Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

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Guidance notes are available to assist with completing this template. For further help please contact the Equality and Human Rights Unit ext 20539.

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

Service Framework for Mental Health and Wellbeing

1.1.2 Is this an existing, revised or a new policy / decision?

This is a revision of an existing Service Framework launched in December 2010.

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

Service Frameworks set out the standards of care that individuals, their carers and wider family can expect to receive from the HSC system.

The revised Service Framework for Mental Health and Wellbeing 2016 reflects the principles and values of 'You In Mind' Regional Mental Health Care Pathway, launched in 2014, which recognises that all treatment and care needs to be highly personalised and recovery orientated. It is based on valid, relevant published research, where available.

The Framework provides the mechanism to audit the 'You in Mind' care pathway. The domains, standards and indicators for this Framework are all extrapolated from You in Mind. The You in Mind document therefore represents the key reference point for all staff implementing the Framework.

You in Mind explains how people can access mental health care and the steps involved from the point of referral to the point that care is no longer required. It describes the standards of care expected by mental health professionals who will work in partnership with people towards their recovery. It outlines how care decisions are made with people and for people. It places people, families, partners and nominated friends (as appropriate) at the heart of all decision-making.

The content of You in Mind was informed by expert advice and by national standard setting bodies such as the National Institute for Health and Clinical

Excellence (NICE) and the Social Care Institute for Excellence (SCIE) – these are noted in the Supporting Resources of the document.

You in Mind sets out generic standards of care expected for secondary mental health services, using the stepped model of care.

Service and condition specific care pathways have also been produced, or are currently under production. These will set out the standards of care for secondary mental health care specialist areas and mental health conditions**.** These will also be informed by expert advice and by national standard setting bodies, and will be subject to audit under the Framework.

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

One of the aims of Service Frameworks is to ensure that health and social care services do not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status.

This approach ought to benefit those groups who currently might face difficulty accessing mental health services or who face a variation in the quality of service provided – see section 1.6 below.

1.1.5 Who initiated or wrote the policy?

The Service Framework was initiated by the Department of Health and was drafted by an expert panel drawn from across the HSC and other relevant interests.

1.1.6 Who owns and who implements the policy?

The Framework is owned by DoH with its implementation to be overseen by the HSC Board.

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

Factor		Please explain
Financial	x	Please explain: Financial constraints will always pose a risk to the successful implementation of the Framework.
Legislative		
Other		

1.3 Main stakeholders affected

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

Stakeholder		
Staff	x	
Service users	x	
Other public sector organisations	x	HSC organisations
Voluntary/community/trade unions	x	Vol/Comm groups working in the mental health sector
Other, please specify		

1.4 Other policies with a bearing on this policy / decision. If any:

The Service Framework for Mental Health and Wellbeing is one of a suite of Service Frameworks. These are being developed for key areas of health and social care and include Cardiovascular Health and Wellbeing, Respiratory Health and Wellbeing, Cancer Prevention, Treatment and Care, Learning Disability, Older People's Health and Well-being and Children and Young People's Health and Well-being.

Policy	Owner(s) of the policy
The Bamford Review of Mental Health and Learning Disability	DoH
Making Life Better	DoH
'You in Mind' – Regional Mental Health Care Pathway	HSCB
Transforming Your Care	DoH
Health and Well-being 2026: Delivering Together	DoH
Clinical Guideline 136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	NICE

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.

It should be noted that the development of the Framework has been overseen by a multi-disciplinary Programme Board, which is jointly chaired by the Chief Medical Officer and Deputy Secretary of the DoH.

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* 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).

The revised Service Framework for Mental Health and Wellbeing was developed by a Regional Project Board, chaired by Mr Aidan Murray, Assistant Director of Mental Health and Learning Disability, HSC Board, with representation from all aspects of the service including people with lived experience, carers, advocates, voluntary organisations and community groups, as well as professionals working in the field, professional bodies, commissioners and DoH drawing on a wide range of information available, including the Bamford Review, GAIN Surveys and a data analysis of information held by HSC Trusts.

It is estimated that **one in four people** will suffer from a medically identified mental illness during their lifetime.

Mental illness is the single largest cause of disability, and leading cause of sickness absence from work, in the UK. Mental health problems are one of the main causes of the burden of disease worldwide. In the UK, they are responsible for the largest burden of disease– 28% of the total burden, compared to 16% each for cancer and heart disease.

Section 75 category	Details of evidence/information
Religious belief	Information on religious belief can be found in the 2011 Census. One sixth (17 per cent) of the usually resident population on Census Day either had No Religion or Religion Not Stated. The figures for the main religions were: Catholic (41 per cent); Presbyterian (19 per cent); Church of Ireland (14 per cent); Methodist (3.0 per cent); Other Christian or Christian-related denominations (5.8 per cent); and Other Religions and Philosophies (0.8 per cent). Bringing together the information on Religion and Religion Brought up in, 45 per cent of the population were either Catholic or brought up as Catholic, while 48 per cent belonged to or were brought up in Protestant, Other Christian or Christian-related denominations. A further 0.9 per cent belonged to or had been brought up in Other Religions and Philosophies, while 5.6 per cent neither belonged to,

	nor had been brought up in, a religion. **As health and social care services are available to everyone equally, no differential impact** on the grounds of religious belief has been identified.
Political opinion	There is limited data available on **political opinion**, however data on the first preference votes per party in NI Assembly Elections 2016 can be used as proxy information: • DUP – 202,567 • Sinn Fein – 166,785 • UUP – 87,302 • SDLP – 83,364 • Alliance – 48,447 • Other – 105,845 **As health and social care services are available to everyone equally, no differential impact** on the grounds of political opinion has been identified.
Racial group	Based on **main ethnic group**, 98 per cent of people usually resident in Northern Ireland on Census Day 2011 were White, 1.1 per cent (19,100) were Asian, 0.3 per cent (6,000) were Mixed, 0.2 per cent (3,600) were Black and 0.1 per cent (2,400) belonged to Other ethnic groups. Of the population 3.14% (aged 3 and over) considered a language other than English as their main language. It should also be noted that of the 98 per cent of people usually resident Northern Ireland on Census Day 2011 who identified their ethnicity as White, almost 10 per cent (179,000) were born outside of Northern Ireland. This includes 19,300 individuals from Poland, 7,250 from Lithuania, 4,000 from America, 3,800 from Germany and 1,650

	from South Africa. The largest minority ethnic sub-groups in 2011 were Chinese (6,300 people; up from 4,100 in 2001), Indian (6,200; up from 1,600), and Other Asian (5,000; up from 200), each accounting for around 0.3 per cent of the usually resident population (Table DC2248NI). Including the 1,300 Irish Travellers, 1.8 per cent (32,400) of usual residents belonged to Minority Ethnic groups in 2011, more than double the proportion in 2001 (0.8 per cent). It is recognised that different ethnic groups have different rates and experiences of mental health problems. (See https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities). In addition, while it is expected that the number of people born outside of Northern Ireland has increased significantly since the 2011 census, as **health and social care services are available to everyone equally**, no differential impact on the grounds of racial group has been identified.
Age	Northern Ireland's **average age** increased from 34 years to 37 years between the 2001 and 2011 Censuses. Over the same period, the share of the population represented by children aged under 16 years fell from 24 per cent to 21 per cent, while the proportion of people aged 65 years and over rose from 13 per cent to 15 per cent. Public Health Agency's report *Improving the Mental Health of Northern Ireland's Children and Young People: Priorities for Research (2011)* draws on the Bamford Review's acknowledgement that "very little epidemiological study of **child mental health** problems has been carried out in Northern Ireland and the rates of many problems and disorders have to be extrapolated from British and international studies" (*A vision of a comprehensive child and adolescent mental health service*, *Bamford Review, 2006*). Compared with the 2001 Census, the number of people **aged 65**

	years and over living in Northern Ireland increased by 18 per cent (40,400) to 263,700 on Census Day 2011. Between 2002 and 2012, the number of people *aged 60-84* rose by 20%, while those *aged 85+* rose by 38%. In February 2007, the Alzheimer's Society published a major study on the social and economic impact of **dementia** in the UK. The research, commissioned through King's College London and the London School of Economics provides a detailed and robust picture of prevalence and economic impact of dementia in the UK. This report estimates that one in 14 people over 65 years of age and one in six people over 80 years of age have a form of dementia. A further report published by Alzheimer's Society: *Dementia 2013: The hidden voice of loneliness* indicates that 18,862 people in Northern Ireland have dementia. **Mental health in-patients** can be broken down with the following age structure (as of 17 February 2016): • Under 18: 5.8%; • 19 – 44: 37.3%; • 45 – 64: 31.8%; and • 65 and over: 25.0% With the exception of those under 18 the spread of mental health in-patients are broadly proportionate to the general population. Of those patients **compulsory admitted** to hospital the spread is similar: • Under 18: 2.8%; • 18 – 44: 45.5%; • 45 – 64: 27.5%; and • 65 and over: 24.2% It is estimated that **eating disorders** affect about 1% of the population. Female teenagers have the highest rate of new cases of anorexia nervosa each year, at 51 per 100,000. The peak age onset

is 13-18 and most cases develop between 13-25 years. However, an increasing number are now being reported among those under 10 years of age.

Disproportionately high levels of mental health difficulties have been identified among young people in the care system and those who have experienced abuse (Teggart & Menary 2005, Mullan et al 2007).

Marital status

The 2011 Census data provides information on **marital status**. It showed that almost half (48 per cent) of people aged 16 years and over were married, and over a third (36 per cent) were single. Just over 1,200 people (0.1 per cent) were in registered same-sex civil partnerships in March 2011. A further 9.4 per cent of usual residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8 per cent were either widowed or a surviving partner.

Recent research has indicated a correlation **between marital status and suicide** rates in Northern Ireland (O'Reilly et al 2008, Corcoran Nagar 2009). Unmarried men over 55 and younger divorced men were shown to be at a higher risk than the population as a whole.

As health and social care services are available to everyone equally, no differential impact on the grounds of marital status has been identified.

Sexual orientation

The Health Survey Northern Ireland records:-

	2012/13	2013/14
Heterosexual/Straight	93%	94%
Gay/Lesbian	1%	1%
Bisexual	2%	1%
Other	1%	1%
Not specified	3%	3%

	0.09% of all usual residents aged 16 or over are in a registered same-sex partnership (Source: NI Census 2011). The 2012 Life and Times Survey interviewed 1204 adults to establish their **sexual orientation**. 98% of respondents identified themselves as Heterosexual/Straight, 1% as Gay/Lesbian, and 1% provided No answer/Refusal. In a systematic review of international research literature the National Institute for Mental Health in England (2007) found that levels of depression and anxiety disorders were higher in lesbian, gay and bisexual people. The risk of attempted suicide was over four times (4.28) greater in gay and bisexual men than in heterosexual men and almost doubled (1.87) in lesbian and bisexual women as compared with heterosexual women. Research conducted in England suggests that lesbian, gay and bisexual young people experience disproportionately high levels of bullying, distress and self-destructive behaviour (Rivers 2000). **As health and social care services are available to everyone equally, no significant differential impact** on the grounds of sexual orientation has been identified.
Gender (Men and women generally)	• The Northern Ireland Census (2011) indicated that 5.8% of Northern Ireland's 1.8million population has some form of mental health ill-health. Women are more likely than men to have a common mental health problem and are almost twice as likely to be diagnosed with anxiety disorders • In the 2013-2014 Northern Ireland Health Survey, 19% of respondents showed signs of mental ill health. Of these, 45% of females and 29% of males were taking medication for stress, anxiety or depression. One in ten (9%) adults had two or more symptoms of depression or anxiety. • There is some evidence to suggest that brain development in boys is different than girls which may explain differences in coping with stress etc (http://www.bbc.co.uk/news/health-37936514)

Accurate figures on the number of transgender persons in the population are not currently available; however research by Ruari-Santiago for OFMDFM (2013) found that the number of people who have presented with gender identity dysphoria in Northern Ireland is 8 per 100,000 people (aged 16 and over). Ruari-Santiago suggests that scaling this figure up would suggest there are c.144 individuals who have presented with gender identity dysphoria in Northern Ireland and that this estimate is corroborated by anecdotal information collected by McBride and Hansson (2010) who report that there 140-160 trans individuals currently in contact with adult trans support organisations.

Source: http://www.ofmdfmni.gov.uk/grasping-the-nettle-transgender-youthliving-in-ni.pdf

As health and social care services are available to everyone equally, no significant differential impact on the grounds of gender has been identified.

Perinatal mental health disorders occur in up to 15% of all pregnancies. Given that there are approximately 25,000 births in the North of Ireland every year, this implies that there are around 3,750 cases of perinatal mental illness annually. One third of cases occur before birth, with two-thirds post-natally.

Most cases are mild-to-moderate and can be managed in primary or community settings. Moderate-to-serious disorders that require secondary care intervention occur in relation to around 3% of pregnancies, implying approximately 750 cases annually. Severe/complex disorders requiring hospital admission occur in 0.4% of pregnancies, equating to approximately 100 admissions per year. Maternal death as a result of perinatal mental illness occurs in 3.7 of every 100,000 maternities.

As perinatal mental health disorder affects during, or shortly after, pregnancy it has a disproportionate effect on women.

Disability (with or without)	In 2011, Census data showed that just over one in five of the usually resident population (21 per cent) had a long-term health problem or **disability** which limited their day-to-day activities. The most common long-term conditions among the usually resident population were: a mobility or dexterity problem (11 per cent); long-term pain or discomfort (10 per cent); shortness of breath or difficulty breathing (8.7 per cent); chronic illness (6.5 per cent); and an emotional, psychological or mental health condition (5.8 per cent). **As health and social care services are available to everyone equally, no significant differential impact** on the grounds of disability has been identified.
Dependants (with or without)	In 2011, one-third (34 per cent) of households in Northern Ireland contained **dependent children**, down from 36 per cent in 2001. Two-fifths (40 per cent) of households contained at least one person with a long-term health problem or disability; made up of those households with dependent children (9.2 per cent) and those with no dependent children (31 per cent). In March 2011, 5.8 per cent of households contained dependent children and no adults in employment. Although Davidson et al (2003) draw from the Acheson report on Inequalities in Health (1998) the particular relationship between caring for young children, poverty and poor mental health there is **no direct differential impact** on the grounds of having, or not having, dependants. The mental health and well-being of carers is becoming more widely recognised as an area that needs attention (see http://www.cause.org.uk/for-carers/carers-stories/ and http://www.niamhwellbeing.org/SiteDocuments/campaigns/Carers.pdf) See also above in gender in relation to perinatal mental health

	disorder

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

Section 75 category	**Details of needs/experiences/priorities**
Religious belief	No evidence of specific need has been identified.
Political opinion	No evidence of specific need has been identified.
Racial group	People in this group often have difficulties accessing mental health services due to language or cultural barriers. The experiences and needs of people from different ethnic background differ. The commissioners and providers of Mental Health services need to recognise these issues and respond accordingly.
Age	People in this group often have difficulties accessing mental health services and understanding the treatments and interventions needed. The commissioners and providers of Mental Health services need to recognise these issues and respond accordingly.
Marital status	n/a
Sexual	People in this group often have difficulties accessing mental health services. The commissioners and

orientation	providers of Mental Health services need to recognise these issues and respond accordingly.
Gender (Men and women generally)	It is recognised that there is a gender imbalance in those experiencing mental health problems and in accessing services. The commissioners and providers of Mental Health services need to recognise these issues and respond accordingly.
Disability (with or without)	People in this group often have difficulties accessing mental health services. The commissioners and providers of Mental Health services need to recognise these issues and respond accordingly.
Dependants (with or without)	n/k

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) One of the aims of Service Frameworks is to ensure that health and social care services do not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status.		
Section 75 category	Details of policy impact	Level of impact? minor/major/none
Religious belief	n/a	

Political opinion	n/a	
Racial group	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and Key Performance Indicators (KPIs) for accessing services. It would be expected that accessing MH services, the quality of the information provided and therefore outcomes would be improved for people belonging to this group.	Minor
Age	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services. It would be expected that accessing MH services, the quality of the information provided and therefore outcomes would be improved for people belonging to this group.	Minor
Marital status	n/a	
Sexual orientation	The Framework aims to ensure that access to mental health services is improved for all users irrespective of	Minor

	Section 75 category. The Framework includes specific standards and KPIs for accessing services. It would be expected that accessing MH services, the quality of the information provided and therefore outcomes would be improved for people belonging to this group.	
Gender (Men and women generally)	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services. It would be expected that accessing MH services, the quality of the information provided and therefore outcomes would be improved for people belonging to this group.	Minor
Disability (with or without)	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services. It would be expected that accessing MH services, the quality of the information provided and therefore outcomes would be improved for people belonging to this group.	Minor

Dependants (with or without)	n/a	

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

Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		n/a
Political opinion		n/a
Racial group	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services.	
Age	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services.	
Marital status		n/a

Sexual orientation	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services.	
Gender (Men and women generally)	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services.	
Disability (with or without)	The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes specific standards and KPIs for accessing services.	
Dependants (with or without)		n/a

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? (minor/major/none)

Good relations category	Details of policy impact	Level of impact minor/major/none
Religious	N/A	None

belief		
Political opinion	N/A	None
Racial group	N/A	None

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		Not applicable
Political opinion		Not applicable
Racial group		Not applicable

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

The Framework aims to ensure that access to mental health services is improved for all users irrespective of Section 75 category. The Framework includes standards and KPIs for accessing services.

The impact on people with multiple identities is hard to assess, however, it would be expected that those in the more vulnerable groups (young people/LBGT; older people/ethnic backgrounds, etc) should benefit more from the implementation of the Service Framework, primarily through better communication and signposting.

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.

Responses to the consultation exercise will be analysed and the screening reassessed accordingly.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact	x	
Minor impact		Consider mitigation (3.4 – 3.5)
Major impact		

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in	
No - screened out	x

3.3 Please explain your reason for making your decision at 3.2.

One of the aims of Service Frameworks is to ensure that health and social care services do not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status. However it is acknowledged there are section 75 categories that have specific needs but as the health and social care services are available to everyone equally, no significant differential impacts have been identified.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is '**minor**' and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

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

Yes	
No	x

3.5 If you responded "Yes", please give the reasons to support your decision, together with the proposed changes/amendments or alternative policy.

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?

The Framework includes standards and Key Performance Indicators for all aspects of mental health services. Performance against the standards will be reported by the Trusts to the HSC Board. The HSCB, in turn, reports to the Department. Reports will be closely monitored by the Service Framework Programme Board throughout the three-year life-cycle of the framework.

The Reports are shared within the Department with relevant policy and professional leads. The views of the SFPB/Department are relayed back to Trusts via the HSCB so that improvements can be made, good practice shared and data collection problems resolved.

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

The “You in Mind” survey was run in 2015 and will be used to baseline some of the KPIs and to evidence some of the standards. As it provided qualitative data it would be expected that a similar survey – perhaps using 10,000 Voice – would be run towards the end of the Frameworks life-cycle to show evidence of progress. Quantitative data collection is hampered by the use of different IT systems across the five HSC Trusts, however, work is being undertaken to ensure that meaningful data is collected that is relevant to the KPIs. The SF Programme Board is expressed its desire to see KPIs monitored using robust data sources, such as self-assessment audit tools and case note reviews. The MHSF project team continue to work on resolving the data collection issues.

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 Framework aims to ensure that use of mental health services is improved for all users including those with a disability. Therefore it does promote positive attitudes towards disabled people within the HSC by recognising that they may have differing needs but also that mental health services are for all who need them.

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?

No

Part 6. Human Rights

6.1 Please complete the table below to indicate whether the policy / decision affects anyone's Human Rights?

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT = human right interfered with or restricted	NEUTRAL IMPACT
Article 2 – Right to life			✓
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment			✓
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			✓
Article 5 – Right to liberty & security of person			✓
Article 6 – Right to a fair & public trial within a reasonable time			✓
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			✓
Article 8 – Right to respect for private & family life, home and correspondence.			✓
Article 9 – Right to freedom of thought, conscience & religion			✓
Article 10 – Right to freedom of expression			✓
Article 11 – Right to freedom of assembly & association			✓
Article 12 – Right to marry & found a family			✓
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights			✓

1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			✓
1st protocol Article 2 – Right of access to education			✓

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

Not applicable

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).*

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.

N/A

Part 7 - Approval and authorisation

	Name	Grade	Date
Screening completed by	Mark Anderson/ Linda Greenlees	SO/ DP	26 October 2016
Approved by[1]	Fergal Bradley	G6	26 October 2016
Forwarded to E&HR Unit[2]	MA	SO	1 November 2016

Notes:

[1] The Screening Template should be approved by a senior manager responsible for the policy this would normally be at least Grade 7.

[2] When the Equality and Human Rights Unit receive a copy of the final screening it will be placed on the Department's website and will be accessible to the public from that point on. In addition, consultees who elect to receive it, will be issued with a quarterly listing all screenings completed during each three month period.