Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Protect Life Strategy: DHSSPS/Public Health Agency Briefing

16 January 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

Witnesses:

Mr Gerard Collins	Department of Health, Social Services and Public Safety
Dr Elizabeth Mitchell	Department of Health, Social Services and Public Safety
Ms Mary Black	Public Health Agency
Ms Madeline Heaney	Public Health Agency

The Chairperson: I welcome Mary — Mary, I worked with you years ago; I feel 28 now — Gerard, Liz and Madeline. Liz, I take it that you are taking the lead. Do you want to introduce your team and make your presentation, and then we will go into questions and comments?

Dr Elizabeth Mitchell (Department of Health, Social Services and Public Safety): Good afternoon. Thank you for inviting us to provide evidence on the evaluation of Protect Life. My colleagues are Mary Black, the assistant director for health improvement, whom you know from the Public Health Agency (PHA), and Gerard Collins, the principal officer in the health improvement policy branch. We had hoped that Eddie Rooney would be able to join us but he has had to send apologies. In his place, we have Madeline Heaney from the PHA, who carries the portfolio for mental health, including suicide prevention.

Suicide remains one of the biggest public health and societal challenges in Northern Ireland. Provisional figures for registered deaths by suicide for the first nine months of 2012 show that the rate remains high, with 223 deaths recorded during that period. I will make the point that these are registrations, and that, therefore, many of the deaths have actually occurred in the two or three years before 2012. It takes some time for the coronial processes to go through before the deaths are actually registered as suicide, but they are retrospective.

To address this, we have put in place, through the PHA, a new sudden death notification system. It was introduced in April 2012. The idea was that we wanted to provide more timely information on suspected deaths by suicide rather than waiting for the formal registration process to give us the official figures. From April to the end of December 2012, there were 159 suspected deaths notified to the PHA through that system. Obviously, we do not have previous years to compare with, because the system was introduced only in April 2012, and that figure has not been confirmed by the coroner as suicide. However, it provides us with an up-to-date estimate of the number of suicide deaths for the last nine months of 2012. Our feeling is that, if confirmed through the formal registration system, it could represent a reduction on previous years, but it is difficult to say, because we are comparing two different recording systems.

For registered deaths, Belfast continues to have the highest suicide rate among the five health trusts. The figures for the first nine months of 2012 show that the suicide rate in the Belfast Trust area was more than twice that in the South Eastern Trust area, and well above those in the other trust areas.

The north and west of Belfast city continue to suffer the highest suicide rates in Northern Ireland. The highest rates are seen among young to middle-aged men living in deprived areas. Figure 3 on page 35 of the refreshed Protect Life strategy, I think, demonstrates this very clearly. It shows, by age, the suicide rates for men and women and the differential in the rate between men in deprived areas and those in more affluent areas, and between women in deprived areas and those in more affluent areas. The stark difference really is the rate for men in deprived areas, particularly those from about 15 years of age to those in their mid-50s. There are much higher rates among that group than among all the other groups.

We published the refreshed Protect Life strategy in June 2012. Reflecting on that very stark difference in the rates for deprived areas and for men versus women, we have set a new aim of reducing the differential in the suicide rate between deprived and non-deprived areas. We think that this is a very important aspect and has the potential to make the biggest impact and save lives.

The new aim is supported by a number of new objectives that will help to provide a more rounded assessment of the impact of the strategy. The objectives are mostly output-focused, because the refreshed strategy has a lifespan of less than two years. They include increased awareness of suicide and mental health-related issues; increased uptake of suicide prevention and mental health awareness training; and enhanced outreach services for males at risk of suicide in deprived areas.

A number of new actions have been developed on which the Department of Culture, Arts and Leisure (DCAL) and the Department of Agriculture and Rural Development (DARD) will lead. There are also actions for mental health services, such as the provision of support at A&E departments and more assertive outreach for patients who miss appointments.

Implementation arrangements remain unchanged, with the PHA having the lead role in implementing the Protect Life strategy and in the suicide strategy implementation group advising on implementation. The five local implementation groups remain in place, and the families' voices forum continues to represent the interests of bereaved families.

Coming out of the Protect Life evaluation, the report on the independent evaluation of Protect Life was published in October 2012. Component parts of the strategy had been evaluated previously, but this was the first evaluation of the overall totality of the strategy. Independent evaluation was considered essential due to the wide range of stakeholder interests and involvement in the implementation of Protect Life, and the need to ensure an objective perspective.

The evaluation was carried out by Moore Stephens Consultancy. A project steering group was established to draw up terms of reference for the exercise and oversee its progress. The group considered the final report to be a comprehensive and robust piece of work.

Rather than go through all the findings and recommendations at this stage — we can obviously come back to any particular points — I will focus on three issues arising from the evaluation that are particularly important from a departmental perspective. Those are community engagement, governance and a range of actions in the strategy.

The evaluation report notes that community engagement in the delivery of the strategy has been very strong. That is a very positive finding, as there was a deliberate decision from the outset to ensure effective community engagement and build the capacity of community groups to develop suicide prevention services.

That approach is based on the understanding that communities are best placed to know their local resources, issues and challenges, and that that knowledge is vital in tailoring services to address local needs. The approach also acknowledges that community groups are often the first point of contact for people experiencing emotional distress.

Coincidentally, a recently published independent evaluation of the community network approach to suicide prevention in the Northern Trust area found that it had encouraged greater awareness of mental health issues, promoted help-seeking behaviour and supported communities to take a more proactive role in suicide prevention. That separate piece of work, therefore, reinforces some of the overall evaluation findings.

The evaluation report recommends a refresh of the overall governance and accountability framework for the oversight and implementation of Protect Life. Indeed, it presents a suggested structure for implementation and oversight. There is no doubt that the Protect Life oversight arrangements are quite complicated at present. They have evolved over time. They reflect the interdepartmental, cross-sectoral and regional and local aspects of the strategy.

We recognise that we need to give particular attention to the development of more coherent and co-ordinated governance structures in the development of the new suicide prevention policy. One of the priorities will be to ensure that a relatively small strategy implementation steering group is put in place to monitor and report on progress of the implementation of the successor to Protect Life. The evaluation also found that there are too many actions in Protect Life, and we fully accept that, along with the associated recommendation to reclassify, group and streamline actions. With over 60 actions in the strategy action plan, it has been difficult to maintain momentum across all of them simultaneously and prioritise interventions. We feel that fewer higher-level actions will allow for more flexibility in implementation and will assist in monitoring implementation more effectively.

It is worth noting that, at recent meetings with Northern Ireland Ministers and local groups last autumn, Dr Annette Beautrais, an internationally respected suicide prevention researcher, advised that nearly every country's first generation suicide prevention strategy contains too many actions. So, we are not alone in this. It is only now, as nations are developing second generation strategies, that more streamlined action plans are being developed. There is clearly learning from elsewhere, and we can build that in.

The overall evaluation of Protect Life has been a very useful exercise. It produced information, findings and recommendations that, together with the review of learning conducted for the strategy refresh, will help us inform the development of a new suicide prevention policy from 2014 onwards. We hope that that work will commence very soon, subject to ministerial approval, so we are hoping that it will commence in February, if the Minister gives us the all clear. Thank you very much, Sue. That is all that I wanted to say by way of introduction. My colleagues and I are very happy to take questions.

The Chairperson: Thank you. The suicide rate does remain high. It remains higher in some constituencies than others, but suicide knows no boundaries and, unfortunately, knows no age limit. We are all aware of that. I have been reading the document, and I thank you for that. A couple of things have struck me, and I am going to go on a rant for a minute.

In relation to point 8, what strikes me — and it struck me in the Programme for Government — is that suicide is one of the biggest killers of our community. It affects everybody, it is cross-cutting, yet it was not mentioned in the Programme for Government. To me, that is an indictment of us as a Government. It is an indictment of Ministers and of Departments, and it is an indictment of society. What really annoys me is that you then say that it is noted that, at an Executive level, there is a clear commitment to addressing suicide. That is only because of the work of this Committee. It was never a commitment at Executive level, at ministerial level, in the Department, or at permanent secretary level or your level, when the suicide group had not met in 18 months. It was only the work of this Committee that put pressure on the Department. That play on words annoys me a bit.

I take on board your last comment that evidence has shown that it is the second generation of a prevention strategy that seems to work. However, on the whole issue of the evaluation of the Protect Life strategy, one of the criticisms that I hear, and I represent an area with high levels of suicide, is that because of the extension of Protect Life, new groups, new ideas and new ways of thinking cannot access funding. We have added a few more years to this, and we will probably be into two and a half generations before we get it right. I think that we need to be very open and honest about that.

The Card before You Leave scheme is still a problem. All Committee members, especially those who represent constituencies in the greater Belfast area, have heard that. The scheme was implemented in the Belfast Trust area only recently. North and west Belfast have the highest levels of suicide, yet the Belfast Trust was the last trust to implement the Card before You Leave scheme. However, there are still problems and difficulties with it.

The issue of the statutory agencies — Lifeline, general practitioners or other medical people — referring people to community counselling means that it is under pressure and is having to scramble for funding. The evidence that I have from my constituency is that 80% of the referrals that community counselling groups get are from statutory agencies. Is this just offloading? It is putting more pressure on the community and voluntary end, yet it is not getting the recognition for the work that it is doing. That work is sometimes 24/7, and I need to commend some of the people involved in that. When we all had a few days off over Christmas, they were working, because that is one of the bad times. You may not have the information today, but how many referrals go specifically to the community and voluntary sector?

I do not know where this fits in, but I have also heard that there is an issue about community counselling not being able to access funding from the victims and survivors fund. That is adding to the problems. Are we saying to community projects that they can only deal with people who need counselling because of a, b, c, d and e? Some of those people are victims as well. I am concerned about that.

I know that you are going to have a new suicide prevention policy in place by April 2014 and that work is going to start on that shortly. When will it start? Will you give us more detail on what you are going to do?

I am sure that other members have picked this up, but one of the key points is that people want a safe place. It does not mean that it has to be A&Es necessarily, and we are putting A&Es under pressure by assuming that they can deal with everything. The community and the young people want a safe place to which they can take friends or relatives who are contemplating suicide. We still do not have safe places. We do not need millions of pounds for that. They could be health centres or other buildings in an area that can provide safe places. Safe places have been talked about, but we have not got to the point where we have them. Will that come into suicide prevention?

Indications show that mental health plays a part in suicide. However, I do not see any radical strategies to deal with mental health and mental health issues. Where does mental health fit in with the Department? In fairness, I know that some good work is being done by Ministers, but it has taken us time to get to interdepartmental and cross-departmental working. If that is the case, what is happening in the Department of Health on mental health, associated illnesses, suicide and protection?

Dr Mitchell: OK, Sue. I will start by commenting on the ministerial group. As you know, there is now a commitment for six-monthly meetings. We have had a lot of interest and support from other Ministers, and that is very welcome. Particular work has been done by the Minister of Culture, Arts and Leisure to use sporting associations to raise the profile and awareness of mental health and suicide prevention issues. I think that we can build on that. We also have an agreement from the other Ministers to report back to the group on the actions they are taking and the processes they are putting in place to help to address the issue of suicide. That is very welcome. However, I hear what you are saying. It could have been done earlier and more quickly. I am going to ask Mary to pick up on the refresh; that groups cannot access funding; and that new ways of working cannot be introduced.

The "card before you leave" scheme links in with how we work with the mental health services policy people. I will ask Gerard to pick up on that.

I do not know whether any of us have information to hand on how many referrals to the community and voluntary sector come from statutory agencies, GP surgeries, etc. We will have to see what we can find out about that for you.

I am not sure that I understood the bit about the victims and survivors. Was it difficulty in accessing counselling or funding for that counselling?

The Chairperson: There is a discussion going on and stuff happening within the victims and survivors stuff that you probably need to get a handle on. It means that some of the counselling projects that

previously got part-funding through the fund are now being told that they are unable to access it. That is adding pressure.

Dr Mitchell: OK. Do you want us to find out more about that outside the meeting?

The Chairperson: Yes.

Dr Mitchell: OK. I am just wondering who is best placed to pick up on the issue of safe places.

Ms Mary Black (Public Health Agency): I think that we can start with it.

Dr Mitchell: OK. I will pass over to Mary to discuss the funding and the new initiatives and innovations until we have the new strategy in place.

Ms Black: The first things are the extension of the current Protect Life strategy, the new strategy and what that might mean. Irrespective of what happens with the strategy, one of the views from the community and voluntary sector was the point you made about people being unable to access funding unless they were already receiving funding from a previous legacy organisation. Irrespective of what stage the strategy is at, we have drawn up specifications for the new service delivery mechanisms, and we will work with those over the coming year. We have determined nine specifications for service areas and we will go forward with a specification in two phases to which anybody can bid. That picks up the issue of those who were unable to access funding, and they will now be able to access that funding.

The new system will also pick up another issue that was identified in the evaluation, which was the longer-term funding for some groups. As a result of all the reorganisation and the funding in different legacy organisations, we were in a situation in which there was a roll-forward year on year for a number of years. The new system will open up funding for a three-year period in the first instance. We will tender for another organisation to help support community and voluntary sector organisations to bid for some of that work. This will mean that everybody is on a level playing field.

For example, we have done a lot of work developing the principles and practice of complementary therapies that did not exist. So, as far as we can, we now have a set of uniform standards. We will help everybody to reach those standards by employing another organisation to help them get to that standard. They will then bid in two separate phases of bidding opportunities to provide those services.

With reference to your first point, Sue, we hope that the new system will make it much more open. As I said, it will also pick up the length of funding available for groups, so that they can plan. In fairness, that does not link in with the victims unit and the decisions it has been making. We have had some early conversations with the unit, but given the implications that may flow from those decisions, through Liz, we will need to have much more urgent discussions with it.

The Chairperson: The tendering process needs to be welcomed. There is genuine concern, because of our strong community infrastructure, that bigger organisations will make great bids. However, the reality is that such organisations do not have community knowledge or the ability to work with the community. The tendering process has to be welcomed. Fair play on that.

Ms Black: This will also apply to counselling and those who provide it. They will be in a position to bid for those services against a set of standards — we want the best services to be available. Our strategy in that area is the same. We will also bring it in for a three-year period for counselling along with the other service areas. That should improve access.

The other thing that we are doing with Lifeline and its referral to some services is to monitor those who formally provide services and use that funding in a slightly different way to engage them in that process.

The Chairperson: What about the safe places?

Ms Black: Yes. As part of the piece of work carried out by the suicide strategy implementation body, a study group from Belfast went to look at a safe place in England to see what is meant by "safe place". People have a different understanding of what a safe place is. They are unsure whether it should be a physical or a virtual place, and if it is a physical place, how we should connect it to all the

other services, whether they are community and voluntary or statutory. From that, we established a pilot model in the Belfast area — admittedly, it is based around A&Es — in which a community and voluntary service organisation is based alongside statutory service providers to provide additional support and follow up for those who present at A&Es. That is being piloted at the moment with a view to inform what can be done in the longer term.

That does not answer your point about having a physical place that is not an A&E. Based on the findings, the other trusts are looking at other locations. However, it is fair to say that it is still early days for that practice. Madeline, is there anything else on that from the other trust areas?

Ms Madeline Heaney (Public Health Agency): The mental health side and the Bamford group have been in touch with all the trusts to ask them what they have in place, what their thoughts are about having a separate place or what they might consider to be a safe place. Most of the trusts have come back and said that they feel that there has to be a close link with A&E sites. For example, the Northern Trust has said that if there is anything, it should be on a hospital site and that there is no point having a safe place in Cookstown, for example, as it is too far away from the A&Es if an intervention is needed.

The board is going back to each of the trusts and asking them to work up a bit more on what model would work for them. It is linked to the physical infrastructure, where the A&Es are, the layout of the different trust areas and what is practical. At this stage, the trusts have had engagement with their directors of mental health and have had their first cut at it. The board has asked the trusts to come back with more detailed ideas and proposals around how it might work.

Alongside that, another piece of work is being undertaken by the board, the trusts and the PSNI on places of safety. That has a slightly different emphasis and is about the statutory responsibility for someone who is deemed to be mentally ill. Sometimes those terms are used interchangeably, but they are slightly different. That is about the PSNI having a method or place to hand over someone who is deemed to be mentally unfit. There are two slightly different pieces of work going on.

Dr Mitchell: Would you like us to cover the Card before You Leave scheme?

The Chairperson: Yes.

Mr Gerard Collins (Department of Health, Social Services and Public Safety): My understanding from the Belfast Trust is that, in the initial implementation of the protocol for the Card before You Leave scheme, the trust found it useful, in addition to giving patients the card, to follow up with a phone call the next day and offer an appointment. The practitioners said that that worked better in many cases than just handing out a card with an appointment. In very many of those cases, the card was lost and a very high number of patients did not attend their appointments. I cannot recall the exact figure, but it was extremely high.

I think that we would need to check the feedback from users to see how the Belfast Trust implements the Card before You Leave scheme. Some users who might have been expecting an appointment card may not have got one, but I am told that every user is followed up with a phone call the next day and offered an appointment.

The Chairperson: Can you get us that information?

Mr Collins: Yes. I can go back to the trust on that.

As you probably recall, the 10-year longitudinal National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that 70% of those who died by suicide in Northern Ireland over that period had not been in touch with mental health services in the 12 months prior to their death. That represents another issue about how we identify, screen and get in contact with people who are suicidal or at risk of becoming suicidal.

Mental health services are still a major player in suicide prevention on a couple of levels. Crisis response teams are available in each trust area on a 24/7 basis, and, in the longer term, the psychological therapies implementation plan has been put in place to improve access to the various talking therapies and cognitive behaviour therapy that help with suicide prevention and mental health promotion. On a longer-term basis, mental health services, in adopting the recovery model, have a huge role to play in helping people with mental health issues to become well again. Depression,

anxiety, and so on, are some of the major influencing factors on suicide. As we move through, I think that the adoption of the recovery model will play an important role in helping people to reduce their risk of suicidality.

The other issue is not about mental health services but the broader promotion of mental health and well-being in the community. That is particularly the case for groups that are at risk of poor mental health and well-being and that are possibly in danger of becoming suicidal. In that regard, the Public Health Agency, through its thematic action plan for the implementation of Protect Life, has moved upstream a little bit. In addition to front line services for those who are suicidal, the agency is focusing on actions to promote mental health and well-being and to build emotional and psychological resilience.

For some time, the Department has been working to develop a strategy for the promotion of mental health and well-being. That was somewhat delayed because of the focus on suicide prevention and the need to get the refreshed strategy in place, and we need to get that work up and running. That strategy will look at the broader influences on mental health and well-being. It will have a very particular focus on early years, because early years are the foundation of life-long emotional resilience. It will also look at different life stages and settings, for example, the school setting, and the work we are doing with the Department of Education on the pupils' emotional health and well-being programme is very important in building emotional resilience in school-age pupils and young people. The new Fit and Well strategy also includes mental health and well-being within its general remit of health improvement at population level.

The Chairperson: OK. There are a number of things that you have to come back to me on. We will await them. A number of members want in.

Mr McCarthy: Thank you very much for your presentation. I want to back up the Chair in commending those people in the community who do sterling work to prevent suicide.

Gerard, you mentioned the slowness of people coming forward with mental health problems and the question, or maybe even the fear, of the stigma attached to coming forward. Will you give us an update on the findings on stigma in the Protect Life evaluation report and how work to further reduce stigma will be taken forward on a cross-departmental basis? Liz mentioned DARD and DCAL and you mentioned the Department of Education, so there seems to be a good bit of work going on. How do you plan to effectively address the wider socio-economic factors that underlie suicide and ensure that links and strategies are cross-departmental?

Mr Collins: I will take stigma first. It is well known that stigma about mental health is all too pervasive. It prevents people seeking help and talking to others. As part of its awareness-raising campaign, the Public Health Agency has attempted to tackle stigma and encourage help-seeking, and many of our partners in the voluntary sector have run campaigns and have done extensive work to change public attitudes towards mental health and to reduce stigma.

We feel that there is a general reduction in the stigma associated with mental health. People are now more willing to come forward. You do not see the same headlines in newspapers that you saw maybe 10 years ago. The Frank Bruno headline comes to mind. You may remember that. There have been moves forward. Media guidelines are part of suicide prevention, and they also encourage a sensitive approach to the reporting of mental health issues. Within that whole remit, action is being undertaken to reduce stigma, and that action will continue through public awareness raising and public education campaigns.

Mr McCarthy: If that stigma were done away with, it would encourage people who are suicidal or who have suicidal thoughts to come forward earlier.

Mr Collins: Absolutely. That is what we hope, and that is why we are focusing a lot of our work on young people. That is where you have the best chance to change attitudes for a lifetime.

You also mentioned the underlying social determinants that lead to suicide. Protect Life deals largely with issues of stigma and front line support for people who are suffering poor mental health and are potentially suicidal. It does that through, for example, deliberate self-harm registry support, mentoring services, counselling and research into suicide. The strategy does not really get into the social determinants that affect mental health and well-being. That is more the field of the Fit and Well strategy. In fact, to broaden it out, a lot of the factors that lead to poor mental health and which

influence suicide, such as low educational attainment, unemployment, poverty, low employability and substance misuse, are addressed by other strategies that have been put in place by other Departments. I am thinking, for example, of the new NEETs — not in education, employment or training — strategy, our own strategy on drugs and alcohol, and the child poverty strategy.

All Departments need to be involved in suicide prevention. Most Departments will be involved at the upstream rather than front line level, with the possible exception of the Department of Justice because of the services that it puts in place for addressing mental health in prisons and safer custody. Most of the Departments will be involved in trying to improve the factors and social conditions that are protective factors against suicide, and that is the level at which they will come in, as opposed to the front line services. That is what we will try to do through working with the ministerial co-ordination group on suicide prevention, the Fit and Well strategy and generally through the Programme for Government.

Mr Brady: Thanks very much for the presentation. I have a comment to make. You mentioned that one at-risk group is young males in deprived areas. It strikes me that welfare cuts, particularly benefit cuts, are coming down the line, and some are already in place. Under changes to single-room rent, the definition of a young person has been raised from under 25 to under 35. From my experience of many years as an advice worker, I know that a lot of people who are between 25 and 35 and living in single rooms may well be people with mental health problems. Again, those people are being migrated from incapacity benefit to jobseeker's allowance and are then having to go for work-focused interviews for non-existent jobs. That all puts more and more pressure on that group. Although there is a suicide prevention strategy and an action plan, and that is very commendable, you are then putting pressure on the groups that you are trying to help.

We have been told by the Executive that the change to the single-room rent has the potential for 6,000 young people under 35 to become homeless and that the capacity to rehouse those people simply is not there. One Department is putting pressure on an at-risk group, and, on the other hand, your Department is trying to prevent that group from succumbing to pressures. It seems to be a total contradiction. As I said, it is just a comment, because there is no doubt that although you are trying to equalise for the better the differential between deprived and non-deprived areas, there will be a lot more people in deprived areas under pressure. Such people have undiagnosed mental health problems and face the problem of stigma, which Kieran mentioned, and that will increase the problem and put more pressure on the health system. It seems that that has not been addressed in the lead-up to this.

Dr Mitchell: I entirely agree with you. The actions and things that other Departments do and other things that happen in Westminster with regard to social reform can have a big impact. From research, we know that every 1% increase in unemployment leads to a 0·8% increase in the rate of suicide. Those things are extremely important, and that is why it is important that we have the whole Executive and the whole Programme for Government tackling this and that it is not just seen as a Department of Health issue. There are many of those issues that we cannot tackle. We do what we can. We have projects like the maximising access in rural areas — MARA — project, where we try to increase access to benefits and support people through that. We can talk more about that, if that is of interest to you.

As Gerard and Mary said, we are trying to do a lot. We are trying to increase resilience and trying to increase people's coping capacity as well as providing services once people are in emotional distress or have mental health issues. That is where our role comes in. However, we need others to tackle some of those broader societal and economic issues.

Mr Brady: The point that I am making is this: policy decisions and issues are brought in almost in isolation of the impact that they will have on other areas, particularly vulnerable groups. The group that we are talking about today is very vulnerable and is likely to become much more vulnerable and, therefore, increase, rather than decrease, the problem. That is where the whole cross-departmental co-operation is needed. Interaction is also needed, because there does not seem to be a lot of that. I sit on the Social Development Committee as well as the Health Committee, as do Paula and Pam, and I can see that there are many overarching issues. However, they never seem to mesh, particularly around the areas that we are talking about today.

Dr Mitchell: It is very helpful that MLAs like yourselves, particularly members of Committees, have the opportunity to try to emphasise some of those cross-departmental issues, and that is all to the good.

Mr Collins: Through the Institute of Public Health, we also encourage the use of health impact assessments in all policy development. Now, that is hit and miss: some get in somewhere and some do not. However, that is the sort of thing that would help to pick up on mental health issues that could be impacted on. The other thing is that, under the Protect Life strategy, we encourage training for all front line staff who deal with vulnerable people. We encourage benefit staff in the Social Security Agency to undertake training in mental health awareness and suicide awareness so that they can spot people who are in emotional difficulty and know where to refer those people if necessary.

Mr Brady: A risk assessment is supposed to be carried out by the Department for Social Development (DSD) or by the Department for Work and Pensions (DWP) in Britain on the potential adverse impact of the changes, but that does not appear to have been done to any great degree, certainly not by DWP and, so far, not to any great degree by DSD. That is an important assessment, because it highlights and profiles the potential risk to particular groups such as those we are talking about.

Mr Collins: I suppose that that also goes back to the importance of the ministerial co-ordination group. The Minister for Social Development is a member of that group. Therefore, issues relating to the impact of welfare reform can be brought up and discussed at a ministerial level.

Mr McDevitt: I think that the whole review is not great, or do you think that it is?

Dr Mitchell: Do you mean the review or the —

Mr McDevitt: The outcome of the review. It is far from a ringing endorsement.

Dr Mitchell: I suppose that the purpose of it is to give us learning for the future. We take on board its messages.

Mr McDevitt: Which bits of it most disappoint you?

Mr Collins: I suppose that the lack of progress on some of the interdepartmental working would be the one that strikes me. I think that we have started to accept the need to balance innovation and evidence. The PHA has a number of innovative projects that are leading the way. The project undertaken with young men who have been affected by suicide, for instance, was innovative, and there are a number of projects that are going to develop Northern Ireland-specific evidence to help to inform mainstream services.

We agree that there are far too many actions, but, as Dr Mitchell said in her presentation, that was common across the world. We are moving away from that. We will start to group the actions. I am quite pleased that that was qualified in the report, because that is what we have been thinking for a long time. Suicide prevention is not in a wider number of departmental strategies, but I think that the link between what other Departments can do and the ability to reduce suicide could be more strongly made. However, I think that there is difficulty there, because when you are producing a strategy on transport, for example, it is difficult to link that into suicide prevention. You could link it into reducing isolation and improving a person's mental well-being, but the step down to suicide prevention is, perhaps, a bit far for Departments. I think that we need to look at where Departments can realistically play a part. That might be in promoting better mental health, as opposed, directly, to suicide prevention, and then linking the two strategies — mental health promotion and suicide prevention — and, of course, other strategies such as those on drugs and alcohol.

Mr McDevitt: Which Departments have been the worst offenders with regard to failing to grasp the fact that suicide is a societal problem rather than a Department of Health problem?

Mr Collins: I do not know that I can point the finger at Departments.

Mr McDevitt: You must. You sit there; you go to working groups. You can tell me who the worst offenders are.

Mr Collins: We have been very pleased with the —

Mr McDevitt: No. I want to know who the worst offenders are. We do not have a lot of time. Who are the worst offenders?

The Chairperson: The ministerial subgroup, which did not meet for 18 months, is headed by our Minister, the Health Minister. If there was no lead there, other Ministers were not being held to account.

Mr McDevitt: Would you accept primary responsibility for the lack of progress in interdepartmental co-operation?

Mr Collins: It obviously falls to us to try to promote interdepartmental engagement, which we have tried to do. In developing the action plan, you can see that some of the actions fall to other Departments. There is input in training, for example, in various agencies that belong to other Departments.

Mr McDevitt: The bottom line is that this is not acceptable? Is it?

Mr Collins: If we keep focusing on people who are suicidal, I do not think that we are going to be able to reduce the suicide rates in the long term, because we have to stop people becoming suicidal. It took us, maybe, four or five years to understand that and to get to that position. Of course, front line services for people who are suicidal remain absolutely essential, but unless there is an upstream focus to improve the psychological resilience of at-risk groups, we are going to continue to have people moving into the suicidal group and needing front line services. We need to reduce the risk of people moving into that group, and that is where we need to work with other Departments.

Mr McDevitt: I have a final question. Dr Mitchell, what personal commitment will you give to this Committee that interdepartmental co-operation will improve and that, when we come to talk about this matter again, there will be clear evidence that it is a whole-government problem and that there is a whole-government approach to it rather than just a failed Department of Health approach?

Dr Mitchell: Chair, I think that I have already emphasised that there has been a commitment, under the current Minister, for the ministerial group to meet six-monthly. Gerard, have we had two or three meetings?

Mr Collins: The most recent meeting was in June, and the next meeting is in 10 days' time, at the end of January.

Dr Mitchell: Other Ministers have agreed to report back to that group the actions that they are taking on suicide prevention. Perhaps, it is not in my gift to deliver that for you, but I can say that our Minister is committed to that. Our Minister has been chairing those meetings. The other Ministers have been attending, and they have agreed to report back.

The Chairperson: When I met the Office of the First Minister and deputy First Minister, it accepted that there was an issue, and it agreed to make it a priority within the Executive. That is the oversight of it. We wrote to every Minister, and I met with some of the Ministers to prioritise some of the issues.

Ms Black: I would just add that the need for cross-departmental and cross-government action is absolutely critical. I offer the perspective that Annette Beautrais, who is a world-leading expert on suicide from New Zealand, gave us when she came here in November. We engaged Annette; she did a number of seminars. Her perspective on what we were doing was very helpful for us because she, rightly, took a hard look, and she said a number of things to us. She said that, first, what we are doing on public information was absolutely right, and that we should keep the focus on help-seeking behaviour and removing stigma. She said that we should frame it around suicide prevention rather than suicide, and that we should get the public debate off suicide and onto prevention.

Secondly, she said that we are doing some extraordinary things here in Northern Ireland. The sudden-death information that enables us to respond to clusters is unique here in Northern Ireland. We have trialled it, and we are working on it. We are absolutely not complacent about it, but others are not doing it. The other thing was the self-harm registry database that we have here in Northern Ireland. We do not have that anywhere else. We have learnt from the Republic, and we have imported it here. We started it in the west, and it has now rolled out across Northern Ireland.

She also said some really important things about engagement with the community and voluntary sector. As the evaluation highlighted, that is a critical point. Perhaps the most important thing that I

heard her say was about the focus of the suicide prevention strategy. She said that we should frame it around positive mental health and that it should not focus only on the most vulnerable groups. It has to be a population approach. You may need to do some tailoring in the population approach. It is a little bit like what Marmot said about health inequalities. Some groups, such as lesbian, gay bisexual and transgender people, and so on, are more vulnerable. It has to be for the whole population; we have to own it. This is a societal issue, and we have to focus on promoting positive mental health and making sure that people can access care when things get a bit tricky.

I hear what you are saying, and I absolutely agree with your concern. We also need to put ourselves alongside what others are learning across the world about this extremely complex issue. We need to keep sight of that, and we need to keep learning those lessons. We need to keep interrogating, but we should not ignore the progress that has been made and what we need to continue to do to learn from others.

The Chairperson: In fairness, most members said that a lot of good work is being done. I know for a fact that, through interventions, a lot of people have been saved from taking their own life. The reality, however, is that we have a high level of suicide. I do not want to get into the issue, but the Committee is trying to do what it can, and sometimes the Department forgets to work in partnership with us. We should be the conduit between you, as the Department, and the community. We all live, work and socialise in the areas that we represent. Most, if not all, of us are involved in our community infrastructure. The stuff that we pick up is genuine criticism.

That is not taking away from the work. I know that interventions that the PHA has done in my area have worked. However, we had to battle to get that intervention; it happened only when the PHA saw the benefit of it. We were up against battles. Professional people were not working beyond five o'clock on a Friday evening, and communities were crying out for help. People do not take their own lives and then stop at five o'clock on a Friday; statistics have shown that it normally happens early in the evenings or at the weekend. We are up against all that stuff.

I do not believe that anybody could have a problem with the vision of Transforming Your Care. However, turn that into reality on the back of what we have come out of and some of the care packages and some of the stuff that happens on the ground. Crisis intervention needs to happen. If we are saying that we want to take people out of the acute sector through Transforming Your Care, that should include mental health issues. If we are saying that people need to go into either secondary or primary care or that we need to go further into prevention and proactive approaches, crisis intervention through mental health needs to be available in the community. We need to continue to build on the health and well-being centres — Gerard mentioned health and well-being earlier — because that can have a positive impact on suicide and mental health. However, not only do communities not know what is in some health and well-being centres, but those centres do not take on board what the population of that community needs. So, there is very little crisis intervention.

When I talk about a safe place — I take your point, Madeline — I am thinking of young people and not-so-young people who want to hand over a loved one or a friend who has tried to take their own life to those whom they think know best. That is the safe place. Without getting into it, we need a joined-up approach towards health and well-being, prevention and early intervention, whether it is universal early intervention, that fits into all the strategies in the Department. I do not see suicide fitting into Transforming Your Care. I do not see any crisis intervention to deal with the reality, as we still have a high level of suicide. I accept that a lot of good work is being done, but we still have a high level. That is another rant; you have got two rants out of me and it is only the first meeting of the year.

Ms Brown: Thank you for your presentation. In my constituency of South Antrim, there have been a large number of suicides recently, and there has been a lot of focus on that in the media and on social networking sites. I attended a meeting that was pulled together at very short notice by Antrim Together, a group that set up a Facebook site, such was its concern about its experience with friends or loved ones who had committed suicide or attempted to. It met in a local hotel, and there was a terrific turnout of people, voluntary organisations, statutory bodies and services. It was incredible, and I think that everybody there was amazed by what is available by way of help and support for those who are bereaved, thinking of suicide or simply have problems with their mental health.

When we sat down, there were umpteen leaflets and pieces of information and lots of contacts, but if you are in that place and struggling, and even if you have all that information in your hands, what do you do with it? Who do you go to? How do you decide who to contact and where to reach out to for help? It struck me that so much help is available that surely some strategy should be brought together to deal with the sheer amount of help. We could possibly amalgamate groups or encourage them to

work together and pool their services and resources to create a better service. A lot of people there had loved ones or family who had been through all that, or had been through it themselves, but they were not aware of many of the services. Everybody went away thinking that it is amazing and fantastic but they did not know about it previously. That is my main point.

I agree that the focus needs to be on good mental health in the first place. It is very hard to draw back once you get to the point of having suicidal thoughts. As a mother of three, I know from stories that my kids tell me about the talk and thoughts amongst very young children. It is very worrying. It was not like that in my day when you did not have a mobile phone or even a computer, and there was no method of communicating in the way that there is now. Children probably know much more than we do about all those subjects, and it is very frightening how familiar they are with the concept of suicide. What is our emphasis in trying to tackle that through social media? That is where they get that information. I do not mean typing the word "suicide" into Google and getting instructions on how to do it, although we know that people have done that. You want people to be Googling all the sources of help available, not the other way round.

Obviously, stigma and awareness are still huge issues, and that is probably why we struggle with that. It is mainly males who are taking their own life because it has always been hard to get men to seek help and talk about their difficulties. We need to banish the stigma that is there, and we all need to accept and realise that there are very few of us who have not suffered some kind of mental health issue or some form of depression, whether mild or otherwise. That is a new reality for everyone, and everyone has to face up to it. We all need to talk about it and make it an everyday subject.
I do not mean that we should glamorise it. That is another issue with the social media. There is so much talk among the young ones about going to be with the angels. It seems to be becoming very glamorous. If you are having a hard time, you might think, "I would not mind being with the angels instead of being down here dealing with all this." I think that there is a lot of glamorisation, and it is very worrying. What are we doing to tackle those issues?

Dr Mitchell: I will ask Madeline to come in on the first point that you raised, which was about the multiple sources of help and how people find their way through that. I will ask Gerard to come in on social media, the internet and what we have been doing on that. Mary, do you want to come in after that?

Ms Heaney: Just to pick up on the meeting on Saturday, which I was at as well. The challenge was that there were so many organisations in the room, and it goes back to what we were saying about suicide and its prevention being so complex. We had church groups present, as well as anti-poverty groups, Women's Aid, Youth Service and education groups. There are so many elements to it. Suicide may be caused by a debt issue, to pick up on a point that was made earlier, and unemployment might contribute to it. What we picked up was that there is a Z card and poster approach, through which we are trying to pull all those services together. The challenge is to make a card that is the size of a credit card and that opens out. It is something that you can put in your purse or wallet. Young people, particularly, can slip it in their pocket and no one knows that they have it. We are limited, in that we cannot give screeds of information on it, so what we are trying to do is link all that into the Minding Your Head website. However, there is a constant challenge of promoting services. One of the actions that came out of the Antrim meeting is that we should link up better with the local media to get positive stories out there and not just leave it until the media pick up on the negative stories. Our experience is that people do not generally pick up the message until they need the service, by which stage they are in a place where it is very difficult to wade through it all. One of our strategies, particularly in south Antrim, though we are looking at it across the region, looks at how we improve our communications. It involves working with the media, getting the positive messages out there, promoting the website and tying it in with the public information campaign, so that people know where to go to access services.

Part of what we are trying to do is to look at the quality of services. That can be difficult because groups can literally form overnight, and have done. How can you decide whether that is a good group to put on the list? We are hoping that, as we go forward, we can set standards. If it is a bereavement support service or a counselling service, does it meet the respective standard? It is so that we can have some confidence as to what we can promote. People can form groups, but we must try to get the information out about recognised standards and which groups meet them.

As you said, and we heard it on Saturday, the use of media, particularly social media, is important. How do we do that positively? It was flagged up at that meeting. The young people themselves have set up a Facebook page on which they put a lot of information about services. I do not know whether you have had a chance to look at the page yourselves. You also had people coming onto that page

and saying, "If you are in distress, please send me a message; my inbox is always open". That was worrying. It was raised with regard to monitoring. Again, we are trying to promote the positive services and not leave people vulnerable to other services and people coming in. The whole media is changing so quickly. We try to keep up with it, and we have been working with the young people and people who are more familiar with that sort of media.

Mr Collins: I will touch on the point about social networking sites on the internet in a moment. You described a situation in south Antrim in which people do not know where to go, despite the fact that there is a huge amount of information and a large number of interested and well-meaning community groups. That seems to mirror what has happened over the past six months in east Belfast, where the number of people seeking help has increased. People were going to groups, but the groups were acting in isolation or did not know what other groups to involve. So, from that point of view, the Belfast Trust and PHA have worked with the East Belfast community association to start work on developing a very local co-ordination and information strategy. That may be an approach that south Antrim could look at to see whether it would be useful in making people aware of what is available and where to go to.

I will move on to the internet. The Ombudsman for Children in the Republic of Ireland was asked about cyberbullying and internet regulation following the deaths of a number of teenage girls connected with a social networking site in eastern Europe. Her view was that, even if we had the power to ban those sites, they would just open up again under another name, and because they are outside the UK's jurisdiction, we would have a great deal of difficulty in regulating them. That was backed up in the Leveson inquiry, which looked at internet sites as well. The general view, which is shared by the UK Council for Child Internet Safety, which looks at keeping children safe online, seems to be that the approach should be to educate parents to be more careful, know what their children are accessing online and keep a reasonable eye on it. They need to know what to do if their children are being bullied online. Children who use social networking sites need to be taught what to do if they have been bullied, who to report it to, how to respond to it and how to make sure that they can deal with it.

It is more an issue of education than regulation. I think that Australia tried to ban sites that promoted suicide. There were issues around social networking sites and cyberbullying, and there are a number of sites that promote suicide and explain suicide methods. I do not think that Australia had a huge amount of success with that. In fact, I do not know of one prosecution or one case of a site being banned.

We seem to be hearing that education is the answer; education through schools and education about how to be safe online. It is also about working with the internet service providers. I know that Facebook has been working on this issue. It provides a tool that allows individuals to block someone from posting on their site. If a young person is being bullied on Facebook, he or she can block that person from posting offensive comments. Facebook also has a facility that allows people who are being bullied online to report it to Facebook so that Facebook can contact the individual doing the bullying. Facebook has reported that that has been very useful in reducing repeat bullying by particular individuals. So, that seems to be the way in which we need to go to keep children and young people safe online from cyberbullying and the issue of suicide.

Ms Black: I will just add to that by mentioning public information. The social media stuff is moving so rapidly, and, as Gerard said, it is about education and giving people the tools to deal with things that appear on a website. It is about what you can do to close it down rather than risk the glamorisation of it.

Another issue is public information. We have already mentioned the need to focus on help-seeking behaviour, removing the stigma and promoting mental health and well-being. That has been endorsed by the most recent qualitative information and the research that we did to inform the next public information campaign. You may remember that we have run a number of campaigns, including the one with the young man wearing a mask and one which featured Linda Bryans. There was a view at one point that the next campaign should have a sharper edge and be geared more towards suicide and its prevention. All the qualitative research completely vindicates the view of promoting positive mental health and well-being, rather than a focus on suicide.

The other really important thing that came out of the focus group discussions — I think it is a salutary point — is that people overestimate the level of suicide that we have here in Northern Ireland by a factor of 10. So, we do well in paying attention to the issue, but we also have a real job in hand to make sure that, in whatever interaction we have with the media, public information, and community

and voluntary groups, we do not somehow add to the sense of dismay and confusion out there. It is already a wee bit skewed. First, we have to be really careful that we do not in any way risk normalising suicide by suggesting that it is somehow more common than it actually is and that we, as a society, somehow find it more acceptable. Secondly, we have to be careful that we do not inadvertently contribute to modelling or copycat behaviour. That is why addressing the glamorising that you mentioned is so important in the event of someone's death from suicide.

So, it is a complex issue, but it is very clear that the focus of public information should remain on promoting positive health and well-being and help-seeking behaviour.

Mr Collins: It is important that we do not demonise the internet and social networking sites, because they can be used for very positive purposes and to promote mental well-being. Today, the Forum for Action on Substance Abuse (FASA) is launching its web initiative, to which a variety of community groups can sign up. I am talking about church groups and sports clubs, which are what we call community gatekeepers. They do not deal day in, day out with people who are in emotional crisis but will, from time to time, meet someone who is. That initiative is about getting those various groups involved in the online community so that an appointed person from each group can go online and find out where there is help or where there are groups that specialise in suicide prevention. They can, one, undertake training and, two, refer the individual who has come to them to the relevant group. So, that is a very positive use of the internet. Another positive use is the young men's suicide prevention project, which is being launched next week, I think. It is an all-island project, and it has developed an app for young men to test their mental fitness and get tips for improving their mental fitness. Those are two extremely positive uses of the internet.

To add to what Mary mentioned about memorial sites, the international evidence is that memorial sites, or legacy sites, for someone who has died by suicide should be closed down, and bereaved parents or some other family relative should be taken through the steps for closing them down because they can be very dangerous. Friends and peers of the deceased person, particularly of a young person, can go online and converse on those sites, and that might give the impression that the person is still living online and therefore that, if you die by suicide, you go on living. I know that, in New Zealand, other legacy sites, such as trees that were planted to commemorate people who died by suicide, became meeting places for young people who would meet at night and drink around those areas, and they became a focus for suicide attempts 25 years down the line. In New Zealand, those trees were cut down.

The Chairperson: You could not argue against that.

Mr Beggs: Thanks for your presentation. I commend the many community organisations that are working in this area. Frequently, they can access individuals in the community when the statutory sector cannot. You should also commend yourselves. Significant sums are being pointed towards this issue. It was £7·1 million in the last financial year. I am not sure what the figure is for this year.

What about areas where there is a weak community infrastructure? There might not even be a community group, never mind a group that specialises in trying to help people who have this difficulty. How do you try to ensure that there is a group in every geographical area of Northern Ireland?

Ms Black: That is a very important point because rural isolation is one of the issues that we know can be a problem for people. We have a plan, if you like, of working through all the network organisations in the community sector. For example, there are rural community networks in many parts of Northern Ireland, and we work with them on not only mental health and suicide prevention but a whole raft of other issues. Mental health and suicide prevention is wedded in as part of that work. That is one factor. You hope that by building that into ongoing work with those community organisations, you are allowing them to include it in a natural way in their agenda.

The second factor is the Lifeline service, which is provided through the organisation Contact. It is available right across Northern Ireland and is promoted fairly heavily. We know that uptake and awareness are greater in some areas than in others, and we know that we have a job to do to build that understanding in some of those areas. Nevertheless, it is a service that is available across Northern Ireland, and it is heavily supported and encouraged. I think that those are the two key mechanisms that we use.

Mr Beggs: I am thinking particularly of a deprived community in an urban setting. Who is carrying the message there? It has been highlighted that there is a slightly higher propensity in such areas. Are you identifying any of the hotspots where there is no active group at present?

Ms Black: There are some areas that are not serviced by community groups. It is impossible to cover the whole of Northern Ireland, but, at the same time, we have a very good understanding of the local community infrastructure. It does not mean that you can cover everywhere, but I guess that, in those areas, you have to rely on traditional routes, such as health visitors, GPs, schools, and so on. That is why, as we have all just recognised, going across different organisations and structures is so very important.

Mr Beggs: Finally, I concur with your focus on the importance of a positive mental attitude. I am aware from a briefing from the YMCA a long time ago that resilience has been identified as being very important to young people in America. There is a range of factors that can help them to deal with risks that they might face. One of the issues was sport, involvement in church organisations and having an adult you can talk to. In respect of pastoral care, are all schools open to giving access to young people who need help? Our schools and Youth Service are bound to be important access points. Are all schools giving you that access at this time?

Mr Collins: I think that I mentioned earlier the pupils' emotional health and well-being programme, which the Health Department and the Department of Education have worked on together and have developed. It is almost there; it is to be launched this year. It is now branded as iMatter, like iPhone, and it is really about ensuring that there is good quality emotional resilience and mental health promotion in every school. It deals with post-primary schools at the moment. A lot of tools, leaflets, documentation, protocols and guidebooks have been developed for schools to ensure that they are doing their utmost, through a whole school approach, to promote positive mental well-being in schools, and that includes addressing bullying, which is a major issue.

It is worth noting that, since 2007, emotional well-being has been part of the Northern Ireland curriculum at primary level and at secondary level. It is up to each school how it actually interprets and delivers that element of the curriculum. iMatter is designed to pull all that together at secondary school level. At primary level, the PHA has been rolling out the Roots of Empathy programme as well. That is now in a large number of schools — 500, I think — and there is an effort to work within education to roll that out further. That is a very important programme for building emotional resilience and empathy, which is a key aspect of emotional resilience in young children, especially vulnerable young children.

Ms Heaney: There are two things. One is that New Life Counselling has the contract, through the Department of Education, to provide the counselling service to all post-primary schools. Every school has access to that in addition to whatever other pastoral care they put in. The other thing we are doing, through the work we are leading on with the trust and education side, is looking to provide training to teachers and people in the school setting; training in suicide awareness, safeTALK, mental health promotion and resilience. It is really to train up the staff who are there, as opposed to us constantly going into schools. We need to skill up the staff to help them to work with the young people.

The Chairperson: Does that entail new teachers going through the process of being trained? As far as I am aware, very little time is spent on that in colleges.

Ms Heaney: We are beginning to pick that up now with the universities, and ask how we can get that into the curriculum in the various areas, whether that is education, health service staff, community or youth community workers.

The Chairperson: That would save money and energy, rather than having to do it after they have qualified. Is there going to be movement on that? Is there a time frame?

Ms Heaney: We are just starting the negotiations now. It is about how we get that onto their curriculum and get those slots.

The Chairperson: Is there anything that we can do to support you in that?

Ms Heaney: We have started with some of the health service staff; nursing students and others on that side. That is where we are at at the minute. Education will be next. We have already developed links with the regional training unit for the Department of Education so as to get things onto its agenda. However, there is still a conversation —

The Chairperson: The ministerial subgroup is due to meet in 10 days, or whenever the date is. My information is that there is a good working relationship between the Health and Education Departments, DCAL and DARD. I know that what you are talking about gets us into the remit of DEL, but could it not be on the agenda for the next meeting in two weeks? All it would take is a nod from Ministers to get it sorted, rather than starting negotiations.

Dr Mitchell: We can take that back. Certainly the Employment and Learning Minister is on that group.

The Chairperson: Will you update us on that? If Ministers agree to this, it could be sorted overnight.

No other members have indicated that they wish to speak. We have dealt with a lot of the issues. I do appreciate you coming to give us an update. I know that a lot of good work is done in communities, but the reality is that suicide rates are high. There is a lot of frustration out there in our communities, because some people, rightly or wrongly, believe that nothing is being done. Getting the evaluation and hearing some of the stuff you are doing is actually useful. I thank you for that. As for any information we are due to get, can you try to get it to us as soon as possible? I am keen to know whether that is going to be on the agenda for that meeting in two weeks' time. If not, you need to let me know. The Office of the First Minister and deputy First Minister has told me that it will be a priority. If we need to speak to other Ministers, let us know. Thank you.