



*National Treatment Agency
for Substance Misuse*

DIVERSITY: LEARNING FROM GOOD PRACTICE IN THE FIELD

*Effective treatment
Changing lives*

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Diversity: learning from good practice in the field

Title: Diversity: learning from good practice in the field

Purpose: a guide intended to share good practice identified by partnerships that scored highly in the diversity theme of the NTA and Healthcare Commission joint service review 2007-08

Publisher and date: NTA, 2009

Target audience: joint commissioning managers and all other partners in 149 Drug Action teams (DATs). Drug treatment providers in the NHS and voluntary sector

Action required: Note examples of good practice and take local action if appropriate

Business reason: *Drugs: Protecting Families and Communities* acknowledges that barriers to access to effective drug treatment exists and commits the NTA and the drug treatment system to improve their responses to groups who have not previously received an adequate service

Cross reference: 1.The 2007-08 service review on diversity, and inpatient and residential rehabilitation services carried out by the NTA and the Healthcare Commission. 2.Existing UK diversity legislation

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The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA works in partnership with national, regional and local agencies to:

- Ensure the efficient use of public funding to support effective, appropriate and accessible local services
- Promote evidence-based and coordinated practice, by distilling and disseminating best practice
- Improve performance by developing standards for treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce
- Monitor and develop the effectiveness of treatment.

The NTA has achieved the Department of Health's targets to:

- Double the number of people in treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

The NTA is in the frontline of a cross-government drive to reduce the harm caused by drugs. Its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities. Going forward, the NTA will be judged against its ability to deliver better treatment and outcomes for a diverse range of drug misusers.

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Diversity: learning from good practice in the field

A summary

Background

This report highlights good practice in diversity, based on interviews with local drug partnerships that performed well in a related service review. It follows publication of the National Treatment Agency for Substance Misuse (NTA) and the Healthcare Commission (HCC) 2007-08 service review on diversity, and inpatient and residential rehabilitation services. The Commission for Social Care Inspection (CSCI) supported and endorsed this review.

Service reviews

Service reviews assess drug services and systems against national standards. During 2007-08, the third of three service reviews assessed 149 local drug partnerships on two key areas – diversity, and inpatient and residential rehabilitation services.

Measuring diversity

The service review used 11 criteria. Six criteria focused on diversity, and five on inpatient and residential rehabilitation. The review scored each criterion on the basis of several questions. Each local drug partnership received a score based on these totals (up to a maximum of 43), and an overall score (from 1 to 4).

This report focuses on diversity. The diversity theme assesses how effectively local drug treatment services meet the needs of people from a wide range of communities and groups. In particular, it assesses commissioners and drug treatment providers on three main strands: compliance with relevant equality and diversity legislation; how well commissioners and service providers understand the needs of people from a range of communities and groups; and how they commission and deliver services that meet those needs.

Interviewing high-scoring partnerships

We interviewed partnerships that scored highly on diversity to find out about their strategies and practices, and to see if they provided lessons for others to learn from. The interviews involved several types of drug partnerships (such as urban and rural) and a variety of staff, in order to identify any common themes the partnerships believed contributed towards good practice in this area.

Key factors influencing good practice in diversity

1. Fulfilling statutory duties

Service commissioners and providers need to develop and implement race, gender and disability equality schemes to comply with legislation, and because different groups in the communities they serve have different needs. For example, there are distinct drug using trends among different ethnic groups, while there are higher rates of disability among the drug-using population.

- All the public body members of the partnerships interviewed have fulfilled their statutory duties to develop equality schemes for race, gender and disability
- The partnerships recognise the importance of these schemes as an expression of local policy on diversity and as a foundation for ongoing diversity work
- They recognise they can improve the impact of their schemes by introducing other factors.

2. Needs assessments and equality impact assessments

These share a similar ongoing cycle of data analysis, consultation, publishing the results, and action planning improvements. Most partnerships see them as essential, parallel processes for identifying the relative needs and harm among different sections of their local populations. Most partnerships say they focus on diversity as a routine part of their needs assessment processes, which often involves:

- Reviewing a wide range of data
- Seeking input from established and well-supported service-user and carer groups, as well as frontline staff
- Speaking with the community and any particular groups known to have difficulties accessing services (though this can present practical difficulties)
- Commissioning research to improve to the quality of needs assessment
- Undertaking an equality impact assessment (EIA), is an essential part of an equality scheme and provides a welcome focus on diversity issues within substance misuse services.

Case study A: Nottinghamshire DAAT

An example of partnership-wide planning in diversity is Nottinghamshire DAAT, which has a three-year diversity strategy and a diversity lead answerable to a steering group. The partnership says its approach is rooted in the equality impact assessment (EIA) process. Two EIAs have informed its diversity strategy to date. Published in 2005, the 'ASK' report assessed the needs of local ethnic minority communities for drug and alcohol interventions. Its recommendations included:

- Build staff confidence and competency with ethnicity codes in data monitoring systems
- Use a standardised client tracking system
- Undertake case audit review
- Produce an equality service action plan based on the DAAT equality framework
- Embed equality and diversity in service reviews
- Establish specific language facilities
- Involve communities in commissioning, planning and delivering services
- Set up links between ethnic community projects and drug services, and work with ethnic minority community organisations
- Support ethnic minority drugs workers
- Develop resources for drugs education and prevention work with ethnic groups
- Develop a communications strategy
- Be sensitive to cultural, religious and community needs

- Research the needs of dual-heritage young people and families, and of ethnic minority offenders, prisoners and ex-prisoners.

The findings shaped the DAAT's diversity agenda; identified the gaps in local service provision; and informed SLAs and contracts. The partnerships say: "the ASK report made us understand that not one size fits all. Some people look at equality and diversity by saying 'if you do it well for everybody then that's fine, everyone should be treated the same'. It's actually about individual assessments of everyone's individual needs". Equally important was the need for the subsequent work plan to be "focused and time limited to make sure the recommendations and objectives are achieved" and that a strategic group exists to "bring the recommendations together". A second EIA in 2006, the 'REACH' report, looked at the needs of black and minority ethnic offenders. The recommendations and action included:

- Recruit culturally competent and trained black and minority ethnic workers, including ex substance misusers, across the workforce
- Add treatment options requested by black and minority ethnic misusers, including abstinence-based programmes and faith/spiritual-based approaches
- Commission a specific group support service for black and Asian people seeking recovery
- Prison in-reach for black and minority ethnic clients: culturally appropriate, sensitive and specific one-to-one help and group work
- In-depth drugs, addiction and recovery material for non-English speaking families.

Case study B: Bexley and Greenwich

Neighbouring partnerships in south east London, Bexley and Greenwich commissioned service user organisations to review local services.

In Bexley, service users asked a range of other users how they accessed services, and discussed barriers to access, keyworker skills, care plans and gaps in provision. As a result, a number of improvements to the system were put in place. For example, processes for referring users between treatment providers were reviewed to ensure a smooth transition, service literature was revamped to ensure it targeted a wider range of groups, and GPs and hospital staff received training to increase their awareness of substance misuse issues and treatment options.

Greenwich recruited local service users to call services in the borough with a variety of scripted scenarios. Responses were assessed for the quality of the welcome and the accuracy of the information given. Overall, staff were described as respectful and informative. The commissioner in Greenwich says, "we realised it would be great to have a refresher on the key things to communicate when somebody first phones a service". As a result, Greenwich commissioned a trainer to work with service users to develop a training course based on their experiences of entering or phoning a treatment service for the first time. From this, training was given to 36 frontline workers on the key pieces of information to give during this crucial first contact.

3. Good-quality local data and consultation

Partnerships say successful needs and equality impact assessments rely on good-quality local data. They all collect ethnicity and gender data via the National Drug Treatment Monitoring System (NDTMS), although their experiences reflect national review findings that disability data is not collected systematically.

- All partnerships consider complete NDTMS datasets as part of their core business. They guarantee completion of these datasets by making it part of their agreement with providers, and enforce this with routine contract-review meetings
- In areas where complete data has previously been an issue, partnerships have made improvements with regular, clear communication with frontline staff about the reasons for collecting the data, and with discussions at provider-manager meetings
- Most partnerships feel it is important to consult and involve service users and carers in service planning, management committees, boards and other governance structures
- Consulting service users and carers typically involves feeding the views they express during regular meetings into the assessment and treatment planning processes
- To consult, partnerships use client surveys, information from advocacy services, open days, feedback from service users, their representatives and outreach workers
- Consulting groups not currently accessing services is difficult, but highly important for partnerships that have identified access issues among these communities
- Efforts to engage with and seek the views of the community are important. Partnerships use a variety of approaches, including street marketing campaigns; focus groups with the treatment naïve; partnership and provider open days; and using the local press to highlight local services.

Case study: South Gloucestershire

Safer South Gloucestershire's drug action team (part of the Safer & Stronger Communities Partnership) invests a lot in community engagement. The partnership's consultation culture is exemplified by its ongoing awareness-raising events, public perception surveys and work with the local media. Together, these help raise awareness of local treatment services, and increase treatment engagement.

Last year, the partnership designed a survey to gauge perception of local drug issues and to see if the public know where to seek help for a drug problem. More than 140 people were surveyed when they visited the partnership's stand at leisure centres during National Tackling Drugs Week. This was in addition to the partnership's drug-related questions that are a routine part the council's annual citizens' questionnaire.

The partnership also employs a marketing and communications officer. Part of the role is to work with the council's communications team to ensure positive stories about the treatment system appear in local media. The local commissioner says: "public perception is massive, and we have to promote the right thing. For example, we have a new building open and that's great, but we have to be aware that the public will not necessarily see that as a positive thing." A recent positive communications campaign came out of discussions with local carers and service users. The communications officer used these to draft anonymous case studies of treatment and support. These were used in ongoing publicity campaigns and to advertise local helpline information and family and carer support services. These stories also demonstrate the benefits of successful and innovative projects and initiatives to the wider community.

4. Embedding diversity into the system

Partnerships use treatment plans, SLAs and contracts to address any diversity and equality issues, and to embed the agenda into the mainstream business of delivering local services.

- Most partnerships say their treatment plans will address any differential impact issues identified by needs assessment
- Proposed changes resulting from needs assessment and equality impact assessments are added to diversity action plans or diversity sections in their adult drug treatment plan
- Diversity strategy groups, or existing partnership or local authority subgroups oversee delivery. These groups meet regularly and feed in through local structures
- Partnerships' SLAs and contracts clearly express the requirements of equality and diversity legislation
- In some cases, partnerships include further diversity expectations and targets within their contracts, such as attracting and retaining clients from certain BME backgrounds or ongoing diversity training for workers
- Partnerships monitor compliance with diversity expectations as a matter of course in SLA and contract review meetings
- Some partnerships say diversity expectations are a standard part of their retendering processes, and they will not commission any tenders failing to address how the service would meet the requirements of diversity legislation.

Case study: Harbour Recovery Centre, Tower Hamlets

The population of the London borough of Tower Hamlets is one of the most deprived, ethnically diverse and youthful in England. About a fifth of the population are under the age of 15. People from a Bangladeshi background make up a third (33.4%) of the total population and two thirds of all those under-19. In 2006-07, 39% of individuals in treatment were Bangladeshi, a figure that closely matches local demography.

Despite a recent rise in poly drug use, heroin is the main problematic drug of use for the Bangladeshi community – injecting is rare, most smoke the drug. Bangladeshi drug misusers presenting to treatment are most likely to be young men.

Commissioned by the DAAT in 2006, the Harbour Recovery Centre is a local residential detoxification and rehabilitation unit for young non-complex, non-injecting heroin users. It provides a culturally appropriate service at an early stage in users' drug careers. Early findings from the evaluation show most patients have unsuccessfully accessed community options in the past. A longitudinal study of client outcomes for the Harbour Recovery Centre is expected to be completed and published in 2009-10.

Case study: Telford and Wrekin BME outreach worker

The role of Telford and Wrekin's community BME outreach worker is to raise awareness about local drug treatment services and increase BME treatment numbers in the area.

To raise awareness of the local treatment system, the worker uses a range of methods: one-to-one meetings; Punjabi and Urdu leaflets and posters for GP practices and hospitals; targeted satellite clinics in non specialist settings. The worker has established links in a variety of different community settings: local mosques and temples; meals on wheels; council open days; schools; the Muslim women's group at the Sure Start; GPs surgeries; victim support; the local library; and a Caribbean coffee morning.

Early evaluations of the role have found that it has increased referrals to drug treatment. Assessments have also highlighted the importance of:

- Developing and maintaining visibility within communities to build trust
- Clearly communicating that local treatment services are confidential
- Indirect approaches to communities that attach significant stigma to illegal drug use
- Patience: many in BME communities are reluctant to ask for help
- Research into patterns of drug use among local BME groups to target interventions.

5. Making different communities aware of local drug treatment services

Partnerships use a range of means to raise awareness about drug dependency and local drug treatment services among local groups

- Printed publicity materials, written in plain English and accessible to service users with literacy needs, are the most common form of publicity for local services
- In areas with significant non-white British populations, leaflets are produced in the most commonly spoken local languages
- However, partnerships recognise the reach of printed materials is limited, especially in areas where access and engagement with services is poor among BME groups, primary stimulant users, and women
- Many partnerships adopt more proactive approaches: typically, targeted outreach and community engagement to raise awareness of local services and raise numbers in treatment from underrepresented groups
- Other partnerships take advantage of local community networks to increase referrals, and train existing mainstream health and social care staff in substance misuse issues
- Partnerships talk about the real challenges of treating non-English speaking clients after initial assessment – language barriers are a challenge during aspects of drug treatment such as group work, and make referral to inpatient and residential rehabilitation services difficult
- Solutions to this issue include translation and signing services; mapping the language ability of the local workforce; and ‘stacking’ assessment appointments in order to get best value from spot-purchased translators.

6. Competent staff

Competent staff, with relevant training and a sensitivity towards diversity issues, are essential to providing effective services for such diverse groups

- All commissioners and treatment staff have received standard diversity training, and all partnerships see this as a basic element of good practice
- In the vast majority of services, equality and diversity issues are well integrated into training and management mechanisms
- In some partnerships, diversity is also a standard item during staff supervision and in continuing personal and professional development expectations
- Commissioners in two areas with BME and gender specific services require their management to provide culturally specific training to the partnerships’ other services.

Case study: diversity and workforce development in Nottinghamshire

For Nottinghamshire DAAT there is a close association between equality and diversity training and workforce planning. The DAAT equality and diversity lead, who also leads on the workforce

development agenda, says: “The crux of it is that if people understand it, then they’re more likely to embrace it. Flying the flag of legislation isn’t enough ultimately it comes down to the workforce confidence as well. If people understand it, then they feel confident in it, and then they embed it”.

Nottinghamshire ensures that equality and diversity training requirements are part of the partnership’s workforce strategy, requiring action at DAAT level, including:

- Regular partnership-wide workforce skills audit – “twice a year we do a skills mapping exercise to find out the levels of training and qualification across the workforce. We know exactly the makeup of the workforce, numbers wise, qualifications wise and what their continuing professional development (CPD) needs are. CPD needs are then fed in operationally and strategically to local training providers and further education establishments in order that learning opportunities to meet the needs of the workforce are planned delivered upon and made available for the workforce.”
- Culturally specific training across the local drug treatment system to be delivered by a DAAT-commissioned training organisation and other specialists
- Local gender and BME-specific services to deliver training to staff at other providers across the partnership: front line staff as well as managers and policy makers.

And at provider level, including:

- Mandatory equality and diversity training programme for all staff
- Equality and diversity training as part of each individual staff continuing professional development requirements.

7. Room for improvement

Partnerships see diversity as a wide-ranging agenda and accept there is always room for improvement in its delivery. Being performance-focused, most are eager to build on existing good practice by recognising weak areas of performance and then addressing them. Interviews echoed two national service review findings in particular:

- Tackling issues related to disability is a weak area of performance and requires further work
- All partnerships report ongoing efforts to address local shortfalls of provision for stimulant misusers.

8. Other factors

- It’s important that senior leaders within local partnerships champion diversity and ensure that everyone involved in delivering drug treatment services see it as their responsibility
- Some partnerships work on fostering a culture of continuous improvement in diversity.

1 Background to the full report

1.1 Focusing on diversity

Substance misuse affects a broad spectrum of communities and people with diverse needs. It is therefore vital to ensure that drug treatment is able to meet these needs appropriately and effectively.

When the 2007/08 review was conducted, commissioners and drug treatment providers were required to be compliant with six strands of equality and diversity law: gender; sexuality; religion; age; race and disability. Under law, they only had positive duties for three: disability, race and gender. As compliance with these positive duties could be systematically assessed, the service review and the subsequent good practice interviews that form the basis of this report largely focused on these three strands. Therefore, the diversity theme assessed local drug partnerships, commissioners and drug treatment providers on:

- Compliance with positive duties required by the relevant legislation on three equality and diversity strands: disability, race and gender
- How well commissioners and providers of services understand the needs of people from a diverse range of communities and groups;
- And then commission and deliver services that meet diverse needs.

1.2 Purpose of this report

The aim of this good practice guide is to help improve the commissioning and provision of drug treatment services for diverse groups. Local drug partnerships that scored highly in the diversity theme in the 2007/08 service review were interviewed to identify a range of good practice principles and highlight specific examples of practice. Good practice findings are presented so that all partnerships can learn and improve from examples of specific good practices and improve their performance in delivering this agenda.

1.3 Rationale and methodology

1.3.1 Interviewing local drug partnerships

A range of local drug partnerships were interviewed for this report, in urban and rural areas. All were relatively well-established treatment systems, and included NHS and third sector providers.

The interviews were conducted with a range of staff in the local drug treatment systems, including joint commissioning managers, partnership diversity leads, clinical leads and other clinicians, service managers and user and carer representatives. These meetings were arranged in collaboration with the relevant NTA regional team, involving the NTA deputy regional manager responsible for covering the particular partnership. All of the interviews took place with all relevant key staff in a meeting using a set of questions as the basis for discussion.

1.3.2 Identifying good practice in diversity

The rationale behind the report is that top scoring partnerships are exhibiting good practice from which others might learn. Partnerships that scored well on diversity were selected by examining in detail the scores across the individual criteria in the diversity theme. This produced a shortlist of partnerships approached to participate in good practice interviews. This was similar to the rationale used to produce Good Practice in Care Planning (NTA, 2007) based on the results of the 2005/06 reviews and Good Practice in Harm Reduction (NTA, 2008), based on the results of the 2006/07 reviews. For more information on how these partnerships were selected, see Appendix 2.

The NTA developed a semi-structured interview schedule based on the assessment framework and scoring construction developed for the 2007/08 service reviews. Using this, the NTA spoke to key individuals in the commissioning and provision of drug treatment in a number of the high-scoring partnerships, to gain information about their strategies and practices and determine what lessons could be learnt. From the interviews, a number of good practice points were identified which were believed by the partnerships to contribute towards good practice in providing diversity services. These themes are set out in section three alongside a number of case studies from partnership areas, which feature policies and practices that were considered good practice.

2 Factors influencing good performance

2.1 Introduction

This section presents the findings of the interviews with the high-scoring partnerships, and links them directly to the diversity theme's criteria and questions from the service review.

2.2 Criterion 1: Local drug partnerships' compliance with diversity legislation

This criterion was made up of three questions:

- Q1. Have the public body members of the local drug partnership fulfilled their statutory duties to develop equality schemes for race, gender and disability?
- Q2. Have the public body members of the local drug partnership implemented the positive duties required as part of the development of equality schemes for race, gender, and disability?
- Q3. How effective is the local drug partnership's monitoring of ethnicity?

National criterion results are shown in Table 2.

	Q1	Q2	Q3
Weak	1%	46%	2%
Fair	1%	13%	12%
Good	55%	21%	60%
Excellent	43%	19%	26%

Table 2: Results of criterion 1 by question (local drug partnerships' compliance with diversity legislation)

2.2.1 Public body members of the local drug partnership fulfilled their statutory duties to develop equality schemes for race, gender and disability

Primary care trusts, the probation service, the police and local authorities are the public body members of local drug partnerships. Nationally, 100% of public body members of local drug partnerships had race equality schemes and were developing schemes for gender and disability. Approximately 40% of these schemes, specifically mentioned substance misuse services, which was the requirement for achieving a score of excellent on this question.

In all the partnerships interviewed, all the public body members of a substance misuse partnerships had developed race, gender and disability schemes. In most areas, substance misuse services were mentioned in their equality schemes.

2.2.2 Public body members of the local drug partnership implemented the positive duties required as part of the development of equality schemes for race, gender, and disability.

Nationally, just over half (54%) of the local drug partnerships had undertaken a race equality impact assessment (REIA) specifically relating to substance misuse services on behalf of the partnership. While just over a third had (36%) had consulted Black and minority ethnic (BME) communities as part of a REIA and less than a quarter had published results of their REIA.

All the partnerships interviewed had undertaken at least one race equality impact assessment (REIA) or wider equality impact assessment specifically relating to their local substance misuse services. The majority of these had been conducted in the two year period prior to the 2007/08 service review and had fed into their host local authority REIA and equality and diversity processes. Two partnerships had undertaken two REIAs to date. For most, REIA results or differential impact identified through needs assessment led to a written diversity action plan or separate diversity section in the adult drug treatment plan and resultant action was overseen by a diversity strategy group, or by using existing partnership or local authority subgroups. These groups met regularly and fed in through local structures.

Equality impact assessments and needs assessment share similar principles, both involve an ongoing cycle of data analysis, consultation about findings, publication of results and action planning to improve. Some partnerships noted these similarities, whilst also welcoming the particular focus on diversity that conducting their REIA had provided. They saw that parallel processes of needs assessment and EIAs represented good practice in both drug treatment commissioning and in

addressing the needs of diverse groups and communities within substance misuse.

The most common REIA findings included the need to:

- Improve poor access and engagement with drug treatment services for people from BME backgrounds; primary stimulant misusers
- Improve diversity training among local workforce
- Tighten up equality and diversity requirements within substance misuse SLAs and contracts
- Produce drug treatment literature in community languages
- Commission a telephone based or face to translation service

In just under half of the partnerships, their REIA found few, if any, negative differential impacts within the local drug treatment system hence there were no major changes in delivery of drug treatment as a consequence. All of these partnerships served local populations with a very low proportion of non-white British people.

Within many partnerships, there was some evidence of changed practice in terms of decision making, one off initiatives and service as a result of REIAs and EIAs. In most cases, real change in terms of the local treatment population was expected but not enough time had elapsed for changes to take effect. This was perhaps unsurprising given the challenging issues that the REIAs had brought up and that in most cases REIAs had only been conducted recently. In particular, many commissioners and service managers reported that finding a solution to improving BME engagement and retention in services was a significant challenge – one in which it would take time to see measurable improvement.

Case study: Nottinghamshire DAAT REIAs

One notable example of systematic planning and a partnership approach to the diversity agenda in substance misuse was Nottinghamshire's DAAT who have a three year diversity strategy, and a DAAT diversity lead answerable to an equality and diversity steering group for delivery.

Building on national policy documents such as Models of Care (NTA 2002, 2006), Changing Habits (Audit Commission, 2002) and the national drug strategy (HMG, 2008) the partnership's comprehensive approach to addressing diversity issues in their local drug treatment system was reported to be rooted in their equality impact assessment process. To date, the partnership's diversity plan has been informed by two targeted equality impact assessments.

Commissioned in 2004 and published in 2005, the "ASK" report (ASK - Asking Nottinghamshire's Black and minority ethnic people and communities about substance misuse – their needs and experiences) presented findings from the local assessment of the needs of ethnic minority communities for drug and alcohol interventions.

The report's recommendations included the following:

- Train and build staff confidence and competency with ethnicity codes in data monitoring systems
- Use a standardised client tracking system
- Undertake case audit review
- Produce a comprehensive equality service action plan based upon the DAAT equality framework
- Embedding equality and diversity as a standard item on all service reviews
- Establish specific language facilities
- Develop community involvement in the commissioning, planning and delivery of services
- Set up links between ethnic minority community projects and drug services
- Engage in collaborative work with ethnic minority community organisations
- Give support to ethnic minority drugs workers within services
- Develop resources for use in drugs education and prevention work with ethnic minority groups in Nottinghamshire
- Develop a communications strategy
- Be sensitive to cultural, religious and community needs
- Commission specific research into the needs of

- dual-heritage young people and families
- Commission specific research into the needs of ethnic minority offenders, prisoners and ex-prisoners.

The ASK report findings informed subsequent decision-making about service development and commissioning priorities within the area. They shaped what the DAAT's diversity agenda should be; where the gaps were in terms of local service provision for diverse communities and informed subsequent DAAT SLAs and contracts. The partnerships commented that "the ASK Report was very creative for us. It made us understand ... that not one size fits all. ... some people look at equality and diversity by saying well if you do it well for everybody then that's fine. Everyone should be treated the same. ...It's actually about individual assessments of everyone's individual needs". Equally as important was the need for the subsequent work plan to be "very focused and time limited to make sure that the recommendations and objectives are achieved and done" and that a strategic group existed to "bring all the recommendations from the reports together".

A second REIA conducted in 2006, the 'REACH' report, part of local DIP community engagement work, looked at the need of black and minority ethnic offenders. Results informed subsequent treatment plans in Nottinghamshire. Some of the recommendations and action included:

- Active recruitment of culturally competent and trained black and minority ethnic workers, including ex substance misusers, as staff across the workforce
- Additional treatment options requested by local black and minority ethnic substance misusers in consultation, including abstinence based treatment programmes and faith based and spiritual approaches
- The commissioning of a specific service offering group support for black and Asian people seeking recovery from substance abuse
- Prison in reach for BME clients: culturally appropriate, sensitive and specific one-to-one help and group work support for BME inmates

- with substance misuse problems
- In-depth drugs, addiction and recovery material for non-English speaking families.

2.2.3 Effective ethnicity monitoring

Effective ethnicity monitoring was gauged by how complete the data for ethnicity was on the National Drug Treatment Monitoring System (NDTMS), the national database for drug treatment. Sixty% of partnerships scored 'good' on this question, indicating data completeness of 98 to 99%, and a further 26% scored 'excellent', indicating that all records had valid ethnic monitoring.

All partnerships interviewed reported that the completeness of their datasets for the ethnicity of their clients was seen as core business. Commissioners stated they had achieved this through written expectations about data completeness (including ethnicity data) of NDTMS returns with their commissioned providers. These were enforced through routine contract review meetings. Partnerships reported that by taking these steps, the completeness of their datasets for ethnicity had met their expectations. In areas where data completeness had previously been inadequate, partnerships reported that they drove improvement with a clear and regular communication with frontline staff about the reasons why the data was being collected, backed with regular data discussions within provider manager forums.

Some areas mentioned the limitations of the 16 main ethnicity codes used in NDTMS to accurately record service uptake by some of their minority populations, including clients from Eastern Europe or from Africa. This was especially significant for partnerships with large proportions of non white British people. One provider had introduced more detailed ethnicity codes into their local data collection to better reflect their treatment population.

2.3 Criterion 2: Needs assessments and treatment planning for diverse populations

This criterion was made up of two questions:

- Q1. Has the local drug partnership carried out a needs assessment which includes consideration of the needs of diverse populations within the locality?
- Q2. Does the local drug partnership have a treatment plan with an effective focus on diversity?

National criterion results are shown in Table 3.

	Q1	Q2
Weak	1%	4%
Fair	29%	72%
Good	27%	24%
Excellent	43%	N/A

Table 3: Results of criterion 2 by question (needs assessments and treatment planning for diverse populations)

2.3.1 Needs assessments to consider the needs of diverse populations

If local drug treatment systems are to effectively meet the needs of drug misusers from diverse communities, consideration of these needs must be central to the processes for local needs assessment and treatment planning. Nationally, the majority of partnerships conducted a needs assessment that included consideration of the needs of diverse populations within the locality. Over two thirds of local drug partnerships scored “excellent” or “good” on this question.

All the partnerships interviewed in the review had local needs assessment processes which sought to consider the needs of drug misusers from diverse communities. All had presented their analysis to local expert groups for review and used the resulting recommendations to form the basis of future adult drug treatment plans.

Systematic review of available data and input from well established and well supported service user and carer groups and frontline staff were considered key ingredients in assessing the diverse

needs of local drug treatment populations. They were also relatively well established procedures.

All of the commissioners interviewed used a wide range of contributory data to fully understand diverse needs and un-met needs of drug misusers from diverse communities. The majority of those interviewed built on the understanding that NDTMS gave them by analysing non-NDTMS datasets such as local authorities, police, probation and housing datasets.

Almost all had dedicated analytical staff or purchased analytical capacity to examine a range of locally available data for trends. This was seen as a key element to good practice in diversity because it improved commissioners’ understanding of drug using trends, treatment demand, service take-up and experience of drug treatment among local diverse communities. All of them acknowledged the valuable contribution of analytical staff within the commissioning team for this purpose. Where knowledge gaps remained, some partnerships commissioned bespoke research, targeting specific groups in the community in order to bolster the quality of their needs assessment.

Nationally, 73% of partnerships failed to involve service users from diverse groups when considering local needs. Among all the partnerships interviewed, there was widespread recognition of the important contribution that active, well supported local service user and carer groups could make to needs assessment. In areas with well established service user and carer groups, this had been achieved by embedding the groups into local commissioning and needs assessment processes. In areas where this had happened, commissioners felt that the groups helped improve their understanding of local needs of diverse populations. Areas less well served by user and carer groups were engaged in ongoing work to bolster user and carer involvement locally.

Most areas also sought the views of frontline staff during needs assessment and in the few areas with BME and gender specific services they were involved as a matter of course.

A less well established key ingredient was reported to be the engagement with local community groups. For some partnerships, the potential benefit of engagement with local community groups was that it would help them gain feedback from communities currently less well served by local drug treatment. Many partnerships described the processes involved in engagement with community groups in either formal needs assessment expert group settings or as part of wider local drug partnership community engagement initiatives. This was seen as quite difficult and the results mixed. The most common experience was difficulty in engaging with communities for whom drug misuse was perceived as controversial or taboo and where communities were therefore reluctant to talk about it.

Best practice interviews confirmed national review findings that effectively tackling issues associated with disability within substance misuse services was the weakest area of performance in the delivery of the diversity agenda. Those who scored well in this aspect of the diversity review took a partnership approach and attempted to look at disability access across their whole local drug treatment estate. In some cases, this included partnership-funded assistance for service relocation, re-design or rebuilding (where possible) to make sure that the premises of drug services were suitable for physically disabled clients.

2.3.2 Treatment plan with effective focus on diversity

Although the 2007/08 service review found that the majority (96%) of local drug partnerships had a diversity focus during needs assessment, only a quarter (24%) carried this through adequately to result in strategic planning and delivery.

All but one of the high-performing partnerships stated how they were going to address differential impact identified through EIA or needs assessment in their treatment plans. Examples of changed service delivery included culturally or gender specific stand alone services and improved treatment pathways for marginalised groups.

Case study: Harbour Recovery Centre, Tower Hamlets

The population of the London borough of Tower Hamlets is one of the most deprived, ethnically diverse and youthful in England: about a fifth of the population are under the age of 15. People from a Bangladeshi background make up a third (33.4%) of the total population and two thirds of all those under-19. In 2006/7 39% of individuals in treatment were Bangladeshi, a figure that closely matches local demography.

Despite a recent rise in poly drug use, heroin is the main problematic drug of use for the Bangladeshi community. Among drug misusers in this community, injecting behaviour is rare and the vast majority smoke heroin. Bangladeshi drug misusers presenting to treatment are most likely to be young men.

Commissioned by the DAAT in 2006, the Harbour Recovery Centre is a local residential detoxification and rehabilitation unit aimed at young non complex, non-injecting heroin users. The service is designed to provide a culturally appropriate service at an early stage in a client's drug-using careers.

Early findings from the evaluation show that the majority of patients have unsuccessfully accessed community options in the past. A longitudinal study of client outcomes for the Harbour Recovery Centre is expected to be completed and published in 2009/10.

2.4 Criterion 3: Commissioning services to meet the needs of diverse populations

This criterion was made up of four questions:

- Q1. Does the local drug partnership ensure that information is made available to diverse populations?
- Q2. Do current service level agreements and contracts include expectations that service providers comply with statutory requirements?
- Q3. Are joint commissioning managers and members of the joint commissioning team trained in commissioning services for diverse populations?

Q4. Does the local partnership commission services that meet the needs of stimulant users?

National criterion results are shown in Table 4.

	Q1	Q2	Q3	Q4
Weak	24%	64%	26%	2%
Fair	27%	10%	1%	79%
Good	49%	26%	19%	17%
Excellent	N/A	N/A	54%	1%

Table 4: Results of criterion 3 by question (commissioning services to meet the needs of diverse populations)

2.4.1 Information about local drug partnership made available to diverse populations

Nationally performance was mixed on this question, with a quarter (24%) scored as weak and half (49%) scored as good (the maximum score available for this question). Over half (57%) of the partnerships provided information that was presented visually for service users with literacy needs, and over two-thirds (68%) provided leaflets in a range of languages spoken locally.

Within high performing partnerships in communities with significant non-White British populations, leaflets about the local drug treatment system were produced in a range of languages representative of those spoken in the local population. Some partnerships reported that there was not enough level of need to justify printing drug treatment literature in different languages, although one such area offered translation into key non English languages on the back page of its literature.

Some partnerships talked about the importance of presenting information visually in a way that was inclusive to service users with literacy needs.

In one partnership, the commissioning team's equality and diversity officer role included reviewing all local drug treatment literature to ensure that it was written in plain English and was 'visually appropriate' not 'just printing black on white and then churn it out on a typeface of ten". In another, local authority based partnership, all

local drug treatment literature had to pass through the local authority readers group which checked content for readability and that it was clearly presented.

In interviews with high performing partnerships grappling with the issue of access to treatment for BME, primary stimulant and women clients, they talked about the limited reach of printed materials alone in encouraging engagement. While these partnerships recognised the importance of appropriate literature highlighting local drug treatment, their concern about low treatment penetration in certain communities and drug using groups (which in some cases represented a risk to future pooled treatment budget allocation) meant that they had to adopt a more proactive approach to attract their identified treatment naïve groups into treatment and retain them.

In many partnerships, the most commonly proposed solution was to invest resources (time and effort) into a range of targeted outreach and community engagement approaches. These had two stated aims: to raise awareness about local drug treatment services among communities with little history of accessing services and to ensure that people from these communities access treatment if they need it.

Some mapped existing local community engagement networks such as health visitors, community wardens and neighbourhood officers. By training mainstream health and social care staff about substance misuse and local services, some partnerships hoped to increase awareness about local services and referrals.

Case study: Telford and Wrekin BME outreach worker

The role of Telford and Wrekin's community substance misuse services BME outreach worker was commissioned to raise awareness about local drug treatment services and increase BME treatment numbers in the area.

In order to raise awareness about the local drug treatment system, the worker used a range of

community engagement mechanisms from one-to-one meetings; Punjabi and Urdu leaflets and posters for GP practices & hospitals, and targeted satellite clinics in non specialist settings. The BME outreach worker had established links with a large variety of different community settings including local mosques and temples, meals on wheels, council open days, schools, the Muslim women's group at the Sure Start, GPs surgeries, victim support, the local library and a Caribbean coffee morning.

Early evaluations of the role found that this range of engagement had referrals. Initial assessment from the post also highlighted the importance of:

- Developing and maintaining visibility within communities to build trust
- Clearly communicating that the drug treatment services are confidential
- Indirect approaches to members of communities which still attach significant stigma to illegal drug use
- Patience: many in BME communities are reluctant to ask for help
- More research into local patterns of drug use with local BME groups to better target interventions.

Other partnerships took a more direct approach and actively sought to develop links with existing community, culturally specific, refugee and religious groups. Outreach workers in a few partnerships targeted local mosques in their area. In one, the outreach worker persuaded the local imam to discuss the importance of treating drug misuse and highlight local services during Friday prayers. Another persuaded their local imam to deliver training on Islamic culture to the local drug treatment workforce. Some partnerships emphasised that it was good practice to ensure that any initiative designed to attract BME services users was also accompanied by work to ensure that recipient services are culturally competent and provide services relevant to local BME populations.

Another approach is to make the drug treatment services more mobile, running satellite clinics in mainstream service. Within some partnerships,

substance misuse specific nurses and drugs workers worked alongside other healthcare professionals in areas with limited access to drug treatment services (for example drop-in based in health centres on particular days). One commissioner said that their "outreach team have really have got themselves plugged into the community", another "I think having the outreach really has enabled us to extend the circumference of our funnel, we've been able to really promote those access routes. Literature and spoken word has a limited effect, we've actually had the workers going out and sitting in community forums in the outlying estates areas, in places that do have a diversity mix because they're interested in community issues and it's not solely sold under the tag of drug services". A few partnerships harnessed local media and ran partnership and provider open days to help raise awareness about local drug treatment services.

All partnerships who had adopted these strategies recognised that they needed time to bed-in before their relative success could be evaluated. All agreed that success, would be measured by how effectively the work had highlighted the local treatment system in the first instance and then by future presentations at services.

2.4.2 Expectations within SLAs and contracts about provider compliance with statutory requirements

Nationally, nearly two-thirds (64%) of partnerships were scored as weak and a further 10% were scored as fair on this question. While 82% of partnerships specified compliance with the Race Relations Act (1976) as amended by the Race Relations (Amendment) Act 2000 in all their contracts, only 54% specified compliance with the Sex Discrimination (Gender Reassignment) Regulations 1999 in all their contracts. In all the partnerships interviewed, the various requirements under the suite of diversity legislation were explicitly articulated in their SLAs and contracts with commissioned providers. Most partnerships used existing or modified local authority or primary care trust (PCT) contracts and many were able to use legal teams in their host local authority or PCT

legal team to ensure that all legal requirements were met. In most partnerships diversity expectations were monitored and reviewed as a matter of course in contract and SLA review meetings.

Some partnerships included further diversity expectations and targets within their contracts, including requirements to:

- Attract and retain clients from certain black and ethnic minority backgrounds
- Requirements to train managers and practitioners in appropriate levels of cultural competencies
- An expectation that provider managers review the ethnicity of their workforce.

Some partnerships reported that diversity expectations were a standard part of their local re-tendering processes. Any service tenders that did not address how the service would meet the various diversity requirements required by legislation would not be commissioned.

2.4.3 Diversity training for joint commissioning team staff

Nationally, 91% of joint commissioning managers had undertaken training in equality and diversity issues. At interview, all joint commissioning managers, commissioning officers and other representatives of local drug treatment partnerships had equalities and diversity training. The majority of commissioners interviewed worked under local authority and PCT structures. Usually, this training was undertaken as part of their induction in their host organisation and was a part of their continuing personal and professional development. Very few commissioners had undergone advanced commissioning training and the few that had did not find the course content especially relevant to commissioning for diverse populations.

2.4.4 Appropriate provision for stimulant misusers

Analysis conducted in the overall service review report indicated a national shortfall in provision for stimulant misusers. In half of local drug partnerships, less than 30% of crack misusers

accessed drug treatment services and in a further 30% of partnerships, between 30 and 40% of crack misusers accessed services. This was judged by comparing national Home Office estimates of crack misuse (Hay et al, 2006) with treatment presentations. This compares to 40% or more of the estimated number of heroin misusers accessing drug treatment in over four fifths (84%) of partnerships. There was a clear indication that, nationally, crack cocaine misusers are less likely to access drug treatment services than heroin misusers.

Partnership interviews echoed this national finding. All areas spoke about the historic opioid focus in their local drug treatment system. Some observed that, among clients primarily misusing stimulants, the perception that local services only treated heroin dependency was often cited as a barrier to accessing treatment. The majority highlighted a recent rise in primary and secondary stimulant use. Partnerships with negligible primary stimulant use identified rises in powdered cocaine use (often in conjunction with alcohol use), with clients usually coming through criminal justice referral routes. Within most partnerships, there was an under-representation of primary stimulant users in local treatment populations.

All partnerships reported recent and ongoing efforts to re-design their treatment systems in order to adequately meet the needs of stimulant users. Only one partnership had a stimulant specific service, which was re-tendered in 2006/07. As a result, the service is able to offer a range of psychosocial options to 520 Tier 2 and 3 clients annually, with 200 clients being seen as Tier 3 clients. For other partnerships with less identified needs, resources had been directed towards a range of options including: brief interventions and more structured psychosocial interventions delivered in open access and day-care settings. Stimulant training for the workforce was also commonly reported.

2.5 Criterion 4: Service providers' compliance with diversity legislation

This criterion was made up of two questions:

Q1. Do service providers fulfil the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006, and the Disability Discrimination Act 2005 in relation to equality schemes?

Q2. Have race, gender and disability equality issues been addressed in the regular reviews of the drug treatment service?

National criterion results are shown in Table 5.

	Q1	Q2
Weak	2%	6%
Fair	46%	45%
Good	18%	48%
Excellent	34%	N/A

Table 5: Results of criterion 4 by question (service providers' compliance with diversity legislation)

2.5.1 NHS providers have developed and implemented race, gender and disability equality schemes

The development and implementation of race, gender and disability equality schemes is especially important within substance misuse because of factors like different drug using trends within certain ethnic groups and higher rates of disability among the drug using population. Across the country, the service review found that nearly all (99%) NHS service providers had developed race, gender and disability schemes. Less than a fifth (18%) of NHS service providers had undertaken service-specific impact assessments for race, gender or disability. Nationally, this suggested an increased risk of services' equality schemes failing to drive actual improvements in substance misuse service delivery. Only a few of the NHS services interviewed had developed and implemented race, gender and disability equality schemes; most operated under the policies and procedures of their host primary or mental health care trust.

2.5.2 Regular review of race, gender and disability equality issues

Across the country there were poorer rates of compliance with requirements in relation to disability than there were in relation to race and gender. Results showed 70% of services collected disability data, 56% analysed it and just over half

(53%) used it to plan improvement – revealing that statutory services address disability issues less consistently than gender and race issues, through their reviews of service provision.

The experience of all partnerships interviewed echoed this national finding. All providers interviewed collected data on service uptake by ethnicity and gender through NDTMS. Most managers of successful providers analysed this data, which fed into planned improvements. This work usually took place in advance of routine monitoring meetings with local commissioners. None had begun systematically to record service uptake by people with disabilities.

2.6 Criterion 5: Services meeting the needs of diverse populations

This criterion was made up of three questions:

Q1. Does the service provider use data on uptake of services by diverse populations to plan provision?

Q2. Does the service provider carry out a Disability Discrimination Act (1995) access audit?

Q3. Does the service provider have access to trained interpreters?

National criterion results are shown in Table 6.

	Q1	Q2	Q3
Weak	1%	4%	1%
Fair	7%	65%	15%
Good	92%	31%	84%
Excellent	N/A	N/A	N/A

Table 6: Results of criterion 5 by question (services meeting the needs of diverse populations)

2.6.1 Service providers use monitoring data to plan appropriate provision

National results indicated that the vast majority of services reviewed data annually and used it to plan provision. Most providers interviewed did this and reported that analytical work on their NDTMS data tended to coincide with contract review meetings with commissioners.

2.6.2 Service providers conducted disability access audits

Many services across England had conducted a Disability Discrimination Act (1995) access audit and used it to make adjustments to practices, policies, and procedures. However, only 40% of services had met their legal requirements by making their audit available to the public.

Best practice interviews confirmed national review findings that the way in which substance misuse services tackled disability issues was the weakest area of performance in the delivery of the diversity agenda. Most statutory providers had conducted disability access audits as part of their legal obligations under disability legislation.

Some relatively successful commissioning bodies took a partnership approach and attempted to look at disability access across their whole local drug treatment estate. In some cases, this included partnership-funded assistance for re-designing, re-building or relocating drug treatment premises to ensure they were accessible to physically disabled clients.

2.6.3 Service provider access to trained interpreters

The majority (91%) of services had access to a range of interpretation services and a similar percentage (88%) had access to trained interpreters who can offer communication using sign language.

In most partnerships, the experience of providing services to non-English speaking clients was rare and for deaf clients even more uncommon. In all successful partnerships, statutory services were able to access a translation service, the most common being Language Line, which in most cases was funded by the partnership's host PCT or local authority. In some areas, partnerships would spot purchase translation and signing services from their local authority as and when local providers used the service. In one treatment system with significant voluntary sector provision, attempts were made to 'stack' necessary assessment appointments for various providers across the

treatment system in order to maximise value for money once a translator had been spot purchased.

Some partnerships talked about the real challenges of treating drug dependency in non-English speaking clients after initial assessment. They pointed out that for these people the language barrier was a real obstacle to their ability to engage with elements of drug treatment like group work. For some clients, their lack of English made referral to in-patient and residential rehabilitation services extremely difficult. No partnerships were complacent about trying to find a solution to this difficulty and some partnerships assessed the language ability within the local drug treatment workforce in order to map any language skills that were available.

2.7 Criterion 6: The planning of services

This criterion was made up of three questions:

- Q1. Does the service provider consider the views of diverse populations when reviewing and planning the service?
- Q2. What is the service user's experience of being respected by service providers?
- Q3. Does the service manage and support staff to deliver services to diverse populations?

National criterion results are shown in Table 7.

	Q1	Q2	Q3
Weak	18%	26%	0%
Fair	41%	51%	4%
Good	32%	23%	48%
Excellent	9%	N/A	48%

Table 7: results of criterion 6 by question (The planning of services)

2.7.1 Service providers consider views of service users when reviewing and planning of services

Nationally, 59% of services consulted with diverse populations in contact with services, during review of services. Less than a third (31%), however, consulted those not currently accessing services. Only half of local drug treatment partnerships included non service using representatives from diverse groups during consultations for service

planning, in management committees, boards and other governance structures.

At interview, successful local commissioners and providers were asked who they consulted with in order to inform future service delivery and how they sought these views.

Most partnerships emphasised the importance of consultation with service users in the planning and delivery of local services, and most had a range of approaches to obtain service user feedback on the delivery of local drugs services. In areas with well established and well supported service user and carer groups there was evidence that these groups were seen as natural partners in the planning and delivery of drug treatment services. In many areas, there were established processes to feed views expressed in regular service user forums into needs assessment and treatment planning. Partnerships also used local service user surveys, information provided through advocacy services; provider and partnership open days; complaints and suggestions and feedback from service users, service users representatives and outreach workers to consult and inform future service delivery

In partnerships with identified drug treatment access issues among certain groups, staff sought the views of the wider community they served. Approaches included street marketing campaigns designed to gauge the communities' perception of substance misuse, focus groups with treatment naïve drug misusers, partnership and provider open days, and using the local press to highlight local services. One partnership ran joint DAAT and provider stalls at community events in deprived housing estates. The commissioner commented, "we always make sure we've got stalls down there, we can hand out information, go round speaking to people. Actually we've managed to engage quite a lot of people through those routes".

Case study: Community consultation in South Gloucestershire

Based in a local authority with a strong track record in community consultation, Safer South Gloucestershire's drug action team (which forms

part of the Safer & Stronger Communities Partnership) invests considerably in community engagement. The strong consultation culture within the partnership is best exemplified by their ongoing use of awareness raising events, public perception surveys and their work with the local media. Together, these approaches are intended to help raise awareness about local drug treatment services within the local community, and to help increase treatment engagement.

Last year, the partnership designed a survey to help gauge public perception of the local drug problem and to see if members of the public knew where to seek help with drug dependency issues. More than 140 people were surveyed when they visited the partnership's stand at local leisure centres run throughout National Tackling Drugs Week. This bespoke survey was in addition to the partnership's annual drug-related questions that are routinely included in the local council's annual citizens' questionnaire.

The partnership also employs a marketing and communications officer. Part of the officer's role is to work with the council's corporate communications team to ensure that the positive news stories about the local drug treatment system appear in local media. Speaking about the partnership's work with the local media, the local commissioner commented, "as you know public perception is massive, and we have to promote the right thing. For example we've got a new building open and that's great, but we have to be aware that the public will not necessarily see that as a positive thing". One recent example of a positive communications campaign came out of consultation with local carers and service users. The partnership's communications officer used these discussions to draft anonymous case studies that illustrated their experiences of treatment and support. These case studies were used to illustrate ongoing partnership publicity campaigns and to advertise local helpline information and family and carer support services. These stories also demonstrated the benefits of successful and innovative projects and initiatives to the wider community.

2.7.2 Service users feel respected by service providers

Service users' answers from the NTA's Third National Service User Survey, on whether they felt they were treated with respect by the staff delivering services used in this question. Twenty-six% of partnerships scored as weak on this question and a further 51% were scored fair.

At interview, both commissioners and providers in successful partnerships were asked how they ensured that people using their services were treated with respect. The approach of one commissioner was to include confidentiality and respect clauses in SLAs and contracts with providers and to actively encourage local provider managers to foster a culture of reflective practice within local services. The rationale behind this was that any client feedback, positive or negative, should be treated as a potential learning opportunity rather than something negative for the service to react against.

The providers' respective answers reflected a range of very similar approaches. Many providers had a range of approaches to ensure that their clients were treated with respect. These started with good recruitment; staff monitoring and supervision; transparent complaints procedures; encouraging anonymous client feedback through suggestion boxes or 'have your say' sessions (usually with food and transport costs funded by the providers or partnerships); service user group feedback and use of service user group advocacy where appropriate.

Case study: Service user review of services in Bexley and Greenwich

Neighbouring partnerships in south east London: Bexley and Greenwich, both commissioned their respective service user organisations to help review local treatment services.

Greenwich commissioned service user 'mystery shoppers' from within GLASS (Greenwich service users group) and also from the Bexley Users Group to review Greenwich services. Bexley service users were asked to participate due to concern from some of Greenwich's service users about their

voices being recognised by the staff when they phoned up. Services users made a half a dozen calls to individual Greenwich services with a variety of scripted scenarios (e.g. "I'm a crack user" or "My son's using heroin"). Provider responses were assessed for the accuracy of the information provided and the quality of the welcome.

Once checked, responses were fed back to providers. Overall, staff were described as respectful and they gave good information. Reflecting on the exercise's results the commissioner in Greenwich commented, "we realised it would be great to have a refresher about what are the key things to communicate to somebody when they first phone up a service". As a result, a trainer was commissioned by Greenwich to collaborate with the local service user group to develop a training course called In the Shoes of a Service User, based on service users' experiences of entering or phoning up a drug treatment service for the first time. The aim was to establish the key pieces of initial information a service user wants from this crucial first contact. The resultant interactive training was delivered to 36 frontline workers in Greenwich who positively evaluated it.

In Bexley, service user representatives undertook interviews with a range of service users within the borough to find out how they accessed services, and to discuss barriers to access, keyworker skills, care plans and gaps in service provision. Twenty-four interviews took place in total and results were analysed and fed back to service providers. As a result of this work, a number of improvements to the treatment system were identified and put in place. For example, processes for referring clients between treatment providers were reviewed to ensure a smooth transition for service users. Likewise, service literature and publicity was revamped and reissued to ensure that it targeted a wide range of groups. Training programmes were developed for GPs and hospital staff to increase awareness of substance misuse issues and treatment options.

2.7.3 Staff are managed and supported to deliver services to diverse populations

The management and support of staff is an intrinsic part of effective provision of services to diverse populations. Local drug treatment partnerships interviewed mirrored national findings that diversity issues were well integrated into the staff induction, training and management mechanisms in the vast majority of services. All statutory and non-statutory providers reported that equality and diversity training was a standard component of staff induction. When asked about equality and diversity issues within supervision and appraisal, some providers reported that it was a standard item for discussion, others that it would be discussed as and when required. Commissioners in two areas with BME and gender specific services required managers and staff of these services to provide culturally specific training. Within one area the commissioning team set aside a training budget to cover essential training for the workforce which would cover some voluntary sector equality and diversity training needs if required.

Case study: Diversity and workforce development in Nottinghamshire

For Nottinghamshire DAAT there is a close association between equality and diversity training and workforce planning. Commenting on this, the DAAT equality and diversity lead, who also leads on the workforce development agenda, said, "The crux of it is that if people understand it, then they're more likely to embrace it. Flying the flag of legislation isn't enough ultimately it comes down to the workforce confidence as well. If people get it and people understand it and then people feel confident in it, then they embed it".

Nottinghamshire ensured that equality and diversity training requirements were part of the partnership's workforce strategy which required action at DAAT level, including:

- Regular partnership wide workforce skills audit – "twice a year we do a skills mapping exercise to find out the levels of training and qualification across the workforce. We know exactly the makeup of the workforce, numbers

wise, qualifications wise and what their continuing professional development (CPD) needs are. CPD needs are then fed in operationally and strategically to local training providers and further education establishments in order that learning opportunities to meet the needs of the workforce are planned delivered upon and made available for the workforce."

- Culturally specific training across the local drug treatment system to be delivered by DAAT commissioned training organization and other specialists
- Local gender and BME specific services to deliver training to staff at other providers across the partnership: front line staff as well as managers and policy makers.

And at provider level, including:

- Mandatory equality and diversity training programme for all staff
- Equality and diversity training as part of each individual staff continuing professional development requirements.

2.8 Other factors contributing to high scores in partners

In addition to the issues that correspond to the criteria and questions used in the service review, there were some other issues raised in the interviews, which were thought to be relevant to the partnerships' good performance on the diversity theme.

2.8.1 Leadership

Many areas talked about the advantages of having a 'strong' joint commissioning group. They reported that a lot of work had been done with partners to ensure that diversity was seen as everyone's responsibility. Some identified the importance of strategic leadership within the partnership in order to drive the delivery of the agenda.

2.8.2 A "learning partnership", fostering a culture of continuous improvement

Many partnerships conceptualised diversity as a very wide ranging agenda and accepted that there was always room for improvement in its delivery. Being performance focused, most were also eager to build upon a platform of existing good practice.

2.8.3 Strategic drivers for the diversity agenda

Many partnerships interviewed were well integrated within their host local authority or PCT structures and described their substance misuse specific diversity work as dovetailing with the implementation of their host authority's diversity work. By developing equality schemes and conducting equality impact assessments, local drug treatment partnerships helped bolster their own understanding of local need, while at the same time satisfying wider political imperatives for strong performance on the diversity agenda. For example, many partnerships interviewed identified that strong performance on diversity helped contribute to their local authority star rating.

3 Conclusions

Partnerships reported that good practice in diversity starts by fulfilling statutory duties and developing and implementing equality schemes relating to race, gender and disability. These ensure compliance with legislation and form an articulation of local policy on diversity and a foundation for ongoing diversity work.

Partnerships interviewed believed that equality schemes alone were insufficient though. They were also committed to the parallel processes: needs assessment and equality impact assessments, which helped them systematically identify the relative needs and harms among different sections of their local populations. These processes both involved a systematic review of a wide range of good quality contributory data and were enhanced by consultation with service user and carer groups and frontline staff.

Any planned improvement required as a result of needs assessment and equality impact assessments were then be embedded into mainstream drug treatment delivery through treatment plans and expectations within SLAs and contracts, progress against which were routinely monitored.

Raising awareness about drug dependency and local drug treatment services to encourage engagement among the treatment naïve was seen as important, especially in partnerships with identified unmet needs among local groups and communities. Partnerships used a range of approaches to do this. Accessible printed publicity materials, where necessary produced in a range of the most commonly spoken local languages, were a common publicity tool. Other useful tools were targeted outreach and community engagement: pro-active approaches designed to raise awareness of local drug treatment services and increase numbers in treatment from under-represented groups.

Other important elements of effective provision of services to diverse populations include competent staff; support for the agenda among senior leadership within local drug treatment

partnerships; and avoiding complacency about diversity issues by fostering a culture of continuous improvement. This last point was seen as important because most partnerships conceptualised diversity as a very wide ranging agenda within substance misuse and accepted that there was always room for improvement in its delivery.

There was plentiful evidence of good, innovative practice and robust, strategic service development in the services and partnerships interviewed. Their practice, highlighted in this report, aims to provide useful pointers for other areas and should provide a basis for building good-quality drug treatment services that meet the needs of all sections of local communities.

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5 Appendix 1

Key documents and guidance

Models of Care: Update 2006

Models of Care for the treatment of adult drug misusers is the national framework for the commissioning and provision of drug treatment services in England. Although the NTA had already stressed the importance of diversity in the original Models of Care for the treatment of adult drug users (NTA, 2002), the 2006 update had a specific aim of a greater emphasis in diversity as a core component of all structured treatment interventions (Tiers 1–4). One of the main reasons for this was the reported rises in blood-borne viruses and site infections among injecting drug users and an increase in drug-related deaths.

www.nta.nhs.uk/publications/documents/nta_model_sofcare2_2002_moc2.pdf

www.nta.nhs.uk/publications/documents/nta_model_sofcare_update_2006_moc3.pdf

Diversity assessment package (DAP)

There are plans to update the DAP, a self-assessment tool and guidance on equality and diversity for the drug misuse treatment field.

Supplementary guidance on diversity legislation

Published as part of the 2007/08 suite of planning guidance for commissioners and local partnerships. www.nta.nhs.uk/areas/treatment_planning/docs/diversity_supplementary_guidance_140807.pdf

Women in drug treatment services

Released in June 2005, the NTA research team review of the epidemiological evidence regarding drug use prevalence rates among women in England and the level of their access to drug treatment services. www.nta.nhs.uk/publications/documents/nta_women_drug_treatment_services_2005_rb6.pdf

Black and minority ethnic communities in England: a review of the literature on drug use and related service provision

A review of the literature of drug use and related service provision, May 2003 www.nta.nhs.uk/publications/documents/nta_bme_literature_review_2003.pdf

6 Appendix 2

Partnerships involved and rationale

Partnerships interviewed

Table 8 shows the partnerships (in ranked order) that were selected for interview about their diversity practice. Partnerships were selected according to their scores for the diversity criteria and their total scores. The highest scoring partnerships on the diversity theme – the nine partnerships scoring 21 and 20 – were automatically selected for interview. There are 19 partnerships which scored 19 for diversity in the review. Since time and resources do not allow us to interview all of these, a simple selection rule was applied, which involved looking at the partnerships' total score. Of the partnerships which scored 19, a cut-off was applied after the overall score of 36.

Region	Name of local partnership
South West	South Gloucestershire
London	Bexley
South East	Southampton
London	City of London
London	Barking and Dagenham
London	Waltham Forest
London	Westminster
Yorks & Hmb	Calderdale
East Midlands	Nottinghamshire
North East	Northumberland
North West	Blackpool
London	Greenwich
South East	Windsor and Maidenhead
North West	Stockport
West Midlands	Telford and Wrekin
London	Tower Hamlets

Table 8: Partnerships selected for interview in ranked order