Area: DACT Connections

Evidence of practice

(narrative of previous model based on PMR data, uptake of service, etc)

There are five Connections teams, one per Trust area, attached to the local Drug and Alcohol Coordination Teams (DACTs).

The role of Connections is to support the development and implementation of each DACT's action plan. Each team also offers a range of services including:

- Awareness raising through social media
- Drug and alcohol awareness presentations
- Signposting to services
- Local campaigns and initiatives, including providing support to others' campaigns and initiatives, eg. Police & Community Safety Partnership
- Input to the development and implementation of regional campaigns and initiatives, eg. Dry January, Feel Good February
- Community involvement, including the recruitment and support for Drug & Alcohol 'Responders' for accredited training (Responders training is delivered via the Workforce Development contract. Ongoing support for Responders is provided by Connections teams)
- Taking part in stakeholder forums
- Responding to local drug and alcohol incidents (working with the DACT to develop a multi-agency planned response. This can involve raising awareness, developing events and initiatives and bringing in or signposting to relevant support services)
- Promoting Northern Ireland's 'Early Warning' system – DAMIS (Drug and Alcohol Monitoring Information System), helping those working in drugs and alcohol services to be aware of changes in drug use or consumption methods, and any potential risks.

Each Connections team generally comprises 2-3 officers and a part-time manager.
They are costed to PHA at £120,000 p.a. each.

An additional £23,000 is usually ring-fenced to support the Connections initiative, covering costs of a dedicated website, printed drug and alcohol information resources, etc.

There has been no formal evaluation of the service, however, each team submits quarterly narrative reports on their activity and an end of year summary. An evaluation of the Drug & Alcohol 'Responders' initiative was completed early in 2020, using a qualitative approach, and indicating that Responders training is filling an evident gap .

Generally, there appears to be a high level of involvement of PHA in this initiative compared to other drugs and alcohol contracts. PHA staff has an active role in their local Connections team's work, and a PHA Manager oversees regional initiatives and coordinates a regional steering group.

Since inception in 2015, there has been variation between team approaches and some conflict between the teams. There have been difficulties agreeing consistency between teams and, in some cases, it has not been possible to gain agreement. During 2020 the teams have been working more closely across geographies and across host organisations, achieving more consistency in their work and less conflict.

Services have a range of targets to meet, usually expressed as a minimum annual 'output', allowing flexibility over and above those minimum numbers to respond to local emerging issues and opportunities.

D&A Evidence Scoping Template

Targets include:

- Deliver at least 40 Awareness sessions reaching a total of at least 400 participants.
- Support and promote at least 2 regional alcohol events/initiatives.
- Support and promote at least 2 alcohol events/initiatives in response to local concerns.
- Support and promote at least 1 regional drugs event/initiative.
- Support and promote at least 1 drugs event/initiative in response to local needs/concerns.
- Maintain a database of local stakeholder contacts.
- Coordinate and host meetings of a Service Providers Network.

All services have reached their targets, and in most cases surpassed them in 2018/19. The volume of outputs delivered varies noticeably between localities - it is not clear whether this is down to legitimate differences in need between localities, or down to inconsistency in defining and counting the outputs.

	exceeded		met		not met

	Number of awareness raising sessions		**Number of attendees at awareness raising sessions**	
	Target	**2018/19**	**Target**	**2018/19**
Belfast	40	57	400	619
SE	40	40	400	528
North	40	75	400	2729
South	40	101	400	2452
West	40	45	400	420

Alcohol	**No of regional events/ initiatives supported & promoted**		**No of events/ initiatives to local concerns supported & promoted**	
	Target	**2018/19**	**Target**	**2018/19**
Belfast	2	4	2	17
SE	2	2	2	6
North	2	5	2	8
South	2	4	2	4
West	2	3	2	5

Drugs	**No of regional events/ initiatives supported & promoted**		**No of events/ initiatives to local concerns supported & promoted**	
	Target	**2018/19**	**Target**	**2018/19**
Belfast	1	4	1	58
SE	1	2	1	4
North	1	2	1	1
South	1	1	1	-
West	1	3	1	3

Overview of main areas from commissioning framework previous evidence review

DACTS were specifically required (as laid out in the New Strategic Direction On Alcohol and Drugs 2011-2016) to put in place a community support service.

Commissioning priorities within the subsequent Alcohol and Drug Commissioning Framework 2013-16 (https://www.publichealth.hscni.net/sites/default/files/Drug%20and%20Alcohol%20Commissioning%20Framework%20Consultation%20Document.pdf) were primarily based upon two documents:

- European action plan to reduce the harmful use of alcohol 2012–2020: WHO 2012 http://www.euro.who.int/__data/assets/pdf_file/0006/147732/RC61_wd13E_Alcohol_111372_ver2012.pdf
- Exploring community responses to drugs: Joseph Rowntree Foundation http://www.jrf.org.uk/sites/files/jrf/1859352685.pdf

In the Commissioning Framework Consultation document there were sections on Education and Prevention in both the Children, Young People and Families section as well as the Adults and General Public section. It was proposed that one service would be provided to cover all age groups, and the priorities to be combined.

Despite there being very little evidence of the effectiveness of community interventions, the proposed commissioning priorities included:

1. Regional Commissioning Priorities

- Public education initiatives on alcohol and drugs (including prescription medication), concentrating on the following areas;
    - Providing information about the risks of alcohol/drugs and the availability of help and treatment to reduce harmful use;
    - Supporting existing and new alcohol/drug policy measures;
    - Providing access to web-based information and self-help programmes.
    - Public support should be mobilised for current and new government legislation which reduces alcohol and drug related harm.

2. Local Commissioning Priorities

- Ensure that a community support service is in place to deliver Tier 1 services across the Trust/LCG area. This package will include the following components:
    - Delivery of a three year integrated multi-agency education and prevention plan, in communities, workplaces and educational settings, to raise awareness of the impact of drugs and alcohol locally;
    - Evidence-based community mobilisation initiatives which will raise awareness about alcohol related harm and to support policy implementation and change;
    - Local media initiatives to raise awareness and increase acceptability of the interventions provided to address locally identified alcohol-related problems.

There was some direction to regionally relevant information dissemination, namely that NICE (PH24, 2010) noted (but did not review) dissemination of information on alcohol units and related health information stating that these were important measures that needed to be tackled in conjunction with the recommendations on pricing and reducing supply.

Further, a commissioning priority within ‘Capacity’ was to ensure that commissioned alcohol and drugs services would demonstrate effective user involvement.

During the Commissioning Framework consultation in 2013, many respondents had

"commented … that there was too much emphasis given to evidence based practice particularly in the area of prevention and education, much of which originates outside of Europe. The question of applicability to Northern Ireland was raised. It was felt that equal importance should be given to acknowledging good local practice".

The role of the Education sector was discussed, noting room for development.

Based on the findings of the Commissioning Framework consultation, it was recommended that the service would have both a co-ordination and delivery role and that there would be a regional service to support community mobilisation on alcohol and drug issues.

Overview of new evidence base review

Since the development of the original Commissioning Framework (draft), key developments in the evidence base include:

NICE QS 83 Alcohol: preventing harmful use in the community (2015)
https://www.nice.org.uk/guidance/qs83
This focuses on licensing policy and schools and colleges. It recommends that alcohol education is included in the curriculum, and that parents, carers, children and young people are involved in the initiatives to reduce alcohol use, citing examples such as alcohol education and a 'whole school' approach to alcohol (policy, environment, staff development).

Stockings et al., 2018: Whole-of-community interventions to reduce population-level harms arising from alcohol and other drug use: a systematic review and meta-analysis. Addiction, 113, 1984-2018 https://onlinelibrary.wiley.com/doi/10.1111/add.14277
This article indicates a continued lack of evidence that community action impacts on harms from alcohol use, arguing instead that alternative population approaches may have a greater impact on behaviour and be cost-effective, eg. regulation of marketing and physical availability of alcohol.

PHE. Issuing public health alerts about drugs (2016)
https://www.gov.uk/government/publications/issuing-public-health-alerts-about-drugs
(Connections teams already contribute local intelligence to NI's DAMIS system).

EMCDDA (2017). Health and social responses to drug problems
http://www.emcdda.europa.eu/system/files/publications/6343/TI_PUBPDF_TD0117699ENN_PDFWEB_20171009153649.pdf
EMCDDA's arguments support the intention for Connections to support DACTs, highlighting that *"Community based initiatives that deliver a range of co-ordinated interventions through a multi-agency partnership are more effective than single interventions"* but notes the impact of same is focused upon the community safety aspect of alcohol *misuse "they often combine community mobilisation, staff training and enforcement and appear to be effective in reducing violence, problem-drinking and street accidents"*.

EMCDDA highlights some specific groups with particular vulnerability associated with substance misuse

- migrant groups, who are at risk of social exclusion and vulnerable to drug problems
- young offenders, youth out of school or at risk of dropping out, youth with academic and social problems, homeless youth, youth in care institutions, youth from marginalised ethnic groups and vulnerable families
- socially disadvantaged young people and young people with family members and peers who use drugs.

It reinforces the position that interventions that only provide information about the risks of

drug use have not been found to be effective in preventing drug use.

It argues that evidence-based *selective* and *indicated* prevention approaches targeting substance use among vulnerable young people should be provided rather than only awareness-raising and informational approaches. Go-approaches (approaching the target group at home or on the street) are more appropriate than come-approaches (where people are expected to show up to services).

Workplace health initiatives are discussed, with the potential to help address alcohol and drugs issues, preferably as part of a wider health promotion programme.

EMCDDA highlights schools *"as an important setting for early identification of at-risk individuals. Interventions need to address the wider determinants of risky and impulse behaviour rather than the drug use in isolation"*.

EMCDDA describe Community Coalitions as arrangements that coordinate activities and resources to prevent adolescent substance use and delinquent behaviour. They can bring together diverse community stakeholders to address a common goal and mobilise communities to participate in prevention and health promotion initiatives.

EMCDDA features the 'Communities That Care' (CTC) approach, based on the premise that the prevalence of adolescent health and behaviour problems in a community can be reduced by identifying strong risk factors and weak protective factors among young people within that community. This then allows the selection of tested and effective prevention and early intervention programmes to address these specific risk and protective factors. Preliminary evaluations of the CTC point to a need to adapt the organisation of the programme. Research gaps include that the impact of different implementation contexts needs to be assessed systematically across multiple sites and countries.

EMCDDA argues that community drug plans are an important mechanism for translating national strategies into appropriate responses to meet local needs. The level at which these are developed depends on administrative structures and responsibilities. Involving people who use drugs and local communities in consultation processes ensures that plans are better informed by the local situation. It also can help reduce stigma towards drug users and promote understanding between different community members.

Any identified gaps

There is an ongoing lack of evidence in this area of work.

A specific gap in evidence is noted above regarding the Communities That Care approach.

Future approach to reflect the evidence base and changing context

The literature continues to point towards the importance of policy, regulation, and restriction. There is limited potential for the existing Connections model to contribute towards this aspect proactively, however, the role for Connections to *support policy change* would remain.

The development of NI Alcohol and Drugs Alliance has increased the potential for the community and voluntary drug and alcohol sector to lobby for policy change.

The proposed revised function of PHA Health Improvement including 'Influence' and 'agenda-setting' potentially allows for improved PHA contribution towards the policy,

regulation and restriction agenda/s.

The literature does not point to a drug and alcohol specific model for prevention and early intervention. It may be questionable to expect that a drug and alcohol specific approach to prevention and early intervention can address substance misuse separately from other factors and determinants that affect our communities.

There is significant work underway through the DH-sponsored Community Development Transformation Implementation Group, aiming to increase community capacity to address health inequalities.

A key question is whether there is potential for the intended improved capacity among community leaders and local groups to take on any or all drug and alcohol prevention and early intervention functions. This would increase the role of community level organisations as the drug and alcohol prevention and early intervention 'workforce'.

As highlighted by EMCDDA, drug action plans require the involvement of people who use drugs and local communities in consultation processes to ensure that plans are informed by the local situation and to reduce stigma towards drug users and promote understanding between different community members.

The PHA could therefore consider a model where *more local* community-level organisations are supported, and potentially resourced, to be able to deliver drug and alcohol prevention functions more independently than the current Connections model drives.

To maintain a level of 'quality assurance' and to promote consistency where appropriate, initiatives would likely need to be centrally resourced and coordinated, with regular input from a specialist/team.

It could be argued that the current Connections model, with Regional Steering Group chaired and attended by PHA, is already trying to achieve this. However, variation and conflict between the current Connections teams questions whether five separate teams is the best way to provide coordination and resourcing to communities.

There is room for improved efficiency and an improved relationship between the Connections initiative and the PHA PR and public communications function. It could be argued that Connections communications are already resourced through funded contracts, but then require PHA Communications support 'in kind', with a resultant compromise of PR, materials and resources that are neither 'PHA' nor truly 'Connections'. It may be beneficial to include a professional PR and public information role delivered through the Connections initiative in any future contract.

The literature points towards the role of Education and educational settings. More recent development of joint work between PHA and Education, eg Emotional Wellbeing Framework, may pave the way for improved working in this setting. The current Connections model may or may not 'fit' with any anticipated developments here.

Community Planning has been a relatively recent development. The current Trust/DACT based geography of Connections is not an ideal fit for planning and delivery within council geographies.

Given the relationship between drugs and alcohol and mental health, and the similarities in recommended prevention practice in these two areas of health, there is the potential to allow PHA and partners to work better across them.

Indeed the original Commissioning Framework (draft) highlighted that *"Part of the challenge*

will however be to examine how to improve the current delivery of services and also to look at other cross cutting issues such as mental health and encouraging other stakeholders to see the reduction of drug and alcohol related harm as a key part of their work. These challenges are reflected in the "Transforming Your Care" agenda".

Recommendations – When developing any future model:

- Consider geography/ies carefully to take account of Community Planning.
- Consider whether to 'lot' any contract, taking into account unresolved tensions between providers.
- Consider and resource adequately the role of PHA (Health Improvement and others).
- Consider PHA Communications taking a lead role in drugs and alcohol public information resources and PR that has been undertaken by Connections to date and/or
- Consider contracting a professional PR and public information role.
- Consider the ongoing need to support policy change (potentially delivered through the suggested PR role).
- Consider the developing context with Education and the potential to work better together.
- Consider a joint approach to prevention and early intervention with mental health.
- Consider a joint approach with other risk-taking behaviours, eg. sexual health.
- Consider further the potential role of a wider range of community level organisations as the prevention and early intervention 'workforce', with more regionally-coordinated direct support and resourcing.
- Consider Drug & Alcohol prevention within models proposed within the Transformation Community Development agenda.