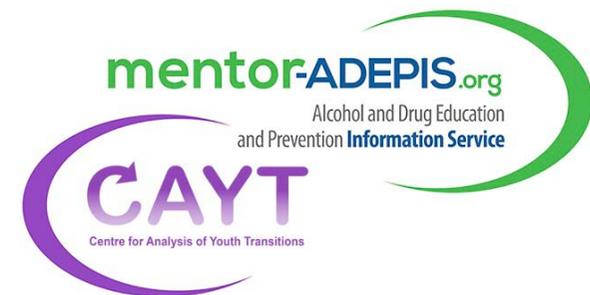


# Ecosystems of prevention: building local practice networks

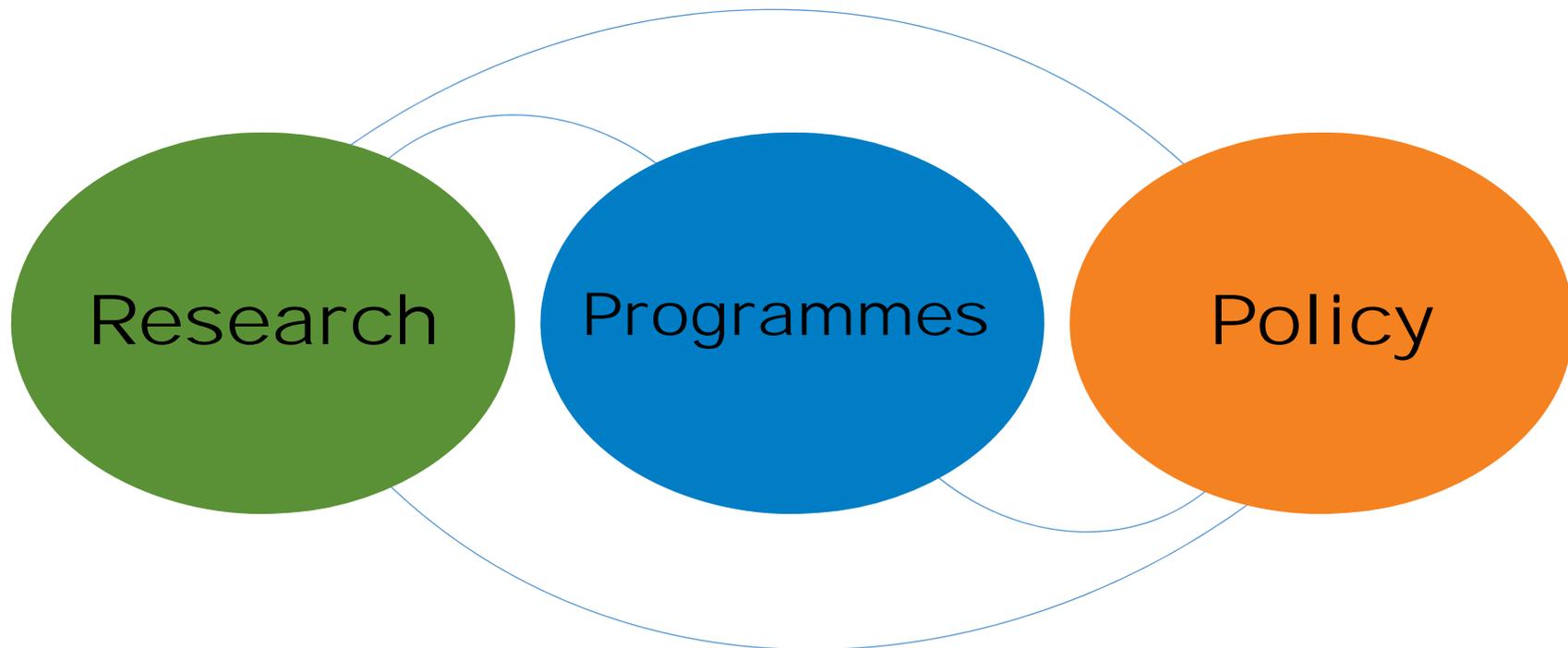
A case study: Mentor UK and  
Brighton & Hove City Council

@Mentortweets | @MentorADEPIS | @IanA\_Mac



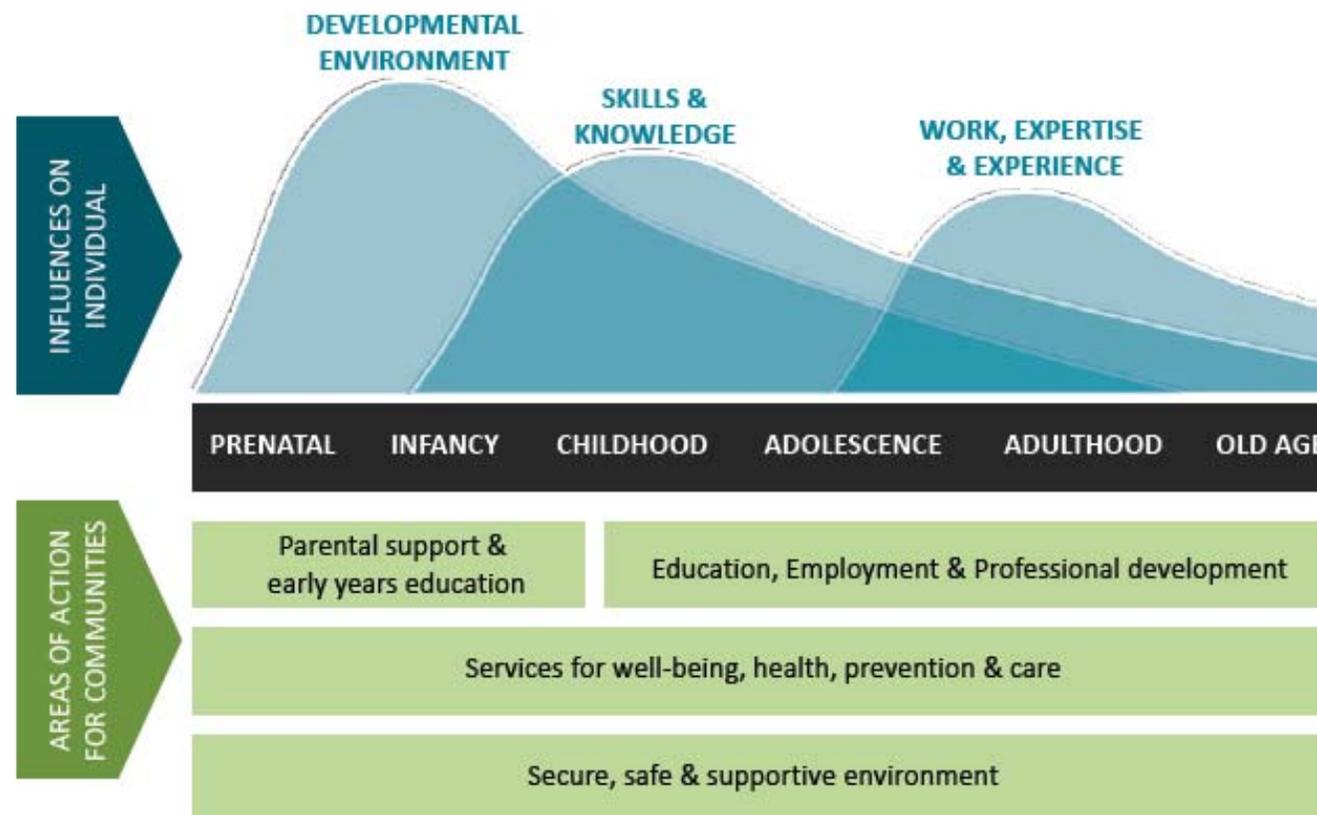
# Who we are

Mentor is the **UK prevention charity** working to protect young people from the harms of drug and alcohol misuse through evidence based practice



# Our approach

A **holistic**, **life-course**, **systemic** approach to prevention:



CMO annual report: 2011 'On the state of the public's health'

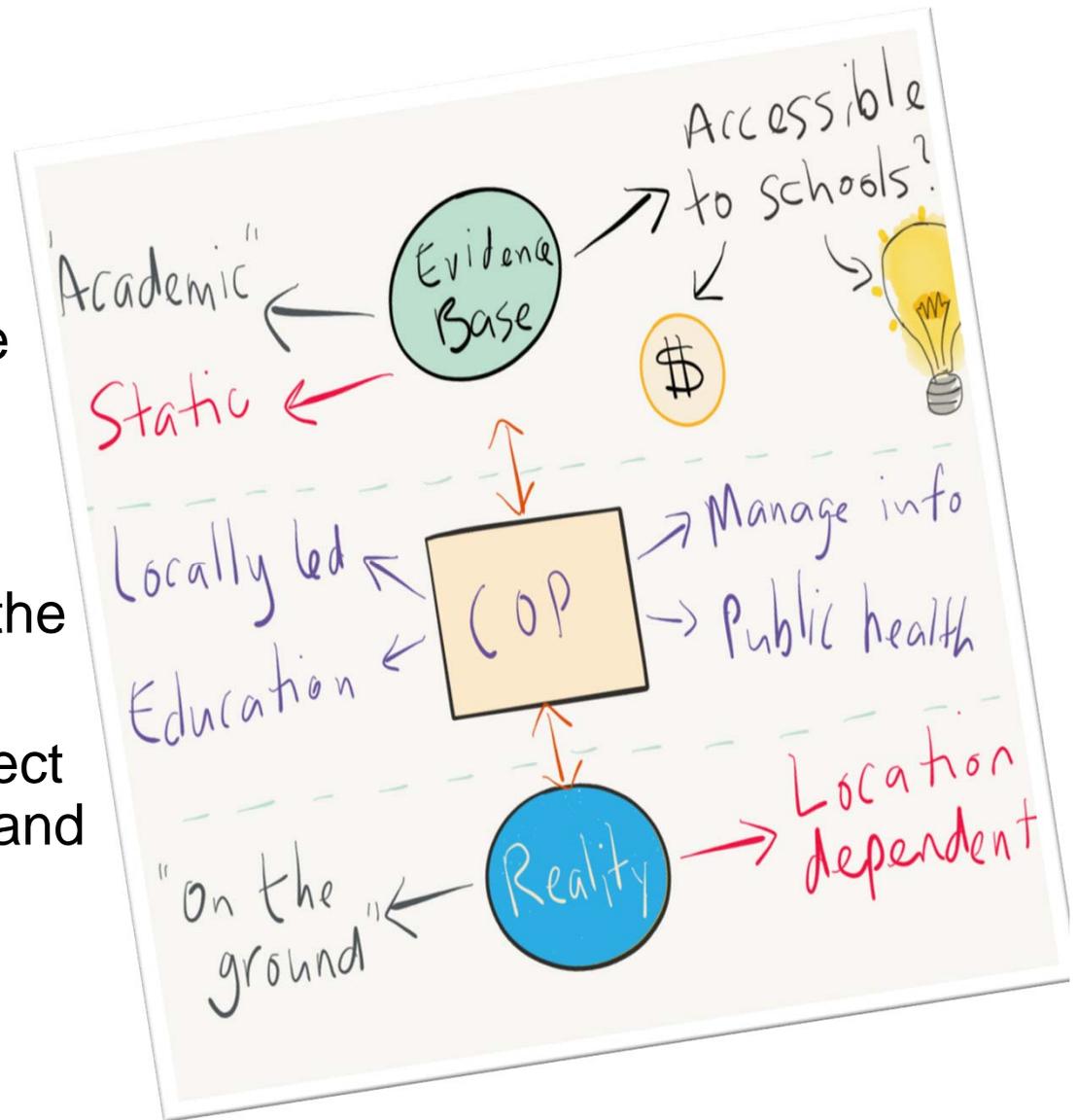
Developing **life skills** that build **resilience** to risk.

# Outline

- The evidence base in prevention
- Identifying the need – Brighton & Hove
- The reality – experiences of the local system
- Making the link between local reality and evidence based practice
- Outputs – shaping policy, advocacy and sustainability
- Exploring replicability

# Implementing the evidence base

- Big gaps between evidence base and reality 'on the ground'
- Developing communities of practice (COP) can bridge the gaps
- Need to be localised to reflect variations in local systems and needs



# Setting the scene

- Universal alcohol and drug education in England is delivered within personal, social, health (& economic) education – PSHE
- PSHE is a non-statutory subject
- BUT gaining increasing support
- Management of schools undergoing big changes
- Changing levers for public health delivery in schools

# Identifying the need: Brighton and Hove

- Brighton & Hove is a unitary local authority on the south coast of England
- Population of 273,000; 16% under 16 (Census, 2011)
- Has a strong and diverse cultural history, hosting vibrant LGBTQ communities
- In the absence of statutory PSHE, local schools deliver alcohol and drug education in a variety of ways with inconsistent outcomes for pupils
- High percentage of under 18 alcohol admissions, smoking, being drunk in the last month, taking cannabis in the last month

# Under 18 alcohol admissions

Area	Value	Lower CI	Upper CI
England	36.6	36.0	37.3
South East region	34.5	32.9	36.0
Bracknell Forest	10.9	5.0	20.8
Brighton and Hove	60.0	48.3	73.7
Buckinghamshire	19.5	15.2	24.7
East Sussex	44.4	37.4	52.5
Hampshire	35.9	32.0	40.2
Isle of Wight	81.6	62.7	104.4
Kent	33.5	30.0	37.3
Medway	26.4	19.5	34.9
Milton Keynes	15.6	10.5	22.3
Oxfordshire	40.9	35.0	47.5
Portsmouth	37.3	27.5	49.5
Reading	13.3	7.3	22.3
Slough	18.8	11.8	28.4
Southampton	78.0	64.3	93.9
Surrey	35.7	31.6	40.2
West Berkshire	23.4	15.1	34.5
West Sussex	32.6	27.8	38.0
Windsor and Maidenhead	23.1	14.7	34.7
Wokingham	20.1	12.6	30.5

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

## Percentage of current smokers

Area	Value		Lower CI	Upper CI
<b>England</b>	8.2		8.1	8.3
Fifth more deprived decile (IMD2015)	-		-	-
Brighton and Hove	14.9		12.9	16.9
Calderdale	9.9		8.2	11.6
Camden	7.1		5.1	9.1
Cornwall	11.7*		9.7	13.7
Croydon	7.2		5.7	8.7
Darlington	9.0		7.2	10.8
Ealing	5.4		4.1	6.7
Hammersmith and Fulham	4.6		2.5	6.7
Isle of Wight	11.2		9.3	13.1
Kensington and Chelsea	5.3		2.3	8.3
Kirklees	7.8		6.2	9.4
Southend-on-Sea	9.9		8.1	11.7
Stockton-on-Tees	6.8		5.3	8.3
Telford and Wrekin	6.0		4.6	7.4
Wigan	7.1		5.5	8.7

Source: What About YOUTH (WAY) survey, 2014/15

## Percentage who have been drunk in last 4 weeks

Area	Value		Lower CI	Upper CI
<b>England</b>	14.6		14.4	14.8
Fifth more deprived decile (IMD2015)	-		-	-
Brighton and Hove	27.0		24.5	29.5
Calderdale	17.8		15.6	19.9
Camden	10.0		7.5	12.5
Cornwall	22.1*		19.6	24.6
Croydon	8.2		6.7	9.7
Darlington	23.4		20.7	26.1
Ealing	7.2		5.7	8.7
Hammersmith and Fulham	5.3		3.3	7.3
Isle of Wight	17.8		15.5	20.1
Kensington and Chelsea	7.4		4.1	10.8
Kirklees	14.6		12.6	16.6
Southend-on-Sea	17.8		15.5	20.1
Stockton-on-Tees	17.9		15.6	20.2
Telford and Wrekin	9.5		7.9	11.2
Wigan	18.1		15.7	20.5

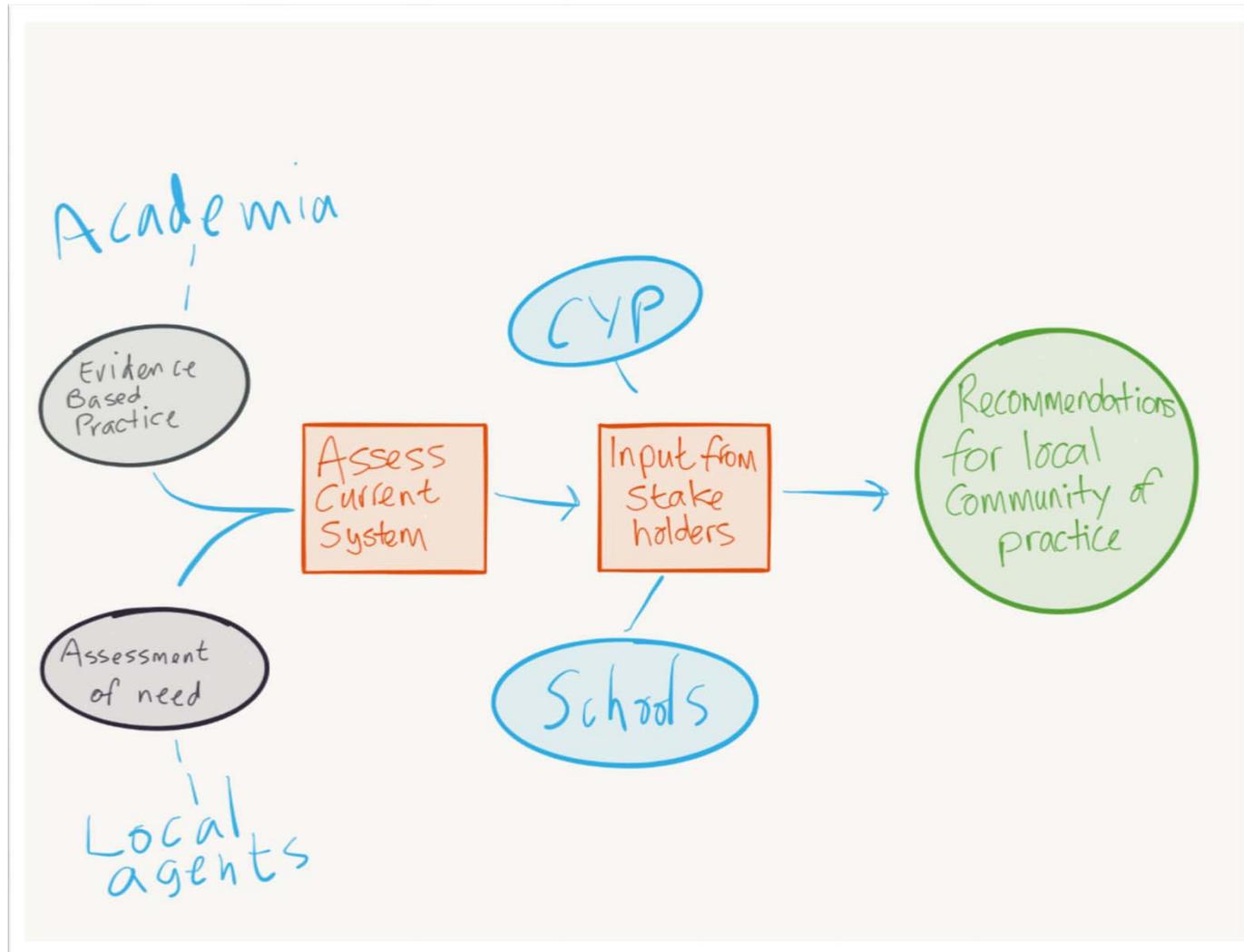
Source: What About YOUTH (WAY) survey 2014/15

## Percentage who have taken cannabis in last month

Area	Value	Lower CI	Upper CI
England	4.6	4.5	4.8
Fifth more deprived decile (IMD2015)	-	-	-
Brighton and Hove	14.4	12.3	16.4
Calderdale	4.2	3.0	5.3
Camden	7.0	4.7	9.3
Cornwall	7.5*	5.9	9.1
Croydon	4.4	3.2	5.6
Darlington	2.7	1.7	3.8
Ealing	3.7	2.6	4.8
Hammersmith and Fulham	4.0	2.2	5.8
Isle of Wight	6.0	4.5	7.5
Kensington and Chelsea	4.6	1.6	7.6
Kirklees	4.1	3.0	5.2
Southend-on-Sea	6.0	4.6	7.5
Stockton-on-Tees	4.2	3.0	5.5
Telford and Wrekin	1.8	1.0	2.6
Wigan	2.9	1.8	4.1

Source: What About YOUTH (WAY) survey 2014/15

# Making the link – planning



# Making the link – what we did

## Whole system

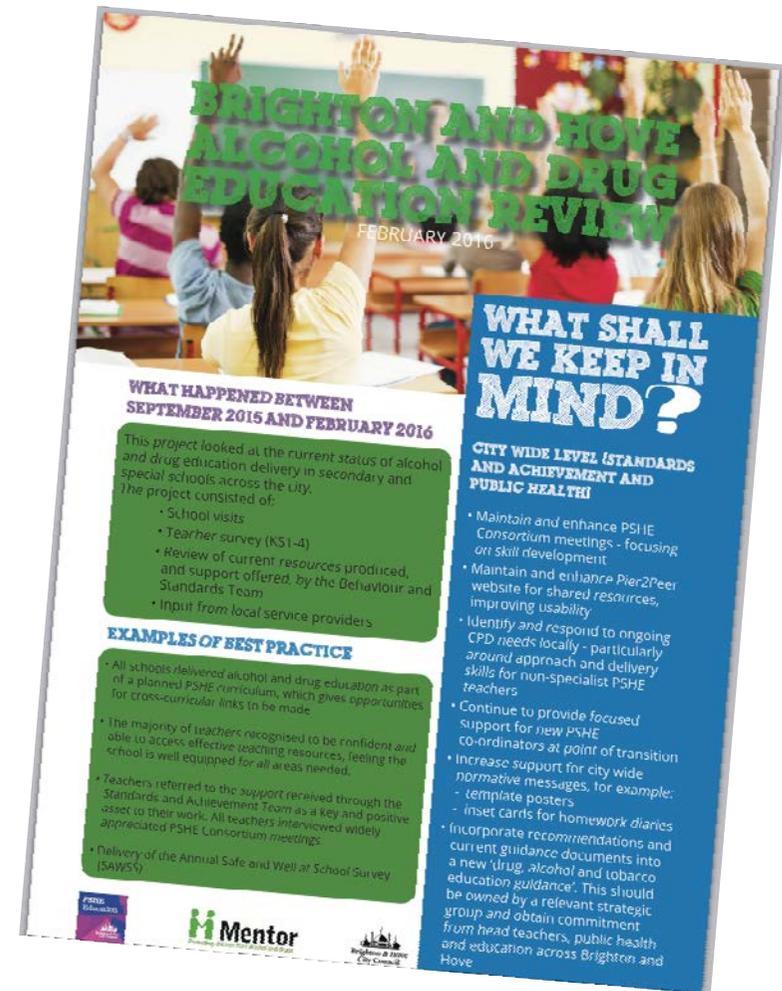
- Appraisal of local support documents
- Staff survey on current provision and gaps
- Pupil focus groups on current provision
- Consultation with key partners

## Curriculum

- Support for 'PSHE' networks
- Advice on suggested learning outcomes for alcohol and drug education
- Focused interviews with PSHE leads and teachers
- 'Learning walks' to ascertain gaps in delivery styles

# Outputs - shaping policy

- Comprehensive report on all activities with themed recommendations for different levels of the local system
- Accessible summaries for partners, teachers and pupils
- Interviews with beneficiaries – pupils and those delivering Alcohol and drug education
- Increased fidelity of approach and outputs



# Outputs – impacting the system sustainably

- Development of new drug and alcohol education policy for schools
- Feeding back outcomes directly to PSHE leads, headteachers and partners through local conference and infographics
- Delivery of training to pastoral teams on YP and substance use, including 'Train the Trainer' sessions for local staff
- Enhancing links between schools and commissioned specialist service
- Support area-wide normative campaigns on tobacco, alcohol and cannabis

**87% of under 15s across  
Brighton & Hove do not smoke**



**You don't need to smoke to be popular**



**Brighton & Hove  
City Council**

**Brighton & Hove  
City Council**

# Integrated System

@lana\_mac

In Schools?

Minimised Risk!

PSHE Life skills  
Social norms  
Needs led  
CPD

Group Work  
↑ needs  
Harm Reduction

1-1  
Structured

→ detox

Whole School Approach

Universal

Teaching teams  
School nurses  
Youth workers

Targeted

Specialist

Specialist services

# Training for school pastoral teams

School identifier	How confident do you feel in responding to pupil questions around substance use?	How confident do you feel in responding to a drug related incident in school?
School 1 (n=12)	2	2.3
School 2 (n=13)	0.8	0.7
School 3 (n=17)	1.1	1.6

- All participants were asked pre and post questions on their confidence in dealing with drug related issues in schools. Self reporting was on a scale of 1 – 6 ('not at all confident' to 'very confident').
- The scores above represent average increases across each cohort
- Referrals to the local support service from these schools is being tracked to evaluate impact on referrals

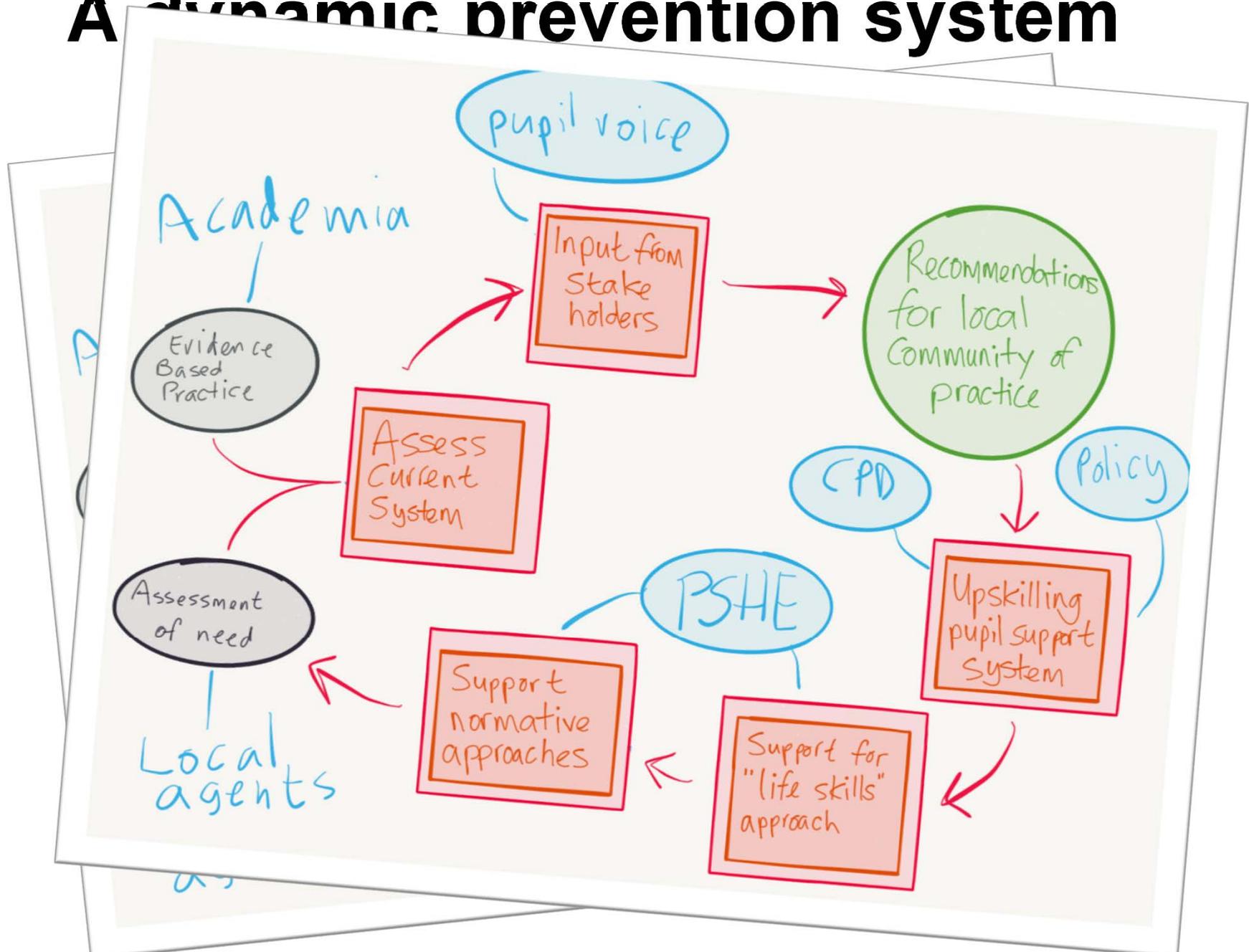
# Outputs – measuring impact

- Pupil survey and public health outcomes data tracking trends in perceptions and self reported behaviours around substance use (ongoing)
- Referral rates from schools to local specialist services (planned)
- PSHE assessment activities (planned)
- Measurement against schools who didn't take part

# Staff survey responses

- 100% responding schools changing their provision in line with recommendations
- 100% responding schools adopting a life skills approach to their alcohol and drug education
- 67% improved their knowledge around delivery models and practice
- Concerns still shown about 'fitting everything else in', and maintaining lesson time

# A dynamic prevention system



# Exploring replicability

## Challenges

1. Differing relationships between health and education depts across areas
2. Differing proportions of academy schools impacting local influence
3. Absence of funding to impact universal AND specialist services
4. Variations in PSHE delivery

## Solutions

1. Flexible approach bespoke to best fit local system
2. Support health teams to engage schools through statutory responsibilities
3. Impacting whole school approaches to engage specialist services
4. Raising profile of PSHE

# Reflections - positives

- Ensured joined up delivery model and engagement of headteachers, service leads and commissioners
- High engagement with schools in PSHE networks and annual pupil survey to ensure future delivery is based on identified need
- Local community of practice
- High value placed by pupils and staff on life skills

**Slide 23**

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**Gu1**

Could we include a slide with key challenges and lessons learned from the challenges?

Guest, 20/09/2016

# Reflections - learning

- Strong links between education and public health services essential – 'community of practice'
- Accessing training for non-specialist teachers still an issue – raised by staff and pupils
- Local funding decisions impact on replicability
- Pupil voice essential in shaping delivery
- Universal v targeted activity (inc harm reduction)
- Recent high profile of mental health and sex education restricting space for drug education to operate

# Reflections – further developments

- Enhancing communication with schools and targeted services to improve quality of referrals via education routes
- Continuing CPD programmes for pastoral staff
- Explore use of new Mentor UK quality marks for schools and services to enhance quality of delivery
- Extension into other areas of PSHE and risk taking behaviour – local COP now focusing on wider emotional health and wellbeing (via Charlie Waller Memorial Trust)

# Some brief questions...

1. Considering your local reality and referring to the diagram shown in the presentation, discuss the following:
  - a. Is a similar model already in place in your area?
  - b. What would be the challenges to implementing such a model?
  - c. Who would be the key agent(s) involved?
  
2. Reflecting on the links between evidence and practice:
  - a. Adapting to changing needs and realities at local areas (life skills)
  - b. Making evidence more accessible for practitioners – targeted messaging,

3. Thinking of the scalability and transferability of this model, and taking into account what was previously addressed, discuss and suggest three key standards for implementation of a similar model in different areas

# Thank you & stay connected

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