Partners in Creation

A review of alcohol IBA and Pharmacy as a setting for delivery in England and Wales: research and practice

Report prepared for Drinkaware

March 2016

1. Executive Summary

Findings from the two-part review into community pharmacy as a setting for IBA delivery in England are summarised below:

- Community pharmacies have been identified as a feasible and appropriate as a settings for IBA delivery by both research and case study review elements
- As yet there is an absence of evidence for the effectiveness of IBA in community pharmacy settings which is complicated by some important but often misinterpreted issues
- It is particularly important to note that although the one Randomized Control Trial (RCT) designed to test the effectiveness was a 'null finding', this should ***not*** be interpreted as evidence that IBA is not effective in community pharmacy settings, as addressed below
- In addition to the need to consider the limitations of RCTs in detecting relatively modest effects of IBA in real world conditions, a subsequent analysis of the single pharmacy RCT identified significant issues particularly in relation to 'assessment reactivity' and contamination between control and intervention groups
- Other research does provide some indicative evidence of the effectiveness of IBA in pharmacy settings, albeit very limited
- An argument may be made that Primary Care evidence is sufficient to justify implementation of IBA in other feasible settings
- A number of barriers to implementation are consistently identified in the research and case study examples. In particular, pharmacy staff beliefs and attitudes were particularly relevant, but scope for addressing these through training and support was possible
- Asides from staff attitudes and beliefs, other important potential barriers included time, possible expectations of an incentivisation framework, and a lack of access to private consulting rooms
- Potential facilitators have been identified as high quality training programmes, investment and engagement with multiple stakeholders and pharmacy staff, good commissioning practice, and printed resources or campaigns to directly support IBA initiatives
- A common model for the delivery of IBA in real world pharmacy settings has emerged based on the use of AUDIT-C scratch cards to initiate the intervention

- However there is almost no evaluation assessing whether real world pharmacy IBA projects and the use of scratch cards have resulted in person centred brief interventions of an acceptable standard
- The successful implementation and evaluation of future community pharmacy IBA projects will depend on carefully considered and well-resourced multi-component approaches.

2. Background

This review aims to assess the current evidence, practice and implications for the delivery of alcohol 'Identification and Brief Advice' (IBA) in community pharmacy settings in England and Wales.

Firstly it should be noted that although IBA implementation has been increasingly sought in a range of settings including community pharmacies over recent years, significant cuts to public health budgets will inevitably impact on these initiatives. An expected 6% cut in national community pharmacy budget is due to be implemented from October 2016, with further cuts to this and other local public health budgets continuing through the duration of the parliament.

As such, many of the current pharmacy IBA initiatives are likely to be under threat, particularly those which are based on specific inventive payments. Nonetheless, many community pharmacy roles may recognise the importance of early intervention and their role in promoting healthier lifestyles.

IBA itself has an extensive evidence base in Primary Care settings (Kaner 2009), but a lack of evidence for IBA specifically in pharmacy settings should not be used as a rationale for abandoning efforts to implement and further research it.

3. Part 1: Understanding the current evidence base

This section focuses on reviewing published scientific evidence considering the feasibility and, more significantly, the likely effectiveness of IBA in pharmacy settings.

Significantly, in 2015 the results of the first Randomized Control Trial (RCT) into the effects of brief intervention in community pharmacy settings were published (Dhital et al 2015). The results of this trial were highly anticipated given that previous research has identified community pharmacies to be highly feasible and appropriate (Holyfield 2009), and indeed many areas have commissioned activity as exampled in section 2.

However the results proved disappointing to advocates of IBA in pharmacy or indeed other settings, as the study was a 'null' findings trial. That is, although both control groups and intervention showed modest reductions in alcohol use, there was no difference between groups. A similar 'null finding' also arose from the large scale SIPS study of IBA in Primary Care, A&E and Criminal Justice settings in 2013 (Kaner et al 2013). Subsequently, significant questions have been raised over both interpretations of null trials, and the appropriateness of RCTs for assessing behavioural interventions with relatively modest impacts (Heather 2014). In simple terms, do 'null' findings show evidence that IBA is not effective, or that there are many challenges and limitations to implementing and assessing IBA in real world conditions?

Heather's 2014 paper on this, notably released before the null pharmacy trial results, sets out a number of reasons explaining why 'null' trials should not be interpreted as evidence that IBA does not 'work'. Crucially, null findings should be interpreted as an 'absence of evidence' rather than 'evidence of absence'. In the case of the SIPS trial then, Heather states it should be interpreted as there being no evidence that either of the two longer interventions were more effective than the 'control' intervention, and not that there was evidence that all interventions were equally effective. This may be counter intuitive at first sight of the results which did indeed show similar levels of reductions amongst all groups.

However the intended 'control' condition included 'feedback' and leaflet, which has in fact come to be interpreted as 'IBA' in many cases - albeit problematically so (Alcohol Academy 2013). Certainly there has been evidence to suggest longer interventions may not add significant added value to shorter approaches (Kaner et al 2009), although also some evidence to the counter (Mdege et al 2013).

Instead, a detailed explanation of a complex number of factors at play in such trials is given by Heather, and how these may interfere with results and their interpretation. These include limitations in reliability of such results (e.g. established phenomenon known as 'the dance of the p-values'), regression to the mean, research participation effects, historical trends, and assessment reactivity.

3.1. What happened in the first pharmacy RCT?

At this point it is worth focusing attention to a very recent but highly insightful study specifically assessing the 'null' pharmacy RCT findings (Quirk et al 2016). The study, entitled 'Qualitative process study of community pharmacist brief alcohol intervention effectiveness trial: Can research participation effects explain a null finding?' had several of the researchers behind the null RCT involved and raises a number of important considerations in view of the findings.

The aim of this paper was to identify the possible role of 'research participation effects', and other potential factors, on the 'null' findings. It firstly summarises wider research demonstrating the importance of the impacts on behaviour of partaking in research and the resulting potential for bias and interference with the results. This has also been demonstrated specifically within alcohol research on assessment effects. However reviewing the trial process and the results of interviews with 24 participants in the study reveals a number of specific 'research participation effects' which may well have impacted on the 'null findings'.

One area explored was exploring participant's reasons for engaging in the trial. One quarter of interviewees said they had taken part to 'find out where they stand' as a drinker: "I wanted to find out a bit more about… how much I was drinking was affecting my health and my emotional wellbeing..". Such reasons could suggest that invitation to participate in the research prompted 'contemplation' in itself, and potentially resulted in selection bias.

Perhaps more significantly, a 'recurrent theme was the importance of a trusting, pre-existing relationship between participant and pharmacist'. One interviewee stated "The pharmacist who served me told me about the study and was very friendly in the way that she did so, which definitely encouraged me to take part in the study". As such, the authors concede that 'empathic pharmacists appear to have exerted some influence on the control group that was not intended by the trial design'. The empathic skills intended to be taught to the pharmacists during the training – or indeed that they may possess generally – were accepted to have possibly spilled over into the control group interactions causing 'contamination'.

Another significant aspect of the RCT which undermines the validity of the control group is that as well as completing the full AUDIT, participants were also provided with 'feedback' (i.e. advised their drinking could be harmful to them) as in the SIPS trial. 'Feedback' has been suggested as perhaps the most significant individual element of brief advice, although research in this area is still lacking (Gaume 2015). A number of quotes indicated significant 'contemplation' amongst those receiving assessment only, including statements such as drinking "more than I realised" or responding to the feedback as "pretty scary". As such, a control that receives assessment (AUDIT), feedback of the results, and potentially

delivered by a clinician demonstrating empathetic skills, certainly undermines the validity of a 'control' group.

A number of examples of 'protocol departures' were also identified, indicating more contamination. One control group participant explained they didn't need to read the basic information leaflet because "he also gave a talk about it, the units and everything else… he was explaining everything for you." Certainly not what feedback in a control group should entail.

Issues were also raised in statements from intervention group participants. About half the intervention group said they hadn't contemplated or changed their drinking because they didn't perceive themselves to have a problem. This suggests in some cases the quality of the alcohol brief intervention may not have been sufficient to help the at-risk drinkers to understand alcohol 'risk' and as such did not see themselves as drinking problematically. Pharmacists had received 7 hours training conducted by the research team, but much of this was on research procedures as well as brief intervention skills.

Further issue can be taken with the finding that 61% of control group participants reportedly recalled a 'discussion' with the pharmacist about their drinking, versus 77% of intervention group participants. This may be reflective of the effect of the assessment process or contamination by the pharmacy roles, but that 27% of the intervention group did not recall a discussion also suggests poor fidelity.

3.1.1. Implications for real world implementation?

This study on research participation effects demonstrates the challenges of not only implementing brief intervention to high quality, but also assessing its impacts under 'real world conditions'. Research under current conditions and ethical guidelines cannot generate true 'control' conditions and there is little doubt that assessment, especially in combination with feedback, are likely to be significant brief intervention elements.

As such the one pharmacy 'null findings' RCT trial should not be considered as evidence that IBA is not effective in pharmacy settings. Instead, the research trial was not able to provide any that it is effective, as Heather has argued in great detail (Heather 2014). Certainly there are a number of significant reasons why IBA may be effective but these effects are challenging for researchers to detect and demonstrate. No doubt there will be further research seeking to identify the effective elements of IBA, and under which conditions and settings these may be best applied. Certainly pharmacy settings are well suited to the delivery of IBA, for which the wider research is still robust.

3.1.2. Drawing on previous research: any evidence for efficacy?

If then the 2015 'null' findings RCT is not to be considered as evidence of ineffectiveness, what can previous research tell us? Firstly it is notable that some limited evidence

supporting efficacy does exist within previous literature reviews (Watson et al 2009, McAuley et al 2012). Two UK studies found non-significant reductions in alcohol consumption within the review, although designed as feasibility studies. Subsequently, a Scottish pilot (Watson et al., 2011) used a pragmatic, cluster RCT design and found significant reductions in FAST assessment scores (1.84) and reported weekly drinking (4.62 units), consistent with primary care reductions. However as a pilot size, the sample size of 846 was not significantly powered to be classed as statistically significant. Some local areas have conducted process evaluation of pharmacy IBA schemes and found reductions in AUDIT scores1, though these results carry very little weight in scientific terms.

3.1.3. Lessons learned: barriers?

Whilst a significant absence of effectiveness may still need addressing, there is arguably a set of consistent findings in relation to implementation issues. A review of IBA in non-health settings (Thom et al 2015) summarised Holfyfield's 2009 review, identifying training as 'as the key to the ability and confidence of pharmacists to intervene appropriately'. As such key difficulties were summarised as:

- Very few pharmacists actually delivered IBA despite receiving training.
- Time management/workload issues were seen as a reason for failure to deliver.
- There was a perception of patient embarrassment.
- There was lack of knowledge and a need for training.

In an evaluation of pharmacy IBA implementation in the North West of England (Gray et al 2012) identified the significant variation in reported IBA delivery rates by different pharmacies commissioned as part of a local initiative. Reported workload and other competing agendas were also identified as significant factors, and the perceived importance of a private consulting room was highlighted. The study also raised the issue of perceived threat of the subject itself, and some beliefs that it was better introduced under a 'lifestyle' agenda.

A 2012 scoping study (Herring et al. 2012) found other notable challenges reported by local area IBA initiatives. Again, significant variation in practice and uptake was identified, with other commissioning issues such as budget limits also influencing reported outcomes. A study in South London pharmacies explored the impact of training, finding that although it could increase knowledge and confidence, in isolation its impact on delivery was limited (Dhital et al. 2013b). 'Booster' sessions were suggested as a possible response, though

[1] An example of which can be found in section 2 – see Devon

pre-existing attitudes predicted which pharmacy staff were most likely to deliver IBA even after training.

NHS Scotland's 2012 review also details consistent barriers including time, lack of training and the need for privacy (McAuley et al 2012). In addition, remuneration was identified as an important factor by one study (Horsfield et al., 2011), whilst also recognising the changing nature of community pharmacy as a facilitator, for instance the availability of private consultation rooms.

Cultural and social barriers were also raised (Horsfield et al., 2011). Pharmacy staff may either perceive the public's attitude to alcohol as a barrier to having an alcohol related discussion, or indeed may identify themselves as part of a drinking culture. Others expressed negative attitudes towards some drinkers which are not compatible with IBA delivery skills. The review also suggests the absence of evidence may be a wider barrier in itself, though not reported by pharmacy staff.

3.1.4. Lessons learned: facilitators?

Whilst training needs and other established barriers may be actively turned into 'facilitators', further considerations have been identified in order to support implementation. A significant point made by McCauley et al is that many of the identified barriers are indeed perceived barriers, not borne out in practice. For instance beliefs that patients will be difficult to engage on the subject or not see it as the pharmacy staff's role have been shown not to be true.

Other potential 'facilitators' have also been identified. Programmes that emphasise the potential for job satisfaction should tie into the 'helping' nature of many such pharmacy roles (Horsfield et al., 2011). In addition, involving the 'wider pharmacy community', i.e. utilising counter staff rather than just pharmacists was identified as a significant facilitator examples in a number of projects (McAuley et al 2012). Finally, wider public health campaigns, printed resources and supporting IBA materials have also been identified by staff as important (McAuley et al 2012).

4. Part 2: Understanding current practice

The following case studies represent a selection of current or recent examples of IBA delivery within community settings.

Rationale for inclusion was based on a mixture of approaching known alcohol commissioning leads or other relevant roles, and an online search to seek any further examples which were perceived to add value. Not all identified examples were included as many examples followed a similar model as explained in the conclusion. As such the below case studies may be considered useful as examples to represent somewhat different or unique elements.

4.1. Portsmouth: the first 'standard model'?

Portsmouth first initiated use of 'scratch cards' in Pharmacies 2010 as part of a one-month campaign conducted by Healthy Living pharmacies (HLPs) (Bowhill et al 2010). Over 3,500 customers were reported to have used an 'AUDIT-C' scratch card, following which 1,784 were reported to receive a leaflet and brief advice on drinking levels, with 830 reported to have received 'more in-depth guidance and a consultation'. Twenty nine individuals were referred to specialist services.

From 2011 Portsmouth continued to incentivise HLPs to deliver IBA and recorded data including basic demographic information and a number of IBA related outputs including:

- Scratch card assessment (i.e. AUDIT-C)
- Score as either 'less than 5', 5+, or 9+
- Intervention given as either printed leaflet and 'very brief advice' or 'a structured intervention

The current contract offers incentives based on

- Alcohol screening 75p per screen up to a maximum of £75 per month (equivalent to 100 screens)
- Brief advice for increasing and high risk alcohol drinkers - £4
- Extended Audit C screening and structured advice for increasing and high risk drinkers - £6
- Referral to specialist service for high risk drinkers - £3

In a draft summary report (Portsmouth City Council 2015), the conclusion states that:

From the data available, it is clear that uptake for this service is good, especially for the younger population (20-24 years). The catchy design of the scratch cards and its easy access at the pharmacies is a definite success and should be continued. In this age group, drinking maybe a relatively new experience and perhaps patterns are not well established.

This presents an exciting opportunity to raise alcohol awareness so that safe alcohol consumption is promoted.

The report also concludes that 31% achieved a score of 5+, whom it suggest should be 'hooked onto an escalating series of steps to make them act upon their drinking'. Those scoring 9+ were suggested to be targeted for structured intervention. It also identifies a number of possible research areas which may be of benefit including:

- Does success in raising Alcohol Awareness result in reduced drinking or safe drinking.
- Giving leaflets and very brief advice and giving structured intervention have an as yet unknown impact. Further research on how these two interventions impact drinking needs to be carried out.
- What escalating series of steps could be employed to impact drinking?
- Specifically target needle exchange service users and assess Alcohol Awareness success.
- How to increase the public uptake from 3% to say 10% (is this feasible?)
- Could this intervention be scaled up to Southampton, Hampshire, Wessex

4.2. Calderdale (West Yorkshire): exploring staff and user beliefs

The Calderdale 'Community Pharmacy Alcohol Identification and Brief Advice' project produced a comprehensive publicly available evaluation in 2015 (Urban R 2015), documenting activity and findings from 19 participating pharmacies. Uniquely the evaluation explored a small sample (n14) of pharmacy staff to assess their beliefs and experiences, as well as 31 patient feedback questionnaires.

A fairly standard approach to implementation was taken, inviting visitors to complete an AUDIT-C scratch card from which:

- For a score of 4 or less the member of pharmacy staff reaffirmed the benefits of drinking to lower-risk levels, offered a general alcohol information leaflet, then asked the individual if they would like any further information (for example on alcohol units).
- For a score of 5 or more the individual was offered the full AUDIT and brief advice to help recognise how alcohol might be affecting their health. Where the patient accepted they were taken to the consultation room and a further 7 questions were completed and scored by an IBA accredited member of staff.

Pharmacies were paid £15 per full AUDIT screen and brief advice, only applicable for completed full alcohol IBA to 'ensure an outcome focus'. This cost was set to cover staff time, training and other duties for all activity, on a modelled assumption that 'several (3-4)

scratch cards would have to be completed before an individual was found who scored for IBA and was willing to continue the conversation'.

Pharmacies received face to face training and a practical step-by-step manual on how to deliver the service, engage with clients and record service delivery. 'Supportive visits' and telephone calls were made to each pharmacy. Initially contact was regarding service implementation, which progressed to 2-way feedback on the service including the sharing of '4 top tips' and sharing good practice. Twitter and Facebook were used to share photos and ideas. Banners and posters were made available for the pharmacies to use in promoting the service and pharmacies were encouraged and supported in alcohol health promotion days/ campaigns.

Outcomes

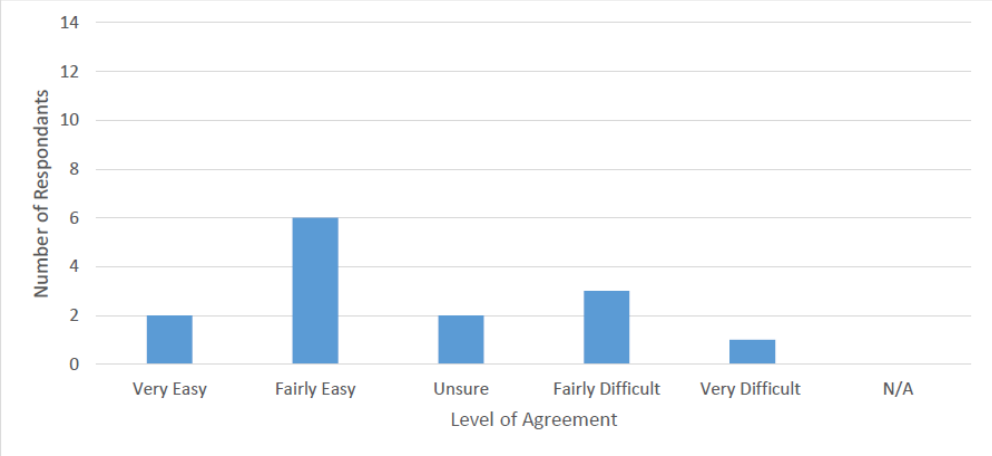
Over the 12-month period, the evaluation report identified:

- Community pharmacies distributed at least 2085 AUDIT-C scratch cards
- Of these 535 (25.7%) scored four or less and 1550 (74.3%) five or more
- This led to 1,518 full AUDITs and 943 patients who were eligible for alcohol brief advice interventions
- AUDIT-C results indicated 50.6% men, and 48.9% (women

Staff feedback

The evaluation report provided some useful staff feedback based on 14 pharmacy staff responses.

Overall, the majority of respondents found it fairly easy to approach patients about alcohol (8/14) – see **figure 1** below.



Many members of staff (9/14) said they had tailored their approach to make it easier to approach patients. Four felt the scratch cards had facilitated their approach, others found it

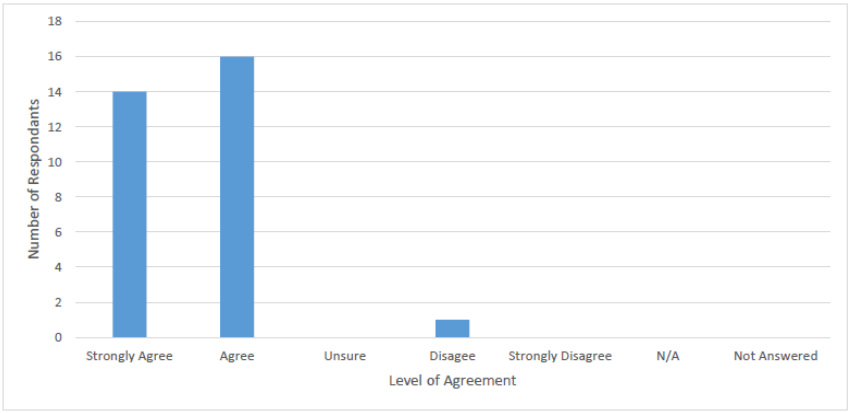
easier where it could be added to another service eg MUR or Blood pressure monitoring (2/14), or where patients were waiting for prescriptions or perusing the shop (2/14).

Four pharmacies had made their own displays of promotional material including items such as posters and unit glasses. One member of staff said they found it easy to approach patients because they knew them socially. Another pharmacy identified patients who may benefit when processing prescriptions eg those on antidepressants, suggesting a preference for targeted approach.

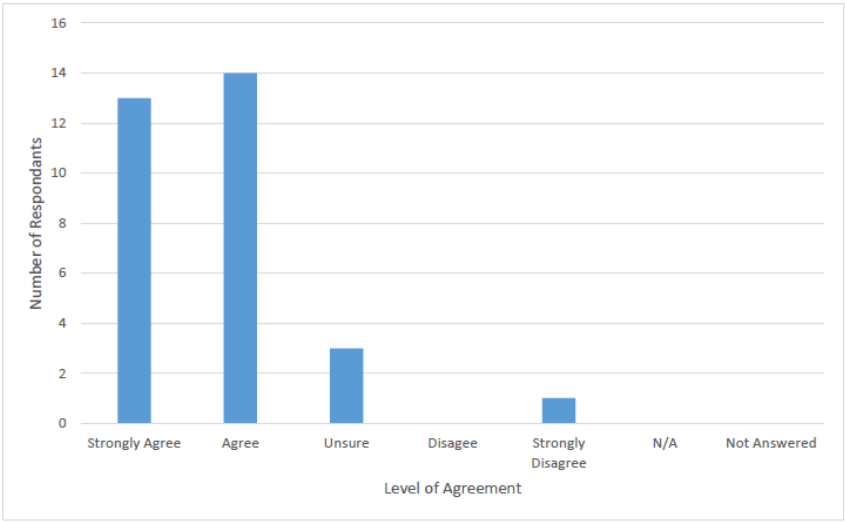
Patient feedback

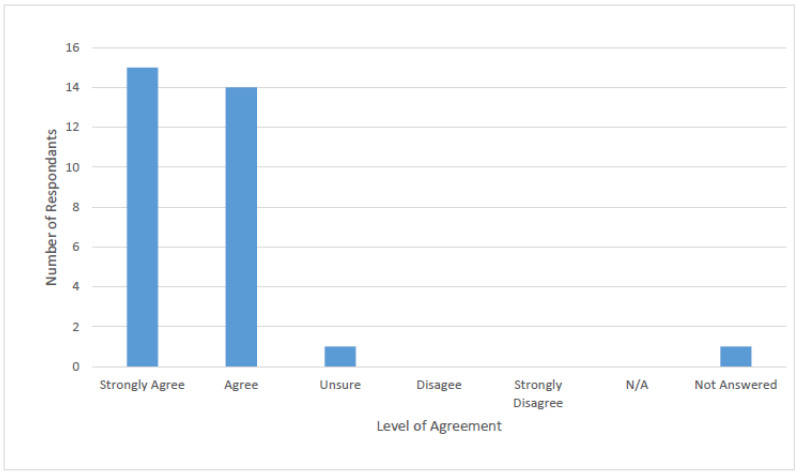
The evaluation identified the results of 31 feedback questionnaires received from patients. Most patients who responded to the questionnaire were between 45 and 64. It summarised that overall patients were 'satisfied' with the intervention and the way in which they were approached to discuss alcohol. Most found the approach 'helpful, confidential, easy to understand and relevant to them'.

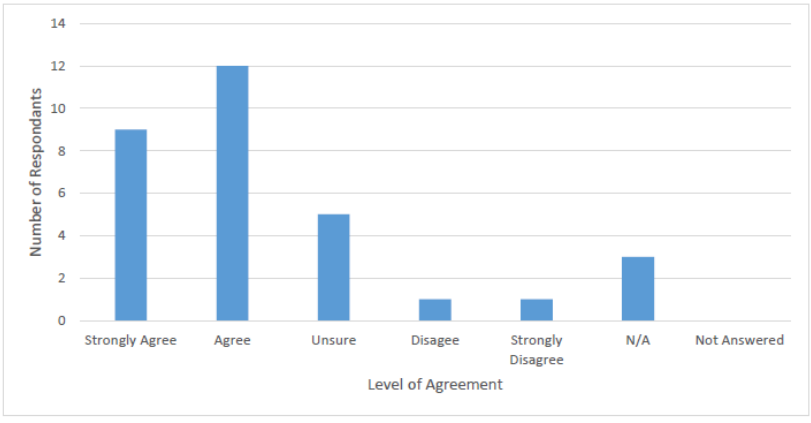
Figures 2-7: patient feedback results on pharmacy IBA service



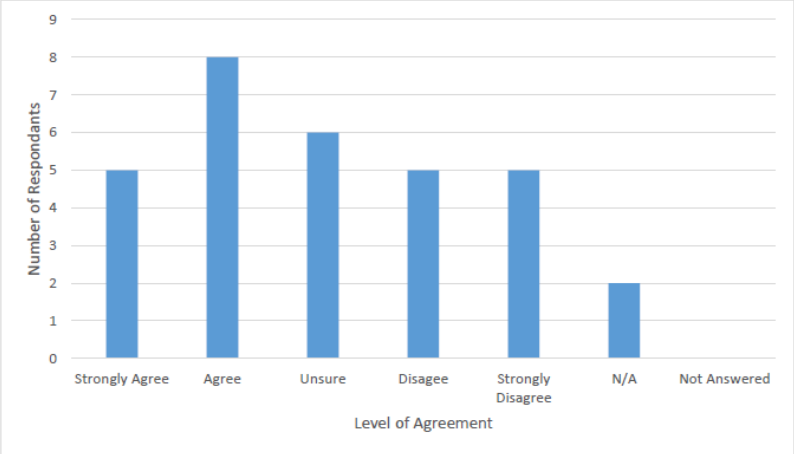
I was satisfied with the way the member of staff raised the conversation about alcohol







The resource(s) I received were useful to me



I intend to make a change to my drinking as a result of my discussion

4.3. London Borough of Kingston: utilising an online resource

Kingston have developed an incentive based Pharmacy IBA scheme and conducted an internal evaluation covering 8 community pharmacies for the period April 2014 – March 2015. Residents were expected to be offered IBA at a number of particular contact points including where:

- involved in any internal pharmacy promotions
- having received an MUR (Medicines Use Reviews)
- having received any other pharmacy service or have engaged in an 'over the counter' discussion with the pharmacist
- having scored above 5 on a AUDIT-C scratch card

As part of the contract, Kingston provided a pathway which identified a number of expected deliverables. Patients identified as increasing risk via a full AUDIT score of 8-15 should be offered brief intervention and offer a referral to a locally developed version of the e-drink-check website.

Figure 8: Poster used to highlight the Kingston e-drink check website
Source: Royal Borough of Kingston Upon Thames

Brief intervention was defined as 'basic five minutes of advice used in WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle – How Much is Too Much?' E-drink check is an online resource providing personalised feedback, advice and further support options. Scratch cards were also made available to support the delivery. Training was identified through the online Identification and Brief Advice e-learning module available from the Alcohol Learning Centre.

Residents scoring high risk (score of 16+) were to be referred to specialist substance misuse services (GP prescribing or Specialist Treatment).

The incentive structure was:

AUDIT C Screen	£1.75
Positive Audit C & Full screen	£5
Positive Audit C, Full Audit & Brief Intervention	£4
Positive Audit C, Full Audit and Referral to Specialist Services	£3

Outcomes

The 2014-15 evaluation identified 1,176 Audit Cs (compared to 2,010 in the previous year), 512 Full AUDITs (compared to 565 in the previous year), 165 Brief Interventions (compared to 248 in the previous year) and 11 referrals (compared to 10 in the previous year). 49% of the population screened were male and 51% were female. Two of the eight pharmacies accounted for the vast majority of the delivery – 875 of the 1,176 AUDIT-Cs and 115 of the 165 brief interventions recorded.

71% of the Audit-C scores were low risk and 18% of the Audit-C scores were increasing risk. 39% of those screened were 20-29 year olds and 12.5% of those screened were 60-69 year olds which accounts for over half of the patients screened.

The evaluation report (which also reviewed GP IBA delivery) made 3 recommendations:

- The quality of data entry by pharmacists and GPs to be improved as some data was 'not recorded'.
- To offer further training to both pharmacists and GPs – there seems to be some misunderstanding with regards to offering and completing brief interventions and referring patients on to other services (the number of referrals were very low).
- To continue to use the scratch cards in order to help to engage people – positive feedback has been received from pharmacists and GPs.

4.4. Pan-London Pharmacy initiative: big numbers?

In 2013 University College London released an evaluation report on a 'Pan-London Pharmacy Alcohol Awareness Campaign' (UCL 2013). The campaign project was developed by Pharmacy London2 and the National Pharmacy Association, with the evaluation financially supported by the London Health Improvement and Lundbeck Pharmaceutical.

The report states the primary aim of the research project was to 'investigate the acceptability of a scratch card as a tool for delivering the AUDIT-C questionnaire in community pharmacies', though details delivery of the IBA approach of the campaign.

Pharmacy London invited all Pharmacies to participate in the project, resulting in 240 pharmacies, from 29 Primary Care Trusts partaking. Pharmacies received a payment to cover implementation costs and a further payment was offered to those recording 200 interventions. Scratch cards and the 'Change 4 Life' alcohol leaflet3 were made available, and access to the Alcohol Learning Centre IBA e-learning training module was promoted.

Outcomes

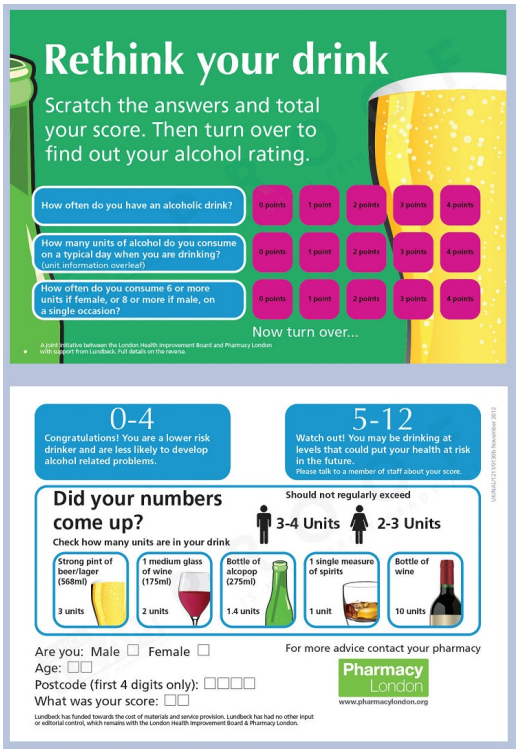
The four-month project resulted in scratch cards being given to 25,908 community pharmacy customers in a four-month period. Of these 23,810 (91.9%) were completed in the pharmacy and recorded on the system. A further 1292 took the scratch card away with them. The remaining 3.1% of customers (n=806) 'refused to complete the card'.

[2] Pharmacy London is a forum for local pharmaceutical committees (LPCs)

[3] 'Don't let the drink sneak up on you' Change 4 Life alcohol booklet

The report identified that 43.5% (10,351) of the pharmacy customers completing the AUDIT-C scratch card recorded a score of 5 or higher. Two fifths (n=9,551) scored between 1 and 4, and 16.3% recorded a score of zero (n=3,886). However there appeared no method to determine whether leaflet, advice, or referral was offered to those scoring positively other than the pharmacist's discretion.

Figure 9 (below): Promotional poster to raise awareness of the Pharmacy London alcohol 'campaign'
Figure 10 (right): 'Re-think your drink' scratch card
Source: Pan-London Pharmacy Alcohol Awareness Campaign' (UCL 2013)



The report identified wide variation in activity across the 240 participating pharmacies. Results showed the project captured a range of age, ethnicity and occupations and an even gender split, giving 'good representation of London's diverse profile'.

The report states that scratch cards 'were acceptable across a large age range, from people as young as 14, up to those aged 93, from both sexes', however some ethnic groups were theorised to have been under-represented as 'Pharmacists and pharmacy staff members may not have offered the cards to Muslim pharmacy users who were known to be abstinent or may have been embarrassed by suggestions to the contrary.

The report also identified that further work is needed to establish 'the best immediate interventional and/or referral pathways for use once harmful and hazardous drinking have been identified'. However it concluded that the delivery of alcohol brief intervention facilitated by scratch cards was both feasible and viable, and an area that should receive further investigation.

4.5. Devon: a systematic approach to training and implementation

The most comprehensive example of a locally delivered and evaluated pharmacy IBA scheme identified was in Devon, evaluating an initial one month IBA pilot in Plymouth Healthy Living Pharmacies (HLPs) (Parsons 2013). Whilst the delivery model itself is fairly typical – essentially use of AUDIT-C scratch cards to identify and trigger further IBA as appropriate with incentives - significant attention to the planning, implementation and evaluation of the scheme are notable. These are summarised by eight 'aims and objectives' which identify key factors and secondary aims which may be considered important to the true success of good implementation. These recognise key individual and environmental influences on the project and objectives to learn from the project and its impact where possible.

From the outset the project was developed in consultation with a range of key stakeholders and a multi-disciplinary steering group. It also appeared to fully utilise mutually reinforcing objectives of the HLP programme, notably; workforce development, a supportive environment for interventions, and multi-disciplinary engagement with stakeholders.

External training for pharmacists was commissioned which was 'fundamentally driven by the need to train the staff in how to primarily ENGAGE with service users rather than delivering information and facts about alcohol per se'. This was in response to the perceived key barrier to implementing the service, but lead pharmacists were also asked to complete the IBA e-learning module. A variety of local alcohol services and representatives were invited to participate in the training to raise awareness and engagement.

Participants were provided with a resource pack including the IBA protocol and a variety alcohol resources, with quantities as below made available to each participating HLP (see table).

Resource	Description	Number supplied to HLP Pharmacy
Service user monitoring form	Used for data input and evaluation of service	Small: 50 Large: 100
NHS brief advice tool	Laminated A4 tool to support brief advice	Small and large: 3
"Don't let drink sneak up on you" leaflet (Change4life)	To support brief advice for the service user	Small: 100 Large: 150
"Your drinking and you" leaflet (DH)	To support more comprehensive advice and action planning by pharmacist after undertaking full AUDIT	Small: 100 Large: 150
"Don't let drink sneak up on you" A3 poster (Change4life)	Laminated poster to be displayed in HLP Pharmacy to support promotion and engagement with alcohol IBA intervention	Small: 1 Large: 2
"Could your drinking be putting your health at risk" A3 poster (DH)	Laminated poster to be displayed in HLP Pharmacy to support promotion and engagement with alcohol IBA intervention	Small: 1 Large: 2
"Drinking causes damage you can't see: male and female" A3 posters (DH)	Laminated poster to be displayed in HLP Pharmacy to support promotion and engagement with alcohol IBA intervention	Small: 1 Large: 2
Rethink your drink scratch cards (NPA)	AUDIT-C scratch card to support identification of alcohol use disorders	Small: 200 Large: 300
AUDIT questionnaire	To support a more comprehensive process if service users choose to take this option up if their AUDIT-C score is "positive" (5+)	Small and large: 30

Table 1: resources issued to HLPs participating in the Devon pharmacy IBA scheme

Figure 11: Devon scratch card example, in association with the National Pharmacy Association

Figure 12: Devonshire Pharmacy utilising materials in the shop front

Evaluation lessons

During the four week evaluation period 515 brief interventions were recorded across the 14 pharmacies. The majority of the interventions were recorded as being opportunistic (66.2%) with a small number being recorded as targeted at an EHC contact (emergency hormonal contraception) (2.3%) or a or a MUR (medicine use review) (2.1%).

A significant proportion of those completing AUDIT-C scored positively - 41% (n=191) for whom:

- 57% were given advice and a “change4life” leaflet
- 31% were given a “change4life” leaflet but formal advice was declined

- 12% were referred to the pharmacist for a full AUDIT to be undertaken. Eight of these were subsequently referred to their GP or directly to the local alcohol service.

Interestingly, 57% of those scoring positively on AUDIT-C appeared to accept 'brief advice', with 31% only taking a leaflet. It is rare to see data on the actual uptake of brief advice following 'identification' if risky drinking, but this appears consistent with NICE estimates that around 61% will accept brief advice (NICE 2011).

Evaluation of the training identified a 'consistent message surrounded concerns about approaching individuals who came into the pharmacy'. Again this may be considered typical, and should be a fundamental objective of the training. Indeed pre and post training assessment showed that training significantly impacted on confidence around this issue and IBA delivery. The review recommended that in addition to the face to face training, all pharmacy staff in partaking pharmacies should do the e-learning module.

Pharmacy staff feedback

Pharmacy feedback with gathered via a post evaluation online survey, largely appearing to identify positive experiences in the training and delivery of the scheme, as well as feedback on barriers and facilitators to delivery.

Key positive drivers for the delivery of an efficient alcohol IBA scheme were identified as (see table for full list):

- engagement of the team
- wide-spread distribution of the scratch cards
- a passionate Healthy Living Champion and team
- full utilisation of the advanced pharmacy services in delivering an interdependent alcohol IBA screen

Key barriers reported included:

- confidentiality (due to a busy consultation room)
- staffing levels
- the inability to undertake in-store alcohol IBA cascade training,
- not enough capacity at the initial training session and
- the time of the year the event was run (pre-Christmas).

Positive factors in delivering an effective commissioned alcohol IBA scheme	Negative factors in delivering an effective commissioned alcohol IBA scheme
• Maximising the training opportunities within your team • Ensuring all staff receive in-store training to disseminate external training • Involving all the team in delivering the service • Capturing ALL people who enter the pharmacy so service users do not feel like they have been "identified" for an alcohol IBA • Providing all people with a prescription a scratch card to complete while they are waiting for their prescription • Discussing alcohol with all advanced services as a "matter of course" • Ensuring an appropriate HLC is chosen who will drive enhanced services within the HLP • Support from commissioners, stakeholders and other alcohol service providers	• Offering too many advanced and enhanced services which impact on the delivery of the alcohol IBA scheme • Not completing all the paperwork and claiming for each alcohol IBA • Limited confidential space due to demands on the use of the consultation room • Not utilising the advanced services to introduce the alcohol IBA scheme • Not having a method or technique for approaching customers which limited engagement if a "blanket" approach was not adopted in the community pharmacy • Not "selling" the alcohol IBA scheme to pharmacy staff who did not attend the initial training event • Incorporating a "paper-heavy" scheme especially at a busy time of the year

Table 2: facilitators and barriers identified in the Plymouth IBA evaluation

Service user feedback & outcomes

Staff were encouraged to obtain permission from service users for a follow-up assessment to allow evaluation of the service through a selection of semi-structured interviews. Forty out of the 515 service users agreed.

All of the 40 service users felt "comfortable" talking about alcohol in the pharmacy with a mean score of 4.5 out of 5 on a Likert scale. Positive comments were recorded such as feeling 'relaxed' and 'very comfortable' during the intervention, with the pharmacy environment judged as suitable for the intervention. Knowledge of pharmacy staff around the subject also rated highly with a mean 4.5 out of 5. However a several neutral comments were identified such as 'fine', with main concerns around confidentiality. One statement identified it as:

> *"bit embarrassing when other people are around (and if there is a problem) embarrassing to talk about it in front of other people in the pharmacy"*

Twelve of the service users also consented to follow up AUDITs, from which seven scored a lower AUDIT-C score, whilst and the mean AUDIT-C score had reduced from 8.3 to 6.5 (see figure). However the report acknowledges the 'very small sample size and large

confidence interval associated with this result (95% CI -0.4 to 4.0) means it is not statistically significant'.

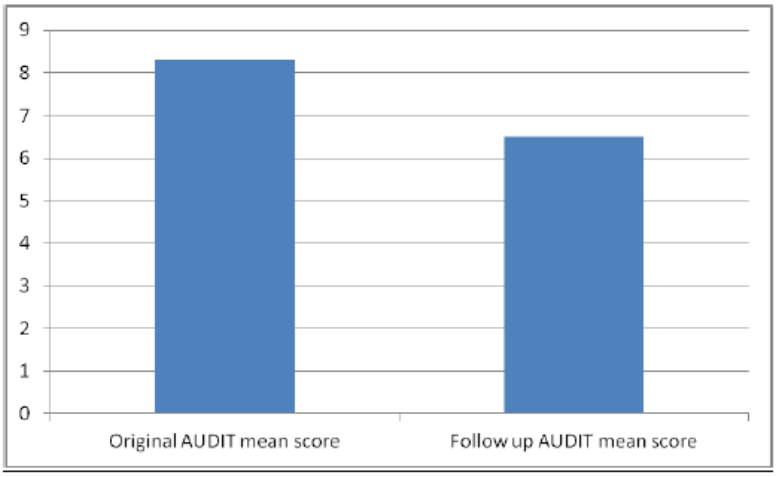


Figure 13: small follow up sample showed reduction in AUDIT scores (non significant)

4.6. London Borough of Wandsworth: lessons from low numbers?

In July 2015 LB Wandsworth launched a new pharmacy IBA project across ten pharmacies known as ''too much drink'. The project used scratch cards which were intended to be offered either opportunistically or targeted, such as at Medicine Use Reviews (MURs), or where a visitor expressed interest.

Positive AUDIT-C scores on the scratch card (5+) are to be followed with the remaining 7 full AUDIT questions with patients offered 'brief advice' or signposting where relevant. Each pharmacy was provided with 120 scratch cards, copies of the full AUDIT, 'too much drink' campaign posters, NHS standard alcohol unit posters and an alcohol unit calculator wheel.

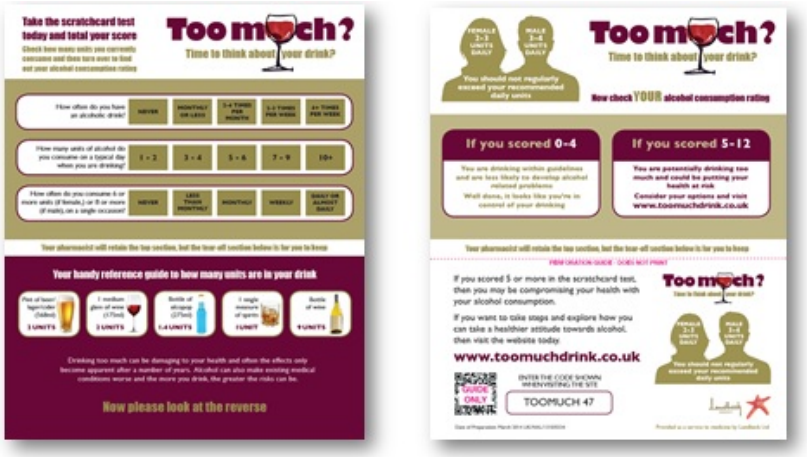


Figure 14: the two sided scratch card provided by Lundbeck Pharamceuticals

In addition to the printed resources, Lundbeck Pharmaceutical also made available a website[4] to support the process as an online IBA similar to other products.

Figure 15: screenshot from www.toomuchdrink.co.uk, produced by Lundbeck Pharamceuticals (NB no longer active)

Outcomes

Following the project launch in July 2015, issues regarding data and compliance were identified which triggered site visits to be conducted in November. The visits were intended to identify:

- performance,
- overall project compliance,
- advertising of the project within the pharmacy,
- staff knowledge and participation,

[4] Not currently active: www.toomuchdrink.co.uk

- project lead within the pharmacy
- data returns

The conclusion from the site visits were that the project could operate well where there was sufficient responsibility taken by a pharmacist for its delivery, but there was evidently mixed practice. Some counter staff were confident to deliver the project, whereas others reported that customers felt offended when approached by them to take part in the project. A training session had been run for participating pharmacist but not all attended.

Data from July 2015 to January 2016 indicated:

- 667 customers completed the AUDIT C screening scratch card
- There were 239 positive AUDIT C scores
- Of those who scored positive on the AUDIT C screen, 115 customers received a 'brief intervention'
- Of the 115 who received brief intervention, 90 had completed the full AUDIT
- 27 referrals were made to local drug and alcohol services or clinics
- 2 out of the 10 pharmacies involved submitted zero data during the project

The project was 'wound up' at the end of February 2016 as was not considered to be as successful as commissioners had intended.

4.7. Kirklees: a detailed 'LES' service specification

NHS Kirklees developed a 'Locally Enhanced Service' (LES) as an incentive framework for pharmacies to deliver IBA. Whilst LES approaches are generally no longer utilised for General Practice, they may still be utilised to facilitate specialist services such as IBA delivery. Kirklees therefore used a LES specification to set out the requirements for pharmacists who wished to participate in incentivised IBA delivery.

Whilst not necessarily unique in its service model, the Kirklees LES may be considered a good example of comprehensively defining a range of requirements necessary for pharmacies to deliver quality IBA. Some key elements of the IBA LES are explored below.

Firstly, pharmacies were only able to participate in the service if in the first instance:

1. The pharmacy has achieved Healthy Living Pharmacy Level 1 status or higher
2. Pharmacy has committed to at least 2 individuals within the pharmacy team to become accredited to provide the service

In addition, to be eligible pharmacies were also required to:

1. Actively participate in the Healthy Living Pharmacy (HLP) initiative
2. Have a HLP leader who has completed the 1 day HLP Leaders programme

3. Have two qualified HLP champions
4. Two members of the pharmacy team have been trained in RSPH level 2 and are able to deliver the Making Every Contact Counts agenda
5. Staff delivering the service have undertaken the Public Health core Brief Intervention training (or equivalent to be agreed with Public Health)
6. Commit at least two individuals within the pharmacy team to become accredited to provide the service – refer to training and accreditation
7. The pharmacy premises meet the requirements of the Pharmaceutical Services (Advanced and Enhanced Services)(England) Directions 2011

Whilst the service was identified as being based on an 'opportunistic universal (i.e. not targeted) approach of engagement and delivery' for adults aged 1 and over, the specification also identified a number of priority groups for consideration:

- Females aged 16-21 years accessing emergency health contraception
- Individuals frequently presenting with symptoms that may be associated with alcohol misuse e.g.
- Gastric conditions e.g. peptic and duodenal ulcers
- Falls and associate injuries
- High blood pressure
- Depression and/or anxiety
- Individuals with chronic diseases/long term conditions
- Individuals accessing other pharmacy local enhanced services
- Women of child-bearing age

The LES also set out a detailed 3 stage approach to the delivery of IBA. Firstly, 'pre-screen' stage included AUDIT-C, for which a positive score 'must be followed by the provision of ScreenPLUS'. ScreenPLUS includes full AUDIT 'combined with the provision of simple structured advice within the context of a focused discussion'. The third 'referral' stage included signposting to local services where probable dependence was identified.

As with many other examples, initial engagement such as invitation to take part or to complete an AUDIT-C scratch card were expected to take place over the pharmacy counter. However the specification identifies that 'all other aspects of IBA delivery MUST take place in a confidential consultation room'.

Wales: a national approach

Public Health Wales (PHW) have attempted to promote IBA rollout (known as 'ABI' in Wales) via the 'Have a word' branded campaign, including within Pharmacy settings. PHW have worked with the Welsh Centre for Pharmacy Professional Education (WCPPE) to deliver annual training programme. In addition PHW have worked with Cardiff and

Swansea Universities to include IBA learning on under and post grad Pharmacy courses via 'Train the Trainer' approaches.

PHW have produced a wide range of resources to support their IBA programme, including pharmacy specific training sessions (2 hours), a training 'webinar'5, and specific scratch cards as shown below.

Figure 16: PHW 'AUDIT-C' based scratch cards for Pharmacy ABI in Wales

Crucially PHW have actively argued against the use of incentives on the main basis that other settings do not. Instead PHW secured agreement that alcohol would be one of the three annual campaigns that pharmacies are required to run as part of their central contract. This has happened for the past three years and is currently agreed for another two years. PHW report that this has enabled them to monitor activity

[5] Available at https://hml.cardiff.ac.uk/player?autostart=n&fullscreen=y&width=835&height=505&videoId=5139&quality=hd&captions=n&chapterId=0

4.8. Other examples: resources and materials

Some examples of other information or resources are identified are shown below which were identified in other areas and may be of value in assessing varied delivery approaches.

Figure 17: A Hertfordshire pharmacy develops its own approach to 'alcohol awareness' as a method to support IBA engagement.
Source: Hertforshire LPC Briefing
http://www.hertslpc.org.uk/about-us/lpc-committee/think-pharmacy-event-30-september-2015/

"Our pharmacy participated in a local alcohol awareness campaign. Patients were asked to guess the alcohol units in different glasses. The campaign was good way of approaching patients on a sensitive subject matter. It also allowed us to proactively target patients drinking excessively for the alcohol IBA service." Mitesh,
St Albans Pharmacy, St Albans

Figures 18 - 19 : Locally adopted or developed alcohol leaflets and IBA tools. Source NHS Kirkless

Alcohol Use Disorders Identification Test (AUDIT)

		Questions	Scoring system 0	1	2	3	4
FULL AUDIT / Audit C	1	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
	2	How many units do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+
	3	How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	4	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	5	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	6	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	7	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	8	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	9	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
	10	Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year

To score, see scoring sheet.

Identification and brief advice

CM2249

NHS Kirklees

Pharmacy Alcohol IBA LES Scoring sheet

AUDIT C scoring

A score of 5 or more is regarded as positive for AUDIT C.

If positive, the remaining questions of the full AUDIT questionnaire should be used to determine increasing or higher risk drinking, or possible dependent drinking.

FULL AUDIT scoring

This is the total score of all 10 questions.

AUDIT score	Category	Action required
0 – 7	Lower risk drinking	No further action. Re-screen in 12 months.
8 – 15	Increasing risk drinking	Simple Structured Advice. If Extended Brief Intervention required, signpost to GP or refer to On TRAK (18+)
16 – 19	Higher risk drinking	Simple Structured Advice. If Extended Brief Intervention required, signpost to GP or refer to On TRAK (18+)
20 +	Possible dependent drinking &/or drinker with complex needs	Onward referral to On TRAK Kirklees (specialist alcohol service) if 18+; or to CRI - The Base, if 16-17 years.

In cases where score is 20+, ask for permission to share result with GP. Explain that this is to ensure that information or support can be provided and also to avoid duplication.

Individuals aged 16-18 and concerned about their alcohol use should be asked if they would like to be referred for more support, to CRI The Base, regardless of risk category. See 'onward referral' sheet for more information.

Identification and brief advice

KD67831b

5. Conclusions on local area case studies

- Most local evaluations/data are consistent with evidence that pharmacy is a feasible and acceptable setting for the delivery of alcohol information and IBA.
- However a lack of robust local evaluation, especially assessing the quality of IBA interaction is evident, as with other local IBA implementation efforts.
- Pharmacies appear to place significant value on resources to enable engagement. This may explain the enduring popularity of 'scratch cards' to initiate IBA.
- A fairly standard implementation approach is evident, based on AUDIT-C via scratch card to initiative potential IBA delivery. Most areas appear to encourage or require full AUDIT following AUDIT-C positive, but not all.
- Gender split overall appears fairly even, with a wide age range distribution. In most areas engagement with ethnic minorities did not appear an issue, although some evidence of a potential barrier for staff offering the intervention to Muslim groups was found.
- In nearly all areas, activity varied significantly by pharmacy. Typically the 'top' two or three pharmacies would deliver the majority of interventions, with many recording zero or very low numbers.
- In England it appeared that all pharmacies identified were financially incentivised to deliver the scheme. In contrast, Wales deliberately avoided this approach.
- Training appears highly variable. Many of the projects included face-to-face training but the quality or duration of this is largely unknown. Promotion of IBA e-learning was evident in many cases, but how well online training builds perceived confidence and skills is unclear.
- A minority of pharmacy staff expressed a lack of confidence, or a belief that patients would be 'offended', and/or a preference for 'targeted' approaches. Failure to implement IBA 'opportunistically' could suggest a lack of competence/skills in some cases, which may be a reflection of limited training access/effectiveness.
- As identified by the literature review, there is an absence of evidence to suggest that pharmacy IBA is effective. However as also noted, this should not be interpreted as suggesting pharmacy IBA is not effective, but something that requires further research.

6. References

The Alcohol Academy (2013). Clarifying Alcohol Brief Interventions: 2013 Update.

Bowhill J, Bowhill S, Evans D, Holden M, Nazar Z, Portlock J. (2010) An interim report on the outcomes from the Portsmouth Health Living Pharmacy initiative.

Davies J, Gill J, Crisp M, Taylor D (2013) Pan-London Pharmacy Alcohol Awareness Campaign.

Dhital, R., Norman, I., Whittlesea, C., Murrells, T. and McCambridge, J. (2015a) The effectiveness of brief alcohol interventions delivered by community pharmacists: Randomized controlled trial, Addiction, Vol. 110 , Issue 10, pp. 1586-1594.

Dhital R, Whittlesea CM, Milligan P, Khan NS, Norman IJ (2013b) The impact of training and delivering alcohol brief intervention on the knowledge and attitudes of community pharmacists: a before and after study. Drug and Alcohol Review 32(2): 147–156.

Fitzgerald N, Youngson E, Cunningham S, Watson M, Stewart D (2015). Support for community pharmacy-based alcohol interventions: a Scottish general public survey, Journal of Public Health, Online.

Gaume, J., McCambridge, J., Bertholet, N., Daeppen, J.B., 2014. Mechanisms ofaction of brief alcohol interventions remain largely unknown—a narrativereview. Front. Psychiatry 5, 108

Gray, N., Wilson, S., Cook P.,Mackridge A., Blenkinsopp A., Prescott J., Stokes L., Morleo, M., Heim, D., Krska, J., Stafford, L. (2012) Understanding and optimising an identification/brief advice(IBA) service about alcohol in the community pharmacy setting. Final report. Liverpool PCT

Heather, N. (2014) Interpreting null findings from trials of alcohol brief interventions, doi: 10.3389/fpsyt.2014.00085

Holyfield G. (2009) The role of community pharmacy in reducing alcohol consumption in individuals drinking at hazardous or harmful levels: a rapid review of the literature National Public Health Services for Wales

Horsfield E, Sheridan J, Anderson C. (2011) What do community pharmacists think about undertaking screening and brief interventions with problem drinkers? Results of a qualitative study in New Zealand and England. Int Journal of Pharmacy Practice, 19, 192–200.

Kaner E. et al (2013) Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial BMJ 2013;346:e8501

Kaner E. et al (2009) Effectiveness of brief alcohol interventions in primary care populations (Review). The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd.

McAuley, A. et al. Increasing capacity in alcohol screening and brief interventions: A role for community pharmacy? NHS Scotland

Mdege N.D., Fayter D., Watson J.M. et al. (2103). Interventions for reducing alcohol consumption among general hospital inpatient heavy alcohol users: a systematic review. Drug and Alcohol Dependence: 2013, 131(1–2), p. 1–22.

NICE (2011). CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

Parsons, G. (2013) Evaluation of the Alcohol Identification and Brief Advice (IBA) service in Plymouth Healthy Living Pharmacies (November to December 2011)

Portsmoth City Council (2015). The role of community pharmacy in health promotion linked to safe alcohol consumption.

Urban, R (2015). Calderdale Alcohol Identification and Brief Advice Service Evaluation 1st November 2013 – 31st October 2014

Quirk, A. MacNeil, V. Dhital, R. Whittlesea, C. Norman, I. MacCambridge, J. Qualitative process study of community pharmacist brief alcohol intervention effectiveness trial: Can research participation effects explain a null finding? Drug and Alcohol Dependence Volume 161, 1 April 2016, Pages 36–41

Watson, M. C. and Blenkinsopp, A. (2009) The feasibility of providing community pharmacy-based services for alcohol misuse: A literature review, International Journal of Pharmacy Practice, 17(4): 199-205.

Watson MC, Stewart D. (2011) Screening and brief interventions for alcohol misuse delivered in the community pharmacy setting: A pilot study. Edinburgh: Chief Scientist Office. CZG/2/449.

T./ 020 7498 8055
E./ info@partnersincreation.uk
W./ www.partnersincreation.uk