Healthcare Improvement Scotland | Community Engagement

Equality Impact Assessment (EQIA)

August 2022

NHS SCOTLAND

Name (policy/ procedure/ practice/ function)	ADP and Homeless Programme: Reducing Harm, Improving Care
Directorate	ihub
Team	Portfolio: Housing and Homelessness in Healthcare
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Contents

1. Background

For all new or revised work, Healthcare Improvement Scotland has a legal requirement under the Public Sector Equality Duty to actively consider the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Additionally:

- We give consideration to the principles of the Fairer Scotland Duty by aiming to reduce inequalities of outcome that are based on socio-economic disadvantage.
- If the work will have a specific impact or relevance for children up to the age of 18, its impact on children's human rights and wellbeing should be independently assessed.
- As the Children and Young People (Scotland) Act 2014 names Healthcare Improvement Scotland as a corporate parent, we must consider the needs of young people who have experienced care arrangements, and young people up to the age of 26 who are transitioning out of these arrangements.
- If the work is relevant to islands communities as well as mainland communities, any specific impacts on islands communities should be assessed.

This template is designed to guide teams through assessing the impact of their work. A team should begin this assessment as soon as they start planning a new piece of work or revising an existing piece of work. A team might use this template solely as a planning tool or keep it as a live document to review and update as the work progresses.

2. EQIA overview

Use this section to provide details about the status **(new or existing)** of the work (which could be policy/practice/procedure/function) and provide an outline of the proposal including **aims** and **outcomes**. Please note all tables within this template are expandable.

Status	New ☒	Existing ☐
Aim(s) Intended Outcome(s)	Healthcare Improvement Scotland has been commissioned by the Scottish Government to work with services that support people experiencing homelessness and drug and alcohol issues to improve the way they work together, with the aim of widening access to services, reducing harm and improving care. This work is being supported by the Scottish Drugs Forum and Homeless Network Scotland who are helping us to facilitate peer research-led interviews with people with lived and living experience of services. The knowledge gained from engagement with services and the people who access them will allow us to better understand the support people need, and support HSCP areas we are working with to identify feasible change ideas to test. This programme intends to positively benefit everyone experiencing homelessness and drug and alcohol issues. The EQIA will support the programme team to identify the potential for negative impacts or specific barriers particular groups may experience in accessing improvements and take mitigating action.	

Is there specific relevance for children and young people?	Yes ☐	No ☒
Are island communities included in the work?	Yes ☒	No ☐

3. Advancing equality

Provide details of how the work could impact on people who share the characteristics listed below.

It will be helpful to consider any access issues, health inequalities or experiences of discrimination that might impact these groups within your area of work. It will also be helpful to think about human rights and whether these will be impacted for any group. Our rights are described in the Human Rights Act. Some groups are also protected by specific conventions, which are highlighted for your information in the relevant sections below.

There is no word count – you should include the information you think is required. Please ensure the information you use is evidence based (e.g., articles, public involvement, previous work). There is space at section 8 for you to record the evidence sources you use in your assessment.

Age	Think about people from different age groups. Will the work affect specific age groups, including in particular ways? If children are specifically affected, use a Children's Rights and Wellbeing Impact Assessment to provide more information. Convention on the Rights of the Child
What we found	
Figures show that the homeless population is younger than the overall Scottish population, with only 15% of the homeless population being over the age of 50 compared with 48% of the overall Scottish population. Drug/alcohol dependency is most common amongst 35-49 year olds.[1] Drug-related death figures in Scotland report the most severe increase in numbers in the 35-44 and 45-54 age groups,[2] while the latest alcohol-specific deaths figures state that the most common age groups are: 50-54, 55-59 and 60-64 years.[3] It is important to note that drug and alcohol issues often emerge at a younger age, e.g., over 70% of those accessing structured community and residential treatment	

[1] https://www.gov.scot/publications/homelessness-scotland-2020-2021/documents/
[2] https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf
[3] https://www.nrscotland.gov.uk/files//statistics/alcohol-deaths/2020/alcohol-specific-deaths-20-report.pdf

for problem drug use in 2015/2016 started using drugs under the age of 25, with a median age of 15. Three-quarters of people who died from drug-related causes in 2015/16 had been using drugs for 10 years or more, and 43% for 20 years or more.[4]

One finding frequently cited regarding age is that women seeking treatment for substance use tend to be younger than men, despite having a similar or later age of drug use.[5]

Older people with drug issues have highlighted age specific issues they face, compared with younger people.[6]

- Life problems and physical problems accumulate with age, e.g., increasing isolation
- Stigma
- Feeling forgotten about (e.g., being considered a 'lost cause' and viewed as being less receptive to support)
- Lack of services (or lack of knowledge about services)
- The benefit of experience

Harm is not limited to those directly affected by drug/alcohol use. Scottish Families Affected by Alcohol and Drugs reported that each person using alcohol or drugs was harming, on average, 11 other people around them (every type of relationship was harmed, including those with children).[7] Families facing harm are waiting an average of 8 years to reach support for themselves.

What we did

In collaboration with Scottish Drugs Forum and Homeless Network Scotland, we have undertaken 53 peer research interviews and surveyed 18 people. Age categories were captured to better understand the age groups we were engaging with and to establish any issues experienced by particular age groups.

Of the 53 peer research interviewees, two percent were aged 15-24, 22% were aged 25-34, 47% were aged 35-44, and 22% were aged 45-54 (three people did not state their age).

For our online survey of 17 respondents, 6% were aged 18-35, 47% were aged 36-50 and 47% were aged 51-65.

Analysis of the interviews and surveys did not reveal any further age-specific issues.

Engagement with Scottish Families Affected by Alcohol and Drugs suggested that the impact on children includes feeling stigmatised due to a parent experiencing issues relating to alcohol, drugs, and homelessness. We heard that young people

[4] https://www.drugsandalcohol.ie/35107/1/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland.pdf
[5] https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland-9781787810129/
[6] https://www.sdf.org.uk/wp-content/uploads/2017/06/OPDP-mixed-methods-research-report-PDF.pdf
[7] https://www.sfad.org.uk/content/uploads/2021/04/Ask-The-Family-Report-March-2021.pdf

also experience a decline in their mental health and wellbeing due to caring for a family member.

Care Experience	Think about children and young people up to the age of 26 who have experience of being in care. Care can include foster care/supported care, kinship care, residential care, or being looked after at home with the support of a supervision order. Healthcare Improvement Scotland is named as a corporate parent under the Children and Young People (Scotland) Act 2014. You can find information and working examples of what this means for us in our Children's Rights Report or by speaking to a member of our Children and Young People Working Group about our Corporate Parenting Action Plan.

What we found
Research consistently highlights that care leavers are more likely than other young people to become homeless or experience housing instability.[8] There are a number of factors and life experiences that can increase the risk of homelessness, such as facing significant challenges and responsibilities at a much earlier stage in life than their peers.The literature also highlights care experienced people as a group more likely to develop problematic drug and alcohol use.[9] While relatively dated, a 2001 study of young people leaving care (14-24 years) in Glasgow found that 84% and 60% had used cannabis and ecstasy at least once, respectively, and 14% were drunk almost every day. Two-thirds had started taking drugs (31%) and drinking alcohol (29%) while in care. Use was attributed to being 'stressed out in care' and as an attempt to forget negative experiences. Another showed that 45.8% of individuals resident in children's units had used drugs in the last month. Those in foster care consume less alcohol and have been found to be less likely to use drugs than children in residential care, due to those in residential care being exposed to factors including frequent movement of care placements, and rejection by adoptive or foster parents.The Care Review[10] heard that failures in adult services supporting people with drug and/or alcohol use can have a profound impact on children's health and wellbeing. Families experiencing these issues must be supported with flexible, creative services and relationships.
What we did
Contacts from third sector organisations supporting and advocating for care experienced people were unable to provide additional information and advice at

8 https://www.celcis.org/application/files/7215/5835/3996/Beyond_The_Headlines__Homelessness_May_2019.pdf

9 https://www.gov.scot/publications/review-existing-literature-evidence-young-people-experiencing-harms-alcohol-drugs-scotland/

10 https://thepromise.scot/assets/UPLOADS/DOCUMENTS/2020/10/The%20Promise%20Alcohol%20and%20Drugs%20Briefing%20Autumn%202020.pdf

this point due to competing pressures due to COVID-19 and the challenging timescales of the programme.

Disability	Think about people with sensory impairments, communication difficulties, learning disabilities, physical impairments, sensory impairments like sight or hearing loss, energy impairments, autism spectrum disorder, mental health conditions and cancer. Think also about Deaf users of British Sign Language. You might also consider unpaid carers here. Convention on the Rights of Person with Disabilities

What we found

Housing Rights Watch reports that disabled people are at an increased risk of becoming homeless[11]. Information from a 2014 health audit found that 41% of people experiencing homelessness have long-term physical disability compared to 28% of the general population, while 45% of people experiencing homelessness have a diagnosed mental health issue, compared to 25% of the general population[12].

Among a sample of 54 women with drug problems in North Ayrshire who took part in a peer-led research project, 56% said that their mental health had prevented them from fully benefiting from substance use treatment by affecting their ability to attend appointments or to participate in group work[13].

What we did

Our activity confirms what we found from the literature. We surveyed 18 people with lived/living experience of homelessness and drug and alcohol issues, and 9 of these people reported being disabled.

Our peer research interviews in the four participating HSCP areas did not ask specific questions about mental health, but many people with experience of drug and/or alcohol issues also reported requiring access to mental health support.

Our work with area sites to carry out demand analysis also revealed that people experiencing issues with their mental health and drugs and/or alcohol are often referred to community mental health teams that will not take them unless they are abstinent and are instead referred back to drug and alcohol services or their GP to get appropriate support.

[11] https://www.housingrightswatch.org/content/homelessness-and-disabilities-impact-recent-human-rights-developments-policy-and-practice%E2%80%8B
[12] http://www.healthscotland.scot/population-groups/homeless-people
[13] https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland-9781787810129/

Gender Reassignment	Think about trans / transgender people - anyone whose gender does not match the sex they were assigned at birth.

What we found

LGBT young people are disproportionately represented in the young homeless population. As many as 24% of young homeless people are LGBT, and 77% state that their LGBT identity was a causal factor in becoming homeless, with 69% of homeless LGBT young people having experienced violence, abuse or rejection from the family home.[14]

A growing body of evidence suggests that LGBT people face issues that make them particularly vulnerable to drug and alcohol issues, e.g., experiences of stigma, internalised homophobia and concealing/disclosing their LGBT identity. These stressors can lead people to use substances as a coping strategy.[15] Dimova et al's (2022) qualitative study reports that many people perceived their drinking to be closely associated with their sexuality/gender identity.

Valentine and Maund (2016) report that many transgender people in Scotland are often afraid to access drug and alcohol services, citing concerns about harassment, lack of understanding, and even fear of violence.[16] Those who had accessed alcohol and other drug services noted experiences of feeling that services didn't know enough about being transgender to help them, hearing hurtful or insulting language about being trans, being misgendered, or experiencing silent harassment (being stared at or whispered about).

Dimova et al's (2022) study reports that service providers (particularly in statutory services) were uncomfortable discussing trans issues because of a fear of 'getting it wrong' and upsetting clients, their belief that identity was not relevant to alcohol treatment, or the perception that people accessing the service would raise this issue if they felt it was relevant.[17]

However, in a BMJ article, Phillips (2021) argues that "it's time to get comfortable asking about gender identity and sexual orientation as routinely as we do about age, postcodes, and disabilities".[18]

What we did

We sent our online survey via Twitter to LGBTQI contacts and the Glasgow LGBTQI Substance Use Partnership (@LGBTQISubUse) who shared it with their networks. The survey was further shared through the December 2021 edition of the Trans Community Newsletter. In addition to using Twitter and email, we also provided printable versions of the survey in Word format for people who wanted to write down their feedback instead of using an electronic device.

[14] https://www.gov.scot/publications/covid-19-health-and-social-impact-assessment/
[15] https://onlinelibrary.wiley.com/doi/epdf/10.1111/dar.13358
[16] https://www.scottishtrans.org/wp-content/uploads/2017/03/trans-inclusion-in-drug-and-alcohol-services.pdf
[17] https://www.shaap.org.uk/downloads/408-lgbtq-alcohol-services-2022/viewdocument/408.html
[18] https://www.bmj.com/content/372/bmj.m4828.long

Although we reached people from the LGBTQI community digitally via social media, we were unable to speak to people directly through a discussion group or interview due to tight timelines and lack of capacity in third sector organisations to support due to COVID-19 and other factors.

Furthermore, the current HIS online survey equality monitoring form does not include an option to identify as non-binary/transgender, meaning that we do not know if any respondents had a non-binary gender or identified as trans. This issue is being taken forward by the HIS Equality and Diversity Advisor. No trans-specific issues were identified through the survey response.

Marriage & Civil Partnership	Are there any implications for people who are married or in a civil partnership?

What we found

Recent figures show that the most common reasons for making a homelessness application were:

- People being asked to leave (27%)
- Non-violent household dispute (22%)
- Violent household dispute (14%)

30% of people became homeless from accommodation shared with parents/family/relatives, while 22% became homeless from accommodation shared with friends/partners. A significant percentage of people are therefore likely to be homeless due to the breakdown of a relationship.

70% of homeless applications were from single people, 25% of which had children.[19]

Scottish Drugs Forum (2014) found that being in a relationship could be a barrier to drug and alcohol treatment if with someone who does not wish to seek treatment or who discourages their partner from doing so.[20]

What we did

We have engaged with Scottish Families Affected by Alcohol and Drugs to better understand the experience of family members, including (ex) husbands/wives/partners.

Simon Community Scotland informed us that the number of people who were homeless increased during COVID-19 due to relationship breakdowns and one person having to leave the family home. People also spoke about being housed in

19 https://www.gov.scot/binaries/content/documents/govscot/publications/statistics/2021/06/homelessness-scotland-2020-2021/documents/homelessness-scotland-2020-21/homelessness-scotland-2020-21/govscot%3Adocument/homelessness-scotland-2020-21.pdf

20 https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland-9781787810129/

temporary accommodation which was unsafe/inappropriate to have their children visit.

Pregnancy & Maternity	Think about people who are pregnant, breast-feeding or who recently gave birth.

What we found

It is thought that young women experiencing homelessness have an exceptionally high pregnancy rate compared to the general population, e.g., a UK study from 2000 found that 24% of women experiencing homelessness were pregnant within one year (Gorton 2000). Pregnancy is considered a stressful life event with significant health impacts. Homelessness exacerbates this life stress, increasing antenatal distress experiences, which can be a contributing factor to increased use of substances and poorer outcomes (Mukherjee 2016). Women who are homeless are also less likely to receive timely antenatal care and an increased risk of maternal, fetal and neonatal complications. Furthermore, women with drug and/or alcohol issues have also reported being treated poorly by services and being worried about engaging with services in case they had their children taken from them.[21]

What we did

From collecting demand analysis pregnancy has been mentioned across both housing services and services responding to near fatal overdose from substances.

We have sought to better understand issues around pregnancy through engagement with women carried out on our behalf by Simon Community Scotland.

Race	Think about people from the diversity of minority ethnic communities. This includes gypsy/travelers. Are there health inequalities or access barriers that should be considered and addressed? Convention on the Elimination of all forms of Racial Discrimination

What we found

Evidence in the literature suggests that certain minority ethnic groups are overrepresented in homelessness applications, and some may be slightly underrepresented, such as 'Chinese' households.[22] Given the differences in defining ethnicity between data sources, small sample sizes and lack of up to date population data, it is difficult to determine whether specific minority ethnic groups

[21] https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12972
[22] https://www.gov.scot/publications/housing-needs-minority-ethnic-groups-evidence-review/documents/

are over-represented in homelessness applications compared to white Scottish/British groups. Therefore, findings should be treated with caution as there could be considerable variation between and within groups.

However, reasons for homelessness for minority ethnic groups identified in a Scottish Government report (2021) include:

- Lack of awareness of housing procedures and rights
- Lack of awareness of services and advice available
- Lack of appropriate temporary and permanent accommodation
- Financial constraints
- Relationship break, including domestic abuse[23]

In terms of drugs and alcohol, the literature suggests that minority ethnic people have been underrepresented in services for alcohol use. While some evidence suggests there are higher rates of abstinence among minority ethnic communities, it has been noted that there is variability in drug and alcohol use between and within communities.[24]

What we did

Equality monitoring from our online survey shows that people from minority ethnic communities were not represented. Ethnicity was not recorded from the interviews undertaken.

Due to challenging timescales for the programme and competing pressures on organisations due to COVID-19 no additional engagement with minority ethnic communities was undertaken.

Religion or Belief	Think about people who follow particular religions, or none. For example: Judaism, Islam, Sikhism, Christianity etc. Are there particular beliefs or practices that are assumed or that may be impacted?

What we found

According to our Interconnected Systems Mapping exercises undertaken in the areas we are working with, supports for people experiencing homelessness and drug and alcohol use are provided often by faith-based organisations, e.g., the Salvation Army, Bethany Christian Trust, Cyrenians, etc. For people of the Christian faith this provides a number of options. However, the faith-based aspect of the services these organisations provide may present barriers to some services, e.g., the religious dimension was noted as a possible reason why self-help groups

[23] https://www.gov.scot/publications/housing-needs-minority-ethnic-groups-evidence-review/documents/
[24] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Drinking-problems-and-interventions-in-BME-communities-Final-Report.pdf

may not be perceived to be safe for LGBT people.[25] It should also be noted that this religious aspect may present additional barriers to minority ethnic communities belonging to different religions.

What we did
Participants in our survey were asked to complete an equality monitoring form which included stating their religion/belief. Out of 18 responses, six people identified their religion or belief as Christianity, with eight people identifying as 'no religion', three people as 'other' and one person not wanting to disclose this information.

Sex	Think about any differences for women compared to men, or vice versa. Convention on the Elimination of all forms of Discrimination Against Women

What we found
Scottish Government statistics show that 58% of homelessness applications had a main applicant that was male, suggesting that men are disproportionately more likely to experience homelessness. This compares to 48% of the Scottish adult population. Women are more likely to be homeless as a result of a violent household dispute, although a higher proportion of men state a reason of non-violent dispute.[26] However, it should be noted that, according to Engender, large numbers of women in precarious housing situations do not engage with homeless services, partly due to perceived stigma and shame and because homeless services are not designed for women and do not understand or respond to their needs.[27] Males accounted for 73% of drug-related deaths in 2020 - a continuation of the pattern that there are considerably more drug-related deaths of males than females. In fact, males were 2.7 times more likely to have a drug-related death. However, this gap has decreased since the early 2000s.[28] The number of alcohol-specific deaths among males has been consistently higher than the number of female deaths since records began in 1979. For 2020, there were 826 male deaths and 364 female deaths.[29]

[25] https://www.shaap.org.uk/images/shaap-glass-report-web.pdf
[26] https://www.gov.scot/publications/homelessness-scotland-2020-2021/pages/8/
[27] https://www.engender.org.uk/content/publications/A-WOMANS-PLACE---GENDER-HOUSING-AND-HOMELESSNESS-IN-SCOTLAND.pdf
[28] https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf
[29] https://www.nrscotland.gov.uk/files/statistics/alcohol-deaths/2020/alcohol-specific-deaths-20-report.pdf

Barriers to men's health-seeking behaviours are well documented, however women may also be less visible in services due to a number of barriers to them seeking support. For example, a study by the Scottish Drugs Forum (2014) stated that fear of losing custody of children was a barrier in women's willingness to engage with services and their ability to be honest with service providers about their drug use. Caring responsibilities were also cited by 27% of women interviewed as a barrier to accessing treatment, as were unwanted advances or sexual harassment in treatment/support settings.[30]

The Centre for Homelessness Impact have also made the case that women need better support when they become homeless due to violence. They note that the impact that violence has will often be missed as being a significant reason a woman is becoming homeless because services focus instead on the trauma response, e.g., drug and/or alcohol use.[31]

What we did
Due to the disproportionate number of men accessing alcohol, drug, and homeless services, we were aware that their views would be included in the peer research interview sample method. We therefore made targeted efforts to engage with women through the Simon Community Scotland Hard Reduction team. Through the Harm Reduction Coordinator, we were able to engage with 10 women about their experiences of services which were recorded through Google Jamboard. Their experiences reinforced the findings from the literature above.

Sexual Orientation	Think about people who are lesbian, gay, or bi or who have another minority sexual orientation (e.g., are not heterosexual / straight). Are there health inequalities or access barriers that should be considered and addressed?

What we found
Scottish Government homelessness statistics are not currently collected on sexual orientation. However, as reported earlier in this EQIA, LGBT young people are disproportionately represented in the young homeless population. As many as 24% of young homeless people are LGBT, and 77% state that their LGBT identity was a causal factor in becoming homeless, with 69% of homeless LGBT young people having experienced violence, abuse or rejection from the family home.[32] Again, as reported earlier in this EQIA, a growing body of evidence suggests that LGBT people face issues that make them particularly vulnerable to drug and alcohol issues, e.g., experiences of stigma, internalised homophobia and

[30] https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland-9781787810129/
[31] https://www.homelessnessimpact.org/post/better-support-needed-for-women-who-become-homeless-because-of-violence
[32] https://www.gov.scot/publications/covid-19-health-and-social-impact-assessment/

concealing/disclosing their LGBT identity. These stressors can lead people to use substances as a coping strategy.[33]

Emslie et al's (2015) study exploring drinking among LGBT people in Scotland, found that barriers to accessing services for LGBT people include:

- LGBT people being invisible to service providers (assumption that everyone is straight and cisgender)
- Services being perceived to be 'macho' and intimidating for heterosexual women and LGBT people
- Self-help groups not perceived to be safe spaces for LGBT people (religious dimension/ aimed at 'white straight men'[34]

As also noted in the 'gender reassignment' section, Phillips (2021) argues that "it's time to get comfortable asking about gender identity and sexual orientation as routinely as we do about age, postcodes, and disabilities."[35]

What we did

As part of the distribution of an online survey seeking people's views and experiences of homelessness and drug and alcohol services, we sent the survey to the Glasgow LGBTQI Substance Use Partnership and a further seven contacts via Twitter.

As part of the online survey equality monitoring questions on sexual orientation, we know what one person identified as a gay man, one person identified as bisexual, two people did not want to disclose this information and one person chose 'other'. No LGBT-specific issues were noted.

£ Socio-economic

Think about people living on low incomes and / or in deprived areas. Consider this as a cross-cutting issue since people from some protected characteristic groups are more likely than the general population to experience poverty.

What we found

In 2020, after adjusting for age, people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas.[36] People in the most deprived areas were 4.1 times more likely to die from an alcohol-related death.[37]

The Hard Edges Scotland report found that people currently experiencing three of more of these disadvantages (homelessness, substance abuse, offending, and/or

[33] https://onlinelibrary.wiley.com/doi/epdf/10.1111/dar.13358
[34] https://www.shaap.org.uk/images/shaap-glass-report-web.pdf
[35] https://www.bmj.com/content/372/bmj.m4828.long
[36] https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/20/drug-related-deaths-20-pub.pdf
[37] https://www.nrscotland.gov.uk/files/statistics/alcohol-deaths/2020/alcohol-specific-deaths-20-report.pdf

mental health) are four times as likely to live in the poorest places as people with no such disadvantages. While there may be 'area effects' which generate or reinforce the risks of deprivation (e.g. young people becoming involved with crime or drugs through local associates or gangs), there will also be quite a strong 'selection effect,' whereby people who face severe and multiple deprivation, especially given its strong association with low income, are more likely to end up (though housing allocation or 'sorting' processes, whether in the social or private sectors) in such neighborhoods.[38]

What we did

Although not exclusively, people experiencing homelessness and drug and alcohol issues are more likely to be facing socio-economic disadvantage, therefore, no additional steps to target people from socio-economic backgrounds were viewed to be necessary. Many issues relating to socio-economic disadvantage are captured through demand analysis carried out with area project teams, peer research interviews and further engagement with Simon Community Scotland and other partners involved in our programme.

Island communities

Think about people living on the Scottish islands. Does the work cover the islands as well as the mainland? What might be different for island communities?

What we found

The Hard Edges Scotland report[39] states that less than 10% of people experiencing severe and multiple disadvantages reside in rural areas. When looking at the rural versus urban split across single factors this changes to 15% of people experience homelessness, while 20% have experienced substance abuse or domestic abuse and violence. Generally, the proportion of rural residents falls as the level of complexity rises.

Participants in MacDiarmid's (2020) study[40] from North Ayrshire and Arran suggested that alcohol use is disproportionate in rural communities, given the lack of alternative recreational activities, while the significance of alcohol is entrenched in cultural and social norms due to traditions, hospitality and economic dependence on tourism and alcohol production. Indeed, NHS Western Isles is one of four health boards with alcohol-related death rates higher than the average of Scotland.[41] However, the rates for the rest of the Highlands and Islands are far lower.

[38] https://www.therobertsontrust.org.uk/umbraco/surface/download/Index/1774
[39] https://www.therobertsontrust.org.uk/umbraco/surface/download/Index/1774
[40] https://www.drugsandalcohol.ie/33061/1/SHAAP_Rural_Matters_Report.pdf
[41] https://www.nrscotland.gov.uk/files/statistics/alcohol-deaths/2020/alcohol-specific-deaths-20-report.pdf

The study also suggested that people in rural communities who need alcohol-related support services face unique challenges, including expensive, lengthy, and infrequent public transport links and limited internet service. Stigma is also exacerbated if living in a small community where privacy is difficult to maintain. Participants from the North Ayrshire and Arran study also expressed fears of social, professional or family consequences if they were found to be seeking assistance.
What we did
As part of this programme, we have been working with an HSCP area team from North Ayrshire. Although the one-to-one interviews were not conducted on the Isle of Arran, the distribution of the smart survey included Arran Council of Voluntary Services (CVS) and the Ayrshire Community Trust (TACT). No further rural/island-specific issues have been identified through peer research interviews and other engagement.

4. Future actions

Where it has been identified that the work has potential to adversely affect people who share one of the characteristics noted, or you think there are certain things you will need to do to ensure all relevant groups benefit equitably, provide details of what you will do to improve outcomes.

Through the peer researcher-led interviews that were facilitated on our behalf by Scottish Drugs Forum and Homeless Network Scotland, we were unable to identify any specific issues/differences in experiences across protected characteristics. This was due to: • Convenience sampling (no targeted engagement) • No questions addressing differences in experiences We note that the experiences/needs of the following groups of people/communities are typically underrepresented/not represented/their representation is unknown: • Younger people/older people • Care experienced people • People experiencing pregnancy • Women • LGBT people • Minority ethnic people • People with a range of faiths/beliefs • Rural/Island communities

We carried out targeted engagement with women through Simon Community Scotland and carers and family members through Scottish Families Affected by Alcohol and Drugs to address the underrepresentation of women in our peer research interviews.

The equality monitoring form for our online survey did not allow people to select any alternatives to ‘male’ or ‘female’. This affected our ability to note any difference in experiences among people with different gender identities and better understand representation in our work. We will work with our Equality and Diversity Advisor to better understand the scope for changing the data we collect.

To address a lack of insights regarding lived/living experience of services for people sharing protected characteristics, new programmes of work (e.g. Pathways to Recovery and Medication-assisted Treatment Standards programmes) within the Housing and Homelessness in Healthcare portfolio will include targeted engagement based on an initial EQIA and interview schedules will include questions about if/how people’s characteristics had impacted on the issues they have faced/service they received and, if so, how. This will need to be done sensitively and with the support of our Equality and Diversity Advisor and others important colleagues from third sector organisations.

Acknowledging that some of our HIS programmes are addressing similar issues, e.g., mental health and substance use, the Housing and Homelessness in Healthcare portfolio will commit staff to attending the HIS internal Multiple and Complex Needs Forum to ensure that related equality issues are discussed, and joint working/learning opportunities are identified.

All characteristics listed in the EQIA for consideration here are pertinent or have some relevance to homelessness/drug and alcohol use. Any change ideas proposed by area teams involved in the RHIC programme must only be implemented if their impact on people sharing these characteristics has been given adequate consideration through an equality impact assessment.

For this reason, area teams are encouraged to link in with equality and diversity/corporate parenting leads in their NHS board areas to seek guidance on how proposed change ideas may impact on communities, building on evidence found in this EQIA.

Where negative impacts could be anticipated, area teams are encouraged to involve people with lived/living experience to develop solutions that meet the needs of people using services. Guidance can be sought by their public involvement teams or by HIS Community Engagement offices.

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
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