Equality and Human Rights Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

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

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

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

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SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template .

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

'Supporting the best start in life' Infant Mental Health Framework (IMHF) and Action Plan 2015-2018
Promoting positive social and emotional development from pre-birth to 3 years

1.2 Description of policy or decision

This IMHF and Action Plan represents a commitment by the Public Health Agency, HSCB and Trusts, as well as academic, research, voluntary and community organisations across NI, to improve interventions from the ante-natal period through to children aged 3 years old.

Framework Vision:

...that all children have the best start in life.

Through the key priority areas of this action plan, the following key objectives will be achieved**:**

- Parents and practitioners understand the importance of attachment and the essential elements of positive social and emotional health in infants.
- Parents and practitioners have skills to engage positively with infants to maximise their social and emotional development.
- Practitioners and parents are able to respond to predictors of vulnerability in infants and families and identify early signs of delayed social and emotional development in infants and /or emotional distress.
- Appropriate services are in place and available to respond to identified infant mental health and wellbeing needs across the region, on an equal basis for all.

The Plan has 3 key themes and outlines commitments to action on:

- **Promoting and disseminating evidence and research** on Infant Mental Health to policy makers, practitioners and the wider population. Mental Health is everyone's business; consequently all organisations across all sectors, including all NI Government's Departments should be in a position to consider and act on the compelling findings and implications.
- **Informing workforce development** to ensure frontline staff have the necessary knowledge and skills to assess risks to the mental health of infants by early identification

of factors associated with parent-infant interaction.

- **Service development** to ensure that universal and targeted services can respond as effectively as possible to maximise the optimal development of newborns and infants**,** particularly taking account of newborns facing the highest levels of risk and adversity**.** Given that infant mental health is fundamentally connected to the physical and mental health and wellbeing of the primary caregiver, as well as their ability to parent, service development is as relevant for those providing adult services as it is for children's services. Ideally there should be an increase in interventions that focus on supporting the parent –infant relationship where the parent faces challenges to their own emotional well-being.

Key Constraints

Timeframe: this framework is time-bound and covers the period 2015-2018. Many of the recommended actions around practitioner training are for a fixed period due to funding constraints.

Resources: Number of available training places are limited by available funding however opportunities have been disseminated equally across the Trusts initially via the Director of Children's Services to ensure equitable opportunity for relevant practitioners.

1.3 Main stakeholders affected (internal and external)

A range of stakeholders are affected by the IMHF. These include:

- Children aged 0-3 years and their parents/carers
- Public Health Agency commissioners & policy makers
- Health & Social Care Board commissioners & policy makers
- Health and Social Care Trust commissioners and policy makers
- Commissioners and policy makers within key government departments
- Practitioners across a range of health, education and social care services, including HSCB, Health & Social Care Trusts, voluntary and community sector. Targeted practitioners include Social Workers, Nurses, Health Visitors, Early Years practitioners, GPs, Psychologists, Psychiatrists and other mental health practitioners.

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

Early child development and the importance of infant mental health has a bearing across a range of policies and strategies in Northern Ireland. There is a strong emphasis in current Northern Ireland policy on early intervention to support children, young people and families, especially those at risk of poor outcomes before their difficulties become more complex and established. The United Nations Convention on the Rights of the Child (UNCRC) also places a duty on States to ensure that children and young people are supported during childhood in order to attain the highest standard of health and wellbeing and to respond robustly where factors may be impacting on children's welfare. Infant Mental Health is particularly important in

the pre-birth to 3 years of age therefore crosses over with the maternity care and support as well as with antenatal, early health and education services. There are a number of regional strategies that include Early Intervention being developed by a cross section of Government Departments, including:

- Department of Education - Every School a Good School(2009); Extended Schools; Learning to Learn; Traveller Child in Education Framework; Newcomer Policy & Priorities for Youth.
- Department of Health Social Services and Public (2012) A strategy for maternity care in Northern Ireland 2012-2018
- Department of Health , Social Services and Public Safety, 2012.Protect Life: A Shared vision. The Northern Ireland Suicide Prevention Strategy 2012-2014. (in revision)
- Department of Health, Social Services & Public Safety (2005) A Healthier Future: 20 year Vision for Health & Wellbeing in NI 2005-2025-Regional Strategy.
- Department of Health, Social Services & Public Safety (2007) The Bamford review of mental health and learning disability NI
- Department of Health, Social Services & Public Safety (2009) Families Matter, Regional Family and Parenting Strategy
- Department of Health, Social Services & Public Safety (2012) Child and adolescent mental health services: A service model
- Department of Health, Social Services & Public Safety (2013) Breastfeeding - A Great Start: A strategy for NI 2013-2023
- Department of Health Social Services and Public Safety – Hidden Harm Action Plan
- Department of Health Social Services and Public Safety - Making Life Better (2014)
- Department of Health Social Services and Public Safety - Healthy Child Healthy Future (2010)
- Department of Health Social Services and Public Safety – Regional Strategy for Tackling Domestic Violence.
- Department of Justice - Framework for the Prevention of Offending. Community Safety Strategy (2012 – 2017)
- Department of Social Development - People and Place – A Strategy for Neighbourhood Renewal
- Office of First Minister and Deputy First Minister- Our Children and Young People, Our Pledge (2006 – 2016)
- New Strategic Direction on Drugs and Alcohol (2011 – 2016)

In addition to the Infant Mental Health Framework, input has been provided to the forthcoming revised ‘Protect Life: Positive Mental health and suicide prevention strategy’, hence ensuring a preventative approach to suicide prevention and a consistent approach to infant mental health.

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

The draft IMHF has been developed by the Public Health Agency with support from an expert advisory group, hosted by the National Children's Bureau NI and made up of stakeholders from across the health and social care sector, both voluntary and community. The Advisory Group met regularly and has had extensive input to the drafting process. Members of the Advisory Group were drawn from a wide range of services representing a cross-section of the population, encompassing all section 75 groups. This included Mencap who advocated and represented perspectives of children with learning disabilities in addition engagement has involved a range of activities, including:

Stakeholder Engagement

In addition to the expert advisory group, engagement with stakeholders has included:

- **Phase 1 (June 2012) and phase 2 (Sept 2013)** audits of current infant mental health training and resources ongoing in Northern Ireland. These were undertaken with key policy makers, practitioners and researchers from the statutory, community, voluntary and academic sectors.
- **Gaps analysis review** of existing resources (completed by a range of policy makers, practitioners, researchers and academics)
- **Seminars and practice sharing sessions:** Since June 2010 numerous seminars have been organised in order to share good practice and provide feedback on the progress made towards the development of this 3-year IMHF and Action Plan for Infant Mental Health. Key speakers at these events included Suzanne Zeedyk, George Hosking, Dr Bruce Perry, Dr Ian Manion and Professor Terence Stephenson. These seminars were attended by over 500 different delegates from across the statutory, community, voluntary and academic sectors. An outline draft was presented to a workshop of over 150 people and their comments have been incorporated in this Framework.
- **Case study visit to Finland** - In September 2013 a delegation of 25 policy makers, commissioners and high-level practitioners participated in a case study visit to Finland. The primary aim of the visit was to increase knowledge on the early education and early years sector in Finland in order to inform the infant mental health agenda and parenting support in Northern Ireland.

Evidence Review

A review of the existing evidence around early child development and the importance of infant mental health was undertaken by National Children's Bureau (NCB NI) to inform the background to the Framework. In addition, the current policy and practice context was reviewed to ascertain the good work already in place, avoid duplication and ensure the IMHF compliments the current Northern Ireland context. No issues particularly relevant to section 75 groups were highlighted during this review.

All consultation events were advertised widely across a range of groups, venues were chosen

to ensure all were accessible for all members of the population. In completing this equality screening exercise, data was sourced across a range of resources including the DHSSPS, DE and NISRA.

Due cognisance was given throughout to the UNCRC and the UN Convention on the Rights of Persons with a Disability.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

While the IMHF is aimed at parents, policy makers, commissioners, academics and practitioners from the community, voluntary and statutory sectors the main group who will be impacted by the actions are children aged 0-3.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	The Northern Ireland Census 2011[1] shows in the general population the proportion of females in 2011 was 51%, the male population was 49%. This same breakdown is reflected in 0-3 year olds Data consulted on Children in Need in Northern Ireland (HSCB figures March 2014) indicated that there were a total of 25, 998 children in need. There were 1,3752 (52.9%) males & 1,2246 (47.1%) females. There were a total of 764 children 0-4 years on the Child Protection Register 388 male (51%) & 374 female (49%) Health professional working in this field are predominantly female (DHSSPS workforce data)
Age	The target group are children aged 0-3 and their parents/carers. The Northern Ireland Census 2011 shows the total population in Northern Ireland as 1,829,725[2] with the breakdown in ages listed below Less than 1 year = 25,250 (6%) 1 - 4 years = 99,132 (23%) 5 - 11 years = 156,740 (36%) 12 – 15 years = 98,201 (23%) 16-17 years = 51,440 (12.%) NI population 0-3 years is 100,994 which represents 5.5% of the total population and 23.4% of the child population from 0-17 years The breakdown in births in NI in 2013 is listed below • 24,279 births • 937 (3.9%) births to teenage mothers under 20 years

[1] Statistical Bulletin: Census 2011: Detailed Characteristics for Northern Ireland on Ethnicity, Country of Birth and Language. Published: 28 June 2013.

	Data consulted on Children in Need in Northern Ireland (HSCB figures March 2014) indicated that there were a total of 25, 998 children in need. This data indicates that 24.7% of children in need are in the 0-4 year age range as detailed below • Age 0- 4 y = 6,431 (24.7%) • Age 5 – 11 = 10,066 (38.7%) • Age 12 – 15 = 6,044 (23.3%) • Age 16+ = 3,201 (13.3%) There were a total of 764 children on the children 0-4 years on the Child Protection Register (HSCB figures March 2014). These figures are consistent with data collated from Family Support Hubs[3] showing a profile of the age groups of children and young people referred for Tier Two support. Analysis of this data indicates that 30% of children referred are in the 0-4 year age range as detailed below. • 30% - 0-4 Years • 42% - 5-10 Years • 23% - 11-16 Years • 5% - 16 Years and over
Religion	The Census 2011 shows that for the general population, religious breakdown is: • 45% Catholic • 36% Protestant • 11% No religion • 7% Religion not stated • 0.7% Other religion No further breakdown by smaller age groups available and not particularly relevant to this framework.
Political Opinion	The political opinion of the affected population of children (aged 0-3) or their parents or carers is not known as tis information has not been collated. There may be an issue in relation to paramilitaries is specific areas cognisance will be taken of this.
Marital Status	Not relevant to the affected population of children (age 0-3) The Northern Ireland Census 2011 shows almost half (48%) of people aged 16 years and over on Census Day 2011 were married, and over a third (38%) were single. Just over 1,200 people (0.1%) were in registered same-sex civil partnerships in March 2011. A further 9.4% of usual residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8% were either widowed or a surviving partner.
Dependent Status	The Northern Ireland Census 2011 indicates out of a total of 703,275 households the breakdown is outlined below Married or in a registered same-sex civil partnership:

[3] 2014 Second Quarterly Family Support Hub Monitoring Report (April – June 2014)

	With no children = 10.28% With dependent children = 19.72% Children non-dependent = 8.31% Co-habiting couple: With no children = 2.92% With dependent children = 2.3% All children non-dependent = 0.26% Lone Parent: With dependent children = 9.13% All children non-dependent = 5.12% Other household types: With dependent children = 2.7% In summary, in 2011, one-third (34%) of households contained dependent children. Out of those with dependent children • 64% - married or in a registered same-sex civil partnership • 7% - co-habiting couple • 29% - lone parents A review of data from the Family Support Hubs[4] of the household composition of children and young people referred for Tier Two support is outlined below • Home both parents 45% • Home one parent 39% • Home one parent & partner 12% • Kinship/carer 0.6% • Other 3.3% Analysis of the data would suggest that the number of lone parents being referred for early intervention is higher than that within the total population.
Disability	It is broadly acknowledged that there is a limited amount of research and data about children with disabilities in Northern Ireland. Northern Ireland 2011 Census data which indicates that 5.6% of children 0-15 years had a long term illness or disability & 9.9% of the total population of 16 – 44 year olds are recorded as having a long term illness or disability. Specific information for children 0-3 years is not currently available and is reflective of a wider need for research and data on children with a disability. It is estimated that 10-15% of women experience postnatal depression however research has shown that it often goes unreported and could be much higher than this (Royal College of Psychiatrists, 2011). Approximately 2000 (8.2%) of babies are born prematurely per year in NI (NISRA, 2013). This report also indicates that 1.1% of births less than 1,500g in weight – of those births 24% are to mothers living in the most deprived areas.

[4] 2014 Second Quarterly Family Support Hub Monitoring Report (April – June 2014)

Ethnicity	The 2011 Census only provides details on the ethnic breakdown of the wider population in Northern Ireland. 1.8% of people were recorded as belonging to a minority ethnic group. The Northern Ireland 2011 Census provides details on the ethnic make-up of the wider population in Northern Ireland. Statistical analysis of the census data found that 98% of the people usually resident in Northern Ireland were white, with the remaining 2% split between people from Asian, Black, Mixed or Other ethnicity. In 2011, the local government district with the highest proportions of people born in EU accession countries were Dungannon (6.8%), Craigavon (4.2%), Newry & Mourne (3.5%), Armagh (3.2%) and Ballymena (3.1%). At 2.6%, Dungannon also had one of the highest prevalence rates for people born outside the EU, along with Belfast (3.7%), Castlereagh (2.8%) and North Down (2.6%). North Down has the highest rate of people born elsewhere in the UK (8.5%), while Fermanagh had the highest rate for those born in the Republic of Ireland (6.7%) A review of data from the Family Support Hubs[5] provides a profile of the ethnicity of children and young people referred for Tier Two Support as outlined below • 84% White • 10% Unknown • 2.1% Eastern European • 1.2% Mixed Ethnicity • 0.7% Asian • 0.5% Irish Traveller • 0.2% Portuguese • 0.1% Pakistani • 0.1% Indian • 0.1% Black African This data indicates that in cases where ethnicity is known 5% of referrals were for children and young people from minority ethnic groups. The Northern Ireland 2011 census data indicates 1.8% of the usual resident population belong to ethnic minority groups. This data suggests that there is a higher referral rate for early intervention from ethnic minorities in comparison to the total population.
Sexual Orientation	Not relevant to the affected population of children (aged 0-3) There is no Northern Ireland census data on sexual orientation for this age group. There is some data available for the UK as a whole. In 2010, the Office of National Statistics (ONS) published the report 'Measuring Sexual Identity: An Evaluation Report, based on the data generated by the Integrated Household Survey (IHS).This evaluation found that 1.4% of the population in the UK identify as lesbian, gay or bisexual. (the report does not cover

[5] 2014 Second Quarterly Family Support Hub Monitoring Report (April – June 2014)

	transgendered people). For N.I. specifically, this figure was 0.9%

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.
The Infant Mental Health Framework makes recommendations for practitioners working with children aged 0-4 years and their families

Category	***Needs and Experiences***
Gender	This Infant Mental Health Framework includes all children within the target population (0-3 years) and their parents/carers equally and on an individualised basis. Information provided will be gender appropriate and accessible.
Age	The project targets children and young people 0-3 years of age and their parents and carers. There is a clear difference in the age profile of mothers by deprivation. In 2012/13, 37% of all mothers aged less than 24 years of age were from the most deprived areas. In comparison, 7% of mothers in this age group were from least deprived areas in 2012/13. 3.9% of births in 2012/13 were to teenage mothers under 20 years. In relation to age of parents, there is a widely held view that children born to teenage and young parents are more likely to have a range of poorer outcomes when compared to children of older mothers (Bunting and McAuley, 2004). The reasons, it is argued, are two-fold. Firstly, women who give birth whilst young are more likely to have pre-existing problems that both hinder their ability to parent as well as impacting directly on the children. For example, there are a higher proportion of young mothers from socially deprived and lone parent households (Lopez Turley, 2003). Secondly, as a result of giving birth at a young age, these mothers are less likely to have completed their education, to have married or to have secured a well-paid job, these factors in turn increasing the overall number of children she is likely to have. Domestic Violence (DV) affects people of every class, age, race, disability and sexuality (NSPCC, 2009). DV is not restricted to physical violence but sometimes it is more subtle and also involves psychological, verbal, sexual, financial and emotional abuse. Children are very much the silent victims of domestic violence. They may witness it or be subject to it but often their voices are not heard. Although most incidents of DV are reported by an adult, it is important to note that violence in the family cannot be kept hidden from the children. Children will often witness the violence, be aware of the tense atmosphere,

	suffer as a victim themselves or suffer in the aftermath of the violence (Women's Aid, 2009). Exposure to DV can have very damaging long-term effects on a child's mental health, sense of identity and ability to form relationships. Research highlights that the effects of DV are amplified for pre-schoolers, who are completely dependent on parents for all aspects of their care and may therefore witness greater amounts of violence than older children.
Religion	The IMHF addresses all children and their parents/carers equally and on an individualised basis. Cognisance will need to be given to choice of location and access routes for interventions e.g. parenting programmes to ensure children' young people and families feel safe both attending and accessing the associated programmes as recommended within the IMHF.
Political Opinion	While there are no specific needs, or priorities in this area, cognisance will need to be given to the political sensitivities that may exist within the local areas. The political opinion of the affected population of children & parents/carers is not known as it has not been collated. Dependent on location of services there may be an issue in relation to paramilitaries in specific areas cognisance will need to be taken of this.
Marital Status	The marital status of the affected population of the parents/carers of the children within the target population (0-3 years) is not known or collated. Cognisance will be given to the needs of single parents as these may differ from couples a flexible service will be required to meet the needs of single parents.
Dependent Status	The dependent status of the population of parents/carers of the children within the target population (0-4 years) is not known or collated at this time.
Disability	In relation to service provision there will be a percentage of children (0-3 years) and their parents/carers who may have a disability, this may be declared or apparent, it may be identified later or it may not be identified at all. Disability, like any other individual issue, will be addressed by practitioners on the basis of that individual's needs and wishes. Children (0-3years) and/or their parents/carers with disabilities may experience communication difficulties, they may have particular needs regarding both communication and information.
Ethnicity	Children 0-3 years and their parents/carers from ethnic minorities may have particular needs in relation to cultural and communication needs. They may experience language barriers and may have particular needs regarding accessible communication and information including the provision of translated information as well as interpreting services and they sometimes rely on children and young people to interpret. Experience in working with families from ethnic minorities is that language and culture often act as a barrier to getting families to engage with services;

	in addition some groups e.g. Roma Community and Asylum Seekers do not engage as they tend to be suspicious of services which can be caused by a lack of understanding of the health and social care system within Northern Ireland.. Some BME families live in cramped, poor conditions sometimes in unsafe areas. It has been reported that some BME families are indirectly limited in their choice of housing and are often allocated housing in certain areas or are excluded from others. Traveller support workers have identified gaps in relation to children aged 2 to 4 in respect of identifying particular needs, such as speech and language, behavioural disorders, immunisation uptake and developmental delay. This impacts in relation to support for children being ready for school (Southern Area Outcome Monitoring Report 10/11) DV happens in all societies however, it would appear that it is more acceptable and prevalent within the Traveller community. Traveller Support Workers in the Southern Trust are aware of incidents of DV not only through the victims of the abuse but also from other health agencies –including staff at A&E who follow up on some incidents. DV is linked to Drug and Alcohol abuse and impacts on Mental Health (Southern Area Outcome Monitoring Report 10/11)
Sexual Orientation	This programme addresses all children and their parents/carers equally and on an individualised basis. Children of same sex couples may have particular needs.

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

The IMHF acknowledges the cross cutting needs of the equality groupings. It recognises the need to take into account geographical differences and issues facing people who live in areas of high deprivations.

The 20% of most deprived areas in Northern Ireland represent nearly 340,000 people. groups with the highest poverty risk are: Ethnic minorities and migrant workers; Travellers; young people, especially aged 16-18, lone parent families; families of ex-prisoners; people with low or no educational qualifications; long term unemployed; people living in disadvantaged communities; people living in border areas. (Northern Ireland Anti-Poverty Network). Many of these groups themselves and / or their children who experience poverty, especially persistently, are at higher risk of encountering difficulties for example, health problems, developmental delays and behaviour disorders and they are also more likely to fall into low income themselves in adulthood (Kornberger et al. 2001, Finnie and Bernard 2004).

The research findings in relation to the importance of early intervention are unambiguous:

poor nutrition, maternal and family stress, and poverty, affect brain development from the prenatal period or earlier. There is considerable evidence of the negative impact of neglect on the developing brain. Major studies, such as the ACE Study (Felitti & Anda, 1997) conclude that adverse childhood experiences have a profound, proportionate and long lasting effect on well-being. The research evidence is summarised in the UNICEF (2010) report 'The Children Left Behind'. The task of redressing the impacts of disadvantage in childhood will take at least the life span of a generation to achieve – a central theme is preparation of parents who will raise the next generation of children.

The underlying premise of Early Years Intervention is that by intervening earlier, children are more likely to develop into socially and emotionally capable people who are more productive, better educated, tax-paying citizens that help the economy compete globally and make fewer demands on public expenditure.

The OFMDFM Strategy for Children and Young People in Northern Ireland (2006-2016) is also underpinned by a commitment to prevention and early intervention. The strategy states that this should not be construed solely as the need for intervention at a point which prevents a problem worsening or a situation developing further. The aim is "to improve the quality of life, life chances".

2.5 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The IMHF vision is that all children have the best start in life Key Objectives of the IMHF are • Parents and practitioners understand the importance of attachment and the essential elements of positive social and emotional health in infants. • Parents and practitioners have skills to engage positively with infants to maximise their social and emotional development. • Practitioners and parents are able to respond to predictors of vulnerability in infants and families and identify early signs of delayed social and emotional development in infants and /or emotional distress. • Appropriate services are in place and available to respond to identified infant mental health and wellbeing needs	• The equality screen has identified equality issues that need to be taken into account by the IMHF. • Methods of communication will be developed to meet particular needs of Section 75 groupings e.g. key publications available in a number of formats e.g. translated into languages, use of plain English, easy read & pictures and diagrams. • The PHA through the Infant Mental Health Implementation Group (IMHIG) will seek feedback from all organisations in relation to gaps in service provision and unmet need and communicate this information to the relevant commissioners. • Communication links will be developed with parenting networks to ensure parental engagement on

across the region, on an equal basis for all. The IMHF development included • Input from the Public Health Agency (PHA), Health & Social Care Board & Health and Social Care Trusts as well as academic, research, and voluntary and community organisations across Northern Ireland to ensure it reflected the effectiveness of what will be done by all organisations to improve interventions from the perinatal and antenatal period through to children 3 years of age. • Input to the IMHF was sought from a range of organisations including Mencap, NSPCC, Beacon (NIAMH), Lifestart Foundation &Tinylife to help ensure the views of children and families within section 75 categories were represented. • The PHA are keen to ensure that other bodies working on Infant Mental Health take into account specific needs and experiences of children and families within each of the section 75 categories. • Workforce development is a key theme within the IMHF through which key tasks have been set in relation to professional development to ensure staff develop professional expertise to work effectively with the diverse needs of children and families.	perspectives on Infant Mental Health and ensure views of Section 75 groupings are sought.

2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	***Impact***	***Suggestions***
Religion	None	
Political Opinion	None	

Ethnicity	None	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	x
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	**x**

The IMHF sets out the key priorities areas for the next three years for Infant Mental Health. An IMHIG will be established to ensure each of the key tasks identified within the action plan are taken forward.

As each task is taken forward equality issues will be reviewed and addressed as appropriate. It is recognised that some of the key tasks will impact on groups within each Section 75 category more than others the IMHIG will carefully monitor this and recommend action by the member agencies.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
Not specifically the IMHF and this equality screen recognise that children and parents/carers with disabilities have particular needs. The IMHIG will play a critical role in working with all agencies and services and encourage them to become involved in user, reference and advisory groups as appropriate.	The IMHG will be established for the for the 3 year period of the IMHF representation on the group will be sought from a range of organisations such as Mencap, Disability Action, Bryson House, , to ensure the views of families within Section 75 categories are represented.

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
Not Applicable	Not Applicable

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

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

*If you have answered no to all of the above please move on to **Question 6** on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

The objective of the IMHF is to support families with newborns and infants and to optimise interventions aimed at reducing the negative impact of adverse childhood experiences for 0-3 years olds at a critical period of development which has been shown to have considerable implications for later life outcomes.

The IMHF will take into account the views of children and the important role played by parents/carers in safeguarding children and promoting their welfare. Engagement will be open and transparent, proportionate and consistent. The IMHF treats all children equally, taking account of the particular vulnerabilities of some groups of children to abuse and neglect, such as those with disabilities. Account will also be taken of the communities in which children live and religious, cultural and ethnicity factors, all of which can impact on children‟s safeguarding and welfare needs.

The IMHF will take cognisance of the Convention on the Rights of Persons with Disabilities. Of particular relevance for the IMH Plan is Article - Children with disabilities. The basis of this Article is that Governments agree to take every possible

action so that children with disabilities can enjoy all human rights and freedoms equally with other children. They also agree to make sure that children with disabilities can express their views freely on all things that affect them. What is best for each child should always be considered first.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

Equality & Good Relations	Disability Duties	Human Rights
• On-going monitoring of data by the PHA to identify gaps in knowledge of data and service delivery. A follow up of a sample of women who have indicated a need for support in the antenatal period will be undertaken to assess the extent of support provided. Stats will be collated on Section 75 backgrounds of this client group. • Uptake of all training courses in relation to Infant Mental Health and as outlined in the IMHF that are funded by PHA & HSCB will be monitored and qualitative information collated as part of the evaluation process through education providers.		• Advice and guidance will be sought by the IMHIG on an on-going basis from the voluntary members on the Regional Mental Health Reference Group who operate from a rights based perspective including NSPCC, Lifestart Foundation, Tinylife & Mencap.

Approved Lead Officer: _____

Position: _____

Date: _____

Policy/Decision Screened by: _____

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

Please forward completed template to: Equality.Unit@hscni.net

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

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 90535531 (for Text Relay prefix with 18002); fax: 028 9023 2304