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Equality Screening, Disability Duties and Human Rights Assessment Template

Guidance on completion of the template can be found on the Equality Commission website at S75 screening template 2010 (web access checked 230920) .docx

Part 1. Policy scoping

1.1 Information about the policy

Name of the policy:

Independent Review of Tier 4 In-Patient Detoxification and Residential Rehabilitation Services in Northern Ireland 2024

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Is this an existing, revised or a new policy?

This is a Review into existing Tier4a and Tier4b addiction services in Northern Ireland

_____

What is it trying to achieve? (intended aims/outcomes)

The purpose of the Review is to provide direction on a best practice model for In-patient Detoxification and Residential Rehabilitation addiction services in Northern Ireland.
The Review relates to specialist provision for detoxification/stabilisation treatment within a hospital in-patient setting currently referred to as **Tier 4a** services and the provision of rehabilitation care in specialist residential facilities, **Tier 4b** services.
The Review was commissioned by the Strategic Planning and Performance Group (SPPG) in the Department of Health in 2023, in response to a number of policy directives and recommendations which requested a review of existing service provision to accommodate changing demand and complexity, and address inequitable service delivery and access arrangements across Tier 4 services in the Region. These policy directives include the Substance Use Strategy "*Preventing Harm, Empowering Recovery"* 2021-2031 and NI Audit Office Report into Addiction Services in Northern Ireland, 2020.

The Review is aligned to a number of workstreams relating to the HSC Strategic Commissioning and Implementation Plan for Substance Use and to wider policy direction including the development of Northern Ireland's new Integrated Care System (ICS) and the Regional Single Mental Health Service.

Support and treatment for people with substance issues in Northern Ireland is currently structured into a 4-Tier model. This model provides a range of support including;

- Tiers 1 & 2 - alcohol/drug related information and advice; screening and harm reduction interventions (including needle exchange);
- Tier 3 -specialist community-based alcohol/drug assessment and co-ordinated care-planned treatment;
- Tier 4 - specialist detoxification/stabilisation treatment within a hospital in-patient setting and provision of rehabilitation care in specialist residential facilities.

The Review was commissioned to review existing Tier 4 services in Northern Ireland to identify gaps in provision and make recommendations to improve Tier 4 provision for those using the services.

The Review makes the following recommendations which may be subject to further screening if adopted:

1. A regionally sustainable network of specialist recovery and treatment services should be developed – the Regional Specialist Treatment and Recovery Service for Substance Use - which will provide value for money and deliver measurable outcomes for the individuals who use these services.
2. The Department of Health/ SPPG should establish a joint Addictions and Mental Health Lead for Northern Ireland within the REMHS to operationalise the integration across addictions and mental health services, and to drive recovery-orientated systems of care.
3. SPPG/ NIHE should undertake a strategic joint needs assessment for the future accommodation and support needs of people discharged from residential rehabilitation services to maintain recovery.
4. Commissioning and accountability processes and arrangements for monitoring performance should be strengthened, and the development of Commissioning Quality standards should be considered.

5. A standardised approach to routinely collate and analyse feedback from service users and families should be developed to inform future service development and improvement. Outcome measures should be developed to track and evidence recovery and meaningful life outcomes.
6. Community Detoxification services should be resourced and become available in every HSC Trust area.
7. Hospital In-patient detoxification beds should be managed with a regional approach similar to that as already in place within acute mental health services.
8. Hospital in-patient provision should be delivered by multi-disciplinary teams across the region.
9. A regional procurement process should be undertaken for Residential Rehabilitation services in order to standardise contractual, access and funding arrangements. This includes the development of a regional service specification for residential rehabilitation with consistent referral criteria (including for people receiving Opiate Substitute Treatment (OST) enhanced preparation, aftercare and family support based on a bio-psychosocial therapeutic approach.
10. Residential Rehabilitation services should be registered with RQIA and subject to the same regulation and inspection regimes.
11. Assertive outreach services should be developed to support individuals before and after specialist recovery services- this should include the use of peer mentor support.
12. Relapse and re-entry should be integrated into treatment and rehabilitation services.
13. Existing community and voluntary groups and social enterprise services which support recovery, should be recognised within the recommended Regional Specialist Treatment and Recovery Service.
14. Gaps in provision for specific groups should be further scoped, this should include support for, mothers/ parents in recovery; young people requiring specialist recovery and treatment support; people within the criminal justice system; and people with Alcohol Related Brain Disorder.
15. New pathways should be developed into and from residential rehabilitation, in particular for those with multiple and complex needs, including a pathway for those within the criminal justice system.

16. Regional Mental Health Crisis Services should be developed to include provision of service for those presenting at hospital Emergency Departments requiring detoxification and for people with co-occurring mental health and substance use issues. short
17. A workforce strategy should be developed for those within substance use services across the Region which recognises the challenges presented when working in this area. Multi-Disciplinary teams should include as a minimum of medical staff, social work, psychology, nursing, occupational therapy, lived experience practitioners and input from pharmacy and alternative therapists. In addition to the core multi-disciplinary team, involvement of criminal justice staff, and robust links and pathways to housing, employment and training services should be included.
18. It is essential that cost analysis and benchmarking of services taking into consideration repeat admissions across facilities be embedded routinely. Data metrics should be developed which collate both performance information and outcomes for individuals.
19. The principles of co-production and co-design should be adopted to ensure that people with lived experience inform policy, commissioning and service delivery.
20. The role of Drug and Alcohol Coordination Teams (DACT's) should include coordination of Recovery Communities in their locality.

Are there any Section 75 categories which might be expected to benefit from the intended policy?
If so, explain how.

All section 75 groups will benefit from the recommendations within this Review as service users and potential service users come from across the whole population of Northern Ireland.

This Review is a "rights-based" inclusive and enabling review that seeks to address existing challenges and reduce barriers and potential barriers for all sections of our population who use addictions services or who may use them in the future, providing equitable access for everyone who needs our services.

Who initiated or wrote the policy?

The Review was commissioned by SPPG and was carried out by 2 independent consultants with subject expertise.

Who owns and who implements the policy?

SPPG is responsible for the Review and will implement the recommendations in partnership with all relevant stakeholders across policy, statutory and community sectors.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision?

If yes, are they (please delete as appropriate)

Financial

The recommendations in this Review will be delivered within a challenging financial environment, combined with increasing service demand and an increasingly under pressure workforce. Implementation requires a commitment to make the best use of the finances available, and will require a comprehensive consideration of current and potential future funding arrangements in line with the recommendations. This may involve commissioning new services where gaps have been identified.

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 the recommendations from the Review.

Legislative

The Review and the subsequent delivery of the recommendations made within it are underpinned by the application of basic human rights and freedoms regardless of where you are from, status, religious beliefs or how someone chooses to live their life.

other, please specify _____

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon? (please delete as appropriate)

Please provide details - for example all staff or particular teams of staff, actual or potential service users, and any other groups of people.

Staff providing commissioned Tier 4a detoxification services in WHSCT, NHSCT, SEHSCT

Staff providing commissioned Tier 4b residential rehabilitation services in the community at Carlisle House Belfast, Cuan Mhuire Newry, and Northlands Derry/Londonderry

Staff within Trust addictions teams who provide Tier 3 services in the 4-step model and who refer into Tier 4a services

Staff from community and voluntary sector organisations who are commissioned by PHA to provide Tiers 1 and 2 services in the 4-step model

Service users and potential service users with addiction issues who are referred into Tier 4a and Tier 4b services and those who self-refer to Tier4b services

The families and carers of the patients who require or will potentially require Tier4a and/or Tier4b addiction services.

Staff in other public sector organisations who interface with addictions services e.g. Prisons, Housing Services.

1.4 Other policies with a bearing on this policy

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- 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
DoJ- Problem Solving Justice
DAERA- Tackling Rural Poverty &Social Isolation Framework
SPPG – Corporate Plan
BCC- Belfast Complex Lives

1.5 Available evidence

What evidence/information (both qualitative and quantitative[1]) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

Who is affected by the policy or decision? Please provide and discuss a statistical profile. Please specify what sources of information you used to identify the statistical profile. Also provide details of how you involved those impacted (service users, staff, voluntary sector organisations etc.).

[1] * Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.

Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

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

• 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

Religious belief evidence / information:

NI population (Census 2021): N=1,903,175

Catholic
805,151
42.31%

Presbyterian Church in Ireland
316,103
16.61%

Church of Ireland
219,788
11.55%

Methodist Church in Ireland
44,728
2.35%

Other Christian (including Christian related)
130,377
6.85%

Other religions
25,519
1.34%

No religion
330,983
17.39%

Religion not stated
30,529
1.60%

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.

Commented [SD1]: Check if this should be ethnicity instead of race

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Political Opinion evidence / information:

National identity data - NI population (Census 2021): N=1,903,175

British only

606,263

31.86%

Irish only

554,415

29.13%

Northern Irish only

376,444

19.78%

British and Irish only

11,768

0.62%

British and Northern Irish only

151,327

7.95%

Irish and Northern Irish

33,581

1.76%

only

British, Irish and Northern Irish only

28,050

1.47%

Other

141,327

7.43%

No data available on differences in prevalence, service uptake and on need for different interventions.

Racial Group evidence / information:

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.

Age evidence / information:

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 (e.g. care leavers) and safeguarding concerns, and to support the transition from young

persons 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 (e.g. 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 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.

Marital Status evidence / information:

NI population (Census 2021): N=1,903,175

- 693,000 adults (16+; 46%) married or in a civil partnership
- 577,000 adults (38%) single (i.e. 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.

Sexual Orientation evidence / information:

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 is 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)).

Men & Women generally evidence / information:

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 limits1, with males (26%) around 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).

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

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.

Disability evidence / information:

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/

Dependants evidence / information:

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.

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 ooked 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 (e.g. 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.

1.6 Needs, experiences and priorities

Taking into account the information referred to above, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision?

Specify details of the needs, experiences and priorities for each of the Section 75 categories below:

Please also specify what sources of information you used to identify the needs/experiences/priorities (such as research papers, professional experience, engagement with those impacted). Also provide details of how you involved those impacted (service users, staff, voluntary sector organisations etc.).

Religious belief

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).

Racial Group

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.

Age

The Review 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. It also recognises the importance of the family member acknowledging their need for help, and low levels of awareness of any help that might be available for family members.

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 (e.g. 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.

Marital status

There is no data that suggest that there would be particular needs based on the martial status.

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.

Men and Women Generally

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 a 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. 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.

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 Mental Capacity Act (NI) 2016.

Dependants

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:

• 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.

Part 2. Screening questions

2.1 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

Details of the likely policy impacts on Religious belief: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Political Opinion: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Racial Group: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Age: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Marital Status: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Sexual Orientation:

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Men and Women: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Disability: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Dependants:

What is the level of impact? Minor / Major / None (circle as appropriate)

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories? Yes/ No

Detail opportunities of how this policy could promote equality of opportunity for people within each of the Section 75 Categories below:

Based on the equality issues you identified in 1.5 and 1.6, what changes did you make and what do you intend to do in future 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? Please specify below for each of the nine equality categories.

What do you intend to do in future to address the equality issues you identified?

The Tier 4 Review makes a number of recommendations to develop person-centred pathways into, through and out of Tier 4 Services to ensure that people receive the right service at the right time. This includes equitable access and consistent referral criteria for everyone using addictions services.

Development of a regionally sustainable network of specialist recovery and treatment which will provide value for money and deliver measurable outcomes for the individuals who use these services.

Commissioning and accountability processes and arrangements for monitoring performance should be strengthened, and the development of Commissioning Quality standards should be considered.

A standardised approach to routinely collate and analyse feedback from service users and families should be developed to inform future service development and improvement. Outcome measures should be developed to track and evidence recovery and meaningful life outcomes.

For consistency of approach and equitable access, hospital In-patient detoxification beds should be managed with a regional approach similar to that as already in place within acute mental health services.

Development of a regional service specification for residential rehabilitation with consistent referral criteria (including for people receiving Opiate Substitute Treatment (OST) enhanced preparation, aftercare and family support based on a bio-psychosocial therapeutic approach.

Residential Rehabilitation services should be registered with RQIA and subject to the same regulation and inspection regimes.

Assertive outreach services should be developed to support hard to reach and vulnerable individuals before and after specialist recovery services- this should include the use of peer mentor support.

Recognising and integrating existing community and voluntary groups and social enterprise services which support recovery.

Further scoping of gaps in provision for specific groups, this should include support for, mothers/ parents in recovery; young people requiring specialist recovery and treatment support; people within the criminal justice system; and people with Alcohol Related Brain Disorder.

Strengthen knowledge sharing between relevant services and gather and analyse data on service users, impacts and outcomes.

Review and consider strengthening advocacy services and peer mentors in treatment and recovery services.

Create a training plan for the substance use workforce to enhance skills to recognise, understand and respond to people using substances.

Strongly encourage family and carer involvement in our planning and decision-making processes to understand their needs and issues better.

Support the use of case studies and personal testimonies.

Religious Belief - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:

Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:

Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Political Opinion - If Yes, provide details:
If No, provide reasons

Your mitigation to date:

Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:
Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Racial Group - If Yes, provide details:
If No, provide reasons

Your mitigation to date:
Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:
Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Age - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:
Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:

Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Marital Status - If Yes, provide details:
If No, provide reasons

Your mitigation to date:

Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:

Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Sexual Orientation - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:
Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:
Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Men and Women generally - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:

Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:

Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Disability - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:
Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:
Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Dependants - If Yes, provide details:
If No, provide reasons:

Your mitigation to date:

Co-production approach and inclusion of the voice of a broad range of people with lived experience in the Tier 4 Review, including service users, staff and commissioners.

The use of case studies and personal testimonies as a key element of the Tier 4 Review Draft Report, including service users, staff and commissioners.

Your intended additional mitigation in future:
Further promoting the involvement of people with lived experience in the implementation of the Tier 4 Review recommendations. This will include service users, staff who deliver the services, commissioners who plan the services and other partner organisations.

Auditing and monitoring implementation of the recommendations in relation to equality implications for this group. Analysing qualitative and quantitative data in relation to impact, experience and outcome.

Having considered the above, are there any opportunities to better promote equality by adopting an alternative policy or decision?
Please specify what alternative policies or decisions you considered

The Tier 4 Review was commissioned by the Strategic Planning and Performance Group (SPPG) in the Department of Health in 2023, in response to a number of policy directives and recommendations which requested a review of existing service provision to accommodate changing demand and complexity, and address inequitable service delivery and access arrangements across Tier 4 services in the Region.

These policy directives include the Substance Use Strategy "*Preventing Harm, Empowering Recovery"*[2] and the NI Audit Office Report into Addictions Services in Northern Ireland, 2020[3].
and its recommendations.

This Review is a "rights-based" inclusive and enabling review that seeks to address existing challenges and reduce barriers and potential barriers for all sections of our population who use addictions services or who may use them in the future, providing equitable access for everyone who needs our services.

[2] doh-substanceuse-strategy-2021-31.pdf (health-ni.gov.uk)
[3] 235243 NIAO Addictions Services Report NEW 4.pdf (niauditoffice.gov.uk)

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group?

Please provide details of the likely policy impact and determine the level of impact for each of the categories below i.e. either minor, major or none.

Details of the likely policy impacts on Religious belief: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Political Opinion: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

Details of the likely policy impacts on Racial Group: (insert text here)

What is the level of impact? Minor / Major / None (circle as appropriate)

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

Detail opportunities of how this policy could better promote good relations for people within each of the Section 75 Categories below:

Religious Belief - If Yes, provide details:

- Ensuring the workforce is aware and up to date on appropriate training, such as in cultural competence and sensitivity.
- The implementation of the Recommendations will target people who are currently not engaged with a treatment/ support service and /or have a history of disengagement and vulnerability on the basis of religious belief.

If No, provide reasons:

Political Opinion - If Yes, provide details:

- Making sure professionals are familiar with people's entitlements to services regardless of political opinion and don't exclude or refuse access to someone who is entitled to your service
- Taking part in outreach activities to bring the services provided to the community where appropriate,
- Ensuring the workforce is aware and up to date on appropriate training, such as in cultural competence and sensitivity.
- Targeting people who are currently not engaged with a treatment/ support service and /or have a history of disengagement and vulnerability due to political opinion.

If No, provide reasons

Racial Group - If Yes, provide details:

In line with inclusion health best practice, the owners of the Review 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 for participation and inclusion
- Ensuring the workforce is aware and up to date on appropriate training, such as in cultural competence and sensitivity.
- The implementation of the Recommendations will target people who are currently not engaged with a treatment/ support service and /or have a history of disengagement and vulnerability due to ethnicity, racial group.
- Taking part in outreach activities to bring the services provided to the community where appropriate.

If No, provide reasons

2.5 Additional considerations

Multiple identity

Generally speaking, people can fall into more than one Section 75 category. **Taking this into consideration, are there any potential impacts of the policy/decision on people with multiple identities?**
(*For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people).*

Provide details of data on the impact of the policy on people with multiple identities. Specify relevant Section 75 categories concerned.

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.

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.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

No. The Review Report will be subject to public consultation and any adverse impacts identified will be addressed.

Part 3. Screening decision

3.1 Would you summarise the impact of the policy as; No Impact/ **Minor Impact**/ Major Impact?
Minor impact

3.2 Do you consider that this policy/ decision needs to be subjected to a full equality impact assessment (EQIA)?
No

3.3 Please explain your reason.

The Review is informed by the voices of people with living and lived experience of substance use, those who use services and those who plan and deliver services, and is underpinned by our belief in equality and fairness for all. It has minor implications in respect of equality of opportunity on the groupings as outlined above. A full Equality Impact Assessment is unlikely to provide any further information on any equality issues associated with the service.

3.4 Mitigation

When the public authority concludes that the likely impact is 'minor' and an equality impact assessment is not to be conducted, the public authority may consider mitigation to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

The Review will be subject to a 12-week public consultation period at the end of which time feedback or comments will be considered and incorporated where appropriate into the final Review report.

If so, give the reasons to support your decision, together with the proposed changes/amendments or alternative policy.
Changes will be made as appropriate following a 12-week public consultation.

3.5 Timetabling and prioritising

Factors to be considered in timetabling and prioritising policies for equality impact assessment.

If the policy has been **'screened in'** for equality impact assessment, then please answer the following questions to determine its priority for timetabling the equality impact assessment.

On a scale of 1-3, with 1 being the lowest priority and 3 being the highest, assess the policy in terms of its priority for equality impact assessment.

Effect on equality of opportunity and good relations – **Rating** ____ (1-3)

Social need – **Rating** ____ (1-3)

Effect on people's daily lives – **Rating** ____ (1-3)

Relevance to a public authority's functions – **Rating** ____ (1-3)

Note: The Total Rating Score should be used to prioritise the policy in rank order with other policies screened in for equality impact assessment. This list of priorities will assist the public authority in timetabling. Details of the Public Authority's Equality Impact Assessment Timetable should be included in the quarterly Screening Report.

Is the policy affected by timetables established by other relevant public authorities?
No

If yes, please provide details.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

Please specify your quantitative and qualitative monitoring arrangements for

(1) Equality and Good Relations

The providers of existing and any newly developed services as recommended within the Review, will monitor attendance and uptake of Section 75 groups, identifying good practice and addressing barriers to ensure equality of provision and access and to promote good relations at all stages of the implementation of the recommendations.

(2) Disability Duties

The providers of existing and any newly developed services as recommended within the Review, will monitor attendance and uptake of Section 75 groups, identifying good practice and addressing barriers to ensure equality of access and compliance with Disability Duties at all stages of the implementation of the recommendations.

(3) Human Rights

The providers of existing and any newly developed services as recommended within the Review, will monitor attendance and uptake of Section 75 groups, identifying good practice and addressing barriers to ensure a human rights-based approach to equality of access and participation at all stages of the implementation of the recommendations.

***Please note**: - For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any Equality issues*.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

The link with mental health is recognised in the Review, given the significant proportion of individuals who have co-occurring mental health and substance use issues. This Review and the recommendations 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 Review and recommendations, 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 recommendations.

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

This Review takes a whole system, universal approach to developing and commissioning services.

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 Review and subsequent implementation of the recommendations 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 Review with people with lived

and living experience and strengthen our network of individuals and communities as we move forward.

The Review will also be made available in accessible format to support those that need it so they can be involved in its consultation.

Part 6. Human Rights

6.1 Does the policy / decision affects anyone's Human Rights?

Details of the likely policy impacts on Article 2 – Right to life: (insert text here)
What is the impact? Positive / Negative (human right interfered with or restricted) / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 5 – Right to liberty & security of person: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 6 – Right to a fair & public trial within a reasonable time: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 7 – Right to freedom from retrospective criminal law & no punishment without law: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 8 – Right to respect for private & family life, home and correspondence: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 9 – Right to freedom of thought, conscience & religion: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 10 – Right to freedom of expression: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 11 – Right to freedom of assembly & association: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 12 – Right to marry & found a family: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on Article 14 – Prohibition of discrimination in the enjoyment of the convention rights: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on 1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

Details of the likely policy impacts on 1st protocol Article 2 – Right of access to education: (insert text here)

What is the impact? Positive / Negative / Neutral (circle as appropriate)

6.2 If you have identified a likely negative impact who is affected and how?

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

N/A

6.3 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/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, justice, 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.

Part 7 - Approval and authorisation

Screened by:	**Position/Job Title**	**Date**
Approved by:		
Copied to EHRU:		

The Screening Template is 'signed off' and approved by a senior manager responsible for the policy (at least Grade 7), made easily accessible on the public authority's website as soon as possible following completion and made available on request.

ADDITIONAL INFORMATION TO INFORM THE ANNUAL PROGRESS REPORT TO THE EQUALITY COMMISSION

(PLEASE NOTE : THIS IS NOT PART OF THE SCREENING TEMPLATE BUT MUST BE COMPLETED AND RETURNED WITH THE SCREENING)

1. Please provide details of any measures taken to enhance the level of engagement with individuals and representative groups. Please include any use of the Equality Commissions guidance on consulting with and involving children and young people.

2. In developing this policy / decision were any changes made as a result of equality issues raised during :

   (a) pre-consultation / engagement;
   (b) formal consultation;
   (c) the screening process; and/or
   (d) monitoring / research findings.

   If so, please provide a brief summary including how the issue was identified, what changes were made, and what will be the expected outcomes / impacts for those effected.

3. Does this policy / decision include any measure(s) to improve access to services including the provision of information in accessible formats? If so please provide a short summary.

Thank you for your co-operation.
Equality and Human Rights Unit.