# Equality Analysis(EA)

Financial Year
**2014/15**

**See Appendix A**

Current decision rating

## Section 1 – General Information (Aims and Objectives)

Name of the proposal including aims, objectives and purpose
*(Please note – for the purpose of this doc, 'proposal' refers to a policy, function, strategy or project)*

### Substance Misuse Commissioning Intentions – Next Steps (V2)

The aim of the proposal is to reduce funding to drug and alcohol treatment by £500k in order that it may be utilised elsewhere as part of the Public Health Savings Programme. This reduction would be achieved via reprocurement of the treatment system modelled to achieve better treatment outcomes for residents in the treatment system, improve overall performance of drug and alcohol services in the borough, attain better value for money and respond better to local needs.

MAB is requested to consider and comment on:

- The proposal to commence consultation around the decommissioning of the Harbour Recovery Centre.

MAB is requested to note:

- The revised timescale outlined in the report.
- The amended proposed grant reduction and consider this amended Equality Analysis relating to these savings following presentation at MAB SARP.
- That (subject to comments / amendments) this report will progress to Cabinet.

**Conclusion - To be completed at the end of the Equality Analysis process**
*(the exec summary will provide an update on the findings of the EA and what outcome there has been as a result. For example, based on the findings of the EA, the proposal was rejected as the impact on a particular group was unreasonable and did not give due regard. Or, based on the EA, the proposal was amended and alternative steps taken)*

**Name:**
(signed off by)

**Date signed off:**
(approved)

Service area:
Communities, Localities and Culture

Team name:
Drug and Alcohol Action Team

Service manager:
Rachael Sadegh

Name and role of the officer completing the EA:
Rachael Sadegh

## Section 2 – Evidence (Consideration of Data and Information)

*What initial evidence do we have which may help us think about the impacts or likely impacts on service users or staff?*

Introduction

- The DAAT completed a Substance Misuse Needs Assessment in February 2014, which involved a variety of consultation exercises with stakeholders and service users. The needs assessment concluded that the re-procurement of drug and alcohol services in Tower Hamlets would be the appropriate way to improve future performance and achieve better value for money. NB this was based on the maintenance of the current budget base for the service.
- The DAAT was initially requested to review the potential for a £1m saving on the current budget. A n Equality Analysis was completed and raised concerns about the potential impact of such a budget reduction. A revised funding reduction of £500k has now been proposed and this Equality Assessment seeks to address the impact of this budget reduction.

Context

- The borough has complex need opiate drug users and a complex treatment structure. In recent months service users successfully completing treatment have decreased, re-presentations back into drug services have increased and new entries into treatment decreased. This trend means that performance compared to other boroughs in the same complexity cluster has worsened.
- The DAAT has access to good data and research about Tower Hamlets on the Borough Profile web pages. This information is setting the scene and provides an understanding of the different communities in the borough. However, we have only limited information about the local problematic drug using population and drug use in general. The majority of data comes from treatment sources, based on information about clients in the treatment system.
- The treatment system will be subject to re-procurement which will commence once a funding agreement has been reached.
- The majority of the reduction required will be achieved via reducing overheads and management costs via the integration of services, however some reduction to frontline service funding will be required.
- The Department of Health has announced that local authorities' public health funding for 2015-16 is expected to remain the same as last year, at £2.79 billion. The funding will remain ring-fenced to ensure it is used solely for improving public health. A further £5 million of funding has also been announced as part of the Health Premium Incentive Scheme (HPIS). The scheme is designed to reward local authorities that make improvements to their localities public health by providing cash incentives. Under the scheme, which will be piloted during 2015 and 2016, local authorities will be rewarded for meeting one mandatory national public health target, related to improving drug and alcohol services, and one local target of their choice.

Analysis

- In this EA we discuss primarily the impact on service users and staff in service providers. The information is taken from local monitoring reports provided directly from service providers and NDTMS data directly accessible via Public Health England.
- Consultation meetings with the community reviewing the plans for re-procurement have played a crucial role to inform this EA, widening our understanding of potential risks and impacts on service delivery and service users. Results of the consultation meetings with service users, service providers and GPs are discussed in this document.
- Both quantitative and qualitative information contributed to our analysis and are represented in our conclusions and recommended actions.

**Section 3 – Assessing the Impacts on the 9 Groups**

Please refer to the guidance notes below and evidence how your proposal impact upon the nine Protected Characteristics in the table on page 3?

**For the nine protected characteristics detailed in the table below please consider:-**

**What qualitative or quantitative data do we have?**

*List all examples of quantitative and qualitative data available(include information where appropriate from other directorates, Census 2011 etc)Data trends – how does current practice ensure equality*

*Quantitative data available for EA*

- Statistics from NDTMS (National Drug Treatment Monitoring System) contains information about who is in treatment and for what. Data about drug & alcohol use and treatment has been analysed extensively in the Substance Misuse Needs Assessment 2013/14. This data set is critical to assessing both service need and performance. It also supports an understanding of treatment demand to inform substance misuse intervention priorities for local partnerships.
- Data about the Tower Hamlets population – Access via Tower Hamlets Borough Profile web pages for statistics about the boroughs population including information from the National Census 2011.
- Results from service user questionnaire with 200 responses delivered as part of Substance Misuse Needs Assessment 2013/14 informing its recommendations
- Service user data from monitoring returns (latest data June / July 2014)
- Staff monitoring data provided by service providers (Q4 2013/14 and July 2014)

*Qualitative information available for EA*

- Substance Misuse Needs Assessment interviews with 29 stakeholders from service providers and DAAT staff. Interviews undertaken in Nov and Dec 2013.
- Four qualitative research focus groups in Dec 2013 with 36 clients with experience of a range of Tower Hamlet drug and alcohol services, including ISIS, THCAT, CDT and NAFAS.
- Consultation workshop with service managers 17th July 2014
- Consultation workshop with GPs, three session 22nd, 23rd and 25th July 2014
- Consultation workshop with Drug & Alcohol Network23rd July 2014
- Consultation workshop with service user 24th July 2014

**What is the equality profile of service users or beneficiaries that will or are likely to be affected?**

*Use the Council's approved diversity monitoring categories and provide data by target group of users or beneficiaries to determine whether the service user profile reflects the local population or relevant target group or if there is over or under representation of these groups*

Data shows that the profile of people in drug and alcohol treatment illustrates both similarities and differences when compared to the general adult population in the borough.

The data discussed in the document shows that the female population is under-represented in the treatment system while White British, Bangladeshi and Christian populations were marginally over-represented in treatment. In comparison, the White-Other groups appears to be under-represented.

Age matters when understanding drug treatment data; it is clear that the drug treatment population in Tower Hamlets is dominated by those aged 30 to 44 / 49.

*Gender*

In 2013/14 there were 1,685 adults in drug treatment, around 324 (19 per cent) were female clients and 1,361 (80per cent) male clients. The female population is under-represented in

treatment and lower than the London average (24per cent) and national average (26per cent) in treatment. (Source: NDTMS 2013/14 All in treatment YTD)
The overall gender split of the 18 plus population in the borough was 51.7per cent males and 48.3 per cent females. (Source: Census 2011)

*Age*
Around 60per cent of clients in treatment during 2013/14 were aged 30-44, a strong overrepresentation compared to the proportion of residents in that age group according to the Census. Remarkably, more clients in Tower Hamlets aged 30 to 44 were in treatment compared to London (49per cent) and England (58per cent).

In Tower Hamlets, those aged 18 to 24 (6 per cent) were under-represented compared to London (9 per cent) and England (9 per cent).

The group of clients in treatment aged 45 and older in Tower Hamlets resembles closely the proportion of clients in England aged 45 and older. In comparison to London, the proportion of Tower Hamlets residents was actually lower. See table below.

| Age group | Tower Hamlets | Tower Hamlets | London | England | | Tower Hamlets |
|---|---|---|---|---|---|---|
| | All in Treatment - Total | All in treatment % | All in treatment (%) | All in treatment (%) | | Census 2011 population 18 plus (%) |
| **18 – 24** | 105 | 6% | 9% | 9% | | 19% |
| **25 – 29** | 184 | 11% | 12% | 13% | | 20% |
| **30 – 34** | 398 | 24% | 17% | 21% | | 17% |
| **35 – 39** | 340 | 20% | 16% | 20% | | 11% |
| **40 – 44** | 264 | 16% | 16% | 17% | | 8% |
| **45 – 49** | 209 | 12% | 14% | 11% | | 6% |
| **50 – 54** | 111 | 7% | 9% | 6% | | 5% |
| **55 – 59** | 47 | 3% | 4% | 2% | | 4% |
| **60 – 64** | 19 | 1% | 2% | 1% | | 3% |
| **65 plus** | 8 | 0% | 1% | 0% | | 8% |

(Source: NDTMS 2013/14 All in treatment YTD)

NB service users tend to come into structured treatment when their lives have become chaotic, their health has worsened and where they have to present because of their engagement in the criminal justice system. Additionally the borough's drug presentations are predominantly opiate based and this is generally a reflection of an older cohort of drugs users. It is clear however that the borough has younger drug and alcohol misusing populations. The treatment system is keen to ensure that this group has equal access to services and to ensure that their problematic substance misuse does not proliferate and / or begin to create greater harm both to them and the communities in which they live.

*Race / Ethnicity*
The majority of clients in treatment were White British (39 per cent), higher than the total population aged 18 plus of 35.7 per cent. Around 29 per cent percent of those in treatment were Bangladeshi which was again above the proportion of British Bangladeshi in the 18 plus population in the borough (25 per cent). In comparison, the Other White population was slightly under-represented in the treatment population. See table below. (Source: NDTMS 2013/14 All in treatment YTD / Census 2011)

| Ethnicity | In treatment population Tower Hamlets % | Census 2011 – 18 plus population Tower Hamlets % |
|---|---|---|
| **White British** | 39% | 35.7% |
| **White Irish** | 2% | 1.9% |
| **Other White** | 11% | 14.9% |
| **White & Black Caribbean** | 3% | 0.8% |
| **White & Black African** | 1% | 0.5% |
| **White & Asian** | 0% | 0.9% |
| **Other Mixed** | 1% | 1.0% |
| **Indian** | 1% | 3.1% |
| **Pakistani** | 0% | 1.0% |
| **Bangladeshi** | 29% | 25.0% |
| **Other Asian** | 1% | 2.4% |
| **Caribbean** | 3% | 2.2% |
| **African** | 2% | 3.4% |
| **Other Black** | 1% | 1.1% |
| **Chinese** | 0% | 3.8% |
| **Other** | 1% | 2.4% |
| **Not Stated** | 4% | N/A |
| **Missing ethnicity code** | 1% | N/A |

(Source: NDTMS 2013/14 All in treatment YTD and Census 2011 18 plus population by ethnicity)

*Religion or Belief*

Tower Hamlets has the highest percentage of Muslim residents in England – 35 per cent compared with a national average of 5 per cent. Conversely, the borough has the lowest proportion of Christian residents in England: 27 per cent compared with a national average of 59 per cent. The third largest group was the group with no religion with 19 per cent.

Recent quarter 4 monitoring data from drug and alcohol service providers indicates that Christian residents (41.6 per cent) were slightly over-represented in treatment while Muslim residents (26.4 per cent) were under-represented. The proportion of residents with no religion including Atheists of 17.6 per cent was close to the Census 2011 figure. See table below.

| Religion | Religious belief of those in treatment |
|---|---|
| **Atheist** | 0.3% |
| **Buddhist** | 0.2% |
| **Christian** | 41.6% |
| **Hindu** | 0.3% |
| **Sikh** | 0.3% |
| **Jewish** | 0.1% |
| **Muslim** | 26.4% |
| **No Religion** | 17.3% |
| **Other** | 13.6% |

(Source: Tower Hamlets Quarter 4 monitoring returns 2013/14)

*Disability*

Census 2011, respondents were asked whether their activities are limited by long-term health problems or disability. They were able to choose between ‘limited a lot’, ‘limited a little’ and ‘no’. Of over 254,000 respondents in the borough, 7 per cent stated that their day-to-day activities were limited a lot, and another 7 per cent stated they were limited a little.

Service providers in Tower Hamlets monitor the take up of treatment by disability. Recent quarter 4 monitoring returns indicate that around 12.2 per cent of clients in treatment had a disability. This would be close to the borough average of 14 per cent taken from the Census2011.

*Gender Reassignment*
The council does not hold information on gender reassignment in the borough. Service providers are monitoring the category to ensure that client data will be available in the future.

*Sexual orientation*
The council does not hold robust information about sexual orientation in Tower Hamlets. However, service providers monitor sexual orientation of those in treatment. Data indicates that 94.3per cent were heterosexual, 1.5per cent homosexual and 1.1per cent Bi-sexual.

| Sexual orientation | Percentage |
|---|---|
| **Heterosexual** | 94.3% |
| **Homosexual** | 1.5% |
| **Bi-Sexual** | 1.1% |
| **Other** | 0.6% |
| **Not Recorded** | 2.5% |

(Source: Tower Hamlets Quarter 4 monitoring returns 2013/14)

Anecdotal evidence shows that drug use by MSM is high but does not show in the treatment data.

*Marriage or civil partnership*
Service providers monitor the take up of treatment by marriage & civil partnership. However the data is currently very limited. We believe that future improvement in monitoring will enhance our understanding of needs in this group.

*Pregnancy and Maternity*
Service providers monitor the take up of treatment by pregnancy and maternity. However the data is currently very limited. We believe that future improvement in monitoring will enhance our understanding of needs in this group.

A number of groups are known to be under-represented in treatment. A new treatment system model for re-procurement has been developed to drive increased engagement of these groups in treatment. However this relies upon increasing frontline capacity which requires continued levels of funding. It is known that different populations access treatment in different ways and have different preferences of intervention. Whilst the treatment system model to be procured will involve fewer contracts, the variety of interventions and specialisms needs to be maintained to ensure different populations access treatment and experience good treatment outcomes.

Reductions in funding to frontline services will impact upon ability to deliver higher quality, more intensive interventions to a larger cohort of people. However, this has been limited by the change in funding decision and can be managed largely outside of frontline services and by the generation of savings associated with reduced management and overhead costs.

**Equalities profile of staff**

*Indicate profile by target groups and assess relevance to policy aims and objectives e.g. Workforce to Reflect the Community. Identify staff responsible for delivering the service including where they are not directly employed by the council.*

Any re-procurement process might involve changes to service providers or internal staff structures, depending on service needs and existing service delivery capacity. This section is focusing on the equalities profile of staff and potential risks.

As part of the re-procurement exercise, DAAT will seek a commitment from service providers to employ local staff and subcontractors as part of the Mayors *Workforce to reflect the community* agenda.

- *DAAT staff*
  The DAAT team is a small team with currently 5 members selected on the basis of expertise. The team represents approximately the local community in terms of ethnicity and gender.
- *Service provider staff*
  For this EA we used up to date monitoring equalities data about staff employed by service providers in the borough. The data relates to period June / July 2014.

The diversity of staff employed by service providers is a strong feature of local service delivery. Analysis indicates that the overall workforce is representative of the diverse Tower Hamlets communities. However, some exceptions were noted in the data and there is scope to address this in the future.

The data shows that women (58 per cent) are more likely to be employed in service provision compared to men (42 per cent), not unusual for the health and social work sector. The age data indicates that only 2 per cent of staff were between 18 to 24 years old. This might be caused by the existing low levels of entry position and lack of apprenticeships. The re-procurement exercise can be used to address this issue with the aim to create entry positions.

In terms of disability, it is noticeable that hardly any disabled staff were employed with current service providers. This will need to be addressed in the re-procurement exercise. In terms of sexual orientation, the current staff structure is close to the borough average.

In terms of ethnicity, the Bangladeshi group (18.2 per cent) was noticeable under-represented in staff employed by service providers. The White British (29.5 per cent) and White other (14.8 per cent) groups were slightly under-represented. In comparison, the Black African group(18.2 per cent) was strongly over-represented, mainly down to one employer, while the Black Caribbean group(6.8 per cent) was slightly over-represented in employment when compared to the Tower Hamlets population. See table below.

| **Ethnicity** | **Residents Aged 18 to 64** | **STAFF Service providers Aged 18 to 64** |
|---|---|---|
| **White: Total** | **51.5%** | **46.6%** |
| *White: English/Welsh/Scottish/Northern Irish/British* | 33.9% | 29.5% |
| *White: Irish* | 1.7% | 2.3% |
| *White: Gypsy or Irish Traveller* | 0.1% | N/A |
| *White: Other White* | 15.8% | 14.8% |
| **Mixed/multiple ethnic group: Total** | **3.3%** | **3.4%** |
| *Mixed/multiple ethnic group: White and Black Caribbean* | 0.8% | 2.3% |
| *Mixed/multiple ethnic group: White and Black African* | 0.5% | 0% |
| *Mixed/multiple ethnic group: White and Asian* | 1.0% | 0% |
| *Mixed/multiple ethnic group: Other Mixed* | 1.1% | 1.1% |
| **Asian/Asian British: Total** | **36.0%** | **21.6%** |
| *Asian/Asian British: Indian* | 3.2% | 1.1% |
| *Asian/Asian British: Pakistani* | 1.0% | 0% |
| *Asian/Asian British: Bangladeshi* | 25.3% | 18.2% |
| *Asian/Asian British: Chinese* | 4.0% | 0% |
| *Asian/Asian British: Other Asian* | 2.5% | 2.3% |
| **Black/African/Caribbean/Black British: Total** | **6.6%** | **28.3%** |
| *Black/African/Caribbean/Black British: African* | 3.5% | 18.2% |
| *Black/African/Caribbean/Black British: Caribbean* | 2.0% | 6.8% |

| | | |
|---|---|---|
| *Black/African/Caribbean/Black British: Other Black* | 1.1% | 3.3% |
| **Other ethnic group: Total** | **2.5%** | **0%** |
| *Other ethnic group: Arab* | 1.1% | 0% |
| *Other ethnic group: Any other ethnic group* | 1.4% | 0% |

(Source: Population Census 2011, Staff data service providers July 2014)

In terms of religion and belief, staff of Christian faith with 36 per cent were over- represented compared to the Tower Hamlets population (27 per cent) while the proportion of Muslim staff (26 per cent) was lower than the Tower Hamlets average of 35 per cent. The proportion of staff with no religion (21.6 per cent) was close to the borough average of 29 per cent.

The staff equalities data shows that while the workforce is diverse, there is scope in some categories to achieve a workforce that better represents the Tower Hamlets community and in this respect, re-procurement could have a positive impact if staffing levels were increased. Clearly this would be limited by a funding reduction. The staff within Harbour Recovery Centre

However, there is the additional risk that changes in service provision might impact some projects with a unique staff structure. This unique staff structure might be caused by its targeted services and / or specific ethics and delivery philosophy. Any changes could result in an overall shift within the equalities categories leading to a less diverse workforce in the borough.

The staff profile of Harbour Recovery Centre, which may be decommissioned, represents particular ethnic and faith groups, namely Black African and Christian (currently over-represented across the system). However the total number of staff is small (10) and therefore there is not a significant impact on these groups

**Barriers?**

*What are the potential or known barriers to participation for the different equality target groups? Eg- communication, access, locality etc.*

- The DAAT understands the potential barriers to user engagement and treatment participation for the different equality groups in terms of communication and access. These barriers will be taken into account when commissioning service providers and formulating new performance targets.

- Interventions by drug and alcohol services in the borough will still need to focus and target needs in specific client groups including BME groups, women, hostel residents, people affected with homelessness or people with mental health issues responding to specific needs in communities. Many of these groups are reluctant to openly access substance misuse services for a variety of reasons and therefore new service specifications include additional interventions expected of providers in order to facilitate improved engagement in treatment across a variety of hard to reach groups.

- Additional communication will be needed to raise awareness of any changes in service provision targeting the following groups including:
    - BME groups
    - Female drug users / access to treatment for women
    - Sex workers
    - Alcohol users who do not mix with drug users
    - Drug use in the gay community
    - Drug users with mental health problems
    - Khat use in predominantly Somali community
    - Hostel residents
    - Homeless users/ rough sleepers
    - Domestic violence victims
    - Young adults 18 to 24
    - Support to families dealing with drug using family member

- *Access / location to services*
  Any potential change in service provision might include the relocation of service providers and treatment centres. If this will be necessary, service users will need to be introduced to the new location which could result in some disruption of their treatment and potentially destabilise their recovery. The new providers will need to ensure that treatment and provision will not be unsettled.

  If it is impossible to travel to treatment, providers should ensure that home visits are a serious option for service provision and this has been included in new service specifications.

**Recent consultation exercises carried out?**
*Detail consultation with relevant interest groups, other public bodies, voluntary organisations, community groups, trade unions, focus groups and other groups, surveys and questionnaires undertaken etc. Focus in particular on the findings of views expressed by the equality target groups. Such consultation exercises should be appropriate and proportionate and may range from assembling focus groups to a one to one meeting*.

- Extensive consultation including focus groups and survey based research with relevant interest groups, service users, service providers and stakeholders were carried out as part of the Substance Misuse Needs Assessment 2013/14. The results informed directly the recommendations of the needs assessment which were used to inform the proposed re-procurement of local services.

- Various consultation sessions were delivered to consult on the preferred service commissioning model in the borough including three sessions with GPs, a consultation workshop with service managers of local drug and alcohol services, a workshop with the Drug& Alcohol Network and a session with the service user group.

- As part of the consultation workshops, participant agreed with the general direction of the plans and supported the proposals including: [1]
  - the streamlined structure, easier to understand and navigate;
  - the clear journey from admission to recovery;
  - the overall recovery focus, and
  - increase of front line staff and level of outreach / in-reach.

- Workshop participants raised concerns about the re-procurement plans. The main concerns included:

  - location of services;
  - the flexibility of service delivery, out of hours availability including home visiting services;
  - the workability of the consortia approach;
  - maintaining the delivery of specific services including Blood Borne Viruses (BBV) or liver disease treatment;
  - risk of losing specialist workers and specialist services, trained staff with negative impact on client relationships;
  - are contract specifications robust enough to deliver results, and
  - TUPE arrangements and service disruption.

  These concerns have been integrated into the service specifications by the DAAT as part of the re procurement exercise and will be further addressed in contract negotiations. The future service providers will be responsible to deliver drug and alcohol treatment that will mitigate those concerns.

**Additional factors which may influence disproportionate or adverse impact?**

*Management Arrangements - How is the Service managed, are there any management arrangements which may have a disproportionate impact on the equality target groups*

- We have not identified any management arrangements which may have a disproportionate impact on the equality groups / 9 protected characteristics.

**The Process of Service Delivery?**

*In particular look at the arrangements for the service being provided including opening times, custom and practice, awareness of the service to local people, communication*

- We anticipate that proposed changes to the service at full budget will ensure that more frontline staff are available to deliver drug and alcohol services in the borough. At the same time we are committed to maintain specific focus on key working, counselling and psychosocial interventions. New developments in service specifications for the new treatment system model include; Increased psychosocial interventions, robust care planning review processes, dedicated referral / outreach capacity for targeted populations, longer opening hours, home visits where appropriate, embedded family interventions, improved recovery support interventions integral to every service user's care plan.

- This approach assumes operating at the full budget seeking an increase of those in treatment, a better retention rate of clients and improved successful completions. Any reduction in funding will reduce capacity and limit engagement and / or effectiveness reducing the services to simply stabilising and maintaining clients and not supporting the key Public Health Outcome target of achieving drugs and alcohol free recovery.

  Tier 4 residential detoxification and rehabilitation are not included in the re-procurement process. However this service would be impacted with this level of budget reduction. The provision is set to give clients access to residential detoxification and rehabilitation either in borough or in appropriate localities. These decisions are reached by the Tier 4 Panel who are formed through a multiagency partnership including clinicians, treatment providers and commissioners. In many cases clients work through their structured treatment to move onto residential detoxification and rehabilitation. Indeed for many this is seen as the panacea of their treatment. Nonetheless in a recovery orientated service residential detox and rehabilitation is an important instrument to secure recovery outcomes.

  There is a proposal in place to decommission the Harbour Recovery centre (HRC) (subject to consultation) and instead purchase places for service users who would normally access the Harbour Recovery centre via spot purchase, approved at tier 4 panel. Ethnicity of service users accessing Tier 4 treatment including HRC is detailed below. Although, this would represent a shift in services, all populations would have the same access to tier 4 services.

| Ethnicity | | | |
|---|---|---|---|
| | **Harbour Recovery Centre** | **Tier 4 Panel** | **Total** |
| Black | 4 | 12 | 16 |
| Bangladeshi/ Asian or British Asian | 86 | 15 | 101 |
| British | - | 4 | 4 |
| Mixed Ethnicity | 5 | 4 | 9 |
| White British/ White Irish | 24 | 66 | 90 |
| White Other | 5 | 15 | 20 |
| Somali | - | 1 | 1 |
| Not stated | 2 | 1 | 3 |
| Chinese | 1 | - | 1 |
| Other | 1 | - | 1 |
| **Total** | **128** | **118** | **246** |

- This proposal will contribute to the One Tower Hamlets objectives of reducing inequalities and strong community cohesion and also supports the community plan themes 'A safe and cohesive community' and 'A Healthy and Supportive community'.

**Value and impact of drugs and alcohol treatment**

- The National Drug Treatment Monitoring System (NDTMS) has established a Value for Money (VfM) tool which essentially calculates thecost impact of drug and alcohol use to the borough if treatment services were not available.

- The model can review previous and future benefits of treatment (with the latter based on trends in service engagement over the last six years) to establish a strategic cost-saving estimate based on service provision and what this has saved the public purse in terms of crime, health and other societal costs which would have been generated by Opiate and / or Crack users (OCU) over the period of the model.

- Based on the latest estimate from NDTMS it is calculated that the cost of not treating drugs and alcohol users would be £23.7M.

- Based on the current levels of expenditure the net benefit of this expenditure would be £12.7m

- Thus for every pound spent on structured treatment there is a net gain of £2.82

- The impact of a £500k budget reduction in terms of this VfM calculation is hard to fully assess however it is safe to say that the ratio of net value will reduce.

| Target Groups | Impact – Positive or Adverse<br><br>What impact will the proposal have on specific groups of service users or staff? | Reason(s)<br>• Please add a narrative to justify your claims around impacts and,<br>• Please describe the analysis and interpretation of evidence to support your conclusion as this will inform decision making<br>Please also how the proposal with promote the three One Tower Hamlets objectives?<br>-Reducing inequalities<br>-Ensuring strong community cohesion<br>-Strengthening community leadership |
|---|---|---|
| Race | Adverse | Service users<br>The majority of clients in treatment were White British (39%), higher than the total population of 31% and the population aged 18 plus of 35.7%. Around 29% of those in treatment were Bangladeshi which was slightly above the proportion of British Bangladeshi in the 18 plus population in the borough (25%). (Source: NDTMS 2013/14 All in treatment YTD).<br><br>However with a £500K reduction this will limit the range of new entrants coming into services and services could focus on opiate and extreme levels of alcohol dependency. This could mean that many presenting with non-opiates (including KHAT, cannabis and legal highs) do not access treatment. This would suggest that the service would return to a strong dominance of White British and Bangladeshi presentation and a reduction in virtually all other ethnic groups. This group will be disproportionately affected by this proposal due to its characteristics? |
| Disability | Adverse | Service users<br>Current service users are overall representative of residents with a disability in Tower Hamlets. We anticipate developing strong links with mental health services improving services for those clients.<br>The re-procured service will be tasked to work with high need groups in the borough. The consortia approach should ensure that the expertise of existing service provision in the borough will be retained. Even with a reduction in funding the proportion of disabled people entering services would remain broadly constant. However there will potentially be less opportunity for disabled people to access services with a reduction in funding. |
| Gender | Positive | Service users<br>We know that women are less likely to enter the treatment system and will be specifically targeted by service providers.<br><br>In 2013/14 there were 1,685 adults in drug treatment, 324 (19%) were female clients and 1,361 (80%) male clients. The female population is under-represented in treatment and lower than the London average (24%) national average (26%). (Source: NDTMS 2013/14 All in treatment YTD)<br><br>Staff – We do not have sufficient information |
| Gender Reassignment | Neutral - Positive | Service users<br>Currently we don't have enough information to access the impact on the group. However, we anticipate, that with general service improvements, a positive impact will be experienced in this user group. |

| | | |
|---|---|---|
| | | Staff – We do not have sufficient information |
| Sexual Orientation | Neutral - Adverse | Service users<br>It is difficult to estimate the size and profile of the lesbian, gay, bisexual and transexual (LGBT) population in the borough as sexual orientation was not a specific category used in the last Census. National surveys indicate that LGBT people make up around 10% of the population in London<br><br>The council does not hold robust information about sexual orientation in Tower Hamlets. However, service providers monitor sexual orientation of those in treatment. Data indicates that 94.3% were heterosexual, 1.5% homosexual and 1.1% Bi-sexual.<br><br>Anecdotal evidence shows that drug use by MSM is high. Moreover the emergence of 'Chemsex' is a growing problem in the borough. A £500k reduction in funding will reduce the capacity for the DAAT and its providers to provide effective targeted services for the LGBT community. |
| Age | Adverse | Service users<br>Around 60% of clients in treatment during 2013/14 were aged 30-44, a strong over-representation compared to the proportion of residents in that age group according to the Census. Remarkably, more clients in Tower Hamlets aged 30 to 44 were in treatment compared to London (49%) and England (58%).In Tower Hamlets, those aged 18 to 24 (6%) were under-represented compared to London (9%) and England (9%).<br><br>We know that age matters when accessing treatment. We understand the relationship between problematic drug use, age and treatment need. The aim of the new drugs and alcohol services will be to offer and provide successful treatment as early as possible in the life of a problematic drug and alcohol user. With a reduction in funding the capacity to support young adults through the treatment system will be limited |
| Marriage and Civil Partnerships. | Neutral - Positive | Service users<br>Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this user group.<br><br>Staff – We do not have sufficient information |
| Pregnancy and Maternity | Neutral - Positive | Service users<br>Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this user group.<br><br>Staff – We do not have sufficient information |
| Other Socio-economic / Carers | Neutral - Positive | Service users<br>Currently we don't have enough information to access the impact on the group. However, we anticipate that with general service improvements, a positive impact will be experienced in this user group.<br><br>Staff – We do not have sufficient information |

**Section 4 – Mitigating Impacts and Alternative Options**

From the analysis and interpretation of evidence in section 2 and 3 - Is there any evidence or view that suggests that different equality or other protected groups (inc' staff) could be adversely and/or disproportionately impacted by the proposal?

Yes? x No?

If yes, please detail below how evidence influenced and formed the proposal? For example, why parts of the proposal were added/removed?

*(Please note – a key part of the EA process is to show that we have made reasonable and informed attempts to mitigate any negative impacts. An EA is a service improvement tool and as such you may wish to consider a number of alternative options or mitigation in terms of the proposal.)*

*Where you believe the proposal discriminates but not unlawfully, you must set out below your objective justification for continuing with the proposal, without mitigating action.*

Any reduction in funding will limit the proposed improvements in drug / alcohol treatment across Tower Hamlets. The new treatment system model has been developed to improve levels of engagement, particularly amongst groups who do not currently engage well, as well as improve outcomes amongst service users. It is hoped that the model will be sufficiently flexible to cater for changing demands and increased expression of need due to streamlined treatment pathways. Whilst the model itself will generate savings via overheads and management costs, these funds should be invested in increased frontline capacity to achieve the desired outcomes. Caseloads across the borough are currently high and less than 50% of the borough's estimated Opiate and Crack users currently access treatment. A reduction in investment will limit outcomes and engagement to current levels which are not satisfactory. The level of reduction required has been reduced from £1m to £500k and work has taken place to ensure most of this reduction will be met without reducing provider services. However, it will impact upon wider promotional work undertaken at a borough level. The impact upon the groups identified will reveal as more pressure is placed on the system via increased access to treatment and therefore these impacts should be reviewed regularly to continually assess levels of capacity and therefore funding. Actions in section 6 are recommended to mitigate against these adverse impacts..

**Section 5 – Quality Assurance and Monitoring**

Have monitoring systems been put in place to check the implementation of the proposal and recommendations?

**Yes**

How will the monitoring systems further assess the impact on the equality target groups?

- Service providers are already monitoring clients in treatment using the nine protected characteristics when possible. The data will be monitored as part of the contract monitoring approach.
- DAAT will update the existing monitoring sheet in time of the re-procurement to incorporate the latest version of Tower Hamlets equalities monitoring.
- The impact on equality groups will be reviewed regularly at Project Team and DAAT Board meetings.

Does the policy/function comply with equalities legislation?
(Please consider the OTH objectives and Public Sector Equality Duty criteria)

Yes? x No?

If there are gaps in information or areas for further improvement, please list them below:

- The information for some of the protected characteristics is limited. Future monitoring will ensure that the recording will be carried out.

How will the results of this Equality Analysis feed into the performance planning process?

- Results of the EA will inform the target setting process and development of key performance indicators with the future drugs and alcohol services.
- Service providers will be asked to use equalities information to target outreach work and specific projects to respond to needs in different communities.

Section 6 - Action Plan

*As a result of these conclusions and recommendations what actions (if any) **will** be included in your business planning and wider review processes (team plan)? Please consider any gaps or areas needing further attention in the table below the example*

| **Recommendation** | **Key activity** | **Progress milestones including target dates for either completion or progress** | **Officer responsible** | **Progress** |
|---|---|---|---|---|
| Better collection of feedback and data. | DAAT will update the existing monitoring sheet in time of the re-procurement to incorporate the latest version of Tower Hamlets equalities monitoring. | New monitoring forms introduced in time for the new providers to start The impact on equality groups will be reviewed regularly at Project Team and DAAT Board meetings | **DAAT Information and Needs Analyst** | |
| Explore greater representation of underrepresented groups in workforce as part of re-procurement process. | Ensure new contractual arrangements allow for diverse workforce including opportunities for young people. | Contracts and contract monitoring in place. | DAAT Commissioning Manager | |
| Ensure groups identified where a negative impact may be experienced are monitored regularly for uptake and effectiveness of services and implement service provider targets for those groups. | Implement and monitor new targets robustly | | DAAT Commissioning Manager | |
| Produce annual needs assessment with particular regard to groups identified | Needs assessment<br><br>Incorporation of emerging needs and under-represented groups in annual targets for providers | Completion and discussion of needs assessment at DAAT Board | DAAT Information and Needs Analyst | |
| Maintain awareness of caseloads and balance of proactive engagement activity with hard to engage groups | Quarterly monitoring and activity recording | | DAAT Commissioning Manager | |
| Monitor budget utilisation and staff profiles in service provider agencies | Quarterly monitoring | | DAAT Commissioning Manager | |
| | | | | |
| | | | | |

ja

Appendix A

**(Sample) Equality Assessment Criteria**

| Decision | Action | Risk |
|---|---|---|
| As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed. | **Suspend – Further Work Required** | **Red**  |
| As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy. | **Further (specialist) advice should be taken** | **Red Amber** |
| As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning* section of this document. | **Proceed pending agreement of mitigating action** | **Amber** |
| As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. | **Proceed with implementation** | **Green:** |