Service: Drug and Alcohol Action Team (DAAT)

Directorate: Public Health

Title of Proposal: Re-tender of Haringey’s adult drug and alcohol services

Lead Officer: Mia Moilanen

Names of other Officers involved: Sarah Hart, Marion Morris

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

State what effects the proposal is intended to achieve and who will benefit from it.

The responsibility for commissioning local drug and alcohol services is transferring from the NHS to the local authority (Public Health) from April 2013 as part of the changes in the Health and Social Care Act (2012). Existing substance misuse contracts are a combination of NHS and council let contracts. The existing council let contracts are all due to be re-tendered in 2013. A report to Cabinet in December 2012 approved recommendations to streamline this process by bringing together the re-tendering of NHS and Council contracts so that a new treatment system could be in place by January 2014. The re-tendering provides the opportunity to examine where there are gaps in the current treatment system and to ensure that as part of the re-tendering process equalities issues are taken into account and ‘protected groups’ needs are not overlooked. It also provides the opportunity to examine how equalities issues can be improved on.

The aim of the re-tender is to:

- Improve equality of access to services.
- Achieve better value for money by reducing the number of providers from five to three: a single drug service, alcohol treatment service and a recovery service provider. Service users will still have access to all of the existing treatment options but it may be delivered by different provider(s).
- Improve and simplify access and routes into treatment.
- Enable service users to have access to combined drug and alcohol treatment options
- Widen the availability and the range of recovery services. Recovery services are focused on helping service users into employment, training or volunteering, preventing relapse, helping with social re-integration, facilitating access to mutual aid (e.g. AA or NA) and so on.
Step 2 - Consideration of available data, research and information

You should gather all relevant quantitative and qualitative data that will help you assess whether at presently, there are differential outcomes for the different equalities target groups – diverse ethnic groups, women, men, older people, young people, disabled people, gay men, lesbians and transgender people and faith groups. Identify where there are gaps in data and say how you plug these gaps.

In order to establish whether a group is experiencing disproportionate effects, you should relate the data for each group to its population size. The Borough Profile data has an equalities profile of the borough and will help you to make comparisons against population sizes.


2 a) Using data from equalities monitoring, recent surveys, research, consultation etc. are there group(s) in the community who:
- are significantly under/over represented in the use of the service, when compared to their population size?
- have raised concerns about access to services or quality of services?
- appear to be receiving differential outcomes in comparison to other groups?

Under/over representation in services

Whilst problematic drug and alcohol use can affect any section of the community, there is a strong correlation between economic disadvantage or deprivation and the development of more serious drug and alcohol problems. In the light of this the DAAT have commissioned services in areas of high deprivation, corresponding to drug and alcohol use (in Bruce Grove, St Ann’s and Seven Sisters wards).

It is difficult to accurately estimate over or under representation by ‘protected characteristics’ without local drug and alcohol prevalence figures - i.e. the number of people misusing drugs or alcohol out in the community broken down by protected characteristics. These figures do not exist on a national or local basis partly because of the hidden nature of drug misuse in particular. We can however make comparisons to Haringey’s overall population (Census 2011) or benchmarked substance misuse treatment population figures against London averages, highlighting any groups that are under or over represented (by 5% or more). It should be noted that the differences in percentages do not automatically equate to under/over representation. For example it is known that Irish people are less likely to abstain from alcohol use compared with other ethnic groups and the general population. Similarly there is a gender gap or difference in alcohol consumption; men drink more than women irrespective of culture all of which means you might expect to see more men and certain ethnic groups represented in drug and alcohol treatment services.

Sex

Women consistently make up a quarter (25%) of the local drug treatment population which is on par with the London average (See figure 1). There are proportionally more women in alcohol treatment, a little over a third (34%, see figure 2). All treatment services run women only groups. to ensure ‘women only space’. This will continue in the new treatment system. Haringey DAAT also commissions a service for women sex workers, SHOC (Sexual Health on Call) which is not part of the re-tender. Given what we know about gender differences in alcohol and drug consumption these figures suggest that there is not an under or over-representation.

Age distribution

The age distribution in drug treatment is similar to London average and Haringey population as a whole (no differences over 5% except for those aged 65 or over). See figure 3.

Source: NDTMS restricted statistics, ONS 2011
National evidence suggests that crack and opiate (e.g. heroin) users, who make up the largest proportion of people in treatment in Haringey, are aging whilst younger generations are increasingly less likely to use these drugs. The new service provision needs to be able to deal with the compounding health issues amongst this group. There needs to be a special consideration that the drive for recovery from drug and alcohol problems does not inadvertently marginalise older drug and alcohol users.

Recent analysis of alcohol related hospital admissions revealed that nearly 60% of admissions are in people aged 55 and over, and the highest age-specific rate of alcohol-related admissions is in those aged 85 and over. This is however likely to be due to the higher prevalence of long term conditions in older people and the generally higher burden of diseases in this group. The percentage of alcohol-specific hospital admissions is highest among people aged 40-49 (fewer than one in three alcohol-specific admissions are in people aged 60 and over). National evidence does suggest that alcohol misuse amongst elders (65+) is often overlooked highlighting the need for targeted work in this area.

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4 NTA (2011) Substance misuse among young people 2010-11 London: National Treatment Agency for Substance Misuse
6 Alcohol-related hospital admissions - Haringey profile: summary, 2013
9 O’Connell, H., Ali-Vym Chin, Fiona Hamilton, Conal Cunningham, J. B. Walsh, Davis Coakley and Brian A.
Older people’s sense of shame and embarrassment about their drinking have been identified as major deterrent to seeking support, particularly from their GP, with whom they will often have a long-term relationship. Other studies have found higher proportions of elderly problem drinkers, especially in men, with an estimated 5-12% of men in their 60s believed to have alcohol problems. Since the number of older people in treatment is very low, both in Haringey and London, it is important that the new services are actively reaching out to people in older age groups.

**Ethnicity**

Black Caribbean and other white ethnic groups are over represented in drug treatment, both compared to London treatment profile and Haringey as a whole (see figure 5). White British make up a proportion very similar to Haringey overall, accounting for just over one in three (35%; 425). The proportion of white British in drug treatment in London is higher than in Haringey (52%)

In alcohol treatment white British and Irish are overrepresented and black Caribbean under-represented in comparison to Haringey overall population (See figure 5). However, as highlighted earlier in this report a literature review into ethnicity and alcohol consumption in the UK shows that both frequency and the amount of alcohol drank is higher in men and women from Irish and Scottish backgrounds. Therefore over representation is to be expected to some extent. London treatment figures for alcohol show white British accounting for more than four in five (84%) in treatment but these figures are so high that it suggests they are not a reliable. This may be a result of inconsistent reporting. Alcohol treatment data in general is less reliable than drug treatment data as not all treatment providers are required to report their data with the National Alcohol Treatment System (the national database for recording those accessing alcohol treatment). It is also a relatively new database compared to NDTMS which is the drugs treatment reporting database that has been in place since 2004.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Drug treatment Haringey</th>
<th>Drug treatment London</th>
<th>Alcohol treatment Haringey</th>
<th>Alcohol treatment London</th>
<th>Haringey Census 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>34%</td>
<td>52%</td>
<td>44%</td>
<td>86%</td>
<td>35%</td>
</tr>
<tr>
<td>White Irish</td>
<td>4%</td>
<td>3%</td>
<td>10%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Other White</td>
<td>21%</td>
<td>12%</td>
<td>19%</td>
<td>3%</td>
<td>23%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Indian</td>
<td>1%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>2%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>13%</td>
<td>6%</td>
<td>3%</td>
<td>1%</td>
<td>9%</td>
</tr>
</tbody>
</table>

White British and Irish over represented in alcohol treatment. Whereas in drug treatment it is black Caribbean over and other White ethnic groups.

Tilda Goldberg Centre and University of Bedfordshire, (2011) Working with Older Drinkers.
Institute of Alcohol Studies (IAS) Factsheet, Alcohol and the elderly, 19th February 2010.
http://www.ias.org.uk/
However, the apparent over-representation of black African Caribbean in drug treatment was not always the case. The DAAT needs assessment completed in 2006 found that black Caribbean men were under-represented in treatment services but over-represented in the criminal justice system. Furthermore it found that younger black African Caribbean men were not accessing existing drug treatment provision which was geared towards the more traditional ‘white’ heroin user. The use of crack cocaine was also at the time disproportionately affecting black African and Caribbean men in the east of the borough. Subsequently a specialist stimulant service (EBAN) was commissioned to cater for the needs of this group. The DAAT also commissions a community group BUBIC (Bringing Unity Back Into Community), run by ex drug users, who serve mainly stimulant (e.g. crack and cocaine) users in the black African and Caribbean community. BUBIC is not part of the re-tender, in order to preserve the uniqueness of this service and ensure we are able to continue to reach African Caribbean men and maintain a service user ethos to our treatment system.

Religion & belief
There is no routine monitoring for religion & belief of clients although services record this information as part of their client assessment. The need for a culturally competent workforce has been raised in focus groups in the annual needs assessments and by regular feedback from treatment agencies, including in the recent consultation for this re-tender the results of which are available from www.haringey.gov.uk. This has been, and will continue to be, addressed with provider recruitment policy that aims to recruit staff from diverse cultural and religious backgrounds. Cultural competence including understanding of client’s religious or spiritual beliefs is an important part of the new recovery model and will be further addressed, by continued diversity training. Routine monitoring of religion and belief will be put in place, however, it will be difficult to provide a benchmark as this data is not collected at a national level by the NDTMS.

Maternity and parental status
Maternity and parental status is monitored through the National Drug and Alcohol Treatment Monitoring System. According to the latest report for December 2012, 12% of new clients (YTD) in drug treatment were living with children. The proportion is lower in comparison to London average (24%, see figure 6). In alcohol treatment over twice as many (27%) of new clients lived with children, having parental responsibility of their own children or someone they live with. Data for alcohol treatment in London is unavailable. Haringey midwifery service employs a specialist substance misuse midwife to look after pregnant women who are dependent on drugs or alcohol. As part of the service provision in the borough the DAAT commissions a dedicated service for children affected by parental substance misuse (Cosmic), which is not part of this current re-tender. The service also provides support to parents. Having access to childcare at treatment appointment times has come up as an issue in several needs assessments and in the re-tender consultation. Therefore the tender specification for each provider contract will stipulate that this needs to be offered.
Disability

Disability is recorded by the providers during the service user’s assessments but it is not routinely monitored since it is not part of the National Drug or Alcohol Treatment Monitoring System which the commissioners rely on for most of their information. Treatment providers systems are generally set up to prioritise reports to the NDTMS. However, mental health issues are recorded as part of the standard monitoring. Anyone with a dual diagnosis, a concurrent mental health and substance misuse issue, is reported for both drugs and alcohol. There is a dedicated treatment service for those with a ‘dual diagnosis’ and all commissioned services must ensure physical access to buildings and/or home visits for those who cannot make appointments.

Since not having a benchmark for the expected number of disabled people in drug or alcohol treatment it is recommended that in addition to routine monitoring a needs assessment is undertaken as part of the J SNA to ensure needs of people with learning disabilities, visual impairments, physical disabilities etc are met. Drug and alcohol treatment services also have role in helping clients who are not currently registered as disabled to access services and benefits that they may be entitled to.

LGBT groups

The prevalence of specific drug use and alcohol amongst LGB & T, populations is higher than in overall population. The current Drugs Strategy acknowledges that services should be responsive to the needs of this group. Haringey treatment agencies reported 6% of their clients to be from LGBT groups. Over one in ten (13%) of the re-tender consultation responses were from LGBT groups which is double the proportion reported by treatment services. This is despite the fact that a large proportion of our drug treatment population are opiate users or crack users, which according the national evidence is not prevalent among LGBT groups. The GLA estimates the total LGBT population in London is somewhere between 6%-10% which is therefore the minimum expected in drug or alcohol treatment services. It is important that when commissioning services the needs of LGBT groups are taken into account by for example training staff and routine monitoring of the uptake.

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14 The 2012 United Kingdom Focal Point Annual Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Available from: http://www.nwph.net/ukfocalpoint/
15 Meads, C., Pennant, M., McManus, J. And Bayliss, S., A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research, Unit of Public Health, Epidemiology and Biostatistics, West Midlands Health Technology Assessment Group, The University of Birmingham, 2009.
of LGBT clients in treatment – otherwise there is a risk that this group and their needs become invisible. We need to monitor that specialist posts such as the Domestic Violence worker currently employed by Haga or couples or family therapy are inclusive to LGBT couples.

Given the higher prevalence of substance misuse among LGB & T populations in Haringey, a separate needs assessment was conducted as part of this EIA and the key findings are available in April 2013.

**Concerns about access to data or quality of services**

Sexual orientation and gender re-assignment, disability and religion & belief are not routinely monitored as this is not reported as part of the National Drug Treatment Monitoring System dataset which the commissioners rely on for most of its information.

In addition to routine monitoring of all protected characteristics, consideration needs to be given for the potential decrease in the number of service locations and how this could potentially affect access – a problem which can be minimised by, for example, commissioning satellite services.

Marriage/civil partnership status is not monitored but in the context of drug or alcohol treatment it is unlikely to be a factor which affects access or outcomes. If however family or couple’s therapy is offered in the new treatment provision, the SLA will specify that the service needs to be made accessible for everyone regardless of marriage or civil partnership status, sexual orientation, or gender re-assignment as indeed all services are.

**2 b) What evidence or data did you use to draw your conclusions and what are sources?**

Annual needs assessment and quarterly performance monitoring are the main methods for identifying gaps and under representation of particular groups, including those with protected characteristics. Data sources include:

- National Drug Treatment Monitoring System (NDTMS)
- National Alcohol Treatment Monitoring System (NATMS)
- Hospital Episode Statistics, North West Public Health Observatory
- Local alcohol profiles for England
- Local drug and alcohol services
- Annual service user survey
- Service user consultation for re-tender
- National Treatment Agency for Substance Misuse (NTA)
- Probation service
- Alcohol-related hospital admissions January 2013 Haringey Profile. NCL Public Health Intelligence
- Published research
2 c) **What other evidence or data will you need to support your conclusions and how do you propose to fill that gap?**

Equal access, encompassing all protected characteristics, was included in the re-tender consultation. [Consultation findings](#) are available on the web.

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

The factors behind substance misuse are complex ranging from individual circumstances to wider social issues. For example, a third of clients in drug treatment come via the criminal justice system where the profile of offenders is not reflective of the wider population. In essence, wider social problems influence who develops drug or alcohol problems and requires treatment. The treatment system as it currently stands is active in ensuring that everyone has equitable access to treatment. This is not to say there are no improvements to be made, but in terms of re-tender process, it should be acknowledged that much of the good work needs to be transferred into the new treatment system.

**Differential outcomes**

How an individual does in treatment is dependent on a multitude of factors, the severity and complexity of each case\(^{18}\) (Strang et. al., 2012): individual’s internal (e.g. mental and physical health) and external resources (e.g. housing, employment, family and friends), the length of time they have been using and the extent that their lifestyle has focussed around opiate use and so on. A local audit on drop outs from treatment, during the 2010 needs assessment, found that the following factors contributed to drop-out: very complex cases, issues ranging from mental health, childhood trauma, to self harm or loss of a family member. No themes relating to protected characteristics were identified although cultural competence and language barriers have been regularly highlighted by services. Services are encouraged to match their staff profile to the treatment population and employ ex users, where possible.

The National Drug Treatment Monitoring System data in 2009-10 demonstrated that women are more likely to leave treatment successfully in comparison to men. Black British and ‘other’ ethnicity groups fared better, and crack, cocaine or cannabis using clients are more successful than those who use opiates, or crack and opiates combined. However, more recent analysis shows that in comparison to boroughs with similar drug user and deprivation profiles Haringey has lower numbers of non opiate users’ completing treatment successfully.

In general, care should be taken when making associations with protected groups and drug misuse. Drug misuse and dependency, especially crack and heroin use, carries a stigma. Some evidence shows this to be even worse than those suffering from mental health or alcohol problems\(^{19}\). Crack and opiate use is closely linked with deprivation\(^{20}\), which in the more diverse and younger east is more prevalent. In 2011-12, only a small minority of people entering drug treatment were employed (17%). Nearly a third (30%) entered drug

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treatment via the criminal justice system and around a quarter (24%) had no fixed abode or had other housing problems\textsuperscript{21}. Although there is no conclusive evidence on whether drug misuse is a symptom or the cause of these issues, the link with deprivation is clear. National research also suggests that those most susceptible to developing problematic substance misuse problems are from vulnerable groups such as children in care, persistent absentees or excludees from school, young offenders, the homeless and children affected by parental substance misuse\textsuperscript{22} \textsuperscript{23}.


\textsuperscript{23} The NHS Information Centre (2011) \textit{Smoking, drinking and drug use among young people in England in 2010 (external link)}. London: NHS Information Centre for Health and Social Care (Last accessed 10 February 2012)
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)

<table>
<thead>
<tr>
<th>Increase barriers?</th>
<th>Reduce barriers?</th>
<th>No change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

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

- Monitoring of all protected characteristic which includes, disability, LGBT status, and religion & belief to be included in all the service level agreements and tender specifications
- Monitor the impact of integration of drug services to ethnicity breakdown
- Improved access to childcare during treatment appointments
- Equalities training for staff, including London Friend training for LGBT groups
- Greater awareness of disabilities including monitoring?
- Include religious or spiritual beliefs as part of routine monitoring
- Monitor DV posts and couples/family therapy inclusive to all, including LGBT groups.

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 locations of the new service(s) are dependent upon which provider wins each contract. Should this impact on the distance to services for clients who may have physical restrictions, it is recommended that satellite services are established in multiple locations and home visits are made available.
Step 4 - Consult on the proposal

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.

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

144 service users were consulted by questionnaires in November 2012 on top of which 60 service users participated in focus groups. In short, the majority were in favour of the changes although there were concerns over the changes in keyworkers and reduction in the amount of support available to service users and distance to services. The full report is available online.

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

Findings from the consultation and this EIA have been incorporated into the new service specifications. Service users are also being provided with training which will allow them to take part in the scoring of potential new provider(s).

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?

Results are published on the web. Posters outlining the results and subsequent actions will also be displayed in treatment services from April 2013.

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?

LGBT training is already in place and new providers will be expected to train their staff to be able to respond to specific needs of an LGBT person from.
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?

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

- **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?**

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

Monitoring procedures are already in place with the current providers that are commissioned by the Drug and Alcohol Action Team. The main data is gathered monthly via the National Drug Treatment Monitoring System (NDMTS) as part of performance monitoring and annual needs assessment. The findings are discussed in the quarterly service level agreement meetings by the commissioner with each agency, and six weekly performance monitoring meeting with all agencies present. Annual needs assessment looks at gaps and unmet needs, and the key findings are published as part of the Joint Strategic Needs Assessment.

For the new service level agreements the providers will be required to:

- Monitor the proportion of clients from each protected characteristic and where possible monitor for any differential outcomes
- Train their staff to understand their duties under the Public Sector Equality Duty in the Equality Act
In the table below, summarise for each diversity strand the impacts you have identified in your assessment.

<table>
<thead>
<tr>
<th>Age</th>
<th>Disability</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Religion or Belief</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing opiate user population is likely require more support for their deteriorating health. Also, they should seen as part of the recovery agenda, including those with long history in treatment.</td>
<td>Routine monitoring of disability status is required</td>
<td>Continued Monitoring of ethnicity profiles after new provision is in place is required to ensure continued equality of access</td>
<td>Childcare during treatment appointments to be added in specifications</td>
<td>Routine monitoring of religious or spiritual beliefs to be incorporated into assessment process</td>
<td>Routine monitoring of LGBT status is required LGBT training of staff is underway</td>
</tr>
</tbody>
</table>
Please list below any recommendations for action that you plan to take as a result of this impact assessment.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action required</th>
<th>Lead person</th>
<th>Timescale</th>
<th>Resource implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGBT</td>
<td>Routine monitoring of LGBT status and training for staff in the new services</td>
<td>Marion Morris</td>
<td>From Q1 2013/14 onwards</td>
<td>Training costs for staff in treatment agencies. Officer's time required to set up routine monitoring</td>
</tr>
<tr>
<td>Disability</td>
<td>Routine monitoring of disability status</td>
<td>Marion Morris</td>
<td>From Q1 2013/14 onwards</td>
<td>Officer's time required to set up routine monitoring</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Monitor if any changes in ethnicity profiles after new services are in place</td>
<td>Marion Morris</td>
<td>From February 2014</td>
<td>Officer's time required to set up routine monitoring</td>
</tr>
<tr>
<td>Gender</td>
<td>Childcare during treatment appointments which mostly affects women has been added to service specifications</td>
<td>Marion Morris</td>
<td>From February 2014</td>
<td>Costs to be included in service contracts</td>
</tr>
<tr>
<td></td>
<td>Single sex groups to continue in the new service provision</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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?*

By the end of March 2013 on the Council website

**Assessed by (Author of the proposal):**

**Name:** Mia Moilanen  
**Designation:** Information Analyst  
**Signature:**  
**Date:** 22 March 2013

**Quality checked by (Equality Team):**

**Name:** Inno Amadi  
**Designation:** Senior Policy Officer  
**Signature:**  
**Date:** 22 March 2013

**Sign off by Directorate Management Team:**

**Name:** Marion Morris  
**Designation:** Drug and Alcohol Strategy Manager
Signature:

Date: 22 March 2013