

DRINKING INTERVENTIONS IN PHARMACIES STUDY (DIPS)

Development, implementation and
evaluation of a pilot project to deliver
interventions on alcohol issues in
community pharmacies

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EXECUTIVE SUMMARY

This project sought to evaluate for the first time, the feasibility and acceptability of the provision of brief interventions on alcohol in community pharmacies. The objectives were to:

- (1) Establish a pilot project in which trained community pharmacists initiate discussion of alcohol consumption with targeted pharmacy clients and screen, intervene or refer as appropriate.
- (2) Explore, with pharmacists and clients, the feasibility, acceptability, perceived value and perceived impact of the provision of such interventions in community pharmacy.
- (3) Identify markers of good practice and formulate recommendations for future practice.

Eight community pharmacies in Greater Glasgow participated. A baseline evaluation was carried out to establish pharmacists' knowledge and attitudes relating to alcohol prevention and education. After a two day training course for pharmacists, the eight pharmacies were asked to recruit clients over a three month period. Standardised protocols were prepared to screen clients for hazardous drinking using the Fast Alcohol Screening Tool, to guide the intervention and to record the whole process for each client. Clients were recruited from specific target groups as well as through posters highlighting the service. Following completion of the recruitment phase, pharmacists and clients were followed-up by the research team.

In the baseline evaluation, all pharmacists agreed that they were interested in the responses that could be made to alcohol-related problems but just one regularly raised the issue of drinking with clients. All felt it appropriate for community pharmacists to "opportunistically identify hazardous and harmful drinkers and to deliver a brief intervention" although they had some concerns about client sensitivities. Most were unable to correctly outline the recognised daily limits for alcohol consumption and none was familiar with the concept of brief interventions to address hazardous drinking. Training was rated highly and had an impact on knowledge and attitudes. On follow-up the pharmacists were positive about the project and felt it worthwhile and importantly noted no aggression or strong negative reactions from clients.

Seventy clients were recruited to the study, 30 screened as drinking hazardously (42.9%) and 7 (10%) screened positive for harmful drinking. Nineteen clients were followed-up and most were happy to have taken part in the intervention and were generally positive about the experience.

In conclusion, this project has been successful in establishing a pilot project in which eight trained community pharmacists conducted a discussion about alcohol with 70 clients. However, the pharmacists and clients researched are not necessarily representative of community pharmacies or clients. Further work is required to test the generalisability of our findings and to measure the impact on alcohol consumption.

SECTION 1: INTRODUCTION & AIMS

There is increasing concern amongst health professionals, social care professionals and policy makers at the rising level of alcohol consumption in the UK and the overwhelming evidence of the negative impact of excessive alcohol consumption on health. Excessive alcohol consumption is associated with an increased risk of a whole range of illnesses that collectively contribute substantially to the morbidity and mortality of the population as a whole (Alcohol Concern, 2006).

Despite this increasing concern, community pharmacy involvement to identify/address hazardous or harmful drinking appears to be virtually non-existent. A search of the national and international pharmacy literature carried out in planning for this project, identified no community pharmacy initiatives designed to reduce alcohol consumption (although an abstract of one small study was presented at a conference while this project was ongoing (Dhital, Greene and Lovejoy, 2005) and no projects could be found using the Community Pharmacy Services Database Committee (PSNC, 2004). This is surprising given the recognised role and track record of community pharmacists' involvement in public health (Anderson, Blenkinsopp and Armstrong, 2003) and the strong evidence that short discussions or "brief interventions" on alcohol delivered in primary care settings are both effective and cost-effective (Public Health Institute of Scotland, 2002; Scottish Intercollegiate Guidelines Network (SIGN), 2003). In fact, SIGN Guideline 74 recommends that:

GPs and other primary care health professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (10 minute) intervention. The intervention should, whenever possible, relate to the patient's presenting problem and should help the patient to weigh up any benefits as perceived by the patient versus the disadvantages of the current drinking pattern.

SIGN (2003)

The argument for pharmacy involvement in addressing alcohol issues is strong, since an estimated 600,000 people visit a community pharmacy in Scotland each day, without an appointment, and 95% of the population does so at least once each year (Public Health Institute of Scotland, 2002). Community pharmacies may well be the first port of call for clients with symptoms such as sleeping difficulties or feeling generally run-down, which may be alcohol related. Such clients may be reluctant to seek help elsewhere until the condition has further deteriorated. There is considerable potential, therefore, for community pharmacists to contribute to changing the culture of hazardous drinking in the UK by regularly and routinely enquiring about alcohol consumption as a potential contributory factor in these conditions.

In addition, pharmacies are accessed by people who may not otherwise have any contact with health service, such as those seeking emergency hormonal contraception ("the morning after pill"). Excessive

alcohol consumption has been linked to unsafe sex and a higher incidence of sexually transmitted infections but current practice guidelines on the supply of EHC in community pharmacies do not include guidance on addressing alcohol consumption (RPSGB, 2004).

In the absence of previous work in this field, this project sought to evaluate for the first time, the feasibility and acceptability of the provision of brief interventions on alcohol in community pharmacies. The objectives of the project were to:

- (4) Establish a pilot project in which trained community pharmacists initiate discussion of alcohol consumption with targeted pharmacy clients and screen, intervene or refer as appropriate.
- (5) Explore, with pharmacists and clients, the feasibility, acceptability, perceived value and perceived impact of the provision of such interventions in community pharmacy settings.
- (6) Identify markers of good practice and formulate recommendations for future practice.

Research Governance

This project was approved:

- via the research governance framework of The Robert Gordon University,
- by the Research Ethics Committee of the Primary Care Division of NHS Greater Glasgow & Clyde,
- and by the Research & Development Department of NHS Greater Glasgow & Clyde.

All reasonable steps were taken to ensure client confidentiality and anonymity, where appropriate. All paper and audio records were securely stored and audio-records will be destroyed on completion of the study, in accordance with good governance practice.

The process of gaining NHS ethical approval took longer than anticipated. As this was required prior to recruiting pharmacies, recruitment took place over a shortened time period than planned and this may have impacted on the number of pharmacies expressing interest.

SECTION 2: DESIGN & MEASURES

All pharmacies in Greater Glasgow (n=222) were informed of the study in writing and asked to express interest. A copy of the letter and form is included in Appendix A. From the 17 interested pharmacies registering interest, a purposive sample of 8 was selected on the basis of availability for training and to include maximum possible variation in terms of pharmacy type, deprivation index, location, and local level of hospital admissions for alcohol misuse. Only pharmacies which had a “counselling area” for clients were allowed to take part. A description of pharmacies involved is included in Table 1.

Table 1: Profile of Participating Pharmacies & Pharmacists

Code	CHP* Area	SIMD ^α Decile	Alcohol Admissions ^β	How busy? **	Description	Pharmacist Profile	
						M/F	1st Yr on Register ^Ω
A	East	1	1473	250/350	Multiple	M	1989
B	East Dun	6	368	70/130	Independent, rural village.	M	1994
C	North	1	2408	150/250	Independent, Deprived Urban area.	F	1998
D	East	1	1991	420/620	Independent in a Health Centre. Few over the counter sales.	F	1983
E	North	2	1206	200/400	Independent, counselling room.	F ^π	2005
F	East	6	590	180/300	Independent in self-contained community, elderly clients.	F	2002
G	South West	9	340	100/200	Multiple	F	2003
H	North	1	2408	300/500	Independent, Deprived urban area, counselling room.	M	1989

Notes:

*Community Health Partnership/Community Health & Care Partnership Area – in Glasgow unless otherwise stated.

** Pharmacists' estimates of number of Prescription Items on quietest day/busiest day

^Ω The Royal Pharmaceutical Society of Great Britain's Register of Pharmaceutical Chemists.

^π Two pharmacists (E1 and E2) were trained from this pharmacy. E2 who implemented the project is described here.

^α Scottish Index of Multiple Deprivation 2004 Decile 1=highest deprivation; 10 = least deprivation.

^β Hospital admissions for alcohol misuse - rate per 100000 population: 1999-2002

- The latter two statistics are based on information for datazones from www.sns.gov.uk

- Pharmacies C and H were located on the same street and were linked such that the pharmacists in each pharmacy also worked at the other one.

Each of the eight pharmacies was asked to formally consent to the project. A copy of the consent form and pharmacy information leaflet is included in Appendix B.

BASELINE EVALUATION

A baseline evaluation was carried out to establish pharmacists' current knowledge and attitudes relating to alcohol prevention and education as well as their perceived levels of competence. This consisted of short semi-structured telephone interviews and two written questionnaires.

The telephone interviews were between 14 and 27 minutes in duration and covered the topics illustrated in Table 3. All interviews were recorded both electronically and manually and were transcribed in full. The transcripts were subsequently analysed inductively to identify themes.

The first questionnaire ("The AAPPQ") completed by the pharmacists was based on the Alcohol Attitudes and Problems Perceptions Questionnaire (Shaw et al, 1978) which measures the readiness of health professionals for working with problem drinkers. A number of factors have been identified which influence professionals' intellectual and emotional preparedness to work with problem drinkers (Shaw et al, 1978; Deehan, Taylor and Strang, 1997). Collectively these factors are called "therapeutic commitment". "Role adequacy" is the belief that the professional has sufficient knowledge. "Role legitimacy" involves the belief that alcohol issues are a legitimate area for the professional to examine. The final factor is termed "role support", where the professional has confidence that advice and assistance is available when needed. It follows that those professionals with a high therapeutic commitment work more effectively in all areas in dealing with patients who may have alcohol problems. Items relating to role adequacy, role legitimacy and role support as well as motivation, work-specific self-esteem and work satisfaction are included in the AAPPQ.

For this project, the shortened (20 item) version of the AAPPQ was adapted to use language consistent with the type of intervention proposed i.e. work with "hazardous/harmful drinkers" rather than "problem drinkers" which could include dependent drinkers, who were not the target of this project. As an introduction to the questionnaire, pharmacists were asked to consider each statement in relation to helping hazardous or harmful drinkers to reduce or modify their alcohol consumption and "hazardous or harmful drinkers" was defined as "those whose drinking exceeds recommended sensible drinking limits, but who are not dependent on alcohol/alcoholic". Table 4 in the results section illustrates each item in the questionnaire, notes what they relate to and outlines the pharmacists' responses. The adapted questionnaire is included in Appendix C.

The second questionnaire ("The Competency Questionnaire") is included in Appendix D. It was completed by the participating pharmacists and asked them to rate their knowledge and confidence in relation to established competencies in addressing alcohol issues from 1 to 4 using the following scale:

1. I would not be confident about managing this task and would not know what to do/say.
2. I think I could manage this task but would be a little unsure of what to do/say.
3. I think I would manage this task well and I would have a good idea of what to do/say.
4. I am sure I would manage this task well; I know exactly what to do and/or say.

This scale was developed by the research team in order to offer clearer and less ambiguous results than simply asking participants to rate their knowledge from 1 to 4 where “4 is most knowledgeable and 1 least knowledgeable”. Other alternatives observed in the past are scales based on descriptions such as “very poor, poor, fair, good, very good” and so on. Although this scale can be criticised for confounding knowledge and confidence measures, it was considered to offer two advantages due to the use of complete sentences. It reduced the likelihood that two participants with the same level of competence would rate themselves differently because the difference between “good” and “very good” in terms of knowledge or confidence is more subjective than the above descriptions. It is also more meaningful when reporting results to know how many people selected 4 using the scale above, than to know that they considered their knowledge or confidence to be “very good”. The competencies included in the second questionnaire (Table 5) were adapted from an original set of competencies on the management of alcohol and drug issues by non-specialist (Tier 1 and Tier 2) staff produced by the Glasgow Joint Addictions Training Board (Fitzgerald and Fleming, 2004).

TRAINING DESIGN

The results of all three strands of the baseline evaluation (see below) were used to develop a two-day training course for pharmacists to prepare them to be able to screen clients for hazardous drinking and to intervene appropriately where indicated using the brief intervention framework. The training addressed all of the items from the Competencies questionnaire with particular emphasis on sensible drinking limits, units of alcohol, screening, brief interventions and communicating with clients. The overall aim of the training was defined as:

“To enable participants to confidently and competently identify and address hazardous or harmful drinking within the parameters of this research study.”

Within this aim, objectives of the course were developed and activities to meet each objective prepared for delivery over two days (12 hours approximately) of training which were delivered in May & June, 2005. A breakdown of the objectives of the course and methods used to train the pharmacists is shown in Table 2. The course was interactive in nature and encouraged discussion at every stage, particularly in relation to sharing good practice in terms of communicating with clients. Pharmacists were provided with notes and handouts for every section of the training including copies of all presentations, written feedback on each case study, “crib sheets” for carrying out brief interventions including language suggestions, and comprehensive answer sheets for quizzes and worksheets. In addition, pharmacists were provided with copies of relevant leaflets and booklets on alcohol including “Alcofacts”; “So You Want to Cut Down on Your Drinking” (published by NHS Health Scotland) and the Portman Group’s “Unit Calculator”.

A short post-training questionnaire was used to ask participants if they believed the aim and objectives of the training had been met and to assess their perception of how the training would impact on their practice. In addition to this, the two questionnaires used in the baseline evaluation were repeated after the training course to assess impact on perceptions of role adequacy, legitimacy and support and on perceptions of competence.

Nine pharmacists attended the training. This included two from Pharmacy E although only one of those actually delivered interventions in that pharmacy. Training was also offered to pharmacy counter assistants as part of the project to enable them to correctly identify possible clients for referral to the pharmacist to take part in the research and to introduce the issue to clients appropriately and sensitively. Thirteen assistants attended training – four from Pharmacy E, three from Pharmacy A and two from a further three (C, F and H). The remaining three pharmacies did not have any assistants trained – Pharmacies G and B were too small and Pharmacy D did not have counter staff.

Table 2: Summary of Pharmacist Training

Objectives: At the end of this course participants will:	Method Used	Duration (approx)
Day 1		
1. Understand the prevalence and consequences of problem alcohol use in Scotland and how problem alcohol use is defined and classified; Understand DIPS aims, objectives & target groups.	Quiz for individual participants. PowerPoint presentation & discussion.	30 mins. 2 x 30 mins.
2. Have explored attitudes to alcohol use, users and working with alcohol users as community pharmacists.	Small group discussion of attitude statement cards.	30 mins.
3. Have a good, clear working knowledge of sensible drinking guidelines and units as a measure of alcohol consumption.	Sensible drinking & units worksheet completed in small groups.	45 mins.
4. Be familiar with the Fast Alcohol Screening Tool (FAST).	Presentation on Screening. Paired role-play of screening case studies.	15 mins. 1 hour.
5. Be familiar with Brief Interventions on alcohol.	Presentation on brief interventions. Paired role-play of brief interventions using case studies.	15 mins. 1 hour.
Day 2		
6. Understand the philosophy and process of motivational interviewing.	Video illustrating MI process.	2 hours.
7. Be able to use motivational interviewing strategies to communicate with clients about alcohol issues.	Whole group discussion & practice of MI method.	
8. Have a good, clear working knowledge of what is offered by the community addiction team and when and how to refer clients.	Presentation from Glasgow Addiction Services.	30 mins.
9. Have a good, clear working knowledge of recruiting, screening and intervening with clients as appropriate including taking a drinking history, screening using FAST, raising awareness around units and sensible drinking guidelines and offering brief interventions where appropriate.	Small group work & whole group discussion to review case studies. Presentation. Paired role-play. Group discussion.	30 mins. 30 mins. 90 mins.
10. Have a good clear working knowledge of procedures for recording and reporting activity to the project team.	Final review & Q&A session.	30 mins.

IMPLEMENTATION

After training, the eight pharmacies were asked to recruit clients over the period from the middle of July to October, 2005. Standardised protocols were prepared to screen clients for hazardous drinking using FAST (the Fast Alcohol Screening Tool, Hodgeson et al, 2002) and to guide the intervention. These protocols also allowed the pharmacist to record the whole process for each client which were returned to the project manager after implementation. Pharmacies were provided with a set of project materials including:

- Individual sets of materials for each participating client including the project protocol, client information leaflet and client and pharmacy copies of the consent form.
- Postage-paid envelopes for return of forms to the project manager.
- A laminated crib sheet for carrying out brief interventions.
- A laminated sheet providing details of alcohol services in Glasgow.
- A flowchart of patient involvement in the project.
- A stock of alcohol-related materials including the following leaflets:
 - So you want to cut down on your drinking, booklet, NHS Health Scotland.
 - Alcofacts, leaflet, NHS Health Scotland
 - Unit Calculator, The Portman Group
 - So you think you know what your child drinks, NHS Health Scotland
 - Alcohol posters, NHS Health Scotland, adapted to highlight that the pharmacy was involved in the research project.

Clients were recruited from four specific target groups as well as through posters in pharmacies highlighting the service. The four target groups were chosen to include clients who reported health needs or issues in which alcohol consumption can be a contributory factor and which would not otherwise be addressed by a health professional or which might not be addressed elsewhere unless it worsened. The chosen target groups were:

1. Clients seeking emergency hormonal contraception.
2. Clients seeking advice or products to address sleep difficulties.
3. Clients seeking advice or products to address fatigue/lethargy/a feeling of being “run-down” (including multivitamins, tonics and/or herbal remedies).
4. Clients seeking advice or products to aid with smoking cessation/reduction.

A copy of the protocol and record form for pharmacists to use with clients is included in Appendix E. A copy of the client consent form and information leaflet can be found in Appendix F. The completed forms returned by the pharmacies were each manually coded and entered into a spreadsheet for quantitative analysis.

Over the course of the implementation period, the project manager visited each pharmacy twice to review how they were getting on with implementation and to offer help and support. Each pharmacy was also contacted a number of times by phone.

FOLLOW-UP

After the completion of the recruitment phase of the project, three interviews were carried out by the project manager with participating pharmacists and included six of the eight pharmacists. A copy of the topic guide for these interviews is included in Appendix G. Although originally planned as focus groups, it proved too difficult to get all the pharmacists together on the one evening and so smaller group interviews were used instead. The actual format of the interviews is described in Table 3.

Interview 1: 30 th November 05	Face to face joint interview with pharmacists E2 & H.
Interview 2: 22 nd February 06	Face to face joint interview with pharmacists C, D & F.
Interview 3: 27 th April 06	Telephone interview with pharmacist A.

In addition to the pharmacist follow-up, clients were asked by the pharmacists if they were happy to be followed up by telephone interview after taking part in the study and 40 agreed and provided their contact details. At least three attempts were made to contact each client. A total of 19 clients (including 9 who were drinking hazardously at the time of the original intervention) took part in telephone interviews of between 5 and 16 minutes in duration which were carried out by the project manager. The interviews included a number of questions to explore the clients' views on the acceptability and usefulness of the project as well as a repeat of the FAST screening to give an indication as to whether or not their drinking patterns had changed since taking part in the project. The interview guide for client follow-up is included in Appendix C.

Data from the pharmacist and client follow ups were transcribed in full and thematic analysis was carried out manually in relation to the key areas of interest, that is, feasibility, barriers/helping factors, acceptability and perceived effectiveness. The framework approach (Ritchie and Spencer, 1993) was considered more suitable than other approaches (e.g. grounded theory) as the research started deductively from preset objectives and more structured data generation. Analysis was undertaken by the project manager and all emerging themes and illustrative quotes were discussed and finalised by the research manager and grant holder.

SECTION 3: FINDINGS

In order to avoid repetition in the findings, the results of the three strands of the baseline evaluation are presented together as they relate to specific themes.

BASELINE EVALUATION

Current Practice in Addressing Alcohol Issues

- The pharmacists interviewed for this project reported that alcohol arises as an issue in community pharmacies rarely or on an occasional basis and primarily in the context of interactions with prescribed medicines including methadone and patients with prescriptions to treat alcohol dependence.
- Most reported that they would not raise alcohol consumption as an issue with clients and would only discuss it if clients brought it up, other than very briefly in the context of general health discussions.

“I would be very rarely asked about alcohol consumption”

Pharmacist D.

“I think it would only come up if they asked about it. I don’t think I would mention it.”

Pharmacist B.

“Don’t really get asked. I don’t really seek it. I find it hard to raise the issue. I know people who do drink but am not quite sure how to tackle it.”

Pharmacist E1.

- A minority of the pharmacists reported having advised clients occasionally on safe drinking guidelines and how alcohol may affect health.
- Only one had referred clients onwards for help in relation to alcohol issues.
- None of the pharmacists had given advice or tips to clients on how to reduce drinking.
- Only two pharmacists considered that they “currently work with hazardous drinkers” and therefore completed questions 18-20 of the AAPPQ which relate to task-specific self esteem. Neither were entirely satisfied with how they currently work (responses of 6 and 4) although they were not often uncomfortable in working with hazardous drinkers (7, 5).

Attitudes to Pharmacists Taking on this Role

All pharmacists agreed that it was appropriate and feasible for community pharmacists to “opportunistically identify hazardous and harmful drinkers and to deliver a brief (10 minute) intervention” focusing on “benefits as perceived by the patient versus the disadvantages of the current drinking pattern” as recommended by SIGN Guideline 74. Among the views expressed was a consensus that:

- Alcohol is a big problem in society that pharmacists should be tackling

“I think it’s very relevant. We ask people about many different things about their lifestyle so I don’t think we should shy away from the drink.”

Pharmacist C.

“In Scotland I think it’s all a joke – alcohol and drinking too much...It’s a cultural problem...I think there are a lot of people who drink too much and there is a whole problem that needs to be addressed.”

Pharmacist D.

“I think it’s a topic that a lot of people don’t see as a health issue; people see it as more of a social habit and never think of the health issues related to alcohol. Obviously the community pharmacist can make people aware on what safe levels and health issues are with regular use. “

Pharmacist F.

- Pharmacists would have to be careful about how they raised and handled the issue with clients to avoid causing offence.

“I think some (clients) might (find it acceptable) and some might not, you would have to judge the situation, some people don’t want counselling and you can’t force it upon them so I think pharmacists would have to use their discretion and judgement on how to approach a patient because not all would be responsive. But it’s about trial and error and we won’t really know until we try it.”

Pharmacist G.

“I think it would be difficult but it would be possible. I think you would need to be very careful not to offend your patients.”

Pharmacist A.

Similar results were found in the AAPPQ in questions relating to role legitimacy (Q5, 6 and 7 in Table 5 below) for which the median response was 4. In addition the median response for the questions relating to work-specific self esteem (Q14-17) was somewhat ambiguous at 3.

Despite this uncertainty, the pharmacists were clearly interested in the nature of alcohol-related problems and the responses they could anticipate (median response of 2 on question 9 of the AAPPQ).

Training Needs

All of the pharmacists interviewed felt that they would need additional training before taking on the role of identifying and intervening with hazardous drinkers. The two topics most requested were:

- Communication – how to raise the issue and communicate with clients effectively without causing offence.

“...the way to broach the subject; who you are targeting, different scenarios and how to ask people. I know it sounds a bit basic but until you know how to do it, it’s quite difficult, but how to ask people questions without offending them.”

Pharmacist C.

“Training - how to go about intervening first of all in terms of talking to them, even if its appropriate to talk to them, what to say.”

Pharmacist B.

- Information about alcohol – limits, motivational interviewing and “helpful hints”.

“At the moment I wouldn’t be very confident and my knowledge isn’t vast. I would like some training on it before I go ahead and do maybe what is in the SIGN paragraph.”

Pharmacist G.

In the interviews, none of the pharmacists were able to correctly outline the recognised daily limits for alcohol consumption and only one was able to correctly explain how much lager, wine and spirits make up one unit of alcohol. This contrasts with the pharmacists’ confidence expressed in the Competency Questionnaire in their responses to the questions on units (median rating 3) and limits (median rating 3) – see comment above. None of the pharmacists reported being familiar with screening tools for alcohol or brief interventions and none rated their confidence in using screening tools higher than 2 in the Competency Questionnaire (Item 11, Table 4). The only item which was rated lower than this was knowledge of specialist services for alcohol (Item 16, Table 4, median rating 1).

In general, the pharmacists did not rate their alcohol knowledge and confidence highly as illustrated in Table 4. This is also reflected in their responses to the Role Adequacy questions on the AAPPQ (Table 5).

All of these results were used to inform the content of the pharmacist training. In particular, the first day of the training sought to gradually build pharmacists' knowledge and therefore confidence starting with basic information and building on this into progressively more complex role-plays of client interaction.

IMPACT OF TRAINING ON CONFIDENCE & SELF-ASSESSED KNOWLEDGE

Immediately after the training was delivered there was an increase in pharmacists' self-ratings of confidence and knowledge as illustrated in Tables 4 and 5 which show the full results of both the competency questionnaire and the AAPPQ at baseline and after the training. Competencies were rated at a median 4 (compared to a median of 2 before training).

Table 4: Competency Questionnaire	Median Rating	
	At Baseline	After Training
1. Explain what alcohol is and how it affects the body	2	4
2. Explain units of alcohol and know the alcohol content of common drinks	3	4
3. Explain the metabolism of alcohol including myths and facts about sobering up	2	4
4. Explain gender differences relating to alcohol metabolism.	2	4
5. Describe the physical/medical harm associated with alcohol use to patients	2	4
6. Describe the psychological harm associated with alcohol use to patients	2	4
7. Describe the social harm associated with alcohol use to patients	3	4
8. Give sensible drinking advice including daily and weekly drinking limits and harm reduction strategies	3	4
9. Outline options and harm reduction strategies to help drinkers to cut down or modify their drinking	2	4
10. Understand, define and explain the following terms: <i>(each term separately)</i>		
a. Hazardous drinking	2	4
b. Harmful drinking	2	4
c. Binge drinking	2	4
d. Alcohol dependence	2	4
11. Understand, administer and interpret validated screening tools relating to alcohol consumption	2	4
12. Be able to respond appropriately to the results of screening including giving advice, and linking individuals to appropriate interventions.	2	4
13. Understand and deliver brief interventions on alcohol	2	4
14. Understand and use basic motivational interviewing techniques in relation to alcohol consumption	2	4
15. Describe and provide information about and contact details for a range of organisations dealing with alcohol misuse or providing relevant services	2	4
16. Understand the role and function of specialist (Tier 3) alcohol services, when individuals should be referred to these services and how to make such referrals.	1	3
17. Understand confidentiality issues of different services around sharing of information	3	4
18. Provide to and discuss with patients health promotion information and advice relating to alcohol including its contribution to other health issues.	2	4
19. Access and use appropriate health promotion materials/resources and provide these to individuals.	2	4
20. Respond, intervene and support appropriately to address situations in which alcohol issues may affect children and families.	1	3.5

Table 5: Adapted AAPPQ. <i>(Negative statements are shaded for clarity in reporting)</i>		1=Strongly agree, 7= Strongly disagree	
		Median Rating at Baseline	Median Rating After Training
1.	I feel I have a working knowledge of alcohol and alcohol-related problems.	4	2
2.	I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with hazardous drinkers.	4	2
3.	I feel I can appropriately advise my patients about hazardous drinking and its effects.	4	2
4.	At times I feel I am no good at all with hazardous drinkers.	4	6
5.	I feel I have a clear idea of my responsibilities in helping hazardous drinkers.	3	1
6.	I feel I have the right to ask patients questions about their drinking.	4	3
7.	I feel that my patients believe I have the right to ask them questions about drinking.	4	3
8.	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a hazardous drinker.	4	1
9.	I am interested in the nature of alcohol related problems and the responses that can be made to them.	2	1
10.	I feel that the best I can personally offer hazardous drinkers is referral to somebody else.	5	6
11.	I feel that there is little I can do to help hazardous drinkers.	7	7
12.	Pessimism is the most realistic attitude to take toward hazardous drinkers.	7	7
13.	I feel I am as able to work with hazardous drinkers as with other patients.	3	3
14.	In general, one can get satisfaction from working with hazardous drinkers.	2	2
15.	In general, it is rewarding to work with hazardous drinkers.	3	2
16.	In general, I feel I can understand hazardous drinkers.	4	2
17.	In general, I like hazardous drinkers.	4	3
<p><i>Do you currently discuss alcohol consumption with patients who may be drinking hazardously?</i></p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>The following questions should only be answered by those who currently work with hazardous drinkers.</i></p>			
18.	On the whole, I am satisfied with the way I work with hazardous drinkers.	<i>This was completed by two pharmacists before the training, but only one completed it after the training.</i>	
19.	I often feel uncomfortable when working with hazardous drinkers.		
20.	In general, I have less respect for hazardous drinkers than for most other patients I work with.		
Key to Statements:	Role Adequacy: Questions 1-3 Role Legitimacy: Questions 5-7 Role Support: Question 8	Task-specific Self Esteem: Questions 4,13, 18 Work Satisfaction: Questions 14-17, 19 Motivation: Questions 9-12	

The most substantial improvements in self-rated knowledge and confidence occurred in relation to screening, awareness of services, describing alcohol metabolism and physical harm and delivery of brief interventions. It is striking that all the pharmacists gave themselves the top rating for “giving sensible drinking advice including daily and weekly drinking limits”, “outlining options and harm reduction strategies to help drinkers cut down or modify their drinking” and for “describing the physical harm associated with alcohol to patients”. These are key elements of an effective brief intervention.

This increase in confidence is also apparent from the post-training ratings on the AAPPQ, where there are clear improvements in perceptions of role adequacy and role legitimacy. Crucially, pharmacists were much more likely after the training to agree with the statement “I feel that my patients believe I have the right to ask them questions about drinking” after the training which relates directly to their concerns about negative responses from clients.

In the third post training questionnaire, pharmacists were asked for their reactions to the course. 7/8 felt that it had “completely” achieved its aim which was “to enable participants to confidently and competently identify and address hazardous or harmful drinking”. The eighth person felt that this had been “mostly” achieved. Their comments on this questionnaire highlight their increased sense of confidence about their ability and legitimacy in addressing this issue. One comment in particular is telling:

“Previously ignored alcohol as not wanting to upset anyone but should be an integral part of healthcare advice and questioning of patients”

Pharmacist E2

Feedback on the pharmacist training was very positive as illustrated in Table 6. These results post-training should be interpreted with caution, as one would expect self assessments of knowledge, understanding and application to increase immediately following training. These changes may not be sustained in the medium to longer term. In addition, the small number of pharmacists trained in this pilot meant that it was inappropriate to statistically test the significance of any changes.

Table 6 Training Feedback, n=8

Question	Not at all	Partially	Mostly	Completely
Do you think that the aim of the training has been achieved?	0	0	1	7
Do you understand the prevalence and consequences of problem alcohol use in Scotland?	0	0	1	7
Do you understand how problem alcohol use is defined and classified?	0	0	2	6
Have you explored attitudes to alcohol use, users and working with alcohol users as community pharmacists?	0	0	3	4
Do you have a good, clear working knowledge of DIPS aims, objectives & target groups?	0	0	3	5
Do you have a good, clear working knowledge of sensible drinking guidelines?	0	0	0	8
Do you have a good, clear working knowledge of units as a measure of alcohol consumption?	0	0	3	5
Are you familiar with the Fast Alcohol Screening Tool?	0	0	1	7
Are you familiar with brief interventions for alcohol?	0	0	4	4
Do you understand the philosophy and process of motivational interviewing?	0	0	5	3
Are you able to use motivational interviewing strategies to communicate with clients about alcohol issues?	0	1	4	3
Do you have a good, clear working knowledge of recruiting, screening and intervening with clients as appropriate to this study including taking a drinking history and increasing awareness around units and sensible drinking guidelines?	0	0	0	8
Do you have a good, clear working knowledge of what is offered by the community addiction team and when and how to refer clients?	0	0	3	5

CLIENT RECRUITMENT & SCREENING RESULTS

Pharmacists from all 8 pharmacies successfully recruited clients between July & October 2005. In total 70 clients were recruited of whom:

- 19 were seeking smoking cessation advice (27%)
- 13 asked about posters/displays in the pharmacy (19%)
- 12 were feeling run-down/tired/lethargic or seeking a tonic/multivitamin or herbal remedy (17%)
- 4 were seeking sleep-aids (6%)
- 2 were seeking emergency hormonal contraception (3%)
- 20 other/not recorded by pharmacists.

Of the 70 clients recruited:

- 30 (43%) were drinking hazardously (3-6 on FAST)
- 7 (10%) were drinking harmfully (7+ on FAST)
- 40 agreed to be followed up of whom 25 had screened as hazardous or harmful drinkers.

For those clients who screened as drinking hazardously or harmfully, pharmacists carried out a number of interventions. The frequency and nature of the interventions is described in Table 7.

Table 7: Interventions Delivered by Pharmacists

Intervention ↓ Number of Clients who received this →	Hazardous (n=30)	Harmful (n=7)
Feedback on screening & risks to health	22 (73%)	5 (71%)
Explanation of sensible drinking & units in clients' preferred drink(s)	25 (83%)	5 (71%)
Discussion of pros and cons of current drinking pattern & link with presenting issue	18 (60%)	5 (71%)
Discussion of options for cutting down	16 (53%)	5 (71%)
Recommended to seek further advice	0	1 (14%)*
Literature: Unit Calculator Wheel	18 (60%)	2 (29%)
Literature: Alcofacts leaflet	12 (40%)	1 (14%)
Literature: So You Want to Cut Down Booklet	15 (50%)	4 (57%)
Literature: Alcohol Support Services Contacts	1 (3%)	0
No intervention recorded	3 (10%)	1 (14%)

*This client was referred to their GP. Other referral options given but not used by the pharmacists were the local Community Addiction Team; Glasgow Council on Alcohol or Alcoholics Anonymous.

The details of client recruitment provide only limited information on the profile of clients involved for two reasons. It is clear from the number of clients for whom a reason for recruitment was not recorded and from the discussions with pharmacists in follow up interviews that a large number of clients were recruited informally by assistants or pharmacists without falling into the target groups. This raises an important issue for future recommendations on this kind of intervention in this setting. The SIGN guideline clearly states that recruitment for alcohol screening should be opportunistic and should relate to the client's presenting problem. In reality, this was often not what happened in this study.

The proportion of clients who screened as drinking hazardously is higher than that reported in general population studies where 14% of women and 28% of men have been found to be exceeding weekly limits (Rehn et al., 2001) and higher than that found by Dhital et al. (2005) in pilot work in one London community pharmacy where 36% initially screened as hazardous using the AUDIT screening tool (Babor & Grant, 1989).

The average times per consultation were 9 m 2s with non-hazardous clients (n=29) and 12 m 58s with hazardous or harmful clients (n=31). The average for harmful clients was 15m 50s (n=6). A breakdown of the number and nature of clients recruited by each pharmacy is included in Table 8.

TABLE 8: CLIENT RECRUITMENT DETAILS BY PHARMACY

PHARMACY	A	B	C*	D	E	F	G	H
Total # Recruited	12	12	0	13	16	6	7	4
# Male	4	8		3	0	2	0	2
#Female	7	3		9	14	4	7	2
# Hazardous	5	5		5	7	1	3	4
# Harmful	3	0		1	1	1	1	0
# Agreed to Follow-Up	8	1		8	11	2	6	4
Average Time Per Non-Hazardous Client	7m 30s	9m		6m 10s	13m 7s	6m 45s	n/r	n/a
Average Time Per Hazardous Client	9m	9m		11m	15m 43s	20m	n/r	16m
Average Time Per Harmful Client	13m 20s	n/a		20m	25m	10m	n/r	n/a

n/r = not recorded; n/a = not applicable.

**Pharmacies C and H were located on the same street and were part of the same small group and the pharmacists in each pharmacy also worked at the other one. In practice, although both pharmacists recruited a small number of clients, they both did so while working at Pharmacy H.*

The pharmacists also recorded 39 clients in total with whom they had discussed the research study but who did not consent to take part. The reasons for non-consent were:

- 19 stated that they did not drink alcohol.
- 10 stated that they did not have time to take part.
- 7 did not give a reason.
- 3 gave other reasons including one client who reported that he/she was currently attending psychiatric treatment for alcohol dependence.

Comments

We had initially anticipated recruiting 400 clients during the study. There are several factors which contributed to the actual numbers being much lower. The time required to gain NHS ethical approval was longer than anticipated and hence there was less time available for pharmacy recruitment, training and subsequent client recruitment. In addition, there was no published literature on which to base this estimate as this was a very new activity for community pharmacy practice, as can be judged by the pharmacists' comments.

Informal discussions with the pharmacists involved revealed that some initially (for the first month or so of the project) forgot to complete forms when clients were not interested in taking part, and others admitted that it was unlikely that all refusals were recorded. It is therefore difficult to estimate the frequency of client participation.

Pharmacists recorded the time at which they commenced a consultation and when they finished a consultation on the record sheets. The majority of pharmacists completed this for almost all clients and the time figures are therefore thought to be an accurate estimate of the time actually involved. It is worth noting however, that this included time to consent clients, and may therefore be longer than the actual time spent screening and delivering the brief intervention.

PHARMACIST FOLLOW-UP RESULTS

Overall Impressions of Project, Training & Materials Provided.

The six pharmacists who were followed up were all positive about the project and felt that it was worthwhile.

“I think the idea behind the whole project was really quite innovative because although everybody drinks basically and there is so much knowledge about other healthcare issues out there but there is not a whole lot about alcohol except the extreme of alcoholism.”

Pharmacist F

Many of them commented on the impact of the project on their own knowledge and awareness of alcohol issues. This was largely attributed to the training, which the pharmacists felt was “excellent” and helped them to feel comfortable implementing the project.

“I certainly feel I’m in a better place to speak to people about [alcohol] now than I was before. I feel more comfortable speaking to people about it now because we have been speaking to people about that subject but also because I’ve had a bit more training and a bit more knowledge.”

Pharmacist C

“I don’t remember doing anything on [alcohol] in Uni apart from the extreme of an alcoholic or whatever. But I felt that I didn’t have enough knowledge to speak to people about it but after doing the training I feel as if I could now...I certainly gained a lot from the training day and the girls on the counter they gained a lot as well.”

Pharmacist F

“I felt [the training] was a good length. I do agree it was interesting and it was in the right depth.”

Pharmacist D

Inviting Clients to Take Part

When recruiting clients, pharmacists reported no major problems such as aggression or strong negative reactions in terms of how clients reacted to being asked to take part in a project on alcohol. A number of points were raised. Those clients who were not interested in being involved gave various reasons for not wanting to take part such as a lack of time (the most common reason given) or because they didn’t drink any alcohol at all.

“I think the only thing people said was the time factor. I don’t know if the words “this is a research project”, I don’t know if people associated it with “its going to take forever”. But that was the only thing people said.”

Pharmacist F

"I don't think there were many who said they didn't have time. A couple of them said they didn't drink so they weren't wanting to take part. We didn't have any aggression and I don't think we had much negative reaction. Some people indicated that they were either giving up drinking or they didn't drink and didn't think it was worth their while."

Pharmacist A

A number of possible explanations for the lack of negativity were given.

"I think intuition. You're not going to ask, I mean your sixth sense says I'm not going to ask this person who's going to clout me over the head, something tells you who to ask and who not to ask."

Pharmacist D

"I think probably most of them [the clients who took part] know myself and the staff so I think they were comfortable with us discussing it with them."

Pharmacist A

Although none reacted badly to a request to take part, a mixed picture emerges as to how willing clients were to actually engage with the project. It is not possible to get a clear sense of what proportion of people who were asked to take part, actually agreed or refused to do so.

"Although people were really interested [in our display of alcohol bottles] and asked "are you giving away free drink or something?", in terms of people wanting to discuss what they drank it was one extreme to the other. Some people were fine about it and others were like "there is nothing wrong with what I drink". So they were quite kind of guarded about it but in terms of the actual questioning it was quite straightforward asking people."

Pharmacist F

"The odd one or two maybe were a bit embarrassed but it was only one or two. Most people were quite happy to discuss it."

Pharmacist A

“The only people who, well I wouldn’t say they reacted badly, but the only people who were maybe a bit shocked were older people, pensioners. They thought they may be branded as closet drinkers, I think. I think they weren’t expecting to be asked. The majority were positive. Again it’s a time thing. Most people want to get into the shop and be out again as quick as possible.”

Pharmacist H

“I found the vast majority of ours, if not all of ours were women, we had no men approaching to ask questions and if you did ask them they were kind of “we don’t have time” or they didn’t really want to talk about it. I don’t know if that was because I did most of our things and maybe me being quite a young female they didn’t feel that comfortable so maybe it reflects who’s asking the questions...[Those] who didn’t want to be involved just said no I don’t have the time and we just left it at that. Obviously these people will come back into the shop at some point and we don’t want to make anyone feel bad.”

Pharmacist E2

Practicalities of Implementing the Service

Despite the fact that there were no major negative reactions, pharmacists reported that they found it difficult to provide the service to as many clients as was initially envisaged. The most common reason for this was that they, as pharmacists, did not have time to implement the project due to the pressures of people waiting for prescriptions. This was partly affected by the pharmacy being short-staffed in general at the same time as the project was implemented.

“It could be a bit involving at times. But overall I thought it was a worthwhile thing to do...The materials were fine. It was just time-consuming going through the forms. I don’t know if it could be shorter and still do the same intervention..”

Pharmacist A

“I think we underestimated it, although we had two pharmacists in our shop... a lot of the time there was only one of us. We had a couple of staffing issues as well at the time which meant that even if we were both there we were short-staffed and I realise that most pharmacies just operate with one pharmacist but as soon as we step away for five minutes...and as I say with other staffing issues we weren’t very successful.”

Pharmacist C

“The other problem you had was the time factor. In a busy pharmacy I was very conscious of people. We just have a small booth for counselling and we were conscious that people could see me talking to somebody or they could see me anyway and if you’re talking to somebody for ten to fifteen minutes then really it’s not practical really we found... It was just time. I felt rushed to try and get through it.”

Pharmacist H

A number of possible solutions to this were mentioned:

- Two of the pharmacists mentioned they had checking technicians¹ by the time of follow-up which they did not have when implementing the project which should free up the pharmacist for a more clinical role.

“Maybe in the future when we’ve all got checking technicians we could maybe move away from the checking desk a wee bit. I’d certainly prefer to be doing stuff like that.”

Pharmacist F.

- In Pharmacy E, which was the most successful in implementing the project, there were two pharmacists, which made this easier.

“We were quite lucky because we had John [Pharmacist E1] and myself so we didn’t have that problem [of pharmacist time] but if you were in on your own then that’s something... I mean definitely when you are chatting to somebody you can’t look at your watch, if you do bring something up and then you hit on something and they want to start talking about it and then for you to kind of go I’ll be back in five minutes, you kind of break somebody’s rhythm.”

Pharmacist E2

- This pharmacist suggested that if more pharmacies move towards having two pharmacists, perhaps as a result of the new pharmacy contract in Scotland, it would be easier to implement this kind of project.

Pharmacists commented on a number of things that helped recruitment.

Posters and/or Displays in the Pharmacy

“We actually struggled to get people to do it I think. What we ended up doing was putting a display table out, got some pint glasses and wine glasses and whatever else and a few leaflets on the table to try and attract, just a kind of focal point for it...it seem to help generate interest amongst patients because everybody did notice it because we put vodka out, well it was water, but it did get everyone talking about it. So it was a good way without having to approach people directly, they would maybe approach us instead.”

Pharmacist F

“I’m not 100% easy about talking to customers without some introduction from them, maybe asking about the project. Having the posters up I think helped a wee bit because it made them aware that it wasn’t just them we were picking on in particular...I think once you got somebody talking I didn’t really find it a problem. It was really actually trying to get the people.”

Pharmacist H

¹ A ‘checking technician’ is trained to check the accuracy of another technician’s dispensing. The pharmacist is still responsible for checking the legality and clinical appropriateness of the prescription for an individual patient and advising the patient on its appropriate use.

Recruiting through the front counter staff at the pharmacy.

"I think it was useful having the staff trained as well as the pharmacists because obviously they are at the forefront. I think it was good having the staff on the course as well to make that initial contact with people because otherwise I think it would have been a nightmare if it had been pharmacist training only trying to recruit everyone that was quite good that the staff could do it as well."

Pharmacist F

"We had front counter staff and dispensers so that certainly made a difference and we went round, John [Pharmacist E1] and I went round with the front counter staff and asked them and pointed out people were asking for this type of thing or that these are the type of people, if you can, highlight them to us. So we think that made a difference for them... They [the counter staff] definitely put the idea out there through posters and stuff and if people are sitting waiting for prescriptions, they'll maybe go, sitting and chatting, "oh what's this" and that actually got us quite a lot of people."

Pharmacist E2

The official paperwork/official nature of the research.

"I also thought it helped having quite official paperwork because I think the public in general quite like paperwork, they feel they are taking part in something quite official. You know, it is a study, it's not something being casually done or anything so I think it was well presented."

Pharmacist D

Recruiting clients who were attending the pharmacy as part of a smoking cessation programme.

"Smoking cessation did the best recruiting. We were conscious that when we had someone in for smoking cessation we couldn't really introduce the topic at the first meeting because you've got their spiel about smoking cessation so you would try and remember the next time they came in to maybe introduce the topic when you hadn't so much to say or do."

Pharmacist H

It is worth noting that in contrast to the comments above about counter staff, two of the pharmacists stated that they only had one or two referrals from the counter staff on this project. One explained that they had not sent the most appropriate staff to the training for counter assistants.

"We did [have staff trained] but they were both dispensers which wasn't the best choice. We should really have gone for the counter staff. The dispensers were too busy dispensing to deal with it, which was our mistake. We should have chosen different staff."

Pharmacist H

Apart from time constraints, the physical space in the pharmacy was not always reported as ideal for private discussions with clients. [Although all pharmacies involved had a “counselling area”, this was not always a private room. See Table 1]

“Probably having a consultation room would have been better, we still don’t have one although one is planned. I think a totally private area would have helped.”

Pharmacist A

Views on Actual Implementation

Once clients had agreed to take part in the study, pharmacists found the process of screening and delivering the intervention relatively easy.

“Having the acetate was a great help. The acetate sheet [crib sheet]. That certainly made it easier. It gave you inroads into what to ask and you could just ad lib from that. And the actual sheet that you worked out whether they were hazardous or not – that was quite easy to follow. Simple to use.”

Pharmacist H

“That I found fairly easy. After I had done the kind of first one, I know the training was kind of based on how you were going to phrase certain questions with different kinds of people... I must admit I did find that fairly easy if I’ve got the time to stand and go through it I found it fairly easy. “

Pharmacist F

This pharmacist goes on to comment about the value of practice.

“There were always still a few things that threw me right enough. I think the more you did it, the easier it got but when I first did it I was like oh my goodness I’m going round this wee wheel [unit calculator] all the time and you’re sitting there, because it’s never just one kind of drink, it would be like three different drinks but the more you did it the easier it got. Having the wheel certainly helped.”

Pharmacist F

Pharmacists felt that clients found their involvement in the project valuable and they felt that clients appreciated the service given. In particular, they commented that clients were previously unaware of some of the information and advice that was being provided and might have been “surprised”.

“I’d say people aren’t used to being asked about their drinking habits and I think there is a lot of information you can actually provide for people and I think a lot of people were interested because again it’s not something you discuss with them on a regular basis. I think a lot of people were surprised as well at the sensible drinking limits. A lot of people were still in the attitude of weekly limits and didn’t really think too much about binge drinking as being a problem so I think a lot of people appreciated me speaking to them.”

Pharmacist C

This pharmacist went on to comment:

“I think once you start writing down what people drink over a period of time they do surprise themselves because a lot of people don’t actually think about it and its only when you ask them about it that they maybe think maybe there is a slight problem there.”

Pharmacist C.

A number of suggestions were made by pharmacists as to factors that contributed to this generally positive reaction from clients.

The Information & Resources Provided to Clients

“I think in general they were ok about the results and obviously you explained why you asked them the questions and as long as you can provide them with a wee bit of information at the end most of the people went away with the wheels, they liked the wheels and the information leaflets as well and as long as if you were prepared to back it up with some information and not just make a statement at the end of it, it was fine.”

Pharmacist C

"I found with the unit calculator, I was kind of using that and going through with people if they drank a couple of bottles of wine or something, you know it was quite easy to kind of go through with them and say well a bottle of wine is nine units and I don't think a lot of people appreciated that... I think all the books and things are good kind of props just to kind of help you through it. Sometimes I think it's good if you've got something to go through with people."

Pharmacist E2

Empathising with Clients

"The idea to not kind of, it's just your tone with them, making sure you're not treating them as sub-standard because they are not drinking in what would be considered a safe manner. You know, I think it's just how you talk to them really. Just your manner."

Pharmacist H

"You're not sitting there with a clipboard and a pen saying "how much do you drink?" so it's more of a discussion then people are more relaxed and they'll open up a wee bit more. I found I was telling them I was out at the weekend you know so it's ok, I'm not sitting here on my high horse waiting to come down on you."

Pharmacist E2

Although reactions were positive, pharmacists were unsure as to what impact the project would have on clients' drinking behaviour.

"Not everyone was really wanting to cut down even though they knew they were drinking more than was recommended. But I mean everyone I think learned something from it even though they didn't want to change their weekend drinking habits."

Pharmacist F

Pharmacists felt that clients who agreed to take part in the study were generally honest about their consumption.

"I definitely found everybody quite honest and open and I think people especially with all this publicity about pharmacies people do sort of see you as a health professional but without that white coat formality almost, kind of judging you. You know this why this is happening."

Pharmacist E2

"I think you get people who will kind of cock their head to the side and kind of smile and roll about. Even if you say it yourself you know that's how much I went through, I didn't appreciate that. So to reiterate that, it's bad enough you've done it yourself, to say it to somebody else and recording it down, it can be a bit daunting sometimes....we had a few younger girls, they were like it started off with just a couple round at my friend's and two bottles of wine later and I think that it's when you're clocking it up and you're going through with them that that's so many units and it's all on a Saturday night and you're exceeding your weekly limit at that. I think people were honest."

Pharmacist E2

One of the reasons suggested as why people were generally honest was because pharmacists felt they did not realise how much they were drinking until it was added up or that they were unaware that even low levels of drinking could be hazardous.

"I think again once they started to say how much they were drinking I think it more or less dawned on themselves that they were probably drinking too much if they were drinking too much. We had one chap who takes his father to the pub and his father's blind and this is his way of entertaining his father. I suppose he wouldn't really think about how much he was drinking because it's something he always did. You'd hate him to keep his father cooped up but he just didn't realise how much he was drinking."

Pharmacist H

"I think sometimes people knew it was coming you know when you're going through it when people actually verbalise it and it's maybe not in the strict confines of a doctor's surgery, who's maybe the only other person that would question somebody's drinking in a health manner when they're sitting with their wee glass of wine on a Sunday. They're much more sort of chatty and much more sort of relaxed so in that sense when you are targeting people you are getting a more truthful sort of judgement so I think people are quite open and quite easy to you saying the term hazardous opposed to you are a hazardous drinker."

Pharmacist E2

Other Personal/Professional Outcomes:

I feel my husband and I have cut down. Because we did tend to be drinkers on one night of the week drinkers. Not that we were ever frazzled or anything. I think we drink a lot more steadily and smaller amounts.

I scared the living daylight out of my sister.

Pharmacist D

Pointers for Future Implementation

Some pharmacists suggested that the implementation of the project should be extended to include other pharmacy staff either for all or part of the interventions with clients. It was agreed that not all staff would be suitable for this and it was suggested that the pharmacists should still be fully trained in any pharmacy where it took place.

"I think the staff are sometimes they are better at it from the point of view that they've got more time because we find that with the smoking project. We find that the girls are probably better doing it than I am. I'm always thinking oh my goodness there are so many people waiting there and I'm stuck in here. Whereas they are more relaxed and talk things through and I think the patients get more out of speaking to the staff than sometimes the pharmacists."

Pharmacist F

One of the pharmacists (D) was not convinced however and commented in one of the group interviews *"I don't have the trust in my staff that you girls obviously have."*

Pharmacists also commented that it would have been valuable to have received all of the project materials on the day of training rather than having to wait. They felt that the gap between the training and getting started meant that they had to revise materials and were less confident.

"The only thing I would say is that maybe there was too much time between the training day and actually getting started. It might have been easier for us if we had just come away and gone straight into it."

Pharmacist C

Some of the pharmacists commented on the value of having formal paperwork for implementing the project and recommended that this be used even if the interventions became part of mainstream pharmacy practice (see above).

There was some discussion of the appropriateness of the target groups for this intervention. In general, the pharmacists felt that the target groups gave them a useful starting point for raising alcohol as an issue with patients but that the project should not be restricted to these groups. They were less positive about the idea that they would discuss alcohol with clients who attended the pharmacy to pick up prescriptions for chronic illnesses that could be affected by alcohol. Their main concern in relation to this was related to time.

"I think with the prescription ones you would need a lot more time because inevitably I think they'd start to talk about the drugs and they would start to go into a conversation and I think they would go off the plot quite easily."

Pharmacist E2

Another suggestion was that pharmacies where the pharmacist/staff were trained to provide interventions on alcohol would have posters and leaflets advertising the service.

CLIENT FOLLOW-UP RESULTS

Table 9: Client Follow-Up Details				
Client	FAST Score	Fast Score at Follow Up	Change in FAST Score	Time Lapsed (months)
A2	0	0	0	8
A3	3	3	0	7
A4	3	0	-3	6
A7	8	5	-3	5
A10	2	1	-1	4
B1	0	0	0	7
D3	3	3	0	7
D4	3	1	-2	4
D5	3	1-2	-1-2	4
D8	0	0	0	5
D9	0	0	0	5
E4	5	5	0	8
E7	2	2	0	7
E8	4	3-4	0 - -1	6
E9	1	1	0	6
E11	1	0	-1	5
F6	1	3	+2	6
G4	1	1	0	6
G5	5	5	0	n/a

Table 9 illustrates the characteristics of the clients who were followed up at each pharmacy (identified by the letter at the start of the code) and initial screening score as well as the timeframe of follow-up and the screening score at follow up. Of the 19 clients, 7 appeared to have reduced their drinking and 1 appeared to have increased his/her drinking. These changes should however be interpreted with caution for two main reasons. Firstly, there was attrition in the number of clients who agreed to be followed up and then the number who actually participated in the follow-up interviews and these clients are unlikely therefore to be representative of the total group who took part. Secondly, the study was not powered to detect a significant difference in the FAST scores as the main objective of the interviews was to explore clients' views on the acceptability of the intervention and any indications of good/poor practice. These views are explored below. Further work to test the effectiveness of the intervention will ideally utilise a randomised controlled design.

Overall Reaction to the Intervention

Most of the clients were happy to have taken part in the intervention and were generally positive about the experience. Some found it valuable as they were not previously aware of the sensible drinking guidelines.

“It was quite interesting actually because I didn't realise how much you can't actually drink and you know if you're driving and that I didn't realise how little you could drink.”

Client B1

"It was good advice but obviously I thought at the time it was basically on a Friday I would drink a bottle of wine and the pharmacist was saying that was too much to drink on the one night. But I didn't feel [realise] that – I thought that was ok."

Client A4

"I actually found it quite interesting. Very interesting. I'm not a great drinker, well I wouldn't think so anyway, maybe a bottle of wine at the weekend and I'd maybe sit with my husband, who doesn't drink by the way, and that would last me the whole night and that would be me once a week. But I found it really interesting when she said that was actually coming under hazardous drinking...Personally I didn't have any problem with it and as I say I did find it quite interesting but you know a bit of a shock as well."

Client D5

When asked what might have helped the consultation to be a positive experience, some of the clients commented on the non-judgemental or informal style of the pharmacists. It is worth noting that this style is a key element of motivational interviewing which had been discussed in detail on the pharmacists' training course.

"I thought it was very good. It was marvellous. It was very encouraging...They were very relaxed with you and said I didn't have to answer any questions if I didn't want to."

Client D8

"It was just very natural you know. He [the pharmacist] didn't seem as if he was judging you."

Client B1

"She [the pharmacist] was friendly and didn't make you feel like you had to do it and didn't make you feel embarrassed about it and just encouraged you to be honest and I felt I could be honest with her."

Client G5

Some clients mentioned that they knew the pharmacist or staff and that this made it easier.

"I go to the pharmacy quite often because I'm on medication for high blood pressure... and I know the girls there and when you're standing waiting on a prescription you just kind of bletcher away so I feel quite comfortable."

Client F6

"[It was] not awkward because with it being your own pharmacy they know you anyway."

Client A10

Some other comments that described what made the consultation a positive experience were the clear explanations given by the pharmacist (D9) and the privacy available in the pharmacy for the discussion (A4).

A small number of clients (G5, E4, E7, A3) expressed less positive reactions to the consultation and significantly, all of these had initially screened as hazardous or harmful drinkers. Only one of the four was actually overtly negative about the project however, the others reported that they did not mind or were not embarrassed. They reported that it was not worthwhile or interesting for them but that it would be a good thing for other people to take part.

"I would say it would be worthwhile to other people but I didn't really find it worthwhile... I don't feel I've got a problem with alcohol. I'm young and just enjoying myself but some people may have a problem and doing something like this might make them realise that or face up to that... Myself and a lot of other people especially my age don't know the limits and aren't aware of how much they are drinking and what your weekly and daily limits are and I think it's good to know that."

Client G5

"It wasn't embarrassing or anything no... Well they asked me questions and I answered so there was nothing really useful about it... They can ask if they want. I went into buy straighteners so it's not really the thing you want to be asked when you're in buying a pair of straighteners.... It's just kind of time consuming when you are in a rush but it was fine, it didn't bother me."

Client E4

"It wouldn't bother me [but] I don't think it was interesting, no. I can't really remember what he said, something like "do you want to stop?"... I've got no intentions of stopping drinking. I like a drink you know. He was just talking."

Client A3

Client E7 noted that she was quite friendly with one of the staff at the pharmacy who was aware that she was going to a club that night and she reported quite a negative experience.

"I think she [the staff member] thought I had a drink problem but I didn't... I felt as though she jumped on me because drink was mentioned... it was very uncomfortable. [I agreed to take part] aye more out of embarrassment..."

It is worth noting that only Client A3 had actually been recruited through one of the formal target groups for the project (smoking cessation) rather than simply through promotional materials or activities in the pharmacy.

Future Implementation

Clients were asked for their views on the implementation of alcohol screening and interventions in community pharmacies in the future. In general, clients felt that it was a good idea because many people were not aware of how much they were drinking but they noted that the people involved had to be willing to discuss the issue.

"I think that yes [it is a good idea] ...to promote that [safe drinking limits] probably a wee bit more towards people so that people know exactly what they are drinking because I don't think people realise because as I say I would say "no I don't drink a lot" but by god you get a shock when you actually see written down how many units that is."

Client D4

“I wouldn’t have known otherwise that drinking a full bottle of wine on a Friday night was too much...I don’t think it’s their [pharmacists] responsibility but it is a good idea for them to do it. I mean obviously you have to have the person that’s willing to receive the information as well.”

Client A4

“As long as the people don’t feel pressurised into answering the questions or talking about it I think it’s good idea. If people are willing to do it, I think it’s a good thing.”

Client G5

The follow-up interviews included a lot of discussion with clients about the best way to involve clients in discussions about alcohol consumption and no clear consensus was apparent. Some clients felt that posters and promotional materials in the pharmacies were sufficient and that pharmacists should not directly ask clients about alcohol.

“I think posters that people could read themselves in the pharmacy and maybe a poster saying ask your pharmacist’s advice if needed then that would mean they could go to the pharmacist rather than the pharmacist going to them.”

Client D9

“Aye if there was a notice up if you want to talk to someone but I don’t think they should just come right out and ask.”

Client E7

“If the pharmacist can open up the person a bit more then there wouldn’t be problem with that I don’t think. I wouldn’t have a problem talking about it but then again I don’t have a problem and I never probably will have. If a person has a problem they may not open up to it.”

Client A2

Others felt that it was necessary to ask.

“I mean how many people ask for advice? Normally we try to keep away from it, we don’t want to hear the truth half the time... I think you should ask directly.”

Client D8

Like the pharmacists in the baseline evaluations, some clients felt that people would feel a bit uncomfortable or get upset about being asked.

“Some people might get a bit upset and think it was none of their [the pharmacist’s] business but in general if they are just trying to help you then I don’t see why not.”

Client G4

One client suggested that if it was part of a survey this would make it more acceptable.

“They should know the safe limits and things like that and be able to advise you on it...[They shouldn’t ask directly.] Not unless they, like when I went in they told me they were doing a survey to see whether it is a good idea for pharmacists to be doing this. I think that unless it is a survey then I don’t really think they should be asking. I think some folk would find it a wee bit uncomfortable.”

Client B1

Finally, some clients felt that a combination of posters, leaflets and discussion with clients would be best.

“I think a bit of both sounds good. It’s good to discuss it and be able to ask questions to understand and it’s good to have leaflets to refer back to when you are at home or whatever.”

Client G5

The importance of privacy was referred to by more than one client.

"I don't think people would open up if it was in front of other people...I think that would maybe be embarrassing for some people. Obviously on a one to one basis it would be easier but pharmacists are usually dealing with people in a crowded waiting room and things like that so I think that would maybe be embarrassing."

Client D9

Others were not bothered by this however.

"I didn't notice (if there were other people in the pharmacy), but I didn't feel uncomfortable anyway."

Client B1

Other clients were unsure of how the pharmacists would advise people to reduce their drinking (D9), or how honest people would be in reporting their drinking to the pharmacist (D4).

Professional Roles

Clients were asked to comment on whether they felt this was an appropriate role for pharmacists to take on and in some cases also commented on whether they thought it was something more appropriate for a doctor to do. Most clients who commented were positive about the pharmacist's role in this area for a variety of reasons.

Less embarrassing/more convenient than going to the doctor:

"A lot of people maybe don't want to go to their doctor or some other counselling group and pharmacists are quite an impersonal way of doing things, although people do have a relationship with them it's less personal than with a doctor and less kind of embarrassing... Your own GP knows you or maybe knows your family and knows your history whereas your pharmacist might not know you as well as your doctor. Some people do have that kind of relationship with their pharmacist but personally I don't. I would feel more comfortable talking to someone who I didn't know as well and who didn't know me as well, like pharmacists."

Client G5

"Maybe it's more relaxing (for the pharmacist to do it rather than the GP)."

Client D8

"I think that people speak to pharmacists as a second person to their doctors. They would be more embarrassed to go to a doctor than the pharmacist for advice. When you go to the doctor you need to make an appointment whereas a pharmacist you can just go to the pharmacy and ask questions. For a bit of advice."

Client E8

Pharmacists as Health “All-Rounders”

“I think so yes (it is something pharmacists should do). They are all rounders, they tell you everything about your health really to help you.”

Client B1

“Well they are medically qualified in a certain sense aren’t they? And obviously they see people perhaps a lot more than the doctor if they’ve got ailments. The doctor sees you once or twice and continues your prescription and you don’t see them again so the pharmacist might see you a lot more and a lot of things in your life deteriorating.”

Client A2

Others were unsure and thought that it might be more appropriate or more acceptable for the doctor to carry out a project like this.

“Well I think more or less it should be your doctor doing that because he’s the one that treats you...Because when you’re in the pharmacy you’re not really in to complain about alcohol problems.

It’s maybe if you’ve got the cold and things like that. It’s not normally related to alcohol...I think if they are showing signs that they are drinking a lot then a pharmacist would recognise that anyway but whether people take the advice and want referred, I mean it’s up to the individual person.”

Client A10

“I think it would be a good thing but then you’re back to people that might take a bit of umbrage at it you know because it’s not a doctor as such. I don’t know...Well I’ve always been under the impression that a pharmacist is a pharmacist that made up you know done your medicines and out the door you went but now they’re obviously getting more involved in certain issues which will maybe take people a wee while to come round to that.”

Client D5

Impact on Drinking

In addition to repeating the FAST screening during follow-up, clients were also asked to give their own perception of whether their drinking habits had changed as a result of the intervention. Many clients did not drink very much prior to taking part in the project and so had no cause to change their habits. Of the others, some reported no change in their drinking although they were more aware.

“I haven’t changed my drinking habits because of that. I’m still drinking the same amount or whatever... I learned and realised that I probably was binge drinking as young people do.”

Client G5

"It makes you think about the amount of alcohol [you drink]... and the impact that it's having. I read through the booklet thing that I was given but it's not really had any big major impact."

Client E8

Others reported a clear change in behaviour, particularly those who were wine drinkers. The comment of Client A4 below is very similar to another comment made by Client D5.

"I don't drink a full bottle of wine on a Friday night now. I tend to drink it more throughout the week now, like a glass a night, which is more acceptable, obviously than a full bottle on one night."

Client A4

What she [the pharmacist] did tell me was the way I drink can be a slight problem to my health. That was basically what came across because I don't drink a lot but obviously when I do drink I overindulge which overall can cause a health problem so that's what I was to change and also maybe what I choose to drink I was maybe to change, which I have done so... Being honest I'm not saying I've given it up but I've changed... to a spirit, diluted with either coke or lemonade... I still drink the way I did but I've changed what I drink.

Client D4

Other Impact

Some clients reported discussing the project with relatives or friends.

"I mentioned it to my mum at home. Just about the units and how many units you were drinking each week and not realising you were over what the recommended amount was and stuff."

Client G5

"I was advising him [my father] and saying to him maybe you should try this or cut down on this but I was basically told to forget it."

Client D9

"Well I go on at my husband and told him how much he was drinking and how many units that would be."

Client B1

"I had mentioned it to friends at the weekend because obviously they'd never had it before. They thought it was quite good as well but none of them are heavy drinkers either but they also see the potential."

Client E11

STRENGTHS AND WEAKNESSES

This is the first piece of research that has studied the feasibility of the provision of screening and interventions with hazardous drinkers in a variety of community pharmacies. Eight community pharmacies were recruited to implement the project and were provided with comprehensive training which increased the pharmacists' self-rated knowledge and confidence in this field. This contrasts with other work in this field published while this project was underway in which an alcohol screening service was provided in one London community pharmacy by a pharmacist who was leading the research and had not received any particular training. Strengths of our research lie in the variety of pharmacies and pharmacists involved, the quality of the training and materials provided to the pharmacies and the insights gained into practical and ethical issues for future implementation of this kind of service.

While acknowledging these positive aspects, the findings should nonetheless be interpreted with caution. This research was planned as a pilot feasibility study and hence the pilot pharmacies are not necessarily representative of community pharmacies in general, either locally or nationally. The pilot pharmacists may have been particularly interested in this area and hence more likely to recruit clients. Similarly, those clients participating in the study may not be typical of the general community-pharmacy attending population. It is not possible to say what proportion of clients who were approached refused to participate in the research in the first place and there was further attrition among those who agreed to be followed up and those with whom a follow up interview was actually carried out.

IMPLICATIONS

The objectives of this project were to:

- (1) Establish a pilot project in which trained community pharmacists initiate discussion of alcohol consumption with targeted pharmacy clients and screen, intervene or refer as appropriate.
- (2) Explore, with pharmacists and clients, the feasibility, acceptability, perceived value and perceived impact of the provision of such interventions in community pharmacy settings.
- (3) Identify markers of good practice and formulate recommendations for future practice.

This project has been successful in establishing a pilot project in which eight trained community pharmacists conducted a discussion about alcohol with 70 clients including screening using the Fast Alcohol Screening Tool. Where clients screened as drinking dangerously or harmfully, the pharmacists provided a brief intervention including advice about sensible drinking guidelines and alcohol units, appropriate literature and options for cutting down consumption. Further work is needed to investigate the most appropriate target groups (if any) for screening in this setting as in practice in this project as many as half of the clients recruited may have been from outside the original target groups.

The baseline information on the pharmacists involved does not suggest that they had any special prior knowledge of this topic although all were interested in alcohol issues. The data show that while none of the community pharmacists were previously involved in regular and routine enquiries about alcohol with clients, it was feasible for them, with training, to screen and intervene with clients on alcohol issues broadly in line with SIGN guidelines. While client recruitment was low (70 clients across 7 pharmacies over 3-4 months), a high proportion of those recruited were drinking dangerously or harmfully and there were preliminary indications that some reduced their consumption as a result of the project.

The reasons for the high figures for hazardous drinking are unknown however it is possible to speculate. It is possible that a Glasgow population may have higher levels of alcohol consumption than other areas or that clients attending community pharmacies have higher levels of alcohol consumption than the general population. It is also possible that the high figures are due to the nature of the screening process used. In particular, pharmacists were encouraged to ask clients to describe their drinking in their own words and the pharmacists then calculated the number of alcohol units they were consuming and completed the screening tool on their behalf. As the pharmacists were carefully trained in calculating units, they may have more accurately estimated consumption than if the clients had completed the screening tools by themselves or had simply been asked how many units they drink. As it is common for clients (and professionals) to underestimate unit calculations, this may have led to higher figures.

Although the views of clients dissatisfied with being approached on this topic would naturally be unlikely to be recorded using this method, the pharmacists reported no aggression or strong negative reactions and were generally positive about the project. The clients who took part were also positive in the main about the experience finding it useful and interesting, though some were surprised at their own consumption. One client reported that she took part out of embarrassment and found it an uncomfortable experience.

Further work is necessary to determine the best way to approach clients in relation to alcohol issues, that is, whether posters and leaflets advertising the service are sufficient or whether pharmacists should raise the issue specifically with certain groups, and if so, which groups. The concept of having a form of accreditation for some pharmacies as an “alcohol screening pharmacy” may have some potential as giving the pharmacists an “excuse” to ask any client about their drinking without that client feeling singled out. This also requires further investigation. The issue of how comfortable “other” people would be in being asked about their drinking was an important feature of the client feedback although no consensus of opinion was apparent in terms of the best way to involve clients in discussions about this topic.

The variety of pharmacies recruited suggests that this is not an area that needs to be reserved for a small number of specialist pharmacists although the project allowed the identification of some key factors which were thought to contribute to its success. These pointers for good practice are listed below.

- The provision of a second pharmacist, or failing that a checking technician, would free up the pharmacists to provide more screening and interventions.
- A private area for consultations away from other people is necessary for both client and pharmacist to feel comfortable discussing drinking behaviour.
- Both clients and pharmacists were in favour of posters in pharmacies highlighting where the pharmacist had been trained in this field.
- Comprehensive training for pharmacists is necessary to enable them to feel confident in providing this kind of service in community pharmacies. Pharmacists felt that the training in this case was of appropriate duration and content although they felt that there should have been no gap between training and the commencement of service provision.
- Formal paperwork is useful in helping clients to feel comfortable in discussing their drinking in this setting and possibly would contribute positively to how acceptable they felt it was for pharmacists to ask about alcohol in the future even outside of a research project.

FURTHER RESEARCH

Several research questions are emerging from this project.

- What are the views and attitudes of community pharmacists in Scotland in general towards working with clients with drinking issues and what is their current practice in relation to this issue? [It is worth noting that The Robert Gordon University has recently funded a postal survey of the main pharmacist in each community pharmacy on Scotland (n~1150) for which data are soon to be published.]
- What clients, if any, should community pharmacists target when providing alcohol screening?
- What role can pharmacy staff other than the pharmacist take in relation to the provision of screening and brief interventions on alcohol? How can these staff best be involved in such provision?
- What is the impact of the provision of brief interventions to hazardous drinkers in community pharmacies on the level of alcohol consumption of such clients?
- What are the economic implications of the provision of screening and brief interventions on alcohol in this setting?
- What impact does the provision of training to community pharmacists on alcohol screening and brief interventions have on pharmacists' knowledge and practice in relation to alcohol issues in the medium to long-term?
- Is the provision of this service something that should become part of everyday practice by all community pharmacists (and therefore included in the formative training of all community pharmacists?) or is it best implemented as a targeted service provided only by pharmacies which are specially trained to do so?

DISSEMINATION

Findings of this project were presented as:

- An oral presentation at the Health Services Research and Pharmacy Practice Conference, Bath, April 2006
- A poster presentation at the Scottish School of Primary Care Conference, Perth, April 2006
- An oral presentation at the European Society for Clinical Pharmacy Conference, Lithuania, May 2006
- An oral presentation at the Drugs and Alcohol Today Scotland conference, Glasgow, May 2006.

An abstract has also been submitted to the International Network on Brief Interventions for Alcohol conference, Lisbon, October, 2006. Full papers are planned on the design and impact of the pharmacist training and on the project as a whole.

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To All Community Pharmacists

Date 23 March 2005

**Primary Care Division
NHS Greater Glasgow**

Direct Line 0141 211 0255
Fax 0141 211 0306
Email David.thomson@gartnavel.gla.comen.scot.nhs.uk

Dear Colleague

Drinking Interventions in Pharmacies Study (DIPS)

The Alcohol Education and Research Council recently awarded funding to The Robert Gordon University to investigate the feasibility of utilising the skills of community pharmacists in providing brief interventions on alcohol misuse to clients within the Greater Glasgow NHS area. This research has the full support of NHS Greater Glasgow Primary Care Division and is being carried out in collaboration with Glasgow Caledonian University. Despite overwhelming evidence that many adults in Scotland drink at levels considered hazardous to their health, no research studies can be found indicating the involvement of community pharmacists specifically to identify and address hazardous or harmful levels of drinking. This is despite strong evidence that short interventions on alcohol in other primary care settings are successful in reducing alcohol consumption and are recommended in the SIGN 74 guideline.

The specific objectives of this unique and innovative project, targeting people who may be drinking more than recommended limits, are therefore:

- (1) To establish a pilot project in which trained community pharmacists initiate discussion of alcohol consumption with targeted pharmacy clients and screen, intervene (by discussion) or refer as appropriate
- (2) To explore, with pharmacists and clients, the feasibility, acceptability, perceived value and perceived impact of the provision of such interventions in community pharmacy settings
- (3) To identify markers of good practice and formulate recommendations for future practice.

It is proposed that up to 10 pharmacies will be selected for the study. The research protocol is currently being considered by the Division's Ethics committee and therefore the details of the project may change slightly once ethics approval has been obtained. At this stage, it is planned that each selected pharmacy will be offered two days of training for one pharmacist and two half-days of training for four pharmacy assistants. Costs incurred in releasing staff to attend training (locum/staff cover and travel expenses) will be paid in addition to a professional fee being paid to each pharmacy for implementing the research project protocol. Ongoing support will be provided by the project manager over the course of implementation.

Subject to ethical approval, formal recruitment of pharmacies will begin shortly. **At this stage however, the research team would like pharmacies who wish to be considered for selection to register their interest using the enclosed form.** This does not represent a commitment on your part to take part and your fully informed consent will be sought prior to finalising any involvement. Interested pharmacies will be selected for the study in order to ensure that a wide variety of pharmacies are included in terms of size, geographic location, local deprivation and independent/multiple status. Only those pharmacies which have a confidential counselling space will be eligible for selection.

Further details of the project can be obtained by contacting the Project Manager, Niamh Fitzgerald on 0141-337 1250 (n.fitzgerald@rgu.ac.uk) or David Thomson, Director of Pharmacy on 0141-211 0255.

Yours sincerely

**Niamh Fitzgerald
Project Manager**

**David Thomson
Director of Pharmacy**



NHS Greater Glasgow Primary Care Division

Expression of Interest Drinking Interventions in Pharmacy Study (DIPS)

Pharmacy Name: _____

Address: _____

Postcode: _____

Pharmacy Phone No: _____

On behalf of the management and staff at the above pharmacy, I wish to express our interest in the above project.

Signature of Pharmacist: _____

Name of Pharmacist: _____

Pharmacist Phone No: _____

&/or
e-mail address: _____

Please return completed form by Friday 1 April 2005 to:

Fax: 0141 - 211 0306	Or by post to:
	Pharmacy Directorate Office Primary Care Division Headquarters Gartnavel Royal Hospital 1055 Great Western Rd GLASGOW G12 0XH

Drinking Interventions in Pharmacies Study (DIPS)



Development, implementation and evaluation of a pilot project to deliver interventions on alcohol issues in community pharmacies

- You and the pharmacy in which you practice are being invited to take part in a research study.
- Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the following information carefully and to discuss it with the staff in the pharmacy.
- If there is anything that is not clear or if you would like more information, **please contact Dr. Fitzgerald.**

What is the purpose of the study?

Despite overwhelming evidence that many adults in Scotland drink at levels that are hazardous to their health, no research studies of community pharmacy activity specifically to identify/address hazardous or harmful drinking can be found. This is despite strong evidence that short interventions on alcohol in other primary care settings are successful in reducing alcohol consumption.

The aim of this project is to develop, implement and evaluate a pilot project to deliver interventions on alcohol issues in community pharmacies. This project does not target individuals who are dependent on alcohol, but rather people who may be drinking more than recommended limits. The project will be carried out over one year.

The specific objectives are:

- (1) To establish a pilot project in which trained community pharmacists initiate discussion of alcohol consumption with targeted pharmacy clients and screen, intervene or refer as appropriate
- (2) To explore, with pharmacists and clients, the feasibility, acceptability, perceived value and perceived impact of the provision of such interventions in community pharmacy settings.
- (3) To identify markers of good practice and formulate recommendations for future practice.

All pharmacies in the Greater Glasgow NHS area have been informed about this research and given the opportunity to express an interest in taking part.

The project aims to engage a minimum of eight and a maximum of ten community pharmacies in the Greater Glasgow NHS Board area. Interested pharmacies will be selected for the study in order to ensure that a wide variety of pharmacies are included in terms of size, geographic location, local

deprivation and independent/multiple status. Only those pharmacies which have a confidential counselling space will be eligible for selection.

You do not have to take part.

Once satisfied that you wish to take part, you should return the enclosed consent form to the research team on behalf of the pharmacy in which you work. Please feel free to contact Dr. Fitzgerald for further information (0141 337 1250). If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will be involved?

There are four stages to this research project.

Stage 1

You will be asked to participate in a short telephone interview to discuss your current and past activity in relation to alcohol. Specifically, the audit will ask if, when and how frequently in the past, you have discussed the issue of alcohol consumption with a client and what, if any, interventions have you made.

Stage 2

You will be asked to attend a practical and interactive training programme (which will be accredited by NHS Education for Scotland (Pharmacy)). This course will be delivered over two days and will cover the following topics:

- Alcohol Use in Scotland
- Recognising when and how to make sensitive enquiries about alcohol
- Screening in practice: interpreting results – including when to refer.
- Introducing brief interventions – why, what, how?
- Delivering brief interventions in practice – activity
- Procedures for the pilot project
- Contacts for referral, advice and further information and support.

Two pharmacy assistants in each pharmacy will also attend relevant aspects of the training. All expenses incurred in attending the training will be reimbursed including travel expenses, locum cover (£150 per day) and pharmacy assistant cover (£50 per assistant per day).

After training and prior to commencement of the implementation phase, each pharmacy will be visited by Dr. Fitzgerald (the lead researcher) to help you with briefing staff and to give all staff in the pharmacy an opportunity to ask any questions they may have about the pilot project.

Stage 3 (Three months)

During this phase, you will implement the project, with support as required from Dr. Fitzgerald. Clients fitting into defined target groups will be given the opportunity to take part in the study by

assistants or by you. If the client is interested in taking part, you will inform him/her about the research and gain informed consent. You will then conduct alcohol screening to determine if clients meet the criteria for hazardous drinking and provide advice or another intervention on alcohol issues or refer the client onwards where necessary. The pharmacy will be paid a professional fee at the end of the project to compensate for the time taken to be involved including time to screen clients and to intervene with hazardous or harmful drinkers. This fixed fee will be £400 per pharmacy.

During this phase, each pharmacy will be visited once a month by the project manager to support and encourage staff and to find out if they are providing interventions as planned. These visits will be used to identify and address any potential difficulties with or barriers to implementing the pilot as designed with a view to finding appropriate, practical solutions as well as observing any features of good practice.

Stage 4

After the implementation phase, you will be asked to take part in two focus groups with the other pharmacists involved to elicit your views as to the value, feasibility and acceptability of the project and to discuss the findings of the project with you. In addition, pharmacists will be asked if the project has resulted in any change in their practice since the end of the pilot. Focus groups will be tape recorded and transcribed in full. All tapes and transcriptions will be stored securely and tapes will be destroyed at the end of the research.

What are the possible benefits of taking part?

This project will yield valuable information about the feasibility of community pharmacists' involvement in providing brief interventions on alcohol issues.

Will my taking part in this study be kept confidential?

Your participation in this project will be kept confidential and at no stage will either you or your pharmacy be mentioned or named in any report or publication or in connection with any quotation used. There is however a possibility that someone might recognise a quotation used in a report or publication as being from you if they are familiar with how you speak. Personal data collected during the project will be held and shared within the research team only and will not be shared with any other organisations.

What will happen to the results of the research study?

Results of the research will be disseminated via conference presentations and publication in peer reviewed journals.

Who is organising and funding the research?

This research is being funded by the Alcohol Education Research Council and is being conducted by the School of Pharmacy at The Robert Gordon University in collaboration with Glasgow Caledonian University and NHS Glasgow.

Who has reviewed the study?

The research has been reviewed by the Research Ethics Committee of the Primary Care Division of NHS Greater Glasgow Research Ethics Committee.

Contact for Further Information

Dr Niamh Fitzgerald (Project Lead)	The Robert Gordon University/ Create Consultancy, Glasgow	0141 3371250 niamh@createconsultancy.com
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A full list of the research team members is available from Dr. Fitzgerald on request.

CONSENT FORM

**THE
ROBERT GORDON
UNIVERSITY**
ABERDEEN

**Drinking Interventions in Pharmacies Study (DIPS)**

Development, implementation and evaluation of a pilot project to deliver interventions on alcohol issues in community pharmacies

Name of lead researcher: Dr Niamh Fitzgerald, MRPharmS

Name & address _____
of pharmacy: _____

Pharmacy Phone No: _____

Name of Pharmacist: _____

Pharmacist Phone No _____
&/Or Email Address: _____

Please tick the boxes below:

- I understand the purpose and origin of the above study and what is involved.
- I agree to the audio-recording of the telephone interviews and focus groups in which I will be involved.

APPENDIX B

- I have been given a copy of the information sheet dated 31st March, 2005.
- I have discussed its contents with pharmacy staff, and other personnel as necessary and am in a position to make a decision on behalf of the above pharmacy.
- I agree on behalf of the above pharmacy to take part in the study.

Signed: _____ Date: _____

One copy to be kept by pharmacist, one to be returned to:

Dr Niamh Fitzgerald
Create Consultancy
1/2, 28 Woodcroft Avenue
Glasgow, G11 7HY

Please indicate how much you agree or disagree with each of the following statements. Please consider each statement in relation to helping hazardous or harmful drinkers to reduce or modify their alcohol consumption (hazardous or harmful drinkers are those whose drinking exceeds recommended sensible drinking limits, but who are not dependent on alcohol/alcoholic).

Please circle one number for each question.	Strongly agree	↔	Strongly disagree				
1. I feel I have a working knowledge of alcohol and alcohol-related problems.	1	2	3	4	5	6	7
2. I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with hazardous drinkers.	1	2	3	4	5	6	7
3. I feel I can appropriately advise my patients about hazardous drinking and its effects.	1	2	3	4	5	6	7
4. At times I feel I am no good at all with hazardous drinkers.	1	2	3	4	5	6	7
5. I feel I have a clear idea of my responsibilities in helping hazardous drinkers.	1	2	3	4	5	6	7
6. I feel I have the right to ask patients questions about their drinking.	1	2	3	4	5	6	7
7. I feel that my patients believe I have the right to ask them questions about drinking.	1	2	3	4	5	6	7
8. If I felt the need I could easily find someone who would be able to help me formulate the best approach to a hazardous drinker.	1	2	3	4	5	6	7
9. I am interested in the nature of alcohol related problems and the responses that can be made to them.	1	2	3	4	5	6	7
10. I feel that the best I can personally offer hazardous drinkers is referral to somebody else.	1	2	3	4	5	6	7
11. I feel that there is little I can do to help hazardous drinkers.	1	2	3	4	5	6	7
12. Pessimism is the most realistic attitude to take toward hazardous drinkers.	1	2	3	4	5	6	7
13. I feel I am as able to work with hazardous drinkers as with other patients.	1	2	3	4	5	6	7
14. In general, one can get satisfaction from working with hazardous drinkers.	1	2	3	4	5	6	7
15. In general, it is rewarding to work with hazardous drinkers.	1	2	3	4	5	6	7
16. In general, I feel I can understand hazardous drinkers.	1	2	3	4	5	6	7
17. In general, I like hazardous drinkers.	1	2	3	4	5	6	7
<p><i>Do you currently discuss alcohol consumption with patients who may be drinking hazardously?</i></p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>The following questions should only be answered by those who currently work with hazardous drinkers.</i></p>							
18. On the whole, I am satisfied with the way I work with hazardous drinkers.	1	2	3	4	5	6	7
19. I often feel uncomfortable when working with hazardous drinkers.	1	2	3	4	5	6	7
20. In general, I have less respect for hazardous drinkers than for most other patients I work with.	1	2	3	4	5	6	7

APPENDIX D

PHARMACY CODE:

Please rate how you feel in relation to the carrying out the tasks below according to the following scale:

1. I would not be confident about managing this task and would not know what to do/say.
2. I think I could manage this task but would be a little unsure of what to do/say.
3. I think I would manage this task well and I would have a good idea of what to do/say.
4. I am sure I would manage this task well; I know exactly what to do and/or say.

Please circle one number for each task.				
21. Explain what alcohol is and how it affects the body	1	2	3	4
22. Explain units of alcohol and know the alcohol content of common drinks	1	2	3	4
23. Explain the metabolism of alcohol including myths and facts about sobering up	1	2	3	4
24. Explain gender differences relating to alcohol metabolism.	1	2	3	4
25. Describe the physical/medical harm associated with alcohol use to patients	1	2	3	4
26. Describe the psychological harm associated with alcohol use to patients	1	2	3	4
27. Describe the social harm associated with alcohol use to patients	1	2	3	4
28. Give sensible drinking advice including daily and weekly drinking limits and harm reduction strategies	1	2	3	4
29. Outline options and harm reduction strategies to help drinkers to cut down or modify their drinking	1	2	3	4
30. Understand, define and explain the following terms: <i>(tick for each term separately)</i>				
a. Hazardous drinking	1	2	3	4
b. Harmful drinking	1	2	3	4
c. Binge drinking	1	2	3	4
d. Alcohol dependence	1	2	3	4
31. Understand, administer and interpret validated screening tools relating to alcohol consumption	1	2	3	4
32. Be able to respond appropriately to the results of screening including giving advice, and linking individuals to appropriate interventions.	1	2	3	4
33. Understand and deliver brief interventions on alcohol	1	2	3	4
34. Understand and use basic motivational interviewing techniques in relation to alcohol consumption	1	2	3	4
35. Describe and provide information about and contact details for a range of organisations dealing with alcohol misuse or providing relevant services	1	2	3	4
36. Understand the role and function of specialist (Tier 3) alcohol services, when individuals should be referred to these services and how to make such referrals.	1	2	3	4
37. Understand confidentiality issues of different services around sharing of information	1	2	3	4
38. Provide to and discuss with patients health promotion information and advice relating to alcohol including its contribution to other health issues.	1	2	3	4
39. Access and use appropriate health promotion materials/resources and provide these to individuals.	1	2	3	4
40. Respond, intervene and support appropriately to address situations in which alcohol issues may affect children and families.	1	2	3	4

Please feel free to make any additional comments on a separate page.
Thank you for your time and help which are much appreciated.

Drinking Interventions in Pharmacies Study (DIPS)

Pharmacy Reference: H

Step 1: Record ALL clients with whom you discuss the research study.

Which target group does client come under?

They have sought advice or products for:

- Sleep aids
- Feeling run-down/tired/lethargic e.g. tonic/multivitamin/herbal remedy
- Smoking Cessation
- Other (please state)

.....

Step 2: Introduce study to client

Client Response:

- Interested – Refer to Pharmacist for full consent – Give this form to Pharmacist.

If NOT interested, tick below and COMPLETE CONSULTATION AS NORMAL.

- Not interested – No reason given.
- Not interested – Does not drink alcohol.
- Not interested – No time.
- Not interested – Other reason given – Record below.

.....

Things you might want to say:

What have you tried so far? Do you drink at all? The reason I ask is that [trying to give up smoking/feeling run-down/not sleeping well] can sometimes be affected/caused by drinking alcohol and this pharmacy can give you advice on healthy drinking which might help you – see our posters!

- Would you be willing to have a chat with the pharmacist just now?
- Have you seen our posters – would you mind if the pharmacist had a chat with you and checked out your knowledge about alcohol?

Drinking Interventions in Pharmacies Study (DIPS)

Pharmacy Ref: H

Client No:

🕒 Time Commenced
Consultation:

Step 1: Record Time in Box Above & Tick Box for Client.

- Referred by pharmacy assistant – Attach Assistant’s form to this one.
- Requested EHC at counter
- Asked to speak directly with pharmacist and requested help/advice on:
 - Sleep aids
 - Feeling run-down/tired/lethargic e.g tonic/multivitamin/herbal remedy
 - Smoking Cessation
 - EHC
- Other (please state)

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Step 2: Seek Informed Consent

- Give out the information leaflet
- Briefly go over what is involved in the taking part in the study.
- Consent Given – GET CLIENT TO SIGN THE CONSENT FORM.

If consent NOT given, record response below and COMPLETE CONSULTATION AS NORMAL.

- Consent not given – No reason given.
- Consent not given – Does not drink alcohol.
- Not interested – No time.
- Not interested – Other reason given – Record below.

.....

.....

.....

Step 3: Ask client what they normally drink in a week.

- Ask the client to describe what they would normally drink in a week
- Complete the screening tool overleaf.

Notes:

**The Fast Alcohol Screening Test (FAST)
for the detection of probable hazardous drinking.**

For the following questions please circle the answer which best applies.

1 unit = 1/2 pint of beer or half a standard 175ml glass of 12% wine or 1 single spirits

1. MEN: How often do you have EIGHT or more units on one occasion?

WOMEN: How often do you have SIX or more units on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

Only ask Questions 2, 3 & 4 if the response to Question 1 is "Less than monthly" or "Monthly"

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than monthly Monthly Weekly Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drink?

Never Less than monthly Monthly Weekly Daily or almost daily

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, on one occasion Yes, on more than one occasion

Scoring is quick and can be completed with just a glance at the pattern of responses as follows:

Stage 1

The first stage only involves the answers to question 1.

Never = the client is not misusing alcohol.

Weekly or Daily or almost Daily = the client is a hazardous, harmful or dependent drinker.

Less than monthly or Monthly. consider Questions 2, 3 & 4

Stage 2

If the response to Question 1 is Less than monthly or Monthly or you want to gauge how serious the client's drinking is – ask all four questions and then calculate the client's total score as follows:

Score Questions 1,2 & 3 as follows: Never = 0 Less than monthly = 1 Monthly = 2 Weekly = 3 Daily or almost daily = 4	Score Question 4 as follows: No = 0 Yes, on one occasion = 2 Yes, on more than one occasion = 4
---	--

The minimum score is 0. The maximum score is 16.

The score for hazardous drinking is 3 or more. The score for harmful drinking is 7 or more. You should also consider if the client has reported any signs of dependence.

Record Result of Screening Here:

Not Hazardous

Hazardous

Harmful

Possible Dependence

Client Score:

Step 4: Address Presenting Issue & Provide Brief Intervention if appropriate.

Record Your Intervention Here:
You may tick more than one box.

- Feedback on screening result & risks to health
- Explanation of sensible drinking guidelines & alcohol units in client's preferred drink(s)
- Discussion of pros and cons of current drinking pattern including link with presenting issue.
- Range of options for cutting down discussed.
- Recommended to attend the Community Addiction Team.
 - Referral form sent to CAT – Date: _____
- Referred elsewhere for support/advice (give details):



any

.....

- Literature provided – Which ones?
 - Unit Calculator Wheel
 - Alcofacts leaflet.
 - Alcohol: What Every Parent Should Know Leaflet
 - So You Want to Cut Down on Your Drinking Booklet
 - Copy of Alcohol Support Services Contact List

Other Intervention or Literature?

.....

Step 5: Complete Consultation

- Ensure that the client's presenting issue is appropriately addressed.
- Thank client, ask if they have any questions.
- Ask client if they are happy to be followed up by telephone to find out what they thought of having this chat. Remind them of confidentiality.

- Consent for follow-up NOT given.
- Consent for follow-up given – GET CLIENT DETAILS.

Client Name: _____ **Client Phone No:** _____

Alternative Phone No: _____ **Date of Birth:** _____

If someone other than the client answers the telephone or the client is not available when the follow-up call is made, are they happy for the researcher to identify the purpose of the call by saying simply "I am following up on some (unspecified) research in which [the client] took part at [name of pharmacy]"?

- Yes, happy for purpose of call to be revealed as above.
- No, caller should not identify the purpose of their call in any way.

Please use reverse of sheet to record any comments you have about the consultation.

🕒 Time Completed Consultation:

Drinking Interventions in Pharmacies Study (DIPS)



- You are being invited to take part in a discussion to help with some research being carried out in this pharmacy.
- Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve.
- If there is anything that is not clear or if you would like more information, **please ask the pharmacist.**

What is the purpose of the discussion?

- Many people in Scotland drink more alcohol than is healthy.
- This research team is investigating how pharmacists can give advice about alcohol to people who come to the pharmacy.
- This advice is more commonly given by GPs or nurses, and this research wants to find out if the same advice can be given in local pharmacies.
- The team wants to know how you feel about pharmacists providing this advice.

Why have I been asked to take part?

You have been asked to take part because you have come to a pharmacy that is participating in this research and you were interested in finding out more about healthy drinking levels or have asked for advice or a product relating to one of the following:

- (1) Sleep difficulties
- (2) Feeling tired or “run-down”
- (3) Trying to stop smoking
- (4) Needing emergency hormonal contraception (“the morning-after pill”)

People seeking advice on these have been chosen because it is known that drinking alcohol can be linked to these issues.

What will happen to me if I take part?

If you agree to take part, the pharmacist will ask you some questions about alcohol use and depending on your answers, may give you further verbal or written advice.

After this, the pharmacist will ask you if you are willing to be contacted by telephone by one of the researchers to find out what you thought about pharmacists providing advice on drinking in this way. If you agree, your contact details will be recorded. Everyone who agrees to be telephoned may not be contacted as we only need a small number of people for this part of the research. If you are contacted by telephone, we expect this

to last about 15 minutes. Your telephone conversation will be recorded, stored confidentially and destroyed at the end of the study.

How long will it take?

We expect the whole discussion to last no more than 15 minutes.

You do NOT have to take part.

It is your choice. If you do decide to take part you will be given this information sheet to keep and be asked to sign a form to say that you understand the research.

You can stop taking part at any time.

If you decide to take part you are still free to withdraw at any time and you do not have to give a reason.

What are the possible benefits of taking part?

You may personally benefit from greater awareness of how alcohol use can affect our health. In addition, you will have helped the researchers to find out if community pharmacists can give advice to people on safer drinking.

Will my taking part in this study be kept confidential?

Your participation in this project will be kept confidential and at no stage will you be mentioned or named in any report or publication or in connection with any quotation used. There is however a possibility that someone might recognise a quotation used in a report or publication as being from you if they are familiar with how you speak. Personal data collected during the project will be held and shared within the research team only and will not be shared with any other organisations.

What will happen to the results of the research study?

Results of the research will be presented at conferences and published in scientific journals.

Who is organising and funding the research?

This research is being funded by a charitable foundation called “the Alcohol Education and Research Council” and is being conducted by the School of Pharmacy at The Robert Gordon University in collaboration with Glasgow Caledonian University and NHS Glasgow.

Who has reviewed the study?

The research has been reviewed by the Research Ethics Committee of the Primary Care Division of NHS Greater Glasgow Research Ethics Committee.

Contact for Further Information

Dr Niamh Fitzgerald (Project Manager)	The Robert Gordon University Create Consultancy, Glasgow	0141 3371250
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Drinking Interventions in Pharmacies Study (DIPS)

Follow-Up Evaluation of Participating Pharmacists Focus Group Topic Guide

Pharmacy No:

Topic 1: What are your overall impressions of the project?

Topic 2: Do you feel it was worthwhile to intervene in this way with patients?

Topic 3: How easy/difficult did you find it to implement the project?

Discuss this in relation to:

- Getting referrals from assistants?
- Raising the issue with clients?
- Gaining consent?
- Screening?
- Providing the intervention?
- Using the record sheets provided?

Topic 4: What helped the successful implementation of the project?

Discuss possible value of:

- Support from pharmacy staff
- Support from pharmacy ownership/senior management
- Training
- Protocols
- Posters/other documentation
- Assistance from lead researcher
- Other things that helped?

Topic 5: What hindered the successful implementation of the project?

Discuss possible impact of:

- Time
- Staffing levels

- Confidence
- Protocols
- Pharmacy staff
- Pharmacy ownership/management
- Lack of resources – documentation etc.
- Possible patient resistance (see also next topic)

Topic 6: How did clients react to the project?

Discuss various reactions of those who were invited to be involved, who were screened, who received an intervention.

Topic 7: Do you think that community pharmacists in general have a role to play in addressing alcohol consumption among clients?

If so, what do you think that role is?

Discuss:

- To recognise clients who are dependent on alcohol and refer them onwards
- To recognise clients who may be drinking more than recommended and refer them onwards
- To provide advice on safe drinking limits
- To advise clients of how alcohol may affect/be affecting their health
- To give clients advice or information on how to reduce their drinking

Topic 8: Do you feel that the project has changed your professional practice in any way?

Possible prompts:

- More likely to ask clients about drinking?
- More likely to recognise clients with alcohol problems?
- More likely/better equipped to provide advice on safe drinking limits/how alcohol may affect/be affecting health/how to reduce drinking
- Greater contact with agencies for referral/information
- Any other possible changes?

Topic 9: Has being involved in the project had any other impact?

Possible prompts:

- Effects on awareness of own drinking
- Effects on awareness of family/friends' drinking
- Other unintended outcomes?