STANDING COMMITTEE
OF
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OFFICIAL REPORT

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SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Suicide

HANSARD

Douglas, Monday, 2nd September 2019

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Members Present:

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

Clerk:
Mr J King

Contents

Standing Committee of Tynwald on Social Affairs Policy Review

Suicide

The Committee sat in public at 11.30 a.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, which is a Standing Committee of Tynwald. I am David Cretney MLC and I chair the Committee. With me is Mr Martyn Perkins MHK, and we have apologies from Ms Julie Edge MHK.

If we could all ensure that 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.

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, Department of Education, Sport and Culture, and the Department of Home Affairs. Our Report on Mental Health was laid before Tynwald in November 2018 and debated in January 2019. In that Report, we said that we would undertake a further enquiry into suicide. This inquiry has been running since November 2018, and we are very grateful to everyone who has provided written and oral evidence so far; and we also met some people in private.

EVIDENCE OF
Hon. David Ashford MHK, Minister, and
Dr Henrietta Ewart, Director of Public Health,
Department of Health and Social Care

Q164. The Chairman: Today we welcome representatives of the Department of Health and Social Care. Welcome and thank you for your written evidence. For the record, please could you each state your name and job title and how long you have been in that role?

The Minister for Health and Social Care (Mr Ashford): Yes, certainly. David Ashford MHK, Minister for Health and Social Care, and I have been in the role since January last year.

Dr Ewart: I am Dr Henrietta Ewart, Director of Public Health, and I have been in the role since March 2015.

Q165. The Chairman: Good, thank you very much.

Thank you for the figures that you have sent us. From our point of view, there are two big questions. Is suicide increasing and how does the Isle of Man compare to other jurisdictions? So if you would like to give us your views on that.

Dr Ewart: Over the last four years, since I have been in post, we have moved, in the Directorate of Public Health, to routinely analysing statistics around a range of public health outcomes. This was not done before I came into post. So we have been playing catch up compared to other jurisdictions, shall we say. But certainly suicide is a key public health outcome indicator so we have been analysing that and we have been able to do it retrospectively for as far back as we have a body of death certificate data.

The methodology we use is to exactly replicate what is used by the Office of National Statistics across. So it is based on death certification where the cause of death was either suicide or undetermined cause. That gives the widest interpretation and allows for the fact that sometimes it is difficult to determine whether a death was with deliberate intent or not. Looking at all of that data – and bearing in mind that we have a very small population, which means that purely by chance we will get a saw tooth graph over years – it looks as if we have got peaks troughs, peaks troughs, but that is simply an artefact of small numbers, and the fact that with small numbers a difference of maybe one or two appears to be a big difference, but statistically it is not significant.

We use, again, a standard statistical methodology to compare our data with that of England and that involves calculating a confidence interval which allows us to say our actual figure for … and we do it on a three-year average to balance out those spikes. So the confidence interval gives you a range of where your figure could have been highest and lowest compared to a much bigger population. And when we do that we find that, actually, over the years that we have been doing this, our numbers are pretty steady on a three-year rolling average, and we are in line with England. We are not better than England, we are not worse than England.

That does not mean this is not a problem. It means that we very definitely should have a strategy and action plans to deal with it, which we have not had, and that is really the position where we are.

The numbers have fallen a bit since the late 1990s and some of the causes or methods of suicide have changed; the notable one being a fall in poisonings and substances. The driver for that is really the change in the late 1990s to restrict the sale of paracetamol, which has made it much more difficult for people to access that as a means of either self-harm or suicide.

Q166. Mr Perkins: Any noticeable increase with the advent of social media?

Dr Ewart: I beg your pardon?

Mr Perkins: Was there any notable increase with the advent of social media?

Dr Ewart: No. Social media – and there have been some big reviews done of it – is a two-edged sword. On the one hand, potentially, trolling, nasty behaviour and cyberbullying could be a risk factor for tipping somebody into doing something, and you will be aware of some of the very high-profile cases of teenage girls, I think, largely, across, where it has been said to be a factor.

But on the other hand, it can actually be protective because it enables people to access a whole host of anonymous advice about mental distress, and in fact the World Health Organization included social media in their big systematic review of interventions around suicide prevention and their conclusion was actually that there is this balance between the potential negatives and the potential positives.

Q167. The Chairman: Thank you.

You explained that from your professional point of view, you do it over a three-year average and as such there may be spikes. Do you think, given that we are a small island and lots of people know each other – which is a good thing I think, we have a good community – that there sometimes is more of an impact because of that very thing?

Dr Ewart: Yes, and I think when we use terminology we have to be careful what we mean by it. So when I say a 'spike', I am really meaning an artefact of a small number. Now, there is another aspect to that which is you can get clusters, and there is a very clear definition that is used by WHO, it is used by Public Health England etc., about a cluster being … and this applies to communicable disease or any other thing where there is a possibility that behaviours transmit almost like a virus, shall we say, and that can be a feature with suicide. So if you get a spike you need to test it to see, is it just random or is it a cluster? And to be defined as a cluster you need three or more cases that are clearly related in space and time and you can show that there was a connection between people.

We have not found any clusters in the data that we have been able to analyse.

Q168. The Chairman: Thank you.

In your figures, you use the definition – and you have already referred briefly to this – 'deaths by suicide and undetermined intent'. Could you please explain how this differs from the definition used in previous studies based on inquest findings?

Dr Ewart: I think there are a number of key points.

The in-depth studies based on inquest findings are not something we can replicate regularly, whereas the methodology we now use means it is a standard indicator that gets updated every year. So I think it is much stronger in that respect. I think the problem with the studies that have been done in the past is the methodologies have differed depending on the preferences and the backgrounds of the people who did them, and that is probably not really very helpful.

Q169. The Clerk: Can I ask a couple of questions on that, Mr Cretney?

You said that the collection of data that you are doing now did not happen before you came into post four years ago, but I think you said something about going back, so you were able to go back as far as there were (***Dr Ewart:*** Yes.) death certificates. So how far back have you gone?

Dr Ewart: There is another interesting little story behind that. I mean, why were we not doing this? I was horrified when I came into post and found that none of this was being done.

How have we been able to go back much further than I have been in post? The reason is death, obviously, has always been certified. You have to get a death certificate and the methodology for that has always been in place, going back, really, to 1837 and the General Registrations Acts. But nobody was doing anything with that data. So when I started developing the intelligence function in the Directorate, we actually set up a contract with the Office of National Statistics (ONS) to receive from the registrar here the raw death data – the stuff that is written on the certificates – send it off to ONS for them to classify and process exactly as happens to deaths across.

So they have been able to do that going back, I think we have got to 2006.

Q170. Mr Perkins: One of the problems with suicide is sometimes the GPs, in order to save the family, would not put down the primary reason. Have you taken that into account?

Dr Ewart: Well, I think that is very difficult to do now because of the rules for reporting a death to a coroner. So if somebody has hanged themselves, you cannot cover that up any more.

Now certainly historically there was a very well-known feature in medical jurisprudence; erotic asphyxiation, which often led to accidental death by hanging and often the circumstances

in which the person were found – they would often be dressed up, there would be things associated with the scene which were obviously going to be very distressing to families etc. if it came out. There is very strong documentation that very often that was modified, shall we say. You still could not get away from the fact that the person had died as a result of asphyxiation from a ligature, but you could maybe change their clothes, change the scene. It should not have happened, but it did and is well-documented as having done so.

I do not think we would expect to find that now. And, as I say, most of the other causes of death that are likely to be related to suicide would be instantly referable to the coroner, so there would not really be scope for medical practitioners, however well-intentioned, to try and give an alternative cause of death.

Q171. Mr Perkins: So somebody that is suffering from intense pain and committed suicide would be different to somebody with a mental problem? That would be clearly –

Dr Ewart: In what respect?

Mr Perkins: Well, suffering from depression, which drove them to suicide, and somebody who was suffering from probably terminal pain and decided to end it, would that come out in the statistics?

Dr Ewart: It would come out in the coroners' reports. (**Mr Perkins:** Yes.) We probably would not see it in the first cut of the statistic, but the routine stats are very much intended to be what we might call a high-level diagnostic tool. So if it is waving a red flag at you then you dig in deeper and then you would get the detail in the coroner's report and obviously, with suicide, the range of findings in coroners' reports is very wide.

Sometimes there is a clear link to an obvious mental health condition, sometimes people have actually taken the trouble to leave a very detailed record about why they decided to do what they did and then you can say the balance of mind was disturbed; they actually made what to them, at that time, was a very rational decision – or so it appeared.

Mr Perkins: Thank you.

Q172. The Clerk: Can I just ask one more on the figures?

Dr Ewart said she had gone into death certificates going back to 2006, and it so happens that is a date which I recognised from the other suicide audit which was 1996-2007. Have you spent any time comparing the findings in 2006 and 2007 with what the previous person was finding? And presumably you would have captured more deaths under your definition than they would have done, (***Dr Ewart:*** Yes.) but how many more?

Dr Ewart: Sorry?

The Clerk: How many more?

Dr Ewart: I am not sure that they presented it analysed by year.

The Clerk: Okay.

Dr Ewart: It was as a series.

The Clerk: Yes. Thanks.

Q173. The Chairman: Okay.

Are you able to explain the difficulties with recording attempted suicide?

Dr Ewart: Yes, that is where we get into the area of self-harm and self-harm is reckoned to have an incidence about 30 times that of actually completed suicide. So it is very important, and one reason why it is so important is because it potentially offers a window of opportunity to work with that person. So it is important and it is under-recognised.

Some people who actually have had an attempt, and within self-harm there are those who did what they did with a view to intending it to end in death, but there are also people who did it with much less thought through intention, possibly as what we vernacularly call a 'cry for help'. (**The Chairman:** Yes.) So within that number of people there are all sorts of issues and backgrounds, so it is not a single category.

Some people will abandon the attempt, get over the attempt and not actually present to healthcare services or anything else; so they are not recorded at all. Others do present. A lot of those would come through the Emergency Department and we do not have good recording of self-harm at the moment and there are a lot of other things, actually, that EDs are also like the canary in the coalmine for, and so we are just about to start a piece of work with our Emergency Department colleagues to actually look at improving routine recording across all those issues.

I think that will be very helpful, and I think then, not only can we know the numbers, but then we can actually start planning pathways to pick people up and offer them help and access to other services.

Q174. Mr Cretney: Okay.

I am going to go back in time now, in terms of previous strategies, and I am conscious that I am the only person in here who has perhaps been around for all this time. In fact, I raised the subject of suicide in Tynwald in 1993; so it is something I am long-concerned about. Anyway, bear with us. In 2005 an audit was completed of suicides in 2000 to 2003 and in 2006 a Suicide Prevention Forum was established. You have told us in your written evidence that in September 2006 the group was disbanded. Do you know why this was?

The Minister: I have tried to look at that, Mr Chairman, to find out, because obviously the forum was tasked with drawing up a framework to develop good practice and also to examine the statistics. As far as I can find, it ran for approximately six months, it managed some education and awareness training but then it just seemed to fall away. It was disbanded in September 2006. There was no framework put in place, the implementation plan and suicide prevention toolkits had been partially developed but they just did not seem to have been implemented across the board, from what I can see.

I have tried to dig deeper, but I cannot seem to find any reason as to why it was disbanded in September 2006. Of course, being 13 years on now – (**The Chairman:** Yes.) a lot of the people involved have moved on to other things.

The Chairman: Yes.

Q175. Mr Perkins: In 2008 the Department completed a Report on suicides up to 2007 and made various recommendations. But in 2015 the Minister, Mr Quayle, said:

> The recommendations of the Isle of Man suicide audit, January 1996 to [December] 2007, were not formally supported…

Any ideas why that happened?

The Minister: Again, I have looked at that and my understanding is that the Mental Health Service said that the recommendations that were made within that audit did not actually match

the evidence that they had. So the Mental Health Service did not actually support the recommendations within that audit. I assume at the time that was backed by the then political Members; which is why it did not progress.

Dr Ewart: I think overall what has been an issue here, firstly, is that it has been seen as sitting within Mental Health, and a suicide prevention strategy does not. It needs to be cross-Government and beyond. Mental Health has a part to play, but it is only a part. And I think the problem in the past was that it was people at the wrong level, quite junior, kind of having a go from within the Mental Health Service. I think the thing I struggle with is why the Director of Public Health was not the lead for a suicide prevention strategy, because everywhere else I have worked they have been. In fact, we have now, as Director of Public Health and my Directorate, agreed that it comes over to us and we will be taking it forward.

I think in order to take it forward, though, it is absolutely essential that there is high-level commitment and leadership. Just leaving people who work at a middle level to do their best and come up with a few random ideas of something that could be done, it is not going to go anywhere. If we are going to do this, it has got to be done properly. One of the reasons I have not moved forward quicker on this is because we have to think very carefully about the governance of how we are going to make sure it is owned and that the right people are accountable for it, take responsibility for it and do not accept when the strategy does not progress.

I hope I am not talking out of turn, I am speaking very bluntly, there is a big history on this Island – and it is not unique to this Island – of writing very nice documents that have perfectly reasonable objectives in them, but absolutely nothing happens as a result. I think one of the things we need to do is establish a high-level board with political oversight and highest level – Chief Officer level – from Government to actually own these areas. And it is not just suicide; substance misuse would be another one, domestic violence, there is a whole long list that we can come up with. The problem is, if we keep generating a group for each one of those topics separately, it is the same people all the time and actually we cannot resource it like that.

So I think what we need to put in place is at least one, and possibly two, overarching partnership boards. I think one would probably generally follow the arrangements across for health and wellbeing boards and the other one for community safety and I think suicide prevention is one that actually sits across those two structures. But I think until we have that; I mean I could write you a lovely strategy right now for suicide prevention, but it will not have teeth and it will not happen, because resources have to be committed. It is not enough, for example, just to offer training to a few professionals or professional groups. You have actually got to realign their job descriptions, make sure their managers are holding them to account for actually delivering what they have learned in their job, monitoring and evaluating to make sure we are seeing a difference; and there is a lot of work involved in that.

So until we are aligned with a framework that will enable us to do it meaningfully, I would suggest we go cautiously on it.

The Minister: And I think that is a very important point to make Mr Chairman: it does need to be cross-Government. (**Mr Perkins:** Yes.) Because one of the interesting things when you look through the stats – and whatever arguments we can have about how correct the previous stats were – when you look at the audit, for instance, that was conducted on suicide between 2008 and 2014, of the 66 they identified there were 24 who did not have any contact, as far as people could find, with the Mental Health Service whatsoever, and even those that did, when you look at the breakdown, 22 of those were actually at the community mental health level. So it was not a huge amount.

When people think of people having contact with Mental Health, they think of the Crisis Team, they think of people coming forward and saying, 'I have got serious problems here, I am going to do myself harm' – only 15 of the 66 actually had contact with the Crisis Team. So it is

important, if we are going to catch people and provide prevention and support, it has got to actually be across Government and across agencies, not just this focus that sometimes can be drawn to Mental Health, as if it is all themselves.

Q176. The Chairman: I think what has just been said by both of you is very positive.
Any idea of time scale?

The Minister: Well, actually, some of the changes are starting to filter through now, from what I can see as Minister. Obviously in terms of setting up a board and everything else, we need to make sure that is done properly, so I do not have an exact timescale for that at the moment. But one of the things that is being trialled by the Mental Health Service is the e-clinics, which are now from running with Qwell, so people can get in touch confidentially and seek support that way. Because one of the other things which I found quite interesting that has been drawn out of all the audits is it is more likely for men to be in a situation where they end up committing suicide, but they are also the group least likely to seek help. I think that is something that is got to be overcome.

As males we do not tend to talk about our emotions, we do not tend to talk about problems, we let things build up. So just even having these clinics in place, where they can privately talk to someone who is not potentially on-Island, does not necessarily know who they are, and there is not that worry or risk that people are going to find out about whatever they are discussing, I think that is a step forward.

But in terms of driving it across Government, it is something, certainly as Minister, I am keen to do. And I want to emphasise what Henrietta said when she said she might have thought she was talking out of turn, she most certainly is not. Government over the years has been very good at writing lots of pretty documents that then go nowhere and it has been – as I think both my colleagues here know – one of my pet hates as well. That is something we have got to make sure that we actually deliver on, and make sure we have a strategy going forward.

Q177. Mr Perkins: I think one of the things we have we have got to bottom out is GDPR, because certain Departments hide behind GDPR when they could be acting in the interests of the person that is having a crisis.

The Minister: If I can just come in on that – (**Mr Perkins:** Yes.) because nobody should be hiding behind GDPR. It is a nonsense to say that, 'Oh, because of GDPR information cannot be shared'. I have had this clarified previously: if you are in a position where the sharing of that information benefits the individual and it is to stop the individual coming to harm, there is nothing to stop agencies sharing that information. As far as I am aware, that has been communicated across the DHSC and across all of our teams.

So I would look very dimly on anything that came forward that suggested information was not being shared because people were trying to put up this false barrier of GDPR.

Q178. The Chairman: Can I just say, I agree that there have been reports over the years which do not seem to have been acted upon, and it is very sad in some situations what arises out of that. However, there also have been expressions of good intent made, and I do hope that you are able to complete the work.

In 2017 a suicide prevention stakeholder group produced a draft needs assessment report. What is the status of that document?

The Minister: Yes, so in relation to the needs assessment, the final sign-off and implementation was put in place in September 2018. There were a couple of changes that needed to be looked at. The one year post-implementation review was also completed and signed off in November 2018 and two further actions have been completed as part of that

implementation. Those two further actions, for the Committee's information, are a new needs assessment form, which is evidence-based, was drawn up, because I believe the previous one was not very evidence-based. Also, there is advanced suicide prevention training currently being provided to staff. The most up-to-date figure I have is that so far across DHSC there have been 304 individuals that have now been trained to be mental health first aiders. So it is been taken up very well.

Longer term, my personal ambition is to have that rolled out to other Government Departments as well, but I have also got to be a realist in terms of the current budgetary constraints and we will look to see, once we have got the staff trained up within DHSC, how we can actually move that forward. Of course, you will also be aware, from previous evidence you have had, about the general wellbeing policies now across Government and how that is expanding across Departments.

Dr Ewart: And I think this is something that we also need to work with private employers about, because employers do have an opportunity to look after their employees' mental health generally and obviously suicide awareness prevention is part of that.

The Minister: Yes.

Q179. Mr Perkins: And particularly the high stress jobs, nursing and the Police and what have you.

Dr Ewart: Yes, the medical profession (**Mr Perkins**: Yes.) has one of the highest suicide rates.

The Minister: And that is why it has been important that with this we have focused primarily on DHSC staff – (**Mr Perkins:** Yes.) and also ensuring there are people in the workplace, colleagues, who can help and assist with wellbeing.

Q180. Mr Perkins: Are you targeting specific groups along your thinking, the high-risk groups?

The Minister: Well, I think it is for everyone to be perfectly honest, it is not just the high-risk groups. I think the problem with these sort of things is if you focus too much on the high-risk groups you then start isolating out others. Maybe it is a very high level, but in my view, in relation to suicide, one death is too many. I think once you start breaking it down, it is fine for collating data, but when you are trying to offer support to people on the ground, if you are saying, 'Well, you are a male between 45 and 55 so we are going to focus on you more primarily' you are potentially missing the female who is in the 30 brackets who is requiring equal if not more support.

I personally would say it has got to be dealt with on an individual basis and individual needs That is why one of the things I am very keen within mental health that the triaging they do in relation to people coming to see them is very important.

Q181. The Chairman: In the past I remember a previous report, or something, saying males of a certain age – middle-aged – in rural communities were more at risk. Back to what you just said about males not being prepared to talk sometimes, I think younger males are certainly much better than those of my age, which has got to be a good thing, hasn't it?

The Minister: Yes.

Q182. The Chairman: In April 2019 Dr Ewart sent us a copy of a paper entitled 'Suicide Prevention Overview Paper' dated January 2019. She told us the paper had recently been presented to the Department, Minister and Members. So what is the status of that document?

Dr Ewart: Right, well, that comes back to what I was saying about us actually taking on the strategic need for suicide prevention within Public Health and that was the document that we presented as the basis for the discussion of that to get it all agreed. As I was saying before, we have not taken it forward yet, and I am hesitant to start doing so until we have got the governance framework to really give it some teeth and get some traction because just producing another nice document is not going to help us.

Q183. Mr Perkins: Is that based on the 2017 Report or as separate?

Dr Ewart: No, I have to say, that actually there are methodological issues with all those reports and one of the reasons for that is because Public Health had no involvement in them and Public Health does actually have that (**The Chairman:** Absolutely.) skillset for looking at the epidemiology, for looking at the evidence and for all the rest of it, which is why I was really very surprised to find that Public Health was not really involved with it at all in any of its earlier history.

Now, the National Institute of Health and Care Excellence (NICE) published comprehensive state-of-the-art evidence-based guidance in October last year for the prevention of suicide in community and also in custodial settings. That gives very clear actions that need to be taken, and that is going to be further strengthened by publication, which is expected on the 10th of this month, of quality standards; which actually is the tool that enables you to say, here on the Isle of Man, are we meeting this quality standard for this element of suicide prevention, yes or no? And that very easily leads into an action plan to close those gaps.

So actually, the time is really ripe for us to get a grip on this and do it properly. As I say, those quality standards are going to be published later this month and I hope we are soon going to make progress in terms of establishing the appropriate sort of board governance framework for taking the ownership of this.

The Minister: And again, just very quickly, Mr Chairman, from a high-level political point of view, again, this is crucial. It is about joined-up government or lack thereof. This has been the problem I think (**The Chairman:** Absolutely.) going look back for a long time. You have got individual agencies collating individual statistics. There needs to be one central body that collates the statistics and drives the policy, and that should be Public Health. That is one of the reasons a Sir Jonathan Michael Review recommendation was to move Public Health out of the Department and into Cabinet Office, to give it that all-world view.

Q184. The Clerk: Sorry, Mr Cretney, I think the Minister also said there was a whole lot of action already going on under the 2017 proposal, with which Dr Ewart says there are methodological problems?

The Minister: No. Under the 2017 proposal what has come out of that is in relation to the training. Well, from my point of view the training should be happening anyway. Regardless of what the 2017 Review had actually said, we should be training up our staff as mental health first aiders and there should be people on the ground. The new needs assessment form, which is something internal to the Department anyway … So what has come out of the 2017 … it is not suddenly driving stuff down a particular pathway that we would not have gone down anyway, and also, obviously, the e-clinics – which I am a great supporter of – is an initiative that should have happened even without that particular assessment.

So none of the stuff that is going on plays against what (***Dr Ewart:*** No.) Henrietta has said. If anything, it actually complements it.

Q185. The Chairman: Until we get to what has been stated today, which I think is certainly good progress, are there any particular initiatives being aimed at reducing the suicide risk in groups with statistically high suicide risks – young people, middle-aged men, prisoners and former prisoners, people with depression, alcohol and drug users, veterans and survivors of abuse?

Dr Ewart: I think within all of those it really comes back to the point that the Minister made, that some of them are actually quite global groups. If we talk about males, we have got young males, we have got middle-aged males, we then get another group that are older males. In terms of, actually, how do you target a risk group, that is one that actually needs universal … and it is about really getting as far upstream as possible around just opening up the ability to talk about emotions and feelings. A lot of people who would benefit from that are not people who would ever have gone on to attempt or complete a suicide. So those sorts of initiatives will actually have huge impact on overall emotional and mental health and wellbeing. Hopefully a reduction in suicides or attempted suicides will also be a feature of that.

For some of the other groups, people who have an alcohol misuse problem, a substance misuse problem, depression, they are going to be often in touch with services already. So there is something there, and it comes back to what the Minister has been saying about making sure that the staff in those services – because those are DHSC services – are trained around suicide prevention; how to actually spot the signs in somebody that you are seeing for their alcohol misuse that they may actually be at risk of suicide, ditto somebody with a depression.

Certainly there have been some fears in health professionals that actually you must not mention suicide because that could put the idea in the person's head and create the thing you do not want to create. But we now know that all the evidence is that that is not the case and there are some, what you might call, simple standard questions that use forms of words that health professionals can be confident are appropriate to use just to open up that area as something to talk about with the person.

So that is within the initiatives that the Minister was talking about as going ahead already.

The Minister: And I hate to bang on about it, but with the e-clinics it gives that more private forum. Because again, with men not likely to speak about it, rural communities, which you mentioned before, Mr Chairman, even in the UK tend to be close-knit communities and the problem is there is this perceived fear that if I go off and speak to someone, they know me or they know my friends, they know my family; that information is going to get shared. It is not, but there is that perceived worry there, on top of everything else. So having that private forum for people to be able to go and seek help is absolutely essential for that group.

Q186. Mr Perkins: So what sort of timescale are we looking at then when the mental health first aid is going to be rolled out across the Department and the rest of Government, hopefully?

The Minister: Well, it is already being rolled out across DHSC. As I say, 304 are already taking place. I am a very impatient person, as you know Mr Perkins, I would quite happily do it tomorrow, people then have to rein me in. As I said, we have got to be realistic, because the five mental health first aid trainers are all DHSC staff, they have day jobs as well, so I am going to have to look for some form of budget in order to actually be able to drive that forward. So that is why I cannot put a timescale on it at the moment. But from my point of view it is important, internally within the Department, we have got that training up and running. But then it is something that –

Q187. The Clerk: So 304 is what proportion of the Department's workforce?

The Minister: So 304, off the top of my head, would be roughly about 9%. As a Department I think we are about 3,500 staff across the entire Department, so with quick maths in my head, about 8.5% or 9%. And the training is still ongoing.

Q188. The Clerk: But there is no timescale for it to be finished?

The Minister: Well, as I say, we have got five trainers internally who are delivering the training; they have day jobs as well. What we are trying to do is get various staff around the different areas of the Department, so there is at least someone in each area that has had the training.

Q189. The Chairman: Why does it still take so long to access psychological interventions such as CBT and counselling?

The Minister: The simple fact is it is sheer numbers coming through the service. You will be aware, Mr Chairman, in fact I think you alluded to it in a previous evidence session, I think it was Mr Henderson's evidence session. There has been an increase in budget for Mental Health, so Mental Health's budget did see an increase this year, but the numbers that are trying to go through are still increasing.

One of the reasons as well, and certainly in relation to children's mental health, and I think I have stated this in Tynwald, it is important we get the autism pathway up and running; because currently those with autism are being referred into CAMHS and they should really be separated out and have a separate service. That will then alleviate pressure to be able to deal with the more difficult cases in children's mental health.

But the plain and simple answer is it is sheer numbers going through.

Dr Ewart: And I think that is one where there needs to be a lot of pathway work, and I think this will get picked up within the transformation. Because, again, it is that thing of getting upstream and doing simple things quickly which stop the problem becoming chronic and growing, and then requiring referral to specialist services. There is increasing evidence about how to do that; because ultimately what we want to aim for is a population that is emotionally and mentally resilient to all the stuff that life throws at all of us.

Clearly, the answer to that is not to refer people into specialist services.

The Minister: And I think – following on from that – it leads very nicely into another one of my pet topics, which is integrated care and getting more out into the community as well. I keep talking about the Hospital being very acutes focused, while other services in the past have always been very clinical focused, and mental health certainly falls into that bracket.

I think there have been changes since we created the Community Division that has brought services together rather than operating in silos, and Angela Murray, who you will be hearing evidence from next week, great credit to her for pulling that all together. But I think with integrated care there should be more community services available to people where they live, so they are not being pulled into a clinical environment; they can actually have support in their community. And that is absolutely crucial.

The Chairman: Okay.

Q190. Mr Perkins: And I think the evidence we have had over the years on mental health is the quicker you can get an intervention, the lower down the scale of the problem, it stops it escalating. I think that is vitally important.

The Minister: And that is the problem with the clinical referral, because you get referred up the chain, you have then got to be assessed as to where you are in the priority of being seen and that is before you even go into the system for an actual appointment. So I would say, personally, at the moment it is rather cumbersome, and it has been for a very long time.

That is one of the things that we need to break down with the integrated care model that we are looking to roll out across the Island.

Q191. Mr Perkins: So when somebody first presents themselves, do you do suicide risk assessments for your frontline staff?

The Minister: My understanding is, if they present themselves – by present, Mr Perkins, can I just clarify what you mean by present? Because there are various different ways they might present, so if you gave me an example.

Mr Perkins: Well, I suppose through the mental health route –

The Minister: So say they presented through the Crisis Team, (**Mr Perkins:** Yes.) let's take that as an example. My understanding of the way it works is the Crisis Team would be called in to speak to the individual, the individual would then be triaged, so they would actually do an assessment to decide are they a risk to themselves, are they a risk to others and what is the actual issue? And then from that assessment that would decide then the priority of how quickly the person is seen.

Q192. Mr Perkins: And what about the Mental Health people that are going with the Police to a distressed person? Is that working well?

The Minister: I have spoken to the Chief Constable about it to see how it was going and he is actually – I was going to use the phrase overjoyed, but I think maybe that is … But he is greatly enthused by what is actually happening on the ground. I think it has made a big difference. And I think I have said during one of our general evidence sessions, the first general evidence session I gave as Minister, we should not be putting police officers through having to become mental health workers and make assessments of people on the ground. Having that support there has actually massively assisted the Police, both enabling the speed they can deal with people and getting the person to the right point to help them.

I am keen to look to see how we can expand that and build on it.

Mr Perkins: Thank you.

Q193. The Chairman: Just to go back to Dr Ewart for a moment, where you spoke about resilience, is there any evidence or is there any work being done, not only here but elsewhere, as to whether society is less resilient than once it was? And is there anything –?

Dr Ewart: I think that is very difficult (**The Chairman:** Yes.) to actually quantify in any way. I think sometimes there is the kind of thing between the stiff upper lip of days gone by and the snowflakes of today. Now, I do not think that the stiff upper lip was necessarily a particularly good thing, and clearly being too much of a snowflake is not particularly good either.

But I think that there is increasing evidence about trying to build resilience from birth up really, and a lot of that is about building resilience in individuals, but also resilience in communities, so that there is more going on within a community that can support people and instead of the old model – the very medical model – of we do things to and for people, it is actually enabling people and communities to do things for themselves.

Q194. The Chairman: So if there is anywhere that should have a positive opportunity to capitalise on resilient communities, then the Isle of Man should be a perfect model really, shouldn't it?

595

The Minister: Yes.

Dr Ewart: Yes.

600 **Q195. The Chairman:** What screening procedures are in place relating to depression? Has the Department considered adopting a 'zero suicide' approach, where all primary care patients would be screened for depression?

Dr Ewart: There is no evidence to support that.

605 There are questions which have been validated for use when a health professional is with somebody who they think may be depressed, but you would not use them for everybody. If I went in with a sore throat, I would not expect to be asked the questions. The two questions are very simple: in the last two weeks have you found that you are not getting any pleasure from anything that you are doing? And – actually I cannot even remember what the other one is – I 610 could quickly look it up for you if you are interested, because it is in the NICE guidance. Do you want me to do that?

The Chairman: Yes.

615 ***The Minister:*** Just while Henrietta is going that, from my personal point of view, and obviously it is a layman's point of view, there are grades of depression as well. I have got friends who suffer quite (**The Chairman:** Yes.) badly from depression and certainly in one particular case that question would not necessarily capture them, because they go through phases where they may have two or three days being deeply depressed and then on day three and four they are as 620 bright as anyone and you would not know anything was wrong.

I think that is the difficulty with depression, it can come and go. So while it might be easy to identify those who are in a stable, long-term bout of depression, you are not necessarily going to pick up the others. And also, to be honest, to be frank again, people are not necessarily always honest and open – (**The Chairman:** No.) about depression or they do not even recognise the 625 signs of it themselves, for them it is just the norm.

Dr Ewart: The guidance for case identification from NICE is:

> Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:
>
> - During the last month, have you often been bothered by feeling down, depressed or hopeless?

And then the other one is:

> - During the last month, have you often been bothered by having little interest or pleasure in doing things?

If you get a positive answer to those then you should move on to doing what is known as a 630 full mental state examination. And if you are a health professional who does not know how to do that full examination, you would suggest the person sees somebody who is.

Q196. The Chairman: I think I read somewhere, in some of the papers we have received, where persons who have attempted to take their own life then do a questionnaire or something

afterwards and say, 'No it was not something I did deliberately.' Is it not likely that people are likely to give that answer?

The Minister: From my point of view, yes. The likelihood of anyone being completely and utterly honest (**The Chairman:** Yes.) in relation to such a questionnaire; I mean I personally would question the validity of any stats that came off that because – (**The Chairman:** Yes, good.) I am not convinced that it would give a true picture.

Dr Ewart: No, and certainly the evidence-based guidance from NICE does not recommend using such a questionnaire as part of standard, post-incident work.

The Chairman: Good.

The Minister: And also post-incident there is nothing to say that person still will not be (**The Chairman:** Absolutely.) suffering from depression –

The Chairman: Well that was my concern –

The Minister: And you could actually push them (**The Chairman:** Yes.) the other way back again.

Q197. The Clerk: The excerpt that Dr Ewart just read out, you said it was from NICE guidelines. I am sorry, can you remind me, is it the NICE guidelines … what is the theme of the overall guidelines? Because you were talking about depression, but you have also told us there is more –

Dr Ewart: That particular guideline is the guideline called 'Depression in adults: recognition and management.'

Q198. The Clerk: But you have also told us there is a lot more to suicide prevention than looking out for depression. So is there a policy, or is there going to be a policy, where people working at all services are supposed to be vigilant for something? We have talked about how do people present, but is there an issue about spotting people who have not presented?

The Minister: This ties in with the mental health first aiders that I was talking about before, that we are currently only doing within DHSC. Longer term, like I say, I want to roll out further, but it ties in with that. It is about training people up to spot the signs and get early intervention. Evidence shows that sometimes people feel in a workplace they cannot go up to someone if they are worried about them, because they feel (1) they are either going to make matters worse, or (2) that person is just going to tell them to find the nearest door, (**The Chairman:** Absolutely.) rather impolitely. There is always that fear. And this is what this mental health first aid training is all about, is getting people in place over those barriers, who do not mind walking up and saying, 'Fred, Frank, are you okay?' Asking the question and just picking up those early signs. Some people who unfortunately will shut off completely, it may not help, but even if it helps one or two people and gets them into the system …

Q199. The Clerk: So the first aid can be proactive, it is not only reactive?

The Minister: Yes.

Dr Ewart: Oh yes. And, in fact, the Minister has been talking about the mental health first aid, which is a recognised programme, so that is a thing, and it is an extremely valuable thing, so it is great that that is going ahead.

There is actually another programme which is very specifically around suicide intervention and that is called ASIST, and that stands for Applied Suicide Intervention Skills Training. That is a two-day course, which can be delivered to anyone you want to deliver it to. It could be done by employers for people in the workplace, it could be done, and in fact I think it is being used, alongside within DHSC.

I can give an example of where I have used it in the past. This was when I working in Peterborough and we had a very particular problem in Peterborough with multi-storey car parks and people literally catching buses into Peterborough to jump off them. Obviously one of the things you do there is try to reduce access, so you use barriers, you have bright lighting, you have positive upbeat music. But one of the other things we did was actually get the parking attendants through the ASIST training, so that they could see if somebody was hanging around the stairwell or whatever, and then knew how to go and open a simple conversation with them. So I think there are a number of interventions that can be put in place.

I think one of the things we have to be careful, with training, is you can risk scatter-gunning with it. So, 'Everybody is going to get mental health first aid training, everybody is going to get ASIST training, we have sorted the issue'. But one of the things is – we touched on it before – that people have to be supported to actually use that training, because it is perfectly possible to go off on a lovely two-day training course, or whatever it is, have a jolly good time and then actually never use what you learnt ever, and that is not what we want.

So there is definitely something about how we monitor and evaluate what happens as a result of putting these initiatives in place.

Q200. Mr Perkins: We have heard a lot about people that have taken their own life. The real victims in all this, of course, are the loved ones and the families that are left behind.

What is the Department doing to support them?

Dr Ewart: Again, we have to look at the evidence to support what we should do, and again, that is very well-covered in the NICE evidence-based guidance. They do need support and that can be in a number of ways. Public Health England actually has written guidance that people can be given, for some people that might be all they need. There are also obviously a lot of peer-to-peer bereavement services, things like Cruse, which are very valuable.

There has been a bit of a vogue in some places for what are called 'postvention' programmes, but the evidence base to support them simply is not there. In fact, some of the evaluations of those programmes have shown they were actually harmful. So I think we have to be very careful not to buy into some of the advocates for some of these things. I am sure the advocates are coming from a place of very good motivation, but with all of these things, rather than fall into the trap of, 'This is a dreadful thing, we must do something, let's do this', we always need to stand and look at the evidence.

Q201. Mr Perkins: I think is particularly difficult on the Island as well, isn't it? With a close community.

Dr Ewart: Yes.

The Minister: And I think, again, just to add to that, it comes down to the individual support needed. We cannot really box all families the same and say this is the pathway you will follow. Families and individuals are affected in different ways, so for me, it is ensuring that there is tailored support there to help the individuals, but the help they want, because the help that they

do not want could not just potentially be seen as interference, it can actually do detrimental damage. It is important we avoid that as well.

Q202. The Chairman: The last of my prepared questions is about the connection between the judicial process and the Department. What processes are in place to ensure the implementation of recommendations made by the Coroner of Inquests?

The Minister: I will take that one Mr Chairman.

In relation to the Coroner of Inquests, as the Committee will be aware, under rule 34 of the Coroner's Act, the coroner, if he has any recommendations will write to me, as Minister. In relation to suicide, which is the topic we are talking about today, what would happen is – although it is a similar process throughout the Department – it would be referred into the Community Division. What will then happen is within 20 days they will draw up a plan as to how they are going to respond and what they are going to do about the action points. I will then formally write back to the coroner listing out what we are going to do in light of the recommendations and we do then follow that up and write back to the coroner in the future saying what we have actually done in relation to that.

The Department does keep a log of it all as well. I think it was released as part of a Tynwald Question not long ago; I cannot remember who asked me the Question, but we actually went back and provided the stats in relation to what the Department has done in relation to coroners' recommendations.

The Chairman: Okay.

Q203. Mr Perkins: Have you any views on how the media should report the coroner's result?

Dr Ewart: Yes, there are again very good guidelines around this.

This is something that is touched on by NICE, and the Samaritans have also done an awful lot of work in that area and have a publication of guidelines for good practice for media reporting. I am not aware that that has been formally done here. I think when we move on with the strategy, and particularly because it will come through in one of the NICE assessments when we benchmark against the quality standards we will be testing that. But certainly the reporting that I have seen when cases have happened actually seems to be within those guidelines already.

So it is not waving a red flag, shall we say.

Mr Perkins: Right. Thank you.

Q204. The Chairman: I can say that was not always the case, and I got myself into big trouble with the press a long time ago because they felt that I was interfering with what was a public process, and of course the coroner's inquest is a public process, but the extent to which they were reporting, to me, felt to be more than was necessary.

Dr Ewart: Yes, exactly.

The Chairman: Anyway that is all I have, anything…?

Q205. Mr Perkins: Just one quick one, if I may; it is not actually related to what we are looking at today, but you mentioned epidemiology – I am a great one for that. Are you looking at other areas within the Island? Because I think that is so important for the long-term health benefits.

Dr Ewart: Absolutely, and, as I say, it is really something that was for whatever reasons just completely not happening. So what we now have in place is the beginnings of a Public Health Outcomes Framework, which is very much modelled on the Public Health England one. When we were deciding where to go with this when I came into post, we actually looked at what was being done across the four nations of the UK, plus Ireland, plus further afield, and actually Public Health England is by far the most developed. Nobody else has one that is publicly available in the way that that one is or that enables you not only to look at the England figures, but you can actually compare yourself to different areas, which is also quite useful.

So we are developing that. We have now published two editions. The first one we did in 2017, the second one was published in June. We cannot yet replicate all the data items that are in the Public Health England data-set. A lot of those data items do not come from health. They come from education, they come from housing, they come from employment and social security, and we have a big job, I think, to actually look at why those branches of Government are not routinely publishing data items and to see whether we can get agreement.

Again, this comes back to having the national governance framework for all of this to actually say, 'You publish that'. I would like us to look at that and at least if people take the view that we are not going to publish those data items, they need to say that they have considered the question and why they are not. I think, in my mind, we should call them out and hold them to account for that.

So the Public Health Outcomes Framework is really, as I was saying with the suicide statistic, our top-level diagnostic, and benchmarking against England or regions within England enables us to say, 'Actually, we have got a red flag waving here, we are worse on this indicator than England and we are worse than the north west, and if we are worse than the north west that really is a problem because the north west has a lot of post-industrial, very deprived conditions. So anything where that is a feature we then need to do the much deeper dive and we need to start doing that by really having a rolling programme of what are called, across, Joint Strategic Needs Assessments, which brings together the epidemiology, the patterns of who is affected by this issue and how and where and why, and also the evidence for what is known to be effective. Because it is one thing knowing about the needs, but you also need to know what evidence-based interventions you need to be thinking about to address them and try and reduce the indicator.

The Clerk: Can I?

The Chairman: Yes.

Q206. The Clerk: Just on the on the governance point, I think Sir Jonathan Michael recommended, and Tynwald agreed, that the Public Health Directorate should move to the Cabinet Office, the Minister mentioned this earlier today. Is that a move which will need a Tynwald vote?

The Minister: Not my understanding.

Q207. The Clerk: And second question, is there going to be a date by which or on which that is going to happen, is that known yet?

The Minister: It will be done as part of Transformation. So we are currently in the process of directing the Director of Transformation – if I say it right – to lead the project, and then as part of that it will be a done alongside the other transformations. But as far as I am concerned, it should be as soon as possible really. But the work that Public Health … the move is not going to affect that. Henrietta has done a great job since she took over as Director in pulling things together and that work will be ongoing regardless of where it sits.

But from my point of view, to give it that all-world approach, it should sit in the Cabinet Office. My understanding is which functions rest with which Department is ultimately the responsibility of Council of Ministers, but if anyone can show me otherwise then I will be happy to look at it.

The Clerk: Can I just ask one last one, Mr Cretney?

The Chairman: Yes.

Q208. The Clerk: Just coming back to social media and online harm, I spotted that in the UK there is a joint consultation between, I think, Department of Health and the Home Office about online harm. Is that something which people are following here? I do not know what sort of recommendations will come out of that, but do you?

Dr Ewart: Yes, I think as a general rule we try to keep a finger on the pulse of everything that is going on across, not least because they have the capacity and resource to do the big pieces of work which we just cannot do here. So we would soon take the starting point of whatever is found that is evidence-based from elsewhere, we would expect to apply here – obviously you need to test that to make sure there are not issues that would make our context take us down a different route. But certainly in respect of that we will definitely be watching for what comes out of that and thinking about how we need to take that forward here.

Q209. The Chairman: So anything you would like to say that you do not think you have covered already?

The Minister: Personally, I would just like to thank the Committee for looking into this and pulling it to the public's attention, because suicide prevention is absolutely essential. We have come a long way in Mental Health Services compared to where it has been even in the last few years, thanks to interventions from Public Health –

Dr Ewart: And from within the Mental Health Service.

The Minister: Yes, and also the management we have currently got there. It is an absolutely crucial area to be looking at and I think there is still a lot of work to be done, but we can get there, I think.

Q210. The Chairman: Thank you. Dr Ewart, anything? No?

Dr Ewart: No, other than to say that with health and wellbeing generally, the Department of Health and Social Care actually only has a minority effect. It really is the wider determinants of health that are so important. We have seen that, we have been talking about suicide, but it applies to most other health outcomes as well.

The Chairman: Okay. So from our point of view I think it seems timely with the work that you are undertaking and our review of this subject; so hopefully we can make some significant progress rather than just reports on a shelf.

So thank you very much for coming along and being so open and helpful today. (***Dr Ewart:*** Thank you.)

And that concludes our sitting.

The Committee adjourned at 12.34 p.m.