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COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

**Departmental Briefing on the Gender
Equality Strategy**

18 February 2010

NORTHERN IRELAND ASSEMBLY

**COMMITTEE FOR
HEALTH, SOCIAL SERVICES
AND PUBLIC SAFETY**

Departmental Briefing on the Gender Equality Strategy

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Members present for all or part of the proceedings:

Mrs Michelle O'Neill (Deputy Chairperson)

Mr Thomas Buchanan

Mr Sam Gardiner

Mrs Dolores Kelly

Mr John McCallister

Mr Conall McDevitt

Mrs Claire McGill

Witnesses:

Dr Maura Briscoe)

Mr Gerard Collins)

Ms Linda Devlin)

Ms Margaret Rose McNaughton) Department of Health, Social Services and Public Safety

The Deputy Chairperson (Mrs O'Neill):

I welcome the departmental witnesses. Ms Linda Devlin is the Department of Health, Social Services and Public Safety's director of equality and human rights, and Mr Gerard Collins is from the Department's health improvement policy branch. Dr Maura Briscoe — no stranger to the Committee — is the Department's director of mental-health and disability policy, and Ms Margaret Rose McNaughton is from the Department's secondary care directorate. They are here today to brief the Committee on the gender equality strategy. I invite you to make a presentation,

after which members will ask questions. We can allow a maximum of 10 minutes for your presentation, and we are quite strict about that.

Ms Linda Devlin (Department of Health, Social Services and Public Safety):

Good afternoon. I am the Department's director of strategic management, and equality and human rights are among my areas of responsibility.

Our purpose today is to update the Committee on the progress made on the actions assigned to the Department in the cross-departmental gender action plans. The briefing paper that we provided to the Committee sets out the background to the OFMDFM-led gender equality strategy. It highlights how the Department has mainstreamed the section 75 equality requirements, and it reports the progress of each specific health action in the action plans. Those actions were centred on two of the nine strategic objectives of the gender equality strategy: to improve the health of men and women and to eliminate gender-based violence.

Members will appreciate that the work of the Department and the remit of health and social care cover a vast spectrum of issues, all of which have a gender dimension. We are not experts in all those areas, so we will be happy to provide the Committee with written responses to any questions that we are unable to answer today.

The Committee is already familiar with the Investing for Health strategy. When it was launched in March 2002, its aim was to focus on prevention, and, in doing so, to tackle the factors that adversely affect health and perpetuate health inequalities. Members should not be surprised that there is some correlation between the inequalities that are identified in the Investing for Health strategy and those in the action plans.

In October 2007, the Equality Commission published its statement on key inequalities in Northern Ireland. In the context of health and social care for men and women, it identified a key concern about the use of gender-neutral language and the setting of general, rather than gender-specific, targets for the whole population. The fact that we now have one action plan for women and another for men goes some way to addressing that issue. That does not mean, however, that there will be no overlaps between the two plans, particularly in areas such as smoking, obesity and alcohol, which are driven by lifestyle choices that both men and women can freely make.

It is important to note that, although the plans are described as gender action plans, they cannot be divorced from the other identities that we all have. Everyone has a gender, and, therefore, it is possible to measure inequalities and describe actions in those terms. Realistically, however, inequalities do not always exist purely in the context of gender. Often, an overlap exists with other equality categories, such as age, ethnicity, sexual orientation and other important categories that lie outside the section 75 groups, such as region and socio-economic status. The OFMDFM gender advisory panel and the Equality Commission recognised that such overlaps exist and identified a need for more disaggregate data with the OFMDFM Committee.

The current plans not only feature actions to address inequalities between men and women, such as the lower life expectancy for men and the higher prevalence of mental-health problems for women, but inequalities within a gender. Access to maternity services, for example, is exclusively a women's issue, but the associated action plan is targeted at reducing inequalities in access for subgroups of women, such as those with a disability or those from an ethnic background. It might be argued that those inequalities more correctly belong in action plans for ethnicity and disability, but gender is the common factor, and that is the reason for their inclusion in the plan.

From the Investing for Health strategy, the Committee will be aware that many issues that are known to have a significant impact on both physical and mental health are outside the Department's remit. One such issue is the need for good social housing measures to tackle poverty and social exclusion. Ultimately, if the plans are to deliver the desired strategic outcomes, it will be necessary for all Departments to pull together and play their part. OFMDFM will have a pivotal role in monitoring progress and revising the action plans as appropriate.

The Committee for the Office of First Minister and deputy First Minister agreed that the gender action plans will be viewed as living documents, which means that they will be subject to revision, although it has still to obtain ministerial approval for that. Given the interest in that area and the potential need for change, it seems to be a sensible approach.

In the context of reviewing and updating the plans, I ask you to note three items. First, in May or June 2010, OFMDFM plans to hold a workshop to bring together the cross-departmental policy leads and OFMDFM's gender equality panel. That workshop will review the current plans and inform OFMDFM's mid-term review of the gender equality strategy.

Secondly, it is expected that the Equality Commission will launch its revised guidance on section 75 in the next few months. It is understood that the commission will ask all public authorities to carry out an inequality audit. The exact details of that audit have yet to be clarified, but, given that gender is a section 75 category, it is not possible to rule out the need to revise the action plans in light of what that audit may identify.

Thirdly, as members will be aware from the Committee's hearing on the review of the Investing for Health strategy on 21 January 2010, a review of that strategy is due to be published later this year. Given the close overlap between the strategy and the gender action plans, the review may also identify additional issues that need to be considered.

If the Committee has any suggested revisions or additions to the action plans, we will be happy to take note of them and factor them into our consideration.

Mr Gerard Collins (Department of Health, Social Services and Public Safety):

I will cover those sections of the health strand of the gender equality strategy that relate to Investing for Health and the associated strategies on tobacco, drugs and alcohol, suicide prevention, Fit Futures and the promotion of sexual health. Investing for Health is the overarching strategy for the promotion of better physical and mental-health well-being in our population.

We acknowledge the gap between the life expectancy of men and that of women. However, the public service agreement target relating to Investing for Health is to reduce the differential between the life expectancy of people who live in the most disadvantaged areas of Northern Ireland and the average life expectancy in Northern Ireland.

The gender-specific actions on improving health and well-being are embedded in the supporting strategies that I mentioned. The tobacco action plan is being revised and will be rolled out for a further five years. Given that young people who take up smoking in their teens are three times more likely to die of cancer than those who take up smoking in their mid-20s, that plan will continue to focus on children and young people, both boys and girls, as a priority. The number of actions in place includes a minimum age requirement for buying cigarettes and proposed legislation on retailer sanctions, retail displays and vending machines. All are designed to

prevent young people from taking up the habit.

Overall, smoking levels for boys and girls aged 11 to 16 year are decreasing, but recent surveys show that the number of girls in that age bracket who smoke is increasing. In light of that, the Public Health Agency has launched a public information campaign, which is aimed primarily at girls and identifies the 4,000 dangerous chemicals in cigarettes. Interestingly, there is not the same pattern of smoking in the 16- to 19-year-old age group. On reaching that age bracket, the rate of smoking among boys has caught up with that of girls.

The revised tobacco action plan will, therefore, consider commissioning further research to obtain a more accurate picture of smoking prevalence among young people in Northern Ireland. The revised action plan will also focus on pregnant women who smoke. To maintain a focus on that group, consideration is being given to a 2010-11 priority for action to increase the number of pregnant smokers who use the smoking cessation services.

Work also continues to address alcohol and drug misuse through the new strategic direction. The Public Health Agency is running an information campaign focusing on the consequences of misusing alcohol, in particular the increased risk of breast cancer. The target audience for that campaign is women aged between 30 and 59, because an increasing number of women in that age group drink more than the recommended limit. However, there are some encouraging signs in respect of alcohol use: a reduction in the proportion of men who drink more than the weekly limit; a reduction in the proportion of adults who binge drink, and a reduction in the proportion of young people aged between 11 and 16 who report getting drunk.

Suicide rates present one of the starkest contrasts in gender differentials. Between 2005 and 2008, males accounted for more than three quarters of suicides here. The suicide strategy acknowledges that differential impact and names specific actions targeted at young males. Members may be aware of a number of the campaigns that the former Health Promotion Agency ran. The Protect Life strategy is currently being reviewed, and a refreshed version of the strategy will be published before the summer. As part of that review, there has been a detailed assessment of the latest international evidence on best practice. As a result, there is likely to be an even greater focus on young males in the new strategy.

A fair degree of progress has been made on teenage pregnancies. However, future actions on

teenage pregnancy will be directed at areas of disproportionate social and economic need.

The obesity prevention framework is being developed, and it will identify vulnerable groups for whom targeted interventions will be developed.

The sexual health promotion strategy was launched in 2008. However, there has been a delay in getting the sexual health promotion network up and running. That was due, primarily, to the fact that the Public Health Agency was faced with swine flu and other priorities at its inception and had to direct staff to different areas. However, the first meeting of that network is likely to take place in April 2010.

That concludes my quick overview of the work on areas identified in the Investing for Health strategy.

Dr Maura Briscoe (Department of Health, Social Services and Public Safety):

Good afternoon, everyone. I wish to take the Committee through some of the actions that the Department has taken to tackle sexual and domestic violence and outline some of the broader themes within mental health. I do not intend to give a very detailed summary, and I promise that I will be as quick as I can.

As Members know, the Department has two five-year action plans. One aims to tackle domestic violence, the other focuses on sexual violence, and each has an underlying annual action plan. We have an appropriate infrastructure that recognises the multi-agency, cross-departmental issues relating to domestic and sexual violence. Minister McGimpsey chairs an inter-ministerial group on domestic violence and sexual violence.

There have been several key achievements in addressing domestic violence. The 24-hour domestic violence helpline provides information, advice and support to victims of domestic violence; I am happy to say more about that. For pregnant women, routine checks for domestic violence have been introduced into antenatal and post-natal maternity services. Guidance on domestic violence has been produced for employers, agencies and faith communities. Specialist domestic violence officers have been appointed in each PSNI command, and special domestic violence training for court and prosecution service staff has been provided. The Department is also funding the NSPCC to provide support services for women and children who experience

domestic violence. This year, there has also been a particular focus on multi-agency risk-assessment conferencing to identify women and others who experience, or are at high risk of experiencing, domestic violence.

As we recognise the need for multi-agency arrangements and the importance of education, we work in partnership with the Department of Education on a number of programmes on domestic violence and sexual violence. The need to engage with groups that are hard to reach or vulnerable is included in our action plan, and we recognise the importance of that as part of any domestic violence action plan. As we move forward, we want to roll out the domestic violence inquiry into A&E departments, minor injury units, GP surgeries — including out-of-hours surgeries — and services for older people.

The last domestic violence issue that I want to highlight is our funding of the Men's Advisory Project, which is carrying out research for the group into domestic violence against males and establishing what services are available to them.

As far as sexual violence is concerned, the key achievement has been sending out the message and increasing awareness that sexual abuse and sexual violence are wrong. I hope that members have seen the public information campaign around the countryside. That is supplemented by a helpline and additional information on the NIDirect website. I am pleased to say that the business case for the regional sexual assault referral centre (SARC) has been approved, and we have now moved on to the design phase. In addition, we are carrying out a review of counselling services for sexual violence. Imminently, we will publish a regional directory of services, which will detail all existing services for children and adults across the voluntary and community sector. That will help to inform how we move forward to fill any gaps that may be highlighted.

I talked about the importance of education and working in partnership, not only in primary schools and secondary education, but through further education. A scoping study on pastoral care arrangements for students in further education colleges has been commissioned through the Department for Employment and Learning.

My colleagues talked about the inequalities in mental health. Given the various conditions that people have, mental health has a multifactorial basis. We recognised that in the Bamford action plan, which we published in October 2009, and we produced a cross-departmental action

plan that was endorsed by the Executive. The plan covers public health issues, supporting people to live independent lives, supporting carers and families, promoting better services for the needs of individuals and the legislative structure that we talked about previously.

In the Bamford action plan, we recognise that there are gender issues in mental health, not least that there is evidence that women in Northern Ireland have a wider variety of mental-health conditions than men and that the prevalence among women is higher. Common conditions among women include depression and anxiety disorders.

We recognise that dementia is more prevalent in women, and we are developing a dementia strategy. In the Assembly last week, the experiences of women with perinatal mental-health conditions were discussed, and we recognise that it is an issue not only for women, but for their broader family and children.

The Deputy Chairperson:

Thank you; I was not too strict about time after all.

Dr Briscoe:

It is a big subject.

The Deputy Chairperson:

It is indeed, and plenty of members want to ask you about it. I want to pick up on your final point about perinatal mental health: as was pointed out in the Assembly debate, suicide is the biggest indirect killer of pregnant women, so perhaps the review will consider targeting that area in the strategy. Are you seeking suggestions today?

Ms Devlin:

We are happy to take suggestions.

The Deputy Chairperson:

Given the gender-specific nature of the issue and the fact that pregnant women are most likely to die as a result of suicide —

Dr Briscoe:

Michelle, I shall defer to Gerard on that, because he is involved in suicide prevention and in promoting mental health.

Mr Collins:

We are considering the points that Maura raised about perinatal mental health, and we are developing a new plan to promote mental health and well-being. It may be that the subject of perinatal mental health should rest in that plan, rather than in the suicide prevention plan. Nevertheless, we will certainly give some consideration to the subject.

The Deputy Chairperson:

It is like a jigsaw, in that we can see the pieces coming together: the gender equality strategy, the Investing for Health Strategy and the roll-out from the Public Health Agency.

Dr Briscoe:

It is important to acknowledge that the vast majority of perinatal mental-health services are delivered through primary and community care, and we must also recognise that there is a spectrum of seriousness for women who have those conditions. Nevertheless, by far the majority of such services are delivered through primary and community care.

The Deputy Chairperson:

The Assembly debated reproductive rights. The access to fertility services has improved, and people have access to services within a year of applying for them. Waiting lists and the number of cycles were considered, and the action plan states that the planned outcome remains a matter for public debate. The Minister has often said that, if he had more money, he would offer more treatment cycles. Where does that sit at present? Are we any closer to achieving that goal?

Ms Margaret Rose McNaughton (Department of Health, Social Services and Public Safety):

As you know, last year, £1.5 million was invested to ensure, initially, that waiting lists would be maintained at within 12 months. We have reduced waiting times to 11 months, so no one should have to wait for more than 11 months for their first treatment cycle. With the remaining money, we want to see how much we can spend on offering a frozen embryo transfer service, which is the next stage. That treatment is not appropriate for all women, but it is the first step to offering more

than one cycle of treatment. From monitoring the programme on a three-monthly basis, we know that waiting times are down to 11 months. We now have to work out how much money is left and decide which women are eligible to receive a frozen embryo transfer. The situation is constantly under review.

Mrs McGill:

Welcome, and thank you for your briefing. The trend in mental health care is towards mixed wards, an example of which was raised with me in my constituency. I shall not go into detail, and I am not always in favour of how issues are thrashed out in the media. Nevertheless, we have heard much on the subject in the media and from the general public.

Parents are concerned about the safety of vulnerable young females in mixed mental-health wards. I accept that the strategy must be gender neutral and sensitive, but does the sense that people will be faced with stays in mixed wards not contradict that requirement? Potentially, a female who has suffered mental-health problems as the result of having suffered an assault by a male could face a further assault within the confines of a mental-health ward. Indeed, the case that was brought to involved the repetition of such an assault. Are those issues being discussed as part of your review?

Dr Briscoe:

We acknowledge that there has been much talk in the media about those issues and, in particular, about Rathlin villa at Knockbracken. In my view, Rathlin villa is not a mixed-sex ward. It comprises two conjoined units, with a male wing and a female wing separated by a nursing station and recreational and eating areas. Rathlin villa has wings rather than wards, and the accommodation in those wings is excellent. The accommodation is en suite, which is a vast improvement on many facilities in the past.

As facilities develop, the emphasis will be on having en suite facilities in an environment that is appropriate to the individual concerned. Policies are devised, and risk assessments are undertaken for individual patients in any environment. One would expect that the person-centred planning in any unit that has male and female wings would accommodate the needs of the individual patient in that environment. I cannot speak about the particular circumstance that you mentioned but, if you contact me later, I will be happy to speak to you about it.

Mrs McGill:

I want to make it clear that the discussions in the media did not relate to my constituency of West Tyrone. I was merely making a connection between the media reports and a case that was presented to me. As I said, I do not want to go into the details of that case. However, I understood perfectly the concerns of the parent who came to speak to me about her young daughter. The public are concerned about where the plans are heading. I was not making any comment about Rathlin villa.

The Deputy Chairperson:

Claire, if you wish, you can take the matter up with Maura personally.

Mrs McGill:

Yes; thank you. How do we reconcile those concerns with the gender equality strategy?

Dr Briscoe:

You should consider the mental-health facilities that are provided at the Bluestone unit in Craigavon and the new unit in Downpatrick. Patients there have en suite rooms that provide them with more privacy than they had before.

Mrs McGill:

Are you confident that females will be reassured by that, even though there may be male patients in the same ward?

Dr Briscoe:

I disagree with your concept of a ward. The new facilities that I am talking about have wings, not wards. There has been some confusion about that in the recent publicity. I re-emphasise the fact that people admitted to hospital are risk-assessed and that a person-centred care planning approach is then taken to that individual.

Mrs McGill:

I do not want to disagree with you, Maura. However, my constituent raised a difficulty that must be addressed. We may disagree about whether those facilities are located in wards or wings, but the fact is that my constituent had a problem with her young daughter's being in that environment.

The Deputy Chairperson:

Maura has offered to discuss that issue with you outside the Committee. That would be more appropriate.

Mrs D Kelly:

Thank you for your presentation and your wide-ranging briefing paper. I wish to clarify a couple of points in the paper. The introduction says that OFMDFM has yet to publish the action plans. Why is that the case four years on?

Ms Devlin:

Those actions plans —

Mrs D Kelly:

Are you talking about the cross-departmental plans?

Ms Devlin:

Yes, I am. The cross-departmental action plans have not been published. However, 'Implementing the Gender Equality Strategy: Progress Report 2006-2008 Monitoring and Review' has been published, and it includes those actions plans.

Mrs D Kelly:

I understand that, but, overall, you are way behind schedule.

Ms Devlin:

The progress report was published in June 2009.

Mrs D Kelly:

I wish to make three points. First, everything that you described boils down to the equality of access to services and how to ensure that specific needs are met and that people have access to information. However, the gender equality action plan does not mention anything about your workforce, even though the Health Service primarily employs women. It is my understanding that the majority of women working in the Health Service are still paid less than men for doing equivalent jobs.

Secondly, I wish to address the issue of suicide prevention. In the past week, I have heard of three suicides. Therefore, there is not much evidence to suggest that the preventative measures are working yet. However, I know that spring is a difficult time of year. Has there been any movement on conducting all-Ireland research into suicide? Significant research was conducted in the South of Ireland and some cross-border working groups were seeking to pool resources. It is important that that happens, because suicide is one of the biggest killers of young people.

Thirdly, your paper states that a directory of services for people suffering sexual violence and abuse will be produced early in 2010 alongside a report on the gaps in service provision. Has that report been published yet? If not, it would be useful to know when that will be. Earlier, we heard evidence from the Youth Justice Agency about the impact that violence in the home can have on young offenders. Will you also provide an update on when the new regional sexual assault referral centre might be ready?

Ms Devlin:

First, the gender equality strategy, on which OFMDFM is the lead Department, has nine objectives. As two relate to health, the responsibility for developing those objectives in accordance with the action plan lies with our Department. The two objectives are to improve the health of women and men, including their reproductive health, using gender-sensitive decision-making and priority setting; and to eliminate gender-based violence in society.

Another objective is to ensure the economic security of men and women and to address the gender inequalities that lead to poverty and social exclusion. That objective acknowledges women's vulnerability to poverty in particular. However, the Department for Employment and Learning (DEL) will lead on that issue, because it deals with the total workforce rather than with specific areas of the workforce that have been broken down into categories such as health or education.

Mrs D Kelly:

I understand what you are saying, but we want to see collaborative working. We can write to DEL about its gender action plans, but I am aware that a number of health and social care trusts have difficulty retaining and recruiting staff. People who work in Tesco receive higher hourly wages than those who work in social care.

Ms Devlin:

As I said at the outset, all Departments are required to work together on the cross-departmental strategy, and OFMDFM is its lead co-ordinator. Your second point was about suicide prevention.

Mr Collins:

I too have heard of three suicides in the past week or so. A great deal of work is ongoing in many quarters to try to address that problem. This year, the Department invested some £6.7 million in suicide prevention through the Lifeline service and the implementation of the Protect Life strategy. A large element of that funding goes to community-led initiatives, because we recognise that communities know best what happens in their areas.

A number of wider pilot projects include the registry of deliberate self-harm. We have been working with Dr Ella Arensman from the National Office for Suicide Prevention, which is based in Cork. Dr Arensman conducted a comprehensive review of international evidence and best practice, and her findings will inform the updating and refreshing of the Protect Life strategy. We expect that a number of new and revised actions in Protect Life will be based on that evidence. The all-island suicide action plan, which includes 10 actions, is ongoing. Shared learning and shared resources are incorporated in the public awareness campaigns that are often run on an all-island basis. The establishment of a men's mental-health forum is also under consideration. There is one in the South, and we will try to bring a similar forum to the North to provide suicide prevention initiatives that are directed at young men in particular. A wide variety of activities is ongoing.

Given that the causes of suicide are wide-ranging and include many societal factors, it is difficult to identify the impact of the suicide prevention strategy. Anecdotal evidence from the South of Ireland suggests that the number of suicides is increasing, partly because of the recession, which has left some people mired in debt. The misuse of drugs and alcohol is also a factor. There is such a wide range of factors that it is virtually impossible to identify the unique impact of the strategy on the overall suicide rate. As part of the refreshed strategy, we want to develop a more sophisticated range of indicators so that we can follow up on people who have been in touch with suicide prevention services one year, two years, three, four or five years down the line to determine what difference the strategy has made to their lives. It is a question of more effective data collection.

The research that we commissioned on some of the causal factors of suicide in different areas across Northern Ireland will produce useful information. The deliberate self-harm registry already produces useful information. The information provided by Lifeline is also extremely helpful. We use it to find out, for example, whether a call relates to bullying or debt and break down the information by gender and age groups. All that information is starting to emerge, and we must use it to try to inform future policy direction so that programmes can be targeted at those areas in which they will have the maximum impact.

Mrs D Kelly:

That is interesting. Has the “card before you leave” scheme been launched yet?

Mr Collins:

The scheme was launched last month and is now in place in every trust. That is an example of the statutory services working with the community sector. The idea of the “card before you leave” scheme came from one of the community groups involved in implementing the suicide prevention strategy.

The Deputy Chairperson:

It came from the suicide inquiry that the Committee held, during which various community groups gave evidence.

Mr Collins:

As I recall, the idea came from the Public Initiative for the Prevention of Suicide and Self-Harm (PIPS) and the Practice of Rights Project (PPR).

The Deputy Chairperson:

The idea was carried through into what is now a great scheme that provides people with a lifeline when they leave hospital.

Dr Briscoe:

SARC is scheduled to be operational at the end of 2011. It will provide a 24-hour crisis response to adults and children. It will provide a focus and a catalyst for training, and it will be a centre for the collection of robust data and information on domestic violence. We hope that data will

inform future policies.

We are on target to publish the report on the directory of services, and we hope to do that in the next month or so.

Mr Gardiner:

Before I left home today, I received a call from a concerned GP in my constituency. Have you heard of the drug mephedrone?

Mr Collins:

Yes, I have heard of the drug.

Mr Gardiner:

Are you aware that it can be bought in any shop that sells plant food? The GP said that more and more young people are buying that drug. It puts them on a high without having to buy illegal drugs. It is an issue that must be given serious consideration. The GP said that he came across some of his patients who were out of their minds on the drug, and he was extremely concerned. Today's meeting has come at the right time for me to request that you take action. Before you leave, I will give you the name of the doctor and his practice.

The Deputy Chairperson:

Samuel, are you talking about the new drugs that are called legal highs?

Mr Gardiner:

It could be one of those, yes. They can be bought in shops that sell plant food.

Mr Collins:

We will take that matter back to the Department for consideration.

Mr Gardiner:

Yes, it must be addressed.

Mr McDevitt:

You determine what will be included in the equality impact assessment. Why are eating

disorders, which overwhelmingly affect women, not included? Why does the strategy remain silent on such issues? How do you decide what goes into the action programme and what does not? To me, eating disorders seem to be obvious candidates for inclusion, but I cannot see any mention of them.

Dr Briscoe:

The issue of eating disorders is part of the Bamford action plan and comes under mental health. In that context, we feel that it is covered. However, I recognise that there is a gender issue, in that eating disorders predominately, but not exclusively, affect females. A specific action on eating disorders is included in the Bamford action plan.

Mr McDevitt:

Eating disorders remains one of the areas for which there is least provision.

Dr Briscoe:

In the past couple of years, there has been considerable investment in tackling eating disorders. It is a priority in the Bamford action plan. The investment has focused on the development of community eating disorder teams to allow people to stay in their community and ensure a focus on early intervention and ongoing support. Quite a lot of development has taken place. The regional Eating Disorders Network co-ordinates all eating disorders' services, and the drive forward is through that group.

Mr McDevitt:

There is not yet a residential facility on the island.

Dr Briscoe:

It depends what you mean by a residential facility.

Mr McDevitt:

I mean a specialist residential facility.

Dr Briscoe:

The majority of people who have eating disorders do not require residential facilities. Indeed, evidence exists that those who are treated in community settings close to their homes do better

than those who are not. To date, the focus has been on community specialist services.

Mr McDevitt:

Am I correct in saying that the update relates to the position as of June 2009?

Ms Devlin:

Yes.

Mr McDevitt:

Have you an update on any of the action points since June 2009? That was some eight months ago: is the information up to date or is it eight months old?

Ms Devlin:

The written material in our briefing paper is up to date.

Mr Collins:

I think that more information was fed through in December 2009.

Ms Devlin:

Yes, it was.

Mr McDevitt:

Thank you. I appreciate that. I have one last question about a point in your briefing paper on the rise in the number of young professional females who put themselves at risk through drinking too much. That is a growing concern that extends beyond young professional females to young females generally. We are all aware of the significant increase in the number of young women who binge drink. I note that the major action proposed is the development of a leaflet. Do you consider that to be an adequate response to the problem?

Mr Collins:

I mentioned the campaign that highlighted the dangers of excess alcohol consumption and linked it to breast cancer. That comprehensive campaign is running again this month. Therefore, our action is not confined to the leaflet; it also involves broader TV and radio campaigning.

Mr McDevitt:

Do you consider the leaflet to be the best way to reach that demographic?

Mr Collins:

It is one of a number of ways. The more costly TV advertising campaigns are probably the most ready medium through which to reach a wider range and number of people. However, the success of leaflets depends on where they are distributed. Workplaces are a useful location for their distribution to young professional women.

Mr McDevitt:

What is your strategy for distributing the leaflet?

Mr Collins:

The Public Health Agency is involved in the detailed implementation of that action.

Mr Buchanan:

Thank you for your presentation. It contained a great deal of information and is to be welcomed. I could ask about many matters, but I will focus on one issue today. We have been talking about the equality of access to services. I want to focus on access to maternity services. Recently, the Northern Health and Social Care Trust launched a new maternity strategy with six core elements. It is important that we note them: promoting pregnancy as a normal life event; providing a comprehensive range of maternity services; reducing inequalities; ensuring a seamless service; and being women-centred. The main overall focus is on avoiding too much separation from the family and providing encouragement and confidence for pregnant women.

How do you propose to roll out that equality of access across Northern Ireland? I am from the west of the Province. I make no apology for saying, once again, that pregnant women do not have access to a maternity facility, midwife-led facility or consultation process anywhere in the entire county of Tyrone. The largest county in Northern Ireland does not have any of those facilities. Indeed, it does not have even one of the core elements of the Northern Trust's strategy.

That is an example of gross inequality, and it impinges on a basic human right, in that no child can be identified with County Tyrone at birth. How do you propose to address the inequality faced by women in the south-west quarter of Northern Ireland? None of those services is

available in my constituency of West Tyrone or, indeed, anywhere in the entire county of Tyrone.

Ms McNaughton:

The fundamental issue for all maternity units is the provision of safe services. At one stage, it was suggested that a community, midwife-led unit be provided at Omagh, and a feasibility study was carried out. We plan to produce a maternity strategy, the timing of which is being considered by the Minister. It has not yet been issued because of the development of other strategies, such as the Northern Trust strategy.

You raised the issue of equality of access to services. The underlying issue is the provision of safe services. We must ensure that there would be a sufficient number of births in a particular area to make a facility sustainable. Services for people in the west are provided at Altnagelvin Area Hospital, the Erne Hospital and Craigavon Area Hospital. There will, I hope, also be a maternity-led unit at Lagan Valley when the business case has finally been approved. We must ensure that we provide safe services and that access to services is as good as possible. That is all that I can say on that subject at the moment.

Mr Buchanan:

With all due respect, the provision of safe services is being used as a smokescreen, and equality of access to services is not being provided. The idea of having a midwife-led service at Omagh has been considered time and time again, but, using the smokescreen of safe services, it has not been provided. I ask you to examine that gross inequality. You must agree that it is unacceptable that none of those services is available in County Tyrone, which is the largest rural county in Northern Ireland. I want that matter to be addressed urgently.

Mr McCallister:

I welcome the report, and I am sorry that I missed the start of your presentation. Gerard said that the sexual health strategy will finally be published soon. The Deputy Chairperson previously raised the issue of the delay in its publication in Committee. How do you envisage getting to some of the groups that, as Maura mentioned, are harder to reach, such as the Travelling community? How will you tackle violence against women and, indeed, against men — an issue that is massively under-reported — among those groups? What strategy is in place to persuade males who suffer domestic violence to come forward with information that might enable something to be done? How will you develop your approach to all those groups that are harder to

reach? It is easy to state in a strategy that something must be done for them, but what action are you taking, and has anything been achieved so far?

Ms Devlin:

Under section 75, all public authorities are obliged to communicate in ways that are appropriate to the people whom they need to reach. The range of ways to do so includes producing material in various languages and using various print media. There is a range of activities across health and social care bodies. In addition, a working group specifically considers Travellers' health issues. I do not have details about that work with me, but I am happy to provide the Committee with more information, because it is a good example of engaging with people and of the person-centred approach that we must adopt. Perhaps Maura Briscoe will provide further examples.

Dr Briscoe:

Mr McCallister is quite right that there are particular issues with the reporting by male victims of domestic or sexual violence. We fund the Men's Advisory Project, and we have commissioned it to carry out research into domestic violence against males and to establish what services are available to men. Our starting point is to recognise that such issues exist.

Our communications plan recognises the need for targeted public information in certain areas, including, for example, male victims of sexual violence. Beyond that, we recognise the importance of reaching out and engaging with minority and ethnic groups. The Rainbow Project, for example, is part of the infrastructure designed to tackle sexual violence. Our action plan includes a specific action to continue reaching out to such groups.

We have made a start, but we must do more. It is interesting that the number of males who are victims of sexual violence is increasing, and the number who present at Police Service care units and sexual violence units is increasing. There are many reasons for that, but a general raising of the awareness of domestic and sexual violence allows people to recognise that it is appropriate to report violence and seek help.

Mr Collins:

I refer the Committee to action 2 in our 'Sexual Health Promotion: Strategy and Action Plan 2008-2013':

"To further develop community based programmes to promote sexual health and wellbeing ... with a particular focus on

those most at risk and taking account of the needs of those with a disability or from an ethnic minority community.”

The key to reaching the hard-to-reach groups is in how we implement the plan, which is why it is important to have a multi-sectoral sexual health network that includes community groups and representatives of relevant groups, all of whom can inform us how funding is used, how services are delivered and how people are reached. The Public Health Agency and the Investing for Health teams from the former boards have a great deal of expertise and experience in that area.

Mr McCallister:

You briefly mentioned faith groups. The engagement with faith groups and ethnic minority communities, many of which have different cultural backgrounds to ours, can be problematic and controversial, and we must maintain a strong focus on that.

You mentioned a group, chaired by the Minister, which aims to tackle such violence. Does that group include representatives from the NIO? If policing and justice powers are devolved, will that group include representatives from the new Department of justice?

Dr Briscoe:

The group has representatives from all ministerial Departments.

Mr McCallister:

Does it include representatives from the NIO, which is not an Executive Department but has responsibility for policing and justice?

Dr Briscoe:

The regional group on domestic violence and the inter-ministerial group on sexual violence are jointly chaired by representatives from the Department of Health, Social Services and Public Safety and the NIO.

The Deputy Chairperson:

That concludes our questions. Thank you very much for coming to the Committee, and I look forward to receiving your renewed strategy.