Haringey Council

Equality Impact Assessment

Name of Project	Substance misuse peer support service re procurement	**Cabinet meeting date** ***If applicable***	15th December 2015
Service area responsible	Public Health		
Name of completing officer	Sarah Hart	**Date EqIA created**	February 2015
Approved by Director / Assistant Director	Jeanelle De Gruchy	**Date of approval**	26th November 2015

The Equality Act 2010 places a '**General Duty'** on all public bodies to have '**due regard'** to:

- **Eliminating discrimination, harassment and victimisation and any other conduct prohibited under the Act**
- **Advancing equality of opportunity between those with 'protected characteristics' and those without them**
- **Fostering good relations between those with 'protected characteristics' and those without them.**

In addition the Council complies with the Marriage (same sex couples) Act 2013.

Haringey Council also has a '**Specific Duty'** to publish information about people affected by our policies and practices.

All assessments must be published on the Haringey equalities web pages. All Cabinet papers MUST include a link to the web page where this assessment will be published.

This Equality Impact Assessment provides evidence for meeting the Council's commitment to equality and the responsibilities outlined above, for more information about the Councils commitment to equality; please visit the Council's website.

Stage 1 – Names of those involved in preparing the EqIA	
1. Project Lead – Sarah Hart	5.
2. Equalities / HR	6.
3. Legal Advisor (where necessary)	7.
4. Trade union	8.

Stage 2 - Description of proposal including the relevance of the proposal to the general equality duties and protected groups. Also carry out your preliminary screening (Use the questions in the Step by Step Guide (The screening process) and document your reasoning for deciding whether or not a full EqIA is required. If a full EqIA is required move on to Stage 3.
EQIA duty – An equalities analysis has been carried out as part of the commissioning process for the substance misuse peer support service. The substance misuse Joint Strategic Needs Assessment (JSNA) contains data published annually from Public Health England (PHE) which enables the council to continuously explore better meeting the needs of our residents. This data along with focus groups, stakeholder interviews and monitoring information has helped review the service from an equalities perspective **Background -** The current service Bringing Unity Back into the Community (BUBIC) was an NHS contract transferred to the Council in 2013. It has been running for over 10 years. BUBIC was started by a group of black African male residents who had successfully overcome their addiction, and identified the need for an additional service to be run by those who had themselves been through treatment. There is evidence that substance misuse clinical services benefit from having a peer support service working alongside them delivering community support[1]. BUBIC has achieved its ambition to help black African male crack cocaine users. Although not set up to work with women it has also successfully engaged with black female drug users. It has also attracted in other BME (black and ethnic minority) residents. This wide diversity of service users has been achieve through the peer support model, where a resident from a community entering the service is used to reach and support others. Examples of success with this model include having peers currently who are Turkish, Somali and Polish. In 2014/15 69% of the services users reported being from a BME group.

[1] Bernstein J, Bernstein E, Tassiopoulos K, et al.: Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence* 77:49–59, 2005

[1] Tracy K, Burton M, Nich C, et al.: Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *American Journal of Drug and Alcohol Abuse* 37:525–531, 2011

Stage 3 – Scoping Exercise - Employee data used in this Equality Impact Assessment **Identify the main sources of the evidence, both quantitative and qualitative, that supports your analysis. This could include for example, data on the Council's workforce, equalities profile of service users, recent surveys, research, results of recent relevant consultations, Haringey Borough Profile, Haringey Joint Strategic Needs Assessment and any other sources of relevant information, local, regional or national.**	
Data Source (include link where published)	**What does this data include?**
Haringey Joint Strategic Needs Assessment (JSNA) http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment/health-improvement/drug-misuse-adults	Estimated level of drug use in Haringey, data on those accessing treatment in terms of age, gender, ethnicity.
Haringey Lesbian, Gay, Bisexual and Transgender needs assessment http://www.haringey.gov.uk/social-care-and-health/health/joint-strategic-needs-assessment/health-improvement/drug-misuse-adults	Report highlighting national data showing substance misuse in LGBT communities as being high and suggested recommendations for Haringey
PHE/Drug Scope www.drugscope.org.uk – Its about time	National report highlighting how the drug using population are aging and their needs are generally hidden
Literature review completed by the Public Health team around the evidence base for peer support	Key evidence from 2 randomised trials[2,3], which address the effectiveness of peer-support as an adjunct to substance misuse recovery services.

Stage 4 – Scoping Exercise - Service data used in this Equality Impact Assessment

[2] Bernstein J, Bernstein E, Tassiopoulos K, et al.: Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence* 77:49–59, 2005

[3] Tracy K, Burton M, Nich C, et al.: Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *American Journal of Drug and Alcohol Abuse* 37:525–531, 2011

Data Source (include link where published)	What does this data include?
JSNA and monitoring information	**Data regarding effectiveness of peer support** • Randomised control trials on peer support show generally positive outcomes with increased satisfaction, improved relationships between service users and providers, reduced relapse rates and increased engagement and completion of treatment.[2] there is also some evidence from the prison setting that peer-support services can have a positive impact on the health of the service users.[4] • It is thought that the value of peer-support in substance misuse comes from the experience of the peers who are in recovery themselves, and share their experience of forming a new and demanding lifestyle.[5] Peer support within communities can inform and engage people in their health status, improving their health literacy. As a result, both individual and community are empowered to reduce health inequalities.[6] It is generally accepted that peer-based and professional-based services should be seen as complementary to each other with peer-support acting as an adjunct to mainstream services.[6] **Prevalence** ■ In 2012 the estimated prevalence of crack cocaine and opiate users in Haringey was 1,847 or 10.0 per 1,000 (Haringey Health Profile, 2015). The national rate for England was 8.4 per 1,000. Given that Haringey's population has risen by less than 3,000 since 2012 we can make the assumption that this estimation remains accurate. ■ Women consistently make up a quarter of the drug treatment population and this reflects the national ratio of males to female reported problematic drug use. (Home Office 2014)

[4] South J et al. A systematic review of the effectiveness and cost-effectiveness of peer-based interventions to maintain and improve offender health in prison settings. *HEALTH SERVICES AND DELIVERY RESEARCH* 2014 VOL. 2 NO. 35

[5] White W.L. Peer-based addiction recovery support: history, theory, practice, and scientific evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services, 2009

[6] Harris J et al. Can community-based peer support promote health literacy and reduce inequalities? A realist review. *Public Health Research* Feb 2015;3(3)

- Around one in 100 people in Haringey use crack and/or opiates. Those most vulnerable to problematic drug use, especially crack cocaine and heroin use, are more likely to live in deprived areas, suffer from mental ill health, live in poor housing and be involved in other criminal activity (National Treatment Agency, Oct 2011) and the same is also true of Haringey. Current data (TOP 2015[7]) shows that locally those entering treatment for cocaine and crack use were using at a frequency above the national average, however completion rates for treatment in Haringey are above national averages (PHOF 2015)
- Substance misuse is not confined to certain racial groups nor is it totally absent, thus it would be expected that services reflect the local demographic
- In 2014/15 the current peer support service had contact with around 2000 residents and had just over 1000 attendances at its peer support services. 69% of those using the service were from BME groups. (see table below)

White (British,Irish,European)	31%
Black (African, Caribbean)	44%
Mixed (White/Black/Other)	17%
Asia (Indian,Pakistian,Bagladish,Chinese)	5%
Other (Turkish,Kurdish,Cypriot)	3%

Table of breakdown of BUBIC clients in 2014/15

- Lesbian Gay Bisexual and Transgender (LGBT) (see Haringey JSNA for full review)
- Nationally, recent drug use is estimated as three times higher amongst those reporting themselves as gay or bisexual (32.8%) than heterosexual adults (10.0%).
- The risk of alcohol dependence is twice the rate in LGB people compared to control groups and four times the rate in lesbian and bisexual women.
- Prevalence of new psychoactive substances (NPS) is high where as crack and heroin use is uncommon.
- Pattern of use is changing – among gay men drugs such as amyl nitrite (poppers), cannabis, amphetamine and LSD are becoming less common, and the use of drugs such as cocaine, ecstasy, ketamine and GHB is increasing.
- LGB &T is not a homogenous group, needs differ as does the evidence – majority of which currently reflects patterns of substance misuse among gay men or men who have sex with men.
- Stigma, discrimination and harassment contribute to the high prevalence of substance misuse, along with social settings which involve drug taking and alcohol use.
- Many still report experiencing prejudice and discrimination from health services as well as inept responses following

[7] TOP is Treatment Outcome Profile

	disclosure • In health services in general there is a lack of engagement with the LGBT community to understand their specific needs. • Lack of monitoring is in evidence across health services – e.g. 31% of mainstream mental health services monitor LGBT status in comparison to ethnicity (93%) • Lack of evidence and monitoring means that LGB & T groups and their needs are invisible. • Between 6%-13% of clients in alcohol or drug treatment in Haringey are likely to be bisexual, lesbian or gay
Qualitative data from focus groups and stakeholder interviews	As part of the consultation two focus groups were run, one for current service users and one for those not currently/previously using the service; in total there were 25 participants, participants included women (40%) and BME (75%) residents . The consultation was designed by the service user involvement lead for Haringey and the public health commissioner; it was undertaken by independent members of the public health team. The consultation looked at the following - What was beneficial about the current service - Whether there were any reasons/barriers to using the service - What improvements could be made - How service users like to be consulted in future The key findings were: Views were commonly shared across the focus groups and are summarised below **1. Benefits of a peer led service** • Everyone has different stories/a different journey and it's important for these to be shared/heard • Peers have insight and understanding of what people are going through • Peers help to build 'emotional literacy' (understanding what we do and why) and social skills **2. Essential elements of the existing service that must remain** • Run by peers who have come through their addiction • Support from local peers, people you know from your own community who have recovered • Night outreach into the heart of the community and to reach people sleeping rough • Women and men only groups, • Active follow up if you drop out, a service not afraid to come to your home • Volunteering and accredited training to help get you into employment • Socialising space • Holistic view of people, seeing housing, exercise, diet; as elements of recovery not just stopping the use of drugs.

Qualitative data from It's About Time [8]	**3. Improvements** • Targeted advice and information outreach to various more marginalised groups i.e. BME gay men • 24 hour help telephone number **4. Ways to consult in future** • Attendance at service user forums and support groups by Council Officers • NOT feedback surveys and boxes in receptions/waiting rooms This paper highlights that older people have specific needs linked to their physical health, many have disabilities and that these are not taken into consideration by drug services. It also described how older people's recovery goals are seldom explored and they are often not expected to have recovery aspirations.

[8] PHE/Drug Scope www.drugscope.org.uk – It's about time

Stage 5a – Considering the above information, what impact will this proposal have on the following groups in terms of impact on residents and service delivery: Positive and negative impacts identified will need to form part of your action plan.				
	Positive	**Negative**	**Details**	**None – why?**
Sex	YES		24% of those using the service are women, this is reflective of both estimated prevalence and current usage of Haringey substance misuse services (per the Haringey JSNA women consistently make up a quarter of the drug treatment population). The women in the focus groups expressed the importance of there being a balance of women in the service; the challenge in maintaining this ratio is that women's drug use is more stigmatised than men's and they often have fears related to being recognised as drug using mothers/grandmothers. Many of the women accessing the service will have experienced violence and the service will be expected to be part of the Haringey programme to end violence against women and girls.	
Gender Reassignment			Data not currently collected and this will be included in the new data collection requirements	
Age	YES		This service is only for those over 18 years as Haringey has a young people specific drug service. The largest age group in services is 35-45 years but the average age has been rising. There is a need for the new service to provide a wide spectrum of recovery support activities to meet the needs of each age group, avoiding assumptions that older people cannot change and thus are not interested in recovery. We would expect the new service to continue to deliver examples of older adults undertaking recovery activities i.e. time credits, volunteering, accredited training and accessing work placements.	
Disability	YES		There is no evidence that those with a disability are any more likely to have a drug problem, neither are they less likely to, therefore services should be adaptive and responsive to those with any form of disability. There is evidence that those in treatment are ageing and developing physical disabilities[9]. The service will be encouraged to consider recruiting peer supporters who have a disability and will be encouraged to invite guest speakers from the council i.e.	

[9] PHE/Drug Scope www.drugscope.org.uk – It's about time

			social workers to provide up skilling. In terms of access, home visiting was identified as a key element that this service provides and substance misuse services in Haringey do not. Mental ill health is also strongly associated with substance misuse and staff and peers currently attend public health 'mental health first aid' training.	
Race & Ethnicity	YES		69% of those using the existing service are from BME groups, those interviewed were clear that having a service in Haringey that was led by BME peers was important. Offering a mentoring qualification has proved a good way to attract in a diverse range of peers. English not being the first language of clients is often an issue and so it is of great benefit having peer supporters drawn from Haringey's' diverse community i.e. currently there are Polish, Turkish and Somali peers who can work with people in their first language, better support families and understand barriers to recovery.	
Sexual Orientation	YES		The service does not currently collect data on sexual orientation; however national estimates suggest that between 6-13% of those in treatment are LGBT. Many still report experiencing prejudice and discrimination from health services as well as inept responses following disclosure. The consultation highlighted engagement with LGBT residents particularly through outreach as a gap. The new service will collect data on sexual orientation and will work through its outreach with organisations such as, Wise Thoughts and London Friends to support LGBT residents. Previous needs assessment highlights the importance of specific LGBT substance misuse training.	
Religion or Belief (or No Belief)	YES		The service has a church based in the same building and there are joint outreach activities. In 2015/16 the service ran a peer mentoring programme for faith leaders, this was attended by a broad section of faith leaders. It would be expected that this work continues.	
Pregnancy & Maternity	YES		Pregnant women are cared for at The Grove the main drug service, which is co located with the peer support service, so they would be encouraged to engage. Mothers can get support from the specialist substance misuse parenting service Insight Platform.	

Marriage and Civil Partnership (note this only applies in relation to eliminating unlawful discrimination (limb 1))	YES		The service whilst developing, found that there was a need to create a support mechanism for the friends and families of those with a substance misuse problem, in their own right, irrespective if their partner was in treatment. Included within the specification is to offer a peer led friends and families support group.	

Stage 6 - Initial Impact analysis	Actions to mitigate, advance equality or fill gaps in information
Sex - The initial assessment of the data has highlighted that women are accessing the service **Age** – the treatment population is aging and they may have specific needs, low recovery expectations by services can be a barrier **Disability** – people with disabilities are as likely as other residents to need services **Race and ethnicity** – the existing service is 70% BME **Sexual orientation** - LGBT residents may be at higher risk than the general	**Sex**-There are targets within the specification regarding the ratio of women attending the service, which are achievable and will be monitored quarterly. To support reaching the target the service will be expected to train and use female peer supporters, do targeted outreach and community engagement i.e. work with Holloway Prison and the local female sex worker project and provide women only groups. In the consultation men asked for a men only group which has been specified within the contract. **Age** – Data on age of service users will be reviewed at quarterly monitoring meetings to ensure that it is extending to older people; this will include those being offered accredited mentoring and volunteering opportunities. **Disability** – In terms of physical disability and some mental health issues the tender specification included home support and access via a wide number of community settings. The service will have access to training, advice and support from social workers/education workers working with those with learning disabilities to ensure all written service/ support materials are accessible. Peers can attend the Public Health commissioned mental aid first aid training **Race and ethnicity** – Tender specification requires the service to meet 70% BME access and they are expected to demonstrate how they will achieve this in the evaluation. There will be ongoing monitoring to ensure targets are met.

population of having a substance misuse issue.	**Sexual orientation** – Other Haringey substance misuse services are now all expected to provide an annual report on the percentage of LGBT residents accessing the service, this will now include the peer support service. As per recommendation in the Haringey LGBT needs assessment, all substance misuse workers/volunteers and peer mentors have been trained by an LGBT organisation in assessment of need and case management. The new service will collect data on sexual orientation and will work through its outreach with organisations such as, Wise Thoughts and London Friends to support LGBT residents.

Stage 7 - Consultation and follow up data from actions set above	
Prior to tendering 2 focus group events were undertake with service users, one group using the service and another not using the service ; in total there were 25 participants. Participants included women (40%) and BME (75%) residents. The write up from the event was published to the participants who had an opportunity to revise any inaccuracies. The presentation was given to the public health team for peer review. The findings of the focus group was incorporated into the tender documents and given to all bidders. 5 current and ex service users were trained and supported to participate in the evaluation. The participants were given the focus group findings and asked to take these into consideration when scoring. No further consultation has taken place at this stage, there will be ongoing discussions and surveys of service users when the contract is awarded **Data Source (include link where published)**	**What does this data include?** See qualitative data section
Stage 8 - Final impact analysis	
This EQIA process identified that this was a service which was highly relevant to those with protective characteristic, this was taken into consideration at every stage of the procurement process i.e. focus groups, specification, method statement and having service users trained to be part of the evaluation panel. The existing service was clearly meeting a wide range of needs, but it had just evolved to work in this way. Within the new contract the richness of the service has now been captured and will be further built upon from suggestions from focus groups and the successful tender winner's method statement.	

The provider does need to ensure that it is monitoring its ability to meet its equalities duties and this is best demonstrated in providing information quarterly to the commissioner on protective characteristics. The focus groups made clear the need to create services that target women. A recommendation is that a constant level of female peer mentors is maintained and women's groups provided. The peer mentorship programme is an opportunity to have a very diverse range of peers that have competencies through lived experience to work with those with protective characteristics.

The literature review highlights how older drug users have specific needs often linked to physical disabilities. It should also be noted that there are often negative assumptions made regarding what they aspire to in their recovery, the service should review its offer to older drug users and ensure that they are accessing recovery elements of the service.

The EQIA highlights ways for the service to improve access to those with disabilities through skills training i.e. mental health first aid training. Suggestions from the focus groups that will be expected within delivery include an out of hours help line, women only groups, supported outreach to LGBT residents.

Stage 9 - Equality Impact Assessment Review Log

Review approved by Director / Assistant Director		Date of review	
Review approved by Director / Assistant Director		Date of review	

Stage 10 – Publication

Ensure the completed EqIA is published in accordance with the Council's policy.