

## Equality and human rights duties impact analysis for provider handbook on substance misuse services

### 1. Introduction

This equality and human rights impact analysis covers the specialist substance misuse services provider guidance.

The purpose of this equality and human rights impact analysis is to ensure that, in developing our regulation of hospitals, we meet our duties:

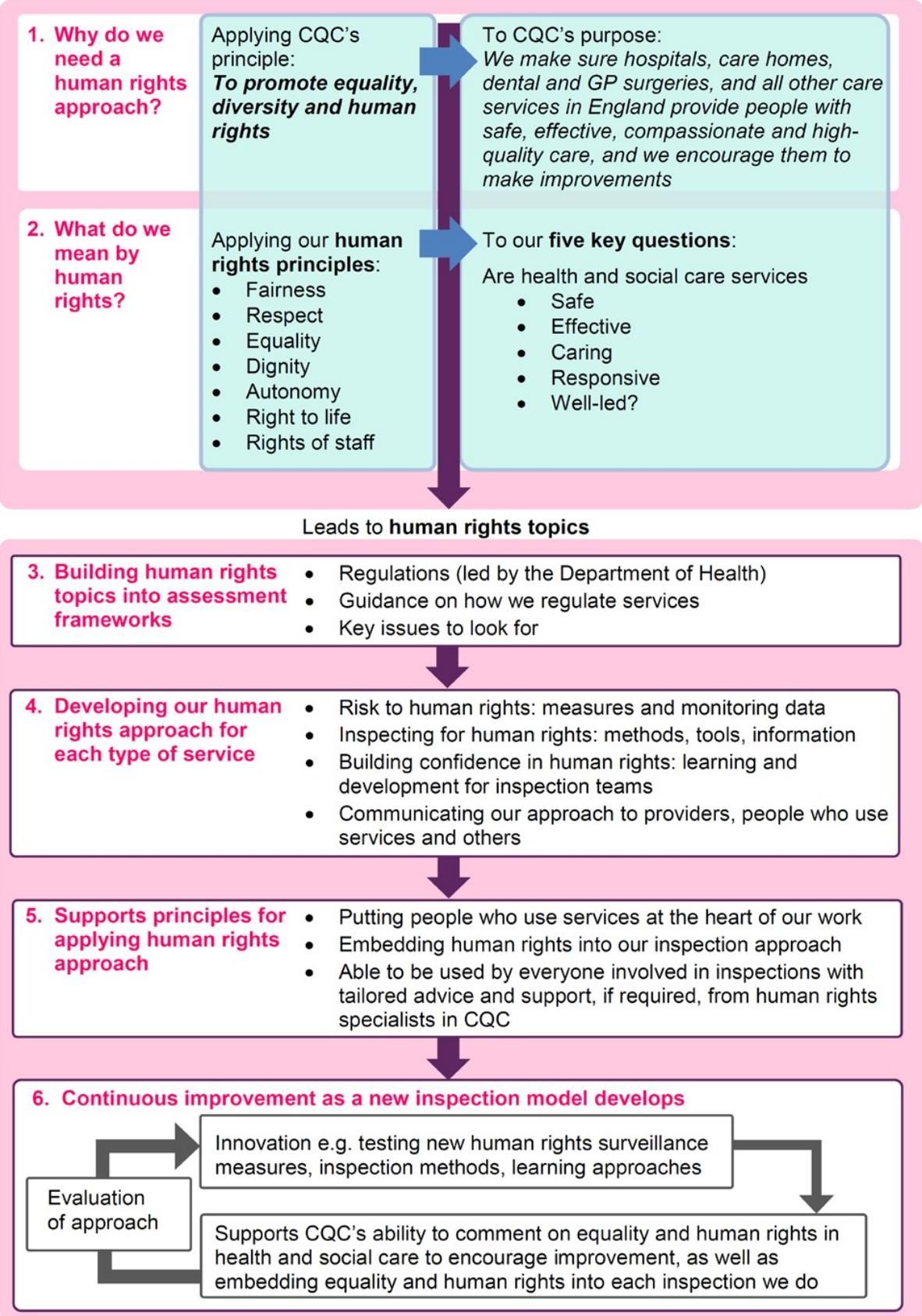
- Under the Human Rights Act 1998 to respect, protect and fulfil people's human rights.
- Under the Equality Act 2010 to have due regard, when delivering our functions, to the need to:
  - eliminate discrimination
  - advance equality of opportunity, and
  - foster good relations between groups

in relation to the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

However, we view this as more than mere legal compliance – we have made one of CQC's principles to promote equality and diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this principle into practice, we have developed a human rights approach to regulation. This approach looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask. Our human rights approach is integrated into our new approach to inspection and regulation as this will be the best method to ensure equality and human rights is promoted in our work. We have integrated the human rights principles into our key lines of enquiry, ratings descriptors, intelligent monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement. The diagram overleaf summarises our approach.

Figure 1: Our human rights approach to regulation



## 2. Engagement in developing our handbooks for the sector

The responses to the consultation on our strategy for 2013-16 and on our document 'A fresh start' have helped us shape our approach to our inspections. In particular, this impact analysis picks up consultation responses from the [equality and human rights duties impact analysis for 'A new start'](#). A summary of these responses can be found in our Human Rights Approach consultation document.

We have engaged with the public, people who use services and specific equality groups on our new approach:

For specialist substance misuse services covered by the provider guidance, we have:

- Published a signposting document with email address for responses/comments.
- Carried out social media activity to promote the signposting document.
- Compared our draft key lines of enquiry (KLOEs) and ratings descriptors to the insight gained through consulting with people who use services and the public about proposed fundamentals of care.
- Created definitions of human rights principles, which have influenced the key human rights topics in our human rights approach
- Developed key human rights topics, which have influenced our substance misuse KLOEs.
- Engaged with an external advisory group (EAG) about a range of matters including what issues inspectors should consider in relation to specific groups of service users. The EAG includes an expert by experience, and three external organisations relevant to specific groups.

### 3. What we know about equality and human rights in the substance misuse sector

What we know about equality for people using substance misuse services, in relation to:

<p><b>Age</b></p>	<p>Substance misuse issues of various kinds affect people across a wide age range.</p> <p>Statistics for alcohol treatment in England in 2013–14 gained from the <a href="#">National Drug Treatment Monitoring System (NDTMS)</a> show that:</p> <ul style="list-style-type: none"> <li>• 114,920 clients aged 18 and over in contact with structured treatment cited alcohol as their primary problematic substance in 2013-14.</li> <li>• The highest percentage (17%) of clients accessing alcohol treatment services were aged between 40 and 44.</li> <li>• The lowest percentage (3%) of clients accessing alcohol treatment services were aged between 65 and 75.</li> <li>• Clients’ median age at their first point of contact with treatment in 2013–14 was 42.</li> </ul> <p>Statistics for drug treatment activity in England in 2012–13 from the <a href="#">NDTMS</a> show that:</p> <ul style="list-style-type: none"> <li>• 193,575 clients aged 18 or over were in treatment during 2012–13.</li> <li>• The highest percentage (22%) of clients accessing drug treatment were aged between 30 and 34.</li> <li>• The lowest percentage (1%) of clients accessing drug treatment were aged over 60.</li> <li>• Clients’ median age at their first point of contact in their latest treatment journey in 2012–13 was 35.</li> </ul> <p>When looking at age equality, we also need to consider substance misuse among younger people. Statistics for young people in specialist drug and alcohol services in England 2011-12 from the <a href="#">NDTMS</a> show that:</p> <ul style="list-style-type: none"> <li>• 20,032 young people accessed specialist substance misuse services in 2012–13. This is a decrease of 656 (3.2%) since 2011–12 and 1,923 (8.8%) since 2010–11.</li> <li>• The highest percentage (27%) of young people accessing specialist substance misuse services were aged 17.</li> <li>• The lowest percentage (&lt;1%) of young people accessing specialist substance misuse services were aged less than 12.</li> </ul>
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	<p>Older people with substance misuse problems have historically been a marginalised group. DrugScope is the national membership organisation for the drug and alcohol field and the UK’s leading independent centre of expertise on drugs and drug use. In their publication, <a href="#">It's About Time – Tackling substance misuse in older people</a> it is stated that the proportion of older people with substance misuse problems is increasing rapidly in correlation with the increasing proportion of older people in the population. The European Monitoring Centre for Drugs and Drug Addiction estimate that the number of older people with substance use problems or requiring treatment for substance misuse will more than double between 2001 and 2020 in their report <a href="#">Substance misuse among older adults: a neglected problem.</a></p>
<p><b>Disability</b></p>	<p>Disabled people make up a significant percentage of the population (ONS Census 2011 data: 9.5 million people have a limiting long term illness or impairment) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age.</p> <p>The <a href="#">definition of disability in the Equality Act 2010</a> includes people with a physical or sensory impairment, people with a learning disability and people experiencing mental distress, as well as people with other long term conditions that have a substantial and long term effect on the ability to carry out daily activities.</p> <p>The UK Drug Policy Commission’s (UKDPC) report, <a href="#">Drugs and Diversity: Disabled People Learning from the evidence</a> provides an overview of the differing needs and challenges associated with drug use among diverse minority communities within the UK. We know that disabled people are not a homogenous group and that there will be as wide a range of needs and experiences within the group as will be found in any other population.</p> <p>Evidence used within the UKDPC’s report was limited, but key points highlighted, which may increase drug use risk among disabled people, included:</p> <ul style="list-style-type: none"> <li>• Isolation, exclusion and “social distance” – some disabled children may find it difficult to participate in school culture or have communication issues leading to drug use to deal with distress, frustration, isolation and bullying.</li> <li>• Social pressure – drugs may be used as a means of fitting in and gaining social acceptance by non-disabled contemporaries.</li> <li>• Mental health problems and poverty – may increase risks for disabled people – being linked to social exclusion and problematic drug use in the general population.</li> <li>• Communication difficulties and lack of accessible information –</li> </ul>

	<p>may aggravate drug problems and inhibit help seeking for some disabled people.</p> <ul style="list-style-type: none"> <li>• Self medication – some people find that cannabis alleviates the symptoms of long term illnesses, including Multiple Sclerosis, back pain and arthritis.</li> </ul> <p>Further evidence from the UKDPC suggests that substance misuse services are often ill equipped to support disabled people. Commissioners of substance misuse services should seek to meet the needs of disabled people by building the capacity and competencies of specialist generic disability bodies and support networks regarding substance misuse issues, and enhancing the capacity of existing substance misuse providers to respond to the needs of people with disabilities.</p>
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<p><b>Gender, including pregnancy and maternity</b></p>	<p>Males make up 49% of the population of the UK, however, official statistics from the <a href="#">NDTMS</a> show:</p> <ul style="list-style-type: none"> <li>• 64% of people accessing treatment for alcohol misuse were male.</li> <li>• 73% of people accessing treatment for drug misuse were male.</li> <li>• 66% of young people in specialist drug and alcohol services in England in 2012-13 were male.</li> </ul> <p>The Advisory Council on the Misuse of Drugs (ACMD) state in their report, <a href="#">Hidden Harm – Responding to the needs of children of problem drug users</a> that:</p> <ul style="list-style-type: none"> <li>• An estimated 1% of pregnant women are problem drug users and another 1% are problem drinkers.</li> <li>• 2 to 3% of children in England and Wales have a parent with serious drug or alcohol problems.</li> </ul> <p>A study by Hall and van Teijlingen (2006), <a href="#">A qualitative study of an integrated maternity, drugs and social care service for drug-using women</a> explains how women who use drugs are more likely to attend antenatal care late and/or conceal their drugs use from health professionals. This may be due to a number of factors including:</p> <ul style="list-style-type: none"> <li>• Fear of professionals’ reactions – staff attitudes are more important to women in determining use of services than clinical care.</li> <li>• Anxiety and guilt about the impact of drugs on the baby.</li> <li>• Fear of the child being taken into care.</li> <li>• Denial – some women avoid facing the reality of pregnancy.</li> </ul> <p>On the other hand, pregnancy may be an important opportunity for change, when a woman is highly motivated to come off drugs or stabilise her drug use in order to have a healthy pregnancy and keep her baby.</p>
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The National Institute for Health and Care Excellence (NICE) make recommendations in their 2010 guidance document, [Pregnancy and complex social factors \(CG110\) A model for service provision for pregnant women with complex social factors](#):

NICE recommends that health professionals should:

- Integrate care from different services by:
  - Jointly developing a coordinated care plan across agencies.
  - Including information about opiate replacement therapy in care plans.
  - Co-locating services.
  - Offering women information about the services provided by other agencies.
- Ensure that the attitudes of staff do not prevent women from using services
- Address women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their needs.
- Address women's feelings of guilt about their misuse of substances and the potential effects on their baby.
- Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor.

NICE further recommends that women who use drugs should have the following advice and support:

- The first time a woman who misuses substances discloses that she is pregnant, offer her referral to an appropriate substance misuse programme.
- Use a variety of methods, for example text messages, to remind women of upcoming and missed appointments.
- The named midwife or doctor should tell the woman about relevant additional services (such as drug and alcohol misuse support services) and encourage her to use them according to her individual needs.
- Offer the woman information about the potential effects of substance misuse on her unborn baby, and what to expect when the baby is born, for example what medical care the baby may need, where he or she will be cared for and any potential involvement of social services.
- Offer information about help with transportation to appointments if needed to support the woman's attendance.

<p><b>Race</b></p>	<p>We know that the usage of substance misuse services varies by ethnicity.</p> <p>White British people make up 84% of the population, (<a href="#">ONS, Mid-year statistics 2012</a>).</p> <p><a href="#">NDTMS</a> statistics show that:</p> <ul style="list-style-type: none"> <li>• 87% of people accessing treatment for alcohol misuse were of white British origin in 2013–14.</li> <li>• 83% of people accessing treatment for drug misuse were of white British origin in 2012–13.</li> <li>• 81% of young people accessing substance misuse services were of white British origin in 2012–13.</li> </ul> <p>The UKDPC report <a href="#">Drugs and Diversity: Ethnic minority groups</a> highlights the extent and nature of drug use in ethnic minority groups:</p> <p>In general, overall drug use is lower among minority ethnic groups than among the White population.</p> <ul style="list-style-type: none"> <li>• Reported drug use prevalence is highest among those from mixed ethnic background in a number of studies, largely as a result of high levels of cannabis use. However, when the younger average age of this group is taken into account, their drug use levels are similar to those in the White population.</li> <li>• Lowest overall levels of drug use are reported by people from Asian backgrounds (Indian, Pakistani or Bangladeshi).</li> <li>• Cannabis is the most commonly used drug across all ethnic groups and age groups.</li> <li>• Rates of Class A drug use are higher among people from White or mixed ethnic background than among other ethnic groups.</li> <li>• Poly drug use is most common among White groups, compared with other ethnic groups.</li> <li>• Men are more likely than women to use any illicit drugs in many ethnic groups, particularly among Asian, White and Chinese/other groups. Black and mixed race men and women have similar levels of use.</li> <li>• National and local records of treatment services, and some small scale studies, indicate that the types of drugs that cause individuals to seek help vary between different communities: <ul style="list-style-type: none"> <li>○ Among the Asian community the most common reason for seeking treatment is problematic use of heroin.</li> <li>○ Asian drug users also appear to be more likely to use smoking or chasing as their method of administration,</li> </ul> </li> </ul>
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	<p>those in white communities are more likely to inject.</p> <ul style="list-style-type: none"> <li>○ Drug users from black groups are more likely to seek treatment for crack cocaine and cannabis use.</li> <li>○ Women make up a bigger proportion of white people in treatment than they do of black people.</li> <li>○ Almost half of all people from white, mixed and black ethnic groups report alcohol use prior to entering treatment compared with only about a third of those of Asian background.</li> </ul> <ul style="list-style-type: none"> <li>● In some minority ethnic communities, khat use may be a cultural or social recreation. Khat was made illegal in 2014 following concerns having being raised regarding its potential negative health impacts.</li> <li>● BME communities may be at risk of drug use because they often live in disadvantaged and deprived areas, where drug markets thrive.</li> <li>● A number of minority ethnic groups, particularly refugees and asylum seekers, face high levels of unemployment, isolation and social exclusion. Limited opportunities can lead to frustration, boredom and anxiety increasing the likelihood of drug use.</li> <li>● Factors suggested as linked to high levels of cannabis use within black communities include: <ul style="list-style-type: none"> <li>○ A perception that it is safe and less harmful than other drugs.</li> <li>○ A history of cannabis use within families.</li> <li>○ For Rastafarians, cannabis use is a spiritual act and part of the culture of the movement.</li> </ul> </li> <li>● Among some BME groups, particularly South Asian people and Chinese people, high levels of stigma are attached to drug use and directed at both drug users and their families. This can lead drug users to hide the extent of their use, and levels of drug problems being underestimated.</li> </ul>
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<b>Religion and belief</b>	<p>There are many ways in which religious practices and beliefs have the potential to affect health and to have an impact on whether substance misuse services are appropriate for different religious and belief groups.</p> <p>Although a high proportion of people in England (59%) state that they are Christian (ONS mid 2012 figures), providers of substance misuse services should not make assumptions about the religion of people based upon ethnicity. For example, although 68% of people of Muslim faith are from the Asian/Asian British ethnic group, 32% are not: 10% are from the Black African/Caribbean British group. This is particularly relevant to delivering care appropriate to people's individual religious background.</p> <p>There are many ways in which religious practices and beliefs have the potential to both affect health and the appropriateness of substance misuse services:</p> <ul style="list-style-type: none"><li>• Diet choice, and preparation of the food.</li><li>• Observance of fasting times.</li><li>• Orthodox Jews observance of the Sabbath.</li><li>• Ethics around Blood transfusion.</li><li>• Views on termination of pregnancy and contraception.</li><li>• Provision of Chaplaincy and prayer facilities.</li><li>• Ablution facilities where appropriate to the religious background of the patient.</li></ul> <p>A document produced by DrugScope, <a href="#">Focus: Views of the Religious Faiths on Substance Use and Abuse</a>, summarises the views of a number of religions in relation to substance misuse.</p>
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<p><b>Sexual orientation</b></p>	<p>The Government's <a href="#">Drug Strategy 2010</a> acknowledges the need for services to be responsive to the needs of certain groups such as lesbian, gay, bisexual and transgender (LGBT) users. Evidence indicates that these populations are more likely to use alcohol and other substances, and to be using different drugs in different contexts to those typically seen in many drug services, with more emphasis on 'party' or 'recreational' drug use.</p> <p>Under the Equality Act 2010 publicly funded service providers such as health services now have a duty to consider the needs of LGBT people when planning and delivering their services, and ensure that their staff have an understanding of how to work with these communities sensitively and effectively.</p> <p>LGBT service users may prefer services identified as specifically for LGBT people for reasons of safety, and due to a perception these services will better understand their circumstances. An example of this type of service is the charity <a href="#">London Friend</a>, the UK's oldest LGBT charity and home to Antidote, the UK's only LGBT specific drug and alcohol service.</p> <p>It is important for practitioners working within substance misuse services to bear in mind the hugely destructive nature of homophobia and heterosexism, both on a person's individual development and on their potential expectations of mainstream services. It is essential to create an environment which gains trust and allows the service user to be open and frank about their substance use.</p>
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<p><b>Gender identity</b></p>	<p><a href="#">The Gender Identity Research and Education Society (GIRES)</a> estimate the number of transgender people in the UK to be between 300,000 and 500,000. Existing evidence suggests that transgender people experience, and are affected by, discrimination.</p> <p>Like all other people, transgender people will need treatment for a full range of health conditions over the course of their lives including accessing substance misuse services in some circumstances.</p> <p>Accommodation for transgender people in residential substance misuse services should be provided according to their presentation: the way they dress, and the name and pronouns that they currently use. <a href="#">EHRC guidance</a>.</p> <p>Supporting information for inspection teams has been produced by CQC to be used as a learning resource to help staff by providing background information and awareness of key issues when inspecting gender identity clinics: <a href="#">Supporting Information: Gender Identity Clinics</a>.</p>
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<b>Carers</b>	<p>The <a href="#">UKPDC</a> report that 1.5 million people are affected by a relative's drug use, this figure does not include those affected by alcohol misuse whose figures are much harder to quantify.</p> <p><a href="#">Carers Trust</a> highlight that these carers do not have the same rights and protections as other carers which in itself may exacerbate feelings of discrimination through isolation or exclusion.</p> <p>Support for carers affected by someone else's substance misuse should be a fundamental consideration for commissioners and providers of substance misuse services. The National Treatment Agency for Substance Misuse report, <a href="#">Supporting and involving carers: A guide for commissioners and providers</a> gives the following key messages:</p> <ul style="list-style-type: none"><li>• Providing services to meet the needs of families and carers, leads to improvement for families, carers, children and drug misusers.</li><li>• Areas without provision or with limited provision can benefit from developing services for families and carers.</li><li>• Involving families and carers can improve engagement, retention and outcomes for drug users in treatment.</li><li>• Involving families and carers in the planning and commissioning of services improves the effectiveness of services and the drug treatment system.</li></ul>
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<p><b>Human rights principle of fairness</b></p>	<p>People should be treated fairly by healthcare providers, regardless of their background. This not only includes people with the protected characteristics under the Equality Act 2010, but includes the four vulnerable and excluded groups prioritised by the Inclusion Health Board in their report <a href="#">Hidden Needs</a> because they experience some of the poorest health outcomes in England:</p> <p>In the 2014 CQC document, <a href="#">A fresh start for the regulation and inspection of substance misuse services</a>, it is described how there will be a consistent focus on people who are in especially vulnerable circumstances or from specific population groups such as:</p> <ul style="list-style-type: none"> <li>• Pregnant women (and their unborn children)</li> <li>• Young people</li> <li>• Lesbian, gay, bisexual and transgender people</li> <li>• People with complex needs, for example a dual diagnosis</li> <li>• Homeless people</li> <li>• Older people</li> <li>• Victims of domestic abuse</li> <li>• Offenders returning to the community</li> <li>• Sex workers</li> </ul> <p>It is recognised that resources are limited but in order to be fair, any services that are offered should relate to the level of assessed needs a person might have.</p> <p>The <a href="#">NHS Constitution</a> says that people have the right to drugs and treatment that have been recommended by NICE for use in the NHS, if their doctor says they are clinically appropriate for them.</p> <p>The performance of all healthcare providers around complaints can also make a major contribution to fairness.</p>
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<p><b>Human rights principle of respect:</b></p> <p><b>People who use services are valued as individuals, are listened to and what is important to them is viewed as important by the service</b></p>	<p>All people have the right to respect. Rather than treating everybody in a uniform way which ignores difference, healthcare providers should be aiming to treat every individual with the same level of dignity and respect. There is the potential for people to disengage from health services if they have not been treated with respect by a clinician or by other healthcare staff and staff working within substance misuse services, in all settings including both hospitals and community based services. <a href="#">Duties of a Doctor</a> (General Medical Council). This involves for example:</p> <ul style="list-style-type: none"> <li>• Being polite to people using services</li> <li>• Listening to them</li> <li>• Keeping them informed of decisions and changes</li> <li>• Meeting their needs, or if this is not possibly, explaining why.</li> </ul> <p>Respect involves cultural and other needs: if a person is in a hospital or residential setting, those caring for them should respect their cultural needs such as religious practices or dietary requirements, or any other needs which may be part of their private life.</p> <p><a href="#">NHS Outcomes framework indicators</a> Domain 4 - Ensuring that people have a positive experience of care looks at the importance of providing a positive experience of care for patients, service users and carers.</p>
<p><b>Human rights principle of dignity:</b></p> <p><b>People who use services are always treated in a humanitarian way—with compassion and in a way that values them as a human being and supports their selfrespect ,even if their wishes are not known at the time</b></p>	<p>Within the caring domain of the CQC key lines of enquiry (KLOE) that will be used by inspection teams during inspection of substance misuse services, there is a specific KLOE to investigate whether people are treated with kindness, dignity, respect and compassion while they receive care and treatment. Inspection teams will use the following prompts to inform judgments based around this KLOE:</p> <ol style="list-style-type: none"> <li>1. Do all staff understand and respect people’s personal, cultural, social and religious needs, and how these may relate to their substance use? Do they take these into account?</li> <li>2. Do all staff take the time to interact with people who use the service and those close to them in a respectful and considerate manner?</li> <li>3. Do all staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them?</li> <li>4. Do all staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes?</li> <li>5. How do all staff make sure that people’s privacy and dignity is always respected, including during physical or intimate care?</li> <li>6. When people experience physical pain, discomfort or emotional distress do all staff respond in a compassionate, timely and appropriate way?</li> <li>7. Do all staff respect confidentiality at all times (within the limitations</li> </ol>

	<p>of the law)?</p> <p>Privacy is an element of dignity. The <a href="#">NHS Constitution</a> includes a pledge that people will not have to share sleeping accommodation with people of the opposite sex – including inpatient wards.</p>
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<p><b>Human rights principle of autonomy</b></p>	<p>People have the right to choose where they want to be treated for illness and health conditions. This includes the right to make routine decisions and to be consulted about professional decisions about their care and treatment.</p> <p>The NHS Constitution reflects this: for example:</p> <ul style="list-style-type: none"> <li>• People have the right to accept or refuse treatment.</li> </ul>
<p><b>Human rights principle – right to life</b></p>	<p>Healthcare providers have a duty to take steps to protect the life of people for whom they provide care.</p> <p>This includes not placing do not attempt resuscitation (DNAR) notices on patients' files without the person's consent or knowledge or appropriate use of the Mental Capacity Act, nor should a hospital make decisions about DNAR notices based on purely on age or disability.</p> <p>Right to life also includes all healthcare providers preventing "avoidable" deaths.</p> <p>For example, safeguards should be in place to prevent people from avoidable harm or death. In substance misuse services, this mechanism includes the need for staff to have adequate knowledge about the prevention of drug and alcohol related harm such as overdose or unsafe withdrawal, and the transmission of blood borne viruses. In addition prescribing staff must have appropriate knowledge of prescribing for different types of substance misuse problems.</p> <p>This is an outcome measured in the NHS Outcomes framework indicators: <b>Domain 1 - Preventing people from dying prematurely</b></p>

<p><b>Human rights for staff working in the sector</b></p>	<p>NHS staff have rights to help ensure they have healthy and safe working conditions and are treated fairly and equally (NHS Constitution section 4a. For example, staff should:</p> <ul style="list-style-type: none"> <li>• Expect reasonable steps to have been taken by the employer to ensure protection from less favourable treatment (e.g. bullying or harassment) by fellow employees, people using the service and others.</li> <li>• Expect a working environment free from unlawful discrimination.</li> <li>• Expect employers to deal appropriately with safety risks that staff might face.</li> </ul>
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#### **4. Development work on equality and human rights to date**

It is vital when looking at substance misuse services that the views, opinions and experiences of people who use them are listened to and that any judgement that we make about those services reflects what we have heard.

CQC have engaged with an Expert Advisory Group in relation to what should be taken into account during inspections to ensure that the needs of all service users are addressed, including the needs of specific groups. In addition there is an ongoing work programme to determine how CQC can best engage with some groups during the inspections process, for example engaging young people who use substance misuse services.

Within the document [A fresh start for the regulation and inspection of substance misuse services](#), CQC detail the new approach to inspecting substance misuse providers. Substance misuse treatment is a unique, diverse sector and people using these services often have complex and varied needs. Treatment may be short or long term and people often need help from a number of agencies. To address this requirement, inspections will include greater involvement from Experts by Experience, who have experience of services, and a greater focus on engaging with people, and on gathering the views of families and carers. Inspections will be carried out by inspection teams of varying sizes, dependent on the size and type of service. They will include professional experts, including doctors, psychologists, pharmacist and therapists, as appropriate. In addition, equality data published by Public Health England will be an integral part of pre-inspection data packs.

In [A fresh start for the regulation and inspection of substance misuse services](#), we also recognised that in order to provide a safe and effective service, people who use substance misuse services can expect to receive a service that is structured and may include restrictions, for example to daily routines, movement and personal relationships. We have included a question in the prompts that accompany our Key Lines of Enquiry to ensure that where these restrictions exist, they are:

- Based on specialist need and risk and/or are required by a treatment programme
- Agreed with people at the time of assessment
- Reviewed as they progress through treatment.

## 5. Conclusion and actions required

- Our approach to inspecting substance misuse draws on our overall human rights approach which aims to have a positive impact on equality and human rights:
  - Mainstreaming human rights by applying human rights principles to our five key questions in developing lines of enquiry that cover human rights topics
  - Integrating human rights into our inspection approach through new surveillance, tools and methodologies that address key human rights principles and topics
  - Enabling inspection team members (who are not human rights specialists) to know, understand and apply the human rights approach, with specialist advice/support if needed.
- General features of CQC's new approach to inspections, that will have a positive impact on our ability to protect human rights through include:
  - Larger inspection teams enabling human rights topics to be covered in more depth
  - Increased emphasis on gathering the views of patients and their carers as many human rights issues can only be identified through people's experiences.
  - The widened scope of regulation looking across a range of performance to make judgements for ratings. This enables us to look at equality and human rights issues outside the scope of the regulations, such as are services planned to meet the needs of the whole population and service access issues that affect groups as well as individual patients.
  - The new 'well-led' domain which enables us to look at the culture of organisations we inspect, and check if this culture protects and advances equality and human rights for people using the service and for staff.
  - Using specialists in inspection teams – we may use equality and human rights specialists from within CQC, who could support inspections.
- However, there are some issues which still need to be resolved, or they could negatively impact on equality and human rights:
  - We need to analyse intelligent monitoring measures for substance misuse services, to check coverage of key human rights topics, e.g. in information we use to evaluate risk and in data provided to inspection teams
  - Throughout the development of our new inspection approach, we have tested our methodology to ensure that key lines of enquiry, guidance and tools, intelligence and learning and development integrate human rights principles and topics. We have also started to evaluate how well these

topics are covered in inspection reports. We will continue to do this during our pilot inspections of substance misuse services.

- Our assessment frameworks and methodology will continue to develop – we need especially to ensure that these developments will enable inspectors to assess performance against key human rights topics for substance misuse services.

## Proposed actions

Issue to address	Proposed action	Lead	Timescale (start and end)
Assessment frameworks and KLOEs will develop over time – need to ensure continued attention to human rights topics in frameworks	1. Continue to use the human rights topics list to check that assessment frameworks adequately reflect the human rights topics for the service type	Policy teams to provide assessment frameworks and make amendments  EDHR team to provide specialist check at appropriate development stages	January 2015-March 2016
Developing tools and methods will continue over time – need to ensure continued attention to assessing human rights topics in methods and tools	2. Embed human rights topics in generic tools  3. Develop specific tools where required to address human rights topics	Policy teams to provide tools for checking and make amendments  EDHR team to provide specialist check at appropriate development stages variable	January 2015-March 2016
Intelligent monitoring measures in substance misuse services are under-developed for many human rights topics	4. Work to review and develop monitoring measures for gaps, where data is already available but is under-used	Intelligence (with advice from EDHR team)	January 2015-March 2016

Many human rights topics are dependent on obtaining the experiences of people using services or those supporting them beyond those gathered actually on inspection visits	5. Ensure local teams have links, methods and skills to gather information about human rights topics e.g. at listening events and through local engagement work	Engagement (with advice from EDHR team)	January 2015- March 2016
Differences in quality of care for equality groups can often only be uncovered through talking to people using services beyond those gathered actually on inspection visits	6. Confirm the scope of the engagement approach for substance misuse services and develop the proposal for local relationships to include engagement with local equality groups	Engagement (with advice from EDHR team)	January 2015- March 2016
Inspectors need knowledge, understanding and confidence to apply the human rights approach in substance misuse services	7. Develop role specific learning on applying the human rights approach and human rights topics for substance misuse service inspection teams.	Learning and development, with specialist input from the EDHR team	January 2015– March 2016
We need to be able to focus some inspection activity on people in equality groups who might be at a higher risk of poor care when using substance misuse services	8. Continue to develop methods to reach experiences of specific equality groups e.g. case tracking people from specific population groups who are using substance misuse services. 9. Look at whether thematic approaches are required to reach experiences of some equality groups using generic services.	Lead dependent on topic – but overall approach is Joint work between EDHR team and Policy Teams  EDHR team	January 2015- March 2016  After evaluation of EDHR in inspections
Need to ensure service specific equality and human rights information is integrated (where available) into the	10. Work to integrate key EDHR information into data packs and other pre-inspection resources	Intelligence – with advice from EDHR team on content	January 2015- April 2016

main pre-inspection information available			
Need to ensure that inspection teams work together to ensure that the views of experts by experience are equally valued in team discussions/decisions, and given the same weight as the views of professionals	11. Develop cross sector thinking for a solution to this	Policy teams (with input from engagement and EDHR)	January 2015- April 2016

**How will the actions be evaluated?**

The individual actions will be evaluated as part of our regular Equality and Human Rights Impact assessment evaluation cycle. We also aim to carry out an evaluation of our overall human rights approach before March 2015 – seeing what difference our regulation has made overall to equality and human rights for people using services.