Executive Summary

Alcohol plays an important role in the economic and social life of countries such as the UK. Yet its excessive consumption creates complications and costs for health and social care systems, along with considerable distress for a significant minority of those who use alcohol, and those who come into contact with them.

There is an extensive morbidity burden associated with alcohol use, which is the direct cause of about 10,000 (mainly male) deaths a year in the UK. Problem drinking is often defined in terms of alcoholism, and behaviours and consequences such as domestic and public violence, accidents and loss of employment. However, there are comparatively large numbers of individuals who consume hazardous amounts of alcohol and yet continue to function at work and in their homes.

Chronic liver disease and cirrhosis deaths have, uniquely as against most other significant causes of premature death, been rising in the UK over the last 50 years. Further, the NHS in London spends over £250 million a year on alcohol attributable hospital admissions. This is the equivalent of £34 for every resident in the capital.

There is an opportunity for community pharmacy to deliver community-based services traditionally provided by GPs or hospital outpatient clinics to individuals who wish to stop or reduce their drinking. This may in future reduce hospital admission rates.

The results of a London wide community pharmacy public health campaign, reported here, show that the delivery through pharmacies of a scratch card based (AUDIT-C) alcohol use assessment tool is acceptable to both men and women of all ages and ethnicities in London. In three months over 24,000 scratch cards were distributed across London, with over 23,800 returned to pharmacies and recorded in an online system. Just over four out of every ten (43.5%, n=10,351) pharmacy customers completing the AUDIT-C scratch card recorded a score of five or above, indicative of higher risk drinking.

These findings add weight to arguments in favour of enabling community pharmacies to develop further as ‘public health’ or ‘healthy living’ care and support centres. Future work is needed to establish the most cost effective interventions and referral practices for pharmacists seeking to help people who wish to reduce their alcohol related health and allied risk levels. Beyond immediate alcohol hazards, there are linked opportunities for community pharmacists to contribute to public and personal health improvements in areas such as sexual health protection, smoking cessation, weight management and the prevention of conditions such as oesophageal cancer (the incidence of which is also increasing in the UK).

James Davies, Jennifer Gill, Martin Crisp and David Taylor
Background

In modern British culture, alcohol consumption is widely regarded as a normal activity. It plays an important role in the nation's economic, social and cultural life, although – like most if not all other pleasurable activities – it also causes various forms of harm alongside its benefits. Hence the health and social outcomes of alcohol consumption are complex (World Health Organisation, 2007). National statistics for the UK suggest that on at least one day each week 36% of men and 28% of women consume above the recommended daily limit of four units for men and three for women (Office of National Statistics, 2010: p28).

Recent media attention surrounding binge drinking and alcohol abuse would suggest that excessive alcohol consumption is a recent trend, and that heavy drinking is most common in the young. But neither is entirely true. In the 18th century, for example, consumption became alarmingly high. The conflict between France and England presented gin as an alternative to French Brandy. It was consumed in large quantities, especially in London. Per capita spirit consumption tripled (Warner, 2003). In response the government set about introducing legislation, predominately based on the taxation of gin production to help curb public disorder and reduce consumption.

In the modern era alcohol consumption steadily increased over the last century (Figure 1). The exception to this was the dramatic decline observed during the First World War (due to increased taxation – opiate consumption was also controlled during this period) followed by a continuing dip during the depression of the 1930s.

Figure 1 – per capita alcohol consumption between 1900 and 2005 in the UK (litres of pure alcohol)

Source: Statistical handbook British Beer and Pub Association, 2012

Today older and more affluent people drink more in total per capita than younger and less affluent adults. The recent upward trend in consumption has partly been driven by availability, but also by increased affordability (Figure 2). Indeed, it is almost an exact mirror image of the reduction in price relative to income. There is robust evidence that price has influenced consumption patterns over the last 50 years (Tighe, 2003). Increases in cost can be expected to impact most on those who drink most.

There is similar international evidence. In Switzerland in 1999, for instance, reduction in taxation on foreign spirits from 30 to 50% led to a near 30% increase in consumption of spirits. There was no significant change in wine or beer intake (Heeb et al., 2003). Similar effects were observed in Finland following a tax cut. Liver cirrhosis deaths were found to have risen by 30 per cent in just one year and alcohol consumption increased by 10 per cent (Helakorpi et al., 2010; Koski et al., 2007).

Since the mid-1990s wine consumption in particular has shown a marked increase in the UK (Figure 1). This is partly due to an increase in the female population drinking regularly and the trend for bars and pubs to serve large (250ml) glasses of wine, each of which is equivalent to one third of a bottle. During the same period ‘alcopops’ were marketed, which may also have impacted consumption by some women and young adults.

Figure 2 – Relationship between price and alcohol consumption, 1960-2002

Source: Tighe, 2003

Managing alcohol consumption has increasingly become a national priority, along with issues such as curbing obesity rates. Alcohol use was one of the key areas highlighted in the 2004 ‘Choosing Health” White Paper (Department of Health, 2004). Policy action was, in part, implemented through ‘Safe, Sensible, Social’, an alcohol strategy that committed all Government departments to work together to tackle alcohol problems (Department of Health, 2008c). This call was repeated in a subsequent report on health inequalities (Department of Health, 2008a).

Such initiatives appear to be having some effect. Since 2004, UK per capita alcohol consumption has actually decreased. It is now 12 per cent lower than in 2004 (Office of National Statistics, 2012; British Beer and Pub Association, 2012). Some observers attribute this to public health initiatives, others to the increased taxation on alcohol. The economic downturn following the 2008 ‘crash’ is another likely factor.

Many approaches to tackling excessive alcohol consumption have been suggested. The House of Commons Health Committee Report Alcohol, First report of session 2009-10, Volume 1 (Health Committee, 2009) called for interventions aimed at changing
attitudes towards drinking, suggesting a broad range of policies involving education, information campaigns and a mandatory labelling scheme to highlight the number of units of alcohol and weekly limits. In addition they pressed for a review of licensing arrangements for drinking establishments, and amendments to the Licensing Act 2003 to include a public health objective. As part of this, they also recommended that early detection and intervention initiatives be built into healthcare screening services, and called on the government to improve alcohol treatment services.

The Scottish government is, in a similar vein, utilising minimum unit pricing as a strategy to manage excessive drinking due to evidence showing that cheaper alcohol is causing high levels of harm – in the UK on average, harmful drinkers buy 15 times more alcohol than moderate drinkers, yet pay 40% less per unit (Meier et al., 2010).

Sir Liam Donaldson, the previous Chief Medical Officer (CMO), argued that minimum unit pricing of 50 pence offers a key to reducing alcohol consumption. Evidence suggests that this would reduce total alcohol consumption by 6.7%, reducing hospital admissions by around 20,000 in the first year and 97,000 per year, once the policy has been in place for ten years (Purshouse et al., 2009). However, in March 2010, close to his retirement, Sir Donaldson said that his greatest disappointment was the government’s rejection of his proposal to introduce minimum alcohol pricing (Domnelly, 2010).

The coalition government has taken some steps towards implementing the recommendations of the Health Select committee. In May 2010, The Coalition: our programme for government (H M Government, 2010) proposed a ban on the sale of alcoholic drinks below cost price as a loss leader, and pledged to “review alcohol taxation and pricing”, yet fell short of introducing the minimum pricing recommendations advocated by the medical community and by NICE commissioned research on alcohol use disorders (Jackson et al., 2010).

The Health Risks of Alcohol Consumption

Excessive alcohol intake has many adverse effects. It can cause concentration, attention, understanding and memory problems and excessive drinking often results in inappropriate behaviour, paranoia, irritability and aggression. The BMA reported that alcohol contributed to over sixty medical conditions (BMA Board of Science, 2008), ranging from wholly alcohol related (such as alcohol dependence syndromes) to an array of chronic conditions including, but not limited to, cancer, epilepsy, hypertension and cardiovascular disease, to acute conditions such as falls where alcohol is a contributory factor (Figure 3). Alcohol consumption is an attributable cause in many deaths, in 2011 there were 8,748 alcohol-related deaths in the UK (ONS, 2013), over two thirds of which were in men.

Figure 3 – Effects of High Risk Drinking


Chronic harm typically occurs from a longer period of regular drinking at or over the recommended ‘safe’ limits. Liver disease is seen as a barometer of alcohol related ill health because alcohol accounts for four in every five deaths due to liver cirrhosis (Office of National Statistics, 2012). Therefore it is worrying in public health interest terms that mortality relating to liver dysfunction is rapidly increasing (See Figure 4).

By comparison with the rest of Europe, the UK does not fare well in liver related mortality statistics. Standardised death rates of chronic liver disease and cirrhosis in the UK have steadily increased since the 1970s, whilst those of France, Italy and Spain – whilst starting much higher in the 1970s–have sharply declined, becoming lower than the UK in 2005. Between 2000 and 2009, deaths from chronic liver disease and cirrhosis, mostly alcohol related, in the under 65s increased by around 20% in England, while they fell by the same amount in most large EU countries (Davies, 2012).

Figure 4 – Movement in mortality, 1971-2008. Cause of death per million population

The cost of this is being felt across the health service. It is estimated that NHS London spends £264 million a year on alcohol attributable hospital admissions, which is the equivalent of £34 for every resident in the capital (Baker et al., 2012). As shown in figure 5, in 2008/09, there were just under 111,000 alcohol attributable hospital admissions in London, representing about 6% of total hospital admissions in the capital (Baker et al., 2012).

Figure 5 – Number of alcohol-attributable hospital admissions by method of admission, London, 2008/09

Source: London Health Observatory Analysis of Hospital Episode Statistics (HES), NHS Information Centre for Health & Social Care (Baker et al., 2012).

Nationally there were an estimated 1.17 million admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (Office of National Statistics, 2012). Due to this a national government public sector agreement target (NI39PSA) was set to reduce alcohol-related hospital admissions by at least one per cent every year.

There is international agreement that the excessive consumption of alcohol is a major public health challenge, which some describe as an ‘epidemic’ (BMA Board of Science, 2008), and that effective measures are needed to address it. In 2006 the European Union published its first ever Strategy on Alcohol (Commission of the European Communities, 2006) in recognition of the international nature of this problem, which affects all member states.

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Whilst the focus here has been on health, excessive alcohol consumption also has detrimental effects across the criminal justice system, emergency services and the economy. The statistics compiled by the London Health Improvement Board quantify some of the economic costs of this in London (Box 1).

Box 1 – Cost of Alcohol Consumption in London

- An estimated 280,000 Londoners are dependent on alcohol
- In 2010 there were 788 alcohol related deaths in London
- Alcohol related hospital admissions have increased by 124% since 2003
- Liver disease is the only major cause of death in England that has increased significantly since 1970, and the age at which people are dying from it is decreasing
- In London alcohol related crime and antisocial behaviour costs an estimated £1.2 billion per annum
- In London alcohol related injuries and sicknesses cost the NHS an estimated £446 million per year
- Employee absenteeism costs the London economy approximately £262 million each year
- A survey of 7,500 Londoners shows that 72% are concerned about the impact of alcohol on their communities

Source: London Health Improvement Board

Identifying Harmful and Hazardous Drinking

Historically, the focus of research and management of alcohol related problems has been on those that experience severe alcohol dependence or alcoholism. Yet in recent years there has been growing evidence leading to the broadening of this base to include definitions of ‘hazardous’ and ‘harmful’ drinking (see Box 2).

Previous efforts have in the main focused their attention on issues such as preventing under-age drinking (which may paradoxically help to make alcohol use an emblem of adult status) and providing treatment and help for very heavy drinkers.

The emphasis of recent policy documents has been on a proactive anticipatory multi disciplinary harm reduction approach, using a variety of professionals across the health and social space to contribute to this public health issue.

Harm reduction strategies include education and identification of ‘at-risk’ drinkers and communication with clients about the impact and consequences of their alcohol consumption (WHO, 2010; SIGN, 2003). In this multi-professional context it is increasingly recognised that pharmacies and pharmacists are potential actors in the public health agenda (Watson et al., 2008; Department of Health, 2005).

One element of such strategies is the identification of those individuals that are drinking alcohol in quantities beyond those limits that are defined as ‘safe’ (See Box 3). In order to reflect the change in approach to alcohol...
misuse from reactive to proactive, the World Health Organisation developed the AUDIT questionnaire (Babor et al., 2001). This ten item survey questions the quantity and frequency of alcohol consumption and usually takes less than two minutes to complete. It has been tested and validated across six countries, and has proved to be a valuable screening tool in both primary and secondary care settings (Saunders et al., 1993b; Saunders et al., 1993a; Allen et al., 1997).

Whilst the AUDIT tool has been a useful intervention in many settings, a growing body of evidence raised the need for a screening tool that could be completed in even less time (Reinert and Allen, 2002). In keeping with a proactive anticipatory approach, it was believed that if alcohol misuse could be identified in a very short period of time (less than 30 seconds) it was more likely to become a routine component of health and social interventions. Therefore several modified versions of the AUDIT tool were created to enable screening to take place in a shorter time period (See Box 2). One of these modifications was the AUDIT-C (Bush et al., 1998), a three question tool which is able to differentiate between ‘harmful’, ‘hazardous’ and ‘mild dependence’. It was developed for use in Emergency Departments, but has since been shown to be effective in primary care (Babor et al., 2001). It has been reported to be acceptable to patients and effective in in-patient settings (Groves et al., 2010). Once they have been identified, patients can be offered a variety of interventions to help reduce their alcohol intake and improve their health.

### Box 2 – Tools for Screening Alcohol Consumption

A number of tools have been developed to access alcohol consumption in individuals that enable health and social care workers to identify potentially problematic drinking habits (See Box 3). The most popular screening tools are:

**CAGE**
(Cut, Annoyed, Guilty, Eye-opener). This is a four item screening questionnaire that is primarily aimed at helping the user to become more aware of their drinking.

**AUDIT**
The full Alcohol Use Disorder Identification Test provides ten alcohol identification questions. It is the gold standard of identification tests and was developed by WHO. This has good sensitivity for identifying hazardous drinking among people not seeking treatment.

**AUDIT-PC**
The Alcohol Use Disorders Identification Test Primary Care (AUDIT-PC) provides an adapted Primary Care version of the full AUDIT with questions 1, 2, 4, 5 and 10 of the AUDIT asked first.

**AUDIT-C**
A revised Alcohol Use Disorders Identification Test Consumption (AUDIT C) which places questions 1, 2 and 3 of the AUDIT first.

**FAST**
The FAST Alcohol Screening Test is a 4-item initial screening test taken from AUDIT. It was developed for busy clinical settings as a two-stage initial screening test that is quick to administer with an intended mean completion time of less than 20 seconds, since >50% of patients are identified using just the first question.

**MAST**
The Michigan Alcohol Screening Test was developed in 1971 and is one of the oldest alcoholism screening tests used to identify dependent drinkers. It consists of 25 questions and is therefore inconvenient in many settings.

**MSASQ**
The Modified Single Alcohol Screening Question (M-SASQ) tool provides one question for identification purposes. M-SASQ was modified from the original SASQ (Cananasaby and Vinson, 2005) by SIPS.

**SSAQ**
This was the original Single Alcohol Screening Question developed in the US.

**PAT**
Paddington Alcohol Test was developed in London in 1996, and updated in 2011. This tool detects alcohol misuse early in a drinker’s natural history. It encourages clinical staff to provide immediate feedback on the health consequences of drinking during screening.

**LDQ**
The Leeds Dependence Questionnaire is a screening tool used for measuring alcohol dependence over the previous week. The LDQ is derived from a psychological understanding of the nature of dependence and is, therefore, suitable for measuring dependence during periods of substance use or abstinence.

**TWEAK**
Tolerance, Worried, Eye Opener, Amnesia, Kut Down, is a short, five-question test which was originally designed to screen pregnant women for harmful drinking habits.

**T-ACE**
Tolerance, Annoyance, Cut-Down, Eye Opener, is a measurement tool of four questions that are significant identifiers of risk drinking during pregnancy, (i.e., alcohol intake sufficient to potentially damage the foetus.)
Dependent drinkers’ behaviour is characterised by psychological dependence, often with an increased drive to use alcohol and difficulty in controlling its use. They experience symptoms of dependence including impaired control or a subjective experience of a compulsion to drink. In the extreme it is associated with physical withdrawal symptoms upon cessation.

### Box 4 – The advantages of community pharmacy as a location for alcohol screening.

- Community pharmacy is easily accessible to the vast majority of the population. 97% of people are within 20 minutes of a community pharmacy, and an estimated 1 million people visit a community pharmacy each day (Department of Health, 2008b). This presents teachable moments in consultations in which community pharmacists can embrace the government policy of ‘making every contact count’ by discussing alcohol related illness and relevant social issues (Department of Health, 2010).
- Many community pharmacies are located in non-healthcare environments, such as supermarkets and therefore are not associated with the stigma attached to attending primary care facilities such as drug and Alcohol misuse centres.
- Community pharmacists have a high credibility in the community in terms of trust by the public. Readers digest reports consistently place pharmacists among the most trusted professionals, often ahead of doctors.
- Nationally commissioned advanced pharmaceutical services, such as Medicine Use Reviews and the New Medicines Service, allow community pharmacists the opportunity to assess drug interactions that may be associated with alcohol use.

### Box 3 – Definitions of Drinkers

Hazardous drinking refers to a pattern of consumption that is associated with a high risk of psychological or physical problems in the future. The Scottish Intercollegiate Guidelines Network (SIGN) guideline defines hazardous drinking as the regular consumption of over five units per day for men, and three for women (SIGN, 2003). One unit in the UK usually means a beverage containing 8 g of ethanol (Miller et al., 1991). This is half a pint of a 3.5% beer or lager, or one 25 ml pub measure of spirits.

Harmful drinking relates to those that are already experiencing problems, and suggests a pattern of drinking that is causing damage to physical or mental health. Harmful drinkers often already show clear evidence of harm by experiencing, for example, gastrointestinal complications, insomnia or falls. They typically consume more than hazardous drinkers and above the levels recommended for sensible consumption.

Dependent drinkers’ behaviour is characterised by psychological dependence, often with an increased drive to use alcohol and difficulty in controlling its use. They experience symptoms of dependence including impaired control or a subjective experience of a compulsion to drink. In the extreme it is associated with physical withdrawal symptoms upon cessation.

### Brief Interventions for Alcohol Users

Brief interventions are intended to provide early treatment following the detection of alcohol-related problems. Guidance from NICE (following an evidence review) concluded that interventions delivered in primary care are beneficial and effective in reducing alcohol-related outcomes (Jackson et al., 2010).

There are some consistent factors in basic brief interventions. Patients are provided with personalised feedback on the risk and harms of excessive drinking provided by a competent practitioner. Often this advice is then supported by written self help materials such as leaflets or supportive websites. In some studies the trained practitioners adopted the elements of brief motivational counselling to change behaviour. These approaches can reduce alcohol consumption (Kaner et al., 2009; Higgins-Biddle et al., 1997), and reduce alcohol related injuries in non-dependent drinkers (Crawford et al., 2004).

However, there is a lack of homogeneity in the approaches used which makes it difficult to determine the most successful components of a brief intervention (Moyer et al., 2002). Therefore there is no consensus as to the most appropriate interventional design. Some studies suggest no additional benefits to longer interventions compared with brief ones (Kaner et al., 2009). Others show benefits by providing a patient information leaflet (Kaner et al., 2013).

It is on the basis of this evidence that Pharmacy London set out to design and develop an alcohol screening tool with a basic brief intervention in the community pharmacy setting. Before turning to the actual details of this intervention and the methods adopted, this report first considers the role of community pharmacy as a location for such an intervention.

### The Role of Community Pharmacy in Alcohol Intervention

The World Health Organisation manual for primary care emphasises the variety of locations in which alcohol based interventions can be provided (Heather, 2006). One such location is community pharmacy. It was suggested in Choosing Heath through Pharmacy: a programme for pharmaceutical public health 2005–2015 that alcohol- related problems could be addressed by the pharmacy profession and that with appropriate training pharmacists and their teams could provide Identification and Brief Advice to help customers modify their drinking patterns. The white paper suggested that ‘Pharmacy- based interventions for people with alcohol problems should be further piloted and evaluated’ (Department of Health, 2005: p43).

Community pharmacy could make an important contribution to the ‘alcohol epidemic’ through the delivery of opportunistic advice, brief interventions, and offering floor space to other health professionals. The
accessibility and high footfall of community pharmacy provides pharmacy staff with the opportunity to identify people with risky drinking behaviours. There is much potential for community pharmacists to regularly and routinely enquire about alcohol drinking behaviours. Consumers will often present in a pharmacy with symptoms associated with alcohol misuse, such as sleeping irregularities, indigestion and gastric problems, requests for hangover ‘cures’ or generally feeling run down.

Yet, against this background of policy direction, alcohol misuse interventions delivered by community pharmacies, have until relatively recently been lacking. There are a few notable exceptions (Table 1) in areas such as South London, Leeds and Glasgow (Fitzgerald et al., 2008; Dhital, 2008; Goodall and Dawson, 2006), which have begun to demonstrate the feasibility of community pharmacy as a location for alcohol intervention (McCaig et al., 2011; Horsfield et al., 2011; Sheridan et al., 2010).

Since these studies were published in the mid-noughties further attention has been drawn to the role that community pharmacists can play in public health. The 2008 pharmacy white paper for England, which was published with cross party support, described the future opportunities for pharmacists to engage with the public health agenda (Department of Health, 2008b). Table 1 – Feasibility Studies in Community Pharmacy

<table>
<thead>
<tr>
<th>Area</th>
<th>Pharmacists</th>
<th>Duration</th>
<th>Tool</th>
<th>Clients</th>
<th>Risky Drinkers</th>
<th>Follow up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>1</td>
<td>3 months</td>
<td>AUDIT</td>
<td>73</td>
<td>26 (36%)</td>
<td>40 (55%)</td>
<td>Drink Diaries showed that 12/40 (30%) appeared to reduce drinking</td>
</tr>
<tr>
<td>Glasgow</td>
<td>8</td>
<td>4 months</td>
<td>FAST</td>
<td>70</td>
<td>37 (53%)</td>
<td>19 (27%)</td>
<td>n/a</td>
</tr>
<tr>
<td>Leeds</td>
<td>5</td>
<td>3 months</td>
<td>FAST</td>
<td>105</td>
<td>352</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Community pharmacy’s position in public health has been supported by the coalition government. One such initiative, the Healthy Living Pharmacy concept, has received widespread support. The concept was developed in Portsmouth and launched in 2009. It was followed a year later by widespread roll out through pathfinder sites across the country.

The Healthy Living Pharmacy concept represents a change in attitude and direction for community pharmacy. The concept, instead of concentrating on the pharmacist, embraces the whole pharmacy team, where team members are qualified to be health trainers. As part of the initial work carried out in Portsmouth, the Healthy Living Pharmacies undertook a campaign in June 2010 that aimed to raise awareness of excessive alcohol consumption. Customers were asked to complete a scratch card containing three questions. Those who achieved scores indicative of harmful or hazardous drinking were offered brief advice and a leaflet about their consumption. During this campaign over three and a half thousand scratch cards were distributed to members of the public. More than two fifths of those completing the card were drinking at levels that were considered ‘at risk’, with 29 individuals being referred to specialised alcohol intervention services. 1784 customers took a leaflet with very brief advice, 830 people had more in depth guidance/consultation (National Pharmacy Association, 2011).

This model has since been adopted by Primary care organisations and Drug and Alcohol Teams across the country, with pilots running in the Midlands and in Wiltshire (See Box 5). Against this background, Pharmacy London, the forum for London LPC’s, formed a partnership with the London Health Improvement Board (who are funded by NHS London), the Mayor of London and London Councils. With support from Lundbeck pharmaceuticals they developed a similar service for community pharmacies across the capital. This UCL School of Pharmacy report describes the ambitious alcohol awareness campaign that this collaboration rolled out across the capital. The first part of this report describes the aims and methods associated with this programme, before presenting the data collected in relation to the supply of over 23,000 scratch cards across the capital. The final part of this report explores the implications of this service and ideas for future service commissioners.

### Designing and Delivering an Alcohol Screening service in Community Pharmacy – ‘Rethink your drink’

**Aim and Objective**

The scratch card approach to alcohol screening in community pharmacy has been shown to reduce alcohol consumption (National Pharmacy Association, 2011). Therefore the aim of the research reported here was to investigate the acceptability of a scratch card as a tool for delivering the AUDIT-C questionnaire in community pharmacies.

The secondary objectives of this evaluation were to provide a profile of harmful alcohol consumption across London and to assess the ability of community pharmacy to identify and screen those people experiencing alcohol misuse. An overview of this intervention is shown in Figure 6.
The Intervention

Pharmacists pro-actively approached and encouraged members of the public to complete an alcohol awareness ‘scratch card’ that identified potentially high levels of alcohol consumption. This innovative approach aimed to encourage participation and to (depending on score) provide an opportunity for one of the following:

- Signposting to a local centre offering professional support or referral to a GP
- Brief intervention and advice highlighting practical ways to reduce alcohol consumption
- Provision of a leaflet detailing information and advice on safer drinking

Scratch Card Design

A team of healthcare professionals, including pharmacists, academics and public health officials designed and developed a scratch card that contained the AUDIT-C questions (See Figure 7). The card was based upon the design that had been piloted across Portsmouth, but was updated to include information that was particular to London, such as local contact numbers. With the collaboration of the National Pharmacy Association, these scratch cards were printed and delivered to participating pharmacies across the capital.

The scratch card tool consists of three multiple choice questions each with a score of 0-4. Across the tool, a score of 5 or more is indicative of higher risk drinking.

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>0-4</td>
<td>Congratulations! This may be a lower risk situation and you may have difficulty developing alcohol-related problems.</td>
</tr>
<tr>
<td>5-12</td>
<td>Congratulations! This may be a higher risk situation and you may have difficulty developing alcohol-related problems.</td>
</tr>
<tr>
<td>13+</td>
<td>Professional support is available and you may have difficulty developing alcohol-related problems.</td>
</tr>
</tbody>
</table>

Pharmacy Recruitment and Training

All pharmacy contractors across London were invited through Pharmacy London (the forum for LPCs in London) to participate in this public health campaign.

Pharmacists that wished to participate were provided with procedural instructions through their local pharmaceutical committees (LPC) and the Pharmacy London website.

The pharmacies were supplied with ‘Don’t let drink sneak up on you’ leaflets, which are produced by the Department of Health as part of the Change 4 Life campaign (Figure 9). These leaflets were then distributed to those patients identified as being at increased risk from alcohol.

Training

Pharmacists were given access to an online learning package that was specifically designed for community pharmacists and their teams. The alcohol learning centre online learning packages allowed them to self accredit their competence in alcohol screening and intervention. The modules in this training package covered: Facts about alcohol; about alcohol identification and brief advice; tools for identifying alcohol misuse; clinical approach to brief advice; practising brief advice; and an assessment.
Funding

Participating pharmacies received a payment to allow sufficient time to train the support staff in the pharmacy and to ensure that adequate promotional materials were in place. To encourage participation in this public health campaign, the first 250 pharmacies to record 200 outcomes on the system were given an incentive payment.

Recruitment of Customers

Clients were recruited by pharmacists and by pharmacy staff as well as through posters (See Figure 8) that invited the public to enquire about their alcohol consumption and highlighted that the service was ongoing.

Figure 8 – Recruitment Poster

Pharmacy teams were encouraged to proactively offer the scratch card, rather than leaving them out for customers to collect. This was so that data could be captured on how effective the scratch card was as a tool for engagement.

Outcomes

The pharmacy team recorded anonymous data on outcomes, as well as a range of demographic data using a bespoke specialist web based pharmacy reporting system developed by Sonar Informatics.

For each card handed out the pharmacists recorded one of three possible outcomes:

- The patient declined the scratch card
- The patient accepted the scratch card, but wanted to complete it at home
- The patient accepted and completed the scratch card in the pharmacy and was subsequently offered advice, a brief intervention or signposted appropriately (if necessary they were referred into alcohol misuse services).

In addition, the scores of those patients that chose to return the cards as well as the patients’ age, gender, occupation and ethnic profile were recorded by each of the pharmacists onto Sonar’s electronic database.

The pharmacists offered advice appropriate to the customer’s score. Those with higher scores (between 5 and 12) were offered brief advice. The brief advice concentrated on the meaning of the results and the supply of a Change 4 life leaflet on alcohol consumption (Figure 9). If patients wished, they were able to use the pharmacy consultation room to discuss their alcohol consumption in more depth.

Figure 9 – Change 4 Life Leaflet

Service Launch and Public Relations

The service was launched on Monday 10th December 2012, in a bid to target excessive consumption of alcohol over the festive period. As part of the public health campaign the service received interest in the press. There was a short segment on ITN London evening news and a short piece in the Evening Standard.

The service received widespread support from a range of organisations including the Mayor of London’s Office and the London Health Improvement Board.

Ethics and Consent

Advice was sought from the UCL ethics committee. As this was deemed a service evaluation, it did not require formal ethical approval.
Service Evaluation Outcomes

Scratch cards were offered 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.

Pharmacies

240 pharmacies, from 29 PCTs took part in this public health campaign, across the capital. On average each of these pharmacies supplied 99 scratch cards. However, there was wide variability between the Primary Care Trust areas and the pharmacies that chose to participate in the scheme. It has been suggested that this may be due to the enthusiasm and support that was provided by LPCs in each of these areas.

This variability in uptake by pharmacies is also reflected in the number of scratch card scores recorded in the system. Of the 23,810 scratch cards completed in the pharmacy, Barking and Dagenham PCT and Havering PCT each only recorded one consultation on the system. By contrast Westminster PCT recorded 4512 consultations. In Kingston PCT, the pharmacy customers completed on average 168 scratch cards that were entered into the system (Table 2). Comparison of the data with alcohol-attributable hospital admission between different PCTs failed to show any significant correlations between the mean scores recorded from the scratch cards.

Service Rollout

The service was officially launched in December 2012, however a few cards were completed in late November 2012 (n=11), with the largest number being completed in February 2013.

Table 2 – Uptake by PCTs

<table>
<thead>
<tr>
<th>Pharmacies Participating</th>
<th>Scratch Cards Recorded</th>
<th>Records per pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham PCT</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Barnet PCT</td>
<td>9</td>
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<td>951</td>
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<tr>
<td>Camden PCT</td>
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<td>3832</td>
</tr>
<tr>
<td>City and Hackney Teaching PCT</td>
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<td>3338</td>
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<tr>
<td>Croydon PCT</td>
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<td>Harrow PCT</td>
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<td>Hounslow PCT</td>
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<td>Richmond and Twickenham PCT</td>
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<tr>
<td>Westminster PCT</td>
<td>27</td>
<td>4512</td>
</tr>
</tbody>
</table>
| **Total**                | **240**                | **23810**            | **99**
**Consumers Completing the Cards**

**Age and Gender Profile**

Age was recorded by 23,694 of the customers that completed the card in the pharmacy. Age was relatively typical for a community pharmacy population in London with the mean of 40.97 years old (SD 15.802). The UK mean age is about 40. The service was provided to a wide range of patients from age 14 to 93 (Figure 11). 1.2% (n=410) were between 14 and 18 years old and 3,604 (15.21%) were aged 60 or over.

There was a roughly even split by gender with 51.8% (n=12,342) females. The women tended to be slightly younger (Female mean age 39.16, Male mean age 42.92).

**Figure 11 – Age Profile of Customers**

![Age Profile of Customers](image)

1 Figure 11 shows the peaks for age at each decade point (e.g. 30, 40, 50, 60, 70). These peaks may be indicative of the age of the patients being approximated by the pharmacists. This may be because customers felt uncomfortable with writing their age on the scratch card.

**Ethnicity**

Ethnicity was recorded for 17,173 (72.1%) of the consumers completing the card in the pharmacy. This ethnic profile is broadly similar to that of London, with an overrepresentation of White customers and an underrepresentation of Asian and Black customers (Table 4). This was not significant (Student’s Paired t-Test, with a two tailed distribution, p = 0.994). This may be a manifestation of the cultural differences associated with alcohol consumption which may have prevented these ethnic groups being offered the scratch cards.

**Table 4 – Ethnic Groups**

<table>
<thead>
<tr>
<th>Ethnic groups in London (2011 Census)</th>
<th>Ethnic groups in this evaluation (%)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>59.8</td>
<td>68.1</td>
</tr>
<tr>
<td>Mixed/Multiple Ethnic Groups</td>
<td>5.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>18.5</td>
<td>14.0</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British</td>
<td>13.3</td>
<td>7.8</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>3.4</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Occupation**

Pharmacists recorded the occupation status of 15,476 (65.0%) of the customers presenting in their pharmacy into one of seven categories. Table 5 suggests that community pharmacy is an acceptable location for a wide range of occupational backgrounds, with the most frequent users of the service being from managerial or professional backgrounds.

**Table 5 – Occupation Status**

<table>
<thead>
<tr>
<th>Occupation Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>2083</td>
<td>13.5</td>
</tr>
<tr>
<td>Never worked (unemployed)</td>
<td>1098</td>
<td>7.1</td>
</tr>
<tr>
<td>Home carer</td>
<td>722</td>
<td>4.7</td>
</tr>
<tr>
<td>Managerial/professional</td>
<td>6556</td>
<td>42.4</td>
</tr>
<tr>
<td>Routine &amp; manual</td>
<td>3057</td>
<td>19.8</td>
</tr>
<tr>
<td>Sick/disabled and unable to work</td>
<td>417</td>
<td>2.7</td>
</tr>
<tr>
<td>Full-time student</td>
<td>1543</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>15476</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Audit Scores**

Of these 23,810 entered scores, 23,788 usable AUDIT-C scores were recorded. A score of five or more is indicative of increasing or higher risk drinking, whereas scores of 5 or less are considered ‘safe’.

43.5% (n=10,351) of the pharmacy customers completing the AUDIT-C scratch card recorded a score of 5 or higher. Two fifths (n=9,551) had a score between 1 and 4, and a further 16.3% recorded a score of zero (n=3,886).
In summary, the results from a diverse range of pharmacies across London indicate that presenting the AUDIT-C questionnaire as a scratch card was acceptable to the population. Some 24,000 community pharmacy customers from 240 community pharmacies engaged with this public health risk and awareness screening campaign. The approach used presented participants with individualised feedback on their alcohol consumption. Broad public health marketing campaigns have previously been used to deliver health messages locally, although there has been limited analysis of their effectiveness (Stokes, 2012). One challenge is that they have to compete with advertisers in an already cluttered marketplace. However, in this instance the approach taken was more personalised and selective, which allowed a diverse and varied population across London to be directly engaged.

Identification

Scratch cards were acceptable across a large age range, from people as young as 14, up to those aged 93, from both sexes. In addition, pharmacy users from a range of ethnicities used this service. This is in contrast to most primary care brief intervention trials. These have typically under-represented minorities, instead focussing on middle aged white male drinkers (Kaner et al., 2007; Edwards and Rollnick, 1997). However, some ethnic groups were poorly represented. 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 average customer completing a scratch card was slightly older than the London mean, but broadly representative of the overall customer base. The elderly segment of the population remains neglected in terms of research into drinking habits, but were well represented in this research. Alcohol tolerance is said to decrease with age, and moderate amounts of alcohol may therefore have a greater propensity to impair older adults. Alcohol is a factor in some 60% of hospital admissions involving elderly people where reasons for admission include confusion, repeated falls and related injuries at home and/or with chest infections or heart failure (Adams and Jones, 1998).

Screening, Case Finding and Awareness Promotion

There is extensive technical debate around terms such as screening. But broadly defined it is a key stage in the treatment process and contributes in itself a therapeutic element alongside diagnostic functionalities (Patton et al., 2004). This is because it can not only help define any professional intervention required, but also creates an important opportunity for alcohol users to question their own drinking habits and contemplate change.

The content of the conversations associated with the distribution of these cards was not evaluated. However, previous research suggests that pharmacists are able to provide alcohol interventions effectively (Watson and Blenkinsopp, 2009), although some pharmacy staff may not always be neutral in their delivery of an AUDIT assessment.

Over two-fifths of people in the evaluation reported a score that was indicative of higher risk drinking. This suggests that customers felt able to openly report their consumption using the scratch card approach. This may be because it operates at the interface between healthcare and retail, and therefore provides informality conducive to full disclosure during screening that may not be offered in other settings. NICE guidance shows that customers have preferences over the ‘status’ of the person dealing with their alcohol issues (NICE, 2011). They can feel stigmatised when having to seek support from specialists and prefer accessing generalists such as nurses or GPs.

Advice and Referral

If appropriate following ‘screening’, customers were offered an intervention. Its nature was not formally reported, as the primary aim of the research reviewed here was to investigate the acceptability of the card as a screening tool. However we know that in many cases people screened were provided with a Change4Life information leaflet about alcohol consumption. This may be effective as a longer intervention aimed at changing alcohol consumption behaviour, at least for service users who are motivated to take protective action (Kaner et al., 2013).
Box 5 – Community Pharmacy Alcohol Intervention Schemes

**Lambeth Pharmacy-based Identification and Brief Advice (IBA) Project**
The Lambeth Pharmacy-based Identification and Brief Advice (IBA) project is a five month programme, within a two-year study, developed to determine the success of IBA delivered by community pharmacists. The aim of the project is to implement IBA procedures-appropriate to community pharmacies and their customers–over a five-month period, and further, to evaluate the clinical data, cost and sustainability of implementing the service on a long term basis. The project is active across 28 community pharmacies. The project uses the AUDIT-C tool, a seven day drink diary and the STRCQ Questionnaire. More details available at (http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6335)

**Leeds Pharmacy Brief Alcohol Interventions**
The aim of this project was to investigate the feasibility of screening for Hazardous Drinking, with subsequent Brief Interventions if indicated, as a routine part of the community pharmacist’s public health role. Pharmacists from one community pharmacy targeted brief interventions to patients, particularly women, who presented with prescriptions which could have potential interaction with alcohol. In the pharmacist-patient encounters, the prescription or purchased medicine was used as a pretext for screening. The Pharmacy support staff were trained by the Pharmacist to conduct the FAST questionnaire. Of the 352 people entered into the study, approximately 1 in 3 was found to be hazardous drinkers. Whilst 80% of people interviewed expressed concern over the drinking of a friend or colleague. More details available at: http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6335

**Hampshire Pharmacy Alcohol Brief Intervention Pilot Project**
As part of the Hampshire Innovation Fund, two pilot projects took place in 2009 using pharmacies to deliver brief interventions and support those people drinking at a low and medium risk level. The project was delivered by a total of 60 pharmacists. The head of the Hampshire and Isle of Wight pharmaceutical committee co-ordinated the training and distribution of materials. People were screened using AUDIT-C. At the end of three months, in the ten pharmacies a total of 801 Interventions and 794 consultations were undertaken opportunistically and proactively. Of the 801 interventions, 464 included educational information, 296 advice and 41 referral. The full report outcomes are available here: http://www.alcohollearningcentre.org.uk/__library/ABI_projects_report_HantsIOW_LPC_2009_FINAL.pdf

**North West Pharmacy Alcohol Service Evaluation Team Report**
(Blackpool, Bolton, Knowsley, Oldham, Sefton and Wirral PCTs)
This report contains an evaluation of the delivery of IBA services in community pharmacy settings across a number of areas in the North West and identifies elements of practice that can be developed to ensure consistency and optimise provision. The service involved nearly 100 pharmacies. There was great variability in the numbers of screens undertaken by different pharmacies: a small number of pharmacies were prolific, and others performed few screens. The majority of people screened had low risk AUDIT scores (scoring 0-7) (71% for Wirral and 79% for the rest of the North West), and yet many were still given an intervention. The demographic profile of people offered an intervention was in line with the expected target groups: more males, younger people and those from more deprived areas. The nature of the intervention offered to customers was not always clear with regard to whether it could be considered information or a full brief advice intervention. The full report is available here http://www.alcohollearningcentre.org.uk/__library/Final_Pharmaacy_report_25th_october_2012.pdf.

**Training and Support**
There was great variability between the 240 pharmacies involved in the service. Some recorded over 400 interventions, whilst others recorded only a few. Pharmacists contributing to this evaluation had access to online learning tools through the Alcohol Learning Centre. However, pharmacy support staff were not provided with any formalised training.

In some instances people judged to be at high risk were referred to local services. However, it was reported by those involved in the management of this London project that it was on occasions difficult for the pharmacists to make referrals. This has also been reported elsewhere. It reflects the fact that community pharmacy is often not seen as an integrated part of the wider alcohol (or other public health related) service team/system.

The existing literature points towards problems such as practitioners being concerned over the appropriateness of raising alcohol consumption issues with service users for fear of causing offence, and lacking confidence in the relevance of their role and skills (Sheridan et al., 2008; Fitzgerald et al., 2009). The ease with which pharmacy staff can approach customers to discuss alcohol consumption may have been a factor in this variability. Any future service will need to consider how training might instil sufficient confidence and competence for service delivery to be homogenous across all pharmacies. Research commissioned by NICE has also shown that the effective implementation of alcohol intervention services requires adequate financial and managerial support, not only...
in terms of training opportunities but also covering overall workloads (Johnson et al., 2011). The implementation of any pharmacy service may have workload barriers associated with it. In this instance it appears from the variability in supply and recording of the scratch card data that some pharmacies prioritised the delivery of this service to a much greater degree than others. Widespread uptake of this approach may require the adoption of a framework where community pharmacy culture shifts towards proactively maximising every customer’s future health and wellbeing.

**Service Effectiveness**

A weakness of many pharmacy based alcohol intervention evaluations, including the service reported here, is the failure to include clinical outcome measures at a follow up as a result of the intervention. In this case the original goal was focused on measuring the acceptability of the AUDIT-C scratch card provided in community pharmacy as a tool for measuring alcohol use, as opposed to its effect on consumption. But to justify the large scale roll-out of such a service substantive evidence of health outcome enhancement is arguably vital.

Given this limitation, it is not currently possible to make precise predictions about the cost effectiveness of this service. However, Kaner et al (2013) reported that six months after receiving an information leaflet 32% of the individuals involved were ‘already trying to cut down’ their consumption, and 12% had ‘decided to drink less’. Applying these intermediate outcome rates to the population here implies that in the region of 3,300 higher risk drinkers may have begun to cut down their alcohol consumption as a result of this scratch card service. This figure is a broad estimation, but is an indicative suggestion of the effect that the community pharmacy scheme could have had.

**Future Service Commissioning**

The positive findings reported here are in the main unsurprising. Several pilot schemes have been carried out in community pharmacy settings using the scratch card approach and all have shown to be beneficial in basic uptake terms (National Pharmacy Association, 2011). Yet none have been able to reach the number of people reported here. The current initiative underlines the scale of the access pharmacy has to people living normally in the community, many of whom never seriously contemplate whether or not they consume potentially harmful levels of alcohol.

This report therefore adds to the growing weight of evidence in favour of using community pharmacy for alcohol risk screening/awareness promotion and early stage intervention. The Alcohol Learning Centre lists a number of initiatives that have been trialled across the country (Box 5). For example, the Hampshire Drug and Alcohol Team ran a pilot which demonstrated that pharmacies were more successful than expected in engaging people and delivering AUDIT screening and brief interventions (Alcohol Learning Centre, 2009). This was followed by a similar scheme in the Wirral (Alcohol Learning Centre, 2007). In 2010 Lambeth launched a similar two year pilot. A follow up study measuring impact and outcomes is now in progress (Alcohol Learning Centre, 2010).

Responsible commissioners should consider how community pharmacy based services can help support the wider alcohol harm control network. They ought in addition to be aware of relevant opportunities to involve community pharmacy in other public health campaigns in areas such as sexual health, smoking cessation and healthy living/weight management (Anderson et al., 2008; National Pharmacy Association, 2011).

For example, excess alcohol consumption is on occasions linked to unsafe sexual practices. In London and elsewhere community pharmacies are already key providers of Emergency Hormonal Contraception. EHC supply services do not normally at present include advice on alcohol consumption (Kaner et al., 2007; Kotecki, 2003), but there in future may be a case for this to be addressed in a suitably supportive manner.

**Conclusions**

This project has demonstrated that is it feasible and practically viable for community pharmacists to ‘risk screen’ large numbers of people who, in a population in which regular alcohol drinking is commonplace, may be exposed to relatively high levels of alcohol related harm. It found in London that some 24,000 community pharmacy customers using just 240 community pharmacies were willing to take part in this form of initial risk assessment campaign. At minimum this will have helped to raise awareness of alcohol linked harm, and even without subsequent more specific interventions is likely to have led a proportion of participants to have moderated their alcohol consumption.

The AUDIT-C screening tool in scratch card form was successfully supplied in a variety of community pharmacy settings, from large multiples to small independents. The cards were normally completed in the pharmacy, which allowed a conversation with a trained healthcare professional to take place. There appear to be considerable opportunities for community pharmacists to contribute to reducing hazardous drinking seen in the UK, not least via enhancing the access of alcohol users to linked harm reduction interventions in contexts such as smoking cessation and weight control.

While many consumers may feel comfortable using a pharmacy to discuss alcohol consumption, they may be reluctant to seek help or more formalised care within ‘the managed’ health service. The underlying philosophy of this service is in line with the wider pharmaceutical public health agenda, and the NHS Future Forum’s suggestion to ‘make every contact count’ (Mooney, 2012).

Further work is needed to establish the best immediate interventional and/or referral pathways for use once harmful and hazardous drinking have been identified. But the evidence presented here indicates that community pharmacy could make a significant contribution to anticipatory care and public health gain via the systematic use of AUDIT-C based alcohol use monitoring scratch cards.
Review community pharmacists in Auckland, New Zealand.


Authors

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Pharmacy London

Pharmacy London is the forum for London Local Pharmaceutical Committees (LPC’s). A LPC is an independent group with statutory rights for NHS community pharmacy, that represents all the community pharmacy contractors within a given locality. The LPC works closely with commissioners to develop solutions to meet locally identified health and public health needs.

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