General Equality Impact Assessment (EIA) Form

Support:

An EIA toolkit, workshop content, and guidance for completing an Equality Impact Assessment (EIA) form are available on the EIA page of the EDI Internal Hub. Please read these before completing this form.

For enquiries and further support if the toolkit and guidance do not answer your questions, contact your Equality, Diversity, and Inclusion (EDI) Business Partner as follows:

- Economy, Environment and Culture (EEC) – Chris Brown,
- Families, Children, and Learning (FCL) – Jamarl Billy,
- Governance, People, and Resources (GPR) – Eric Page.
- Health and Adult Social Care (HASC) – Zofia Danin,
- Housing, Neighbourhoods, and Communities (HNC) – Jamarl Billy

Processing Time:

- EIAs can take up to 10 business days to approve after a completed EIA of a good standard is submitted to the EDI Business Partner. This is not considering unknown and unplanned impacts of capacity, resource constraints, and work pressures on the EDI team at the time your EIA is submitted.
- If your request is urgent, we can explore support exceptionally on request.
- We encourage improved planning and thinking around EIAs to avoid urgent turnarounds as these make EIAs riskier, limiting, and blind spots may remain unaddressed for the 'activity' you are assessing.

Process:

- Once fully completed, submit your EIA to your EDI Business Partner, copying in your Head of Service, Business Improvement Manager (if one exists in your directorate), Equalities inbox, and any other relevant service colleagues to enable EIA communication, tracking and saving.
- When your EIA is reviewed, discussed, and then approved, the EDI Business Partner will assign a reference to it and send the approved EIA form back to you with the EDI Manager or Head of Communities, Equality, and Third Sector (CETS) Service's approval as appropriate.
- Only approved EIAs are to be attached to Committee reports. Unapproved EIAs are invalid.

1. Assessment details

Throughout this form, 'activity' is used to refer to many different types of proposals being assessed.

Read the EIA toolkit for more information.

Name of activity or proposal being assessed:	**Reducing Harm from Drugs and Alcohol: Brighton and Hove Drugs and Alcohol Strategy (2024-2030)**
Directorate:	Housing, Care and Wellbeing
Service:	Public Health
Team:	Drugs and Alcohol

Is this a new or existing activity?	New
Are there related EIAs that could help inform this EIA? Yes or No (If Yes, please use this to inform this assessment)	No

2. Contributors to the assessment (Name and Job title)

Responsible Lead Officer:	**Caroline Vass interim Director of Public Health**
Accountable Manager:	Fran Piccoletti Drug and Alcohol Programme Manager
Additional stakeholders collaborating or contributing to this assessment:	Combatting Drugs Partnership Board

3. About the activity

Briefly describe the purpose of the activity being assessed:

The Drugs and Alcohol Strategy for Brighton and Hove describes how the Brighton and Hove Combatting Drugs Partnership will deliver locally the ambitions in the national strategy 'From Harm to Hope'. The strategy describes the longer-term vision to 2030, to reduce harms from drugs and alcohol for everyone who lives in, works in, or visits Brighton and Hove. It is a multi-agency strategy, with multiple organisations taking on responsibility for its objectives.

The strategy has been developed by the multi-agency Combatting Drugs Partnership, comprising leaders from different organisations across the city who have a key role in tackling drug and alcohol related harms. This includes representatives from the Council, Police, Probation service, NHS ICB, mental health providers, treatment and recovery services, community and voluntary sector and people with lived experience.

This strategy is a high-level document that sets out the Combatting Drugs Partnership's vision for changing the culture around drug use and reducing harms from drugs and alcohol in the city. Although there is a focus on both drugs and alcohol, it is not a comprehensive alcohol strategy.

The strategy will be underpinned by the principles to:

- Reduce stigma
- Target resource according to need
- Be guided by the latest research and best practice, local data and intelligence to make best use of our resources and evaluate services and projects
- Work in partnership with people with lived experience of drug and alcohol harms
- Work collaboratively across organisations to support people and communities as effectively as possible

This Equality Impact Assessment (EIA) will be assessing the impact that the Drugs and Alcohol Strategy for Brighton and Hove may have on diverse protected characteristics and different communities, based on our current knowledge and assessment.

A range of barriers to accessing services and support was identified. Some of them are likely to affect all groups equally:

- Missed opportunities by services such as a GP, to identify a drug or alcohol treatment need.
- A lack of compassion from a range of professionals.

- Shame and stigma as a barrier for seeking help.
- Lack of awareness of drug and alcohol support and services available - by professionals and people supported by services.

What are the desired outcomes of the activity?

The desired outcome is to make Brighton and Hove a place where everyone will be safe from the harms caused by drugs and alcohol. The three key priority areas or strategic workstreams are:

- Disrupt the local drug supply chains, reduce the availability of alcohol and tackle/disrupt drug and alcohol related crime.
- Improving the quality, capacity and outcomes of our drug and alcohol treatment and recovery services.
- Achieving a generational shift in demand for drugs.

Which key groups of people do you think are likely to be affected by the activity?

All residents of Brighton & Hove, including children and young people and also people receiving support from drug and alcohol services.

4. Consultation and engagement

What consultations or engagement activities have already happened that you can use to inform this assessment?

- For example, relevant stakeholders, groups, people from within the council and externally consulted and engaged on this assessment. **If no consultation** has been done or it is not enough or in process – state this and describe your plans to address any gaps.

The Public Health team consulted with individuals who have experience using drug and alcohol services in Brighton and Hove through workshops and focus groups to shape the Drugs and Alcohol Strategy.

This engagement informed some of the objectives and framing of the Drugs and Alcohol Strategy. These key stakeholders will be re-engaged as the Drugs and Alcohol Strategy goes out to consultation, as well as throughout the delivery of the strategy.

The draft strategy has been developed by the multi-agency Combatting Drugs Partnership, made up of leaders from different organisations across the city who have a key role in tackling drug and alcohol related harms. This includes representatives from the BHCC, Sussex Police, Probation service, treatment and recovery services, community groups and people with lived experience. All partners have been consulted, and their feedback was taken onboard when developing the strategy.

Partner colleagues from across different organisations have been part of the initial consultation and it has been presented to the Integrated Care Board (ICB) Child Safeguarding Board, the Brighton and Hove Health and Care Partnership Board, the Police-led Drug Related Harm Group, The Sussex Criminal Justice Board, and the Primary Care Network (PCN) Health Inequality Group.

Within BHCC, the draft strategy has been presented for feedback to the Community Safety Partnership, Safeguarding Adults Board, and Mental Health Oversight Board. Further consultation is planned with the BHCC Safeguarding Children Board, Multiple Complex Needs Steering Group, and the Family Help Partnership.

In addition, the Drugs and Alcohol Strategy public consultation opened on 5th December 2024 and will run until 12th January 2025, to engage with residents from Brighton and Hove and beyond.

This EIA also refers to the Safe and Well at School Survey (SAWSS) 2023. This is an anonymous online survey conducted by Brighton and Hove City Council Public Health team in partnership with the University of Sussex, engaging with students across primary and secondary schools in the city. A total of 7,802 young people aged 11-16 took part, and 5,807 8–11-year-olds took part, a total of 13,609 young people.

5. Current data and impact monitoring

Do you currently collect and analyse the following data to enable monitoring of the impact of this activity? Consider all possible intersections.

(State Yes, No, Not Applicable as appropriate)

Age	YES
Disability and inclusive adjustments, coverage under equality act and not	YES
Ethnicity, 'Race', ethnic heritage (including Gypsy, Roma, Travellers)	YES
Religion, Belief, Spirituality, Faith, or Atheism	YES
Gender Identity and Sex (including non-binary and Intersex people)	YES
Gender Reassignment	YES
Sexual Orientation	YES
Marriage and Civil Partnership	Not applicable
Pregnant people, Maternity, Paternity, Adoption, Menopause, (In)fertility (across the gender spectrum)	YES
Armed Forces Personnel, their families, and Veterans	YES
Expatriates, Migrants, Asylum Seekers, and Refugees	Partially
Carers	YES
Looked after children, Care Leavers, Care and fostering experienced people	YES
Domestic and/or Sexual Abuse and Violence Survivors, and people in vulnerable situations (All aspects and intersections)	YES
Socio-economic Disadvantage	YES
Homelessness and associated risk and vulnerability	YES
Human Rights	Not applicable
Another relevant group (please specify here and add additional rows as needed)	Ex-offenders, Lone parents, People experiencing homelessness, People experiencing cuckooing or exploitation, People with experience of or living with a substance use disorder (SUD), Sex workers, People experiencing mental health needs

Additional relevant groups that may be widely disadvantaged and have intersecting experiences that create exclusion and systemic barriers may include:

- Ex-offenders and people with unrelated convictions
- Lone parents
- People experiencing homelessness
- People facing literacy, numeracy and /or digital barriers
- People on a low income and people living in the most deprived areas
- People who have experienced female genital mutilation (FGM)
- People who have experienced human trafficking or modern slavery
- People with experience of or living with addiction and/ or a substance use disorder (SUD)
- Sex workers

If you answered "NO" to any of the above, how will you gather this data to enable improved monitoring of impact for this activity?

Data about these groups is collected and analysed by and from services and partner organisations delivering the strategy. In some cases, this may not be comprehensive and we will work towards improving this, noting in particular gaps in data for armed forces personnel.

What are the arrangements you and your service have for monitoring, and reviewing the impact of this activity?

Detailed action plans will be developed to sit underneath each strategic priority. They will form the basis for an outcomes monitoring framework. The actions and targets will be SMART: specific, measurable, achievable, realistic and timely, and will be developed to meet short-term, medium-term and longer-term needs. The priorities, strategic objectives and the outcomes monitoring framework will be regularly reviewed by the Combatting Drugs Partnership to ensure it continues to meet the needs of our population, to reflect any changes in national policy, and accommodate funding changes (the current supplementary substance misuse treatment and recovery grant [SSMTRG] ends in March 2025).

6. Impacts

Advisory Note:

- **Impact:**
  - Assessing disproportionate impact means understanding potential negative impact (that may cause direct or indirect discrimination), and then assessing the relevance (that is: the potential effect of your activity on people with protected characteristics) and proportionality (that is: how strong the effect is).
  - These impacts should be identified in the EIA and then re-visited regularly as you review the EIA every 12 to 18 months as applicable to the duration of your activity.
- **SMART Actions mean**: Actions that are (SMART = Specific, Measurable, Achievable, Realistic, T = Time-bound)
- **Cumulative Assessment:** If there is impact on all groups equally, complete **only** the cumulative assessment section.
- **Data analysis and Insights:**
  - In each protected characteristic or group, in answer to the question 'If "YES", what are the positive and negative disproportionate impacts?', describe what you have learnt from your data analysis about disproportionate impacts, stating relevant insights and data sources.
  - Find and use contextual and wide ranges of data analysis (including community feedback) to describe what the disproportionate positive and negative impacts are on different, and

intersecting populations impacted by your activity, especially considering for Health inequalities, review guidance and inter-related impacts, and the impact of various identities.
    - For example: If you are doing road works or closures in a particular street or ward – look at a variety of data and do so from various protected characteristic lenses. Understand and analyse what that means for your project and its impact on different types of people, residents, family types and so on. State your understanding of impact in both effect of impact and strength of that effect on those impacted.
- **Data Sources:**
    - **Consider a wide range (including but not limited to):**
        - Census and local intelligence data
        - Service specific data
        - Community consultations
        - Insights from customer feedback including complaints and survey results
        - Lived experiences and qualitative data
        - Joint Strategic Needs Assessment (JSNA) data
        - Health Inequalities data
        - Good practice research
        - National data and reports relevant to the service
        - Workforce, leaver, and recruitment data, surveys, insights
        - Feedback from internal 'staff as residents' consultations
        - Insights, gaps, and data analyses on intersectionality, accessibility, sustainability requirements, and impacts.
        - Insights, gaps, and data analyses on 'who' the most intersectionally marginalised and excluded under-represented people and communities are in the context of this EIA.
- Learn more about the Equality Act 2010 and about our Public Sector Equality Duty.

6.1 Age

Does your analysis indicate a disproportionate impact relating to any particular Age group? For example: those under 16, young adults, with other intersections.	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data relating to Age from the Brighton and Hove Drugs and Alcohol Needs Assessment (D&ANA, 2022), the Brighton and Hove Audit of Drug Deaths 2024, and from the Safe and Well at School Survey (SAWSS) 2023 which pertains specifically to school-age children and young people.

Of 138 drug-related deaths in Brighton and Hove over a three year period between 2020 and 2023, over half (57%) were in people aged 35-54 years of age. This age group is disproportionately affected, despite making up only 28% of the total population of the city. 23% of deaths were in the 15-34 age group (which makes up 32% of the total population), and 21% in people aged 55 and over (which makes up 26% of the total population).
The SAWSS reports that 3% of 11 to 14 year olds and 20% of 14 to 16 year olds have tried cannabis, while 2% of 11 to 14 year olds and 8% of 14 to 16 year olds had tried other drugs. According to the Needs Assessment there were 88 under 18 year olds receiving specialist drugs and alcohol treatment in

2021-2022. Of these, 9% reported their primary substance of concern as Benzodiazepines, which is significantly higher than the England average of 1%. The alcohol specific hospital admission rate for Children and Young People is higher at 53 per 100,000 than the England average of 29 per 100,000.

Data from the Needs Assessment also highlighted that children and young people are particularly vulnerable to exploitation relating to involvement with drugs including involvement in gangs or county lines. 13% of first-time entrants to the youth justice system aged 10 to 17 years have committed offences relating to drugs. Children and young people affected by drugs and alcohol use in the family are also noted to have worse health, wellbeing and educational outcomes than other children. Many children and young people also have co-occurring vulnerabilities such as poor mental health or exposure to domestic violence.

The team also conducted a series of workshops to engage with people with lived experience (PWLE) of involvement with drugs and alcohol and support services to better understand their needs. Approximately 50 adults participated, with representation across an age range of 16 to 74 years. The strategy recognises however, that there was no similar engagement with children and young people via focus groups or workshops.

Age-specific aims are reflected in the strategy, which will be underpinned by multi-agency action plans and assessed against SMART objectives.

These aims include:

- A commitment to further engagement with children and young people
- Work with the Community and Voluntary Sector, Children's services, Sussex Police, school services and the children and young person drug and alcohol service, RUOK?, to prevent involvement of children and young people with organised crime groups, and to prevent exploitation opportunities
- Work with Police, community safety teams and safeguarding agencies to safeguard children and young people who are being exploited
- Support the multi-agency youth disposal pathway to include an out of court pathway for young people to guide them into treatment.
- Improve access to, and experiences of, services for children and young people, including improving the transition for young people into adult services
- Promote healthy lifestyles in children and young people, via engagement with school-based services, family hubs, and supporting parents in treatment via the Parenting Our Children and Accessing Recovery Programme
- Stop children and young people starting to use drugs and alcohol

Older adults might also experience specific barriers in accessing drug and alcohol treatment and recovery services. Those barriers include:

- Isolation.
- Difficulty accessing services due to failing physical health and mobility issues.
- Digital exclusion or due to information being aimed mainly at younger people to prevent them from starting to take drugs and smoking, which can be excluding older generations who are already doing this.

The following measures can be implemented to address disproportionate impact relating to age:

- Expanding the existing Outreach offer – this is a task team which engages with groups who have difficulties accessing community services, such as older adults with mobility issues, and provides at-home support
- Targeting the Outreach offer towards the age group most affected by substance-related death
- Expanding training and supply of Naloxone nasal spray for families, carers and young people over 16 years.
- To ensure that all materials are fully accessible for people of all ages. To provide materials in a variety of accessible formats.

- To ensure that all venues are as accessible as possible in line with known restrictions.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.2 Disability:

Does your analysis indicate a disproportionate impact relating to Disability, considering our anticipatory duty?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data relating to Disability and long term conditions. The 2021 Census ONS data shows that nearly one in five residents (19%) are disabled as defined by the Equality Act. Among residents without a disability, 8% have a long term physical or mental health condition.

The team also engaged with people with lived experience. Of the 23 participants in the PWLE workshops for whom this information was captured, 20 self-identified as having a disability or long-term condition. Themes from the workshops identified disability as a trigger influencing drug and alcohol use. Accessibility of services, including accessible spaces, was identified as a barrier for disabled users. Better mental health provision was identified as an area for improvement.

Further engagement with people with lived experience is planned via the Drug and Alcohol Lived Experience Programme, of which the needs of disabled people will be one of three focussed 'design sprints' (see section 7).

Recognition of disability and unmet physical and mental health needs as risk factors for drug and alcohol use, and as barriers to accessing services, is reflected in the strategy. Priorities relating to this include:

- Improve the capability of services to support clients with multiple needs
- Improve access to, and experience of, services for adults and children and young people, especially from underserved cohorts (which includes people who are neurodiverse)
- Develop an integrated response for people with co-occurring substance use and other needs, including mental and physical health needs and neurodiversity

These high-level strategic aims will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Information not being available in accessible formats,
- Lack staff training in various accessible communication methods.
- Inaccessible venues.
- Lack of flexibility in service delivery to accommodate fluctuating conditions.

- Lack of service provision tailored to meet the needs of people with learning disabilities.

The following measures can be implemented to address these barriers:

- Expanding the existing Outreach offer to support disabled people that make it challenging to access community services
- Use of in-person and telephone interpreters where there is an additional communication need
- To ensure that all materials and media are fully accessible and available in a variety of formats, such as for example large print, Easy Read and British Sign Language.
- To ensure that all venues are as accessible as possible, in line with known restrictions
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

What inclusive adjustments are you making for diverse disabled people impacted? For example: D/deaf, deafened, hard of hearing, blind, neurodivergent people, those with non-visible disabilities, and with access requirements that may not identify as disabled or meet the legal definition of disability, and have various intersections (Black and disabled, LGBTQIA+ and disabled).

The strategy will be designed by the design team to be accessible and will be uploaded in an accessible format for screen readers.

6.3 Ethnicity, 'Race', ethnic heritage (including Gypsy, Roma, Travellers):

Does your analysis indicate a disproportionate impact relating to ethnicity?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data relating to Ethnicity from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022). More than a quarter (26%) of residents of Brighton and Hove are from a Black and Racially Minoritised group (non-White UK/British). 2021 ONS Census data shows that of Black and Racially Minoritised residents, 37% are other White, 18% are of mixed ethnicity, 18% are Asian, 8% are Black, and 4.2% are from Arab backgrounds. Amongst users of drug and alcohol treatment services in 2021-22, 11% were from Black and Racially Minoritised backgrounds.

Unfortunately, the people with lived experience (PWLE) workshops did not reach as many people from Black and Racially Minoritised backgrounds as hoped. The strategy acknowledges this and commits to undertake further engagement with these groups as a priority. This reflects a focus within the strategy of improving access to and experience of services for underserved cohorts including people from Black and Racially Minoritised backgrounds.

Further engagement with people with lived experience is also planned via the Drug and Alcohol Lived Experience Programme (see section 7).

The output of these planned programmes will inform the development of action plans underpinning the strategy.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Information not being accessible to people for whom English is a second language or who face literacy barriers. Content not being provided in plain English, use of complex terminology and professional jargon can form a barrier to access.
- Lack of interpretation services and information not available in multiple languages.
- Cultural stigma within certain communities.
- Lack of culturally competent services.

The following measures can be implemented to address these barriers:

- Continued work of existing team of Black, Asian and Minority Ethnic Recovery Coordinators working in the adult treatment service who work with Black and Racially Minoritised people and people for whom English is their second language, with experience of substance use.
- To ensure that all materials are available in multiple languages.
- To provide content in plain English.
- To provide access to interpreting services.
- To ensure services are culturally sensitive.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.4 Religion, Belief, Spirituality, Faith, or Atheism:

Does your analysis indicate a disproportionate impact relating to Religion, Belief, Spirituality, Faith, or Atheism?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

The development of the strategy did not explicitly consult on data relating to religion.

Based on 2021 ONS Census data, 55% of residents have no religion or belief. 30.9% identified as Christian, 0.9% as Buddhist, 0.9% as Jewish, 0.8% as Hindu, 0.1% as Sikh, and 1% as other religions. 7.1% did not answer the voluntary question.

Data on religious identity was captured as part of the PWLE workshops, with participation of a range of people who identified as having a particular religion or none.

It is not envisaged that the detailed action plans underpinning the strategy will cause any disproportionate impact relating to religion, belief, spirituality, faith or atheism. However, we note that barriers to accessing drug and alcohol treatment and recovery services may include:

- Possible conflict between religious beliefs and certain treatment approaches.
- Lack of consideration for religious dietary requirements in residential recovery settings.
- Lack of awareness of cultural stigma around drugs and alcohol within certain religious communities.
- Lack of culturally competent services.
- Lack of same-sex support when required for religious reasons.
- Services not accommodating people's religious-based preferences in service delivery or interactions.

The following measures can be implemented to address these barriers:

- To ensure services are culturally sensitive and respectful of people's preferences related to their religious identity.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.5 Gender Identity and Sex:

Does your analysis indicate a disproportionate impact relating to Gender Identity and Sex (including non-binary and intersex people)?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

Data from the 2021 ONS Census shows that 51% of residents are female, and 49% are male, with a relatively even distribution of males and females across all ages up to 75, with the exception of ages 19 to 21 where 56% (9,900 people) are female and 44% male (7,900 people). The difference is likely due the higher proportion of female students to male students attending Brighton University and Sussex University.

To inform the development of the strategy, the Public Health team used data relating to Gender Identity and Sex from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022). The data shows that 63% of all Service Users in 2021/22 were male. However, women may find it harder to access drugs and alcohol treatment due to specific concerns such as fear of losing their children, or stigma. They may also find it difficult to access man-dominated environments due to disproportionate experiences of Domestic Abuse and Sexual Violence. From hospital admission data, inpatient episode rates of intentional self-poisoning are significantly higher for women in Brighton and Hove (62.8 per 100,000) compared to England (38.6 per 100,000).

Data from the Safe and Well at School survey suggests 17% of pupils who did not or did not always identify with their gender registered at birth had tried drugs, compared to 12% of those who did.

Of the 23 participants in the PWLE workshops for whom this information was captured, there was representation from participants who self-identified as Woman (n=6), Man (n=11), Non-binary (n=less than 5) and In Another Way (n=less than 5).

Feedback identified the importance of all-female service and activity spaces to enable Service Users to feel safe and comfortable.

Further engagement with people with lived experience is planned via the Drug and Alcohol Lived Experience Programme, of which the needs of women is one of three focussed 'design sprints' (see section 7).

Recognition of specific vulnerabilities and barriers to access relating to Gender Identity and Sex is reflected in the strategy, which includes a focus on underserved cohorts and a priority area led by the women's drug and alcohol treatment service, Oasis. Amongst the specific priorities is a focus on developing an integrated response for people with co-occurring substance use and other needs, including:

- Improving the knowledge and confidence of the workforce to support pathways for those affected by violence against women and girls
- Ensure a joined up approach to complex cases and multiple compound need (for example violence against women and girls)

The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Other barriers to access to drug and alcohol treatment and recovery services may include:

- Childcare responsibilities and lack of childcare provision.
- Underrepresentation of men in seeking help due to societal expectations.
- Inadequate considerations of gender-specific issues in service delivery.

The following measures can be implemented to address these barriers:

- There is an existing dedicated women's service, Oasis, which offers treatment and recovery to women experiencing problematic drug and alcohol use, as well as providing support in matters relating to involvement with social care and safeguarding, such as support attending court cases, and support for women experiencing domestic violence. There is also a dedicated outreach worker for sex workers.
- To signpost parents to available childcare options, including a creche service run by Oasis
- To reduce stigma around men seeking help by providing services in a sensitive and empathetic way.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.6 Gender Reassignment:

Does your analysis indicate a disproportionate impact relating to Gender Reassignment?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

In 2021 a new question on gender identity was included in the Census. It was added to provide the first official data on the size of the transgender population in England and Wales.
The question was voluntary and was only asked of people aged 16 years and over. People were asked "Is the gender you identify with the same as your sex registered at birth?" and had the option of selecting either "Yes" or "No" and writing in their gender identity. The five local authorities with the highest proportion of the population aged 16 years and over who identified as non-binary were all outside London. Brighton and Hove had the highest percentage (0.35%).
Based on a voluntary question from the 2021 Census:

- In Brighton & Hove a total of 220,742 residents (93.8%) of the population aged 16 years and over answered the question.
- A total of 218,401 residents (92.8%) answered "Yes", indicating that their gender identity was the same as their sex registered at birth.
- A total of 2,341 residents (1.0%) answered "No", indicating that their gender identity was different from their sex registered at birth. Within this group:
- 476 (0.2%) answered "No" but did not provide a write-in response
- 362 (0.1%) identified as a trans man
- 329 (0.1%) identified as a trans woman
- 1,174 (0.5%) wrote in a different gender identity

Of the 23 participants in the PWLE workshops for whom this information was captured, seven participants identified as trans. Feedback identified specific barriers for trans people in accessing drugs and alcohol support, in particular where accessing treatment may impact on gender reassignment treatment. It also highlighted the importance of specific trans-inclusive spaces to facilitate access to support, including diversity of staff and volunteers.

Recognition of the specific barriers and needs of trans and gender diverse people is reflected in the strategy, which includes a priority of improving access to and experience of services, especially from underserved cohorts including LGBTQIA+ people.

The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Fear of discrimination and transphobia.
- People feeling discomfort in gendered spaces in residential recovery settings.
- Lack of understanding and awareness from staff and other Service Users.
- Fear of potential impact of seeking help on people's ongoing transition needs.

The following measures can be implemented to address these barriers

- Continued work of the existing team within the adult treatment and recovery service which is trained in and dedicated to supporting people experiencing substance use from the LGBTQ+ community
- To create safe, non-judgmental, trans-inclusive spaces to facilitate access to support, including diversity of staff.
- Use inclusive language and diverse imagery in all materials and communications.
- Ensure respect for people's chosen names and pronouns.

- Ensure that people's ongoing transition needs are part of support planning and delivery.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.7 Sexual Orientation:

Does your analysis indicate a disproportionate impact relating to Sexual Orientation?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

2021 Census data suggests the proportion of adults identifying with an LGB+ orientation (10.6%) in Brighton and Hove is three times higher than in the rest of the South East and England. The Brighton and Hove Drugs and Alcohol Needs Assessment (2022) estimates that in 2021-22 18% of Service Users were from the LGBT community.
Data from the SAWSS shows that pupils who are LGBTQIA+, unlabelled, or unsure of their sexuality are statistically significantly more likely to have tried drugs (15% compared to 12%)

Additionally, of the 23 participants in the PWLE workshops for whom this information was captured, 6 participants identified as gay, lesbian, bisexual or another sexual identity. Feedback included the value of group-specific safe spaces and sessions, including for LGBTQ+ groups.
Further engagement with people with lived experience is planned via the Drug and Alcohol Lived Experience Programme (see section 7).
Recognition of specific vulnerabilities and barriers to access relating to sexual orientation is reflected in the strategy, which includes a focus on underserved cohorts including LGBTQ+ people. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:
- Fear of discrimination and homophobia.
- Lack of safe, non-judgmental spaces.

The following measures can be implemented to address these barriers:
- Continued work of the existing team within the adult treatment and recovery service which is trained in and dedicated to supporting people experiencing substance use from the LGBTQ+ community
- To create safe, non-judgmental, inclusive spaces to facilitate access to support, including diversity of staff.
- Use inclusive language and diverse imagery in all materials and communications.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics

and intersecting identities, as well as to improve access to and experience of services for underserved cohorts. • To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service. • To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.8 Marriage and Civil Partnership:

Does your analysis indicate a disproportionate impact relating to Marriage and Civil Partnership?	See below

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

The development of the strategy was not explicitly informed by data relating to marriage or civil partnership status. ONS census data shows that one third of residents aged 16 or older are married or in a civil partnership. Of these, 5% are in a same sex marriage or civil partnership. Proportionally, Brighton and Hove have the highest number of residents in a same-sex marriage or civil partnership in England. It is not envisaged that the detailed action plans underpinning the strategy will cause any disproportionate impact relating to this. However, we note that there can be specific barriers related to marriage and civil partnership, such as potential lack of family-oriented support services and lack of inclusive language and imagery (for example relating to single people and families) in promotional materials. The following measures can be implemented to address these barriers • To ensure that family-oriented support (via The Family and Carers (FACT) Service) is available when needed. • Use inclusive language and diverse imagery in all materials and communications. • To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts. • To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service. • To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.9 Pregnant people, Maternity, Paternity, Adoption, Menopause, (In)fertility (across the gender spectrum):

Does your analysis indicate a disproportionate impact relating to Pregnant people, Maternity, Paternity, Adoption, Menopause, (In)fertility (across the gender spectrum)?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022), which recognises the specific needs of and barriers to parents and families in accessing drug and alcohol services.

This is reflected in the strategy, which includes a priority area led by the women's drug and alcohol treatment service, Oasis. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Fear of social care involvement and of children being removed from the family home
- Feeling of stigmatisation and that the system will impact them negatively
- Increased experience of domestic violence and sexual assault amongst pregnant people, which may make them less likely to access services

The following measures can be implemented to address these barriers:

- The Oasis service works with pregnant people and parents to support them in accessing treatment, trauma-informed care, psychological support, and for those working with social workers. The service operates within a safe space separated from the mainstream drug and alcohol services.

6.10 Armed Forces Personnel, their families, and Veterans:

Does your analysis indicate a disproportionate impact relating to Armed Forces Members and Veterans?	*See below*

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

The development of the strategy was not explicitly informed by data relating to the armed forces or veterans.

It is not envisaged that the detailed action plans underpinning the strategy will cause any disproportionate impact relating to this group. However, we note that this cohort may experience barriers to accessing treatment, such as stigma, PTSD, availability linked to duty requirements. We will explore potential barriers and ensure the action planning reflects these.

Further work is identified for this cohort

6.11 Expatriates, Migrants, Asylum Seekers, and Refugees:

Does your analysis indicate a disproportionate impact relating to Expatriates, Migrants, Asylum seekers, Refugees, those New to the UK, and UK visa or assigned legal status? (Especially considering for age, ethnicity, language, and various intersections)	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

ONS Census data (2021) suggests one in five residents of Brighton and Hove (54,343 people, 20%) were born outside of the UK. This is a higher proportion than seen in the South East (16%) and England (17%).
Despite the overall number of residents only increasing by 1%, the number of residents born outside of the UK has increased by 27% (11,456 people) since 2011, with the proportion increasing from 16% to 20%.
Two out of five of residents (23,104 people, 42%) born outside of the UK were born in the EU. This is a higher proportion than in the South East and England.
Among residents born in the EU, nearly two thirds 65% were born in EU countries who have been members since before 2004 (EU 14). This is significantly higher than seen in the South East (47%) and England (44%).
A half of all residents born outside of the UK were born outside of Europe (27,670 people, 51%). This is a lower proportion than seen in the South East (57%) and England (59%).
Among residents born outside of Europe, nearly a half (12,517, 45%) were born in the Middle East and Asia and over a quarter (7,863 people, 28%) born in Africa.

The strategy was not explicitly informed by data relating to this group.
As above, the strategy reflects a recognition that engagement with certain groups has been limited, and there is a focus on collaboration with underserved cohorts as a priority.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Concerns relating to disclosure of immigration status, and understanding of available services.
- Information not being accessible to people for whom English is a second language or who face literacy barriers. Content not being provided in plain English, use of complex terminology and professional jargon can form a barrier to access.
- Lack of interpretation services and information not available in multiple languages.
- Cultural stigma within certain communities.
- Lack of culturally competent services.

The following measures can be implemented to address these barriers:

- Continued work of existing team of Black, Asian and Minority Ethnic Recovery Coordinators working in the adult treatment service who work with Black and Racially Minoritised people and people for whom English is a second language, with experience of substance use
- Continued use of trauma-informed support in treatment and recovery services
- To ensure that all materials are available in multiple languages.
- To provide content in plain English.
- To provide access to interpreting services.
- To ensure services are culturally sensitive.
- To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to inform the further development of the strategy and underpinning action plans and also to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.
- To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.
- To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

6.12 Carers:

Does your analysis indicate a disproportionate impact relating to Carers (Especially considering for age, ethnicity, language, and various intersections).	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022).

Carer status was also recorded for participants in the PWLE workshops. Of the 23 participants for whom this information was captured, five identified as parents or carers. Participants identified being an unpaid carer as a life stressor that is a risk factor in drug and alcohol use.

Being a young carer is also a risk factor for drug and alcohol use. The SAWSS reports that 22% of young carers are likely to have tried drugs (as against 12% of other pupils).

There are also challenges associated with being a carer for or supporting someone experiencing harmful substance use.

This is reflected in the strategy, which includes priority areas to develop an integrated response for people with co-occurring substance use and other needs such as being a carer. It also aims to improve access to and experience of services for young carers. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Insufficient support or respite from caring responsibilities to attend treatment and recovery services – either as someone experiencing substance use problems themself, or looking after someone experiencing them
- Fear of social care involvement and of loved ones being removed from the family home

The following measures can be implemented to address these barriers:

- To ensure that support for carers supporting loved ones experiencing harmful substance use (via The Family and Carers (FACT) Service) is available when needed.

6.13 Looked after children, Care Leavers, Care and fostering experienced people:

Does your analysis indicate a disproportionate impact relating to Looked after children, Care Leavers, Care and fostering experienced children and adults (Especially considering for age, ethnicity, language, and various intersections). **Also consider our Corporate Parenting Responsibility in connection to your activity.**	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

Data from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022) recognises the specific challenges and vulnerabilities faced by care-experienced children and young people.

We know that people who are care experienced are disproportionately represented in drug deaths in Brighton & Hove, and the strategy and work planning reflects this.

Data from the SAWSS shows that adopted children are statistically significantly more likely to have tried alcohol than children who are not (51% vs 43%), as well as being more likely to have tried drugs (31% vs 12%)

As discussed above, the strategy recognises that there was limited engagement with children and young people via focus groups or workshops, and this includes looked after children.

A commitment to further engagement with children and young people is reflected in the strategy. The strategy also includes priority areas to ensure an integrated approach to improving the transition for care leavers into adult services. This and other high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Instability in home arrangements which can disrupt continuity of access to services
- Complex needs including experiences of trauma

The following measures can be implemented to address these barriers:

- Trauma-informed service provision

6.14 Homelessness:

Does your analysis indicate a disproportionate impact relating to people experiencing homelessness, and associated risk and vulnerability? (Especially considering for age, veteran, ethnicity, language, and various intersections)	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

There is a high rate of homelessness according to the Brighton and Hove Drugs and Alcohol Needs Assessment (2022). In 2021/22 26% of people in drug treatment had housing difficulties.

Recognition of specific vulnerabilities and barriers to access relating to homelessness is reflected in the strategy, which includes a focus on addressing the causes of harmful drug and alcohol use including housing issues or homelessness. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

The development of the strategy and action plans will be developed closely with partners working in relevant Housing and homelessness teams, and there is homelessness representation on the CDP steering group.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Lack of awareness of services available
- Stigma and previous negative experiences
- Complex needs including co-occurring mental health needs, physical conditions and experiences of trauma

The following measures can be implemented to address these barriers:

- A dedicated Rough Sleepers Drug and Alcohol Treatment Grant held by the adult treatment and recovery service CGL, which delivers support and treatment for people rough-sleeping or at risk of rough sleeping

6.15 Domestic and/or Sexual Abuse and Violence Survivors, people in vulnerable situations:

Does your analysis indicate a disproportionate impact relating to Domestic Abuse and Violence Survivors, and people in vulnerable situations (All aspects and intersections)?	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

To inform the development of the strategy, the Public Health team used data from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022), which reflects the particular vulnerabilities and needs of survivors of Domestic and Sexual Abuse and Violence, particularly in accessing services in man-dominated environments. Domestic violence is also a risk factor for involvement with drugs and alcohol; in 2021/22, 27% of young people in treatment were affected by domestic violence.

This is reflected in the strategy, which includes a focus on addressing the causes of harmful drug and alcohol use including domestic violence and abuse, and improving awareness of, and access into services for people with experience of domestic abuse. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Fear of contact with perpetrator in mainstream services
- Stigma around experience of domestic violence or sexual assault

The following measures can be implemented to address these barriers:

- The Oasis service works women experiencing domestic abuse and violence to support them in accessing treatment, trauma-informed care and psychological support. The service operates within a safe space separated from the mainstream drug and alcohol services

6.16 Socio-economic Disadvantage:

Does your analysis indicate a disproportionate impact relating to Socio-economic Disadvantage? (Especially considering for age, disability, D/deaf/ blind, ethnicity, expatriate background, and various intersections)	YES

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

The strategy was informed by data relating to socio-economic disadvantage from the Brighton and Hove Drugs and Alcohol Needs Assessment (2022) particularly as it relates to housing issues and homelessness and educational outcomes for children. 17% of the population live in the 20% most deprived areas in England, and 15% of under-16 year olds live in income deprived households. In the year ending September 2022 the unemployment rate in Brighton and Hove was 3.5%.

This is reflected in the focus within the strategy on addressing the risk factors associated with drug and alcohol use including poverty. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

Barriers in accessing drug and alcohol treatment and recovery services may include:

- Financial Barriers: Low-income households may struggle to access services due to transportation expenses, or the inability to take time off work. Individuals from socio-economically disadvantaged backgrounds often face competing financial priorities, such as securing basic needs like food and housing.
- Housing and homelessness: Individuals experiencing homelessness or insecure housing are disproportionately affected by substance use disorders, and their unstable living conditions often act as a barrier to accessing long-term care and recovery services. Lack of a permanent address or safety can make attending regular appointments or following treatment plans difficult.
- Stigma and discrimination: People from socio-economically disadvantaged backgrounds often face stigma associated with both poverty and substance use. This may deter them from seeking treatment, as they fear being judged or treated differently by healthcare providers or the broader community.
- Educational barriers: People with lower levels of education/literacy may lack awareness of available services, how to access them, or the benefits of treatment programmes. This can result in a gap in knowledge about where or how to seek help.
- Complex intersections of disadvantage: Socio-economic disadvantage often intersects with age, disability, ethnicity, creating additional layers of exclusion. For example, older adults with low income may face age-related mobility issues, while individuals from ethnically minoritised groups may encounter language barriers, cultural misunderstandings, or a lack of culturally sensitive services. Individuals who are disabled or experience sensory loss may have difficulty accessing services that are not designed to accommodate their specific needs.

The following measures can be implemented to address these barriers:

- Offer transportation vouchers or community transport programmes to ensure people experiencing poverty can attend appointments regularly.
- Implement outreach programmes in deprived areas to raise awareness about available services, breaking down stigma and educating people about how to access treatment.

6.17 Human Rights:

Will your activity have a disproportionate impact relating to Human Rights?	See below

If "YES", what are the positive and negative disproportionate impacts?

Please share relevant insights from data and engagement to show how conclusions about impact have been shaped. Include relevant data sources or references.

The development of the strategy was not explicitly informed by data relating to Human Rights.

It is not envisaged that the detailed action plans underpinning the strategy will cause any disproportionate impact relating to this.

6.18 Cumulative, multiple intersectional, and complex impacts (including on additional relevant groups):

What cumulative or complex impacts might the activity have on people who are members of multiple Minoritised groups?

- For example: people belonging to the Gypsy, Roma, and/or Traveller community who are also disabled, LGBTQIA+, older disabled trans and non-binary people, older Black and Racially Minoritised disabled people of faith, young autistic people.
- Also consider wider disadvantaged and intersecting experiences that create exclusion and systemic barriers:
    - People experiencing homelessness
    - People on a low income and people living in the most deprived areas
    - People facing literacy, numeracy and/or digital barriers
    - Lone parents
    - People with experience of or living with addiction and/ or a substance use disorder (SUD)
    - Sex workers
    - Ex-offenders and people with unrelated convictions
    - People who have experienced female genital mutilation (FGM)
    - People who have experienced human trafficking or modern slavery

Complex intersections of disadvantage: Socio-economic disadvantage often intersects with age, disability, ethnicity, creating additional layers of exclusion. For example, older adults with low income may face age-related mobility issues, while individuals from ethnically minoritised groups may encounter language barriers, cultural misunderstandings, or a lack of culturally sensitive services. Individuals who are disabled or experience sensory loss may have difficulty accessing services that are not designed to accommodate their specific needs.

Additional relevant groups:

Co-occurring mental health need
This is recognised as a particular intersecting factor. According to the D&ANA 2022, 61% of young people in drugs and alcohol treatment had a mental health condition, while 64% of adults in drug treatment and 63% in alcohol treatment had co-occurring mental health needs.

Recognition of unmet mental health needs as a risk factor for substance use and barrier to accessing support is reflected in the strategy.

A particular barrier faced for people with mental health needs is in accessing mental health services, particularly whilst still experiencing substance use issues.

The following measures can be implemented to address these barriers:

- The commissioned Adult Treatment and Recovery Service CGL employs healthcare professionals, including Mental Health Liaison nurses, a psychology team, and addiction psychiatrist who work with people with experience of substance use

Cuckooing:
An additional relevant group are People experiencing Cuckooing or other forms of exploitation. Cuckooing occurs when a criminal befriends an individual who lives on their own to use their house as a base to operate unlawful activity, victims can experience isolation, coercion and manipulation. Often this can be associated with exploitation and sexual assaults.
Cuckooing is often associated with exploitation of vulnerable people by supplying them with drugs and alcohol. In 2021/22 there were 28 new cuckooed properties identified.

Training on how to recognise the signs of cuckooing can support people accessing service, especially for outreach tasked team, as well as prevent reoccurrence.

Co-occurring and compound needs:
The Brighton and Hove Drugs and Alcohol Needs Assessment (2022) recognises the high level of residents experiencing co-occurring and multiple compound needs and the impact of this on drug and alcohol use.

This is reflected in the strategy, which includes a focus on people experiencing multiple disadvantages via the Multiple Compound Need Programme. The high-level objectives in the strategy will be underpinned by multi-agency action plans and assessed against SMART objectives.

A range of barriers to accessing services and support was identified. Some of them are likely to affect all groups equally:

- Missed opportunities by services such as a GP, to identify a drug or alcohol treatment need.
- A lack of compassion from a range of professionals.
- Shame and stigma as a barrier for seeking help.
- Lack of awareness of drug and alcohol support and services available - by professionals and Service Users.

7. Action planning

What SMART actions will be taken to address the disproportionate and cumulative impacts you have identified?

- Summarise relevant SMART actions from your data insights and disproportionate impacts below for this assessment, listing appropriate activities per action as bullets. (This will help your Business Manager or Fair and Inclusive Action Plan (FIAP) Service representative to add these to the Directorate FIAP, discuss success measures and timelines with you, and monitor this EIA's progress as part of quarterly and regular internal and external auditing and monitoring)

1. To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet need in order to inform the further development of the strategy and underpinning action plans.

The Brighton & Hove Drug and Alcohol Lived Experience Programme is a project commissioned to bring together people with lived experience of Multiple Compound Needs, service providers and commissioners in a safe space in order to facilitate the co-production of effective services.

The service will recruit a wide variety of participants with lived experience from drug and alcohol services and volunteer sectors within Brighton & Hove. It will recruit participants that are representative of the demographics of people accessing drug and alcohol services in the city.

The service will be reported on quarterly and is a pilot project for the financial year 2024-2025.

The project will inform the development and implementation of the Drugs and Alcohol Strategy for Brighton & Hove.

2. To increase engagement with diverse people with lived experience of using services, particularly from groups with unmet needs, to gather feedback to help Combatting Drugs Partnership to understand further potential negative impact of barriers on people with protected characteristics and intersecting identities, as well as to improve access to and experience of services for underserved cohorts.

3. To improve data collection and analysis to enhance understanding of people's experience of accessing and using drug and alcohol treatment and recovery services and to routinely inform the delivery of the service.

4. To ensure that culturally sensitive comprehensive equalities training, guidance and support is available to all staff and that their training and support is regularly monitored.

Which action plans will the identified actions be transferred to?

- For example: Team or Service Plan, Local Implementation Plan, a project plan related to this EIA, FIAP (Fair and Inclusive Action Plan) – mandatory noting of the EIA on the Directorate EIA Tracker to enable monitoring of all equalities related actions identified in this EIA. This is done as part of FIAP performance reporting and auditing. Speak to your Directorate's Business Improvement Manager (if one exists for your Directorate) or to the Head of Service/ lead who enters actions and performance updates on FIAP and seek support from your Directorate's EDI Business Partner.

The Drug and Alcohol team and the Combatting Drugs Partnership board

8. Outcome of your assessment

What decision have you reached upon completing this Equality Impact Assessment? (Mark 'X' for any ONE option below)

Stop or pause the activity due to unmitigable disproportionate impacts because the evidence shows bias towards one or more groups.	
Adapt or change the activity to eliminate or mitigate disproportionate impacts and/or bias.	
Proceed with the activity as currently planned – no disproportionate impacts have been identified, or impacts will be mitigated by specified SMART actions.	
Proceed with caution – disproportionate impacts have been identified but having considered all available options there are no other or proportionate ways to achieve the aim of the activity (for example, in extreme cases or where positive action is taken). Therefore, you are going to proceed with caution with this policy or practice knowing that it may favour some people less than others, providing justification for this decision.	**X**

If your decision is to "Proceed with caution", please provide a reasoning for this:

We need to note and ensure that the needs of Armed Forces Members and Veterans and expatriates, migrants and asylum seekers and refuges are adequately met.

Summarise your overall equality impact assessment recommendations to include in any committee papers to help guide and support councillor decision-making:

As above

9. Publication

All Equality Impact Assessments will be published. If you are recommending, and choosing not to publish your EIA, please provide a reason:

10. Directorate and Service Approval

Signatory:	**Name and Job Title:**	**Date:** DD-MMM-YY
Responsible Lead Officer:	Caroline Vass, interim DPH	01/10/24

Accountable Manager:	Fran Piccoletti, Drug and Alcohol Programme Manager	06/01/2025

Notes, relevant information, and requests (if any) from Responsible Lead Officer and Accountable Manager submitting this assessment:

EDI Review, Actions, and Approval:

Equality Impact Assessment sign-off

EIA Reference number assigned: HASC72-11-Dec-24-EIA-Drugs-and-Alcohol-Strategy
For example, HNC##-25-Dec-23-EIA-Home-Energy-Saving-Landlord-Scheme

EDI Business Partner to cross-check against aims of the equality duty, public sector duty and our civic responsibilities the activity considers and refer to relevant internal checklists and guidance prior to recommending sign-off.

Once the EDI Business Partner has considered the equalities impact to provide first level approval for by those submitting the EIA, they will get the EIA signed off and sent to the requester copying the Head of Service, Business Improvement Manager, Equalities inbox, any other service colleagues as appropriate to enable EIA tracking, accountability, and saving for publishing.

Signatory:	**Name:**	**Date:** DD-MMM-YY
EDI Business Partner:	Zofia Danin	11-Dec-2024
EDI Manager:		
Head of Communities, Equality, and Third Sector (CETS) Service: *(For Budget EIAs/ in absence of EDI Manager/ as final approver)*		

Notes and recommendations from EDI Business Partner reviewing this assessment:

Notes and recommendations (if any) from EDI Manager reviewing this assessment:

Notes and recommendations (if any) from Head of CETS Service reviewing this assessment:
