DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text. The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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▶ The effectiveness of brief alcohol interventions delivered by community pharmacists: randomized controlled trial.

Dhital R., Norman I., Whittlesea C. et al.

Addiction: 2015, 110(10), p. 1586–1594.

Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Dhital at ranjita.dhital@kcl.ac.uk.

Despite a clear rationale for embedding brief interventions in community pharmacies, this UK trial found no evidence that they would reduce hazardous or harmful drinking.

SUMMARY The World Health Organization recommends the widespread implementation of brief interventions for hazardous and harmful drinkers across health care settings. This could potentially include community pharmacies, which in recent years have developed to include services designed to promote and protect public health, including medication reviews, sexual health screening, and help to quit smoking.

The UK Department of Health suggests that pharmacy-based brief interventions should be piloted and evaluated as part of the developing public health function of community pharmacies.

A number of exploratory UK studies support attention to this health care setting, having found that:
• Regardless of drinking status, most pharmacy users were willing to utilise screening and brief intervention services, and were positive about pharmacists' involvement.
• Pharmacists unfamiliar with brief interventions could be trained to deliver this service. Those with a positive attitude towards drinkers delivered a greater number of alcohol interventions and experienced increased work satisfaction.
• The community pharmacy-based alcohol brief intervention is a low cost service that may not have an immediate beneficial impact on health and social service use, but can reduce drinking in hazardous drinkers.

Key points
From summary and commentary

Pharmacies in the London Borough of Hammersmith and Fulham were invited to take part in a trial of brief alcohol interventions, aimed at reducing hazardous or harmful drinking.

There was no significant change in levels of drinking between the brief intervention and non-intervention group, or (for either group) between the start of the study and the follow-up at three months.

The pharmacy-based brief interventions appeared to have no effect on hazardous or harmful drinking.

The present study tests the theory that brief alcohol interventions delivered by community pharmacists will be effective at reducing hazardous or harmful drinking among pharmacy customers.

All pharmacies within the London Borough of Hammersmith and Fulham were given the opportunity to take part. Pharmacy staff identified potential participants as customers who were: viewing study posters and flyers; making a general health query or seeking advice linked to drinking; buying over-the-counter products to support attempts to quit smoking; buying gastrointestinal remedies, sleep aids or central nervous system depressants; receiving help to quit smoking; accessing medication reviews, health checks or emergency hormonal contraception; or presenting prescriptions for medications for cardiovascular disease, depression or anxiety, diabetes or gastric problems. Interested customers were asked: "How often do you have three or more drinks on a single occasion?". If the answer was once a month or more they were invited to the second stage of the process, where they were screened using the Alcohol Use Disorders Identification Test (AUDIT) by a pharmacist in a private consultation room.

Customers were eligible to participate if they were aged 18 years or over, and scored 8–19 on AUDIT, indicative of hazardous of harmful drinking. This excluded low risk and high risk (possibly dependent) drinkers. High risk drinkers were given a letter with their AUDIT result and advised to book an appointment with their doctor.

Participants were randomly allocated to one of two groups – either a brief intervention group, or a leaflet-only control group. The brief intervention involved a motivational discussion lasting 10 minutes, delivered by the 17 pharmacists who received half a day of training. Participants were encouraged to talk about how drinking fits in with their lives, any mixed feelings they have about drinking, and any associated problems. They were given a [now out of print] *Units and You* booklet from the Department of Health, a *Unit and Calorie Calculator Wheel* from Drinkaware, and an alcohol services leaflet. Participants in the control group were given a leaflet entitled *Alcohol: The Basics*, which included information about alcohol which was not expected to promote behaviour change. They were not told that they were *not* receiving the intervention. The control group provided a benchmark against which the impact of the brief intervention could be compared.

The primary outcomes measured were: change in AUDIT scores, and proportion of participants assessed as no longer hazardous or harmful drinkers at the three-month follow-up (AUDIT score less than eight). The secondary outcomes were subcategories of the AUDIT assessment (consumption, non-dependence problems, and dependence), and health status (determined by the EQ-5D, a standard instrument for measuring health outcomes).

Main findings

Out of a total 2361 pharmacy customers who were approached, 561 said they would be interested in taking part. In the end 407 met the eligibility criteria to participate, gave their informed consent, and were randomly allocated to the brief intervention (205 people) or leaflet-only control groups (202 people). Of these, 81 (20%) did not take part in the

follow-up assessment at three months

follow-up assessment at three months.

On no measure did the brief intervention improve over the alcohol leaflet alone. For two of the secondary outcomes (dependence and health status), the control group did better, and for the other two (consumption and non-dependence problems) there were no differences. The total AUDIT score did not differ significantly between the two groups, and did not change significantly between the start of the study and the follow-up at three months in either the intervention or control group.

The researchers examined the potential impact of participant drop-out on the findings, working out how different the results would have been had all participants been assessed at the three-month follow-up. This did not change the overall result.

The authors' conclusions

Brief interventions delivered by community pharmacists appeared to have no effect on hazardous or harmful drinking. It was difficult to work out why the brief intervention might have failed because few studies have unpicked which elements make a brief intervention successful or unsuccessful. However, the limited training offered the pharmacists may have been a reason here and also in other settings where trials have not found brief interventions effective.

On the basis of these findings, the authors suggest that it would be inadvisable to extend services for tackling problem drinking to community pharmacies with little or no additional training. However, the successful engagement with pharmacies and implementation of the intervention does suggest that this setting could be conducive to the delivery of brief interventions.

FINDINGS COMMENTARY Studies undertaken before this trial suggested that brief alcohol interventions delivered by pharmacists in community pharmacies could be an acceptable, feasible, low cost, and effective way of trying to reduce hazardous or harmful drinking (1,2,3). The outcomes of this motivational-style brief intervention were not so promising – the brief intervention appeared to have no effect.

The term brief intervention describes a "family of interventions", as opposed to a "single, well-defined activity", with brief interventions differing in terms of duration, number of sessions, style of delivery, and underlying theoretical approach. Two broad classes of brief intervention are often referred to: brief structured advice, and the extended brief intervention. UK guidance from the National Institute for Health and Care Excellence (NICE) says that *as a minimum* interventions should consist of "structured" advice lasting five to 15 minutes, delivered by staff adopting a motivational and empathic style, who have been trained with resources based on FRAMES principles. The extended brief intervention usually lasts between 20–40 minutes, and is almost always based on the principles of motivational interviewing. The present brief intervention was based on a protocol influenced by (but not delivered to the exacting standards, or length of time of) motivational interviewing. All pharmacists taking part received 3.5 hours of training. The aim of the intervention, or "conversation", was to "leave the customer thinking about their drinking and whether they would like to change their drinking in any way" – more akin to the structured brief advice described above than the extended motivational brief intervention, though not following the NICE-recommended FRAMES principles.

Results from the SIPS study (the largest trial of alcohol screening and brief intervention conducted in Britain to date) indicated that a basic warning and leaflet may be *just as effective* as longer and more sophisticated (but still brief) alternatives. For this reason it is worth considering that, in the present study, the leaflet-only control yielded as much benefit as possible, and even if there had been more thorough training and a more extended and sophisticated intervention these would have had no additional impact. However, follow-up interviews with 24 participants a month after the trial ended suggest that the line between the control group and the intervention group was somewhat blurred – routine interactions between pharmacists and participants in both arms of the study may have constituted an active intervention. Participants in both groups were given their AUDIT scores and advised that they may be drinking above recommended levels. They were also exposed to discussions about alcohol with pharmacists during the recruitment process, the administration of the AUDIT questionnaire, and the consent process, despite the discussion of alcohol intended to be part of the brief intervention only. This appeared to "help some people think about their drinking to an extent that was not obviously different for the intervention and control group". These factors suggest that the leaflet-only control group was not akin to no intervention at all, and therefore caution should be exercised before concluding that the brief intervention was no more effective than no intervention. In this case there may be a lack of evidence that the brief intervention does work, but not necessarily evidence that it doesn't work.

One previous study of a pharmacy-based brief intervention reported a significant impact on drinking among hazardous drinkers three months after the intervention. There were significant reductions in the self-reported total number of drinking days and alcohol units consumed in the previous seven days, but no significant reductions in AUDIT-C scores. This study was different to the current study in a number of ways. Participants were initially screened using AUDIT-C and a drinking diary, and the intervention tailored to whether they were classed as hazardous drinkers, low risk drinkers, or harmful (possibly dependent) drinkers. The sample was very small (only 61 hazardous drinkers were followed-up after three months), and there was no control group to compare to without which the study could not show the intervention had been the cause of the reductions in drinking.

Thanks for their comments on this entry in draft to research author Dr Ranjita Dhital of the National Addiction Centre, King's College London. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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REVIEW 2010 A meta-analysis of motivational interviewing: twenty-five years of empirical studies

REVIEW 2011 A systematic review and meta-analysis of health care utilization outcomes in alcohol screening and brief intervention trials