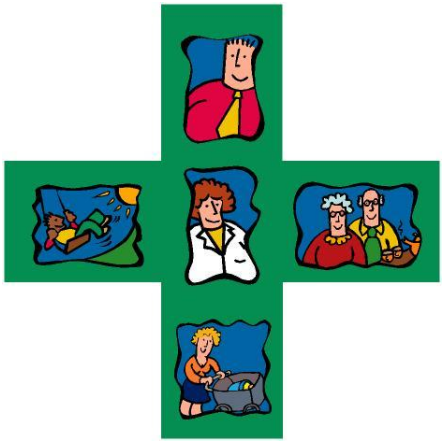
Building the Community-Pharmacy Partnership

Impact summary



COMMUNITY DEVELOPMENT AND HEALTH NETWORK

Contents

1 Introduction

The Building the Community-Pharmacy Partnership is a partnership between the Community Development and Health Network (CDHN) and the Health and Social Care Board (HSCB), with strategic direction provided by a multi-agency Steering Group and funding provided by the HSCB. The BCPP Programme has been operational for over 10 years and is managed by CDHN. Currently, approximately £1/3m per year is allocated to successful BCPP projects from across Northern Ireland.

CDHN is a member led regional voluntary organisation whose purpose is to make a significant contribution to ending health inequalities, using a community development approach.

This paper provides an overview of BCPP; how it operates; rationale for the approach taken and outputs and outcomes emerging from one year's worth of funding to BCPP projects.

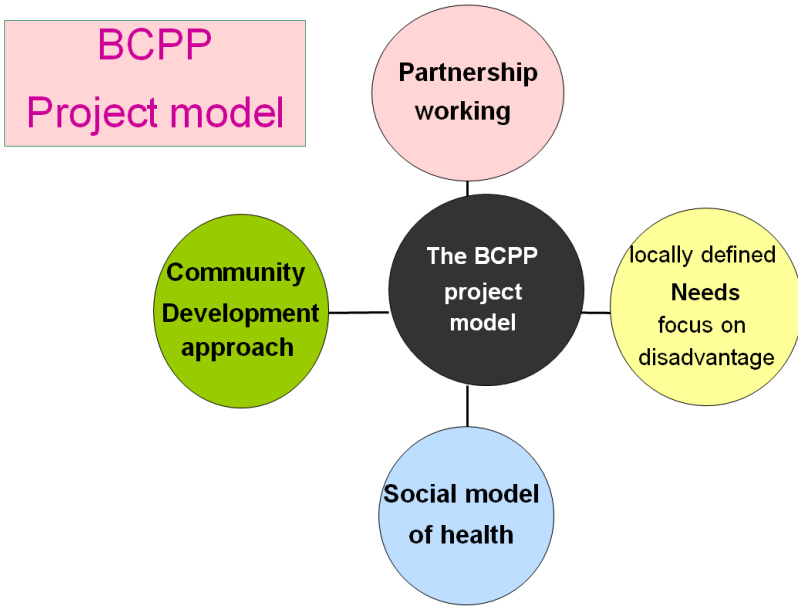
2 How BCPP operates

Over the last decade, a wide range of BCPP initiatives have emerged addressing a great diversity of issues. BCPP has worked with women's groups, early years programmes, people with addictions, older people's groups and mental health programmes, among many others. Projects are mainly level 2 BCPP projects, which receive a max £10,000. Level 1s are offered £2000 max per project and Level 3s receive a max £30,000 over 3 years.

Generally within the BCPP Programme, projects are supported to focus on working with core groups ie people that engage in the project over several sessions. This is to enable BCPP to measure and evidence the impact being made on participants over a period of time. This is also in recognition of the importance of community development being a core aspect of projects, which in itself requires a long term commitment to change. Many of the core groups target 12-15 people. Some projects may also offer some sessions/events to a wider community group. One to one support from pharmacists and other partner organisations is also key to BCPP projects, allowing people to follow up on concerns, ask for advice and be signposted and referred to other services.

The additional support offered by CDHN through the BCPP Programme has had a very positive impact. The focus has and continues to remain on supporting BCPP partners, locally and regionally, understand and utilise a community development approach as a core process that will bring about positive health outcomes. CDHN has provided training, education, facilitation and networking to enable local partnerships to form, develop and address locally defined needs. This has included training on group work, finance, evaluation, defining local needs – understanding health, determinants of health and health inequalities, understanding communities, and partnership working. This support is offered from before applicants apply, to the end of their project, on a group and individually tailored basis. BCPP projects have also benefited from CDHN membership by being able to access the Pathways to Health training programme and other membership support services. More recently BCPP has been fortunate in being able to link with and provide input to the undergraduate pharmacy programme in QUB and UU.

In summary a BCPP project focuses on the following key components with an emphasis on co-design, co-planning, co-funded, co-delivery and co-evaluation:



Key to success has been providing the environment and support to enable partnerships to form and develop. BCPP have balanced the following framework, allowing the Programme to focus on community development principles and partnership working to tackle locally identified health inequalities. The BCPP programme is:

- **centrally co-ordinated with local ownership**
- **driven from the bottom up and responsive to local needs**
- **support intensive, guaranteeing local community involvement**
- **has senior strategic involvement with clear links to policy and alignment to pharmacy**

3 The Approach

The following sets out the evidence as to why a community development approach is and should remain core to the commissioning and delivery of the Building the Community-Pharmacy Partnership as a successful means of bringing about positive health outcomes, particularly in relation to tackling health inequalities at a local and regional level.

Health Inequalities

It is a well-known fact that in N Ireland, health inequalities are generally most experienced in deprived areas.

'indicators such as hospital admissions for drug related mental health and behavioural disorders and drug related mortality showed similar inequality gaps with rates in deprived areas for both more than double the regional figure (138% and

123% higher respectively). This was also broadly true for alcohol related hospital admissions (130%) and alcohol related mortality (124%) as well as self-harm admissions (116%) and suicide (82%). Other sizeable gaps exist for teenage births (93%), smoking during pregnancy (73%) and respiratory mortality (72%)' (DHSSPS, 2012, 4th bulletin).

Impact and Causes

Additional evidence provided over the last 30 years, including The Black Report (Davidson and Townsend, 1982) and The Acheson Inquiry (Acheson, 1998) also demonstrated a growing health inequalities gap. From an economic, commissioning and service delivery perspective, Morrisey (2006) also points to an inequality where the top socio-economic groups make better, more informed choices regarding their use of the NHS and receive 40% more NHS expenditure per person reporting illness than the bottom line, reinforcing the inequality. This is in line with the thinking of Hart (1971), with regards to The Inverse Care Law. Wilkinson and Pickett (2009) also found that globally, even within countries with a relatively high average GDP, inequality can have a marked impact on the wellbeing and economy of the whole population and not just those most deprived.

What causes health inequalities? Slater and Knowles (2008) consider health inequalities to have social roots and are caused by the unequal distribution of the social determinants of health.

Impact on lifestyle

There is much evidence to indicate there are seven individual-level factors responsible for about 60% of the burden of disease: high blood pressure, tobacco use, harmful use of alcohol, high serum cholesterol, being overweight, unhealthy diet and insufficient physical activity (WHO, 2009). However, the WHO has increasingly indicated that mental health, in the next few years, will become one of top two factors that will contribute to the burden of disease.

In response to addressing this burden, there continues to be a focus on reducing these lifestyle-related risk factors by an approach that emphasises informing people about the negative effects on health of different risk factors, so that they are motivated to change their lifestyle and make healthier choices. Yet, it needs to be recognised that healthy choices are most likely to be made by motivated people, who generally have higher levels of wellbeing (Thompson and Marks, 2008).

This approach can also fail to take into account that the seven most commonly mentioned individual lifestyle factors are frequently more apparent amongst people with lower educational attainment, occupational status and income, that is, those affected more keenly by the wider determinants and therefore often those less able and motivated to make changes. It could also be argued that those feeling marginalised from society, may make unhealthy choices as a way of coping with stress or difficult living conditions (Marmot and Wilkinson, 2006).

This reinforces the importance of taking into account the social and economic environments in which people live when planning interventions to promote healthier lifestyles (Dahlgren and Whitehead, 2007).

Community Development
One way of addressing these inequalities is through the better engagement of communities through community development. This approach has been beneficial for pharmacies working in their communities.

CDHN would see community development as bringing about change in, and strengthening, communities. It is a way of working which seeks to encourage communities to tackle for themselves the problems which they face and identify to be important; and which empowers them to change things by developing their own skills, knowledge and experience and by working in partnership with other groups and agencies.

As such this 'assets based' approach to community development offers the potential to enhance both quality of life and longevity by focusing on resources that promote self-esteem, resilience and coping skills of individuals and communities (WHO, 2012). This assets based approach would be closely linked to the building of social capital, often summarised in relation to bonding, bridging and linking between people and with groups.

> *Social capital consists of the stock of active connections among people: the trust, mutual understanding, and shared values and behaviours that bind the members of human networks and communities and make co-operative action possible (*Cohen and Prusak, 2001, p4)

Community Development – the contribution to improving health outcomes
Community development actively seeks to interact and change the environment in which people and communities live. This includes seeking to tackle the social determinants such as the social, political, built, natural and economic environment as well as help readdress some of the process and structures which create the inequality. It does not rely on how people live within those environments. As such, this upstream approach to tackling health inequalities and improving health outcomes, does not focus solely on lifestyle issues which can underplay the influence and impact of social structures that is, the factors that often cause poor health.

As is also the case with BCPP, this has particular relevance within disadvantaged areas and groups with community based action being a key way of engaging communities in bringing about a positive change in their health (Slater and Knowles, 2008). The Marmot Review (Department of Health, 2010) also sought to put individuals and communities at the centre of action to address health inequalities. It advocated concentrating on addressing the causes of the causes; combatting social exclusion and poverty, valuing resilience and supporting the role of local people in communities in promoting health and wellbeing and promoting partnership and collaborative inter-sectoral working. Many of these are key values and principles core to community development.

Active engagement on health determinants

The DHSSPS has consistently emphasised community development as having a strong contribution to make to tackling health inequalities.

> a *community's knowledge and experience is essential in order to define need and develop effective approaches using the leadership of local people. It is also important because the active engagement of individuals and communities fosters empowerment and a greater sense of control over decisions. The multi-dimensional nature of inequalities in health demands a comprehensive and systematic approach, including the participation of those who are most marginalised and disadvantaged (DHSSPS, 2004, p3)*.

Transforming your Care, evidenced through the joint HSCB and PHA Community Development Strategy for Health and Wellbeing, also emphasises the importance of wanting

> *'to see strong, resilient communities…* and … *a reduction in inequalities which means addressing the social factors which affect health and wellbeing'*
> (HSCB & PHA, 2011)

Wanless (2002), writing from an economic perspective, also makes the case for stronger community engagement. Wanless (2002) found the UK had fallen behind other countries in relation to health outcomes and over the next 20 years could not afford the increasing costs associated with delivering high quality health care. Wanless (2002) outlined 3 costed scenarios regarding the future health service. Scenario 3 - the ***Fully engaged*** option cost the least yet had the potential to lead to better health outcomes over, what must be emphasised, was a longer period of time. Wanless (2002) also believed this would result in improved health status; people being more confident in the health system; a more efficient use of resources and a more responsive health service. Interestingly, the potential success of Scenario 3 relied partly on a proposed high level of public engagement and a greater focus on addressing the wider (social) determinants of health; an approach advocated by Dahlgren and Whitehead (2007) and the Marmot Review (Department of Health, 2010). This longer term approach and philosophy is a vital component within BCPP.

Working and learning together

In taking an upstream approach and in recognition of the wider health determinants, there is a strong case to be made for commissioners and providers, including pharmacists to not only partner more closely with communities but also to work more widely within health and social care and with other local agencies and services to address the wider determinants eg poverty, education, employment, housing, environment that affect a person's health, well-being, quality of life and ability to make positive lifestyle decisions. This approach would also lead to better and more appropriate signposting, referral and uptake of services and better long term health outcomes for individuals and communities; an approach advocated by BCPP.

4 Evidencing impact

BCPP seeks to apply community development values and principles through their local projects and at a Programme level and to measure the impact of this approach as well as determining how areas of deprivation and disadvantaged groups are being engaged in BCPP. The focus is on evidencing the impact on the following three key outcomes:

1. Improved accessibility and responsiveness regarding engagement in local services, particularly of more disadvantaged groups;
2. Change in use and understanding of pharmacy and associated services
3. Perceived improvements in health and understanding of how to take increased responsibility for health.

The following provides an overview of some of the findings from BCPP projects over one year's worth of funded projects (2011-12). This included 19 Level 1, 34 Level 2 and 1 Level 3 projects. The majority of projects complete within 18 months. As of August 2013, well over 80% of the activity for these BCPP projects was complete.

4i BCPP Results

BCPP projects are asked to provide detail on issues addressed; level of engagement; 1-1 support given, signposting and referral offered; level of engagement of the pharmacist, community/voluntary partners and level and type of involvement of other organisations. In addition, partners were asked to note how participants were referred into the project, and if participants volunteered or took part in additional training. The focus remains on working with and evidencing activity with core groups. Some projects also offer additional 1-off events delivered to the wider community.

<u>Referral into the programme</u>

Many of the BCPP projects work with existing groups or intend to expand the work with existing groups. If the project is not working with an established group then a variety of processes are used to target people and engage them in a new group eg advertising, word of mouth, linking with other groups and organisations. In some cases, participants are directly referred into the programme. The following Table 1 indicates how new participants became involved in projects; demonstrating wider community engagement and social inclusion:

GPs	3
Statutory Agencies	13
Vol/community organisations	270
Pharmacy 1-1s	79
Self-Referral	91
Other health services	62
Total	**518**

Table 1: Referrals of new people into BCPP Projects

Building of skills

Project partners are encouraged to note, as a result of the project, if participants carried out additional volunteering and took part in additional training and also if staff and volunteers received additional training – demonstrating building of skills and self-help, taking ownership and responsibility (Table 2):

Participants received training	136
Volunteers assisting	208
Staff/volunteers, partners receiving training	183

Table 2: Volunteering, additional training engaged in by participants, staff etc

Profile of engagement in core group

Projects record the level of engagement in core groups. BCPP engaging individuals on a more long term, consistent basis is more likely to bring about health benefits and the building of social capital, particularly when working in disadvantaged areas and with vulnerable groups. By core groups, we mean people who have normally engaged in at least 6 sessions and have been a part of that group for the project duration. In relation to this the following indicates a high level of engagement and participation – profiled by gender and age (Table 3). On average each core group participant attends + 7 sessions within each project:

Total	Male	Female	<16	17-25	26-45	46-64	>65
1314*	314 (24%)	1000 (76%)	102 (8%)	126 (10%)	319 (25%)	284 (22%)	449 (35%)

Table 3: Engagement and participation of individuals within groups (* 34 did not specify their age)

Engagement and partner commitment

Within the series of activities planned with core groups, the pharmacist is central to working with the group alongside the community partner and other organisations. This seeks to achieve a number of objectives including: raise awareness of and address health issues and its wider determinants specific to the group; develop work practices and innovative approaches; improve appropriate use and access to pharmacy and other related services, information and advice and promote greater collaborative working and integration. Table 4 summarises the partners' level of commitment and involvement. Table 6 provides examples of other organisations engaged with.

	Total no. sessions	Pharmacy Commitment	Community partner involvement	Other partner involvement
Sessions	901	589	813	518
Hours	+2000	+1300	+1800	+1100

Table 4: Commitment by pharmacist, community and work with other organisations

Issues addressed

Within projects, issues are identified by the groups that they would like to address and are important to them. Whilst issues are specific to groups eg by population group, chronic conditions, lifestyle etc; common issues have emerged and whilst reflecting and responding to locally identified needs, also reflect current regional issues. Table 5 provides examples of common issues covered:

Drug and alcohol use	Arthritis, osteoporosis	Smoking
Blood pressure	Mental health including depression, anxiety, managing stress, sleep	Diabetes
Children's ailments	Exercise eg walking, Tai Chi. yoga	Heart Health
Minor ailments	Women's health	cholesterol
Dementia, memory loss	Weight management, obesity	Sexual health
Pain management	Understanding pharmacist's role	Skin care
Cancer	Complementary therapies	First Aid
Dental health	Dietary, nutrition, healthy eating	Hygiene
Medicines – review, compliance, side effects, OTCs		
Wider issues… housing, debt, isolation, childcare, relationships, personal safety, food growing etc		

Table 5: Examples of common issues covered

Partnership working

In response to identified health issues and in recognition of the need to tackle wider determinants impacting on health; the pharmacist and community partner have been encouraged to broaden their partnership, signposting and referral network that will support participants improve and manage their health. These other organisations (examples in Table 6) are mainly involved in a co-facilitation role and extend from other health providers to others addressing issues regarding safety, debt etc. Their level of commitment was previously outlined in Table 4.

Cancer Charities eg Action Cancer	craft/Story telling/gardening	Arthritis Care
Drug & alcohol Programmes eg FASA, ASCERT	Benefits Advisor – CAB, CAP	Women's Aid
Dietician/nutritionist including Cook-IT, Chef etc	Red Cross, St John's	NIHE
Complementary therapist eg aromatherapist, reflexologist	Alzheimer's Society	Diabetes UK
Mental Health – eg Aware Defeat Depression/PRAXIS/PIPs, WAVE	PSNI, FSNI, Home Accident Prevention	Beauty Therapist
Chest, Heart & Stroke, Heart Start	Action on Hearing loss	WEA / WRDA
Active Community Coaches/ fitness/tai chi/yoga/walking/outdoor pursuits etc		
HSCT – Health Visitor, Occupational Therapist, Oral Health, Physiotherapist, Podiatrist, Wellbeing teams, Dietician, GUM Clinic, Asthma nurse etc		

Table 6: Examples of other organisations partnered with

1-1 support, advice, signposting and referral

The focus within projects is based on utilising community development values and principles through mainly a group work approach. In addition, participants are also given the opportunity and space to access 1-1 support for individual issues. This support can include an element of signposting and referral to one or more organisations. Issues reflect those mentioned in Table 5. The following Table 7 and 8 summarises the 1-1 support recorded and any resulting signposting or referral from all the partners involved but particularly the pharmacist and community partner. Note, Level 1s do not have to report on 1-1 support given but it is evident the pharmacist especially would offer this type of support on a consistent basis. 1-1s are particularly important with regards to providing support to those more in need, particularly, the more disadvantaged and vulnerable groups and individuals. This can address issues such as not accessing services or not accessing them appropriately; improve responsiveness regarding engagement in local services; reducing inequality; and promoting inclusion.

Total	Male	Female	<16	17-25	26-45	46-64	>65
992*+ **	170	653	24	120	328	204	125

Table 7: Profile by gender and age of those accessing 1-1 support
*169 of these did not specify gender; ** 191 did not specify age

To highlight a few key points

- Across all the 1-1s support recorded, 309 people were advised, signposted/referred to pharmacy services.

- 566 of the 1-1s were delivered by the pharmacist. Within these pharmacy 1-1s, the pharmacist advised/signposted/referred people onto other pharmacy services on 236 occasions ie they dealt with the issues themselves and 173 were advised/signposted or referred onto their GP.

- The lead community and voluntary group partner offered 1-1 support to 293 people. Of these, 60 were advised/signposted/referred to pharmacy services, 62 were advised/signposted/referred to a GP and over 60 were advised/signposted/referred onto voluntary/community groups.

A wide range of issues was addressed by the pharmacist and, were reflective, in the main on issues identified in Table 5. The most common issues included mental health (including depression, anxiety, use of anti-depressants), medication use, blood pressure and cholesterol, smoking, diet, diabetes, STIs, weight management etc. Issues less common extended to fungal nail infection, anorexia, incontinence, migraine, fibromyalgia and GP registration. Support offered by the partners and facilitators also extended to issues regarding isolation, bankruptcy, parenting, housing etc.

Total	**844**
GPs	281
Other health services	77
Pharmacy 1-1	309
Statutory agencies	27
Training organisations	23
Voluntary/community	121
Self-referral	6

Table 8: Total numbers advised/signposted/referred onto other services/ support mechanisms following 1-1 support offered.

Wider community engagement

In addition, projects indicate if they have run events eg health fairs, family days, training days etc with the pharmacist. These sessions are often open to the core groups and also the wider community. Table 9 indicates the number of events that have taken place, level of pharmacy and community involvement and how they have worked with other organisations. Other organisations involved are those similar to organisations listed in Table 6. This supports wider inclusion, engagement and appropriate service use and tackling of health and the wider determinants:

		Session input		
Attendees	Sessions	Pharmacy involvement	Community / voluntary partner involvement	Other contributing partners
2102	52 events	42 sessions	49 sessions	38 sessions (with over 128 different organisations contributing)

Table 9: Participation in events with pharmacist and other organisations

4ii BCPP Outcomes

Targeting deprivation and inequalities

In the first instance, BCPP are asked to record the proportion of BCPP projects targeting people who reside in the bottom 3 quintiles of Super Output Areas (SOAs), indicating levels of deprivation. If a project targets people from a variety of SOA's, only 4 SOAs are logged. Steps are taken to ensure that the lowest is recorded as part of that. Based on this, BCPP can evidence that over 95% of BCPP projects are targeting at least some participants from the bottom 3 quintiles of deprivation. Over 67% indicated they were targeting participants from the bottom quintile. Within projects it must also be noted that BCPP supports working with disadvantaged groups such as homeless, migrant workers, vulnerable adults, and young people at

risk. The location of these groups is not necessarily within areas of deprivation. In addition, over 19% of recipients indicated they had a disability.

Evidence of impact

As part of the process of measuring outcomes, BCPP project participants are supported to complete questionnaires. These are completed by participants at the beginning and end of BCPP projects thus indicating how they perceive the project has impacted on them. The analysis of the outcomes to date for this round of funding is based on over 870 Core Group Start questionnaires and over 510 Core Group End questionnaires having been completed. Over 49% indicated they were from the Catholic community and over 37% indicated they were from the Protestant community. Almost 20% considered they were a disabled person, almost 60% indicated they received Benefits and over 30% indicated they had dependents.

The following outcomes are grouped under the 3 main indicators detailed on page 7 and also reflect the approach advocated by BCPP (page 4-6) regarding evidencing how a community development approach can lead to improved health outcomes.

1 ***Improved accessibility and responsiveness regarding engagement in local services, particularly of more disadvantaged groups***

- I know where to go to get health and support increased from 58% to 78%
- I regularly go to other health workers for advice increased from 43% to 49%
- The quality of my health services is excellent increased from 54% to 64%
- My local health service does meet my needs increased from 45% to 60 %
- My local health services are welcoming increased from 57% to 68%
- Frequency of visit to other services would indicate the use of A & E is generally less often than once a month (97%). On completion over 97.5% said the use A & E less often than once a month, indicating a slight move to less frequent use
- At the project end, participants indicated, they knew more about local health services (over 85% agreed) and that those taking the sessions ie providers, including pharmacists, knew more about their needs - over 81% agreed
- In addition, at the project end, over 22% of participants indicated they were advised to see another health professional and 39% said they were offered advice/information on other services. 92 participants (+17%) indicated issues they were advised to see another health professional about. Issues identified ranged from depression to asthma, skin rashes and smoking. The most common reasons that suggesting needing further advice from another health professional included mental health and high blood pressure. Following this, the next most common issues were sexual health, cholesterol, weight management and medicines use. This reflects the in findings on page 8-10.

2. ***Change in use and understanding of pharmacy and associated services***

- Confidence in going to the pharmacist for advice increased from 64% to 81%
- Regularly visiting the pharmacist for advice increased from 26% to 42%
- 3% increase in those using the pharmacy on a weekly basis (those using it once a month or less decreased)
- 92% agreed they had a better understanding of what a pharmacy can offer

3. ***Perceived improvements in health and understanding of how to take responsibility for health***

- my health is usually excellent increased from 46% to 51%
- I feel my health has NOT got worse over the last few weeks increased 49% to 61%
- Having a good understanding of how to improve health increased from 64% to 83%
- How you live can affect your health increased from 80% to 89%
- Made healthy changes to the way I live increased from 52% to 69%
- I take care of my health increased from 57% to 68%

In addition people gave their views on how well they engaged and connected with others, indicating an increase in social capital and contribution to wellbeing

- things in common with other people taking part increased from 67% to 85%
- I feel confident talking about health to other people increased from 42% to 52%
- I belong to a number of groups increased from 38% to 41%
- I regularly go to other community groups for advice increased from increase from 16% to 25%
- Over 76% agreed they know more about local groups

In general, at the project end

- Over 82% felt more in control of their health
- Over 86% would take part in other activities like this
- Over 88% agreed sessions encouraged them to improve their lifestyle
- Over 82% agreed they felt they had a say in what was talked about
- Over 84% agreed they felt they played a part in the sessions

Psychological wellbeing- Participants were asked to tell BCPP how they were feeling. A General Health Questionnaire 12 (GHQ12), a subjective measure of psychological well-being was used. This comprises twelve questions, asking informants about their general level of happiness, experience of depressive and anxiety symptoms and sleep disturbance experienced over the last four weeks.

At the start of the programme, 32% indicated they had poor psychological wellbeing. This reduced to 11% at the project end.

Impact on Pharmacists

On project completion, pharmacists participating in Level 2 & 3 projects are asked to complete questionnaires to give their perspective on the impact of the programme. 19 questionnaires were completed. Feedback was very positive with the vast majority considering it had a very positive impact on participants and that they had benefited from working more closely using a variety of approaches with individuals and communities. Over 40% indicated they had or intended to make changes to how they engage with customers; how services are delivered, including medicines use; how they train staff; and how they work with other services providers, groups and agencies. Over 94% agreed their pharmacy is now seen as an accessible community resource.

Case studies

The following provides a summary of 3 case studies from BCPP projects.

Oasis, Caring in Action with Boots, E Belfast

Oasis, based in Inner East Belfast provides childcare, training courses, befriending initiative for older people, a housing project and they run a couple of cafes as social enterprises. They have worked with Boots through several BCPP projects. The focus has been on working with women, many experiencing mental health issues and low self–esteem. Each project works with 2-3 groups of women over a 6-12 session programme that utilises a group work approach to cover a range of health and wellbeing issues, promoting self-confidence through personal development. They have also sought to develop the support network of the participants by linking in with Money Advice and other Mental Health organisations. As the programme has developed, previous participants have supported newer members become involved in the programmes and some have gone on to form their own women's group. Feedback from their project indicated:

- The pharmacist has noticed an improvement in participant use of the pharmacy for information and advice.
- At the project end, 1 person indicated poor psychological wellbeing whereas 9 indicated poor psychological wellbeing at the beginning (use was made of the GHQ12 Questionnaire)
- All participants now consider they have a better understanding of the pharmacist's role.
- Through increased confidence and skills, one woman went on to secure full time employment.

Breakthru and Boots, Dungannon

Breakthru, was established in response to the rising issue of drug and alcohol misuse among young people. Over more recent years their remit has expanded to serve the needs of the wider community but the focus remains on providing accurate, relevant and factual information on drugs and alcohol through education, training, intervention and prevention. They have been funded on a couple of occasions through BCPP. More recently they have developed programmes in response to a need identified for a more group based approach to support women who initially accessed 1-1 counselling sessions through Breakthru. BCPP is the first programme that has enabled them to develop this group based approach. For the first time Breakthru through BCPP has also developed a programme for older people with the pharmacist exploring a wide range of health issues including use of medicines. The pharmacist has been able to deliver sessions, co-faciltate with other providers and link in with activities. Both partners have benefited from reciprocal training regarding use of medicines and illicit drug use. Feedback from a recent BCPP project with Breakthru evidenced:

- 7 participants reported having poor psychological wellbeing prior to the project. This decreased to 1 at the project end.
- 2 people became volunteers within the next stage of the project and 4 went on to sign up for other courses.
- During 1-1 support with the pharmacist, 1 person was suicidal and the appropriate referrals and support were given.
- 67% of partcipants perceived they used the pharmacy once a month or more often at the beginning of the project, this increased to 75% at the project end.
- 44% of participants perceived that they used their GP once a month. This decreased to 12.5% by the project end.

First Housing Aid Support Services (FHASS), Shepherd's View with Lloyds Pharmacy, Derry

FHASS works with single people giving support and assistance to young people, families, street drinkers and those in the community experiencing homelessness or the threat of homelessness. Through their Shepherd's View unit they have worked with Lloyds Pharmacy on a couple of BCPP projects focused on working with young parents, many of whose children are on the look after register. Many experience high levels of stress and are at risk. A great relationship has developed between Shepherd's View, the pharmacist and the young people. The pharmacist has also developed a good working relationship with other organizations and has been key to initiating contact with them and co-delivering sessions eg Aware Defeat Depression, HURT. Issues covered include alcohol, drug abuse and misuse, sexual health, stress and anxiety, children's medication, healthy relationships and increasing parental knowledge that parents have primary responsibility for the health and wellbeing of their children. Feedback indicates:

- Young people from previous BCPP projects continue to use the pharmacy for advice, information and other services.
- All participants now considered they had better health and more understanding of what affects their health.
- 90% of participants said the project developed their skills.

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