Jonathan, to be honest, because it is dictating to a way how general health operates, how mental health is still being pushed to an extent to the back, how patients are treated.

Great examples going on right now: confused mentally elderly people – ESME patients – in our nursing homes. If they become ill in an evening or at night time for whatever reason, there is no trained staff on in our residential areas, so the first thing they do is ring the ambulance and paramedics. The elderly person could be whisked off after tea to Noble's Hospital for assessment. Not all the time, but commonly, there will not be much interaction between the staff down there and the elderly person. The elderly person will be kept for the shortest possible time. I have reported this to Sir Jonathan Michael and I am hoping it becomes public. But they

would be shipped back at one o'clock in the morning, two, three, four, five. The minute they can get them out they ship them back. And there is definitely some sort of attitude towards elderly confused patients. I have seen it in the past towards psychiatric patients as well and certainly to folk who have attempted to commit suicide. They have been looked on with disdain in the general medical field.

Q160. The Clerk: Are you saying that attitudes towards mental health are not what they ought to be, not just in the community at large but also within the health professionals?

Mr Henderson: Certainly. It is something that is carried through and percolated and it still affects how we apportion budgets to a degree. Although I have to say I am very pleased with the changes that we see now in the money that has been allocated and the support from the Chief Minister for Mental Health. That was unheard of in the late 1990s when I came in here. I am sure you will back me up on that, David. There was no mention. You did not really mention it.

Q161. The Chairman: I was going to ask you – again this was probably 20 years ago – and I am going to ask you – do you think the situation could, and it probably could, still happen today; and that is people with mental health issues obviously have human rights. (***Mr Henderson:*** Yes.) I was contacted by a family and the family knew that their relative was not well mentally. I got on to Ballamona at the time and the person eventually was taken into Ballamona, but within a couple of days he was deemed okay to go out and when he went out he took his own life. Do you think that situation is still capable ... it probably is capable, but still happening today, even with the improvements, isn't it?

Mr Henderson: Yes. What you are looking for is an improvement in observation capability. I do not think you can improve personal observation capabilities to that extent. When I am talking about improvements I am looking at environment, medication, additional training is put for that. Yes, I suppose there could be new training that would help to improve observations or lessons learned from that applied to the future care.

I cite an example where a patient came to us to Ard Aalin, as it was then, the acute psychiatric admission unit. They were reported as being very suicidal or the potential to kill himself was extremely high. He was on what is called level 4 special observations, where he was within eye contact at all times, but certainly every 10 minutes a record was made and recorded of the patient's wellbeing and circumstances.

Night-time occurred, a nurse outside the door, the door open a little bit to respect the patient's dignity while he slept. But he timed it to such that he knew when the nurse came to check him he had eight to 10 minutes to do something, and within those eight to 10 minutes, even though the door was open and the nurse was outside, he strangled himself on the latch of the window with a lanyard. Worse still was the fact that he was in a slumped position letting it happen and he could have stood up at any time. It is such a terrible, hard thing to do.

Q162. The Chairman: Yes. I think the thing with me in telling that story again is that I still have a bit of a guilt feeling: did I do enough for that person at that time?

Mr Henderson: That is the reason I certainly put in about support for relatives and friends, because it is incredibly ... well lots of people never get over it. 'Could I have done a bit more?' The answer is sometimes you will never know.

Another instance, a similar depressive gentlemen came to us following a suicide attempt. He seemed to pick up over the months and gradually he was taken down on special obs; he would have a special nurse with him to start with, as we called it in those days, where you actually stay with somebody 24/7. He built up the trust of the staff and doctors, walked around the ward

outside and then it was built up to around the bigger lawn in front of the ward to still see him. Months and months, and then he went for a longer walk and never came back.

Q163. The Chairman: Is there anything you would like to say finally in conclusion?

Mr Henderson: Yes, there are some very specific points I would like to put on record to the Committee. One of the comments by Dr King from the 2005 report I cite in there, where she says quite categorically as a professional assessing other professionals, there seems to be a lack of knowledge in GP surgeries – and I have to say this is 2005, but I do not know whether it was ever followed up – of recognising the instance of depression caused by chronic pain and the failure to recognise depressive episodes as being caused by that. She made specific reference to that and I think we need to follow that up. I know GPs are not that well-resourced themselves and we are piling mental health issues on them and they are the new community hub and they need the mental health resources themselves to assist, but that was a major point that was put in one of those reports.

We need to ask the Health Department whatever happened to all the recommendations that were in there; what happened to the 2017 Suicide Strategy I have spoken of? That certainly needs to be looked into. Why has it not received departmental ratification?

The Chairman: Okay. I think we have finished from this side, so can I thank you very much for your report and your paper, which has been very helpful and no doubt will help inform us in terms of our final report to Tynwald. We are very grateful for you coming along today and sharing with us your experience.

That brings to a conclusion our session today.

Mr Henderson: Thank you very much, Chairman.

The Chairman: Thank you.

The Committee adjourned at 4.01 p.m.