Equality and Human Rights
Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

As part of the audit trail documentation needs to be made available for all policies and decisions examined for equality and human rights implications. The screening template is a pro forma to document consideration of each screening question.

For information (evidence, data, research etc.) on the Section 75 equality groups see the Equality Portal - Screening Resources & Evidence.

For advice and support on screening contact:

Equality Unit/ BSO /James House/ 2-4 Cromac Avenue/ Belfast/ BT7 2JA
Tel: 028 9536 3961

SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template .

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Bereaved by Suicide Coordination and Development Project:
Support for Families Voices Forum

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**

  Protect Life 2 (PL2) (2019 – 2014, the Suicide Strategy for Northern Ireland contains renewed support and need for a project to '[f]acilidate support networks for people bereaved by suicide and their role in influencing policy and service delivery'.

  This programme outlines the PHA's approach to ensuring the voices of those who have been bereaved by suicide are supported to contribute to decision making in relation to emotional health and wellbeing, suicide prevention and related implementation structures.

- **how will this be achieved? (key elements)**

  This will be achieved by providing support for the Families Voices Forum (Forum) to increase their membership and provide a regional voice for those bereaved by suicide. Forum members are individuals who have lost family members or friends to suicide.

  The involvement of individuals who have been bereaved by suicide has proved to be an important strand in providing opportunities to enhance service user involvement in this area and also ensuring adherence to PPI requirements.

  The Forum was originally formed in 2006, with funding to support co-ordination and development provided by PHA since January

2014 with the current contract due to finish March 2022. PHA have carried out a review of the project by engaging with members of the Families Voices Forum, Local bereaved by suicide groups and Strategy Groups where the project is represented to:

- Obtain views on how they feel the project has met its aims; and
- Receive feedback on any suggestions/recommendations for improving the project.

Through this review, and quarterly monitoring the project has shown to have achieved a number of successful outcomes including:

- Securing representation from all 5 Trust areas
- The majority of respondents (73%-82%) believe the project has met each aim of:
  - Supporting the Forum to actively contribute to regional debates and decision making in relation to emotional health and wellbeing, suicide prevention and related implementation structure;
  - Ensuring appropriate policies and procedures in place for effective management of the Forum;
  - Developing a training needs analysis and identifying training to meet need;
  - Taking a lead role in coordination of Families Voices Forum meetings and events;
  - Ensuring that the Forum is represented at & actively participate in relevant regional and local meetings with representation, where possible, from Forum members.

However, it was felt that the Forum could improve some areas of work including:

- Uncertainties from non- members on the role of the Forum and how to get involved
- Perceived lack of representation from rural areas.
- Wider engagement to include voices of persons who have been bereaved by suicide, who do not sit on the Families Voices Forum or attend local bereavement groups

For the Forum to improve engagement and develop as a regional network to support bereaved individuals to contribute to discussions

around mental health, emotional wellbeing and suicide prevention, it is proposed that the service is commissioned for 5 years with a possible further extension (up to 2 additional years).

The aims of the service will be to:

- Increase and improve the involvement of Forum members to support their ability to input to the Forum.
- Develop a core membership group to provide representation on local and regional statutory groups.
- Develop a wider forum that provides views and a number of opportunities for input which can be formal or informal.
- Increase representation within the Forum to ensure the voices of under-represented groups are included.
- Promote FVF as a forum for all of those impacted by suicide by improving communication links with local bereavement groups, those who work with the bereaved and growing FVF membership across all areas.
- Support the Families Voices Forum to actively contribute to regional debates and decision making in relation to emotional wellbeing & suicide prevention strategy and related implementation structures.
- Ensure Families Voices Forum are represented & actively participate in relevant regional and local meetings (representation where possible should include FVF members)
- **what are the key constraints? (for example financial, legislative or other)**

  Limited capacity within the programme which limits the level of outreach and ability to increase representation.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

Internal: Public Health Agency staff

External:

- Individuals and communities who have been bereaved or impacted by suicide.
- Families Voices Forum
- Bereaved by Suicide Support Group Members
- Department of Health
- Locality Protect Life 2 Implementation Groups (PLIGs)
- Regional Protect Life 2 Steering Group
- Providers of statutory mental health and suicide prevention, intervention and post-vention services and their staff, service users / carers, advocacy groups and referral agents.
- The six HSC Trusts

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**

what are they?	• **who owns them?**
Health and Wellbeing 2026: Delivering Together https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together .	**DoH**
Making Life Better – A whole system strategic framework for Public Health 2013-2023 https://www.health-ni.gov.uk/topics/health-policy/making-life-better	**DoH**
Mental Health Strategy 2021 – 2131 doh-mhs-strategy-2021-2031.pdf (health-	**DoH**

	ni.gov.uk)	
	PHA - Corporate Strategy 2017-21	**PHA**
	Protect Life 2: A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024 https://www.health-ni.gov.uk/protectlife2	**DoH**
	Preventing Harm, Empowering Recovery", Northern Ireland's new Substance Use Strategy 2021 – 2031 – https://www.health-ni.gov.uk/publications/substance-use-strategy-2021-31	**DoH**
	HSC (SQSD) 29-07 – Guidance on Strengthening Personal and Public Involvement in Health and Social Care	**DoH**
	HSC (SQSD) 03-12 – Guidance for HSC Organisations on Arrangements for Implementing effective Personal and Public Involvement Policy in the HSC	**DoH**

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Qualitative Data **Policy / Research Documentation**
Review of Families Voices, July 2021.
Guidance for commissioners of primary care mental health services for deaf people, (2017), Joint Commissioning Panel for Mental health **https://www.jcpmh.info/wp-content/uploads/jcpmh-deaf-guide.pdf.** Accessed 20/12/2020
http://www.ark.ac.uk/nilt/2016/Background/ANYHCOND.html
https://www.thedetail.tv/articles/deprivation-and-religion-in-northern-Ireland accessed 20th December 2020
LGBT in Britain: Health Report, November 2018. https://www.stonewall.org.uk/lgbt-britain-health. Accessed 20/12/2020
Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide (2012), Samaritans https://media.samaritans.org/documents/Samaritans_MenSuicideSociety_ResearchReport2012.pdf
McBride, R., Santiago (2011): Healthcare Issues for Transgender People Living in Northern Ireland. Institute for Conflict Research.
NISRA, 2018 Suicide statistics by age
Northern Ireland Life and Times Survey 2016 (ark.ac.uk) http://www.ark.ac.uk/nilt/2016/Background/ANYHCOND.html Accessed 27 November 2020.:
Northern Ireland Pooled Household Survey (NIPHS) Tables | Northern Ireland Statistics and Research Agency (nisra.gov.uk)
Northern Ireland Registry of Self-harm, Annual report, 2017 / 2018, Public Health Agency. https://www.publichealth.hscni.net/publications/northern-ireland-registry-self-harm-annual-report-2017-2018. Accessed 27 November 2020
O'Hara, M., (2013) *Through Our Minds: Exploring the Emotional Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People in Northern*

Ireland, The Rainbow Project Download.ashx (rainbow-project.org). Accessed 20/12/2020

O'Neill, S., Corry, C., Murphy, S. Sharon. Brendan. B., & Bunting, P. 'Characteristics of deaths by suicide in Northern Ireland from 2005 to 2011 and use of health services prior to death' , Journal of Affective Disorders, Volume 168,15 October 2014.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-agedmen. 2021. The University of Manchester.

The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland and Wales. 2021. University of Manchester.

National confidential inquiry into suicide and homicide (NCISH) annual report 2015 Reports | Published: 22 Jul 2015 https://www.hqip.org.uk/wp-content/uploads/2018/02/national-confidential-inquiry-into-suicide-and-homicide-ncish-annual-report-2015.pdf accessed 27 November 2020

NISRA and Dept of Communities (2017) Volunteering in Northern Ireland. Available at https://www.communities-ni.gov.uk/sites/default/files/publications/communities/volunteering-in-northern-ireland-research-report-2017.pdf

Census 2011

Northern Ireland Life and Times, 2019. Available at https://www.ark.ac.uk/nilt

NISRA 2019 Mid-year population estimates. Available from https://www.nisra.gov.uk/statistics/population/mid-year-population-estimates

CarersNI State of Caring 2019. Annual survey (UK wide, including NI)

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***

Gender	• Of the 2011 Northern Ireland population, 51 per cent were female and 49 per cent were male.
	• Research commissioned by the Department of Communities shows that a greater proportion of females volunteered with health and social care organisations than males (16% and 6%)
	• Research (McBride, Ruari Santiago, 2011) suggests for the Northern Ireland population as a whole:
	  • 140-160 individuals are affiliated with transgender groups
	  • 120 individuals have presented with Gender Identity Dysphoria
	  • There are more trans women than trans men living in Northern Ireland.
	• Suicide Statistics (NISRA, 2019) indicates 209 deaths, 157 of which are male and 52 female.
	• National Confidential Enquiry into suicide and safety in Mental Health (2021) highlighted that suicide amongst men in the UK is 3 times greater than women.
	• NI self- harm registry annual report (2017 -2018) indicates that 53% of 9,127self harm presentations are female and 47% male with 35% of 4,784 suicide ideation presentations female and 65% males
	• Stonewall Report (November 2018) found that:
	  ○ almost half of trans people in Britain (46 %) have thought about taking their own life in the last

	year ○ 41% per cent of non-binary people said they harmed themselves in the last year
Age	**Mid-year population estimates** published by NISRA in 2019 show that: • 0-19 yrs (inclusive) = 485,064 (25.7% of all NI population) • 20 – 34 yrs = 364,623 (19.3%) • 35 – 49 yrs = 366,967 (19.5%) • 50 - 64 yrs = 356,790 (19.0%) • 65 – 74 yrs = 169,725 (9.0%) • 75 – 89 yrs = 125,334 (6.6%) • 90+ yrs = 13,138 (0.7%) • In 2019 the male suicide rated was 19.4 per 100,000 highest rate of suicide among males is among those aged 35-39, followed by 30-34 and 45-49. • NISRA, 2019 Suicide statistics by age: Under 15 2 15-19 12 20-24 14 25-29 18 30-34 24 35-39 29 40-44 16 45-49 24 50-54 26 55-59 15 60-64 7 65-69 10 70-74 8 75-79 2 80-84 0 85+ 2 • Self-harm presentations by those under 18 years of age contributed to 12% (n=1,096) of all self-harm presentations during 2017/18 (NI Registry of self-harm,

	2017/2018).
Religion	Religion or Religion brought up in • 45.14% (817, 424) of the population were either Catholic or **brought up** as Catholic. • 48.36% (875, 733) stated that they were Protestant or **brought up** as Protestant. • 0.92% (16, 660) of the population belonged to or had been **brought up** in other religions and Philosophies. • 5.59% (101, 227) neither belonged to, nor had been brought up in a religion. (Census 2011) • There is a health inequality aspect to the burden of suicide with the suicide rate in the 20% most deprived areas is almost twice the average in Northern Ireland and three times the rate experienced in the 20% least deprived areas. Research by *The Detail* has shown that 80% of the most deprived wards in Northern Ireland are predominantly Catholic. • Population and Social Inclusion Study', St. Columb's Park House in partnership with INCORE and QUB (2005, updated in 2008), and Healthy Cities research (2007) on participation of people from Protestant/ Loyalist/ Unionist (PLU) working class communities suggested that there was less awareness of the relevance of engaging in health consultations. • Research by the Department of Communities found the proportion of respondents who had volunteered and gave their religion as Catholic had decreased from 30% in 2015 to 22% in 2016. The proportion of respondents who gave their religion as Protestant and indicated that they had volunteered in the last year was similar over the previous two years (2015: 34%, 2016: 30%).
Political Opinion	**"Generally speaking, do you consider yourself as a unionist, a nationalist or neither?" (**Northern Ireland Life and Times, 2019)

	Unionist 33% Nationalist 23% Neither 39% Other 2 % • Suicide and self-harm rates in Northern Ireland by political opinion are not collected.
Marital Status	• 47.56% (680, 840) of those aged 16 or over were married • 36.14% (517, 359) were single • 0.09% (1288) were registered in same-sex civil partnerships • 9.43% (134, 994) were either divorced, separated or formerly in a same – sex partnership • 6.78% (97, 058) were either widowed or a surviving partner (Census 2011) Annual Reports of the Registrar General for NI show that between 2005 to 2019 inclusive, there have been 1298 civil partnerships registered in NI. Of these, 539 have been male civil partnerships, and 571 have been female civil partnerships. • 47% of those who died by suicide were single at the time of death and 22.9% were married.17.5% had experienced a marriage breakdown (O'Neill et al. 2014).
Dependent Status	• Of the Northern Ireland population, 11.81% (213, 863) of the usually resident population provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill – health/disabilities or problems related to old age. • 3.11% (56, 318) provided 50 hours care or more. • 33.86% (238, 129) of households contained dependent children. • 40.29% households (283, 350) contained a least one person with a long – term health problem or a disability. (Census 2011) • Information from CarersNI shows that 64% of carers are female, while 36% were male. • Data on the caring responsibility of those affected by

	suicide and self-harm is not routinely collected.
Disability	• 40% per cent of the deaf or hard of hearing population were affected by mental health issues, compared with 25% of the hearing population (Joint Commissioning Panel for Mental Health 2017). • The National Confidential Inquiry (2015) reports that physical illness is known to be a risk factor for suicide. The report found that around a quarter of patients who die by suicide have a major physical illness (3,410 deaths over 2005-2013) and the figure rises to 44% in patients aged 65 and over. In most cases, the illness has been present for over 12 months. Figures from the last census show the following proportion of the NI population report: • Deafness or partial hearing loss – **5.14%** (93, 078) • Blindness or partial sight loss – **1.7% (30, 785)** • Communication Difficulty – **1.65% (29, 879)** • Mobility or Dexterity Difficulty – **11.44% (207, 163)** • A learning, intellectual, social or behavioural difficulty - **2.22% (40, 201)** • An emotional, psychological or mental health condition - **5.83% (105, 573)** • Long – term pain or discomfort – **10.10% (182, 897)** • Shortness of breath or difficulty breathing – **8.72% (157, 907)** • Frequent confusion or memory loss – **1.97% (35, 674)** • A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy. – **6.55% (118, 612)** • Other condition – **5.22% (94, 527)** • No Condition – **68.57% (1, 241, 709)** (Census 2011) • Research commissioned by the Department of Communities found that people with a disability are less likely to volunteer than those without. Almost one fifth (18%) of adults who have a disability had volunteered in the last year, a similar proportion to that in 2015 (19%).

	However, the proportion of adults who do not have a disability who had volunteered in the past year decreased from 35% in 2015 to 30% in 2016.

Ethnicity	• Northern Ireland Pooled Household Survey (2017) for 11 Local Government Districts is presented as 'Ethnicity White' and 'All Other Ethnicities' due to small cell sizes.
	  ○ Ethnicity White 98.2%
	  ○ All other Ethnicities 1.6%
	• Statistics from the HSC Interpreting Service showed a large rise in requests for interpreters from 1,850 in 2004-2005 to 132434 requests in 2019-2020. The most popularly requested languages in 2019-2020 are described below:
	1. Polish 30,231
	2. Arabic 20,392
	3. Lithuanian 15,503
	4. Romanian 13,059
	5. Portuguese 8,312
	6. Bulgarian 7,881
	7. Tetum 6,623
	8. Slovak 5,696
	9. Mandarin 4,794
	10. Cantonese 3170
	• The national Confidential Enquiry Annual Report (2021) indicated that in the UK from 2008-2018, there were 1,176 patients who died by suicide and who were from different ethnic minority groups. This represents 7% of all patient suicides, an average of 107 deaths per year.

Sexual Orientation	• There are no definitive statistics on the numbers of people of differing sexual orientations in Northern Ireland. However, advocacy organisations estimate 1 in 10 of the population are gay, lesbian or bisexual. • Data from NI found that 64.7% of LGBT respondents had experienced personal, emotional, behavioural or mental health problems (O'Hara, 2013). • Stonewall Report (2018) found that in Britain:

	○ Half of LGBT people (52 %) said they've experienced depression in the last year. ○ One in eight LGBT people aged 18-24 (13 %) said they've attempted to take their own life in the last year. ○ 41 %of non-binary people said they harmed themselves in the last year compared to 20 % of LGBT women and 12 % of GBT men.

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	• Evidence suggests that women are more likely to care for someone in another household (ARK, NI, June 2011) and some women will be single parents. • Men are more likely to die by suicide than women. 'Men and Suicide' (2012) identified the social issues impacting on men not engaging in help seeking behaviour (Samaritans in partnership with Network rail, 2012). • People who identify as transgender or non-binary experience social isolation, marginalisation and discrimination very often in everyday life. • Participation in the Forum will be promoted through current networks that provide support to individuals who have been bereaved by suicide. • The National Confidential Enquiry into suicide & safety (2021) outlined the adversities faced by men, particularly in mid-life, who died by suicide. Of the

<table>
<tr><td></td><td>Study Sample size:<table><tr><th>Variable</th><th>Sampled middle-aged men(%)</th><th>General Population Figure (%)</th></tr><tr><td>Unemployment</td><td>30%</td><td>4.5%</td></tr><tr><td>Deprivation</td><td>25%</td><td>20%</td></tr><tr><td>Divorced / Separated</td><td>21%</td><td>5%</td></tr><tr><td>Alcohol Misuse</td><td>36%</td><td>20%</td></tr><tr><td>Drug Misuse</td><td>31%</td><td>7%</td></tr><tr><td>Physical Health Conditions</td><td>52%</td><td>34%</td></tr><tr><td>Mental Health Diagnosis</td><td>66%</td><td>15%</td></tr></table></td></tr>
<tr><td>Age</td><td>Age can impact on a person’s ability to input to Forums. The equality commission for NI recommends that health and social care meets the specific needs of older people and younger people to ensure age appropriate services.
Older People’s Advocate (2010) recommend that when communicating with older people there is recognition of the diversity of need within that group in relation to literacy levels, access to IT skills and equipment , geographical isolation and accommodation including those in nursing and residential homes.</td></tr>
<tr><td>Religion</td><td>It is recognised that health inequalities impact upon areas of deprivation that may be associated with specific religious identity.</td></tr>
<tr><td>Political</td><td>It is recognised that health inequalities impact upon</td></tr>
</table>

Opinion	areas of deprivation that may be associated with specific political opinion.
Marital Status	• Living alone and social isolation have been identified as a risk factor for adult men. • Single parents may have particular needs in relation to timing of involvement to take into account childcare arrangements. • The National Confidential Enquiry into suicide & safety (2021) indicated that 21% of middle aged men, who died by suicide were divorced or separated.
Dependent Status	• Those with dependents or those that care for dependents with self-harm or suicidal ideation may have particular needs with regard to participation. • A recent publication from the Department of Communities found that one of the most common reasons why people don't volunteer is caring commitments, particularly childcare commitments.
Disability	• We recognise that those with a disability may have more difficulty in becoming involved and have considered this. • People with disabilities may have particular needs regarding both communication and information. • As highlighted above, people with a mental health illness are more likely to die by suicide. However, there is still a stigma attached to mental ill-health, and people bereaved by suicide may find this hard to disclose. As a result they may be more reticent about participating in the programme. • Individuals who have been bereaved through suicide may be more at risk of anxiety and depression, and may find it difficult or distressing to participate in the forum.
Ethnicity	• People from BAME or Travellers may have particular needs in relation to cultural and / or communication needs. Those whose first language is not English may

	experience language barriers and may have particular needs regarding accessible communication and information including the provision of translated information and / or interpreting services.
	• In some communities mental health is rarely spoken about and is viewed negatively. This can discourage people within the community from talking about their mental health and may be a barrier to participation and involvement.
	• Within NHSCT – Barriers to Accessing Mental Health Services - Views of Black and Minority Ethnic People in Ballymena Borough March 2013. This report has been produced by the Ballymena Inter-Ethnic Forum (BIEF) in partnership with NHSCT, funded by PHA:
	  • Half (51%) of survey respondents agreed that not knowing 'who to go to or what kind of help is on offer' would prevent them getting help if they had a mental health problem.
	  • 13% of respondents agreed that they would be prevented from getting help with a drug or alcohol problem because 'in my culture we prefer to get help within our family'.
	  • 53% of survey respondents believe that within their ethnic community there is 'a lot' of stigma towards mental health issues.
	  • One third (34%) of survey respondents agreed that it they had a mental health problem, language difficulties would prevent them from getting help.
	  • There is some concern with the ability of interpreters to communicate mental health terms accurately. 31% of survey respondents wouldn't feel comfortable using an interpreter because 'they might not fully understand what I am saying or what a professional is saying to me'
	  • Monitoring the use of mental health services among different ethnic groups would help to identify low levels of service use and differences in people's pathways to mental health services.

Sexual Orientation	• As discussed above, due to homophobia and heterosexism, people of different sexual orientations are over-represented amongst figures for suicide and self-harm. However, with regards to bereaved relatives, families and friends, considerable stigma still exists with regards to people of differing sexual orientations. This may make it more difficult for people who have been bereaved by suicide to take part in the Family Voices Forum, if their loved one was LGB.

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

- People with multiple identities may face further exclusion or oppression due to race and disability or disability, religion and Lesbian Gay Bisexual Transgender issues.
- When co-ordinating events and Forum input, consideration will take account of such issues and support work which reaches out to those most excluded in society who have been bereaved through suicide. .

2.5 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
• PHA will provide information in	• Monitor requests for

alternative formats as requested. • Interpreting and signers will be made available on request. • Supporting documents will be made available in braille and large text if requested. • PHA will encourage participation through a blended approach to activity availing of a mix of face to face and online engagement and communication tools and through organisations and groups who promote individuals who have been bereaved through suicide. • All Forum Members will be required to adhere to the Code of Conduct and values which requires members to be treated with privacy, respect and dignity, have a respectful attitude and show non- offensive behaviour towards other members. **Gender** • Participation will be promoted through current networks that provide support to men. **Age** • Participation will be promoted through current networks that provide support to persons of different ages e.g. Youth Reference Group, Age Friendly Officers. **Religion** • Participation will be promoted through the Flourish Churches suicide initiative.	alternative formats and / or language to inform the production of future involvement processes.

Political Opinion • Political parties will have the opportunity to input to involvement processes. **Marital Status** • The needs of single parents will be considered in relation to timing of involvement to take into account childcare arrangements. **Dependent Status** • The Forum will avail of a blended approach to activity availing of a mix of face to face and online engagement and communication tools. • Meetings will take place at different times, and various locations when face to face, to facilitate participation of those with caring responsibilities. **Disability** • Participation will be promoted through current networks that provide support to persons living with a disability • Where appropriate a video will be produced with subtitles to outline involvement. • Interpreters and/or signers will be available if required and supporting documents will be provided in braille or large text on request. • Accessibility will be taken into account in all forms of communication and information	

e.g. sign language, interpreting and all requests for alternative formats will be considered. • Participants will be signposted to support services if necessary. **Ethnicity** • Translation/Interpreting services will be provided on request. • Participation will be promoted through current networks that provide support to members of BAME and Traveller Communities. **Sexual Orientation** • Participation will be promoted through current networks that provide support to LGB people.	

2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	***Impact***	***Suggestions***
Religion	No impact identified at this time	
Political Opinion	No impact identified at this time	
Ethnicity	No impact identified at this time	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	√
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	√

Please give reasons for your decisions. All equality issues have been mitigated against as far as possible. It is not thought that subjecting this policy to EQIA will present further opportunities to promote equality of opportunity.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
• •	• The consultation will actively promote the inclusion of disabled people in service planning.

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	*What else could you do to promote positive attitudes towards disabled people?*
• The availability of virtual methods will reduce geography as a barrier to access. • The option of 1-1 engagement for carers and service users will reduce barriers to access. • The availability of interpreting and signing services and information in alternative formats will reduce barriers to access. • The consultation will actively promote the inclusion of disabled people in service planning.	•

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	No
Article 12 – Right to marry & found a family	No
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1st protocol Article 2 – Right of access to education	No

*If you have answered no to all of the above please move on to **Question 6** on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

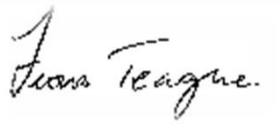
5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

Equality & Good Relations	Disability Duties	Human Rights
Section 75 information and data will be gathered to assist PHA to ensure that there are no gaps.	Data on inclusion and participation of disabled people in public life	N/A

Stakeholders will received an online anonymous equality monitoring form which they will be asked to complete.		

Approved Lead Officer:	Fiona Teague 
Position:	Head of Health & Social Wellbeing Improvement (West)
Date:	20/10/2021
Policy/Decision Screened by:	Shauna Houston Health and Social Wellbeing Improvement Manager 
Business Unit and contact details	Heath Improvement E: Shauna.houston@hscni.net

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

Please forward completed template to:
Equality.Unit@hscni.net

Template updated January 2015

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).