

COMMUNITY PHARMACY ALCOHOL SCHEME EVALUATION REPORT

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1.0 INTRODUCTION

1.1 **Background to Alcohol Misuse & Brief Interventions**

In 2006, the National Public Health Service for Wales published a paper called 'Alcohol and Health in Wales: A Major Public Health Issue'. This paper outlined the adverse implications of hazardous and excessive alcohol consumption to the public health of Wales. It stated "*despite the massive resource implications for the NHS of alcohol misuse, the strategic and financial framework targets for LHBs do not refer to the issue, or define specific actions.*"

In response to the growing concern towards the impact of alcohol consumption on the public health of the UK as a whole there have been a number of research studies exploring the impact of brief interventions on reducing alcohol consumption.

A recent Cochrane review (Kaner et al, 2007) on the evidence on BIs in primary care identified 29 controlled trials from various countries in general practice (24 trials) or an emergency setting (five trials). After one year or more, people who received the brief intervention drank less alcohol than people in the control group (average difference 39 grams per week). The impact on men was greater with the benefit being less clear for women. The benefits of brief intervention were similar in the normal clinical setting and in research settings with greater resources. Longer counselling had little additional benefit.

In addition to the Cochrane review the SIGN Guideline 74, on the management of harmful drinking and alcohol dependence in primary care, provides a clear review of the research evidence in this field and makes unambiguous recommendations for practice based on the available evidence. Key issues highlighted by SIGN (2003) include,

- Primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (10 min) intervention.
- A BI should, whenever possible, relate to the patient's presenting problem and should help the patient weigh up any benefits /disadvantages of their current drinking pattern.
- Brief interventions in primary care can reduce total alcohol consumption and episodes of binge drinking in hazardous drinkers for periods lasting up to a year.
- Very brief or minimal (5-10 minute) interventions were found to be as effective as longer ones, though the evidence was not consistent.
- Brief interventions are not appropriate for individuals who are or who may be dependent on alcohol. Rather they are effective for individuals

who are “hazardous drinkers” i.e. regularly drink more than the recommended daily drinking limits or “harmful drinkers” i.e. those whose drinking is in some way causing them harm at the current time.

- Objective screening tools are important to determine an individual’s current risk and level of drinking i.e. whether or not they need or are appropriate candidates for a brief intervention.
- Training health care providers in the use of structured interventions enhances the efficacy of brief interventions.

It is worth noting that there is also evidence that training in itself is not sufficient and practitioners can be further supported to deliver effective interventions though interactive team-based follow up support in groups or via telephone. Other research has suggested that training combined with written guidelines was most successful in increasing the level of provision of brief interventions on alcohol by nurses in primary care (Kaner et al, 2003).

Overall, there is a large volume of good quality evidence indicating that appropriate screening helps the detection and treatment of alcohol problems and there is a range of related guidance on this topic (Alcohol Concern, 2002; WHO, 2001).

The World Health Organisation has also published a comprehensive manual for the use of brief interventions on alcohol in primary care (Babor & Higgins-Biddle, 2001).

1.2 Brief Interventions in Pharmacy

Despite increasing amounts of research into the area of brief interventions there has been little development of this area within pharmacies to date. A recent study in Scotland (McCaig & Fitzgerald, 2007), investigating the role of community pharmacy, has made some promising findings. The outcome of this, reported in the August 19th edition of the Pharmaceutical journal, stated that *“on follow-up, about six months later, a number in the trial group – particularly those who were wine drinkers – reported a clear change in their behaviour after the pharmacists interventions. The pharmacists involved were also positive about the project and noted no aggressive or strong negative reactions”*.

1.3 Community Pharmacy Alcohol Scheme

In 2007 Monmouthshire Local Health Board invested in the development of a Community Pharmacy Alcohol Scheme where local pharmacists would receive training on brief interventions on alcohol so they could implement screening on alcohol consumption to identify hazardous drinkers who could then benefit from a brief intervention and/or harmful or dependent drinkers who could benefit from referral onto a specialist service.

To progress this scheme Monmouthshire LHB commissioned training for pharmacists on alcohol brief interventions. This 2 day training was delivered by Create Consultancy and was seen as an opportunity to respond to the 'Choosing Health through Pharmacy' paper and the growing concern on the impact of alcohol consumption at a public health level. It also allowed Monmouthshire LHB to build upon the growing body of research that indicates that brief interventions are a successful model in reducing alcohol use.

The overall aim of the scheme was to explore whether pharmacists are a feasible option for delivering this service with the following specific objectives:

1. To engage community pharmacists in addressing identified issues around alcohol misuse.
2. To develop the skills of pharmacists in brief interventions (some transference of taught skills to other issues)
3. To maximise community pharmacy resource to reach those people with pre-hazardous alcohol behaviours who may not otherwise come into contact with a health professional.
4. To ensure Wales is continued to be seen as a leader in pharmaceutical public health.
5. To create strong and lasting community links between pharmacists and agencies to support problem drinking.

The scheme itself was established as a 6 month pilot. All of the pharmacists involved were provided with cribsheets to support the screening process, communicate the results of the screening and to carry out a brief intervention (if required). The pharmacists were also provided with an audit form which they were asked to complete for every screening they carried out. The bottom of the audit form was completed by the pharmacists if they were claiming their remuneration of £10 for carrying out a brief intervention. This remuneration could only be claimed for appropriate brief interventions not the process of screening.

The pharmacists were also provided with supporting resources including the alcohol unit calculator and 'So you want to Cut Down on Your Drinking' booklet.

1.4 Wider Pharmacy Developments

Since the implementation of the Community Pharmacy Alcohol Scheme a number of other developments have taken place that link directly to the future potential of brief interventions in the pharmacy setting:

Medicine Use Reviews: A national development, as part of the enhanced service, for pharmacists to carry out reviews with all medicine users. This usually involves a 10 to 15 minute consultation with clients to discuss their medicines and the appropriateness of each medicine. Pharmacists are given a remuneration of £27 for every MUR that is carried out.

2.0 METHODS

Throughout the duration of the scheme a number of approaches were used to monitor and measure its implementation.

The training was evaluated using pre and post questionnaires. This enabled an assessment to be made on any improvements to the participants' knowledge on alcohol and brief interventions, their confidence levels to implement the scheme and their attitudes towards the role appropriateness of alcohol brief interventions to pharmacists. Appendix A provides an overview of the evaluation responses to the pre and post questionnaire.

Over the duration of the scheme ongoing monitoring of its implementation was assessed through the return of audit forms and the number of remuneration payments. Over the 6 month pilot period very few remuneration payments were given and it was suspected that audit forms were only being sent to the LHB on completion of brief interventions i.e. not after the screening process. Despite this confusion, the low levels of remuneration indicated that there were a number of unidentified barriers to implementing the scheme. Due to this a final evaluation was commissioned.

The final evaluation was carried out by Create Consultancy and used interviews to explore the following:

- how many screenings had been carried out
- what had supported the implementation of the scheme
- what had hindered implementation of the scheme
- whether any additional benefits had taken place via involvement in the scheme i.e. transference of skills
- what learning points could be taken to help shape future developments

Eight interviews were conducted with professionals involved in the scheme. This included six face to face interviews and one telephone interview with pharmacists who had attended the original training (from a potential of 10) and one face to face interview with the project manager.

Each interview took approximately 20 minutes (max. 40 minutes) and followed an interview schedule that had been previously developed (see Appendix B). Detailed notes were taken throughout each interview by the evaluator with comments read back to the participants at the end of the interview to ensure clarity and to minimise any misinterpretation of comments.

The findings of this report have been split into two sections; section one outlines the findings from the interviews and section two provides discussion and conclusions on the findings. The first section is presented without discussion or interpretation from the evaluator. All discussion is found in the 'conclusions' section.

3.0 INTERVIEW FINDINGS

3.1 Implementation

The low number of claim forms received by the LHB did not fully represent the number of screenings and engaging of the public on the topic of alcohol carried out by the pharmacists. The breakdown of the pharmacists' involvement was as follows:

- Two pharmacists had conducted no screenings but had displayed materials and provided clients general information and resources.
- One pharmacist had conducted approximately two screenings and had provided general information to clients.
- Three pharmacists had carried out approximately 5 to 10 screenings and provided general information.
- One pharmacist had carried out 20 to 30 screenings, resulting in approximately 5 brief interventions.

Among the pharmacists that had implemented the scheme the topic of alcohol had been introduced opportunistically in a variety of ways, the most common were:

- Link to MUR's: Two pharmacists raised alcohol consumption as part of the 'Medicine Use Review'. As the process for reviewing medicine requires clients to be taken into the consultation room it was felt that this provided a confidential space for a discussion on alcohol to take place.
- Link to EHC: Two pharmacists had raised alcohol consumption as part of the discussion when supplying the morning after pill. As with the MUR's this was helped by clients being in the consultation room and in some cases alcohol being raised naturally by clients. One other pharmacist felt very strongly that the prescription of EHC was not an appropriate time to raise alcohol. In his/her view, young women had to '*pluck up the courage*' just to come into the pharmacy for the morning after pill. If the pharmacist were to then raise the issue of alcohol, it could potentially be perceived as making a value judgement which would '*alienate them from coming again*'.
- OTC Supply: One pharmacist raised alcohol consumption when clients were purchasing over the counter medicines i.e. sleep aids or vitamins. This pharmacist found it easy to incorporate alcohol into a wider discussion into some of the underlying reasons for the medicines being purchased. This pharmacist had a relatively low number of dispensing items, did not provide EHC and did few MUR's.

Overall, the pharmacists (even those not currently screening) felt it was more appropriate to raise the topic of alcohol when issuing prescription medicine

rather than over the counter medicine as this was felt to provide more opportunities to incorporate it into discussion naturally. In some instances, such as MUR's, the pharmacist already allowed at least 10 minutes for a one to one discussion in the consultation room. This further enhanced the potential to raise alcohol as it alleviated concerns over confidentiality and time pressures.

3.2 Client reaction

Among the pharmacists that had implemented the scheme the reaction from clients had been mainly positive. Pharmacists commented on some clients being '*really grateful for the advice*' particularly when reducing alcohol consumption was suggested as a way of helping a problem i.e. insomnia.

The majority of people who took part in screenings were not found to be drinking hazardously however despite this many clients were open to information being given on alcohol consumption, units and sensible drinking guidelines. Two pharmacists discussed that although clients were open to information they were reluctant to take part in the screening because it involved them going into the consultation room and one pharmacist was aware of stigma surrounding the consultation room as this was where methadone users went.

Only one pharmacist reported a mixed reaction from clients when alcohol consumption was raised. This was among older clients (50 plus) that were receiving an MUR. It appeared that the negative reaction of clients in this situation was limited with the pharmacist describing it as 'a look'. This had been interpreted by the pharmacist as clients thinking that questions on alcohol consumption were 'cheeky'. In these instances clients had not wanted advice on cutting down. This reaction from older clients was felt to be partly due to them having already made their lifestyle choice.

Despite the overall positive client reactions all of the pharmacists, including those that had had positive reactions, highlighted ongoing concerns about potential adverse reactions from clients. For the majority this concern stemmed from the feeling that there was no expectation from clients for this topic to be raised, unlike smoking where there was a high expectation. Due to the lack of expectation pharmacists were concerned about clients feeling that they were 'being judged'. The concerns about 'alienating clients' was more pronounced among the two pharmacists that had not carried out screening. Both stated that their worry about client reaction was one of the reasons they had not implemented the scheme.

3.3 Support for Implementation

The pharmacists identified a number of factors that they valued within the scheme and/or had helped them to implement it. These included:

3.3.1 Training

All pharmacists highlighted that the training had provided them with useful skills to implement the scheme and overall a better understanding of alcohol as a public health concern and the role pharmacists could have in delivering brief interventions. Two pharmacists also discussed how the information about alcohol was useful on a personal level; either in moderating their own alcohol consumption or in providing advice to friends and family

“Training was exceptional, felt extremely motivated afterwards...it made you feel you could better yourself and make a difference”

“Training was very useful as was having two pharmacists trained as could bounce ideas of one another”

“Training was brilliant even for own drinking levels”

One pharmacist raised that although they felt the training was good because of some of the techniques used they hadn't gained as much from it as potentially they could have;

“Although training was very good I didn't feel all that comfortable with it even then, maybe because I am very uncomfortable with role play so I didn't take as much from it as I could have”.

The pharmacists also identified that the techniques and skills promoted on the training were useful in other areas of their work. The particular techniques referred to were the 'open questioning approach' transferable to other areas such as MURs, encouraging clients to take responsibility for their own health and any health behaviour change and the overall emphasis on talking to people in an approachable and non-judgemental way.

“Generally training on how to talk to people is useful as the whole one to one consultation process is more common now”

“Yes the open questioning approach, these are skills worth having and can be transferred to other areas such as MUR's”.

“Yes skills from training are transferable to all lifestyle advice.”

The final point raised about the training was the positive reaction towards the involvement of local voluntary organisations. This had helped to raise awareness of what services were available and to build local links. All of the pharmacists had valued this input and still had the information on local agencies for referral purpose. This was discussed as beneficial as it was felt that pharmacists are often out of the loop when it comes to local public health initiatives and multi-disciplinary networking opportunities.

“Training was very good, particularly the first day as lots of new information and the opportunity to make good links with voluntary organisations”

“Particularly the local organisations that work with the families of those affected by alcohol misuse”

Although this input was valued by all of the pharmacists it was raised that after the training the increased awareness and networking hadn't been built upon to create better relations with voluntary organisations in the long term.

3.3.2 Resource materials

All of the pharmacists commented that the supporting information provided after the training was very useful. In particular, the unit calculators were seen as helpful as they were fun and easily accessible.

“The alcohol wheels were excellent as captures people's interest and can be taken away”

“Thought they were brilliant... you can physically give them to take away to reinforce messages”

Two pharmacists referred to the 'so you want to cut down on your drinking' booklet as being useful. Although due to its size it had only been distributed to a small number of clients (usually relatives of a person misusing alcohol).

3.3.3 Financial incentive

The financial incentive was welcomed by all of the pharmacists and seen as useful as it provided a clear benefit to their organisation for taking part. This helped ensure that cover was arranged for the pharmacist to attend the training. This point was seen as particularly important by pharmacists that work for large organisation where there are many competing targets and prioritise.

Overall the majority of pharmacists commented that the £10 remuneration was a fair amount (similar to EHC and less than MUR's that take longer). However suggestions were given on ways to make the payment process simpler and more reflective of the time required to do screening. This is discussed in section 4 'Discussion & Conclusions'.

3.3.4 General awareness

One pharmacist stated that they had become aware of recent media attention on alcohol consumption and had used this as an 'opening' for raising the topic of alcohol. The inclusion of messages on alcohol in the media had raised the awareness of it among their clients which in turn meant they weren't surprised when it was discussed by their pharmacist.

3.4 Barriers to Implementation

In addition to identifying the factors that had helped support the implementation of the scheme the pharmacists also identified a number of issues that had hindered its implementation. These included:

3.4.1 Lack of opportunity/Client Awareness

The lack of opportunity to raise alcohol consumption and naturally carry out a screening was raised by all pharmacists as the most significant barrier to implementing the scheme. All discussed the importance of raising alcohol consumption in a natural way where it felt appropriate. However, due to a lack of publicity materials and any underpinning public health 'campaign' to raise public awareness it was felt that there were few opportunities where it felt 'natural' or 'appropriate'. For three pharmacists this also linked to their pharmacies not having fully implemented MUR's and/or having low levels of prescribing.

"Can potentially link to patients with heart burn or indigestion but usually difficult to raise opportunistically"

"Shop doesn't have MUR's established so made it more difficult to incorporate in a natural discussion".

"If part of an alcohol awareness campaign then expectations would have been raised among the public at moment it is coming out of the blue".

3.4.2 Time/Staffing pressures

All pharmacists discussed the lack of time and staffing pressures as a barrier to implementing any scheme that 1-2-1 consultation. This was particularly problematic in pharmacies where there was only one pharmacist and/or very busy pharmacies with high levels of prescribing.

"We are a very busy pharmacy with high levels of prescription so time is a problem"

For some of the pharmacists the barrier of time and staffing pressures were heightened by counter assistants not being included in the training. This meant that the pharmacists were implementing the scheme in isolation without the support of other staff to help raise clients' awareness of the scheme or in some instances carry out the screening.

"No support from counter assistants. This would have made it much better and more like a campaign rather than just me raising it"

3.4.3 Motivation/Pharmacist awareness

Many of the pharmacists discussed how their motivation to carry out the screening was reduced as time passed and their own awareness and

mindfulness of the scheme reduced. This was linked to alcohol not being actively raised by clients due to their lack of awareness and because there were few reminders and/or updates about the scheme from the LHB. As the majority of the pharmacists were very busy with competing demands and priorities it was felt that the lack of follow up made it easy for other priorities to supersede the implementation of the scheme.

“Went to the back of my mind with all the other competing demands”

3.4.4 Remuneration

Some pharmacists felt that remuneration should have been linked to the screening, not the brief intervention. All of the pharmacists indicated that the most difficult part in implementing the scheme was raising the issue of alcohol consumption and starting the discussion; by carrying out the screening it was felt they were already 2/3rds through the whole BI process. Due to this, it was felt that if they were given some payment for carrying out the screening this would encourage them to do more.

“The scheme was essentially about doing the counselling part (the BI) but this wasn’t always appropriate or necessary so would be better if not all or nothing but recognising that it may take one chat to raise awareness, another to give information and a final to do counselling aspect”

3.4.5 Confidentiality

With the exception of one pharmacist, who carried out screening over the counter, the pharmacists indicated that raising alcohol consumption was too sensitive to do over the counter and was best if discussed when prescribing medication and/or when in the consultation room. The need for confidentiality brought its own barriers due to the reluctance of some clients to go into the consultation room due to lack of time or simply not wanting to.

The sensitivities around raising alcohol consumption were also discussed in relation to the environment of a small rural town. Many of the pharmacists know their clients on a personal level and there was some concern about approaching people who were well known for drinking too much and/or people thinking that they were being “watched or picked on”.

“I don’t want people to think they are being approached because I have seen them in Wetherspoons the night before”

3.4.6 Role Appropriateness

Although all of the pharmacists felt that raising alcohol consumption was appropriate to their role some did comment on the relatively recent changes in the role of pharmacists. In particular, the expectations for pharmacists to take a proactive, rather than responsive, approach to providing health information and advice.

“Important to recognise that times are changing and this is relatively new so need to get used to it”.

Although all of the pharmacists indicated that alcohol consumption was difficult to approach ‘cold’ the majority felt that they had the confidence to raise it when it was done in an appropriate way i.e. via MUR’s or linked to symptoms/medication. Only one pharmacist discussed feeling very uneasy to raise the topic of alcohol due to their own confidence levels and concerns about client reaction. This was partly due to the pharmacist never drinking alcohol and being concerned about how raising alcohol consumption might be perceived.

3.4.7 Competing priorities

Among the pharmacists working for large organisation (where pharmacy is one of many services provided) they discussed the number of internal targets that staff are expected to deliver upon. For some this meant asking a number of questions i.e. do you want a mobile top up etc at every client purchase. As these targets are monitored by the company and staff get performance managed on them they become the priority.

3.5 Future Learning

Within each interview pharmacists provided their views on what they feel would help to reduce the barriers and support implementation of any future campaign. Their suggestions are:

3.5.1 Part of Wider Campaign

All of the pharmacists believed that any future scheme should be part of a wider public health awareness campaign similar to the level of smoking. This would provide more opportunity to raise alcohol, make the role of the pharmacist easier and reduce concerns about client reaction because it would be less sensitive with more clients expecting alcohol to be raised. They would also be more likely to pick up leaflets and pro-actively raise alcohol in discussion.

Suggestions to support this included campaigning materials ranging from window stickers, display boards and more resources like the alcohol unit calculator.

It was raised that any future community pharmacy alcohol scheme would have more impact if it was part of a co-ordinated campaign across health services i.e. not just pharmacy but GP surgeries, nurse led clinics etc carrying out screening and brief interventions with public information materials on display. It was felt that this

“would make it valuable rather than just say we have done it”

3.5.2 On-going support/ guidance from LHB

Follow up information and support would help to keep up momentum and enthusiasm for any future scheme. This related to the above point but also included pharmacists and other practitioners having the opportunity to share stories and good practice.

Suggestions on how to provide support was better use of e-mail, websites, blogs etc. A comparison was made with MUR's as some of these structures are already in place to support the implementation of them.

In addition, some of the pharmacists went on to suggest that any future scheme would be easier to manage if the LHB provided guidance on what clients to target i.e. diabetic patients one month and others with particular symptoms another month? It was felt that this would help to raise the profile of the scheme and would be preferable to approaching people in a random way. Although clearer guidance on target groups was suggested it should be noted that one pharmacist felt that this would make no difference as alcohol 'is relevant to everyone'.

3.5.3 Better links to essential and enhanced services

It was suggested that highlighting the links between how alcohol screening and brief interventions could contribute to the delivery of essential services would be helpful. This would provide pharmacists with a clear incentive to carry out the screening, particularly if remuneration was linked to this rather than brief interventions. The specific essential services highlighted as linking with the alcohol scheme were:

Essential Service 4: Promotion of Healthy Lifestyles (particularly diabetes, CHD, Smoke, Overweight). This is currently monitored by pharmacies involvement in national public health campaigns and Monmouthshire Local Health Board campaigns. Involvement in the Community Pharmacy Alcohol Scheme could be used to evidence the latter.

Essential service 5: Signposting. The service indicator for this is that the pharmacy has a standard operating procedure for onward referral, anonymised referral forms and leaflets/booklets on local services. The referral aspect of brief interventions clearly links here.

It was also suggested that the LHB should engage at an organisational level with the larger companies i.e. not just with the pharmacists to ensure that they 'buy in' to the implementation of the scheme by incorporating it into their own internal target system that staff are performance managed on.

Finally, It was suggested that alcohol screening is easier to do when linked to an MUR. Therefore pharmacists felt that once MUR's were more widely implemented more alcohol screening would take place. To emphasise the link to MUR's it was suggested that alcohol was incorporated as a prompt on the MUR data screen.

3.5.4 Simpler payments system

Overall there was general agreement that the current remuneration was sufficient and that the payments form was simple. However, all pharmacists agreed that remuneration should be linked to the screening process rather than the brief intervention.

Other suggestions for a simpler payments system was that a base payment is provided for pharmacists to take part in a public health campaign to raise awareness about alcohol with an additional payment given for the next stage i.e. screening/brief interventions.

3.5.5 Involvement of support staff

Overall the majority of the pharmacists indicated that it would be useful for counter staff to get some basic training (1/2 day) so that they could be part of an awareness raising campaign or be involved with the screening. It was suggested that this would help them *'to feel more involved and empowered to make change'*

Only one pharmacist disagreed with this position as they felt that it would be difficult to involve counter staff who tend to be part-time.

4.0 DISCUSSION & CONCLUSIONS

It was recognised at the outset of this evaluation that there were a number of barriers that inhibited the implementation of the scheme. This discussion and conclusions section places the issues raised in the findings section into the context of whether the Community Pharmacy Alcohol Scheme was successful in meeting its initial objectives.

1. To engage community pharmacists in addressing identified issues around alcohol misuse.
2. To develop the skills of pharmacists in brief interventions (some transference of taught skills to other issues)
3. To maximise community pharmacy resource to reach those people with pre-hazardous alcohol behaviours who may not otherwise come into contact with a health professional.
4. To ensure Wales is continued to be seen as a leader in pharmaceutical public health.
5. To create strong and lasting community links between pharmacists and agencies to support problem drinking.

Overall it would seem that the community pharmacy scheme did engage pharmacists on the issue of alcohol and brief interventions. The process of attending training, and for some implementing the scheme, had helped to legitimise the role of pharmacists in addressing issues around alcohol misuse. This was apparent at follow up with all pharmacists stating that it was a legitimate role for them to raise alcohol consumption with clients if done in an appropriate way.

Although few brief interventions have been conducted, with the exception of one pharmacist who highlighted their own lack of confidence, the pharmacists indicated that they had the skills and confidence to carry out brief interventions and screening. What they lacked was the wider support and awareness raising required amongst the public to enable them to raise alcohol in a natural and legitimate way. It was felt that this could be provided if a large public health campaign had underpinned the community pharmacy alcohol scheme.

It was also apparent that the pharmacists all felt that the skills they had developed at the training were transferable to other lifestyle discussions and reviews. This is particularly important due to the changing nature of the pharmacists' role and the increased expectation that they will take a proactive approach to providing public health messages.

Undoubtedly the involvement of local agencies in the training raised the profile of what organisations can provide locally. This was beneficial in so far as all of the pharmacists had kept this information for referral purposes – an essential service outlined in their contract. However, as none of the pharmacies provided examples of meeting any of the agencies since the training it could be said that the potential to create strong and lasting

community links between pharmacists and local voluntary organisations was not fully harnessed.

Overall it is clear that the pharmacists took many benefits from their involvement in the scheme and valued a number of aspects of it including the skills they developed in the training, the raised awareness of local voluntary organisations and the supporting resources they were provided. It was also highlighted that the remuneration amount for the scheme was generally sufficient. However, it was clear that the pharmacists felt that the process of raising alcohol and carrying out the screening was the difficult part. Due to this it was screening rather than the brief intervention that should have had some payment attached. The 'all or nothing' approach to getting paid for completing a brief intervention was one barrier to implementation.

Overall, there were a number of barriers to implementing this scheme in a way that would maximize the community pharmacy resource to reach people with hazardous alcohol behaviours. Some of the barriers included the broader difficulties that pharmacists face with any new scheme such as time management, competing priorities and the need for some information to be provided to clients in a confidential and unthreatening way. Potentially the involvement of counter staff could help to remove this barrier by enabling them to raise the awareness of the scheme and/or carry out the initial screening.

By exploring the barriers and highlighting potential solutions it is hoped that this report will aid the future implementation of similar alcohol behaviour schemes. It is hoped that should planners take on board the suggestions made by the pharmacists involved in this scheme Wales can continue to lead the field in pharmaceutical public health.

4.1 Considerations for future implementation of brief interventions in community pharmacies

Based on the findings from this evaluation the following questions should be taken into account when considering the future implementation of brief interventions schemes in community pharmacies:

- **How can pharmacies be paid for their involvement to encourage them to raise the issue of alcohol as well as delivering brief interventions as needed?**
- **How can counter staff support the implementation of brief intervention schemes?**
- **What ongoing support and reminders will be provided to participating pharmacists to continue their engagement with alcohol as an issue?**
- **How will the community pharmacy project link with national/regional/local campaigns on alcohol?**

- **What support materials are required for the pharmacy setting?**
- **How can pharmacists link with other organisations/primary care staff involved in similar projects?**

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