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

Equality Screening
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Mental Health Action Plan

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Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

Mental Health Action Plan

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

This is a new plan building on existing policy, strategy and broadly within existing resources. It is not intended to create new strategy.

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

The intended outcome is to improve the general mental health of people in Northern Ireland. For the Department of Health it is primarily about delivering good quality mental health services when they are needed and how people can be supported and mental health in the population as a whole can be promoted through prevention, early intervention and, where necessary, appropriate treatment and care.

Delivery partners include the Health and Social Care Board and Public Health Agency, the Health and Social Care Trusts, the Executive Office, Department of Justice, Department of Education, Department for Communities and voluntary and community sector organisations.

The Bamford Review was established by the Minister of Health, Social Services and Public Safety in October 2002. The Review focused on the existing provisions of the Mental Health (Northern Ireland) Order 1986, and directed that particular account be taken of issues relating to incapacity, human rights, discrimination and equality of opportunity.

The strategic context since Bamford has now changed and a new model for mental health policy in Northern Ireland is required. In New Decade, New Approach, commitments were made to a Mental Health Action Plan and to a Mental Health Strategy.

The Action Plan provides foundations for the Strategy, and is as such intended to be short lived, and provide basis for decisions and make immediate service improvements.

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

The impact screening exercise did not identify and adverse impact for any of the section 75 categories and did not identify any significant human rights impacts in the delivery plan. Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

Overall it is likely that the Action Plan will have a positive impact on section 75 groups, however, as noted above, each action will be screened appropriately before completed.

The proposed service developments that will be subject to further scrutiny includes a number of section 75 categories that might be expected to benefit from the intended policy. This includes age, gender, persons with disability and persons with dependents.

1.1.5 Who initiated or wrote the policy?

Mental Health and Capacity Unit in the Mental Health, Older People and Disability Directorate, Department of Health.

1.1.6 Who owns and who implements the policy?

Mental Health and Capacity Unit in the Mental Health, Older People and disability Directorate owns the Plan.

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

Financial	x	Some actions in the plan may require resourcing. Some of the actions may be costs neutral or have low or no costs.
Legislative	x	Other actions may require a change to legislation in order to implement them. As such, their timescales will be subject to the NI Assembly legislative process.
Other	x	Some actions require support by Executive colleagues and as such are subject to political uncertainties.

1.3 Main stakeholders affected

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

Staff	x
Service users	x
Other public sector organisations	x
Voluntary/community/trade unions	x
Other, please specify	

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

Policy	Owner(s) of the policy
Mental Health Strategy	DoH
NICS ODP	NICS

1.5 Available evidence

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

It is estimated that **one in four people** will suffer from a medically identified mental illness during their lifetime. Mental ill-health costs an estimated 3-4% of GDP, mainly through loss of productivity, cost of healthcare and social security benefits.

The 12-item General Health Questionnaire (GHQ-12) is a widely used and validated measure of mental health. It is used to detect psychiatric disorder in the general population and within community or non-psychiatric clinical settings such as primary care or general medical out-patients. It assesses the respondent's current state and asks if that differs from his or her usual state. GHQ-12 has been used consistently since 2010/11 in the Health Survey Northern Ireland (HSNI). A score of 4 or more on GHQ-12 indicates possible psychological disturbance or mental ill health.

Between 2010/11 and 2014/15, there was no real change in the proportion of the population that scored 4 or more on the GHQ-12.

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, on the basis of clinical need, 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, on the basis of clinical need, 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 in 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). Although is expected that the number of people born outside of the Northern Ireland has increased significantly since the 2011 census, as **health and social care services are available to everyone equally, on the basis of clinical need, no differential impact** on the grounds of racial group has been identified. There is little data on how different ethnic groups have different rates and experiences of mental health problems Northern Ireland. However, figure from England and Wales show that people from black and ethnic minority groups are more likely to be diagnosed with mental health problems, are • more likely to be diagnosed with mental ill health; • more likely to be admitted to hospital for mental health reasons; and • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health These differences may be explained by a number of factors, including poverty and racism. It is important to note that these facts do not show

	direct correlation and that there may be other underlying reasons (such as social deprivation) as to why black and ethnic minority groups are more likely to suffer from mental ill health. It is also important to note that the racial profile of Northern Ireland is significantly different than in England and Wales meaning that the facts there may not be relevant here. Mental health services in NI do not collect data on ethnic background. There are clear indication that Travellers are significantly more likely to suffer from mental ill health. Travellers are also less likely to access services meaning that the effect of mental ill health is likely to be greater. This is a factor that must be considered when implementing each action in the Action Plan to ensure that the existing barriers are considered to ensure equal access.
Age	The North'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 NI 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 NI 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 NI 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). Each action in the Action Plan will have to consider how the impact will be on age groups. As some actions are targeted at particular groups (such as transitions between CAMHS and adult services, and adult services and old age psychiatry) these will have a disproportionately positive impact. Overall, the Action Plan does not provide any negative impact based on age.
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.
Sexual orientation	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. Figures published by the Office of National Statistics in 2010 recorded that 0.9% of the UK population identified themselves as gay or lesbian, while a further 0.5% identified themselves as bisexual (Measuring Sexual Identity: An Evaluation Report). It is likely that the true figures are significantly higher. 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). It is accepted that trans people are likely to suffer from systemic barriers in which will have a detrimental impact on their mental health. The suicide rate among trans people are significantly above national average, considering age group, education and employment status. Improvement in mental health services will have to consider how barriers can be reduced and how LGBT+ specific issues can be addressed. The Action Plan provides the high level outline of actions and each project in the Action Plan will require individual consideration on how to ensure no detrimental impact to LGBT+ people.

	No negative impact based on sexual orientation has been identified in the Action Plan.
Gender (Men and women generally)	The 2011 Census data showed that 49% of all usual residents in Northern Ireland are male, with 51% of the population female. In addition a small number identify as neither male or female or both. **Compulsory admission** to hospital for assessment of a mental disorder is evenly shared between men and women, with 50.5% of the admissions being women and 49.5% being men. No significant inequality is therefore present in these circumstances. There is no data, or the numbers are too small to have a statistical impact, for those who are neither identifying as male nor female. It is estimated that **eating disorders** affect about 1% of the population. It is estimated that approximately 1 in 250 women and 1 in 2,000 men will experience anorexia nervosa at some point in their lives meaning that this will affect women at a significantly higher rate than men. About 10% of people diagnosed as having an eating disorder are men. However, these conditions often go undetected in male sufferers. Many men find it hard to ask for help, particularly when the doctor or counsellor does not recognise their symptoms. There are also a high proportion of treatment resistant cases within this client group, which can result in a high cost of treatment. **Perinatal mental health** disorders occur in up to 15% of all pregnancies. Given that there are approximately 25,000 births in Northern 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 (positive) 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). Mental illness can be classed as a disability. However, considering that the Action Plan provides for those with a mental illness, or proposes actions to prevent mental illness, there is **no direct differential impact** on the grounds of disability.
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. 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

Any specific needs, experiences and priorities for individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

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	There are evidence from other jurisdictions in the UK that BME groups are more likely to suffer from mental ill health and indications from NI that Travellers are more likely to be impacted by mental illness. This indicate that there are specific issues that must be considered when developing each action in the Action Plan.
Age	It is acknowledged that the existing framework relating to **children** is complex, encapsulating legislation such as the Children (NI) Order 1995, Mental Health (NI) Order 1986 and the Age of Majority Act, case law such as *Gillick* and the inherent jurisdiction of the court. However, at this stage no specific needs, experiences and priorities have been identified in relation to young persons it is expected these will be identified at a later date during the implementation of the actions in the plan. **Eating disorders** usually has its onset in younger age and affect younger people to a greater extent. The priorities and needs are therefore higher among younger persons than among older persons. No direct differential impact has been identified in respect of **older persons**. However, fully implementing the **Mental Capacity Act** may indirectly affect more older people as the rate of dementia and other causes of loss of capacity are disproportionate among older people than in the population in large.

Marital status	Even though unmarried men are more likely to commit suicide there is **no differential impact** on the priorities and needs in relation to **marital status**.
Sexual orientation	There are indications that LGBT+ people are more likely to suffer from mental ill health. There are a number of reasons for this, including social factors and societal barriers. When each action in the Action Plan is implemented, the need of LGBT+ people must be considered, to ensure that the barriers are not a hindrance for inclusion. Some actions may need to include specific LGBT+ aspects (for example training in primary care), however, this is for implementation of each action to consider.
Gender (Men and women generally)	**Eating disorders** disproportionately affect more women than men. However, the disorders are often undetected among men and therefore represent a disproportionate cost to the health service. Development of policies, projects and service developments in the field of eating disorders will be informed by the facts and may as such be tailored towards its target group. Given the significant impact on perinatal mental health disorder on society as a large, and the mental wellbeing of the population this indicator will continue to develop policy, projects and service developments to further the work on **perinatal mental health** services. However, at the plan level no specific needs, experiences and priorities have not been identified in relation to gender.
Disability (with or without)	No evidence of specific need has been identified.
Dependants (with or without)	No evidence of specific needs have been identified. See also above in gender in relation to perinatal mental health disorder.

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)		
Section 75 category	**Details of policy impact**	**Level of impact? minor/major/none**
Religious belief	None expected	None
Political opinion	None expected	None
Racial group	None expected	None
Age	The plan is not expected to have any, or only very minor, impact on this section 75 category. However, policies, projects and service developments to support the plan may have an impact on this category. The plan notes work on implementing the Mental Capacity Act, developing eating disorder service provisions and developing a support scheme for looked after children. These may have an indirect differential impact on this section 75 category. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	Minor (positive)
Marital status	None expected	None

Sexual orientation	LGBT+ barriers and specific action areas are to be considered in implementing actions which may have a positive impact on (in particular) access to mental health services.	Minor (positive)
Gender (Men and women generally)	The plan is not expected to have any, or only very minor, impact on this section 75 category. However, policies, projects and service developments to support the plan may have an impact on this category. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	Minor
Disability (with or without)	The plan is not expected to have any, or only very minor, impact on this section 75 category. However, policies, projects and service developments to support the plan have an impact on this category. The plan is aimed to improve the mental well being of the population. This will affect those with mental disabilities to a higher extent than those without. However, it is expected that this would be a positive impact and no differential impact can be identified at the time of the delivery plan development. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	Minor

Dependants (with or without)	The plan is not expected to have any impact on this section 75 category. However, policies, projects and service developments to support the plan may have an impact on this category. Individual policies, projects and service developments may have a major impact and individual impact screenings will be carried out at policy, project and service development level.	None

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		No. This is the best way we know of levelling the playing field for everyone. The plan in itself is not expected to have any negative impact on any section 75 category. The individual policies, projects or service developments may have an impact, however, this is expected to be a positive impact. The positive impacts are related to age, gender, disability, sexual orientation and dependents as noted above. Individual policies, projects and service developments may have a major impact and individual impact screenings will be carried out at policy,
Political opinion		
Racial group		
Age		
Marital status		
Sexual orientation		
Gender (Men and women generally)		

Disability (with or without)		project and service development level.
Dependants (with or without)		

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 belief	No expected impact on good relations	None
Political opinion	No expected impact on good relations	None
Racial group	No expected impact on good relations	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		No. The plan offers limited potential to promote good relations between people of different religious belief as the

		main aim is to increase the mental well being of the population.
Political opinion		No. The plan offers limited potential to promote good relations between people of different political opinion as the main aim is to increase the mental wellbeing of the population.
Racial group		No. The plan offers limited potential to promote good relations between people of different racial group as the main aim is to increase the mental wellbeing of the population.

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.

There are no anticipated differential impacts on people with multiple identities.

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 adverse impacts have been identified in relation to the plan. It will be developed in consultation with key stakeholders to address areas where policies, projects and service developments could help increase the mental well being of the general population and will be coproduced.

The plan was not changed to address any adverse impacts and further work identifying any potential adverse impact will be carried out on the individual policies, projects and service developments when appropriate and applicable to do so.

Part 3. Screening decision

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

No impact		
Minor impact	x	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.

The intention of the plan is to provide a high level framework for future policies, projects and service developments.

The impact screening exercise did not identify any adverse or positive impact for any of the section 75 categories and did not identify any major human rights impacts in the delivery plan. Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

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.

The impact is expected to be minor positive.

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 implementation of the plan will be monitored by the Department, in discussion with the Health and Social Care Board and key stakeholders who have a vested interest in this Action Plan. The plan will also be subject to evaluation to ensure it achieves its intended outcomes. Policies, projects and service developments identified for implementation under the delivery plan will be evaluated for their success using an outcomes-focused approach. In addition to the core measure, a range of HSC measurements systems will be used to determine effectiveness as well as linking in with the measurement systems of other Departments.

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

The Department has access to a significant range of data which will enable us to monitor the effects of the implementation and outcomes of individual policies, projects and service developments. The Department publishes the results from annual surveys and can disaggregate this information as required. In addition the Health and Social Care Board also provides half yearly statistics to the Department from the Trusts on delegated statutory functions, which are used to inform policy. As individual policies, projects and service developments are evolved appropriate data will be identified to effectively monitor the outcomes.

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 main aim of the plan is to improve mental health of the general population. This includes reducing the stigma for persons with mental disabilities and encouraging their participation in public life.

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 Does the policy / decision affect anyone's Human Rights?

The impact screening exercise did not identify any major positive or negative human rights impacts in the delivery plan. Individual policies, projects and service developments will likely have a human rights impact, in particular positive impact as the overall objective is to increase the mental well being of the population.

Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT	NEUTRAL IMPACT
Article 2 – Right to life			x
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	X (minor)		
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			x
Article 5 – Right to liberty & security of person	X (minor)		
Article 6 – Right to a fair & public trial within a reasonable time			x
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			x
Article 8 – Right to respect for private & family life, home and correspondence.	X (minor)		
Article 9 – Right to freedom of thought, conscience & religion			x
Article 10 – Right to freedom of expression			x
Article 11 – Right to freedom of assembly & association			x
Article 12 – Right to marry & found a family			x
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights			x
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			x
1st protocol Article 2 – Right of access to education			x

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.

Not applicable.

Part 7 - Approval and authorisation

	Name	**Grade**	**Date**
Screened completed by:	Christine Dale	SO	7 Nov 2019
Approved by[1]	Tomas Adell	G7	18 May 2020
Forwarded to E&HR Unit[2]			

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.