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?

For advice & support on screening contact:

Equality Unit
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ
028 95363961
email: Equality.Unit@hscni.net

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

Substance Use Strategic Commissioning and Implementation Plan which has been jointly produced by the Public Health Agency (PHA) and the Department of Health's Strategic Planning and Performance Group (SPPG).

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

Aims and Objectives

The Substance Use Strategic Commissioning and Implementation Plan (hereafter referred to as the *Plan*) sets out an implementation path for the health and social care commitments as set out in the Department of Health's Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31).

In addition to the health and social care commitments set out in the Department of Health's document, the *Plan* also confirms a number of additional commissioning priorities and other actions that will be taken forward by the PHA and SPPG. Aiming to continue to deliver and build on what is working well within the substance use arena, whilst also targeting resources across the following eight strategic priority areas.

The objectives of the *Plan* are to:

- ensure more people get the right, high quality treatment and support, at the right time and in the right place;
- reduce the harm caused by substance use;
- remove the stigma surrounding substance use;
- empower more people to keep getting better; and

- embed multi-disciplinary partnership working across sectors

How Will This Be Achieved

The Plan has been developed using strategic planning methodology to analyse population need, identify current service provision and conduct gap analysis as well as focus on service development and outcome monitoring, all underpinned by co-production. The Plan and the subsequent delivery of the commitments made within it are underpinned by a number of important Principles, namely:

Human Rights
- The application of basic rights and freedoms regardless of where you are from, status, religious beliefs or how someone chooses to live their life.

HSC Value Based Care
- A commitment to providing safe, timely, person-centred, inclusive care that has a' no wrong door' approach.

Partnership Working, Co-Production and Shared Responsibility
- The need to ensure that people with lived and living experience, their families and carers, are at the centre of the design, delivery and review of HSC services

Inclusion Health
- To address the inequalities that exist, the need to improve the targeting of more intensive interventions and increasing accessibility for those most at risk of exclusion

Research, Evidence and Evaluation
- The need to use high quality and up-to-date evidence to inform and evaluate the services we design and commission

Quality Improvement
- The need to utilise evidence to actively promote innovation and quality improvement approaches to service transformation.

As well as continuing to deliver and build on what is already working well within the substance use arena. It will target resources across the following eight strategic priority areas:

1. Prevention and Early Intervention
2. Pathways of Care and Models of Support
3. Trauma Informed System
4. Family Support
5. Stigma
6. Workforce Development
7. Digital Innovation
8. Data and Research

Within each of the strategic priority areas outlined above, a number of discreet

actions are set out with indicative timeframes for commencement in the short term (Jan 2025) the medium term (Jan 2026) or the longer term (Jan 2027).

In order to achieve this vision, the DoH, PHA and SPPG have developed a collaborative leadership approach to the planning, commissioning, delivery and monitoring of quality, evidenced based HSC services for individuals and communities which are safe, person-centred, accessible, acceptable and effective.

Key Constraints

The plan will be delivered within a challenging financial environment, combined with increasing service demand and an increasingly under pressure workforce. It requires a commitment to make the best use of the finances available, will require a comprehensive consideration of current and potential future funding arrangements in line with the defined strategic priorities. This may involve commissioning new services and disinvesting in others.

However, there is commitment to work collaboratively with service providers to develop pathways and models of care that achieve our outcomes and deliver best value. Our budget allocation, when combined with the skills and innovation of our workforce and that of our partners, offers scope to build on our successes and deliver on the ambitions set out in this Plan.

Decisions will always be guided by achieving the best outcomes for Northern Ireland's population. This process will be supported by transparent contractual management and monitoring arrangements that promote fair employment practice, social considerations and environmental sustainability.

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

Prevention and Early Intervention;

The whole population is affected irrespective of their risk or propensity for a certain behaviour.

Pathways of Care and Models of Support;

- Actual service users of substance use services
- Potential service users of substance use services

- Families and carers
- Other public sector Organisations
- Community and voluntary sector organisations

Trauma Informed System
- Actual service users of substance use services
- Potential service users of substance use services
- Families and carers
- Children and young people.

Family Support
- The families and carers of people using drugs and alcohol
- Children and young people
- Other public sector organisations
- Community and voluntary sector organisations.

Stigma
- Actual service users of substance use services
- Potential service users of substance use services
- Families and carers
- Children and young people
- The wider population
- Other public sector organisations
- Community and voluntary sector organisations

Workforce Development
- HSC Workforce
- Community and Voluntary sector workforce
- Actual service users of substance use services
- Potential service users of substance use services
- Families and carers
- Children and young people
- Other public sector organisations
- Community and voluntary sector organisations

Digital Innovation
- Whole population
- Other public sector organisations
- HSC workforce

Data and Research

- HSC Workforce
- Community and Voluntary sector workforce
- Actual service users of substance use services
- Potential service users of substance use services
- Families and carers
- Children and young people
- Wider population
- Other public sector organisations

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

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

NI Executive and Assembly- New Decade, New Approach
NI Executive and Assembly -Programme for Government
NICS Outcomes Delivery Plan- NICS
DoH- Health and Wellbeing 2026: Delivering Together
DoH- Preventing Harm, Empowering Recovery A Strategic Framework to Tackle the Harm from Substance Use (2021-31)
DoH-Protect Life 2 Suicide Strategy for Northern Ireland 2019 – 2024
DoH-Mental Health Strategy 2021-2031
DoH-Ten-Year Tobacco Control Strategy For Northern Ireland
DoH-Sexual Health Strategy
DoH- 2018 Coproduction Guide
DoH- Integrated Care System NI
DE- Children's and Young Peoples Strategy
DE,DoH,PHA- An emotional Health and Wellbeing Framework for CYP
DfC-Homelessness Strategy and the Interdepartmental Homeless Action Plan
DfI- The Road Safety Strategy to 2020
DoJ- Problem Solving Justice
DAERA- Tackling Rural Poverty &Social Isolation Framework
PHA- Making Life Better
PHA- Corporate Plan
BCC- Belfast Complex Lives

(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.

- DoH Health Inequalities Report 2022 Health Inequalities Annual Report 2022
- HSCB Youth Wellbeing and Prevalence Study 2020
- Young Persons Behaviour and Attitudes Survey 2019
- UK Health Security Agency; What we know about young people in alcohol and drug treatment
- Statistics from the Northern Ireland substance misuse database 2021/22
- (Article) - What we know about young people in alcohol and drug treatment - UK Health Security Agency
- Health survey Northern Ireland: first results 2021/22
- Alcohol-Specific deaths in Northern Ireland, 2021
- Drug-Related and Drug-Misuse Deaths in Northern Ireland 2011-2021
- Young people commissioning support: principles and indicators
- NICE Guidance; Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence
- NICE Guidance; Needle and syringe programmes
- Age UK response to commission on alcohol harm, 2020
- (Article) Royal College of Psychiatrists; Addressing the needs of older adults receiving alcohol treatment during the COVID-19 pandemic: a qualitative study
- NHS Scotland; Drug misuse and dependence; Supporting women reducing harm report.
- www.emcdda.europa.eu; Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice
- www.emcdda.europa.eu; Women and drugs: health and social responses
- PubMed (nih.gov); Different needs: women's drug use and treatment in the UK.
- University College London; Mental health disorders and alcohol misuse more common in LGB people
- Drinkaware; Alcohol use among gender and sexual minorities

- The Kings Fund; Acting on the evidence: ensuring the NHS meeting the needs of trans people.
- QUB & Leonard Cheshire- Evaluation of an alcohol related brain injury rehabilitation unit in NI
- Rainbow Project, 2012 All Partied Out Report
- Cara Friend, 2017, Still Shouting
- Institute of Conflict Research; Grasping the nettle: the experiences of gender variant children and transgender youth living in Northern Ireland
- Addition Centre; The Relationship Between Disability And Addiction
- Children's Social Care Services Northern Ireland – An Independent Review
- Connecting Care; An Overview of the Northern Ireland Framework for Integrated Therapeutic Care for Care Experienced Children and Young People
- RF Associates; report prepared for PHA; In their own right: Exploring the needs and experiences of support among family members of adults/young people who use alcohol and/or drugs

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	NI population (Census 2021): Females = 976,043; Males = 936,132 The most recent survey findings indicate that 77% of respondents drink alcohol; this proportion has remained relatively consistent since 2010/11. In 2019/20, under a fifth (17%) of respondents reported drinking above recommended weekly limits[1], with males (26%) around

[1] The Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

three times more likely to do so than females (9%). Males are also more likely to use alcohol and illicit drugs (see YPBAS 2019, NI Health Survey; Drug Prevalence Survey).

While cannabis, benzodiazepines and cocaine were the most commonly used drugs among males and females. Males had higher or about similar proportions of use of most drugs apart from codeine and Z-drugs which were higher among females (Statistics from the Northern Ireland substance misuse database 2021/22 | Department of Health (health-ni.gov.uk)).

Service data also suggests gender specific patterns, with males being over-represented among drug misuse and mixed alcohol.

While male and female drinking patterns differ significantly, the Chief Medical Officers' guideline for both men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis. In 2019/20, four-fifths of males (80%) were drinkers, with 7% of males reporting that they thought they drank quite a lot or heavily. In 2019/20, almost a fifth of male drinkers (19%) drank on 3 or more days per week. In 2019/20, over a quarter of males (26%) drank in excess of the weekly drinking limit. In 2019/20, almost three-quarters of females (73%) were drinkers, with 3% reporting that they thought they drank quite a lot or heavily. In 2019/20, a tenth of female drinkers (10%) drank on 3 or more days per week. In 2019/20, around a tenth of females (9%) drank in excess of the weekly drinking limit.

Females were more likely to use prescription drugs such as antidepressants and sedatives/tranquillisers. Of drugs misuse clients, just over a quarter are female; however, among alcohol misuse clients, females make up 2 in 5.

There are gender specific patterns of use and vulnerabilities (e.g. among young females more sexual exploitation, mental health issues and self-harm). This needs to be taken into consideration when delivering services.

Women may also be reluctant to access substance use services due to increased stigma/greater perceived deviance of female substance use, parenting commitments and fear of children's services response when accessing support. Also, substance use during pregnancy poses a risk for poor health outcomes for the baby and, therefore, the care of pregnant women represents special circumstances.

	The greatest increases in drug-related deaths over the past ten years have been seen in men, aged 25-34. According to the Substance Misuse Database 2019/20, the majority of clients (79.4%) presenting for treatment for drug use were male. In terms of those among gender minorities, the most recent and so far, the largest survey of the LGB&T community in NI was conducted in 2012 with 941 individuals (Rooney, 2012). Survey respondents were 15 to 64 years old, and only 40 identified as transgender. Transgender people were the subgroup with the highest level of any drug use. Similar to the general population, CNS depressant drugs (cannabis, sedatives, antidepressants) and opiates were used more frequently than "recreational' drugs associated with the nightclub scene" (Rooney, 2012, p.10) A more recent review confirmed that alcohol use is more prevalent among this population group than in the population in general. (Alcohol use among gender and sexual minorities	Drinkaware; Alcohol interventions for LGBTQ+ adults: A systematic review - PubMed (nih.gov)). It suggests only if substance use services are not LGBT inclusive, then LGBT focused substance use services should be provided Although generalised research (The Kings Fund; Acting on the evidence: ensuring the NHS meeting the needs of trans people) on gender minorities accessing services indicated that a barrier due to the lack of providers who are sufficiently knowledgeable on the topic. Among other barriers presents such as; real or perceived stigma and witnessing or receiving negative or discriminatory remarks or receiving inappropriate curiosity.
Age	NI population (Census 2021): N=1,903,175 Persons: 0-4 years 5.98% Persons: 5-9 years 6.54% Persons:10-14 years 6.67% Persons: 15-19 years 5.95% Persons: 20-24 years 5.85% Persons: 25-29 years 6.12% Persons: 30-34 years 6.62% Persons: 35-39 years 6.69% Persons: 40-44 years 6.42% Persons: 45-49 years 6.39% Persons: 50-54 years 6.88% Persons: 55-59 years 6.79% Persons: 60-64 years 5.94% Persons: 65-69 years 4.91% Persons: 70-74 years 4.39%

	Persons: 75-79 years 3.49% Persons: 80-84 years 2.30% Persons: 85-89 years 1.36% Persons: 90+ years 0.71% Among young people, the use of alcohol and drugs rises with increasing age (YPBAS, ages 11-16; Young Persons Behaviour and Attitudes Survey 2019 Substance Use Infographic report (health-ni.gov.uk). Most prevention activities target young people with the aim of delaying onset of use (especially for alcohol), preventing use altogether (especially of drugs), or the preventing the escalation of use. Since 2000, there has been a decline in both the proportion of young people ever having drank alcohol and the proportion of those who drank that report having been drunk. The proportion of young people aged 11-16, reporting to have ever taken an alcoholic drink has fallen from 59% in 2000 to 29% in 2019. In 2019, boys (32%) were more likely to have taken a drink than girls (26%); and those in Year 12 (56%) were more likely to have done so than those in Year 8 (9%). The proportion of young people reporting ever having taken drugs has fallen from 23% in 2003 to 5% in 2019. The most recent findings from the Young Persons Behaviour and Attitudes Survey in 2019 indicate lifetime use at 5%, last year use at 4%, and last month use at 2%. The HSCB Youth Wellbeing Prevalence Study 2020 shows that almost 1 in 5 children aged 11-15 years (19.2%) reported having had an alcoholic drink and, while few young people aged 11-15 years met the criteria for problematic drinking (2.5%), roughly 2 in 5 young people aged 16-19 years (40.9%) did. One in ten 11-19 year olds have used drugs with males significantly more likely than females to have done so (7.0% vs 3.1%). The most common type of drug used was cannabis (63.8%), followed by cocaine (18.1%) and Ecstasy (16.4%). Among adults, the pattern is more complex. Alcohol prevalence decreases from midlife onwards though more older adults (65+) are drinking now than 10 years ago. In contrast, drinking weekly (or 3+ week) is more prevalent among those 55+ than among younger age groups, being lowest among 18-24-year olds. (NI Health Survey Health survey Northern Ireland: first results 2021/22 | Department of Health (health-ni.gov.uk)). Most alcohol-specific deaths also occur in those aged 45-64, caused primarily by diseases from chronic alcohol misuse (Alcohol-Specific deaths in Northern Ireland, 2021 | Northern Ireland Statistics and Research Agency (nisra.gov.uk).

	For drug use, use of illicit drugs was higher among younger adults (ages 16-34) while use of prescription drugs increases with age (Drug Prevalence Survey). Drug-related deaths are highest among 25-54 year olds and primarily cause by accidental overdose (Drug-Related and Drug-Misuse Deaths 2011-2021 | Northern Ireland Statistics and Research Agency (nisra.gov.uk)). Age specific services are recommended. Young adults up to age 24 may need separate provision as they may not have as entrenched patterns of substance misuse yet, to avoid escalation of their use (by bringing them into contact with those with more established user careers), have particular vulnerabilities (eg care leavers) and safeguarding concerns, and to support the transition from young people's to adult services (Specialist substance misuse services for young people (publishing.service.gov.uk); Young people commissioning support: principles and indicators - GOV.UK (www.gov.uk); Drug misuse and dependence (publishing.service.gov.uk)). Even when young people under 18yrs are able to access general services (eg Needle and Syringe Exchange) safeguarding must be considered and relevant policy developed (see recommendation 5; 1 Recommendations | Needle and syringe programmes | Guidance | NICE). The proportion of adults who drink alcohol declines in older age. In 2019/20, around four-fifths of those aged 64 & under drank alcohol compared with two-thirds (67%) of those aged 65-74 and around half (50%) of those aged 75 & over. Older adults will also need more specific (alcohol) provision due to increased risk from physical and mental health comorbidity and age-related changes in alcohol metabolism and will less easily engage in remotely provided support (age_uk_response_to_commission_on_alcohol_harm_february2020.pdf (ageuk.org.uk); Alcohol and older people | Royal College of Psychiatrists (rcpsych.ac.uk); Full article: Addressing the needs of older adults receiving alcohol treatment during the COVID-19 pandemic: a qualitative study (tandfonline.com)). In recent years the proportion of those who died from alcohol-specific causes that are aged 55-64 has increased; in 2019 this age group accounted for over a third of such deaths (35.4 per cent), while those aged 45-54 accounted for 27.1 per cent of the total. We therefore have to think about how alcohol impacts on people as they get older. Of the 191 drug-related deaths in 2019, 62 (32.5%) were in the 25-34 age

<table>
<tr><td></td><td>group with a further 53 (27.7%) in the 35-44 age group. These figures equate to age-specific, drug-related mortality rates of 24.9 deaths per 100,000 people aged 25-34 and 22.0 deaths per 100,000 people aged 35-44.

Age standardised admission rates, which allow for direct comparison over time and between different population groups, show a fall in alcohol-related admissions in NI (from 728 to 662 admissions per 100,000 population) and its most deprived areas (from 1,595 to 1,358 admissions per 100,000 population) over the last five years. Age standardised admission rates for drug-related causes also decreased over the last five years in NI (from 237 to 190 admissions per 100,000 population) and its most (from 471 to 351 admissions per 100,000 population) & least deprived (from 128 to 103 admissions per 100,000 population) areas.</td></tr>
<tr><td>Religion</td><td>NI population (Census 2021): N=1,903,175
<table>
<tr><td>Catholic</td><td>805,151</td><td>42.31%</td></tr>
<tr><td>Presbyterian Church in Ireland</td><td>316,103</td><td>16.61%</td></tr>
<tr><td>Church of Ireland</td><td>219,788</td><td>11.55%</td></tr>
<tr><td>Methodist Church in Ireland</td><td>44,728</td><td>2.35%</td></tr>
<tr><td>Other Christian (incl Christian related)</td><td>130,377</td><td>6.85%</td></tr>
<tr><td>Other religions</td><td>25,519</td><td>1.34%</td></tr>
<tr><td>No religion</td><td>330,983</td><td>17.39%</td></tr>
<tr><td>Religion not stated</td><td>30,529</td><td>1.60%</td></tr>
</table>

Muslims are more likely to abstain, while Sikh and Hindu groups have seen increases in heavy drinking.

No data is available on differences in prevalence (differences by non-Christian religion are included in race section), or service uptake and on need for different interventions.</td></tr>
<tr><td>Political Opinion</td><td>National identity data - NI population (Census 2021): N=1,903,175
<table>
<tr><td>British only</td><td>606,263</td><td>31.86%</td></tr>
<tr><td>Irish only</td><td>554,415</td><td>29.13%</td></tr>
<tr><td>Northern Irish only</td><td>376,444</td><td>19.78%</td></tr>
<tr><td>British and Irish only</td><td>11,768</td><td>0.62%</td></tr>
<tr><td>British and Northern Irish only</td><td>151,327</td><td>7.95%</td></tr>
<tr><td>Irish and Northern Irish</td><td>33,581</td><td>1.76%</td></tr>
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<tr><td>only</td><td></td><td></td></tr>
<tr><td>British, Irish and Northern Irish only</td><td>28,050</td><td>1.47%</td></tr>
<tr><td>Other</td><td>141,327</td><td>7.43%</td></tr>
</table>
No data available on differences in prevalence, service uptake and on need for different interventions.
</td>
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<tr>
<td>Marital Status</td>
<td>
NI population (Census 2021): N=1,903,175

693,000 adults (16+; 46%) married or in a civil partnership
577,000 adults (38%) single (ie never married/civil partnered)
>90,000 (16%) adults separated, divorced, or widowed

Data collected by the General Registrar showed that the average age for marriage for males in Northern Ireland is 36.3 years, and 34.0 years for females.
NICE guidance CG115 recommends behavioural couple therapy for those with a partner receiving services but only if there is no domestic violence.
No data on marital status exists in service databases.
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<tr>
<td>Dependent Status</td>
<td>
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

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	illegal activities and lifestyles • poor physical and mental health in adulthood. Parental substance misuse is an important factor for children and young people being involved with social services. About 40% of children and young people registered on the Child Protection Register and about 70% of those being looked after have this status due to parental substance misuse (percentages from Hidden Harm Strategy). According to the DMD 2011/12 report, 13% of drug misusers were living with dependent children. Also, substance use during pregnancy poses a risk for poor health outcomes for the baby (including FASD; also low birthweight, neonatal deaths) and, therefore, the care of pregnant women represents special circumstances (eg Drug misuse and dependence (publishing.service.gov.uk) ; SUPPORTING-WOMEN-REDUCING-HARM-Report-V1.pdf (scot.nhs.uk)). 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. In the State of Caring 2022 (Carers NI) just over a fifth of carers (21%) said their physical health was ‘bad’ or ‘very bad’. Carers rated their mental health as worse than their physical health, with 30% saying their mental health was ‘bad’ or ‘very bad’ (no change from 2021). It may be reasonable to assume that some carers may experience problematic alcohol or drug use in an effort to cope.
Disability	NI population (Census 2021): N=1,903,175 • 16,923 (0.89%) of the total NI population have a learning disability Staff in drug and alcohol services do not have appropriate training for working with people with learning disabilities and staff working in learning disability services do not have knowledge of assessment,

	treatment and management of substance problems. Due to a lack of integrated service provision, people with learning disabilities may fall between the cracks of specialist learning disability and mainstream addiction services. (gov.uk- Substance Use in People with Learning Disabilities) 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 comorbidities). Treatment guidance therefore acknowledges a lower threshold and more intensive care for alcohol misusers with LD. (Recommendations | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE). Alcohol-Related Brain Injury (ARBI) is an umbrella term used to describe the damage to the brain because of long-term heavy drinking. The symptoms of Alcohol Related Brain Injury vary but include problems with cognitive functioning such as memory loss, difficulty with familiar tasks and with processing new information, depression and irritability, erratic behaviour, concentration problems and poor decision-making (Mental Welfare Commission, 2019). Alongside cognitive problems, individuals with ARBI may experience physical illnesses which include liver damage, heart problems, high blood pressure and malnutrition. (QUB & Leonard Cheshire- Evaluation of an alcohol related brain injury rehabilitation unit in NI) While an addiction to alcohol, nicotine or any other substance isn't a disability, you might be disabled if your addiction caused an impairment. For example, if you have liver disease or depression caused by alcohol dependency, that would be an impairment. Disability and addiction are a tragically common pair. Persons with disabilities are substantially more likely to suffer from substance use disorders than the general population, and they are also less likely to receive treatment for them. Conversely, persons with addictions are more likely to become disabled, either through accidental injury or through long-term side effects of substance abuse. People with physical disabilities experience substance use disorders at 2 to 4 times the rate of the general population https://www.addictioncenter.com/addiction/disability/
Ethnicity	NI population (Census 2021): N=1,903,175

	White 1837575 Irish Traveller 2609 Roma 1529 Indian 9881 Chinese 9495 Filipino 4451 Pakistani 1596 Arab 1817 Other Asian 5244 Black African 8069 Black Other 2963 Mixed 14382 Other 3568 There are no NI data on differences among ethnic groups and alcohol/drug use. However, there are various GB studies and reviews that suggest a complex interplay between ethnic group/nationality, gender, religion, generation, and socio-economic group. Alcohol use (including heavy use) is most prevalent among White people (in particular the Irish in GB), followed by Black Caribbean and Black African, and lowest among Asian groups (higher among those of Indian then Chinese, Pakistan or Bangladeshi heritage). Gender differences (more males than females) are least pronounced among those of mixed ethnic background. When Pakistani and Muslim men do drink, it is more heavily than among other ethnic/religious groups. Fewer findings are available for Central and Eastern European groups and it remains unclear if their drinking is worse than GB/Irish population (home drinking versus pub). Drug use (and polydrug use) is highest among White and mixed-race groups, apart for cannabis which is most commonly consumed by Black ethnic groups. While heroin use is problematic among Asian individuals, it is more commonly smoked/chased (as also among mixed ethnic and Black individuals). In contrast among White people heroin is mainly injected. More males than females used drugs among White and Asian groups, with no such difference among Black and mixed ethnic groups. Treatment uptake can be lower for some ethnic/national groups due to • increased stigma, which can be particularly compounded for females in these groups; • no acknowledging they have a drinking problem.

	Treatment in mainstream services is acceptable but cultural sensitivity of the service is needed. Irish Travellers have a higher rate of abstinence than settled population in Ireland but those who do drink alcohol, drink heavily. Illicit drug use is similar to the White settled population (re drugs used, including polydrug use); women used primarily prescription drugs. Medication sharing was identified as a problem among Travellers. There's a reluctance among Travellers to access substance use services and they prefer to deal with this within the family/through religion.
Sexual Orientation	NI population (Census 2021): N=1,903,175 Straight or heterosexual 1,363,859 90.04% Gay or lesbian 17,713 1.17% Bisexual 11,306 0.75% Other sexual orientation 2,597 0.17% Prefer not to say 69,307 4.58% Not stated 49,961 3.30% 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 (see also Mental health disorders and alcohol misuse more common in LGB people | UCL News - UCL – University College London). A recent review confirmed this again for alcohol use. Only if substance use services are not LGBT inclusive, then LGBT focused substance use services should be provided (Alcohol use among gender and sexual minorities | Drinkaware ; Alcohol interventions for LGBTQ+ adults: A systematic review - PubMed (nih.gov)).

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	There are gender specific patterns of use and vulnerabilities (e.g.

	among young females more sexual exploitation, mental health issues and self-harm). Women may also be reluctant to seek or engage with substance use services due to increased stigma/greater perceived deviance of female substance use, parenting commitments and fear of children's services response when accessing support. Women can experience barriers to engaging and sustaining involvement with treatment and rehabilitation services. Childcare can also be a barrier for women attending treatment and after-care services. Females were more likely to use prescription drugs such as antidepressants and sedatives/tranquillisers. This can present a difficulty in focusing or thinking which may impact ability to take an present/active role in treatment or passivity when engaging in services. We have heard that there is a need to prioritise services for people with ARBI. There is an increasing demand for these services particularly amongst women. On Census day (31 March) in 2017/18, 845 individuals received opioid substitution treatment (OST); 361 (41%) were receiving treatment for 5 or more years. The number of clients on OST has steadily increased in the last 4 years, for both males and females (Figure 21). The number of males is more than double the number of females on OST. (PHA; Extent of substance misuse in NI. Summary of Key Statistics) In most cases an agreement has been reached on the date and time that the service user will present at the pharmacy. This usually happens in the morning, potentially increasing DNA in other services. Gender minorities may face barriers to seeking or engaging with services; the provider not being sufficiently knowledgeable on their needs, real or perceived stigma and being exposed to witnessing or receiving negative or discriminatory remarks or receiving inappropriate curiosity.
Age	The strategy considers the treatment and support services available to young people, both standalone alcohol and drug services, and the need for integrated services that respond to the complexity of young people's lives.

	Young adults up to age 24 are recommended separate provision as they may not have as entrenched patterns of substance misuse yet, to avoid escalation of their use (by bringing them into contact with those with more established user careers), have particular vulnerabilities (eg care leavers) and safeguarding concerns. Older adults who use alcohol (alcohol) are at increased risk from physical and mental health comorbidity and age-related changes in alcohol metabolism and will less easily engage in remotely provided support. Loss of capacity is disproportionate among older people than in the population in large. One of the long-term harms that can be caused by excessive drinking is Alcohol-Related Brain Damage (ARBD). This is a brain disorder caused by drinking too much alcohol on a regular basis over a long period of time. It is possible to reverse many of the effects of this disorder if the symptoms (which can resemble dementia) are caught early enough. We have heard that there is a need to prioritise services for people with ARBI for older people.
Religion	Religious and spiritual beliefs and attitudes towards addiction and addiction treatment may present a barrier to those from conservative religious backgrounds from engaging in treatment and services.
Political Opinion	In some predominately loyalist or nationalist communities there remains informal "justice" systems. Those accused of crimes in the community – such as drug dealing may be in danger of being targeted by paramilitary groups. This may present a barrier if there is a concern about confidentiality or if the location of the venue is not one that potential Service Users perceive as being neutral (i.e. it is not perceived as being in an area where members of a particular community feel they are not welcome).
Marital status	There is no data that suggest that there would be particular needs based on the martial status.
Dependent Status	Family members face a wide range of inter-related barriers to accessing help for themselves. These barriers are not listed in rank order below, rather they occurred to varying degrees for the individuals interviewed: • The family member acknowledging their need for help; • Low levels of awareness of any help that might be available for family members;

	• Some family members have an overriding concern for the confidentiality of the person with addiction issues which prevents them seeking support; • Some family members lack time to access support; • Some family members feel shame and social stigma for having a family member with addiction issues; • There is a lack of support available or it is not available when it is needed, or what is offered is minimal; • Prohibitive cost of accessing or maintaining help; • Family members have preconceived ideas of what the support will be like and what it will involve; • Some parents fear that if they seek help then there will be a social services intervention that will affect their other children. RF Associates; report prepared for PHA; In their own right: Exploring the needs and experiences of support among family members of adults/young people who use alcohol and/or drugs Parental substance misuse is an important factor for children and young people being involved with social services. About 40% of children and young people registered on the Child Protection Register and about 70% of those being looked after have this status due to parental substance misuse (percentages from Hidden Harm Strategy). Whilst substance use stigma is universal, some groups experience heightened stigmatisation. Mothers tell us they feel judged and, in some cases, excluded from support when they come in to contact with maternity, mental health and other services. In the State of Caring 2022 (Carers NI) just over a fifth of carers (21%) said their physical health was ‘bad’ or ‘very bad’. Carers rated their mental health as worse than their physical health, with 30% saying their mental health was ‘bad’ or ‘very bad’ (no change from 2021). It may be reasonable to assume that some carers may experience problematic alcohol or drug use in an effort to cope. Childcare and replacement care may also be an additional barrier to those with CYP or adult dependants.
Disability	Northern Ireland experiences a higher rate of trauma and mental illness when compared to other parts of the United Kingdom

	(UK). Research clearly tells us that people who experience harm from substance use often have a history of trauma. Studies have also consistently shown a high prevalence of co-occurring mental disorders in people who have problems with alcohol and drugs. A common concern is shared about access to services for people who have a co-occurring mental health and substance use problem, often called "dual diagnosis". For some individuals, their alcohol and/or drug use and mental health is inter-related. Both general mental health difficulties and symptoms associated with psychological trauma can lead people to "self-medicate" with alcohol and other substances to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues. Guidelines (such as the UK Guidelines on the Clinical Management of Drug Dependency) are clear – no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, they should work collectively together to address the issues and clients should not be referred back and forward between services unnecessarily. Research shows that neither learning disability services nor substance misuse services have all the skills and training resources to support people with learning disabilities who have substance misuse problems. Staff in drug and alcohol services do not have appropriate training for working with people with learning disabilities and staff working in learning disability services do not have knowledge of assessment, treatment and management of substance problems. Due to a lack of integrated service provision, people with learning disabilities may fall between the cracks of specialist learning disability and mainstream addiction services. Substance misuse in people with learning disabilities: reasonable adjustments guidance - GOV.UK (www.gov.uk) Barriers can include: • failure of drug and alcohol services to recognise someone has a learning disability • failure of learning disability services to detect drug and alcohol problems in people they support and to refer them to mainstream services • some drug and alcohol services specifically exclude people with learning disabilities

	• lack of integrated services and no clear pathways or protocols in place regarding inter-agency working • lack of recognition in mainstream alcohol and drug policies • health promotion messages are too complex In general, mainstream drug and alcohol services fail to adapt the way they work to make services accessible to people with learning disabilities. Some data suggests that people with learning disabilities may not benefit from peer/ group work in the same way as people in the general population. An apparent lack of co-operation may present due to a lack of understanding, rather than a lack of motivation to engage. Services need to adapt the way in which they engage for service users with a LD– often alcohol and drug professionals reported use the same methods as they use for the general service users. In terms of communication for service users with LD there is a need to simplify the information that is provided including promotional material. Alcohol-Related Brain Injury (ARBI) is an umbrella term used to describe the damage to the brain because of long-term heavy drinking. The symptoms of Alcohol Related Brain Injury vary but include problems with cognitive functioning such as memory loss, difficulty with familiar tasks and with processing new information, depression and irritability, erratic behaviour, concentration problems and poor decision-making (Mental Welfare Commission, 2019). Alongside cognitive problems, individuals with ARBI may experience physical illnesses which include liver damage, heart problems, high blood pressure and malnutrition. (QUB & Leonard Cheshire- Evaluation of an alcohol related brain injury rehabilitation unit in NI) There is a small risk in particular circumstances that an individual may be temporarily unable to make decisions because of their misuse or drugs and alcohol. However, providers must be alert to longer term impairments, such as alcohol-related dementia or Korsakoff's syndrome, and act in line with the The Mental Capacity Act (NI) 2016.
Ethnicity	Individuals from ethnic minorities are likely to have particular, cultural and communication needs. They may experience

	language barriers, particularly those not fluent in English, and may have particular needs regarding accessible communication and information including the provision of a translator and/or translated information and resources. We have heard that there is a need to prioritise services for people with ARBI. There is an increasing demand for these services particularly from people who reside in Northern Ireland who may not have English as their first language.
Sexual Orientation	The “All partied out” report suggests the emotional and psychological distress that results from the stigmatisation of LGB&T people is perhaps the most significant reason for higher levels of drug and alcohol use among LGB&T communities. This may be a barrier to seeking or engaging with services due to the perceived stigma.

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.

No potential impacts

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?***

Action to develop person-centred pathways across services to ensure that people receive the right service at the right time. This includes CAMHS, DAMHS, CAMHS Substance Use Services, Children and Family Social Work Services, Maternity Services, Adult Mental Health Services (Including Peri-Natal Mental Health), YJA, Education and Support Services as provided by the community and voluntary sectors. Sought to strengthen knowledge sharing between postnatal community services, peri-natal mental health services and substance use services. Designated Co-Occurring Mental Health and Substance Use professionals to provide operational and strategic links between Trust provided mental health services and addiction services. Commissioned qualitative research exploring the needs and experiences of support among family members of adults and young people who use alcohol and/or drugs	Review Substance Misuse Liaison Services available for people with substance use issues who come into contact with mental health in patient services and acute general hospital services including emergency departments. Review and consider strengthening advocacy services and peer mentors in treatment and recovery services. Review tier 2 service provision ensuring enhanced community-based services for young people who are identified as having substance use difficulties and adults and family members affected by substance use are commissioned. Explore the trauma experienced by asylum seekers, refugees and other at risk groups and make recommendations to adapt services. Create a training plan for the substance use workforce to enhance skills to recognise, understand and respond to trauma amongst people using substances. Strongly encourage family and carer involvement in our planning and decision-making processes to understand their needs and issues better. Ensure the workforce is effectively trained in family inclusive practice and whole family approaches. Support the use of case studies and personal testimonies as a key element

	of how services monitor and evaluate their success. Develop a strategic Northern Ireland Drug & Alcohol workforce framework that sets regional standards of training, competencies and pathways of development across all tiers of services. Develop a plan to optimise the use of digital technology to support substance use advice, support and workforce development, taking stock of the existence and effectiveness of existing digital tools. Ensuring they are information and digitally accessible.

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	Promoting the involvement of people with lived experience of social exclusion being heard in the design, commissioning and improvement of local services	Auditing access to services by people in inclusion health groups, in partnership with people with lived experience, and organisations that work closely with them.
Political Opinion	No impact identified	No suggestions found applicable
Ethnicity	Promoting the involvement of people with lived experience of social exclusion being heard in the design, commissioning and improvement of local	Auditing access to services by people in inclusion health groups, in partnership with people with lived experience, and organisations that work closely with them.

	services Promote good relations, inclusion health the plan will encourage action such as; • offering access to a translator or interpreter instead of waiting for the individual to ask, to ensure they are fully able to communicate and understand • making sure professionals are familiar with people's entitlements to services and that you don't refuse access to someone who is entitled to your service • supporting individuals to attend appointments and engage with treatment and wider support • taking part in outreach activities to bring the services provided to the community The plan continues the development of Low Threshold Services. These are accessible services with minimum criteria for access that adopt a harm reduction approach. The services work to reduce drug and alcohol related harm amongst those with significant substance misuse problems, many of whom have complex needs. The services particularly	Working with local partners, academia and people with lived experience to evaluate and improve how your service supports people in inclusion health groups Ensuring the workforce is aware and up to date on appropriate training, such as in cultural competence and sensitivity. This plan will also take account of selective prevention, targeting individuals or groups of people at risk/with a particular vulnerability that is higher than average because the bio-psychological, behavioural or social risk factors they face are more pronounced than the general population.

	target people who are currently not engaged with a treatment/ support service and /or have a history of disengagement and vulnerability.	

(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.

The Plan is informed by the voices of people from across Northern Ireland wit living and lived experience of substance use and is underpinned by our belief inequality and fairness for all. It has minor implications in respect of equality of opportunity on the groupings outlined above.

A full Equality Impact Assessment is unlikely to provide any further information on any equality issues associated with the service.

(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?*
This plan takes a whole system, universal approach to developing and commissioning services. Therefore, it makes limited specific mention of those living with disability. Individuals with ARBI are currently supported via HSCT Physical Disability, Mental Health and Addiction services along with a regional residential facility run by the Leonard Cheshire organisation. We will prioritise how we improve age-appropriate pathways and services for people with ARBI, including consideration of ARBI teams, increased awareness amongst the workforce and earlier diagnosis of the condition and treatment that supports quality of life for the individual.	The plan will continue ensuring that people with lived and living experience, their families and carers, including those living with disabilities are at the centre of the design, delivery and review of HSC services. We will build on the engagement processes we have used throughout the development of this Plan with people with lived and living experience and strengthen our network of individuals and communities as we move forward. The plan will also be made available in accessible format to support those that need it to be involved in it's consultation.

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	*What else could you do to promote positive attitudes towards disabled people?*

disabled people?	
The link with mental health is recognised in our Plan, given the significant proportion of individuals who have co-occurring mental health and substance use issues. This Plan ensures that strong links are made between substance use and the developments around preventative, crisis, treatment and recovery services as detailed in the Mental Health Strategy. Continuing to keep compassion, hope and co-design sit at the very heart our Plan, alongside the acknowledgment of the fundamental connection between trauma and substance use and the human rights of every individual in the services we provide.	Ensure that the needs and experiences of individuals with a disability are represented and taken account of throughout the consultation and implementation of the plan. This plan will also take account of selective prevention, targeting individuals or groups of people at risk/with a particular vulnerability that is higher than average because the bio-psychological, behavioural or social risk factors they face are more pronounced than the general population.

(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.

A human rights approach to substance use is particularly important due to the stigma associated with the use of drugs and alcohol in our society. A human rights approach is therefore integral to the planning and delivery of our HSC services to ensure that everyone using them has a positive and equitable experience. Human rights go beyond the HSC services we deliver. It is important for us to foster a collaborative, whole system approach to working with

partners responsible for issues such as homelessness, poverty, education and employment, to ensure that the human rights of individuals living with and those caring for people with substance use issues is also considered in these areas.

(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
Providers will monitor attendance and uptake of Section 75 groups, identifying and addressing barriers to ensure equality of access and promote participation.	Providers will monitor attendance and uptake of Section 75 groups, identifying and addressing barriers to ensure equality of access and promote participation.	Monitoring of whether the desired outcomes have been achieved for individuals and our population as a whole. We Develop and implement a new harm reduction database to improve monitoring of these services. Consideration will be given to developing or amending current monitoring mechanisms (such as the health survey, the substance misuse database and the young people's behaviour and attitude survey) to ensure these are robust and fit for purpose. Information on current trends and

		harm reduction support. Gather specific information on overdoses and drug related deaths.

Approved Lead Officer: [signature]

Position: Health and Social Wellbeing Improvement Manager

Date: 24/07/23

Policy/Decision Screened by:

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).