Equality Impact Assessment

Lifeline Crisis Intervention Service beyond 2015

Public Health Agency

August 2015

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CONSULTATION ANNOUNCEMENT

This document is being presented for public consultation. It reports the outcome of an Equality Impact Assessment (EQIA) by the Public Health Agency (PHA) on the proposed service model and delivery mechanism for the Lifeline Crisis Intervention Service beyond 2015 as contained in the **Lifeline Crisis Intervention Service Public Consultation Questionnaire.**

A copy of both the EQIA and Lifeline Crisis Intervention Service Public Consultation Questionnaire are available on the PHA corporate website at **www.publichealth.hscni.net.** Requests for versions of the EQIA in accessible formats will also be considered.

Consultation will commence at **1pm, 27 August 2015,** and end at **1pm, 19 November 2015**. It is intended that other consultation methods will be used to seek views and it may be that you will receive further communication from us in due course.

We hope that you will find time to comment on this document by answering the questions contained in the accompanying **Lifeline Crisis Intervention Service Public Consultation Questionnaire**.

If you would like to submit your comments in writing, you can do so by answering the questions contained in the Lifeline Crisis Intervention Service Public Consultation Questionnaire and returning:

By post: Elizabeth McGrath,
Health Improvement Officer,
PHA office,
Towerhill,
Armagh,
BT61 9DR.

By email: lifelineconsultation@hscni.net
If you prefer to meet with us in person, we would be very happy to do so. Please contact us either by email, by post or **by phone**: (028) 9536 3454.

EXECUTIVE SUMMARY

This document reports the outcome of an EQIA by the PHA on the proposed model and delivery mechanism for the Lifeline Crisis Intervention Service as outlined in the accompanying Lifeline Crisis Intervention Service Public Consultation Questionnaire.

The EQIA was carried out with reference to the Equality Commission's 'Practical Guidance on Equality Impact Assessment' (Equality Commission 2001a).

The organisation

The PHA is part of health and social care in Northern Ireland. Addressing inequalities in health and wellbeing is at the core of our work. As we face a difficult economic climate, health inequalities may worsen over the coming period. For this reason, the PHA will redouble its efforts, working with partners in many different sectors, as well as directly with communities, to ensure we make best use of our collective resources.

The PHA has been systematically examining evidence of best practice and effectiveness to ensure that investment and joint working will bring clear benefits.

The policy

The current Lifeline contract was due to end on 21 March 2015, but was extended until 31 December 2015, with the potential of a further extension to 30 September 2016. The PHA has been keen to engage with relevant stakeholders to ensure that the future delivery model and service specification is appropriately informed and is fit for purpose. A review of available evidence and feedback from the Lifeline pre-consultation process[1], 2014 assisted the PHA in considering the options available that focus on the aim and objectives of the future Lifeline Crisis Intervention Service.

[1] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

The PHA proposes that the preferred Lifeline Crisis Intervention Service model and delivery mechanism as outlined in the accompanying **Lifeline Crisis Intervention Service Public Consultation Questionnaire** is the most appropriate and effective method to ensure the best outcomes for the population of Northern Ireland within the resources available.

It was concluded that equality implications were likely to be major and that an EQIA should be undertaken on the proposed Lifeline Crisis Intervention Service model and delivery mechanism. In turn, this would inform the specification of any Lifeline services to be contracted. This EQIA is therefore concerned with the equality implications of the Lifeline Crisis Intervention Service, with regards to the potential and actual users of the service and the staff assigned to the current Lifeline Crisis Intervention Service.

Data collection

It was decided that any assessment of the equality impacts of the Lifeline contract should be based on:

Quantitative data (statistics) to provide a first overview of the characteristics of those people most likely to be affected by the Lifeline service. Quantitative data was sourced for the Section 75 groups from the Northern Ireland (NI) Census[2], 2011 data from the current Lifeline Crisis Intervention Service to identify the gender and age of actual users of the service to date, and the NI Self-Harm Registry Annual Report[3].

In order to consider the potential impact on those staff currently assigned to delivery of services under the Lifeline contract, the provider has been asked to supply the PHA with equality monitoring data on those staff. When this data is received, it will be added into this EQIA.

[2] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[3] Northern Ireland Registry of Deliberate Self Harm Annual Report 2013/14. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

Qualitative data to provide some insights into the issues, experiences and needs of those who are likely to be most affected by the policy as well as any suggestions for the Lifeline Crisis Intervention Service was sourced from the Lifeline pre-consultation process[4] report, 2014.

Secondary sources that provided some insights into the needs of Section 75 groups in the context of mental health and wellbeing and suicide prevention are referenced in the footnotes throughout this report.

Key findings

A wide range of Section 75 groups were likely to have particular needs in relation to the service including men; older people and younger people; black minority ethnic people; people with a disability; and those with dependents/carers.

A review of data also suggested that several Section 75 groups would be likely to be overrepresented amongst those in need of the service. These include specific age groups (men and women); the lesbian, gay and bisexual community; the black and minority ethnic community; those with a disability; and individuals living alone.

There is limited data available on the equality composition of current service provider staff assigned to the Lifeline contract affected by this policy proposal. Based on anticipated specific needs in a transfer situation, it is anticipated that the potential impacts (in addition to those represented above) are likely to arise for those staff assigned to the Lifeline contract with dependents, and for women.

Conclusions

From an equality point of view, the proposed new Lifeline Crisis Intervention Service model and delivery mechanism constitutes positive action, based on identified need, it seeks to target directly a number of Section 75 groupings and people with multiple identities.

[4] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

Separating the helpline from the follow-on support services which are locality-based, evidence- based and evidence-informed will:

- assist the development of the empowerment and enablement approach;
- focus providers on effective and efficient service delivery;
- protect funding for each element of the service;
- reduce the risk of service failure through improved contingency arrangements.

It is suggested that the additional funding being provided and efficiencies being realised by separating the services and introducing competition into the market place will deliver better return of investment in terms of a broader range of services offered, fairer distribution of resources across localities and increased volume of service delivered.

The referral to emergency services and primary care, enhanced signposting and face-to-face de-escalation have been included to reduce barriers to engagement and, as appropriate, provide a link between the helpline and follow-on support services which are locality-based, evidence-based and evidence-informed for the most vulnerable groups. For some, broadening the range of follow-on support services which are locality-based, evidence-based and evidence-informed to include complementary therapy will reduce barriers to engagement with psychological therapy.

Monitoring the use of mental health services among different Section 75 groups would help to identify low levels of service use, differences in people's pathways to mental health services and inequalities in service usage.

In relation to anticipated specific needs of current service provider staff assigned to the Lifeline contract in a transfer situation, a range of measures to address the equality issues have been identified in the course of this assessment.

1 BACKGROUND

Organisational background

The PHA is part of health and social care in Northern Ireland.

Addressing inequalities in health and wellbeing is at the core of our work. As we face a difficult economic climate, inequalities may worsen over the coming period. For this reason, the PHA will redouble its efforts, working with partners in many different sectors, as well as directly with communities, to ensure we make best use of our collective resources.

The PHA has been systematically examining evidence of best practice and effectiveness to ensure that investment and joint working will bring clear benefits. We are setting out four key themes to our work[5]:

1. Give every child and young person the best start in life

Investment in early years brings significant benefits later in life across areas such as health and wellbeing, education, employment, and reduced violence and crime. We are committed to pursuing strongly evidenced programmes to build resilience and promote health and wellbeing.

2. Ensure a decent standard of living for all

Lower socioeconomic groups have a greater risk of poor health and reduced life expectancy. We will focus efforts in a number of areas where, working with partners, we can impact on achieving a decent standard of living for all.

3. Build sustainable communities

The views, strengths, relationships and energies of local communities are essential in building effective approaches to improving health and wellbeing. We are committed to community development, engaging

[5] Public Health Agency. Corporate Strategy. 2011-15. Available at: http://www.publichealth.hscni.net/what-are-our-priorities-and-how-we-are-doing

people in decision-making and in shaping their lives and social networks.

4. Make healthy choices easier

Creating an environment that encourages and supports health is critical. We are committed to working across a range of settings to ensure that healthier choices are made easier for individuals.

What we do

We do things like:

- Finding out what things people need to protect them from diseases and other hazards.

- Finding out what services people in Northern Ireland need to keep healthy.

- Working with other organisations that are called Trusts, and other voluntary, community and private organisations, which provide the services.

- Buying services from Trusts including, for example, hospital services.

- Organising and buying screening services. This is about finding out at an early stage whether a person is ill or is at risk of becoming ill.

- Trying to make it easier for people to make healthier choices, for example in what they eat.

- Working with other organisations to try and reduce the big differences between different groups of people in Northern Ireland in how healthy and well they are.

- Developing and running campaigns for the general public in Northern Ireland on important health topics, for example on smoking.

- Developing websites on a number of health topics, for example on drugs, alcohol and smoking. Some sites are for specific groups such as young people or health professionals.

- Supporting research. We also buy and pay for research. We carry out some of the research ourselves.

- Making sure we learn from when something goes wrong in how health care is provided in Northern Ireland.

- Working with other organisations to improve the range and quality of services, for example for people of all ages with learning disabilities.

- Making sure services are good quality and check out that they are.

- Working with other health and social care organisations to improve how they engage with those who use their services, with carers and with the public.

- Employing staff.

- Making sure that we obey the laws about employment, services, equality and rights.

Equality Impact Assessments

Section 75 of the Northern Ireland Act 1998 has placed the following statutory requirements on each public authority.

1. A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity –

(a) Between persons of different religious belief, political opinion, racial groups, age, marital status or sexual orientation;

(b) Between men and women generally;

(c) Between persons with a disability and persons without; and

(d) Between persons with dependants and persons without.

2. Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

A key practical element of the statutory equality duties is that public bodies should assess the impact of their policies and procedures on the promotion of equality of opportunity and good relations. This is practically carried out by initially assessing the equality implications of a policy or procedure, called screening. Those policies assessed as having major equality implications should then be considered for an Equality Impact Assessment (EQIA).

An EQIA is a thorough and systematic analysis of a policy to determine whether or not that policy has a negative impact on groups or individuals in relation to one or more of the nine equality categories. It also aims to identify further scope for promoting equality of opportunity. The stages of an EQIA are listed in Appendix 1.

Policy Subjected to an Equality Impact Assessment

The current Lifeline contract was due to end on 21 March 2015, but was extended until 31 December 2015, with the potential of a further extension to 30 September 2016. The PHA has been keen to engage with relevant stakeholders to ensure that the future service specification is appropriately informed and that the future Lifeline Crisis Intervention Service is fit for purpose. A review of available evidence and feedback from the Lifeline pre-consultation process[6], 2014 assisted the PHA to consider the options available that focus on the aim and objectives of the future Lifeline Crisis Intervention Service.

The PHA proposes that the preferred Lifeline Crisis Intervention Service model and delivery mechanism as outlined in the accompanying **Lifeline Crisis Intervention Service Public Consultation Questionnaire** is the most appropriate and effective method to ensure

[6] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

the best outcomes for the population of Northern Ireland within the resources available.

The overarching aim of the Lifeline Crisis Intervention Service, as an integral element of the Protect Life Strategy[7], is to help reduce the number of deaths as a result of suicide and the number of incidents of self-harm in Northern Ireland through enabling access to appropriate services for those at immediate risk of suicide and self-harm, or suicide/homicide.

The current Lifeline Crisis Intervention Service is a free-to-call, 24/7, regional, confidential telephone helpline for people who are experiencing emotional crisis and who are at risk of self-harm and suicide. There are a number of strengths with the current Lifeline Crisis Intervention Service and the PHA will take this learning forward to strengthen the future service model. Aspects of the current service that work well should be maintained as the foundation for any future model, in particular the existence of a regional, 24/7 suicide and self-harm prevention helpline. The level of empathy, compassion and support that call operators provide has been highlighted as having worked well. In particular, its benefits include the process of immediate referral to emergency services when necessary, the ability to undertake a risk assessment, de-escalation, signposting of callers to appropriate care and provision of support to individuals at risk of self-harm and/or suicide.

Findings from the Lifeline pre-consultation process[8], 2014 show a widespread support for the view that the Lifeline Crisis Intervention Service is beneficial. However, 17% of respondents (n=17) did indicate that they were unsure if Lifeline was beneficial as there was 'no clear evidence base'. It is recognised that Lifeline is one element of the multi-faceted Protect Life Strategy. Long-term outcomes will be impacted by

[7] Department of Health, Social Services and Public Safety. 2012. Protect Life Strategy – refreshed. Available at: www.dhsspsni.gov.uk/suicide_strategy.pdf

[8] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

a number of factors, and evaluation will continue to be an important part of the Lifeline Crisis Intervention Service.

The PHA proposes building on this experience to ensure that the future service beyond 2015 represents high quality care, striving for improved outcomes for service users and is focused on its primary aim and objectives.

Equality Screening and Scope of the Equality Impact Assessment

The initial screening of the proposed Lifeline Crisis Intervention Service model and delivery mechanism for the future Lifeline contract indicated that a wide range of Section 75 groups were likely to have particular needs in relation to the service including men; older people on the one hand and younger people on the other; minority ethnic people; and people with a disability.

A first review of quantitative data also suggested that several Section 75 groups would be likely to be overrepresented amongst those in need of the service, including lesbian, gay and bisexual people; some people with a disability; transgender people; as well as men and women from specific age groups.

Moreover, it became clear that equality implications would also be likely to arise for service provider staff assigned to the Lifeline contract, including those with dependants; people with a disability; women; transgender staff; and lesbian, gay or bisexual people.

It was concluded that equality implications were likely to be major and that an EQIA should be undertaken on the proposed Lifeline Crisis Intervention Service model and delivery mechanism. In turn, this would inform the specification of any Lifeline services to be contracted.

This EQIA is therefore concerned with the equality implications of the Lifeline Crisis Intervention Service, with regards to the potential and actual users of the service and their carers. It also examines the impact on service provider staff assigned to the Lifeline contract staff in a potential transfer situation.

It should be noted that an equality screening was also completed in relation to the Lifeline pre-consultation process[9], 2014 to consider how best to reach out to a range of Section 75 groups.

[9] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

2 DATA COLLECTION

It was decided that any assessment of the equality impacts of the Lifeline contract should be based on two types of data:

- **Quantitative data** (statistics) which would provide a first overview of the characteristics of those people most likely to be affected by the Lifeline service. Note that data of less than 10 people will not be reported to protect anonymity.

- **Qualitative data** which would provide some insights into the issues, experiences and needs of those who are likely to be most affected by the policy as well as any suggestions for the Lifeline Crisis Intervention service.

Collection of quantitative data

In order to better understand the equality profile of potential users of the Lifeline Crisis Intervention Service, Census 2011[10] data on the make-up of the Northern Ireland population as a whole was considered in a first step.

Alongside, data from the Northern Ireland Self-Harm Registry Annual Report[11] on suicide rates was analysed. It is recorded for the Section 75 groups of:

- Gender
- Age
- Religion
- Political opinion
- Marital status
- Dependent status
- Disability
- Ethnicity
- Sexual orientation

[10] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[11] Northern Ireland Registry of Deliberate Self Harm Annual Report 2013/14. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

In a second step, the assessment drew on data from the existing Lifeline contract to identify the equality profile of actual users of the service to date. Equality monitoring data from this source is currently limited to the categories of:

- Gender
- Age

Thirdly, in order to consider the impact on those staff currently assigned to the Lifeline contract, equality monitoring data was requested from the current provider.

Collection of qualitative data

The PHA invited a range of Section 75 representative groups to share their views on the Lifeline contract as part of the Lifeline pre-consultation process[12], 2014.

Fourteen consultation workshops were hosted by the PHA with over 200 people attending. Some 154 respondents returned completed questionnaires and a summary report of the key themes is available on the PHA website www.publichealth.hscni.net. There was a total of 146 responses from within Northern Ireland: 57 from individuals; 66 from representatives of community and voluntary organisations; 13 from health and social care organisations; six from other statutory bodies; and four 'other'. Of the four 'other' responses, two were received from the education sector; one from the sports sector; and one was anonymous.

Almost two-thirds of those who responded to the questionnaire indicated that they had direct experience of the Lifeline Crisis Intervention Service, while 31% (n=43) had no experience. Community and voluntary responses were received from across the region in both urban and rural settings. The majority of responses were from agencies working directly in the area of mental health and wellbeing and suicide

[12] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

prevention. Responses were also received from agencies with a focus on abuse, addiction and homelessness service provision.

Given the nature of the subject and to encourage participation, it was decided that the names of individuals and organisations who responded to the Lifeline pre-consultation process[13], 2014 would not be reported. The following are the numbers of organisations who submitted responses in 2014 and can be directly assigned to Section 75 representative groups:

Section 75 group	**Number of organisations who can be directly assigned a Section 75 group**
Gender	Four
Age	Seven
Religion	Not reported
Political opinion	Not reported
Marital status	Two
Dependent status	One
Disability	14
Ethnicity	No specific group responses noted although it would be reasonable to assume this was noted in individual responses.
Sexual orientation	No specific group responses noted although it would be reasonable to assume this was noted in individual responses.

[13] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

Secondary sources

A wide range of research reports were considered that provided some insights into the needs of Section 75 groups in the context of mental health and suicide prevention, both in relation to a Lifeline Crisis Intervention Service per se and its design.

To inform the assessment of equality impacts on staff, the EQIA likewise drew on secondary sources, including research reports and relevant EQIAs undertaken by other organisations on related matters.

All secondary sources are referenced in the footnotes throughout this report.

3 KEY FINDINGS

3.1 Equality of opportunity

In the following, overarching inequalities in relation to suicide rates are presented before equality implications for each of the Section 75 groupings are considered. Under each equality grouping, data is presented in three steps:

I. on the make-up of potential and actual service users;
II. on any particular needs that have been identified in relation to the Lifeline service;
III. on provider staff assigned to the Lifeline contract.

Northern Ireland population statistics draw on Census[14] 2011 figures, which estimate the Northern Ireland population to be 1,810,863 people.

Geography and suicide

Suicide figures show different patterns across the United Kingdom (UK) countries. In the general population, suicide rates are higher in Scotland and Northern Ireland but recent rises have occurred mainly in England and Wales - the rate in Scotland has fallen over the past decade[15].

Approximately 2% of all deaths registered in Northern Ireland each year are recorded as suicide[16]. In 2014, there were 268 deaths in Northern Ireland recorded as suicide. Over the past 10 years, the three-year rolling rate of registered suicide in Northern Ireland has increased from 9.5 per 100,000 in 2001/03 to 15.5 per 100,000 in 2012/14.

Belfast Health and Social Care Trust (HSCT) area has the highest three-year suicide rate for 2012/14 at 20.2 deaths per 100,000, followed by the Western HSCT area at 16.0 per 100,000. The South Eastern HSCT area has the lowest rate at 13.8 per 100,000.

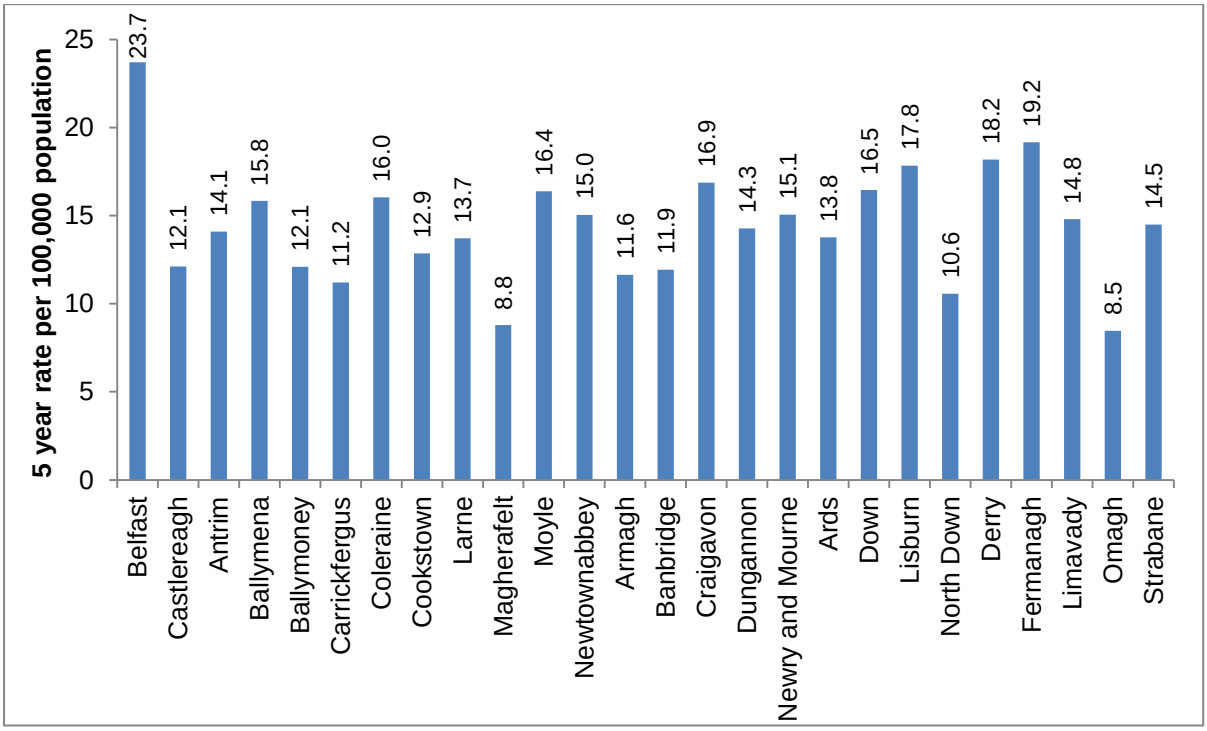
[14] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[15] Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

[16] Northern Ireland Statistics and Research Agency. 2014. Available at: www.nisra.gov.uk/demography/default.asp31.htm

Figure 1 below shows the variation in registered suicide rates by Local Government District (LGD)[17] using a five-year rate to increase robustness (2010 – 2014). The highest rate was recorded for Belfast (23.7 per 100,000), followed by Fermanagh (19.2 per 100,000) and Derry/ Londonderry (18.2 per 100,000).

Figure 1: Rate of suicide by LGD (five-year average), 2010 – 2014



Evidence indicates that there is an increased risk of suicide for individuals who self-harm[18] [19]. As a result of self-harm in 2013/14, 5,983 people presented to Northern Ireland Emergency Departments (EDs), on 8,453 separate occasions[20].

[17] Figures 2010/2014categorised by pre RPA Local Government Districts

[18] Owens, D., Horrocks, J. & House, A. 2002. Fatal and non-fatal repetition of self-harm: Systematic Review. British Journal of Psychiatry. 181: 193-199

[19] Muehlenkamp, J. and Gutierrez, PM. 2004. An Investigation of Differences Between Self-Injurious Behavior and Suicide Attempts in a Sample of Adolescents. 2004 The American Association for Suicidology DOI: 10.1521/suli.34.1.12.27769

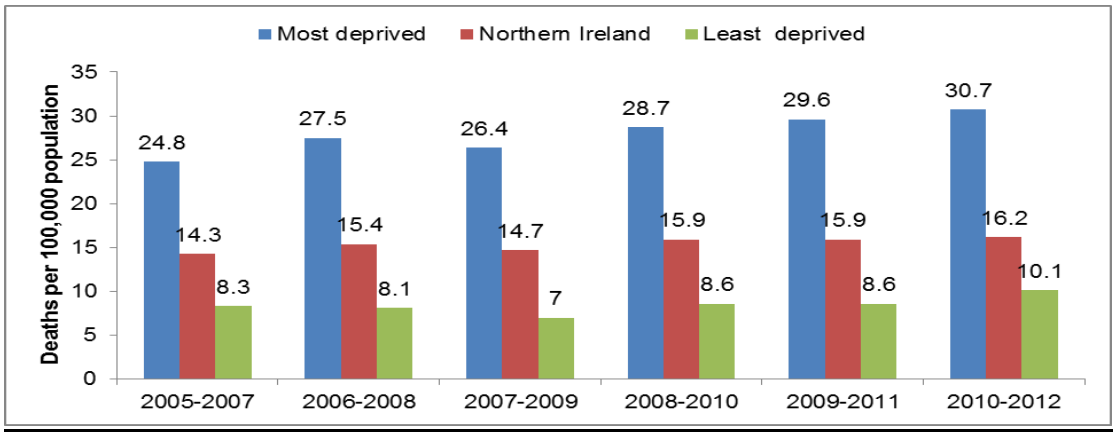
[20] Northern Ireland Registry of Deliberate Self Harm Annual Report 2013/14. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

Inequalities

Increasing rates of unemployment, debt and alcohol use have been identified as possible drivers for an increase in suicide and homicide by people with mental illness, according to the National Confidential Inquiry Study[21]. [Note that this study is limited to those who were in care of mental health services and reflect the health and social care staff perspective].

Inequalities between the 20% most deprived areas (defined using the NISRA Northern Ireland Multiple Deprivation Measure) and Northern Ireland as a whole are measured. The Northern Ireland crude suicide rate was 16.2 deaths per 100,000 population in 2010-2012[22]. The rate in the most deprived areas was 30.7 suicides per 100,000, three times higher than in the least deprived areas (10.1 deaths per 100,000 population).

Figure 2: Crude suicide rate by deprivation (three-year rolling) 2005/07 to 2010/12



In summary, the data on geography suggests that the Northern Ireland population has particular needs in relation to this service. A review of

[21]Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

[22] Department of Health, Social Services and Public Safety Northern Ireland. 2014 . Northern Ireland Health and Social Care inequalities Monitoring system Regional report. Available at: http://www.dhsspsni.gov.uk/hscims-2014-bulletin.pdf

the data also suggests that areas of deprivation would likely to be over-represented amongst those in need of the service.

Staff currently assigned to the Lifeline contract

In order to consider the potential impact of the proposed model and delivery option for the future Lifeline service, the providers were asked to supply the PHA with equality monitoring data that was available on the staff currently assigned to the Lifeline contract. The current service providers have advised that there are over 100 staff assigned to the Lifeline contract. This group comprises helpline counsellors, community-based counsellors, service administrators and clinical managers.

Although limited equality data is currently available on service provider staff assigned to the Lifeline contract, it is reasonable to assume that while the community-based counsellors and community-based clinical managers are geographically spread across Northern Ireland, the majority of the helpline counsellors are more likely to reside within commute travelling distance of Belfast and Derry/Londonderry where the helpline telephony is located.

3.1.1 Gender

Potential and actual service users

Suicide by gender

Suicide in men has risen in the UK since 2006-2008, although the pattern varies between regions - in Scotland, the overall male rate has fallen. The National Confidential Inquiry Annual Report[23], 2015 shows a range of 4,227 (2006) to an estimated 4,840 (2012) recorded suicides in the UK, with a male to female ratio of 3:1 overall, currently 3.4:1.

In terms of the Northern Ireland population (1,810,863 people), 49% were male and 51% were female, Census[24] 2011. The annual rate of suicide for 2014 in Northern Ireland is higher for males (23.1 per 100,000) than for females (6.5 per 100,000). Data on 2014 suicide rates by gender shows that three quarters (n=207) were male.

No specific data is available on the number of transgender people in Northern Ireland. Research suggests that for the population as a whole[25]:

- 140-160 individuals are affiliated with transgender groups;
- 120 individuals have presented with Gender Identity Disphoria;
- there are more transgender women than transgender men.

Based on applying GIRES (Gender Identity Research and Education Society 2014[26]) percentage figures, which are estimated for the UK as a whole, to the Northern Ireland population, it would suggest the following:

- 18,109 people do not identify with gender assigned to them at birth;
- 3,622 are likely to seek treatment;

[23] Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

[24] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[25] McBride & Ruari-Santiago. 2011. Healthcare issues for transgender people living in Northern Ireland. Available at: http://conflictresearch.org.uk/reports/equality-diversity/Healthcare-issues-for-transgender-individuals.pdf

[26] Gender Identity Research and Education Society. 2014. Available at: www.gires.org.uk

- 362 have undergone transition;
- 91 have a Gender Recognition Certificate.

Self-harm registry

The Registry of Deliberate Self-Harm Annual Report[27] 2013/14 suggests that the overall gender balance was even. In the Belfast Trust, males accounted for 53%, and in the Southern Trust they accounted for 52%, of presentations to EDs; in the Northern area, females accounted for 55.6% and in the West they accounted for 55.2%. In contrast, almost two thirds (65.4%) of suicide ideation presentations to EDs were male.

Lifeline data

Lifeline data 2012/15 on gender, supplied from the current provider, shows females made (54%) of interactive helpline calls, and males (44%). Transgender people made 0.2% of the calls. In 2014/15, females aged 45-49 are the highest frequency helpline caller group (8.4% of all calls are from this group). Data on clients who received follow-on Lifeline counselling in 2014/15 shows that 58.7% of the Lifeline clients were female, 38.2% male and 3% classified as 'other'. Clients include transgender people.

Transgender

Transgender research undertaken in 2012[28] suggested that 53% had self-harmed at some point, 84% had thought about ending their lives, 35% had attempted at least once to take their lives, and 25% had done so more than once.

All Partied Out[29] scoping exercise reported that drugs and alcohol was a contributory factor to experiencing suicidal ideation for 47% of trans gender respondents, with 25% reporting attempting suicide.

[27] Northern Ireland Registry of Deliberate Self Harm Annual Report 2013/14. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

[28] McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M. 2012. Trans Mental Health Study. Available at: http://scholar.google.co.uk/scholar_url?url=http://www.academia.edu/download/30289576/Trans_Mental_Health_2012.pdf&hl=en&sa=X&scisig=AAGBfm1Xj2WimFVul1zolLBk8XY53TpSpg&nossl=1&oi=scholarr

[29] All partied out: Substance use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community. Available at: http://www.rainbow-project.org/assets/publications/All%20Partied%20Out.pdf

Though transgender identity is not recorded in suicide and self-harm data, it is reasonable to assume, therefore, that trans people are overrepresented amongst those in need of the service.

Provider staff assigned to the Lifeline contract

The provider has indicated that as of March 2014, 85% of staff assigned to the Lifeline contract were female and 15% were male.

Particular needs in relation to the service

Service users

With regards to the particular needs of men and women in relation to the service, secondary sources revealed a number of key considerations:

- Perceived potential barriers for women accessing treatment for perinatal depression were reported as lack of time, stigma and childcare issues[30].

- The Northern Ireland Protect Life – A shared Vision[31], recognises the need to engage men.

- A perceived barrier for men in accessing health services is the need to develop 'health literacy[32]. It is recommended that communication relating to health services should be carefully monitored in terms of engaging with men.

- Providing Meaningful Care[33] study that interviewed 36 formerly suicidal young men explored the development and provision of mental

[30] Goodman, J. 2009. Women's Attitudes, Preferences, and Perceived Barriers to Treatment for Perinatal Depression. Available at: DOI: 10.1111/j.1523-536X.2008.00296.x

[31] Department of Health, Social Services and Public Safety Northern Ireland. 2012. Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy (Refreshed). Available at: www.dhsspsni.gov.uk/suicide_strategy.pdf

[32] Peerson, A. & Saunders, M. 2009. Men's health literacy: advancing evidence and priorities. Critical public Health. Vol. 19, Issue 3-4, 441-456.

[33] Jordan, J., Mckenna, H., Keeney, S. and Cutcliffe., J. 2012. Providing Meaningful Care – learning from the experience of Suicidal Young Men. Available at: http://qhr.sagepub.com/content/22/9/1207.short

health services and noted that young men did not always access support from established pathways.

- Men and Suicide, a Samaritans report[34] evidenced the range of issues impacting on men in mid-life and the social issues impacting on men not engaging in help seeking behaviour.

A number of respondents to the Lifeline pre-consultation process, 2014 raised concern about equality of provision across the locality, particularly in rural areas, groups identified as high risk, and groups that are socially isolated such as the transgender community.

In terms of signposting and counselling, trans people may have particular requirements as to what services offered by voluntary, community and statutory organisations are appropriate for their particular needs.

Provider staff assigned to the Lifeline contract

The provider indicated that as of March 2014, 85% of staff assigned to the Lifeline contract were employed full-time and 15% of staff were employed part-time. In a potential situation of transfer to a new employer, staff who work part-time or who avail of other flexible working schemes (such as term-time or compressed hours) have particular needs as to the continuity of these arrangements under the new employer. Part-time workers also experience adverse impacts due to increased travel times and costs. This in turn may have negative impacts for those part-time workers who hold two jobs[35] [36]. Women are more likely to be in this position than men.

[34] Kennelly, B. and Connolly, S. 2012. Men, suicide and society: an economic perspective. Men, Suicide and Society. Samaritans: 73.

[35] Department of Finance and Personnel Northern Ireland. 2010. Workplace Equality Impact Assessment, Final Report. Available at: www.dfpni.gov.uk/workplace_2010_equality_impact_assessment_-_final_Report

[36] Department of Finance and Personnel Northern Ireland. 2006. Accounting Services Programme Equality Impact Assessment, Final Report, Executive Summary. Available at: www.dfpni.gov.uk/master_eqia_full_report_v2_-_addendum.pdf

The provider has advised that as of March 2014, 85% of staff assigned to the Lifeline contract were identified as female and 15% of staff were identified as male.

Moreover, given that they are more likely than men to use public transport, accessibility of office locations by public means is particularly important for female staff.

For staff who are transitioning in relation to their gender or who have completed it, a particular concern is likely to be the continued support of their new employer as well as the attitudes and behaviour of their new colleagues.

In summary, the data on gender suggests that males and females have particular needs in relation to this service. Transgender people have particular needs in relation to this service. In particular, males and transgender people would likely be over-represented amongst those in need of the service while the Lifeline data shows that females are the highest proportion of service users. In relation to provider staff assigned to the Lifeline contract, it can be assumed that there are particular needs for females and males in relation to a potential transfer situation. Transgender staff also have particular needs in relation to the proposed change.

3.1.2 Age

Potential and actual service users

The Northern Ireland Census[37] 2011 shows the following age profile of the population:

- number of children aged 0 to 17 years was 430,700;
- number of people aged 18 and over was 1,380,200.

Suicide rates by age

The latest data on suicide by age, 2012-2014, shows the overall suicide rate for males (24.2 per 100,000) and (7.1 per 100,000) for females. The highest rates of suicide for males was among those aged 30-34 years (42.4 per 100,000), followed by 25-29 years (42.3 per 100,000). For females, the highest rates were among those aged 50-54 years (14.4 per 100,000), followed by 35-39 years (13.4 per 100,000). Suicide rate for males under 15 years (1.3 per 100,000) and females under 15 years is (0.6 per 100,000).

Suicide rates in the UK population in those aged under 25 years

The National Confidential Inquiry[38], 2015 Annual Report shows that during 2003-2013, there were 1,070 suicides in the general population in those aged under 25, 12% of all suicides, an average of 97 per year; 38 suicides were aged under 20 years, an average of 35 per year, and 174 were aged under 18 years, an average of 16 per year.

Of those under 25 years, 244 were patients - 9% of patient suicides and 23% of all suicides in this age-group. This represents an average of 22 deaths per year; 80 were aged under 20, an average of 7 per year, and 36 were aged under 18, an average of 3 per year.

[37] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[38] Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

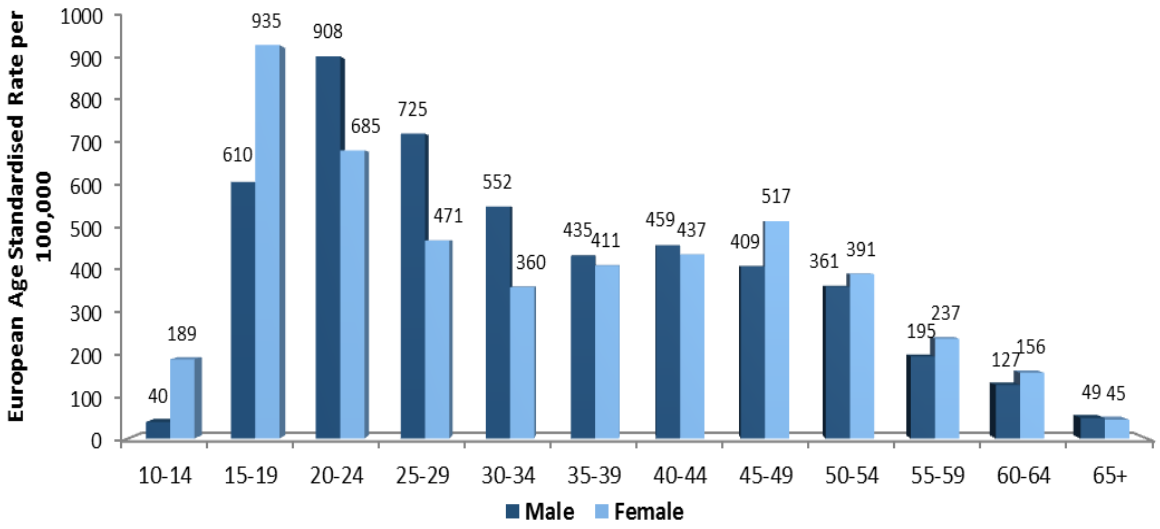
Changing rates by age and gender

The greatest increases in male suicide rates (between 2001/03 and 2012/14) have been observed in age groups 35-39 years (from 20.7 to 41.1 per 100,000), 50-54 years (from 21.3 to 36.6 per 100,000). The greatest increases in female suicide rates, (between 2001/03 and 2012/14) have been observed in age groups 50-54 years (from 4 to 14.4 per 100,000), and 35-39 years (4.5 to 13.4 per 100,000). In the youngest age group, aged 15 to 19 years, the overall rate has increased from 7.3 per 100,000 to 11.4 per 100,000 between 2001/03 and 2012/14.

Northern Ireland self-harm registry[39]

Figure 3 shows that the 15-29 year age bracket accounted for 44.4% of all self-harm presentations to Northern Ireland EDs in 2013/14.

Figure 3: European Age Standardised Rate per 100,000 of deliberate self-harm in Northern Ireland by age and gender, 2013/14.



[39] Northern Registry of Deliberate Self Harm Annual Report 2013/14. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

Lifeline interactive calls by age 2014/15

The total number of incoming calls recorded in 2012/13 was 80,896; the provider classified 66% of the total number of incoming calls 'active' (requiring the interaction of a call operator). In 2013/14 there were a total of 92,266 incoming calls recorded, with 74% classified as 'active'. In 2014/15, 91,826 incoming calls were recorded of which 75% were classified as 'active'.

Table 1: The age distribution of 'active' incoming calls recorded from data supplied by the current provider, in 2014/15:

Age range of caller	Number of calls	% percentage of calls
4-9	13	0.0
10-14	131	0.2
15-19	2121	3.9
20-24	5275	9.6
25-29	4568	8.3
30-34	4660	8.5
35-39	6565	12.0
40-44	6353	11.6
45-49	7748	14.1
50-54	6479	11.8
55-59	4904	8.9
60-64	2492	4.5
65-69	1078	2.0
70-74	405	0.7
75+	15	0.0
Age not recorded	2108	3.8
Total	**54,915**	**100.0**

Lifeline community counselling sessions 2014/15

During 2012/13, 21,554 counselling sessions were attended by 4,434 clients, increasing to 30,742 sessions attended by 6,364 clients in 2013/14. The number of clients receiving Lifeline counselling has reduced significantly during 2014/15, with 3,681 clients attending 15,474 counselling sessions.

Table 2: The age distribution of clients who attended a counselling session recorded from data supplied by the current provider in 2014/15:

Age group of clients who received Lifeline counselling	Number of clients	% percentage of counselling
4-9	51	1.4
10-14	123	3.3
15-19	323	8.8
20-24	451	12.3
25-29	377	10.2
30-34	337	9.2
35-39	314	8.5
40-44	325	8.8
45-49	377	10.2
50-54	371	10.1
55-59	238	6.5
60-64	138	3.7
65-69	61	1.7
70-74	24	0.7
75+	15	0.4
Age not recorded	156	4.2
Total	**3681**	**100**

Provider staff assigned to the Lifeline contract:
While no data is currently available on provider staff assigned to the Lifeline contract by age it is reasonable to assume that they are 20+ years age range as third level qualifications are required for the Lifeline helpline and other counselling roles.

Particular needs in relation to the service

Service users
With regards to the particular needs in relation to age in the service, secondary sources revealed a number of key considerations:

Older People's Advocate[40] recommends that when communicating with older people there is recognition of the diversity of need within that

[40] Northern Ireland Older People's Advocate. 2010. Available at:www.cardi.ie/userfiles/Older People's Advocate NI.

group in relation to literacy levels, access to ICT skills and equipment, geographical isolation and accommodation including those in nursing and residential homes. Documents need to be written in an accessible way – Plain English. Alternative formats should be offered, eg large print, Braille, audio CD, translation etc.

A number of respondents to the Lifeline pre-consultation process[41], 2014 raised concern about the equality of provision across the locality, particularly in rural areas, groups identified as high risk and groups that are socially isolated such as the older population.

The Lifeline pre-consultation process, 2014 found that some groups such as children and young people valued the anonymity of the helpline service and preferred the ability to make use of social media services when seeking support, while other young people indicated that they would be reluctant to contact Lifeline if they were at risk of self-harm or suicide.

In relation to marketing and communication, young people may respond less to mainstream communication methods and thus have a need for targeted communication.

Children and young people

The helpline is available to all ages and the call handlers should be competent and capable of handling calls from children and young people and providing appropriate responses that enable active engagement and access to additional help and support. Children and young people who phone Lifeline will be assessed; if they are deemed high risk they will be referred to statutory gateway services. If they are deemed low risk and they are suitably mature, and it is clinically necessary, they will be signposted to follow-on crisis support services which are locality-based, evidence-based and evidence-informed.

[41] PHA Lifeline Pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

Provider staff assigned to the Lifeline contract and age

Although data is not currently available, it can be reasonable to assume that provider staff assigned to the Lifeline contract are 20+ years of age as third level qualifications are required for the Lifeline helpline and other counselling roles, and the vast majority would need/want to continue in paid employment.

Given that young people are less likely to have access to a car[42], accessibility of office locations by public transport is particularly important for provider staff assigned to the Lifeline contract in the younger age brackets. It is also recognised that additional travel costs have greater effect on young people's finances[43].

In summary, the data on age suggests that adults, older people on the one hand and younger people on the other, were likely to have particular needs in relation to this service. The quantitative data also suggested that the adults, particularly males 25 - 34 years, would be likely to be over-represented amongst those in need of the service and are less likely to access the current service. In terms of provider staff assigned to the Lifeline contract, there may be particular needs in relation to a potential transfer such as access to public transport and additional travel costs.

[42] Department of Finance and Personnel Northern Ireland. 2010. Workplace Equality Impact Assessment, Final Report. Available at: www.dfpni.gov.uk/workplace_2010_equality_impact_assessment_-_final_Report

[43] Department of Finance and Personnel Northern Ireland. 2006. Accounting Services Programme Equality Impact Assessment, Final Report, Executive Summary. Available at: www.dfpni.gov.uk/master_eqia_full_report_v2_-_addendum.pdf

3.1.3 Religion

Potential and actual service users

Population - Census 2011 figures on religion

- Catholic - 738,033 (40.76%)
- Presbyterian Church in Ireland – 345,101 (19.06%)
- Church of Ireland – 248,821 (13.74%)
- Methodist Church in Ireland – 54,253 (3%)
- Other Christian (including Christian related) – 104,380 (5.76%)
- Other religions – 183,164 (10.11%)
- Religion not stated – 122,252 (6.75%)

Suicide rates by religion

No suicide data is available which provides the distribution by religion. A study of differences in morbidity and mortality according to denomination in Northern Ireland highlighted that the difference in mortality by religion was driven by socio-economic variations[44]. Those identified as of no religion and Catholic religion are slightly over-represented in low income households[45].

Protective factors:

A personal belief system along with strong personal relationships and positive coping strategies have been identified as protective factors in the World Health Organization (WHO) report Prevention Suicide – A Global Imperative[46], 2014.

Northern Ireland self-harm and Lifeline data

There is no self-harm data available in relation to religion. Religion has 19.9% 'blank' and 27.8% 'not applicable' in Lifeline raw data on service user religion and therefore it cannot be used meaningfully for analysis.

[44] O'Reilly, D. & Rosato, M. 2008. A Study of differences in morbidity and mortality according to denomination in NI. Social Science & Medicine. Available at: http://www.journals.elsevier.com/social-science-and-medicine

[45] Department for Social Development NI. Available at: www.dsdni.gov.uk/index

[46] World Health Organisation. 2014. Preventing Suicide: A Global Imperative. Available at: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en

Provider staff assigned to the Lifeline contract by religion

The provider has indicated that as of March 2014, 40% of staff assigned to the Lifeline contract identified as Protestant; 58% of staff identified as Catholic, with 2% of staff 'not determined'.

Particular needs in relation to the service

With regards to the particular needs in relation to religion and the service, secondary sources revealed a number of key considerations:

Studies by St Columb's Park House in partnership with INCORE and Queens University Belfast[47] suggested that there was less awareness of the relevance of engaging in health consultations. More engagement with local community groups has been recommended in these areas.

Some respondents to the Lifeline pre-consultation process[48], 2014 indicated that there was an increased need for counselling in the community along with an increase in tensions within some communities particularly Protestant/ Unionist/ Loyalist (PUL area) related to socio-economic issues. Some respondents suggested looking at the bigger picture to meet the needs of local communities by broadening the number of organisations included in the services that specialise in self-harm and suicide, and develop a better understanding between the organisations about how best to collaborate and support people in distress.

Overall, it is crucial that for any face-to-face element of the service, chosen venues are in a neutral location and accessible as to routes to the location as this may influence service users/perceptions of personal safety.

[47] St Columb's Park House and Queens University Belfast. 2005 updated 2008. Population and Social Inclusion Study. Available at: www. derrycity.gov.uk/e52208b7-53eb-4cf3-acd2-d6441ab47291

[48] PHA Lifeline Pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

In summary, based on the quantitative data on religion it is expected that those of 'no' religion and Catholic religion will be slightly over-represented as those in need of the Lifeline Crisis Intervention Service and, likewise, those from Protestant/ Unionist/ Loyalist (PUL area) and 'other' religions where there may be barriers to accessing services.

Particular needs on the basis of religious identity or community background arise as regards the neutrality of the location in which face-to-face services are provided.

Provider staff assigned to Lifeline contract and religion

In terms of a potential transfer situation, EQIAs undertaken on related matters by Workplace and DFP[49] [50] highlight concerns by staff on the basis of religion, arising from perceptions of personal safety in non-neutral areas and the lack of accessibility by some groups. Both the location of the workplace itself and access routes leading to it thus have to be taken into account. In addition, the EQIA carried out by HM Revenue & Customs (HMRC) underlined that if staff have to move to a less diverse office location, it may not provide the same access to networks and support facilities (see also 'ethnicity').

[49] Department of Finance and Personnel Northern Ireland. 2010. Workplace Equality Impact Assessment, Final Report. Available at: www.dfpni.gov.uk/workplace_2010_equality_impact_assessment_-_final_Report

[50] Department of Finance and Personnel Northern Ireland. 2006. Accounting Services Programme Equality Impact Assessment, Final Report, Executive Summary. Available at: www.dfpni.gov.uk/master_eqia_full_report_v2_-_addendum.pdf

3.1.4 Political opinion

Potential and actual service users

Northern Ireland population statistics - Census 2011[51]

- British only – 722,379 (39.89%)
- Irish only – 457,482 (25.26%)
- Northern Irish only - 379,267 (20.94%)
- British and Irish only - 11,877 (0.66%)
- British and Northern Irish - only 111,748 (6.17%)
- Irish and Northern Irish only - 19,132 (1.06%)
- British, Irish and Northern Irish - only 18,406 (1.02%)
- Other - 90,572 (5.00%)

Suicide rates by political opinion

Suicide rates in Northern Ireland by political opinion are not collected.

Northern Ireland suicide rate compared to rest of UK

The National Confidential Inquiry[52], 2015 shows that in the general population suicide rates are higher in Scotland and Northern Ireland but recent rises have occurred mainly in England and Wales.

Self-harm all-Ireland comparison

The Northern Ireland Self-Harm Registry Report[53] 2012/13 provides an all-Ireland comparison. The rate in Northern Ireland is over 50% higher than that for the Republic of Ireland. The rates of self-harm recorded in EDs for males are 71% higher in Northern Ireland than their southern counterparts.

[51] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

[52] Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

[53] Northern Ireland Registry of Deliberate Self Harm Annual Report 2012/13. Available at: http://www.publichealthagency.org/publications/northern-ireland-registry-self-harm-annual-report-201314

Lifeline data

There is no specific Lifeline data available on the political opinion of service users.

Provider staff assigned to the Lifeline contract and political opinion

There is no specific data available on the political opinion of provider staff assigned to the Lifeline contract.

Particular needs in relation to the service

Similar issues may arise on the basis of diverse political opinions of staff as those related under ‘religion’.

No other particular needs based on the political opinion of an individual service user were identified in relation to the service.

Similar issues may arise on the basis of diverse political opinions of staff as those related under ‘religion’.

3.1.5 Marital status

Potential and actual service users

Northern Ireland population statistics - Census 2011

- 47.56% (680, 840) of those aged 16 or over were married
- 36.14% (517, 359) were single
- 0.09% (1,288) were registered in same-sex civil partnerships
- 9.43% (134, 994) were either divorced, separated or formerly in a same-sex partnership
- 6.78% (97,058) were either widowed or a surviving partner

Suicide, self-harm and Lifeline data

There is no suicide, self-harm or Lifeline data available in relation to marital status.

Provider staff assigned to the Lifeline contract and marital status

There is no data currently available on provider staff assigned to the Lifeline contract and marital status.

Particular needs in relation to the service

Living alone and social isolation have been identified as a risk factor for adult men[54]. It is reasonable to assume that individuals who are living alone and not living with their families are at a higher risk of suicide and self-harm.

People who are undergoing transition and who are married may have particular needs which must be considered.

Provider staff assigned to the Lifeline contract and marital status:

There is currently no data available on provider staff assigned to the Lifeline contract and marital status. Potential impacts may arise for staff assigned to the Lifeline contract in civil partnerships linked to their sexual orientation if they move to a less diverse office location and

[54] National Office For Suicide Prevention (NOSP). 2014. The Male Perspective. Available at: http://hse.ie/eng/services/list/4/Mental_Health_Services/NOSP

depending on access routes to these (see discussion under ‘sexual orientation’).

In summary, people living alone and trans gender people who are married are likely to have particular needs in relation to users of the service.

3.1.6 Dependant status

Potential and actual service users

Northern Ireland population statistics - Census 2011

- One in eight people provide unpaid care (almost 214,000)
- 3% of people providing 50+ hours a week (56,310)
- 7% of 85+
- 12% of 75-84 year olds
- 2% 0 -17 year olds
- 62,340 on carers' allowance in 2013

Young carers

According to Patient and Client Council research on young carers in Northern Ireland[55], 1 in 10 young people are carers. Moreover, the share of children per head of population who provide care to their families is higher than in the rest of the UK.

Results of a survey of 3,400 carers across the UK[56]

- 87% of carers stated that caring had a negative impact on their mental health (Northern Ireland=88%)
- 91% of carers were affected by anxiety or stress
- 53% suffered from depression
- 62% expressed social exclusion
- 40-45% give up work
- 34% missed out on promotion

Suicide, self-harm and Lifeline data:

There is no suicide, self-harm or Lifeline data available in relation to dependents.

Provider staff assigned to the Lifeline contract and dependents:

While there is no data on the dependent status of staff assigned to the Lifeline contract, it is reasonable to assume that the majority are 20+

[55] Patient and Client Council. 2011. Research of Young Carers in NI. Available at: www.patientclientcouncil.hscni.net

[56] Carers Week UK. 2012. In Sickness And in Health. Available at: www.carersweek.org.

years old and are more likely to have dependents, in particular children and elderly parents.

Particular needs in relation to the service

With regards to the particular needs in relation to dependent status and the service, secondary sources revealed a number of key considerations:

Those with dependents have particular needs as regards access and cost of services. One respondent thought that communication and signposting to specific counselling organisations could be improved and stated that there is an assumption that [Lifeline] counselling is a 'free' service, Lifeline pre-consultation process[57], 2014.

A partnership approach/collaborative working between service providers, service users and carers is required and there are many accessible sources of guidance on how to deal with the issue of 'confidentiality' in a way that allows for the sharing of information necessary for the carer to care[58].

<u>Provider staff assigned to the Lifeline contract and dependents</u>
Secondary sources[59] [60] identify various negative impacts that can arise for people with dependants in the situation of staff transfers:

[57] PHA Lifeline Pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

[58] National Mental Health Development Unit and The Princess Royal Trust for Carers. 2010. The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care. Available at: http://www.carers.org

[59] Department of Finance and Personnel Northern Ireland. 2010. Workplace Equality Impact Assessment, Final Report. Available at: www.dfpni.gov.uk/workplace_2010_equality_impact_assessment_-_final_Report

[59] Department of Finance and Personnel Northern Ireland. 2006. Accounting Services Programme Equality Impact Assessment, Final Report, Executive Summary. Available at: www.dfpni.gov.uk/master_eqia_full_report_v2_-_addendum.pdf

- concerns whether their flexible working arrangements will be supported by their new employer and colleagues;
- increase in travel time may mean additional care costs and difficulties in balancing work and caring responsibilities (longer working day, doing school runs);
- changes in facilities may increase difficulties in accessing childcare if less local childcare is available;
- negative impact on part-time workers (who are mostly female with dependants) who do two jobs;
- negative impacts on part-time workers (who are mostly female with dependants) when onsite free car parking is lost as it takes longer to respond to emergencies.

Provider staff assigned to the current Lifeline contract are likely to have particular needs in relation to the proposed change in the service. It is reasonable to assume that carers are over represented among provider staff assigned to the Lifeline contract. Working around caring responsibilities which can be delivered through part-time working, unsocial hours and close proximity to home.

In summary people who have dependents are likely to have particular needs in relation to the service. Though dependant status is not available in suicide, self-harm and Lifeline data it is reasonable to assume those who are carers are over-represented amongst those in need of the service. It is reasonable to also assume that carers are over-represented among the provider staff assigned to the current Lifeline contract and there will be particular needs in relation to a potential transfer situation.

3.1.7 Disability

Potential and actual service users

A person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities[61]. More than one person in five (300,000) people in Northern Ireland has a disability. The incidence of disability in Northern Ireland has traditionally been higher than in the rest of the UK. Among those of working age, 30% of those with a work-limiting disability are working. A further 15% lack, but want, paid work and 55% do not want paid work.

Table 3: Northern Ireland population statistics - Census[62] 2011

Type of long–term condition	Percentage (%) of population
Deafness or partial hearing loss	5.14
Blindness or partial sight loss	1.70
Communication difficulty	1.65
Mobility of dexterity difficulty	11.44
A learning, intellectual, social or behavioural difficulty	2.22
An emotional, psychological or mental health condition	5.83
Long–term pain or discomfort	10.10
Shortness of breath or difficulty breathing	8.72
Frequent confusion or memory loss	1.97
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy)	6.55
Other condition	5.22
No condition	68.57

[61] The Disability Discrimination Act. 1995. Available at: www.legislation.gov.uk

[62] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

Mental ill health and disability

There is an increased risk of mental ill health for individuals with a physical disability and association between unemployment, poverty and social exclusion. There are significant barriers to access, and mental health problems are more common for individuals with hearing loss and tinnitus than the general population[63]. The learning disabled population are less likely to get evidence-based screening and continue to face barriers in accessing services[64].

Physical illness and suicide

The National Confidential Inquiry[65], 2015 reports that physical illness is known to be a risk factor for suicide. The report found that around a quarter of patients who die by suicide have a major physical illness (3,410 deaths over 2005-2013) and the figure rises to 44% in patients aged 65 and over. In most cases, the illness has been present for over 12 months.

Lifeline and disability

Lifeline data on disability status was not consistently recorded in data provided by current provider and cannot be used for analysis.

Provider staff assigned to the Lifeline contract and disability

There is currently no data in relation to provider staff assigned to the Lifeline contract and disability.

Particular needs in relation to the service

People with sensory impairment have particular needs as to accessing a telephone based service.

[63] Action Hearing Loss. 2014. Available at www.actionhearingloss.org.uk.

[64] Department of Health, Social Services and Personal Safety Northern Ireland. 2012. Fit and well – changing lives 2012-2022: A 10-Year public health strategic framework for Northern Ireland (Consultation document). Belfast: DHSSPS.

[65] Annual report of the National Confidential Inquiry into Suicide and Homicide by people with mental Illness (NCISH). 2015. Available at: http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf

Transport and access to buildings can pose key barriers for people with a physical, sensory or learning disability in accessing face-to-face interventions.

People with sensory and learning disabilities have a need for written information in accessible formats and appropriate communication methods and support.

Signposting and counselling people with disabilities may have particular requirements as to what services offered by voluntary, community and statutory organisations are appropriate for their particular needs ('disability competent' services).

People with disabilities may have particular needs with regards to the assessments as part of a triage as they may present in different ways than people without a disability.

In addition to having accessible information and communication needs, people with disabilities may respond less to mainstream communication methods and thus have a need for targeted communication.

People with disabilities tend to be less likely to come forward to raise a complaint. Moreover, the accessibility of the complaints process is key to those with sensory impairments or a learning disability.

<u>Provider staff assigned to the Lifeline contract and disability</u>
There is currently no data available on provider staff assigned to the Lifeline contract it is reasonable to assume that staff assigned to the Lifeline contract with disabilities will have particular needs in relation to a potential transfer situation.

EQIAs undertaken to date by other organisations highlight that staff who have a disability may experience a number of negative impacts in staff transfer situations:

- concerns about the attitudes and behaviour of new colleagues (feeling comfortable to advise new colleagues of disability and fears as

to the willingness of colleagues to accommodate reasonable adjustments);

- additional travel time having a greater impact on those with a disability than people without;
- physical access to the new building, accessibility of new location by public transport and the availability of dedicated disabled car parking may be key;
- staff with a learning disability may need support in adjusting to a new office environment;
- negative impacts may arise if support networks and services are less accessible from the new workplace.

In summary, although the disability status was not consistently recorded in Lifeline data and cannot be meaningfully used for analysis, it is reasonable to assume that people with disability have particular needs in relation to the service. It is also reasonable to assume that people with disability are over-represented amongst those in need of the Lifeline Crisis Intervention Service and likely that they are currently under-represented amongst actual service users. In terms of staff assigned to the Lifeline contract, it is reasonable to assume that staff with disability will have particular needs to be addressed in terms of any proposed change.

3.1.8 Ethnicity

Potential and actual service users

Table 4: Northern Ireland population statistics, Census[66] 2011

Ethnicity	Number	%
White	1,778,449	98.21%
Chinese	6,303	0.35%
Irish traveller	1,301	0.07%
Indian	6,198	0.34%
Pakistani	1,091	0.06%
Bangladeshi	540	0.03%
Other Asian	4,998	0.28%
Black Caribbean	372	0.02%
Black African	2,345	0.13%
Black other	899	0.05%
Mixed ethnic group	6,014	0.33%
Other	2,353	0.13%

Language (spoken by those aged 3 and over):

- English – 96.86% (1,681,210)
- Polish – 1.02%(17,704)
- Lithuanian – 0.36% (6,249)
- Irish (Gaelic) – 0.24% (4,166)
- Portuguese – 0.13% (2,256)
- Slovak – 0.13% (2,256)
- Chinese – 0.13% (2,256)
- Tagalog/Filipino – 0.11% (1,909)
- Latvian – 0.07% (1,215)
- Russian – 0.07% (1,215)
- Hungarian – 0.06% (1,041)
- Other – 0.75% (13,018)

[66] Northern Ireland Census. 2011. Available at: http://www.nisra.gov.uk/census.html

Travelling Community[67]

The All Ireland Traveller Survey, 2010 estimated that there were 3,905 Irish Travellers in Northern Ireland. Survey findings:

- Main areas of Traveller population: Belfast, Newry and Armagh, Foyle, Mid Ulster, West Tyrone.
- Travellers live in a range of accommodation types, including social housing, serviced sites, grouped homes, on public land, private rented land, and on the side of the road.
- Mortality rates among Traveller children up to 10 years of age have been found to be 10 times that of children from the 'settled' population.
- The cohort of 15-24 year-olds is particularly marked amongst the Traveller population in Northern Ireland. It appears that 10-24 year olds make up about 36% of this population - around 1,400 individuals.

The All Ireland Traveller survey states: "The most common causes of death include heart disease/stroke and respiratory disease, with external causes of death being particularly prevalent among men which include alcohol and drug overdose and suicide. Male Travellers have a suicide rate which is 6.6 times that of men in the general population."

Chinese population:

Currently there are around 8,000 Chinese residents in Northern Ireland, representing 51% of the total ethnic minority population. The Chinese community is currently the largest and most dispersed ethnic minority group living in Northern Ireland. Irwin and Dunn noted in their study of ethnic minorities that the Chinese community is growing at a faster rate than the general population[68].

[67] Equality Commission for Northern Ireland. 2010. All Ireland Traveller Survey. 2010. Available at: www.equalityni.org

[68] Chinese Welfare Association. 2014. Chinese Welfare Association website. Available at: www.cwa-ni.org.

Mental health and ethnicity

Barriers to Accessing Mental Health Services - Views of Black and Minority Ethnic People in Ballymena, 2013[69] highlighted:

- 51% of survey respondents said that not knowing 'who to go to or what kind of help is on offer' would prevent them getting help if they had a mental health problem.
- 13% of respondents agreed that they would be prevented from getting help with a drug or alcohol problem because 'in my culture we prefer to get help within our family'.
- 53% of survey respondents believe that within their ethnic community there is 'a lot' of stigma towards mental health issues.
- 34% of survey respondents agreed that it they had a mental health problem, language difficulties would prevent them from getting help.
- 31% of survey respondents wouldn't feel comfortable using an interpreter because 'they might not fully understand what I am saying or what a professional is saying to me'.

A briefing by the Migration Observatory[70] on migrant health suggests that there are higher rates of depression and anxiety among asylum seekers and refugees compared to the general population or other migrant groups.

Prevalence of mental health problems varies by ethnicity. Those whose ethnic group is black experience the highest rates of suicide attempt, psychotic disorder, any drug use and drug dependence, while those whose ethnic group is white experience highest rates for suicidal thoughts, self-harm and alcohol dependence. Women from the south Asian ethnic group experience highest rates for any common mental disorder[71].

[69] Ballymena Inter-Ethnic Forum (BIEF) in partnership with NHSCT. 2013. Barriers to Accessing Mental Health Services - Views of Black and Minority Ethnic People in Ballymena Available at: www.supportingcommunitiesni.org.

[70] The Migration Observatory. 2011. Health Of Migrants In the UK: What Do we know? Available at: www.migrationobservatory.ox.ac.uk

[71] The 2007 Adult Psychiatric Morbidity Survey For England. 2009. Available at: www.hscic.gov.uk/pubs/psychiatricmorbidity07

There are a number of difficulties experienced by all migrant and minority ethnic groups when accessing any of the public services. Most centre on language and cultural barriers. The immigration process is a stressful process. Migrants may have to deal with issues relating to their life in their home country such as torture, rape, other trauma. They now have to fit into a new society and potential racism without support. They may suffer stress manifesting as insomnia, anxiety, depression, post-traumatic stress disorder and drug and alcohol abuse[72].

Lifeline data and ethnicity

The Lifeline data supplied by the current provider has 21.16% recorded as 'blank' and 'not known' for ethnicity on incoming calls and cannot be used for meaningful analysis.

Table 5: Distribution of incoming 'active' Lifeline calls from clients by ethnicity 2014/15.

Ethnic group	Number of calls from clients	% of incoming 'Active' calls
Blank /not known	6676	12.16
Arab	8	0.01
Bangladeshi	4	0.01
Black African	19	0.03
Black Caribbean	1	0.00
Chinese	16	0.03
Eastern European	52	0.09
Indian	52	0.09
Mixed ethnic group	25	0.05
Other Asian background	84	0.15
Other black background	1	0.00
Pakistani	10	0.02
Travelling community	36	0.07
White African	89	0.16
White European	47842	87.12
Total	**54915**	**100**

[72] Belfast Health Development Unit. Barriers To health - Migrant health and wellbeing in Belfast, Available at: www.belfasttrust.org

Provider staff assigned to the Lifeline contract and ethnicity

No data is currently available on provider staff assigned to the Lifeline contract by ethnicity.

Particular needs in relation to the service

Ethnic minority people with mental illness[73] have particular needs which need to be addressed for them to access services.

There is an indication that Travellers experience poorer mental health and a higher rate of suicide than the settled community; however, the lack of prevalence figures for Northern Ireland needs to be addressed. Mental health is interrelated with substance misuse and other factors (eg domestic violence, social support) which have also been identified as contributors to the mental health of the general population. However, Travellers often experience worse levels of such influencing factors (eg bereavement/loss). Their effects are compounded by discrimination and Traveller culture itself may ameliorate or exacerbate them. Low rates of help-seeking and negative perceptions of mental health services (ie as insufficient, inappropriate, culturally insensitive) can also be understood in this context.

A recent study[74] of first generation migrants in the UK shows a rather complex pattern as suicide is rarer in some cultures/nationals. One suggestion is that first generation migrants may bring the norms of their home country with them.

Epidemiological research should be conducted to determine the prevalence of self-harm in refugees and asylum seekers and the

[73] University of Manchester. 2011. The National Confidential Inquiry into Suicide and Homicide by people with mental illness. Suicide and homicide in Northern Ireland. Available at: www.bbmh.manchester.ac.uk/reports/northern_ireland_full_report_june_2011

[74] Shah, A., Lindsay, J. and Dennis, M. 2011. Suicides by country of birth groupings in England and Wales: age-associated trends and standardised mortality ratios', in: *Social Psychiatry and Psychiatric Epidemiology*, Vol. 46, No. 3, pp. 197-206.

meaning of self-harm to people from different ethnic and cultural groups[75].

Language issues can create considerable barriers for black and minority ethnic people accessing the telephone based and follow on services.

In relation to signposting and counselling, black and minority ethnic people may have particular requirements as to what services offered by voluntary, community and statutory organisations are appropriate for their particular needs ('culturally competent' services); given cultural contexts, confidentiality and ease of access to services play an even greater role for some people from ethnic minorities.

Black and minority ethnic people may have particular needs with regards to the assessments as part of a triage as they may present in different ways than majority ethnic people.

In addition to having interpreting and translation needs, black and minority ethnic people may respond less to mainstream communication methods and thus have a need for targeted communication.

Black and minority ethnic people tend to be less likely to come forward to raise a complaint. Moreover, the accessibility of the complaints process is key to those not fluent in English.

In summary, it is likely that ethnic minority people have particular needs in relation to the service. It can also be assumed that ethnic minority people are over-represented amongst those in need of the Lifeline Crisis Intervention Service and likely that they are currently under-represented amongst actual service users.

[75] National Institute for Health and Clinical Evidence. 2004. Self Harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE Clinical Guideline 16. Available at: www.nice.org.uk/cg16

Provider staff assigned to the Lifeline contract and ethnicity

While there is no data available on provider staff assigned to the Lifeline contract and ethnicity, it is reasonable to assume that the staff assigned to the Lifeline contract distribution by ethnicity may be a similar profile to the Northern Ireland population. Data from relevant EQIAs suggests that similar to some other equality groupings, black and minority ethnic staff, if moved to a less ethnically diverse office location, may not have access to the same networks and support.

3.1.9 Sexual orientation

Potential and actual service users

Lesbian, Gay, Bisexual and Trans gender (LGB&T) UK population
A review from West Midlands concluded that LGB&T people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. Other issues include access to services and attitudes. Nationally, issues are being raised regarding older LGB&T in communal facilities, with concerns around negative responses on the grounds of their sexuality from institutions when life changing events occur[76]. [Not able to separate transgender in this report. Note that gender identity is unrelated to sexual orientation].

Lesbian, Gay, Bisexual and Trans gender (LGB&T) NI population:
There is variation in estimates of the size of the LGB&T population in Northern Ireland. Estimates are as high as 5-7% (65-90,000) of the adult population (based on the UK government estimate of between 5-7% LGB&T people in the population for the purposes of costing the Civil Partnerships Act). A similar proportion, or more recently the Office of National Statistics, estimate 1.5-2% which would be closer to 20-30,000 adults. This latter document is disputed by various LGB&T organisations. [Not able to separate transgender in this report. Note that gender identity is unrelated to sexual orientation].

All Partied Out[77] a scoping exercise explored substance use within the LGB&T communities related to club culture and stimulant drugs. The findings indicated that although this is occasionally the case, the greater level of substance use is related to misuse of depressants, which correlates with our awareness of LGB&T populations as vulnerable in respect of Mental Health Promotion and Suicide Prevention. [Not able

[76] Meads, C., Pennant, M., McManus, J. and Bayliss, S. 2009. Birmingham, West Midlands Health Technology Assessment Group, University of Birmingham. Available at: www.birmingham.ac.uk/Documents/college-mds/haps/projects/WMHTAC

[77] All partied out: Substance use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community. Available at: http://www.rainbow-project.org/assets/publications/All%20Partied%20Out.pdf

to separate transgender in this report. Note that gender identity is unrelated to sexual orientation].

Some of the top line figures from the scoping exercise are as follows:

Demographics

- 941 LGB&T people responded. The second largest piece of LGB&T research ever conducted in Northern Ireland.

- 34% female which is the largest sum of data ever gathered amongst LGB&T women in Northern Ireland.

Drug use

- LGB&T people are substantially more likely than the Northern Ireland population to use drugs, and are nearly three times as likely to have taken an illegal drug in their lifetime (62% v 22%).

- With the exception of poppers, the main drugs that LGB&T people have taken are not stimulants (associated with the nightclub scene) but depressants (cannabis, sedatives and anti-depressants) and opiates.

Alcohol

- 91% of the LGB&T community drink alcohol, compared to 74% of the Northern Ireland population. Of those who drink alcohol, LGB&T people are approximately twice as likely as the Northern Ireland population to drink daily or most days (13% v 6%).

Consequence of substance use

- In the last 12 months, 8% of survey respondents had blackouts and withdrawal symptoms as a result of drug use.
- Drugs and alcohol have contributed to 44% of LGB&T people having unprotected sex.
- The use of drugs and alcohol has been a factor in 15% of all survey respondents and 36% of transgendered respondents self-harming.
- Drugs and alcohol contributed to 30% of LGB&T people thinking about suicide (suicidal ideation) and 13% attempting suicide.

Lifeline and sexual orientation

Sexual orientation is 67.6% ‘blank’ on the Lifeline Crisis Intervention Service user database and cannot be used for analysis.

Provider staff assigned to the Lifeline contract by sexual orientation

While no data is currently available on provider staff assigned to the Lifeline contract by sexual orientation, it is reasonable to assume that they profile the sexual orientation distribution of the Northern Ireland population.

Particular needs in relation to the service

Signposting and counselling – lesbian, gay and bisexual people may have particular requirements as to what services offered by voluntary, community and statutory organisations are appropriate for their particular needs.

In conclusion, therefore lesbian, gay and bisexual people are likely to have particular needs in relation to the service. Although Lifeline data is not available, it is reasonable to assume that lesbian, gay and bisexual groups are overrepresented amongst those in need of the Lifeline service.

Provider staff assigned to the Lifeline contract and sexual orientation

While no data is currently available on provider staff assigned to the Lifeline contract, it is reasonable to assume that the distribution by sexual orientation is a similar profile to the Northern Ireland population.

In a staff transfer situation, lesbian, gay and bisexual staff may have concerns about potential attitudes of new colleagues and line managers and having to come out again, in particular if they perceive a new office location to be less diverse generally. Moreover, a new location may not provide the same access to networks and support. Access routes to new locations leading through hostile neighbourhoods (such as containing homophobic graffiti or locations of hate crimes in the past) may likewise cause concern to staff. Finally, staff who are not out in their current workplace may have difficulties in raising their personal concerns in any discussions of staff transfers and relocations.

3.1.10 Comparing equality impacts of the options appraised

The previous sections outlined equality issues arising from the consideration of the composition of actual and potential service users as well as the particular needs of individual equality groupings in relation to the service.

When comparing the options for the service model and delivery mechanism appraised in the Lifeline Public Consultation Questionnaire paper, the following additional equality considerations are identified:

(1) Separation between helpline and follow-on support services which are locality based and evidence based and evidence informed.

From a clinical point of view, best practice in recent years has evolved. Recommendations point to the need to clearly separate out the follow-on support services which are locality-based, evidence-based and evidence-informed from the helpline.

The rationale for greater benefits for service users resulting from a split of provision between the helpline on the one hand, and follow-on support services which are locality-based, evidence-based and evidence-informed on the other, is based on an empowerment and enablement approach and the reduction of dependency.

In theory, any model and mechanism based on the service being delivered by one provider has the benefit of a continuity of service provision, from the point of view of the service user. Conversely, a model based on separation of the helpline and follow-on services and the principle of empowerment may increase the risk of service users dropping out.

Some equality groupings may be more likely to be amongst these:

- black and minority ethnic groups – on account of the fear of language and cultural barriers as well as being less familiar with the health and social care and community based services;
- people with a disability – due to the perceived or actual access barriers to services;
- trans people – as above;
- lesbian, gay and bisexual people – as above.

In such a scenario, enhanced signposting, face to face de-escalation and complementary therapies can mitigate against the potential negative impacts on the above groups.

(2) Options 6 and 9 versus options 7 and 10
One regional versus several providers (for follow-on support services which are locality based and evidence based and evidence informed).

A set of local providers is likely to ensure greater geographical spread and thus improved equality of access to follow on services. In turn, this will enhance access for small minority groupings, such as trans gender people, some black and ethnic minority people, people with a disability, and people who are lesbian, gay or bisexual all of whom overall may experience greater marginalisation. While, arguably, those locality based services may in some of these cases have less experience in meeting their specific needs (simply based on scale), the contract management provisions will include provisions for close partnership working and sharing learning. The anticipated long-term outcome thus is the improvement of standards region-wide and thus greater regional consistency ultimately.

(3) It is evident that Options 2, 3, 4, 5, 6, 7, and 8 would all result in a reduction of services. Thus the needs of the equality groupings mentioned under the previous sections would remain unmet.

3.2 Good relations

Impacts of the Lifeline Crisis Intervention Service on good relations, whether on the basis of religion, political opinion or ethnicity, have not been identified.

3.3 Disability duties

Encouraging people with a disability to participate in public life

The PHA as an organisation actively promotes the inclusion of disabled people in service planning, monitoring and evaluation such as through Personal and Public Involvement (PPI) initiatives and advisory groups. People with a disability were encouraged to participate in the PHA Lifeline pre-consultation process[78], 2014.

The Lifeline equality screening acknowledges the requirement of providers to ensure that they encourage participation in all aspects of the service including but not exclusively for disabled people to be company directors, employees, service users and carers.

Underpinned with the ethos of enablement and empowerment the proposed Lifeline Crisis Intervention Service model and delivery mechanism provides enhanced signposting, follow-on support services which are locality based and evidence based and evidence informed, psychological therapy, complementary therapy and provision of face to face de-escalation to reduce barriers to access.

Promoting positive attitudes towards people with a disability

The proposed Lifeline Crisis Intervention Service model and delivery mechanism encourages positive attitudes to disabled people and challenges negative stereotyping through the use of inclusive language during the advertising of the Lifeline Crisis Intervention Service.

[78] PHA Lifeline pre-consultation process. 2014. Available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat.

3.4 Human rights

The potential for interference with Article 2 ‘Right to life’ and Article 8 ‘Right to respect for private & family life, home and correspondence’ of the Human Rights Act 1998 has been identified.

These articles may be interfered with if relevant systems, governance, safe practice and referral pathways are not in place under the given providers.

Several of the target groups are vulnerable people or people at a particularly vulnerable point in their lives. We therefore recognise that what we will need to ensure necessary safeguards are in place. To this end, The PHA will be assessing applicants and providers of the Lifeline Crisis Intervention Service against a range of safeguarding areas. For example, providers will need to present evidence of the following being in place and utilised if/when needed, for example:

- data protection;
- governance arrangements;
- referral pathways;
- child protection/vulnerable adults staff training and policies;
- all provider/s will be expected to produce evidence of having the appropriate PHA standards for promoting mental and emotional wellbeing and suicide prevention.
- Relevant levels of staff training/accreditation/ qualifications.

The following policies / procedures will be in place with any awarded provider:

- COSHH Policy and Guiding Principles
- Complaints Procedure Guidelines
- Drug and Alcohol Workplace Policy
- Untoward incidents procedure
- Protection of children and vulnerable adults (Northern Ireland) Order 2003 (POCVA).

4 CONCLUSIONS

4.1 Summary and assessment of main findings

Service users/carers

The data suggests that the Lifeline Crisis Intervention Service is likely to have equality implications on the basis of all nine Section 75 groups.

Some equality groupings are likely to be overrepresented amongst those in need of the service:

- specific age groups (men and Women);
- transgender people;
- single, separated, divorced, widowed people as they are more likely to be living alone;
- people with dependants;
- people with a disability;
- black and minority ethnic people;
- lesbian, gay and bisexual people.

At the same time, some of these equality groupings have particular needs regarding access to the Lifeline service, based on their communication needs:

- people with a disability;
- black and minority ethnic people.

Current actual and perceived barriers as well as differences in help-seeking behaviours may contribute to some of the above groups including people with a disability, black and minority ethnic people and men to be underrepresented amongst the actual users of Lifeline Crisis Intervention Service.

As regards particular needs relating to the proposed Lifeline Crisis Intervention Service model and delivery mechanism, the data suggests that the following groups have particular needs:

- men;
- women;

- children and young people;
- transgender people;
- people with dependents;
- people with a disability;
- black and minority ethnic people.

Provider staff assigned to the Lifeline contract

There is limited data available with regards to the equality composition of provider staff assigned to the Lifeline contract. Based on their specific needs in a potential transfer situation, impacts are likely to arise for the following equality groups in particular:

- women;
- young people;
- Trans people;
- people with dependants;
- people with a disability;
- black and minority ethnic people;
- lesbian, gay and bisexual people.

4.2 Proposed actions

Service user/carer

From an equality point of view, the Lifeline Crisis Intervention Service constitutes positive action: based on identified need, it seeks to target directly a number of Section 75 groupings and people with multiple identities.

Separating the helpline from the follow-on support services which are locality-based, evidence-based and evidence-informed will support the development of the empowerment and enablement approach, focus providers on effective and efficient service delivery, protecting funding for each element of the service and reduce risk of service failure through improved contingency arrangements. The budget allocation is being enhanced and this additional funding and efficiency provided by separating the services and introducing competition into the market place will deliver better return of investment in terms of a broader range

of services offered, fairer distribution of resources across localities and increased volume of service delivered.

The referral to emergency services and primary care, enhanced signposting and face-to-face de-escalation have been included to reduce barriers to engagement and, as appropriate, provide a link between the helpline and follow-on support services which are locality based and evidence based and evidence informed for the most vulnerable groups. For some, broadening the range of follow-on support services which are locality-based, evidence-based and evidence-informed to include complementary therapy will reduce barriers engagement with psychological therapy.

There will be no change in the care pathway for vulnerable service users such as children and young people and the prison population. The proposed Lifeline model and delivery mechanism recognises that Lifeline is part of a wider health and wellbeing system and vulnerable groups such as children and young people and the prison population require Lifeline to develop a partnership approach with existing statutory and voluntary and community services who provide the specialised services required.

The telephone helpline will be available for all ages; call operators should be competent and capable of handling calls from children and young people. All children and young people who contact the Lifeline crisis helpline service will be risk assessed: if deemed to be at minimal risk, the caller will be offered signposting to other services; if deemed to be at low risk and suitably mature and it is clinically necessary, the caller will be offered enhanced signposting and referral to Lifeline follow-on support services which are locality based and evidence based and evidence informed; if deemed to be at high risk, the caller will be referred to Gateway services; and if deemed to be at immediate risk, the caller will be referred to the emergency services. All assessment will entail follow up with General Practice services. It is also expected that any community based provider would be able to access suitably qualified staff to work with these young people of all ages, and ensuring that they are supported and/or referred/signposted to appropriate services.

The PHA's role covers a wide range of issues across health improvement, health protection, service development and screening and aims to improve health and wellbeing of all people in Northern Ireland (covering all section 75 groups) as well as reducing health inequalities.

Based on need and evidence based practice the proposed Lifeline model and delivery mechanism aims to meet the needs of specific target groups. The proposed Lifeline model and delivery mechanism highlights the requirement to have systems and processes in place to monitor specific outcomes. However in doing this, the PHA was mindful of the need to ensure that the process and related documentation is accessible to all and widely available in different formats, eg accessibility statement, detailed guidance notes for applicants. The collection of monitoring data will allow assessing need for further targeted interventions in the future.

With regards to specific Section 75 groupings, the following actions are proposed to address identified impacts:

Gender

- A planned transition to the empowerment and enablement approach – helpline operators are from a range of relevant backgrounds and experience.
- Awareness raising – Lifeline communication strategy is targeted in particular to adult males.
- Enhanced signposting and follow-on support services which are locality-based, evidence-based and evidence-informed to reduce barriers to engagement particularly for adult males and trans gender people.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include walk in face-to-face de-escalation and complementary therapy to reduce barriers to engagement with psychological therapy.
- Underpinned by evidence based and evidence informed practice to promote effective practice.

Age

- Emerging technologies utilised to promote awareness of the service particularly with younger and older population.
- Enhanced signposting and follow-on support services which are locality based and evidence based and evidence informed to reduce barriers to engagement.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include walk in face-to-face de-escalation and complementary therapy to reduce barriers to engagement with psychological therapy.
- Children and young people who phone the Lifeline will be assessed. If deemed to be at minimal risk, the caller will be offered signposting to other services; if deemed to be at low risk and suitably mature and it is clinically necessary, the caller will be offered enhanced signposting and referral to Lifeline follow-on support services which are locality based and evidence based and evidence informed; if deemed to be at high risk, the caller will be referred to Gateway services; and if deemed to be at immediate risk, the caller will be referred to the emergency services.

Religion

- Locality based follow-on support services which are locality based and evidence based and evidence informed to enable fair distribution of finite resources across different communities.
- A planned transition to enablement and empowerment approach which is respectful of difference.
- Locality based services in neutral or mix of venues to ensure accessibility for all community backgrounds.

Political opinion

- Follow-on support services which are locality based and evidence based and evidence informed to enable fair distribution of finite resources across different communities.
- A planned transition to enablement and empowerment approach which is respectful of difference.

- Follow-on support services which are locality based and evidence based and evidence informed in neutral or mix of venues to ensure accessibility for all community backgrounds.

Marital status

- 24/7 access to helpline service reduce barrier to engagement when in crisis.
- Enhanced signposting for people to engage with follow-on support services which are locality based and evidence based and evidence informed particularly for adult males living alone and some married transgender people transitioning in relation to their gender.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include walk in face-to-face de-escalation and complementary therapy to reduce barriers to engagement.
- Lifeline free at point of service delivery particularly for some people living alone.

Dependent status

- A planned transition to empowerment and enablement approach –helpline operators are from a range of relevant backgrounds and experience.
- Appropriate liaison with carers regarding individual safety plans.
- Lifeline free at point of service delivery particularly for people with dependents.
- 24/7 access to helpline service reduce barrier to engagement when in crisis.
- Follow-on support services which are locality based and evidence based and evidence informed to reduce barriers to engagement particularly for people with dependents.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include face-to-face de-escalation and complementary therapy to reduce barriers to engagement.

- Staff support – ensure adequate measures are in place for staff to debrief.

Disability

- A planned transition to empowerment and enablement approach –helpline operators from a range of relevant backgrounds and experience.
- Emerging technologies utilised in the Lifeline Crisis Intervention Service with promotional materials sensitive in particular to needs of people who are sensory impaired or have a learning disability.
- Enhanced signposting for people who require support to engage with follow-on support services which are locality based and evidence based and evidence informed particularly for disabled people.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include walk in face-to-face de-escalation and complementary therapy to reduce barriers to engagement.

Ethnicity

- A planned transition to the empowerment and enablement approach for frequent service users – helpline operators are from a range of relevant backgrounds and experience.
- Awareness raising – Lifeline communication strategy is accessible and culturally sensitive to black and minority ethnic people.
- Emerging technologies utilised in the Lifeline Crisis Intervention Service with promotional materials sensitive in particular to needs of black and ethnic minority people.
- Enhanced signposting for people who require support to engage with follow-on support services which are locality based and evidence based and evidence informed particularly for black and minority ethnic people.
- Lifeline is free at point of service delivery particularly for black and minority ethnic people.

- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include face-to-face de-escalation and complementary therapy to reduce barriers to engagement particularly for black and minority ethnic people.

Sexual orientation

- A planned transition to the empowerment and enablement approach for frequent service users – helpline operators from a range of relevant backgrounds and experience.
- Broadening the range of follow-on support services which are locality based and evidence based and evidence informed to include face-to-face de-escalation, enhanced signposting and complementary therapy to reduce barriers to engagement.
- 24/7 access to helpline service reduce barrier to engagement when in crisis.
- Enhanced signposting for people who require support to engage with follow-on support services which are locality based and evidence based and evidence informed particularly for lesbian, gay and bisexual people.

To address the particular needs of people from black and minority ethnic people, people with a disability, lesbian gay and bisexual people, as well as trans people in relation to signposting, complementary therapy and psychological therapy and in parts triage, assessment and de-escalation the required competencies and associated training issues of service provider staff will be considered in the development of the specification.

The need for providers to operate accessible complaints procedures will likewise be considered at that stage.

Provider staff assigned to the Lifeline contract

In relation to provider staff assigned to the Lifeline contract, where a service transfers from one provider to another, there would be a working assumption that the Service Provision Change (Protection of

Employment) Regulations (Northern Ireland) 2006[79] (the "2006 Regulations") (S.R. 2006 No. 177) apply. For an employee to transfer, it would have to be established that the employee is working mainly or wholly on the service being transferred.

In addition, the following measures will seek to address the equality issues identified in the course of this assessment:

- Assurance to provider staff assigned to the Lifeline contract who have a disability that reasonable adjustments should be put in place by any potential new employer or in any new workplace in discussion with the individual.
- Assurance to all provider staff assigned to the Lifeline contract that robust policies should be in place by any potential new employer to protect individuals from discrimination on the basis of any equality grounds and to promote equality of opportunity and good relations.
- Assurance to provider staff assigned to the Lifeline contract who currently avail of flexible working arrangements that their needs should be considered in discussion with the individual.
- Address concerns on the basis of religion, ethnicity, trans gender status, or sexual orientation – the development of the specification will give consideration to the need for neutral work environments and accessible office locations and their access route.

4.3 Proposed monitoring

A range of information and data will be collected, including inclusion and participation of disabled people where possible, to assist the PHA to fulfil our legal requirements as well as assist in the planning of services for the future.

Quantitative data to be collected: gender, age, locality, disability, ethnicity, sexual orientation, religion, marital status, dependent status of service users and public awareness.

[79] The Service Provision Change (Protection of Employment) Regulations (NI). 2006. Available at: www.legislation.gov.uk/nisr/2006/177.

Qualitative data to be collected: complaints/compliments, Serious Adverse Incidents and service user feedback systems.

The PHA will be ensuring providers have the essential tools, resources, skills, and arrangements to collect comprehensive equality data.

Appendices

Appendix 1: The steps of an EQIA

- **What is it we are actually looking at? ('Aims of policy')**

The first part of an EQIA involves thoroughly understanding the policy to be assessed; what context it is set in; who is responsible for what; what links there are with other organisations or individuals in implementing the policy etc.

- **How can we tell what is happening on the ground? ('Consideration of data')**

This involves reviewing what data is available in-house or elsewhere and identifying what data needs to be newly collected. 'Data' means both statistics and the views, experiences and suggestions of those affected by the policy. 'Collecting new data' means going out and doing a survey and also talking to people who are affected by a policy or those who are involved in implementing the policy, for example in delivering a service.

- **So are there any problems for any of the groups? ('Assessment of impacts')**

All relevant data that has been identified (whether collected from available sources or newly gathered) is brought together and analysed. Conclusions are drawn as to the impact of the policy on the nine groups.

- **What can be done to make things fairer? ('Consideration of measures')**

Now the findings are related back to action: proposals are what can be done to address any inequalities/ unfairness that the analysis of the data has revealed.

- **Are we getting the right picture and are we thinking of doing the right thing? ('Formal consultation')**

The findings and the proposed actions are brought back to the public at this stage, usually on the basis of a draft report. Now it's time to find out what people think about the analysis and proposals!

- **With what people have told us – what are we going to do? (‘Decision by public authority’)**

After the wider public has had a chance to comment on the analysis and proposals it’s time for the organisation to take final decisions and commit themselves to action points.

- **This is what we have found out and this is what we will do (‘Publication of results of EQIA)**

These decisions and commitments are published in a final report alongside the findings from the analysis of collected data and the comments raised by the wider public during formal consultation.

- **Keeping a close eye on what is happening (‘Monitoring of adverse impacts’)**

An EQIA is not a one off. It’s important to keep a close eye on what difference the changes to the policy actually make.