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.

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

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Alcohol and Drugs Commissioning Framework for Northern Ireland 2013-2016

1.2 Description of policy or decision

This framework outlines the key prevalence figures of alcohol and drug related harm in Northern Ireland. It brings together the current evidence base in relation to what is effective in tackling these issues. It is hoped that this information will inform organisations within and beyond the HSC who are involved in commissioning services to address this issue. Furthermore it provides information on the commissioning requirements and priorities for commissioners in PHA/HSCB and DACTs. The framework aims to deliver on the following outcomes;

- Improved consistency of service provision across the 5 HSCT areas
- Improved understanding of what works and commissioning of services better informed by evidence based practice
- A reformed and modernised service provision
- Integration of PHA and HSCB commissioning plans and priorities

1.3 Main stakeholders affected (internal and external)

Actual or potential service users and their carers

- Regulation and Quality Improvement Authority
- General Medical Practitioners
- NI Medical and Dental Training Agency
- Community Pharmacy contractors
- Hospital Trusts
- Health and Social Care Board
- Public Health Agency
- Business Services Organisation (BSO)
- Department of Health, Social Services and Public Safety (DHSSPS)
- C&V sectors providers working with Children and Young People
- C&V sector providers of alcohol and drug services
- Criminal Justice PBNI/YJA/PSNI/PSCPs/Prison Service
- DSD/DOJ/DE/ELBs/EGSA

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

- New Strategic Direction on Alcohol and Drugs Phase 2 (2011-2016)
- Transforming your care - A Review of Health and Social Care in Northern Ireland. December 2011
- Fit and Well – Changing Lives A Ten Year Public Health Strategic Framework for Northern Ireland 2012 2022
- Refreshed Protect Life Suicide Prevention Strategy (DHSSPS)
- Promoting Mental Health and Well-being Strategy (DHSSPS)
- Sexual Health Promotion Strategy And Action Plan (DHSSPS)
- Our Children and Young People – Our Pledge A Ten Year Strategy For Children And Young People

In Northern Ireland 2006 - 2016 (OFMDFM)
- Regional Hidden Harm Action Plan October 2008
- Hidden Harm Joint Protocol PHA

(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.

Population statistics obtained from NISRA (eg Census 2011, Young Person's Behaviour and Attitude Survey)
Prevalence and treatment figures obtained from DHSSPS/PHIRB (Adult Drinking Pattern Survey, Drug Prevalence Survey, Young Person's Behaviour and Attitude Survey, Census of treatment services, Drug Misuse database, Drug Addict Index, Needle and Syringe Exchange)
Criminal justice related figures obtained from DoJ (NI Crime Survey), PSNI (drug seizures and arrests), and PBNI (alcohol and drug offence related scores)
Prescribing data obtained from BSO
LGBT data taken from "All partied out" report, homeless persons figures from "Research into homelessness and substance misuse"

The development of the Commissioning Framework was informed by a range of workshops looking at each area of work within the framework. These workshops were targeted at key stakeholders including service users, service providers, commissioners and representatives of other sectors likely to be impacted by the Commissioning Framework e.g. Criminal Justice, Education, etc.

The development of the Commissioning framework also included a review of the research evidence for all initiatives contained within it.

This information was also used to inform this equality screening.

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	Census 2011 (NISRA) overall resident population 1,810,863 Males: 887,323 (49%) Females: 923,540 (51%) Fewer females than males tend to engage in alcohol or drug use, the exception being use of prescription drugs such as antidepressants and sedatives/tranquillisers (ADP, DPS, NICS).

	While men show higher rates of illicit drug misuse, women present more often for prescription drug misuse (and also at older age than males) (DMD). It is recognised that men are less likely than women to seek help for health issues before they reach crises. Women are often reluctant to seek help for substance misuse, particularly problems with illicit drugs, as they fear that this will result in the involvement of Social Services and that they may lose custody of their children.
Age	Under 18s: 430,763 (23.79%) Under 25s: 606,957 (33.53%) (Source: Census 2011, NISRA) Children - 0-17yrs =430,763 (23.79%) Children and young people - 0-24yrs = 606,957 (33.52%) Substance misuse services, especially those aimed at preventing substance misuse, are often targeted at young people in order to prevent the onset of, or the exacerbation of, serious substance misuse issues such as dependency. Use of alcohol in general as well as hazardous and harmful drinking decreases with increasing age (ADP). Use of illicit drugs decreases with increasing age, while use of prescription drugs increases (DPS). Young people experiment with alcohol and other drugs, ultimately developing patterns of use which may persist into their adult lives. In order to prevent the onset of substance misuse problems among young people substance misuse services, especially those aimed at preventing substance misuse, are often targeted at this group.
Religion	45.14% of Catholic background 48.36% of Protestant or other Christian 0.92% other religion 5.59% no religion (Source: Census 2011, NISRA)
Political Opinion	The 2011 Census question on nationality revealed the following responses; • British only – 40% • Irish only – 25% • Northern Irish only – 21% • British and Northern Irish only – 6.2% • Irish and Northern Irish only – 1.1% • British, Irish and Northern Irish – 1% • British and Irish only – 0.7% • Other – 5% (Source: Census 2011, NISRA)
Marital Status	Single (never married/never in same-sex civil partnership) 36.14% Married 47.56% In a registered same-sex civil partnership 0.09% Separated (but still legally married or still legally in a same-sex civil partnership) 3.98% Divorced or formerly in a same-sex civil partnership which is now legally dissolved 5.45% Widowed or surviving partner from a same-sex civil partnership 6.78% (Source: Census 2011, NISRA)
Dependent Status	Of the 703,275 households, 238,641 households had dependent children living in them (33.86%) (Source: Census 2011, NISRA) According to the DMD 2011/12 report, 13% of drug misusers were living with dependent children. Children and young people who are dependent on adults for their care can be significantly affected if one or more of those providing care is dependent on, or has problems with, substances. "There is limited information available in Northern Ireland about the precise number of children born to and/or living with parental substance misuse. However, there are pockets of

	information, which indicate that this is an area of growing concern. It is estimated that there are approximately 40,000 children in Northern Ireland living with parental alcohol misuse. In 2007/08, 22% of problem drug misusers presenting for treatment were living with children, which equates to children of 412 adults. Approximately 40% of children on the child protection register are there as a direct result of parental substance misuse. Seventy percent of our "Looked After Children" are living away from home as a direct result of parental substance misuse." PHA/HSCB Hidden Harm Action Plan
Disability	Of the 703,275 households, 283,333 households had one or more persons with a long-term health problem or disability (40.29%) (Source: Census 2011, NISRA) Based on figures gathered for the Bamford review (Taggart et al., 2004; based on 4 HSSTs), 1.7% of people with a learning disability were found to have a substance misuse problem. Community care statistics for NI showed that 7,552 people with a learning disability and aged 16 or older had been in contact with HSCTs in 2011/12. Using the prevalence rate of 1.7%, there may be about 130 adults with learning disability who have a substance misuse problem. In a later extension of this study, Taggart et al. (2006) reported 67 individuals with LD to misuse substances (prevalence of 0.8%). This lower prevalence rate would lead to an overall estimate of 60 LD adults with substance misuse, based on current base figures for LD adults in contact with services The Taggart et al. (2004) report also highlighted that schools for children and young people with learning disability were less likely to provide alcohol and drug education than mainstream schools. However, this should be treated with caution as the response rate among schools was low.
Ethnicity	White 98.21% Irish Traveller 0.07% Chinese 0.35% Indian 0.34% Mixed 0.33% Other Asian 0.28% Black African 0.13% Other ethnic 0.13% Pakistani 0.06% Bangladeshi 0.03% Black Caribbean 0.02% (Source: Census 2011, NISRA) Among Irish Travellers, a larger proportion than in the settled population do not drink alcohol at all; however, those that do drink, tend to drink more excessively (All Ireland Traveller Health Study). There is indication that illicit drug use has been increasing in line with the settled population and that pockets of drug abuse exist within NI. Misuse of prescription drugs, particularly of benzodiazepines and primarily among female Travellers, has been acknowledged as a widespread problem facilitated by overprescribing and drug-sharing within the community (AITHS). It has been suggested that Polish migrants have increased their use of addiction services for both drug and alcohol addiction (Polish Association NI 2009, in BHDU 2011. As no NI data are available, the 2007 British Psychiatric Morbidity Survey provides some indication of the lower rate of alcohol misuse among BME groups compared to white adults:

	White	Black	South Asian	Other (incl Chinese)
Hazardous and harmful drinking				
Males	35.8%	18.6%	12.0%	15.5%

	Females	16.6%	4.6%	3.1%	15.5%
	Alcohol dependence				
	Males	9.6%	3 0%	1.0%	3.5%
	Females	3.7%	-	-	1.45
Sexual Orientation	Different sources provide different estimates for the LGB&T population in Northern Ireland: • Estimates are as high as 5-7% (65-90,000) of the adult NI population (based on the UK government estimate of between 5-7% LGB&T people in the population for the purposes of costing the Civil Partnerships Act). • A more recent estimate by the Office of National Statistics stands at 1.5-2% which would be closer to 20-30,000 adults. (This latter document is disputed by various LGB&T organisations.) The "All partied out" report suggests that alcohol and drug use and misuse are more prevalent among this population group than the population in general.				

2.3 Qualitative Data

Category	*Needs and Experiences*
Gender	Research indicates that consultation rates and help-seeking patterns in men are consistently lower than in women (http://www.ncbi.nlm.nih.gov/pubmed/12167495). Men are less likely to seek help in the earlier stages of a problem than women. Research into parental substance misuse has clearly shown that fear of losing custody of their children is a major barrier to women seeking help for substance misuse problems.

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.

Age	Young people's problematic substance misuse typically moves through the stages of experimental use and recreational use before becoming problematic. Guidance from NICE and the NTA indicates that universal and targeted services for young people should be encouraged to respond to the earlier stages of substance misuse before this develops into problematic use. The Commissioning framework includes workforce development work with staff in universal/targeted services and a consultation role for young people's specialist treatment services to support universal/targeted services in delivering early interventions. The development of the Commissioning Framework was informed by consultation workshops including one on youth treatment and one on education/prevention. These workshops were attended by a wide range of stakeholders including service providers, service users and commissioners; the feedback from these workshops indicated that stakeholders felt the emphasis on screening and early intervention would result in greater numbers of young people receiving appropriate support around substance misuse. The impact of substance misuse can increase as people grow older. In addition, substance misuse in older people can be hidden. Health professional may not spot the signs because they make assumption that older people do not misuse substances,or can attribute the symptoms to general mental or physical ill health. Older people can hide their substance misuse because they think there is a stigma attached to it, Older people who misuse substances are also at increased risk of falls, accidents or deaths from fire. Alcohol, drugs and medication use can not only lead to people having accidents but also reduce their ability to respond in an emergency situation or when an alarm eg smoke or carbon monoxide activates.
Religion	N/A
Political Opinion	N/A
Marital Status	N/A

Dependent Status	Children and young people who are dependent on adults for their care can be significantly affected if one or more of those providing care is dependent on, or has problems with, substances. The potential impact of parental alcohol and/or drug misuse includes: • harmful physical effects on unborn and new born babies; • impaired patterns of parental care and routines which may lead to early behavioural and emotional problems in children; • higher risk of emotional and physical neglect or abuse; • lack of adequate supervision; • poverty and material deprivation; • repeated separation from parents/multiple care arrangements/episodes of substitute care including fostering and care homes; • children taking on inappropriate substitute caring roles and responsibilities for siblings and parents; • social isolation; • disruption to schooling and school life; and • early exposure to drug and alcohol using culture and associated illegal activities and lifestyles poor physical and mental health in adulthood.

Disability	
	For adults with learning disability (LD) in NI, figures gathered to inform the Bamford review and later extension of this study (Taggart et al, 2004, 2006) suggest a prevalence of between 0.8% to 1.7% for substance misuse, with alcohol being the primarily abused substance. This indicates that substance misuse is less common among individuals with learning disability than in the general population. However, it has been raised that people with learning disability suffer a higher rate of problems resulting from their substance misuse. This study described those misusing drugs as more likely to have mild to moderate learning disability and to be living in more independent accommodation (Taggart et al., 2004). The latter my actually facilitate access to and opportunity to use substances. Furthermore, issues around assessment (using tools for general populations, validity and reliability of self-reported substance misuse), treatment goals (proposing abstinence rather than controlled use as simpler) and skills and training for both mainstream addiction (eg how to communicate) and learning disability staff (eg intervention models; cross-disciplinary learning) have been raised. A lack of treatment models for LD and substance misuse has been identified, and provision relies generally on adapting mainstream models for this population. McMurran summarised that substance misuse treatment in LD is "typically simpler, more behavioural, less confrontative, more directional, more educational, of longer duration, and more likely to involve the client's family" (p. 18-19, http://www.liv.ac.uk/fmhweb/EP%20Dual%20Diagnosis.pdf mentions NI study ut with later publ date). NICE Public Health guidance 24 (preventing harmful drinking; 2010) recommends to involve specialists when English language screening questionnaires are not appropriate as is the case with LD. NICE Clinical Guideline 115 (treatment of alcohol use disorders; 2011) recommends that significant LD is considered as a criterion for accessing inpatient/residential withdrawal, together with a lower cut-off for daily unit intake compared to non-LD persons (also applies for psychiatric illness and specific physical comorbitities). Treatment guidance therefore acknowledges a lower threshold and more intensive care for alcohol misusers with LD. http://www.emeraldinsight.com/journals.htm?articleid=1927912

Ethnicity	Cultural background of some BME/migrant groups may prevent them from help-seeking for substance misuse due to increased stigma (particularly for women) language difficulties, and knowledge of services and how to access them. However, it needs to be considered that that BME groups have lower prevalence of alcohol misuse (see section 2.2). With regard to prevention of substance use among young people, there is evidence that interventions (eg school based interactive programmes, family-based interventions) that were developed for white populations can also be implemented with minority ethnic groups. This evidence comes from both the US and UK. "Adding components that increase the cultural sensitivity of the programme can enhance its effectiveness." (Velleman, 2009, Alcohol prevention programmes. A review of the literature for JRF; p.22) The Commissioning Framework includes a requirement that : 'Locality Health and Social Well-being Improvement Teams in partnership with Drug and Alcohol Coordination Teams will be required to review existing provision of services in their area, identify gaps and agree local priorities for the PHA NSD Commissioning Plan 2013-2016.' This will include mapping of ethnic minority groups in each area and ensuring such groups have access to appropriate substance misuse services. Given that ethnic minority groups in Northern Ireland are often clustered in specific areas due to the availability of employment, this work is best carried out at locality level.
Sexual Orientation	While LGB&T persons had overall increased levels of substance use, they had particularly increased prevalence of using drugs associated with the nightclub scene, such as ecstasy and mephedrone (All partied out).

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.

There is no information available to identify the potential impact on people with multiple identities. However we know that there are multiple needs in relation to age, gender, mental health issues. It is anticipated that the implementation of the commissioning framework with have a positive impact on people

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?*
• The impact of parental substance misuse on children and young people was recognised and a commissioning framework for Hidden Harm services (services addressing parental substance misuse) is incorporated within the document. • The commissioning framework includes regional and local commissioning priorities to ensure that young people are offered screening and early intervention in universal/targeted services before their substance misuse becomes problematic. • The Commissioning Framework includes a requirement for PHA locality offices and DACTs to "review existing provision of services in their area, identify gaps and agree local priorities"; this will ensure appropriate services are in place to meet the needs of ethnic minorities in each DACT area. • It is recognised that men are less likely to seek help with health problems before they reach crises than women. In order to increase the number of men who are offered support around problematic substance misuse, and in particular alcohol which is the most widely misused substance among men in Northern Ireland, the Commissioning Framework puts in place screening and brief intervention services in criminal justice and acute hospital settings as well as in Primary Care. • As women often have concerns about the implications of seeking help for substance misuse on their custody of their children, the Commissioning framework puts in place screening and brief intervention service within prenatal care as well as a range of services targeting parental substance misuse. The role of these services is to identify those parents who are experiencing difficulties due to substance misuse and to offer support before their difficulties impact significantly on their parenting ability.	• The PHA/HSCB will continue to implement the regional Hidden Harm strategy, ensuring that work on this strategy is appropriately linked with other work on substance misuse carried out under the New Strategic Direction on Alcohol and Drugs Phase 2 (2011-2016). • Under the Commissioning Framework, workforce development work with staff in universal/targeted children's services will be ongoing to ensure that staff in such services are competent in screening for substance misuse and delivering early interventions. • PHA locality offices and DACTs will continue to monitor local need including the needs of ethnic minorities. • Culturally specific interventions for travellers will be piloted under the commissioning framework. • The numbers of people screened and offered brief interventions within criminal justice and acute hospital settings will; be monitored and the outcomes evaluated. • The Regional Hidden Harm Quality Assurance will continue to monitor the implementation of the PHA/HSCB Hidden Harm Action Plan, which addresses parental substance misuse. • The booklet Drugs, Alcohol and Older People

• The importance of raising awareness of substance misuse in older people and the risks, amongst older people themselves and health professionals was recognised and a booklet on Drugs, Alcohol and Older People was produced in partnership with older people.	will be printed and circulated to a wide range of organisations and individuals. The Alcohol Brief Intervention Training provided to primary care staff will also highlight the need to recognise alcohol misuse nh older 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 further impact	No suggestions
Political Opinion	No further impact	No suggestions
Ethnicity	No further impact	No suggestions

(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.
Substance misuse affects all sections of society. Inequalities in this area are a part of wider health inequalities in access to Health and Social Care Services experienced by some groups. Some specific issues have been identified and action has been taken to address these. It is the intention in the commissioning process which follows to ensure that specific action will be taken as necessary to identify inequality issues and address them.

(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 Commissioning framework requires DACTs to engage with organisations representing all Section 75 groups in reviewing existing services, identifying gaps and agreeing local priorities, in order that the needs of these groups are addressed in DACT action plans and through DACT funded services.	Ongoing work with organisations representing disabled people to ensure that their needs around substance misuse are being met.

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?*
Where barriers to access for disabled people (or other Section 75 groups) are found to exist, the Commissioning Framework requires DACTs to work with organisations representing these groups to ensure that these are addressed, e.g. through training, awareness raising etc.	Ongoing training and awareness raising could be provided in line with identified local need.

(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

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
The planned capture of service monitoring data will consider equality, good relations.	The planned capture of service monitoring data will consider disability	The planned capture of service monitoring data will consider human rights

Approved Lead Officer: Mary Clark

Position: AD Public Health, Health Improvement

Date: 11/3/2013

Policy/Decision Screened by: Cathy Mullan

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact:

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