APPENDIX 4

HARINGEY COUNCIL

EQUALITY IMPACT ASSESSMENT FORM

Service: **Safer & Stronger Communities - Drug & Alcohol Action Team**

Directorate: **Urban Environment**

Title of Proposal: **Deletion of Polish Alcohol Outreach Worker and Alcohol Hospital & Link worker Post at Haringey Advisory Group On Alcohol**

Lead Officer : Marion Morris

Names of other Officers involved: Linda Somerville

Step 1 - Identify the aims of the policy, service or function

Following the Governments comprehensive spending review (20th October 2010) many of the grants that used to come to local authorities have been either trimmed or cut completely. Specifically the Area Based Grant, which the DAAT have used to commission the Polish Outreach Worker post and the Alcohol Hospital liaison post, is coming to an end. These posts are delivered by Haringey Advisory Group on Alcohol – the boroughs' voluntary sector Alcohol service. This proposal will mean that:

The Post of Polish Outreach worker will not be commissioned by LBH as the ABG has ended

T**he Hospital Link worker post has been picked up by temporary funding from Health and will be subject to a 9 month evaluation – at the end of which a decision will be made as to whether Health will continue to invest in this post.**

Whilst **this** EIA is specifically addressing the cuts to the above posts is should be noted that HAGA is being hit by a range of further cuts, which in their totality amount to the end of some key services for people with alcohol problems in Haringey. Alcohol services have historically received a disproportionate amount of 'funding'. The alcohol allocation is made up largely of mainstream health and social care monies and more recently the ABG. This is in comparison to the drugs agenda which has benefitted from a separate 'ring-fenced' budget (Adult Drug Pooled Treatment Budget) from central government, along with historic mainstream monies. This, coupled with the minimal mainstream investment in alcohol services has meant that the impact of cuts from the ABG have been more severe on alcohol services as there is nothing to cushion it.

Equality Duty

As a public authority, Haringey Council is bound by a general duty created by section 149 of the Equality Act 2010. That duty requires that in all its functions, the Council has due regard to the need to:

a) "eliminate discrimination. Harassment and victimisation";
b) "advance equality of opportunity between different groups";
c) "foster good relations between different groups".

As defined by S149(3) of the Act, having "due regards" means having due regards in particular, to the need to:

a) "Remove or minimise disadvantage suffered by persons who share "a protected characteristic". (this includes people who share the protected characteristics of race/ethnicity, sex (formerly gender), disability, age, religion or belief, sexual orientation, gender reassignment, marriage and civic partnership and pregnancy and maternity)

b) "Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share that characteristic".

c) "Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low".

In relation to this proposal, all three aspects of public sector equality duty are relevant. Accordingly, the purpose of this equality impact assessment is to examine this proposal in detail if, in what ways and to what extent the proposal to cut the Polish Outreach Worker Post and the Alcohol Hospital Liaison Post could:

- Have a disproportionate adverse impact any group of existing or potential service users who share any of the protected characteristics listed above.
- Impact on good relations between groups in Haringey.
- What, if any steps could be taken to minimise any adverse effects on those groups.
- To draw the attention of decision-maker to the findings and conclusions of this assessment in a formal report on the proposal in order to inform his/her decision".

Polish Outreach Worker Post

The post is commissioned as a direct result of a piece of research commissioned by the DAAT to help the borough better understand and in turn respond to street drinking in the borough, specifically among the migrant communities. This was a particular concern of residents at the time. In addition, health care professionals were reporting an increase in attendances from the Polish community at the North Middlesex A & E department through excessive alcohol use. There were also concerns about the high numbers of Polish men congregating outside Wickes in the Seven Sisters area, looking for day labour, which if not successful would often result in visible street drinking in the area. Whilst drinking in open spaces in Polish culture is quite acceptable, this is not the case in the UK. Part of this projects' remit was to produce leaflets in Polish to explain that 'street drinking' is not acceptable in the UK and it can result in what was then an ASBO.

The post holder makes contact with the Polish community through street outreach, at hospital (both at A & E and on the wards) and at HAGAs services.

Alcohol Hospital Link Worker Post (complex needs)

The second post is commissioned as part of an overall approach to reducing alcohol related hospital admissions /A & E attendances and improve uptake of alcohol treatment in the community for patients who have been admitted to hospital with alcohol related problems.

Since HAGA commenced a Hospital Link work and Assertive Outreach model, there has been a 30% reduction in individual attendees to NMUH.

Annual figures for cost of "frequent attenders" to NMUH

cost year	**Haringey**	**No of individual "frequent attenders"**
2007	213135	30
2008	249775	32
2009	141580	23
2010	82720	21
Total cost (£s)	**687210**	

The cost of alcohol in London is estimated to be £2.46 billion – 405 million in costs to the NHS, and £825 million in costs to London councils (this excludes costs to social services) and says nothing of the huge social gains to be made by reducing alcohol related harm. The post has been granted 'invest to save' monies by Health and will be subject to a 9 month local review to confirm if the post does save money, reduce A & E attendances and hospital admissions.

Step 2 - Consideration of available data, research and information

The latest data from the North West Public Health Observatory on alcohol indicates that alcohol related hospital admissions per 100,000 populations in Haringey have increased by 24% since Q2 in 2009/10.

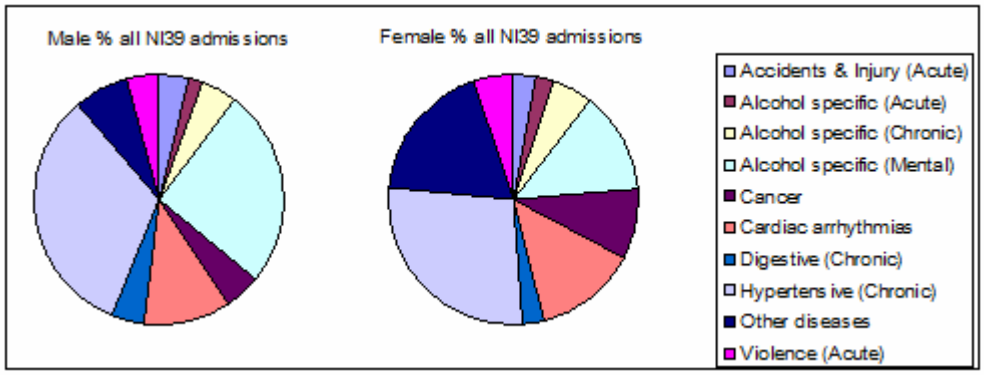
The North West Public Health Observatory has calculated synthetic estimates of the number of increasing risk and high risk drinkers in Haringey which suggests that 20.1% of the local population (equating to 32,864 adults) are increasing risk drinkers with 6.17% of the Haringey population (equating to 10,065 adults) are high risk drinkers.

Alcohol Hospital admissions by gender

Alcohol specific admissions among women in Haringey were significantly below the England rate but in line with the rate for London and alcohol attributable female deaths follow a similar pattern.

Over 76% of all alcohol related hospital admissions in Haringey are male admissions

Figure 1a: Haringey Alcohol related admissions by condition and sex, 2007/08



Analysis of Hospital admission data 2002-2007

An analysis of Hospital Admissions data over a five year period 2002-2007 looking at admissions by gender, ethnicity and age for wholly, partially acute and partially chronic admissions was undertaken in 2009 by Public Health at NHS Haringey.

While an equity profile examines use of/access to a service across various dimensions and compares this against expectations derived from known epidemiological studies. A problem arises in analysing data using attributable fractions, since by its very nature the calculations used to derive case and admission numbers presuppose an underlying epidemiology, which may not exist in a particular population.

The tables below outline access to services for all alcohol attributable cases. This has been examined for 'equivalent' cases i.e. actual case numbers multiplied by the appropriate attribution fraction, thereby giving due weight to the contribution assumed to be made by various diagnoses. This obviously doesn't apply to wholly-attributable cases. *Again tables based upon such calculated data are presented in italics.*

Age and Gender

Table 4a. 'Equivalent' attributable cases of alcohol attributable harm per 1000 population 2004/05 to 2006/07

Gender	16-24	25-44	45-64	65-74	75-84	85+	All Ages
Male	*22.6*	*18.5*	*57.8*	*111.1*	*133.1*	*186.3*	*38.1*
Female	*16.8*	*12.4*	*23.5*	*37.8*	*50.2*	*80.5*	*19.8*
Persons	*19.5*	*15.4*	*39.6*	*72.1*	*85.5*	*112.9*	*28.6*

Throughout **male rates for all attributable cases were higher than female**, with a reduction **for both genders from 16-24 to 25-44 years and a steady increase** thereafter. The relative gender difference was widest for the 65-74 year age group.

Table 4b. Cases of Wholly alcohol attributable harm diagnoses per 1000 population 2004/05 to 2006/07

Gender	16-24	25-44	45-64	65-74	75-84	85+	All Ages
Male	7.3	7.7	18.3	17.4	11.9	18.2	10.8
Female	4.4	3.2	5.4	3.3	1.6	0.0	3.8
Persons	5.8	5.5	11.5	9.9	6.0	5.6	7.2

For wholly attributable diagnoses the gap between male and female rates was wider **with high male rates from 45 years onwards with the exception of 75 - 84**

year olds. Much lower female rates peak in the 45 -64 year age group and then fall away.

Table 4c. 'Equivalent' attributable cases of Partially alcohol attributable chronic harm per 1000 population 2004/05 to 2006/07

Gender	16-24	25-44	45-64	65-74	75-84	85+	All Ages
Male	*3.0*	*5.2*	*35.2*	*91.0*	*114.7*	*153.8*	*21.2*
Female	*7.0*	*7.0*	*15.8*	*33.0*	*45.3*	*72.2*	*13.2*
Persons	*5.1*	*6.1*	*25.0*	*60.1*	*74.8*	*97.2*	*17.1*

Partially attributable **chronic rates increased with age for both genders and gender differences were narrower. Up to age 44 female rates were higher than male, probably as a result of the inclusion of Spontaneous Abortion**

Table 4d. 'Equivalent' cases of Partially alcohol attributable acute harm per 1000 population 2004/05 to 2006/07

Gender	16-24	25-44	45-64	65-74	75-84	85+	All Ages
Male	*12.3*	*5.6*	*4.3*	*2.8*	*6.5*	*14.3*	*6.1*
Female	*5.4*	*2.2*	*2.3*	*1.5*	*3.4*	*8.3*	*2.8*
Persons	*8.6*	*3.9*	*3.2*	*2.1*	*4.7*	*10.2*	*4.4*

Gender differences for partially attributable acute rates were wider and rates for both genders followed a U curve with a low in the 65-74 age group.

(b) Ethnicity

Table 4e. 'Equivalent' attributable cases per 1000 Population (2001 Census based) by ethnicity

Ethnicity	All	Wholly Attributable	Partially - Chronic	Partially - Acute
British	*24.5*	*7.5*	*14.2*	*2.8*
Irish	*40.9*	*20.6*	*17.8*	*2.5*
Any other White background	*25.1*	*4.8*	*16.2*	*4.2*
White and Black Caribbean	*7.9*	*2.2*	*3.9*	*1.8*
White and Black African	*11.6*	*1.9*	*8.3*	*1.3*
White and Asian	*3.3*	*0.4*	*2.4*	*0.4*
Any other mixed background	*13.6*	*2.9*	*8.4*	*2.4*
Indian	*27.0*	*4.5*	*21.0*	*1.4*
Pakistani	*13.7*	*0.5*	*12.0*	*1.3*
Bangladeshi	*15.8*	*0.0*	*14.7*	*1.1*
Any other Asian background	*24.2*	*3.3*	*17.8*	*3.1*
Caribbean	*28.6*	*3.8*	*21.3*	*3.4*
African	*17.1*	*1.9*	*13.3*	*1.9*
Any other Black background	*40.4*	*8.9*	*24.5*	*7.0*
Chinese	*14.9*	*0.0*	*12.1*	*2.7*
Any other ethnic group	*115.4*	*26.9*	*67.8*	*20.6*
All	*26.0*	*6.5*	*16.3*	*3.3*

Crude rates for 'equivalent' cases were calculated based upon 2001 ethnic minority population estimates.

Noteworthy is the high rate for the miscellaneous 'any other ethnic group' category and 'any other white' which could mask Eastern European admissions.

Apart from this group the highest overall rate was for those classifying themselves as Irish followed closely by 'any other Black background'.

Again, apart from the miscellaneous group, the Irish group had much the highest wholly attributable rate.

Aside from the miscellaneous group, partially - chronic rates were highest for the 'any other Black background' group, followed by Caribbean and Indian, probably demonstrating the susceptibilities of these groups to chronic diseases.

Finally, and again aside from the miscellaneous group, **partially - acute rates were again highest for 'any other Black background' followed by 'any other White background'.**

THE IMPACT OF ALCOHOL ON MORTALITY IN HARINGEY[1]

Table 4a: Alcohol specific and alcohol attributable deaths, per 100,000 population (all ages, directly standardised)

	Alcohol-Specific Mortality (2006-2008)		Alcohol-Attributable Mortality (2008)		All deaths from chronic liver disease (2006-08)	
	m	f	m	f	m	F
Haringey	12.93	3.27	42.8	13.1	19.26	5.46
London	11.31	3.81	35.2	12.8	14.51	5.89
England	13.12	6.12	37.1	15.3	14.06	7.26

During the 2006-08 period, the alcohol specific male mortality rate in Haringey was 12.93 per 100,000 population which is higher than the London rate of 11.31 per 100,000 but lower than the overall rate for England. Alcohol specific among women in Haringey were significantly below the England rate but in line with the rate for London and alcohol attributable female deaths follow a similar pattern. **However the rate of alcohol attributable deaths among men in Haringey is high at 42.8 per 100,000 population and all deaths from chronic liver disease is higher than both London and England rate.**

It is difficult to make fair comparisons as the number of actual deaths in each borough/country are low (which is why Haringey has shifted from the highest rate of alcohol related deaths in London in 2005, to close to the London average by 2009).

Nevertheless, if all alcohol specific and attributable deaths among men aged under 75 years in Haringey were prevented, life expectancy at birth of men in the borough would increase by almost one year.

Alcohol consumption is the leading cause of liver cirrhosis. More publicans than any other profession die from liver cirrhosis however **Haringey has one of the lowest rates of employees working in bars in the country at only 1.07% of all employees. Nevertheless the death rate from chronic liver disease, which includes cirrhosis, among men in Haringey is higher than both the London and National average (the**

8th worst mortality rate in London). Many of these deaths will be alcohol related ('alcohol liver disease' itself is underreported on death certificates)[2]

[1] The alcohol specific rate calculates a rate based on deaths wholly attributable to alcohol. The alcohol attributable deaths are calculated according to the application of attributable fractions to deaths from certain conditions. For more information see *Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions, NWPHO 2008*

[2] Bell & Cremona 1987 and Blake et al 1988 quoted in Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions, NWPHO 2008

2© What other evidence or data will you need to support your conclusions and how do you propose to fill that gap?

Data from the Polish Outreach worker caseload covering July 2010-March 11 shows that 30 people Polish people (of which 3 were women) have been helped. The vast majority were defined as either dependent or high risk drinkers at the beginning of treatment, with an overwhelming number becoming abstinent or moving to more controlled drinking during this period. Only 4 of the group had command of English, (which meant the skills of the Polish worker were invaluable) and 8 had no recourse to public funds. Many were of a 'low educational background', finding it difficult to fit into the reality of being in a different and 'foreign' culture. Most of the group claimed to not have anything to go back to, were homeless and had no access to basic primary care because of this. Some of the group had children who were clearly at risk.

All of the above indicates the very real need for such a service and what can be done with minimal investment. Whilst there are other Polish organisations across the borough, this is the only one that provides help to polish people with alcohol problems.

2(d) What factors (barriers) might account for this under/over representation?

The over representation could in part be explained by the fact that Nationally men drink more, they drink more frequently and more heavily than women of all age groups. Men aged between 45 and 65 are the most likely to have drunk above the recommended limit. Interestingly only among the youngest age group are more women reporting drinking above the recommended limit than men. **However, it would not necessarily account for Haringey having the highest rate of alcohol attributable deaths and deaths from chronic liver disease in London.**

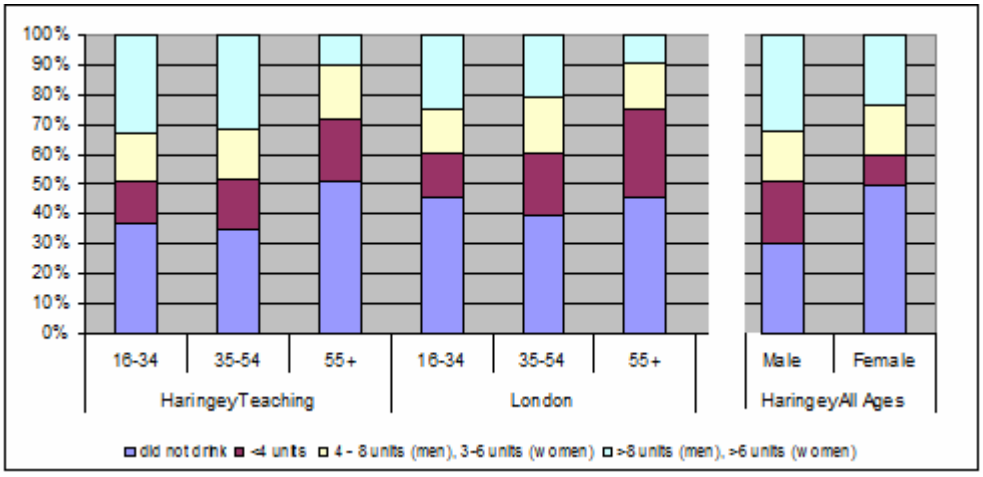
This is probably part of the wider pattern of deprivation in the borough. Haringey is the 5th most deprived authority in London with the worst unemployment rate in London. We know from the recent Marmot review into health Inequalities (Fair Society, Healthy Lives 2010) that being in good employment is protective of health. Conversely unemployment contributes to poor health. This coupled with other factors such as insufficient money to lead a healthy lifestyle means that those who health is not as good as it could be will undoubtedly more readily succumb to the ill effects of alcohol misuse.

The Hospital admission data over a five year period also indicates that those who identify as 'Irish' have the highest rates of wholly attributable hospital admissions – that is conditions that directly relate to alcohol use.

Drinking behaviour in Haringey

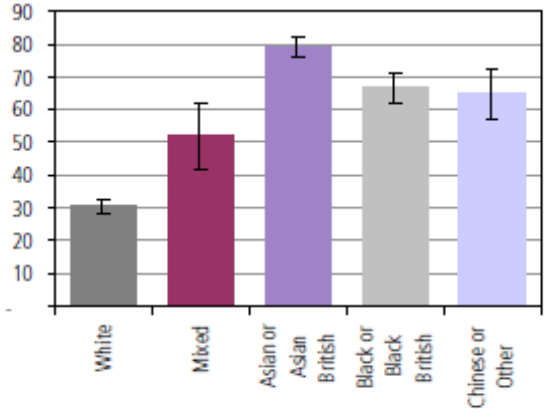
Chart 3a below show the rate of drinking in London and Haringey by age and in Haringey by sex.

Chart 3a: Number of units drunk the week before, General Lifestyle Survey 2009 London Boost



In Haringey, the rate of not drinking was higher in women than men and more likely in the 55+ age group. In line with national patterns, residents working in managerial and professional occupations were more likely to drink and more likely to drink heavily than those in the routine and manual occupations.

Table 3b: Percentage of London adults who did not drink alcohol in the previous week by ethnic group, 2006[3]



[3] Health Survey for England 2006, London boost analysis by the London Health Observatory

Figures from the 2006 survey tell us that people from Asian or Asian British ethnic groups were least likely to have drunk in the last week, with people defining themselves as white or of mixed ethnicity most likely to have drunk alcohol.

Step 3 - Assessment of Impact

Using the information you have gathered and analysed in step 2, you should assess whether and how the proposal you are putting forward will affect existing barriers and what actions you will take to address any potential negative effects.

3 a) How will your proposal affect existing barriers? (Please tick below as appropriate)

Increase barriers? x	Reduce barriers?	No change?

Comment

Polish outreach worker

This proposal will undoubtedly increase barriers to accessing alcohol prevention and treatment services within the Polish community. It is also likely that there will be increased risk of visible street drinking and potential increase in anti-social behaviour. In addition it will mean that we are unable to respond to the needs of this community in the alcohol service, at A & E, on the wards or through street outreach. Many of this group are newly arrived and do not speak English. Having a Polish Outreach has been beneficial both in terms of communication but also in terms of cultural competence and understanding of this community. Further likely consequences are:

- Reduced visible channel of communication between health providers and Polish community many of whom do not speak English.; Poorer engagement for an already marginalised population. Both these effects could impact adversely on social interaction with the wider community of Haringey
- Street drinking and associated police activity will increase, as a result of which the costs of policing will increase. This may also produce a culture clash which could impair good relations between the Polish community and the rest of Haringey communities, thereby having an adverse impact on community cohesion in Haringey.
- Crime will likely increase - 25% of murders reported in Haringey in 2009 were committed within the Polish-speaking rough-sleeping community. That is to say, that the perpetrator and the victim were Polish.
- Deaths could result such as that of Mr U in early 2010 - where he was unable to communicate his health problems to A&E staff and subsequently was excluded was accessing emergency care, which all EU citizens are entitled to. He attempted access on several occasions within 3 days at 2 different hospitals (NMUH and Homerton) before dying of an alcohol withdrawal complication.
- Services will now have to pay for an interpreter in order to facilitate access to treatment – however this is not just an issue for alcohol services – rather it is an

issue that the borough needs to address – how to make our services accessible to all sections of the community.

3 b) What specific actions are you proposing in order to respond to the existing barriers and imbalances you have identified in Step 2?

As already stated the risk to the Hospital Link Worker post and therefore the barriers have temporarily been mitigated by the 'invest to save monies' from Health.

This proposal does not identify any alternatives to the Polish Outreach Worker post as no similar service provision exists

Most of the barriers/imbalances can be redressed by continued commissioning of this post, which is not possible. Most of the harm related to alcohol use is preventable. One in eight harmful drinkers will reduce their drinking to within sensible levels if they receive brief advice (IBA) – a key component of both of these post holders work.

All GP surgeries have information on drinking/units etc training to GPS in the recognition of alcohol dependence and Brief Interventions. Brief interventions will still be delivered at A & E and the link worker post will continue to link people back into the community- but there will be on one able to work with and more importantly communicate with sections of the Polish community who have alcohol problems.

3 c) If there are barriers that cannot be removed, what groups will be most affected and what Positive Actions are you proposing in order to reduce the adverse impact on those groups?

The specific group affected is the Polish community.. There has been some initial discussion at the last Safer Communities Executive Board about how we can more effectively offer services to service users who first language is not English (many of which will pitch up in different services across - the borough - no firm decisions were reached.

The DAAT has produced leaflets about alcohol and alcohol services in Polish but there will not be anyone who speaks Polish working in HAGA. We will continue to work with the Manager in HAGA in attempting to manage these cuts in least detrimental way to service users.

Consultation is an essential part of impact assessment. If there has been recent consultation which has highlighted the issues you have identified in Steps 2 and 3, use it to inform your assessment. If there has been no consultation relating to the issues, then you may have to carry out consultation to assist your assessment.

Make sure you reach all those who are likely to be affected by the proposal, ensuring that you cover all the equalities strands. Do not forget to give feedback to the people

you have consulted, stating how you have responded to the issues and concerns they have raised.

Step 4 - Consult on the proposal

4 a) Who have you consulted on your proposal and what were the main issues and concerns from the consultation?

The main consultation methods were a face-to face meeting and questionnaires. The result of the questionnaire can be seen at **Appendix 3.**

The following is a brief summary of the issues and concerns to emerge from the questionnaires.

Response to the Polish Outreach worker Questionnaire

There were 12 respondents (6 women and 6 men). The main age range was 25-34 with 2 being between the ages of 55-62. 1 Respondent had a physical disability. 10 wren Polish, 1 Russian, and 1 Ukrainian. All were strongly opposed to the cuts. Three of the twelve understood why the cuts had to be made, 6 replied no (Mainly they were simply unaware until they had been told, 3 were not sure. This is a small sample size so difficult to form any clear conclusions

There were a variety of responses to which services do you value the most ranging from, " I am being linked with Polish services in London…" to quite a few instances of key working.

In response to what the impact of the cuts would be again a wide response from "I will have nowhere to go" to "I will feel alone".

All 12 of the respondents reported that the changes would have an impact on them in terms of ethnicity; with three stating it would impact on them in terms of gender (women).

In terms of how the service could be improved on 3 did not know others had not given it any thought and the remainder really had simple ideas fro improvement such as more groups in the evening.

The free text section allows for respondents to give comments, 5 people responded. There were no common themes but clearly the fact that this was a service able to respond to the homeless and Polish people in their own language was much valued.

Responses to Hospital link worker Post Questionnaire.

During the course of the consultation process, monies were identified to conduct a 9 month evaluation of this post (which means it will continue for the time being).

There were 23 respondents to the questionnaire, 11 were male, 6 were female and 6 did not respond. The man ethnic group was 'White British', followed by Irish. The main age group was 35-44.

Twelve were strongly opposed to the cuts, 7 opposed. 1 neither supported nor opposed and 2 respondents who strongly supported (it is clear from reading the comments that these two respondents had not understood the question.

Nine of the 23 understood why the cuts were being made, 12 replied no and 2 were not sure. Of those who understood why the cuts were being proposed none thought it was right. "It is short sighted action that will ruin a lot of people's lives".

All 23 respondents responded to 'which of their services do you value most and why. There were wide ranging responses from "structured programme" to "hospital link worker for her support".

22 respondents responded to the question re what impact these changes would have on them. The main them to emerge is one of 'devastation' in terms of the impact on people lives and ability to cope with an alcohol problem.

The overwhelming response to how the service could be improved or provided differently was that it couldn't be improved "It can't. So leave it alone thanks".

Finally in terms of the free text section which allows for comment 13 people responded. A lot of strong emotions/attachment to the service emerges. "This service saved my life. I am very grateful for it being there for me."

Face to Face Consultation Exercise

The DAAT attended a service user Forum at HAGA on the 10th March. 2011 to consult service users on what the impact of cuts would mean for them. Specifically on:

- Polish Outreach worker post
- Alcohol Hospital liaison post

Clients were advised by the HAGA managers that the DAAT would be attending on this date to specifically consult on cuts as outlined above. Whilst there was good attendance/representation of people who have used the overall HAGA services and/or have accessed HAGA's services via the Hospital Link Worker Post there was no attendance from Polish speaking clients. Attempts were made to set up a separate meeting with the Polish speaking client group but proved unsuccessful. On the advice of the Polish Outreach Worker the decision was made to therefore only use questionnaires. The results of both questionnaires are attached at **Appendices 5 & 6.**

Whilst HAGA are subject to cuts from the Area Based Grant (DAAT funded posts/services) – they are also subject to cuts from the Supporting People (all of the funding that supports the day centre services). Clearly service users wanted to make their views known about these cuts. They also wanted to know why the Council seemed to be using different approaches to consultation with service users e.g. Supporting People had sent out a questionnaire the DAAT were coming to talk to them in person. This is something that should be borne in mind in future consultations – where different directorates may be commissioning the same service.

This is a summary of the main comments/issues that were raised at the meeting on 10th March 2011.

- Service users said "It's the only service that offers a safe haven, stability and is seen as un-judgemental, also a key worker always available"

- "This is a false economy – it will not save money. There will be consequences of the cuts. It will cost the borough even more in other service re-provision. This will not just have a financial impact, but also a social impact - not just money but people's lives. A high percentage of Service users will go back to drinking, increase hospital admission, theft, and other related crimes"

- One Service User commented that when he leaves the service he "feels rejuvenated. He would have been dead long time ago if not for HAGA". This was echoed by many service users and the very real fear that they may not have survived had it not been for HAGA.

- .Another Service user told us how his life had been turned around 2 years ago – he was homeless, alcoholic but HAGA sponsored and re-housed him. Now he is a mentor and at college. His recovery from alcoholism means he is now putting something back into society – "that's what the council have gained by investing in this service".

- Service users told us "It's a place where if they get side tracked or return to bad habits, they know there's a place that can help them"

- One service user told us how he had been picked up by the hospital liaison worker and referred for detox to HAGA – "HAGA help with several different aspects, not only just alcoholism. They also help fill in forms for DHSS for people who may not be able to read or write".

- "HAGA provides respite from the world. You need to understand what HAGA means to Service Users. The place builds community".

- "Losing HAGA would feel like losing hope. Support is always required - all the time and nice to know that there's a place like HAGA where we can go to".

- One service user felt that this is part of the 'payment by results' the government are introducing into alcohol and drugs work. 'To concentrate on at risk drinkers and not on dependant drinkers'

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- "The Day programme, and support from North Mid Hospital link worker is vital for the community as it save lives"

Service users had particular things they wanted to raise with Councillors

- "Why is this decision such short notice – why was there no advance information about the cuts?"

- "Why are no Councillors coming to these consultation meetings"?

- Service users felt that as part of legal process/service level agreements service users should be given alternatives if these cuts are being made – they wanted to know what are the alternatives if these cuts are made

- They wanted to know if there was a forum for service users to discuss and speak to Councillors

- Some felt because of the stigma attached to alcoholism – it would be difficult for people to access this kind of service if taken away? Where will they go? Are there any planned alternatives being offered?

4 b) How, in your proposal have you responded to the issues and concerns from consultation?

Given that the cuts make it impossible to respond in the way that would alleviate all of the concerns – the DAAT will have to work with the Manager of HAGA to try to minimise the impact of these cuts. We will ensure that service users get another opportunity to meet with the lead officer and receive an update on the outcome.

4 c) How have you informed the public and the people you consulted about the results of the consultation and what actions you are proposing in order to address the concerns raised?

Service users were informed of the process re decision making – e.g. I would be writing up the EIA and a covering report for the lead member who would ultimately make the decision.

Lead officer to go back and meet with service users with outcome.

The results of this consultation will be on the council's website.

Service users were supplied with the lead member's details as they wanted to write to her. They also wanted to start a petition and get as many signatures as possible to force a cabinet meeting re these cuts.

Step 5 - Addressing Training

The issues you have identified during the assessment and consultation may be new to you or your staff, which means you will need to raise awareness of them among your staff, which may even training. You should identify those issues and plan how and when you will raise them with your staff.

Do you envisage the need to train staff or raise awareness of the issues arising from any aspects of your proposal and as a result of the impact assessment, and if so, what plans have you made?

There is no training planned as a result of this consultation.

Step 6 - Monitoring Arrangements

If the proposal is adopted there is a legal duty to monitor and publish its actual effects on people. Monitoring should cover all the six equality strands. The purpose of equalities monitoring is to see how the policy is working in practice and to identify if and where it is producing disproportionate adverse effects and to take steps to address the effects. You should use the Council's equal opportunities monitoring form which can be downloaded from Harinet. Generally, equalities monitoring data should be gathered, analysed and report quarterly, in the first instance to your DMT and then to the Equalities Team.

What arrangements do you have or will put in place to monitor, report, publish and disseminate information on how your proposal is working and whether or not it is producing the intended equalities outcomes?

Monitoring of uptake of HAGA services to see if in particular polish community have been affected e.g. reduction in service users. Hospital admission data (available annually) will also have to be examined to see if there is an increase in admissions in particular from Eastern European communities (although this may be problematic as HES coding does not specifically mention Polish. This will need to be built into the 9 month evaluation pilot.

- ***Who will be responsible for monitoring?***

DAAT and HAGA

- ***What indicators and targets will be used to monitor and evaluate the effectiveness of the policy/service/function and its equalities impact?***

- ***Are there monitoring procedures already in place which will generate this information?***

YES

- ***Where will this information be reported and how often?***

HAGA data quarterly – hospital admissions data annually; hospital attendances. (quarterly).

Step 7 - Summarise impacts identified

In the table below, summarise for each diversity strand the impacts you have identified in your assessment

Age	Disability	Ethnicity	Gender	Religion or Belief	Sexual Orientation
In terms of age groups, figures for 2004/6 – 2006/7 show that age groups most represent Ted in cases of wholly alcohol attributable harm diagnoses is the age group between 45 – 64, consisting of over 11% of all cases	No specific impact identified	Yes – The impact will fall predominantly on the Polish and Irish communities as services are deleted For the Polish community, the likely consequences include: * Reduced social interaction with the wider as visible channel of communication between health providers and this community, many of whom do not speak English. * Poorer engagement for an already marginalised	Yes, there is a gender disparity in impact. Figures for hospital admissions and mortality for 2004/5 to 2006/7 indicate that throughout this period, the rate for all alcohol attributable cases were higher for male than for female	No specific impact identified	No specific impact identified

		community, again impacting adversely on their ability to interact with the wider Haringey community. * Increased street drinking, which could produce a culture clash that impair good relations with the rest of Haringey communities * Drink related crime could increase – 25% of murders reported in Haringey in 2009 took place within the Polish – speaking rough sleeping community – that is the say, both perpetrators and victims were Polish * Deaths could result, such as that Mr U in 2010 – who because			

		language barrier was unable to access services on several occasions despite several attempts in 3 days at 2 different hospitals before dying of an alcohol withdrawal complications. * The spirit of the Equality Act 2010 is to increase access to public services for diverse groups and cultures in our society. Withdrawing this funding will be contrary to the spirit of the Act Irish have the highest cases of wholly attributable could potentially be affected disproportionately by any withdrawal of services. Health inequality			

		amongst those in the Polish and Irish communities with alcohol problems will be greatly increased. Alcohol misuse is recognised as a health inequality both at a national and local level._.			

Step 8 - Summarise the actions to be implemented

Please list below any recommendations for action that you plan to take as a result of this impact assessment.

Note: The scope for any mitigating measures is practically non-existent unless money can be found from somewhere to continue the funding of these two posts.

Issue	Action required	Lead person	Timescale	Resource implications
Feedback	Go back to service users and feedback from lead member	Marion Morris	31st May 2011	Lead officer time
Inform decision - maker of the result of this assessment	Provide equalities comment to report, drawing the attention of decision-maker to the findings and conclusions of this assessment in a formal report on the proposal in order to inform his/her decision".	Marion Morris	Mid May l 2011	Lead officer time

Step 9 - Publication and sign off

There is a legal duty to publish the results of impact assessments. The reason is not simply to comply with the law but also to make the whole process and its outcome transparent and have a wider community ownership. You should summarise the results of the assessment and intended actions and publish them. You should consider in what formats you will publish in order to ensure that you reach all sections of the community.

When and where do you intend to publish the results of your assessment, and in what formats?

On the council website and email to HAGA

Assessed by (Author of the proposal):

Name: **Marion Morris**

Designation: **Drug & Alcohol Strategy Manager**

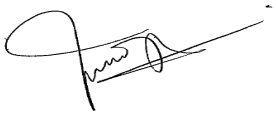
Signature: **MP Morris**

Date: **26th April 2011**

Quality checked by (Equality Team):

Name: **Inno Amadi**

Designation: **Senior Policy Officer (Equalities)**

Signature: 

Date: **26th April 2011**

Sign off by Directorate Management Team:

Name: **Anne Lippitt**

Designation: **Interim Director Urban Environment**

Signature:

Date: