HSC Public Health Agency

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?

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

Development and delivery of Crisis De-escalation service to be piloted in the Belfast Health and Social Care Trust area.

1.2 Description of policy or decision

A Project Board was established in 2017 and representation includes; PHA, Belfast Health and Social Care Trust, Belfast City Council and Belfast Alliance for Suicide Prevention (BASP). The Board has met regularly over the past two years and has consulted widely with the Mental Health and Drug and Alcohol sectors as well as key stakeholder agencies and groups, including local politicians and MLAs, on the proposal which forms the basis of this business case re. how best to deliver a community-led crisis de-escalation service for the BHSCT area. **The decision to select Belfast for the pilot was based on the fact that the Belfast Trust had the highest suicide rate in 2014/16 (22.0 per 100,000) as compared to the Northern Trust with the lowest rate (12.6 per 100,000).** ***(PHA Health Intelligence Briefing-May18)*** **and as a response to the Futuresearch** initiative **'Building Hope, Working Together to Prevent Suicide'** which took place with Belfast stakeholders in **September 2016** (see page 11/12 for more information).The overall intention of this proposal is to develop an out-of-hours facility and service in Belfast which might be a first step towards a 24 hour service which functions as a safe place for individuals and families and enables effective de-escalation support over a period of hours following presentation to Emergency Department or to a select group of community and voluntary sector providers. The service will be supported by BHSCT through secondment of a team leader to the service and with dedicated time from a senior manager in terms of oversight of the project/service enabling collaboration (relationship building, joint working, skills transfer, etc.) between C&V and statutory services. Crisis response staff will be based within a designated 'Safe Place' preferably within the city-centre – or an alternative location which is accepted as broadly neutral and accessible to all – offering containment, de-escalation and referral on (with warm handover) to more longer-term care where appropriate.

Overall service aims:

- Containment and de-escalation of psycho-social crisis in a community setting
- Targeted and timely support for individuals at risk of self-harm and suicide at time of presentation (when most at risk)

- Reduction in adverse outcomes for individuals – and their families
- Reduction in unnecessary and distressing shunting of individuals (and families) in crisis between services
- Reduction in Trust Emergency Department attendances
- Reduction in out of hours crisis drop ins/calls to C&V sector services
- Improved identification of mental illness and transfer into statutory services if appropriate (via crisis service stepping up and use of pathway by CRP service providers)

Staff within this service would work with the person and their family (where they also present) to address underlying issues contributing to, or causing, the crisis. This de-escalation support would:

- **Identify contributing factors** through a standard risk assessment.
- **Identify a support plan** for clients coming through the service, including signposting to services addressing the contributory factors to the presentation. This will include signposting to other services within the context of the Protect Life strategy, however based on knowledge and case studies of other similar models, this will also include signposting to a wider range of services within the context of debt and financial advice, relationship advice, domestic and sexual abuse, etc. In recognition of the fact that a number of those presenting in crisis may benefit from some immediate small-scale financial support a 'hardship fund' has been factored in to the overall budget (this can be used to assist with transport, utility payments, food stamps/parcels, etc.) but will be tightly controlled (by the service provider) and its use monitored (by PHA/Project Board).
- **Provide information, advice and support for the client – and the client's family members** as required.
- **Provide an exit plan** for the client.

<u>Staffing</u>

The service will be overseen by an Operational Team Lead, who should be an experienced mental health practitioner (BHSCT to explore whether a Band 6 would be available to undertake additional hours to work on the project or be seconded in, however, if not a viable option by time of procurement the C&V service provider will be tasked with recruiting someone with suitable qualifications and experience).

The costing options for the model reflects provision of a maximum of 2 community and voluntary sector staff, an Operational Team Lead (possibly seconded from BHSCT) and 24 hours of a senior member of staff within BHSCT to undertake a coordination role, to provide oversight and to review appropriateness of service provision and signposting to other support structures/services. As the service progresses, the need for 3 staff (inclusive of Operational

Team Lead) at all times will be reviewed and adjusted. The team will provide:

- psycho-social crisis de-escalation
- physical space to de-escalate/ contain acute crisis
- Basic psychological approaches for clients/ families

Given the context for this service and reflecting models operating elsewhere in the UK and Republic of Ireland, it is intended to operate on a non-medical model. Team members therefore should be recruited based on knowledge and experience of crisis de-escalation, basic family therapy skills and approaches, art therapy/alternative therapy expertise, etc.

Hours of operation

The service will initially operate from 6pm on a Friday evening, through to 12pm on a Monday morning, reflecting anticipated need for service demand. This will be monitored on a monthly basis and adjusted where necessary as the pilot progresses.

Links with existing services

Lifeline: BHSCT currently operates the Lifeline service for the region on behalf of the PHA and it is envisaged that a separate phone line/number will be installed to enable key C&V contacts (namely those involved on the Belfast Community Response Steering Group) to make direct contact with the service to discuss possible clients who may be more suitable for support via the project. Following consultation with Lifeline staff they will then either be directed to signpost the client to the Crisis service or to ED.

Existing PHA-funded mental health/suicide prevention service providers: Communication with providers as to progress, etc. will be maintained via the Belfast Protect Life Implementation Group, BASP and Belfast Community of Interest structures. Certain providers will have their in-year targets amended in order to be able to provide follow up support to those seen by the crisis service within a short turnaround period. As noted previously, C&V members of the BCRSG (approx. 6 agencies) will also be able to direct people to the service via Lifeline.

BHSCT ED and BHSCT Mental Health Team: Staff within both these departments/directorates will be briefed on the project with BHSCT Mental Health staff able to signpost post-assessment where/when appropriate when the service is operating. A Band 8A post within the Mental Health service will have oversight responsibility for the project (2 days at weekend).

Client group to be seen

Those aged 18years+ presenting in social and emotional crisis to ED in the BHSCT area (and are then assessed as not meeting the threshold for Step 3 statutory mental health services) or within the community setting (via those agencies who lead on Community Response Planning within the Belfast area).

The service must be able to respond to the small numbers of clients who may present to BHSCT-based EDs but who reside in other HSCT areas and the service must also therefore have protocols in place for liaising, and following up, with other HSCT MH teams.

Self Harm Registry data shows that:

15 cases per week of residents of other Trusts will present to Belfast EDs and some of these may require access to the service

Those under 18 years are not included in this phase of the pilot and will continue to be supported via the CAIT team/pathway within BHSCT and the process for accessing this service will be communicated widely. PHA and the Project Board also gave a commitment at a stakeholder workshop held in late 2017 that they would look separately at how best to support young people in social and emotional crisis within a 2-year timeframe. The pilot will however inform future service developments in relation to addressing the needs of young people in crisis.

NB Those unable to engage in the MH assessment process due to having taken alcohol and/or drugs will not be able to be seen by the MH team within ED until they are sober enough to engage in the assessment process.

Project Board has agreed to continue to explore options with the BHSCT Alcohol Recovery Centre in terms of being able to signpost clients under the influence of alcohol and/or drugs during the hours that they operate (i.e. Fri and Sat evenings) and a defined pathway / protocol will be developed.

Constraints

As one of the pilot projects funded under the DoH's Transformation scheme the project is time-bound with an expected start date of 1 January 2019 and an end date of 31 March 2020. However, internal and external evaluation is being undertaken with a view to the findings informing procurement options – for PHA and others – in relation to better supporting people in emotional and social crisis in Belfast and beyond.

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

Potential service users/general public (**& MOST IMMEDIATELY AFFECTED)**
Those 18+ (and their family members/carers), who present in social and emotional crisis to ED services and to Suicide Prevention/Support Services within the Belfast area out of hours and who may potentially be referred to this pilot service.

Successful service provider(s) within C&V setting
The pilot service will be delivered in partnership by BHSCT and a C&V provider – either an individual organisation or via a consortium. The procurement process for this element will be undertaken during Sept-Nov 2018 with contract awarded before 31 Dec 2018.

Project Board
Chaired by PHA – Belfast Health & Social Care Trust (BHSCT), Belfast City Council (BCC) and Belfast Alliance for Suicide Prevention (BASP) – a network of community and voluntary mental health/suicide prevention service providers – are all current members of the Project Board.

BHSCT
Staff specifically aligned to the service (Band 8A/Band 6)
Staff within ED departments and Mental Health Services – particularly Unscheduled Care who will interface with the service.

Organisations funded to provide Mental Health and Suicide Prevention services in Belfast (individually and collectively)
PHA-funded services
BHSCT/Other-funded services
Belfast Alliance for Suicide Prevention (stakeholder collective)
Belfast Protect Life Implementation Group (stakeholder collective)
Belfast Community Response Group (stakeholder collective)

Organisations funded to provide Drug and Alcohol services in Belfast (individually and collectively)
PHA-funded services
BHSCT/Other-funded services
Belfast Drug and Alcohol Coordination Team (stakeholder collective)
Northern Ireland Alcohol and Drug Alliance (stakeholder collective)

PSNI, NIHE, PBNI, YJA, etc. – other statutory stakeholders with an interest in, or remit for, supporting the needs of vulnerable people and/or addressing vulnerability.

Politicians
Local councillors from Belfast City Council alongside local MLAs (Sinn Fein, SDLP and to a lesser extent The Green Party) have all shown a particular interest in the development of the pilot service. Presentations have also been made to the All Party Group for Suicide.

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

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

Protect life: A shared vision – The NI Suicide Prevention Strategy and Action Plan 2012-2014

The DOH currently provides PHA with just over £7m per annum to administer the Protect Life Strategy on its behalf. PHA was asked in September 2016 by DOH to cost the action plan attached to the draft Protect Life 2 Strategy prior to the launch for public consultation. PHA estimated the costs to deliver the draft action plan to be some £3M in excess of the existing

budget allocated to 'Protect Life'. A range of additional programmes have been included in the draft strategy on the basis of consultation received from a wide range of sectors.

One of the new investments proposed was a Crisis Service for the Belfast area to assist in the de-escalation of social and emotional crisis for individuals who present primarily to emergency departments in the Belfast area, but who do not reach the threshold for acceptance by the BHSCT's Unscheduled Care Team (a significant proportion – see figures provided in Section 1b). The service is also intended to provide a signposting pathway for those who present to community and voluntary sector colleagues leading on the Community Response Planning (CRP) process in the Belfast area.

Making Life Better – A whole system strategic framework for Public Health 2013-2023

This framework is fundamental to the health improvement work of the PHA. Within this business case the proposed actions will work towards addressing the six key themes within the Making Life Better framework. In particular, **theme three *Empowering Healthy Living***, where key long term outcomes are: Improved health and reduction in harm, Improved mental health and wellbeing, and Reduction in self-harm and suicide, People are better informed about health matters. **Theme five Empowering Communities** - where key long term outcomes include thriving communities. **Theme six Developing Collaboration** - where key long term outcomes include strengthened collaboration for health and wellbeing.

This proposal also aims to promote the Public Health Agency Quality Standards for Services Promoting Mental and Emotional Wellbeing and Suicide Prevention: These standards apply to all organisations providing mental & emotional wellbeing and suicide prevention services which are funded by the PHA.

Personal and Public Involvement (PPI) is a statutory responsibility for all HSC organisations. PPI requires the PHA to involve and consult service users and carers in the planning and development of services. The development and implementation of this proposal will ensure local service users are involved in the development of proposals. Further, the participation of service users offers an important opportunity to co-design the new service.

Health and Wellbeing 2026: Delivering Together, Department of Health, 2016 places emphasis on a new model of person-centred care focussed on prevention, early intervention, supporting independence and wellbeing with the ambition of:

- Improving the health of our people
- Improving the quality and experience of care
- Ensuring sustainability of our services
- Supporting and empowering staff

This strategy looks at ensuring:

- People are supported to keep well in the first place with the information, education and

support to make informed choices and take control of their own health and wellbeing;

- When they need care, people have access to safe, high quality care and are treated with

dignity, respect and compassion;

- Staff are empowered and supported to do what they do best;

This proposal addresses a number of these key themes.

Health and Social Care (Indicators of Performance) Direction (2015)

Under the priority '*to improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention*'.

In 2015/16 the PHA led on implementation of a **Future Search** event, **'Building Hope, Working Together to Prevent Suicide'**. The purpose of the workshop was to bring together the 'whole system' to help tackle the issue of suicide in the Belfast area. During this three-day workshop, participants discovered common ground and built future action plans. One of the key issues identified by stakeholders was the need to de-escalate people who are in emotional crisis in a timely fashion. Stakeholders acknowledged that a significant number of people throughout the city experience emotional crisis and that there is a need to find more timely and appropriate ways of dealing with that crisis.

(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.

Data gathering – statistics

Statistics for those presenting to various services in emotional crises are difficult to collate as they have not been traditionally monitored and collected. However over the past 2 years, the numbers of individuals presenting to both statutory and community & voluntary services funded by PHA, HSCB and BHSCT in the Belfast area has significantly increased resulting in the PHA Bfs & SE team having to offer and award a large number of service enhancements to most contracts the organisation currently funds under Protect Life in order to alleviate some of the pressure in the system. It is feared that a percentage of those who present in emotional crisis (but do not reach a threshold for consideration as having a mental illness), go on to complete suicide/repeated self-harm. While information and numbers about this group are not held formally, professionals in the Greater Belfast area are aware of a range of instances where patients have presented to various EDs throughout the BHSCT and SEHSCT area, but who have not met the threshold for acceptance to mental health services and who have then gone on to attempt or to complete suicide in the hours/days following that assessment.

As a result, both bereaved families, alongside those who are providing support to bereaved families and those in crisis have been lobbying PHA, BHSCT, DoH/CMO and politicians to consider provision of a 'safe place' in the belief that should such a service be available then there would be more opportunity for those engaging to de-escalate from the crisis they are in, thereby preventing more deaths from suicide and suicide/self-harm attempts. Data presented in the draft Protect Life 2 Strategy suggests that 72 % of those who go on to go on to complete suicide in Northern Ireland are not known to 'mental health' services.

BHSCT (via subcontracting with the C&V sector) delivers on a contract awarded by HSCB for the provision of **Tier 2 Talking Therapy Services** via a hub model for individuals referred from GP Services who have lower level anxiety or depression. This contract has also increased significantly over the past 12 months in order to respond to being faced with

almost twice the rate of referrals than what was originally expected/budgeted for (e.g. May 2017 the hub received 647 referrals where the anticipated volume was 330 per month). Since service was originally commissioned by HSCB, more than 12,000 referrals have been received by BHSCT.

BHSCT has recently confirmed that its **Unscheduled Care Service (USC)** deals with an average of 70 individuals per week in the Belfast area (just over 3,500 per annum), 90% of whom it is determined, post-mental health assessment, have no diagnosable mental illness. Most of these patients present in psycho-social crisis and suicide ideation is often a feature. Crisis for these individuals can quite often be driven by multiple factors which may include community/ family/ relationship stressors, perceived threat, alcohol + drug misuse, social deprivation, etc. It is believed that for many of these individuals in acute crisis (but not exhibiting diagnosable mental illness), that a 'place of safety' – whereby they (and their families) can be contained and de-escalated would be the most appropriate response. Recent meetings with ED Consultants in BHSCT confirm that the current 'default' option for these patients is to remain in ED, which is not appropriate in the absence of an underlying medical issue, or urgent need for treatment of physical injuries. Currently these patients are presented with a 'Card Before You Leave' (CBYL), however the vast majority do not re-engage with the Trust, despite routine follow-up by USC staff. It is estimated that an average of 10 of these patients per week would benefit from a direct referral into a face-to-face crisis support service, operating at the time of presentation, to help them de-escalate from social and emotional crises.

Furthermore, Belfast-focussed data available from the **PHA Self-Harm Registry**, PSNI and NIAS also suggest a high level of need for specific and targeted support for individuals (and their families) presenting in crisis. The Registry reports that, while it is encouraging that the rate of persons presenting with self-harm has decreased slightly in 2016/17 by 4% points across Northern Ireland, the rate of suicidal ideation presentations has increased by 9%. This reflects an increase in BHSCT area of 5% (1,336 presentations) and in the neighbouring SEHSCT area of 9% (409 presentations) and NHSCT area of 20% (842 presentations). Since the Self-harm Registry data began to be collated, the BHSCT area has consistently experienced the highest numbers of ideation and self-harm presentations of all five HSCT areas in Northern Ireland.

PHA Health Intelligence analysed high risk calls to **Lifeline** for the Belfast and South Eastern Trusts areas from April 2016 to December 2017. (High risk into the Lifeline service relate to client and third party calls were the counsellor deems the call to relate to a client in high risk/distress or an emergency call.)

The information showed that the pattern of high risk calls has remained relatively stable since January 2015.

In 2016/17, the average high risk calls per month were:

- 167 in the Belfast Trust and
- 86 in the South Eastern Trust

In 2017/18 (Apr-Dec only), the average high risk calls per month were:

- 146 in the Belfast Trust and
- 66 in the South Eastern Trust

The pattern of high risk calls by the day of the week has changed slightly between the two years with the following patterns emerging:

- In the most recent financial year, high risk calls have peaked at the weekend, on Sunday in particular for both the Belfast and South Eastern Trusts;
- For the Belfast Trust, high risk calls have a secondary peak on Tuesday;
- High risk calls in the South Eastern Trust are relatively stable throughout the week but increase at the weekend.
- Pattern of high risk calls has been consistent between the two financial years with high risk calls mostly occurring outside of normal working hours (i.e. from 5 pm to 2am approximately).
- The pattern of high risk calls occurring in the evening and into the early morning remains consistent despite the day of the week.

Community and voluntary organisations providing mental health/suicide prevention services in the Greater Belfast area have consistently advocated that 'drop-ins' (that is, individuals who drop in unscheduled to their facilities) with suicidal ideation are on the increase in terms of numbers and degree of severity. These drop-ins quite often occur late at the time of operation of services or out of hours. Data is not routinely collected by the community and voluntary sector on such presentations therefore it is difficult to give an accurate picture of demand from this source. PSNI and NIAS report that patients are regularly presenting out of hours in emotional crises and often the only solution is to take patients to the Emergency Department, resulting in long waiting times for officers. In the last financial year, Self-Harm Registry data shows that 57% of people who attended hospital with suicide ideation were brought by NIAS or PSNI personnel. Some 40% of those brought to hospital were brought between the hours of 11pm to 9am.

Data gathering – engagement with stakeholders

Futuresearch 'Building Hope, Working Together to Prevent Suicide', September 2016

Wide-ranging stakeholder event (approx. 100 people attending over 3 days) including commissioners, service providers, politicians, service users, family members, etc. where one of the key issues identified and agreed by all stakeholders was the need to de-escalate

people who are in emotional crisis in a more timely and appropriate fashion.

Safe Place/Street Triage Initial Workshop, Clayton Hotel, Jan 2017 (40+ attendees)

Safe Place/Street Triage Developmental Workshop, The Mount, Nov 2017 (36 attendees)

Two key workshops were organised – one at the start of the process to consider potential models for piloting – and another towards the end of the year to present to stakeholders the preferred models and to give a final opportunity for discussion and debate.

As with the Futuresearch, a wide range of stakeholders were involved and whilst no service users attended on either of these occasions there was however a rep from the regional Family Voices Forum and the BHSCT service user consultant was also in attendance.

Facilitated sessions with Project Board, Phil Rankin/Blue Moss, 2017

PHA resourced an independent facilitator to come on board to assist with ironing out some of the key challenges with the proposed model being put forward, taking account of constraints in relation to budget and capacity to respond/ need to refine target group.

Regular Project Board meetings, ongoing from Feb 2017 to date

Project Board has been meeting on a bi-monthly basis to consider feedback on the proposed model and to discuss and agree any necessary changes.

BASP single agenda item meetings alongside regular email communication with members

BASP reps on the Project Board have led on communicating regularly with the sector on the development of the pilot service.

Presentations/Updates given to stakeholder networks (ongoing):

- NIADA/Northern Ireland Alcohol and Drug Alliance
- BDACT/Belfast Drug and Alcohol Coordination Team
- BPLIG/Belfast Protect Life Implementation Group
- All Party Group for Suicide

Stakeholder engagement events to inform the future procurement of services to implement the pending 'Protect Life 2' suicide prevention strategy, March 2018

Belfast events:

FARSET, Belfast, 26 March, morning (68 attendees)

NICVA, Belfast, 26 March, evening (40 attendees)

Park Avenue Hotel, Belfast, 22 May, morning (21 attendees)

Some findings relevant to the development of the pilot crisis de-escalation service:

A common theme at the events across NI was stakeholders' request for services to be more joined up with greater connectivity. It was believed that community and voluntary sector

organisations could work in closer partnership with statutory partners and in working together they would strengthen structures, build capacity, better co-ordinate services and reduce duplication thereby increasing efficiency. It was also acknowledged that within statutory organisations there could be better collaboration and cross-departmental working, such as in Health and Education. It was suggested that agencies must recognise that a quick, if not immediate, response is essential in many cases and therefore a high priority must be given to implement measures to reduce waiting times.

A lack of 24-hour support provision (aside from Lifeline 24/7 service) was criticised. The development of drop-in services, community "safe spaces" or HUBs for people on crisis would be welcome in some areas.

Based on feedback received through the consultation process, Carers feel unsupported and overwhelmed when it comes to supporting a loved one with suicidal ideation. Specific tailored training, counselling and support services were deemed necessary for Carers to protect and promote their own good mental health.

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.

Geography *(PHA Health Intelligence Briefing-May18)*

- Belfast Trust had the highest suicide rate in 2014/16 (22.0 per 100,000) and the lowest rate was in the Northern Trust (12.6 per 100,000).
- At District Council level, the highest overall rate (2014/16) was Belfast LGD followed by Mourne and Down and Antrim and Newtownabbey.
- With regard to Parliamentary Constituencies the highest 5-year rates (2012/16) are in the areas of Belfast North and Belfast West.

There is a well-established clear link between deprivation and suicide and this is reflected in the suicide rate within the most deprived areas of NI where it is three times that of the least deprived areas while the rate of self-harming is four times higher than in the least deprived areas[1].

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	The estimated population of the **Belfast** Health and Social Care Trust (HSCT) at 30 June 2017 was **355,593**, of which **172,832 (48.6%)** were male and **182,761 (51.4%)** were female *(NINIS)*. NI-wide info *(PHA Health Intelligence Briefing-May18)*: • The male suicide rate is more than three times greater than that for

[1] Minister HSSPP, *Protect Life: Briefing Note for 2 Mar Evidence Session*, 2016.

	females (24.1 for males and 8.0 for females per 100,000 in 2014/16). • Over the last decade (2004/06 to 2014/16), the greatest increases in deaths for males have been within those aged 35–39 years followed by those aged 25–29 years. For females, the greatest increases were among those aged 20–24 years and those aged 45–49 years. *(Trans Mental Health Study 2012, Scottish Transgender Alliance)* Transgender and non-binary people report high rates of self-harm, suicide attempts and mental ill health as outlined below: The majority of respondents felt that being trans or having a trans history, had a mixed effect on their mental health, however for those who answered that the effect was solely positive or negative, many more found it to be a negative impact. Over half of the respondents (58%) felt that they had been so distressed at some point that they had needed to seek help or support urgently – yet 35% of these had avoided seeking support due to being trans/having a trans history. 53% of participants had self-harmed at some point, with 11% currently self-harming. The majority of participants (84%) had thought about ending their lives at some point and 35% had attempted suicide at least once.
Age	• **68,618** children aged 0-15 years; • **124,809** people aged 16-39 years; • **107,760** people aged 40-64 years; and • **54,406** people 65 years and older. *(NINIS)* NI-wide info *(PHA Health Intelligence Briefing-May18)*: In 2014/16, the highest male suicide rate is among 30–34 year olds followed by 25–29 year olds. The highest female suicide rate is among 20–24 year olds followed by 50–54 year olds. https://www.publichealth.ie/document/iph-report/loneliness-and-ageing-ireland-north-and-south *Loneliness and Ageing, Ireland North and South, Institute of Public Health Ireland, Mar 2016* The research found that loneliness can have a significant impact on the physical and mental health of older people and is of increasing concern for public health. It suggested that approximately 10% of older people are affected by chronic or persistent loneliness.
Religion	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population: • **43.50%** belong to or were brought up in the Catholic religion and **47.25%** belong to or were brought up in a 'Protestant and Other Christian (including Christian related)' religion; and • **47.61%** indicated that they had a British national identity, **30.88%** had an Irish national identity and **27.69%** had a Northern Irish national

	identity*. **Respondents could indicate more than one national identity* Suicide and self-harm rates by religion are not reported in NI.
Political Opinion	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population: • **47.61%** indicated that they had a British national identity, **30.88%** had an Irish national identity and **27.69%** had a Northern Irish national identity*. **Respondents could indicate more than one national identity* Suicide and self-harm rates by political opinion are not reported in NI. https://www.qub.ac.uk/schools/psy/files/Filetoupload,784073,en.pdf https://www.irishtimes.com/news/ireland/irish-news/how-the-trauma-of-the-troubles-risks-being-passed-on-1.3178681 https://www.profsiobhanoneill.com/key-publications Evidence indicates that NI has high levels of, often untreated, post-traumatic stress disorder (PTSD) and other mental health disorders as a result of almost 40 years of conflict. Some researchers have suggested a possible link between the conflict and the relatively high suicide rates experienced here. The contention is that the increased rates since the peace agreements in 1998 are the result of a decline in social cohesion and social connectedness (which was characteristic of the conflict period), coupled with high levels of mental disorders (which are partly the result of previous exposure to violence).
Marital Status	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population: • **43.65%** indicated they were single (never married or never registered in same sex civil partnership) • **37.60%** indicated they were married • **0.13%** were in a registered same sex civil partnership • **4.96%** were separated (but still legally married or legally in same sex civil partnership) • **6.11%** were divorced or formerly in a same sex civil partnership now legally dissolved • **7.58%** indicated they were widowed or surviving partner from a same sex civil partnership. The University of Ulster research *Death by Suicide: A Report based on the Coroner's Suicide Database* showed that between 2005-2011 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.

Dependent Status	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population, and based on 148,328 households: **10.28%** were married/same sex reg. **with no children** **19.72%** were married/reg. same sex couple **with dependent children** **8.31%** were married/reg. same sex couple **with children classed as non-dependent** **3.64%** were in a co-habiting couple **with no children** **2.12%** were in a co-habiting couple **with dependent children** **0.26%** were in a co-habiting couple **with children classed as non-dependent** **10.78%** were a lone parent **with dependent children** **5.49%** were a lone parent **with children classed as non-dependent** **2.70%** were classed as 'other household type' **with dependent children** **2.12%** were in a co-habiting couple **0.26%** were in a co-habiting couple **with children classed as non-dependent** https://www.carersweek.org/images/Resources/CW18_Research_Report.pdf Carers UK report for Carers Week in 2018 showed that 87% of carers stated that caring had a negative impact on their mental health; 53% suffered from depression, and 91% were affected by anxiety and stress. Lack of sleep, performing care tasks and the impact on their finances named as top stressors by unpaid carers. https://www.assemblyresearchmatters.org/2018/07/26/carers-in-northern-ireland-key-statistics/ On Census Day 2011, 214,000 people were providing some form of unpaid care, equating to approximately one-in-eight residents in Northern Ireland (12%). This compares with 185,066 in 2001, an increase of 16 per cent. Census 2011 data reveals that the majority of carers lie within the 35–64 age band, with one third (33%) aged 35–49, and a further 31 per cent aged 50–64. There are also a significant number of young carers (those aged under 18). For example, 6,700 young people (aged 0–17) in Northern Ireland provide between 1 and 19 hours of unpaid care per week, while a further 960 provide 20–49 hours, and 820 care for 50 hours or more. There are also 11,300 older carers (those aged 75+), more than half (52%) of whom are engaged in caring for 50 hours or more each week. Given the steady rise in population since 2011, these figures are likely to be an under-estimate.
Disability	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population, and based on 148,328 households: **8.62%** reported **one or more people living in the household with a long-term health problem or disability** and also having **dependent children**

	32.61% reported **one or more people living in the household with a long-term health problem or disability** but with **no dependent children** https://sites.manchester.ac.uk/ncish/ *National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness* The report found that around a quarter of people who die by suicide have a major physical illness and the figure rises to 44% in patients aged 65 and over. https://www.rcpsych.ac.uk/pdf/QNMHD_Standards_2nd_Edition_2015.pdf *Royal College of Psychiatrists: Standards for Adult Inpatient Mental Health Services for Deaf People* This document reports that deaf people are twice as likely as to experience mental health issues such as depression and anxiety compared to hearing people.
Ethnicity	On Census Day 27th March 2011, in the **Belfast** Health and Social Care Trust, considering the resident population: **3.44%** were from an ethnic minority population and the remaining **96.56%** were white (including Irish Traveller) http://www.hscbusiness.hscni.net/pdf/NIAO_Annual_Report_and_Accounts_16-17_v8._-_Final_with_Certificate.pdf It is recognised that some Black and Minority Ethnic persons can face barriers e.g. language in relation to accessing services and that at times additional support is needed. The number of requests received by the NI HSC Interpreting Service continues to increase having risen from 10,257 in 2005/6 to over 100,000 in 2016/17 and over 98% of bookings successfully fulfilled (*BSO Annual Report 2016/17*). The most recent top ten language requests were for: Polish, Lithuanian, Romanian, Portuguese, Chinese (Mandarin), Tetum, Slovak, Hungarian, Bulgarian and Chinese (Cantonese). http://www.ucd.ie/issda/data/allirelandtravellerhealthstudy/ The *All Ireland Traveller Survey (2010)* estimated that there were 3,905 Irish Travellers in NI. The main areas of traveller population are Belfast, Newry and Armagh, Foyle, Mid Ulster and West Tyrone. The survey stated that male travellers have a suicide rate which is 6.6 times that of men in the general population, however the small sample size should be noted. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/267020/Preventing_suicide_equalities_impact-1.pdf *Preventing Suicide in England – Assessment of Impact on Equalities* Research shows that some Black and minority ethnic groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. More recent arrivals, such as some

	asylum seekers and refugees, may also require mental health support following their experiences in their home countries. *Mental Health and Emotional Wellbeing of Asylum Seekers and Refugees: Evidence Review and Scoping, PHA – Outcome Imp, Sept. 2018 (internal doc)* This report found that there was no available prevalence information about mental health issues and emotional wellbeing of asylum seekers and refugees in NI – no local research has been undertaken and monitoring data is not routine collected. However, the report concluded that reducing stress, in the post-migratory context, promoting resilience and providing support to reduce the adverse effects of trauma before and during migration are all important.
Sexual Orientation	Accurate figures are not available on the sexual orientation of the general population and estimates vary considerably. According to research conducted by Rainbow it is estimated the one in ten people in N Ireland are from Lesbian Gay Bisexual Transgender groups. *2012/13 NI Health Survey (DoH)* Heterosexual 93%, Gay or Lesbian (homosexual) 2%, Bisexual 1%, Other 1% and Not Specified 3% http://www.ark.ac.uk/nilt/2017/Background/ORIENT2.html (1,203 adults) The 2017 NI Life and Times survey reported sexual orientation as follows: Heterosexual 97%, Gay or Lesbian (homosexual) 1%, Bisexual 1%, Other 1% http://rainbow-project.org/assets/publications/through%20our%20minds.pdf *Through Our Minds: Exploring the Emotional Health and Wellbeing of LGBT People in Northern Ireland, Malachai O'Hara, Rainbow Project, 2013* The report concluded that: • As previous research reports and other scoping exercises have found, the incidence of poorer emotional health and wellbeing amongst LGBT people is higher than amongst the wider population. • LGBT people have higher rates of self-harm, suicide ideations, suicide attempts and depression than the wider population. • LGBT people presented poor help seeking behaviour in relation to emotional health and wellbeing issues. • 35.3% of respondents had experienced self-harm, 25.7% had experienced a suicide attempt, 46.9% had experienced suicidal ideation and 70.9% had experienced depression. NB As gender identity issues are not related to sexual orientation – please also refer to response given under 'Gender' page 13/14.

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 Age	Gender & Age: Research and statistical evidence have demonstrated that the highest suicide rates are in young and middle aged men. This is partly the result of differences in the methods used in terms of lethality. Cultural perceptions of masculinity also impact negatively on men's help seeking behaviour.
Religion Political Opinion	Religion & Political Opinion: A personal belief system allied with strong personal relationships and positive coping strategies have been identified by the World Health Organisation as protective factors against suicide. It is also likely that church or faith leaders may be among the first to be told, or to recognise, the symptoms of poor mental health – hence why PHA has supported the development and roll out the Flourish suicide prevention training and support programme across NI for the faith sector. Recent research has also demonstrated a link between PTSD and the legacy of the conflict. *https://www.qub.ac.uk/schools/psy/files/Filetoupload,784073,en.pdf* *The transgenerational impact of The Troubles in Northern Ireland is increasingly an area of concern for many researchers and clinicians, with some estimating that potentially 60% of the adult population with mental health problems directly linked to the troubles, have not received support (O'Neill et al., 2015).* *Tomlinson (2014) found a significant association between experience of the troubles and suicide ideation and plans, suggesting that those who had experience of the conflict may be more likely to commit suicide in their first attempt.*

Marital Status	Living alone and social inclusion have been identified as a risk factor for adult men. It is reasonable to assume that individuals who are living alone and not living with their families are at a higher risk of suicide and self-harm. In a third of those who have died by suicide relationship breakdown has been noted – therefore supporting people with, and through, relationship difficulties and in how to manage conflict within relationships is important to prevent suicide.
Dependent Status	Those with dependents can have particular needs with regards accessing services and cost due to caring responsibilities and restrictions. Carers are also under considerable stress due to the nature of their caring role.

Disability	There is an increased risk of mental ill health for individuals with a physical disability and an association between unemployment, poverty and social exclusion. Transport and access to buildings can pose key barriers for people with a physical, sensory or learning disability in accessing suicide prevention services. People with sensory and learning disabilities have a need for written information in accessible formats and appropriate communication methods and support.
Ethnicity	The National Confidential Inquiry into Suicide and Homicide by people with mental illness has highlighted that ethnic minority people with mental illness have particular needs which need to be addressed in order for them to be able to access services. Language issues can create considerable barriers for black and minority ethnic people accessing suicide prevention services. Asylum seekers who have experienced considerable trauma may also have particular and/or additional needs. Research has indicated that Travellers experience poorer mental health and a higher rate of suicide that the settled community. Low rates of help seeking and negative perceptions of mental health services are also noted for this group.
Sexual Orientation	The Rainbow Project estimates that up to one person in ten in Northern Ireland is from the Lesbian Gay Bisexual Transgender community and that there is violence and discrimination directed towards this community. Research has shown that LGBT people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. Reasons behind increased risk of suicide and self-harm for this group may include victimisation, bullying, isolation, trauma, exposure to violence and a sense of hopelessness.

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.

It would appear from the research and statistics that risks for those with multiple identities would be compounded for example – young, male and Gay/Bisexual/Transgender or young, male and disabled or male and single with little to no parental contact, etc.

However, the proposed pilot Crisis Service isn't targeted at any one section of the population – i.e. it is accessible, via ED and Lifeline referral (both of which are also open access) to all those aged 18 and above residing in Belfast who are at risk of experiencing social and emotional crisis resulting in thoughts of suicide and life not worth living.

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?***
Gender and Age: Hospital Emergency Dept and the Lifeline service are both open access (all genders, ages, etc.) and are the primary routes in to being assessed as suitable for signposting/referring on to the proposed Crisis Service. Those under 18 will be directed to the exiting BHSCT CAIT service and those 18 and above will receive help and support via Lifeline, ED or the Crisis Service dependent on the outcome of a standardised risk assessment and capacity within the Crisis Service at any given time. Those identifying as transgender or non-binary will be signposted on to relevant support services, as and when appropriate, by staff within the Crisis Service. Religious Belief and Political Opinion and Disability: The Crisis Service will be located in a neutral and accessible (including being able to meet the needs of those with a disability and/or special needs) venue, close to hospital ED, likely a city centre location (this requirement will be built in to the tender specification for the service). Marital and Dependent Status: The Crisis Service will have a 'hardship fund' budget built in and will therefore be able to provide short-term immediate	Section 75 information Section 75 information will be monitored at point of entry and this information will then be analysed by the service providers and the commissioners to assess how all, and particular, groups are accessing (or not) the service. Direct and/or indirect work may then be undertaken in terms of raising awareness with particular groups or gaining feedback re. experience by those groups to date. The pilot will be subject to both internal and external monitoring and evaluation with the findings then influencing future commissioning direction and decisions at local – and regional levels.

financial assistance to people (and their family members/carers) presenting to it in crisis to help with issues such as poverty, debt, childcare and social exclusion. Ethnicity: Any communication strategies developed will be accessible and culturally sensitive to the needs of BME groups and travellers. The Crisis Service will be able to access the NI HSC Interpreting Service and will ensure that it has knowledge of, and links made with, relevant support groups and programmes working with BME groups and travellers when signposting people on for further help and support (post crisis) – again tender specification requirement. Sexual Orientation: The LGBT sector is represented on the Belfast Alliance for Suicide Prevention (BASP) by the Rainbow Project – and the Co-Chairs of the Alliance have been instrumental in the development of the Crisis Service. Engagement with BASP and its memberswill continue throughout the life of the pilot allowing members to be updated, to raise awareness of the pilot with them and amongst the groups and organisations that they represent, and to discuss any queries or concerns that they may have in relation to service delivery. Poverty, Deprivation – Immediate Practical Support Needs: NB The Crisis Service provider will also be able to access a hardship fund on behalf of service users and their families.	

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	N/A	
Political Opinion	N/A	

Ethnicity	N/A	

(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	X
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	X

Please give reasons for your decisions.

The Crisis De-escalation Service is being piloted in the BHSCT to test the model of intervention and to inform future commissioning of this and/or similar types of service at both local and regional levels.

As outlined, whilst there are differences amongst the Section 75 groups in terms of how they present in relation to self-harm and suicidal ideation and of how they may be influenced by, or be more of risk of, self-harm and suicidal behaviour – the Crisis Service itself is **open access** to all of the Section 75 groups – apart from 'Age.' As noted previously, the service as it is currently proposed will no work with those under 18, however should a young person present to ED/Lifeline and be assessed as in need of further support they will be redirected to the existing BHSCT CAIT service and so their needs will also be met albeit via a different route of support.

The factoring in to the tender specification of requirements such as; a neutral and accessible venue, a hardship fund, knowledge and experience of working with and in a wide variety of communities throughout Belfast, ongoing monitoring of demographic data, production of culturally sensitive written materials and access to interpreting service (as appropriate/required), etc. are to ensure that the identified needs of the relevant Section 75 groups within the screening have been mitigated as much as possible.

The piloting of this service – and its subsequent evaluation – will allow DoH and PHA as commissioners to further explore how best to meet the needs of the population (and all of the Section 75 groups comprised within it) when they present in times of social and emotional crisis and are in need of immediate de-escalation and crisis management support (rather than a statutory mental health intervention).

(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?*
N/A re 'public life' The service provider will be required to make any reasonable adjustments/ offer assistance where communication is an identified barrier to engagement.	Ensure that the findings of the evaluation of the pilot are shared with disabled people/ groups representing disabled people so that their views and experience can influence future service design and potential roll out.

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?*
Those referring into the service (Belfast Emergency Department and Unscheduled Care Teams) alongside a small number of identified Community and Voluntary service providers will all be aware of the need to take account of each individual's personal circumstances and presenting issues and the need to make any reasonable adjustments re. same. Furthermore, the pilot service will be internally monitored and independently evaluated allowing for any issues re. access to, or use of, the service by disabled people to be addressed – both within the pilot and at the service planning stage for regional roll out should this be the outcome.	Ensure that all stakeholder organisations involved (i.e. PHA, BCC, BHSCT, C&V Providers, etc.) adhere to relevant legislation and have appropriate policies and procedures in place.

(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
N/A			

** 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.

N/A

(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 monitoring data will be collected by the service provider and can then be analysed internally (via monitoring) and externally (as part of evaluation).		

Approved Lead Officer:	Kelly Gilliland
Position:	HSWI Manager, PHA, Bfs & SE
Date:	17/09//2018
Policy/Decision Screened by:	Caroline Bloomfield – HSWI Senior Manager, PHA, Bfs & SE 16/10/2018 caroline.bloomfield@hscni.net
Business Unit and contact details	

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).