STANDING COMMITTEE
OF
TYNWALD COURT
OFFICIAL REPORT

RECORTYS OIKOIL
BING VEAYN TINVAAL

PROCEEDINGS
DAALTYN

SOCIAL AFFAIRS POLICY REVIEW COMMITTEE

Suicide

HANSARD

Douglas, Monday, 9th September 2019

PP2019/0117 **SAPRC-SU, No. 5/2018-19**

All published Official Reports can be found on the Tynwald website:

www.tynwald.org.im/business/hansard

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
Ms J M Edge MHK
Mr M J Perkins MHK

Clerk:
Mr J D C King

Contents

Standing Committee of Tynwald on Social Affairs Policy Review

Suicide

The Committee sat in public at 3.30 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 are Mr Martyn Perkins MHK and Ms Julie Edge MHK.

If we could all ensure that 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 from this side of the table.

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. 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 inquiry 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.

Today we welcome a further representative of the Department of Health and Social Care, Angela Murray. Welcome and thank you for your written evidence.

EVIDENCE OF
Ms Angela Murray, Interim Chief Executive Officer,
Department of Health and Social Care

Q211. The Chairman: For the record, please could you state your name a job title and how long you have been in that role?

Ms Murray: My name is Angela Murray, I am the Interim Chief Executive Officer for the Department of Health and Social Care and I came into post in May.

Q212. The Chairman: Thank you.

Have you had a chance to listen to the oral evidence given by the Minister and Director of Public Health last week?

Ms Murray: I have seen some of it. I was actually on leave, so I have caught up with it this morning.

Q213. The Chairman: Okay. And is there anything you would like to add to any of the answers that they gave last week or any statement you would like to make?

Ms Murray: No, I think most of what I would say would be clarification of some of the points; that this is a national issue, it is not a mental health issue – I possibly want to put that marker down. That is not to say that there are some people who ultimately do commit suicide who have mental health problems; but I think the tendency, as we have had discussion in these forums before, is that it is often laid to the Mental Health Services as an issue for the Mental Health Services to resolve. But actually, if you look at national strategies elsewhere, they are mainly driven by a public health initiative and that is across government, it is third sector, it is private organisations etc.; all need pulling together to develop a strategy.

But key to developing the strategy is not just to have a strategy. It is to have an implementation plan that underpins the strategy.

Q214. Ms Edge: Can I just ask, is there not a suicide prevention strategy already in place or a draft one if you are not – there is one?

Ms Murray: There is one.

Ms Edge: Okay.

Q215. The Chairman: I think it was stated at the last meeting that there had been a number of strategies, some of which have ended up gathering dust on shelves.

When would a suicidal person not be admitted for inpatient treatment?

Ms Murray: Not be admitted?

The Chairman: Yes, if they present what –

Ms Murray: That would be a clinical decision led by a consultant psychiatrist and the Mental Health team, assuming that the person has been in touch with the Mental Health Services prior. I think if it was a new presentation the likelihood is that the person would actually have an admission first. So if it was not somebody that was known to the Services, it is possible that they would be admitted to the acute ward for an assessment.

But often – and it is not just here – you will find that somebody can be supported in the community depending on … it is a *very* complicated subject, as you can imagine, and a lot of factors have to be looked at. It is not necessarily always the best place for somebody to be in an acute psychiatric ward.

Q216. Ms Edge: With regard to – you said that they could be admitted – is there any family involvement when the care plan for a patient is taking place?

Ms Murray: There should be, but I do think it is a problem within the Mental Health Services that this is not done consistently and across the board, I have to say.

We have recently, for example, had a report done by Dr Dickinson and he is also suggesting in the report, whilst it is done, it is not done consistently across the board. So that is something, as a result of that review, that we are looking at.

Ms Edge: Thank you.

Q217. The Chairman: In the assessment of a service user's suicide risk, would a clinician inquire into any suicide-related internet use?

Ms Murray: Sorry, could you repeat that?

The Chairman: Yes of course, in the assessment of a service user's suicide risk, would a clinician inquire into any suicide-related internet use?

Ms Murray: Very possibly. Again, it would be on an individual basis. I think you would find certain services, such as the younger persons' service, that would be quite a feature. Because a feature of a lot of child and adolescent mental health issues is around the internet, the bullying and the suicide sites that are aimed at children. But each clinical assessment is done against a standard, but also then the clinicians will look at the individual. You do not want a sort of package that just says 'one-size-fits-all'. You have to look at it in the round on the individual.

Q218. The Chairman: I have been contacted by a family affected by suicide, and their suggestion was that when their son presented he was told that he did not fit the criteria. Is there a particular set of criteria and are they published?

Ms Murray: Without knowing the individual case that is really difficult for me.

But there are criteria into different levels of the Service. Yes, there are criteria. I would welcome information about the case so I can look into it and answer more fully as to why that would be. But there are, yes, to each step of the Service and into different services such as CAMHS – (**The Chairman:** Yes.) there are criteria.

Q219. The Chairman: In terms of a person presenting and it being decided that it would be helpful not to be on a general ward but to be in the facility, are those facilities sometimes with mixed problems; with drug and alcohol problems as well as potential suicide risks? And does that constitute a good situation or not?

Ms Murray: Yes, because they are not separate, often they are not separate.

Within the one person you can have somebody who has an addiction, who also is depressed, who needs acute care. It is multifaceted, as individuals are. So it is mixed in the sense that it is mixed within the people. Nobody is a pure case, are they? Yes, there are services targeted at addiction, and we are widening those services to include addictions outside of drug and alcohol and that specification has been developed now for the development of the service further. But you could not actually say, well … I have had politicians questioning me on this before about, 'Well, how can somebody who has a drink problem be in there?' Because that person with a drink problem might have the drink problem because they have a depression, there are 101 different things. So you cannot separate them and put them into silos because of the fact that we are all human, and we are all a mixture of a lot of things.

Q220. The Chairman: Okay.

Your policy for risk assessment and management of self-injury and the prevention of suicide states, and I quote, 'Wherever possible consent should be sought from the patient. However, there may be occasions where the level and degree of risk necessitates disclosure of information even if consent is not obtained. Where information is shared without consent a clear rationale will be documented in the patient's progress notes.'

Is there a policy or further guidance available to clinicians on this?

Ms Murray: That has to be, at the end of the day, with all respect to sharing information of a personal nature, you have to assess the risk of not sharing that information and I think there are

cases in the past where the Services have been very nervous – the people who work within the Service – have been very nervous, because, constantly, we are told about GDPR and we are very conscious of not sharing information that we should not. Therefore, I think sometimes there is a reticence when really the priority has to be the safety of the person and the risk therein of not sharing that information. Now, once you make that decision as a clinician, or as a team of clinicians, the documenting of it is *very* important. It must be fully documented as to why that decision was made.

Q221. Mr Perkins: Does that include sharing with the Police?

Ms Murray: Not of a criminal nature, no. That is not for us to do.

Q222. Mr Perkins: Not a criminal nature, but somebody who is mentally disturbed and possibly suicidal, and the Police are trying to decide the best outcome for that person – (***Ms Murray:*** Yes.) would you disclose information on that person or not?

Ms Murray: Well, we have resolved that issue in a different way – (**Mr Perkins:** Okay, yes.) We have actually put mental health nurses working in the Police force. So if an officer suspects that there is somebody with a mental health problem or somebody says, 'I have a mental health problem' or 'I feel suicidal', they have an RMN attached to the Police and we are expanding that service. Again, we are working closely with the Police to make that wider and deeper.

We put two RMNs from the Mental Health Services into the Police Force to run as a pilot. We have completed that pilot, we have the evidence of use etc. now and we are moving forward with the business case to expand it.

Q223. Ms Edge: Obviously I have read reports that it is been quite a successful service. But do you know of any times when somebody with a mental health problem has been held within the Police environment longer than they should have because you did not have availability up at Manannan Court, or…?

Ms Murray: Can I widen this out to a custodial setting as opposed to the Police Force? Because sometimes you will have people end up in prison, and either they can be in prison with a mental health problem, or the fact that they have been put into a custodial setting can create a mental health problem. And we have had, in the past, before we actually had an off-Island placement contract in place, a lot of difficulty placing people in the appropriate setting, which is a forensic setting.

If somebody is in the police station, they go through a full assessment and they have a mental health problem, then actually what happens at the police station is the appropriate services are brought in and contacted, and the person transferred, if the mental health problem is the primary issue. It could be that an addiction is the primary issue, in which case you put addiction services into the Police and into the Prison, and we have extended the services that we provide into the Prison significantly in the last 18 months. We have more mental health workers working in the Prison, and that has proved very successful as well.

Q224. Ms Edge: So the mental health nurses are working closely with the Police, police pick somebody up, they come to Police Headquarters, a mental health nurse takes over makes the decision if that person's mental health is seen to be the main reason why they have ended up at a police station? They might not have been charged with anything at that point (***Ms Murray:*** Yes.) so the mental health nurse professional –

Ms Murray: The decision is not just that one RMN alone.

The RMN job in the police station is to assess the person's mental health against our sort of standard protocols, and then bring in other services that may be required to either stabilise, or support or transfer the person out; and that could be a range of services. That also depends on the index offence. So not everybody … depending on the seriousness of the index offence, they would receive the service, but it might be that they stay in custody and they may be transferred to the UK or … As I say, it is multifaceted, it depends on a set of circumstances.

Ms Edge: Thank you.

Q225. The Chairman: With having two registered mental nurses associated with the Police, are they able to cover the situation 24/7?

Ms Murray: That is why we are expanding it.

What we actually do at the moment is the two cover a fair bulk of the shifts, and we assessed when they were most needed – when the most usage was. Now, that proved quite difficult, because actually people commit crime at different times. They do not all commit crime or become unwell, do they, (**The Chairman:** No.) nine to five, Monday to Friday, or hours like that. So the Service is backed up, when those RMNs are not on duty, by our crisis service.

But going forward, as I say, between DHA and DHSC we have put a business case together that says you need … and we have worked out the specification in the model for what is required to actually cover it 24/7. And we are looking at putting physical health nurses in as well, but they will be on more of an on-call basis, because a lot of physical health problems can affect people's mental health.

So you will not just have an RMN assessment if the person says, for example, 'I am diabetic', they would have a general nurse come in and screen them as well.

Q226. Ms Edge: You just mentioned the Crisis Response Team, are there ever any times where they would refuse to see somebody because they were under the influence of drugs or drink?

Ms Murray: Yes. If somebody is actually in custody and they are drunk, you cannot do a mental health assessment, because you do not know what is the alcohol and what is the problem. So this is where, actually, the physical health nurses will help once we get them on-board, because what happens at the moment is that person is then taken to the Emergency Department at the Hospital, and actually, the issue could just be that they are drunk and it often happens that they will say, 'I want to end it', and it appears to be a mental health problem. We take them, unfortunately that ties the Police up for a significant amount of time, the person is sobering up and often creating problems within the ED department. It is not just here, this happens everywhere. And then when they sober up, an assessment is able to be done and actually they are fine. But that does not mean to say we do not monitor them. They are offered appointments and ...

So there are cases like that and then, of course, there are cases where, actually, when the drink wears off, they are not well at all and the drink is as a result of the fact that they are not well, because often people with mental health problems try to self-medicate with drink or drugs.

Q227. Mr Perkins: Just coming back to the physical pain, is there any additional psychological support for people experiencing severe chronic physical pain?

Ms Murray: Okay – another thorny issue here.

We are looking at the development of Health liaison in its broader sense. We did have some Health liaison from Mental Health Services into Noble's Hospital, for example. But again, this is this mixture of where people think everything is a mental health problem. If somebody has a

diagnosis of what is essentially a life-changing disease, and there are plenty of those, then they need support. That is not a mental health problem. That is somebody that needs support from psychological services. And when I first came here that was a service provided by a very senior psychologist, which was all the wrong way around.

What people need is therapists to be intervening at a CBT level, supporting them to come to terms with their pain or their disease or … Now, we have a specification written for that and we are just recruiting two to run a pilot to see exactly what the usage is. So somebody that would go into custody and fall into that bracket would be then referred to that service so that we can assess exactly what is needed.

Mr Perkins: Thank you.

Q228. The Chairman: How often are the anxiety management courses offered by the Community Wellbeing Service run and how long are waiting lists to attend?

Ms Murray: I cannot answer that actually at the moment.

But we have, again, just been successful in achieving funding for our western area pilot, where we are putting Level 2 services, Tier 2 services, into GP practices, and we are starting in the west of the Island. Again, we need to assess the usage.

So that should actually give us some really useful information and be able to assess really whether each locality, as we move around the Island, should have the service and what size it should be. Each area should have the service, but we do not know yet until we have got that information, because it is not just about having access to a psychiatrist or any profession. It is about a team of people dealing with, what we call, the lower intensity on an IAPT programme actually being accessed through with a GP. So if you were going to the GP with low-level anxiety or depression, they would be able to say okay, you can see a counsellor or you can see a psychologist or whoever next Wednesday. The clinic is on next Wednesday. So it is a quick access through.

Q229. The Clerk: Sorry, Mr Cretney, while you are reflecting on that, can I just ask Ms Murray what is an IAPT programme? Is that an acronym that you have…?

Ms Murray: Sorry, it is the Improved Access to Psychological Therapies. It has been in the UK maybe now 12 or 15 years, something like that. But that is its title, yes, sorry.

The Clerk: That is alright, thank you very much.

Q230. The Chairman: When will further psycho-education workshops covering issues such as confidence, assertiveness and sleep be made available?

Ms Murray: I could not quite catch what you said at the end Mr Cretney, I am sorry.

The Chairman: It is no problem. When will further psycho-education workshops covering issues such as confidence, assertiveness and sleep be made available?

Ms Murray: I cannot answer that, because actually we are talking about resources here. And again, is this a mental health service? I am not saying they are not problems, but I think as part of a strategy that looks at what is a national issue, that is what we would have to do, is actually start to classify at what point does this become a mental health problem?

Now, for some people, you talk about sleep deprivation, most definitely some people end up with a mental health problem because they are sleep deprived. But why were they sleep

deprived in the first place? There is a lot of work to do to gather the data around all of that before you could deliver any sort of service or plan a service.

Q231. The Chairman: Before you became the Interim Chief Executive Officer of the Department one of your key roles was in the mental health area. Would you be able to say, in your opinion, do you think things are going in the right direction and is the pace fast enough?

Ms Murray: I think if you look back over the last three years – and I suppose you could say I would say this – but we now have steps of care that were not there before, and all out of the same resources. I think resources are a big issue. We have created Tier 2 services from within the existing services. So they are not as deep and wide as they should be; the sorts of issues you are talking about there. We cannot take everything on, because actually, you talk about waiting lists, the waiting lists would be sky-high. It needs resourcing properly.

But the biggest problem I have found on the Island is the lack of data to plan anything. So this is why we take the approach of saying, as we did with the forensics, we will put a pilot study in for a year and then we will know at least over a year what is needed and then we can start to plan, which is what we have been able to do with DHA. And I think we do need pump-priming monies to do the same sort of thing in the general Mental Health Services.

So I think, yes, we have done quite well with what we have got. If you look at what we were spending off-Island by having individual contracts for each person, we have saved £1.3 million, I think, overall by having a block contract. And so we have all tiers of service in place, we have introduced the pilot and the work that we have done on the forensic and the custodial.

So yes, I think an awful lot has been done. It still is not where it should be, but it is a long way towards it.

Q232. The Chairman: Has any of the £1.3 million been able to be reallocated towards other mental health issues?

Ms Murray: Yes, I think it sort of went back into Treasury and back out for the forensic placements, and that of course fundamentally changed the Prison environment, for example.

So yes, I think it has been reinvested.

Q233. Ms Edge: If somebody has been under your care and they can discharge themselves from it, how do you keep track of somebody to ensure that – I know it is very difficult to do, but there does not appear to be aftercare services. So say somebody has been an inpatient within Manannan Court, there is not a progress moving from being that inpatient in critical care to the next stage down.

Ms Murray: There is. Yes, I mean are – you mean if they self-discharge?

Q234. Ms Edge: Well, they could self-discharge but (***Ms Murray:*** Right.) what is the process? Is there adequate resource, I suppose is what I am asking?

Ms Murray: There is yes, there is a five-day follow-up from the Tier 3 services and we produce a dashboard each month on how many … we have a target figure to make sure that we keep on top of the five-day follow-ups. So again, it depends upon the severity. You may find somebody coming out of Manannan Court and they have immediate follow-up with the Crisis Team and they are supported by the Crisis Team. Other people will come out and have the five-day follow-up, and once they have had the five-day follow-up they might be referred to psychology, or they might have no further treatment.

An awful lot of the problems that are encountered are, if you like, out with the Mental Health Services, they are things like housing and benefits. And, of course, then they are referred to

social workers. What we are working on now is integrating those services, which was the idea of creating the Directorate of Community Care; that you do not have social work sitting in this division and you have mental health sitting here. And if you look at what we are doing in the west of the Island, is exactly how they are working. That the social workers sit down with mental health workers, sit down with the older person services and say, what does this person need?

So there is there is quite a robust system of support, but that does not mean to say that everybody that comes out needs it.

Q235. Ms Edge: So obviously you are planning to extend that – (***Ms Murray:*** Yes.) but if somebody comes out now, currently, the only place to get that service *en bloc* is the west of the Island?

Ms Murray: No. (**Ms Edge:** Okay.) The west is just the locality that we are piloting integrated care services.

There is a Tier 3 service, so if you look at Manannan Court as a Tier 4 service, you come out of a Tier 4 service and you are referred into a Tier 3 service, if you require it. And when that referral is sent through there is a five-day follow-up. So they have to see you within five days, unless there are exceptional circumstances.

So, for example, recently I asked for some information around the figures on the five-day follow-up because I saw that there was a drop in the number, and when I got the information back, some people had refused, one person had gone on holiday – they had left on they had gone on holiday with the family – and again, when you are dealing with small numbers and you are talking about 'You have only reached 85%', it only means two or three people are missed; because we are dealing with very small numbers.

So there is quite a robust five-day follow-up and then an allocation of a community worker goes on within that.

Q236. The Chairman: You will be content, I am sure, to recognise that the Minister and the Director of Public Health both referred to data and the importance of appropriate data collection, (***Ms Murray:*** Yes.) in terms of policy formulation and things, when they visited us last week. I just wondered, in terms of establishing our data, is the best way to do that with the Office of National Statistics in the UK, or should we be comparing ourselves with other Islands or things like that?

Ms Murray: Really difficult one that.

Essentially, first and foremost, we have to set our own minimum data set; which they have done in Mental Health. Then it is about, working with Public Health identifying appropriate populations. Now, that may not be another Island, because we are not all the same. It may be a rural population or a mixed population and that is where the importance of Public Health comes in because all the services should actually be guided by the JSNAs done by Public Health; which we are getting on top of now.

So you would not necessarily say, 'Oh I know, let's benchmark against Guernsey and Jersey', which we tend to do, or frequently people will say to me 'Well, what about the Isle of Wight?', And I do keep pointing out that is Hampshire. So actually, even though it is an island, it is Hampshire, and it runs … The other thing is their systems are completely different so their data collection is different.

I think there are general benchmarks that can be created by Public Health and would work reasonably well, but we have to start gathering our data correctly for us to be able to develop services tailor-made for the Island. Because again, you can take the small figures that we have here for lots of diseases and problems, and you say, well actually if you look at it percentage-wise with Hampshire, then it does not relate at all, it is apples and pears.

So it is key that our data sets are built here, and they were never done before.

The Chairman: I think that is the point I was trying to get from you. I think that is very important.

Q237. Ms Edge: Are you confident with the way it is getting gathered now, that it will be what we require for the future and it is setting policy so it cannot change if you move on from your position? Is it electronic, is it ensuring that everybody that is coming into the Service is collecting the data from the outset at the same format?

Ms Murray: Yes, to some extent, Ms Edge, it *has* to be standardised.

What we have, and what we have found over quite a considerable period of time, is that there is a lot of data and a lot of information. It is on people's spreadsheets, computers and different systems. If you look at the Digital Strategy, there must be – I cannot remember the number now – 10 or 12 different systems that have been set up over the years where data is being input, but they do not speak to each other, and it is a really big digital job to actually get the systems to speak to each other.

But, interestingly enough, I think the key to putting the individual at the centre of what we do is actually people speaking to each other in the same team working together, which is what we are doing in the west of the Island, where some of those professions had communicated with each other, but they had not sat in the same room talking to each other about Mrs Smith and what should happen with Mrs Smith and how we can support her.

Now, the data is critical to planning services and projecting how things will be going forward and the budgets and things that people like me have to live and die by. But, first and foremost, the person who is receiving our care needs the people talking to each other who are the professionals in putting that care and building the data sets up as we go along.

I think in another five years we will have quite reasonable data sets that will give us the ability to project what services we need going forward.

Q238. Ms Edge: So you started saying that we do not have data and that is making it difficult, but you have just said that there are probably about 12 digital systems, through the Digital Strategy, that have data in, but they are not talking to each other.

Is there any action getting taken to make sure that any historical information about a patient is getting gathered in one place?

Ms Murray: Yes, I mean it is one of the key recommendations in Sir Jonathan Michael's report as well; that actually GTS have been working on this for quite a long time and I do attend, obviously, quite a lot of information and technology meetings and the more I hear the more complicated it actually becomes to … You cannot have one system.

If you look at the spread of Health and Social Care and the different types of information that you need to develop somebody's social care package or their health package; if they go to cardiology that system would not support what is needed in social care. So it is about developed something that draws the information from everywhere and puts it into one package. Not easy, but it is being worked on quite hard.

Q239. Ms Edge: I suppose from a historic point of view, the question I am asking is, if I had been a patient 40 years ago, would you have my data today?

Ms Murray: There would be some data on paper.

Ms Edge: Okay. Thank you.

Q240. The Chairman: I was also going to ask, from a historic point of view – having been around here as long as I have – it has come up time and again that the various agencies of

Government from time to time were not working as well together as they should do. Again, were you surprised, when you took office, to see that and do you think that things are improving in that area?

Ms Murray: Absolutely, I do.

I think, as an Island, and the way we have structured Health and Social Care as one Department, gives us the best opportunity to actually do what we are doing now, which is integrated care.

I think it is becoming a little bit hackneyed a way, 'integrated care', what does that actually mean? Well, it does mean that all of the services working together for the person who is at the centre of this, the person who needs care and support and for their carers. If you look at the west of the Island, the reason we piloted it – I just need to be clear about this – is because you do not know until you actually pilot something whether your system is working, whether your protocols are right and whether your assessments are right.

When they started this piece of work operationally, there was something like 17 different assessments. So district nurses, mental health nurses, you name it, everybody in the team had a different assessment, and they spent months and months creating an assessment that gathered all of the information that was needed and can be completed at the start by an individual practitioner. Now we are talking about efficiency as well, aren't we? Because 17 people do not have to ask Mrs Smith the same question. It is asked by one person, the data is gathered. Now we need an electronic system that you can put that on and can be accessed by all the team.

So once all of these things have been worked through, we are then going to roll this out round the Island and, as I say, the data is there to plan it, but this will refine it down. But it will take us years. It is not immediate.

And we do have historical records (**The Chairman:** Absolutely.) still, lots of them.

The Chairman: I thought you were going to say there, at the end, that you have got historical records. That is fine. But we also have historical issues where members of the public have been let down, in my opinion, by Government.

Anything else you wanted to…?

Q241. Ms Edge: Just really with your capacity at Manannan Court; are you comfortable that it is working well and there is enough capacity; if somebody arrives today with an issue they could be an inpatient?

Ms Murray: I think like a lot of services we will hit peaks and troughs.

I think we have had a couple of problems recently where, if you have somebody who is on leave and then you have an emergency then you will use the leave bed; and that creates a problem. But we are also in the process of now – it should be finished, perhaps, by the end of this year – we have extra beds being built that are supported living beds. So what used to be getting Geddyn Reesht is the River Suite and there will be three supported living beds.

Now, that will alleviate the problem that we have on an acute ward when somebody needs to step down. I think that is what you were referring to before, Ms Edge. We have community property, okay, but it is a big step to come from an acute unit into a community property, albeit supervised and supported, when you perhaps have not looked after yourself for a lot of years even, in some cases. So what we have is three beds with an activities kitchen, everything, where people can step down into those beds, be helped with activities of daily living, ready to move out into the community, in supported living just the same, but it is the next step down.

Ms Edge: Okay, thank you.

Q242. The Clerk: Can I just ask a couple of factual points? You mentioned a report by Dr Dickinson at the beginning, is that something that this Committee has before it, or is it a recent report?

Ms Murray: No, I think you have the original one, and then I commissioned another report, which is due to be published on Friday. So we will send a copy to the Committee.

The Chairman and the Clerk: Thank you very much.

Q243. The Clerk: And just on IT, when you were speaking about the registered mental nurses at the police station, how does that work with IT? Do they have access to health records?

Ms Murray: They can access the RiO system, they can access it from the police station.

And interestingly you can access quite a few of the systems from the Prison, but the issue is you have to go into each one and log on individually. So nurses at the Prison can get on RiO, they can get Medway, EMIS, but you have to log on. So the systems are not talking to each other, it is the person who is gathering all the information, and that is not efficient at all and this is what GTS are working on, how we get the systems to give the information and let the individual access all that information.

The Clerk: Yes, and you said it would take years –

The Chairman: Yes, I was just going to…

Q244. The Clerk: How many years?

Ms Murray: How many years? You need to speak to GTS!

As I say, there is a Digital Strategy in place, but it is not going to happen overnight, it is going to be a couple of years. But it has to. It is part of the underpinning of the Sir Jonathan Michael Review and recommendations. It is every bit as important as changes to legislation are in that review.

Q245. The Chairman: So, given its importance, I am sure – not for you to say – but I am sure that the Government can say to GTS, 'This is our top priority, this is something…', because it seems to me that there cannot be many more important priorities.

Ms Murray: In fairness, Tynwald supported the Sir Jonathan Michael Review (**The Chairman:** Absolutely.) and it is one of the recommendations, so it has to go ahead, doesn't it?

Q246. The Chairman: Yes, anything else?

I think that is probably as much as we have got today. Is there anything else you would like to mention that has not come up in our conversation?

Ms Murray: I think it is important to mention the Mental Health First Aid Programme. This is a programme that, again, is not for the Mental Health Service to deliver, but what happened with it, when you say, 'Have we made changes and improved?', is eventually we decided, let's just go ahead with this and we trained up quite a few workers in the field. We also have somebody external that we have employed to drive forward.

It is really key that people working next to people who may be depressed or anxious are able to feel confident to actually approach the person and say, 'You do not look so good today, are you okay?' And give people the confidence. It is a two-day training course. But that needs, again, resources, because we have got the resources out of the Mental Health Service doing that and

then on the other side somebody will be saying, 'Well, you need more resources in this'. But actually, it is not just for mental health workers. This is for the general public, people in offices, people in other Government Departments, and I think that is really quite important, that we can get that programme rolled out.

Q247. The Chairman: I think the Minister said last week that there was something around 300, or something over 300, within the Department who had that.

Mr Perkins: Who had already had it, yes.

Ms Murray: Absolutely, and that is not bad going, because we can only take 16 at a time on the course and we cannot run courses every week. But if we could …300 out of 3,000 is –

Q248. The Chairman: Yes, but also, as you say, in the private sector as well and (***Ms Murray:*** Absolutely.) in other Government Departments, it is very important.

Ms Murray: Absolutely, yes, we want to, and actually we have been approached by banks and other organisations, but we do not have the capacity to go and train them because we do not have enough bandwidth, really.

Q249. The Chairman: But if anybody can do a good job of that, it should be the Isle of Man, because we are a small community (***Ms Murray:*** Exactly.) and hopefully we can all support each other in that regard.

Ms Murray: Yes, absolutely.

The Chairman: Anything else?

Then, if you have said all you need to say, we thank you very much for coming along today. Good luck with your role and that brings our sitting today to a close.

Thank you.

Ms Murray: Thank you.

The Chairman: Thank you.

The Committee adjourned at 4.17 p.m.