Evaluation of feasibility and acceptability of a community pharmacy health promotion scheme – views of users and providers

Alison Blenkinsopp[1], Jennifer Tann[2], Adrian Platts[3] and Judy Allen[4]

Abstract

Objectives To analyse client uptake and obtain feedback on pharmacists' health promotion interventions; to consider pharmacists' perspectives on providing health promotion inputs.

Design Telephone interviews with clients, stakeholders and pharmacists. Analysis of client questionnaires.

Setting Community pharmacies in one health authority area in England.

Method Eleven community pharmacists took part in a scheme to offer health promotion advice to the public about four topics: exercise, dental health, smoking cessation and medicines. The scheme used a behavioural change model drawing on the Transtheoretical Model (TTM) and Motivational Interviewing. The pharmacists received a specific training programme (six days in total). Clients were offered a brief 'Level 1' intervention with a second, extended 'Level 2' where the pharmacist and client thought it necessary. The evaluation included interviews with clients (29), participating pharmacists (9) and stakeholders (7) together with an analysis of client feedback questionnaires.

Results In total 301 Level 1 and 30 Level 2 interventions were provided by the pharmacists. The most popular topic was smoking cessation (140 Level 1 and 29 Level 2) and the least popular, exercise (21 Level 1). Client questionnaires and interviews showed that clients valued the advice they received. Pharmacists' motivations for participating and their level of proactivity and networking were variable. There was some evidence that

[1]Professor of the Practice of Pharmacy, Department of Medicines Management, Keele University. [2]Professor of Innovation Studies, Business School, University of Birmingham. [3]Research Assistant, Business School, University of Birmingham. [4]Research Associate, Business School, University of Birmingham.

Address for correspondence: Professor A Blenkinsopp, Department of Medicines Management, Keele University, Keele, Staffs UK ST5 5BG. a.blenkinsopp@keele.ac.uk

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

limiting the pharmacist's input to one Level 1 and one Level 2 session may provide insufficient flexibility to meet clients' needs. Furthermore, while the TTM has a good fit with some health promotion topics, there are others where a straightforward information-giving model might be more suitable.

Conclusion The health promotion scheme was well received by clients, many of whom had not previously sought health advice from the pharmacist. The findings of this study should give pharmacists more confidence to proactively offer health promotion advice to clients and indicate scope for extending the provision of such advice.

Key words: community pharmacists, health promotion, transtheoretical model, primary care, public health

Introduction

Pharmacists and health promotion

Health promotion is one of the roles identified by the Royal Pharmaceutical Society as a core activity for pharmacists and one of five key themes for the profession's future[1,2,3]. Since the mid-1980s local health promotion schemes in community pharmacies have been trialled throughout the UK[4]. Few pharmacy health promotion projects have resulted in the establishment of long-term services, although the development of Health Action Zones and Health Improvement Plans have led to more attention being paid to pharmacy-based health promotion services, notably smoking cessation.

The strengths of community pharmacies as a setting for health promotion are undoubtedly promising – accessibility, informality, long opening hours, and visited by healthy people as well as those who are ill. The challenge has been to demonstrate concrete outcomes from these potential advantages. Research with the public suggests that while community pharmacists' advice is highly valued, it is largely sought by regular pharmacy users who are already taking repeat medication for chronic conditions[5]. Community pharmacies are not perceived by the healthy public as an obvious place to seek advice about staying healthy or about general health issues[6].

During the last decade the Transtheoretical Model (TTM) has become pre-eminent in health promotion in the UK. TTM is a theoretical model of behaviour change that has been used in interventions to encourage the cessation (for example, in smoking and drug misuse) or adoption (for example, in exercise and healthy eating) of specific behaviours. The model comprises Stages of Change and Processes of Change (including decisional balance and temptation) and is based on negotiation between client and advisor[7]. The literature on community pharmacy-based health promotion suggests that most programmes have used a traditional information-giving model with 'pharmacist as expert' rather than a theoretical model of behaviour change. The literature on TTM

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

suggests that most trials have used a counselling-type model with a series of interventions, each lasting typically 30–40 minutes. The effectiveness of TTM in the type of brief interventions likely to occur in the National Health Service (NHS) has been questioned[8]. In pharmacy the 'Stages of Change' model was used in the Pharmacists' Action on Smoking (PAS) programme whose development was led by the National Pharmaceutical Association in the late 1980s. Our literature search showed that, with the exception of smoking cessation[9], there are no published studies where the TTM model or Stages of Change has been used in community pharmacies.

South Staffordshire scheme

In 1997 a community pharmacy health promotion scheme was established by Staffordshire Health Authority with pharmacists providing short and extended health promotion interventions on specific topics The programme drew on the principles of TTM and Motivational Interviewing. Clients were invited to attend for an extended consultation where they and the pharmacist thought this was needed. A 'short' intervention might last up to ten minutes whereas an extended intervention would last for 20–30 minutes. The pharmacists were paid a fee for each short/Level 1 (£10) and extended/Level 2 (£30) intervention on submission to the health authority of a claim form for each intervention. A project board developed an operational plan, monitored the scheme's progress and decided the topics for the series of campaigns:

1 Dental health
2 Heart I (exercise)
3 Heart II (diet)
4 Smoking cessation

each of which was to run for three months.

All 20 pharmacies in two localities were invited to take part and twelve (60 per cent) agreed. There were some changes/drop-outs during the first year of the scheme, and recruitment of new pharmacists brought the numbers to ten. Training was designed and provided by the Health Authority's Health Promotion department based on the Health Education Authority's 'Helping People Change' programme expanded to cover TTM and Motivational Interviewing. The latter is 'a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence'[10] and was included to support operational use of TTM. A total of six days' training was provided including two 'core' days on the theory and practice of TTM and Motivational Interviewing and four days of health topic-based sessions including implementation in practice, identification of stage of change and decisional balance. The training was evaluated by the Health Promotion Department and the findings discussed by the project board.

The scheme was launched in May 1998 and uptake for the first two topics (dental health and exercise) was lower than anticipated. A provider pharmacist was appointed as project manager to enhance take-up.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

In April 1999 the authors were commissioned to conduct an evaluation of the scheme. At that time the smoking cessation campaign was extended and a new topic introduced whose focus was the use of aspirin and lipid-lowering drugs after heart attacks, which included advice about both medicines and lifestyle-related risk factors.

The findings presented in this paper relate to the following objectives:

1 To assess levels of client uptake and pharmacist involvement in provision of the health promotion service and the key factors which influenced them. More specifically, to determine the effect of:

- campaign topic choices
- the pharmacy environment (premises, layout and support staff)
- pharmacist factors (for example, motivation)
- the applicability of the TTM model in the pharmacy
- pharmacists' strategies for initiating Level 1 interventions
- pharmacists' decision-making processes and criteria for offering Level 2 interventions

2 From the client's perspective, to assess:

- the acceptability of the service
- the approach taken by the pharmacist
- whether clients reported making any changes to lifestyle as a result of the pharmacist's input

Method

There were four elements of data collection:

1 Client numbers and feedback

Pharmacists asked each client who received a brief intervention (Level 1) to complete a short questionnaire, designed by the project board, and used throughout the four campaigns. It asked clients to give their age, to state who had initiated the interaction and its topic. The possibility of client follow-up was introduced by including a question seeking permission to make telephone contact.

Clients who participated in a Level 2 consultation were asked to complete and return a longer questionnaire, also designed by the project board. Here, they were asked a number of questions where they selected a Likert-type rating from 1 to 5 about different aspects of the consultation with the pharmacist.

2 Client interview recruitment

The Health Promotion Unit had intended to conduct brief follow-up telephone interviews and 14 were completed in 1998 (five dental health, six exercise and three smoking cessation). To build on this work the evaluation team designed an extended telephone interview schedule for client follow-up and conducted further interviews. A random sample of 15 clients was taken from the 186 who had received a Level 1 intervention

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

during the two most recent campaigns on smoking cessation and medicines use. All of these 15 clients agreed to be interviewed. It proved difficult to obtain interviews with patients who had received a Level 2 consultation as the data was anonymised. Numbers of Level 2 consultations were low overall and from the fifteen Level 1 clients contacted by telephone, only two had received a Level 2, both of whom agreed to be interviewed.

3 Pharmacist interviews

Eleven of the twelve community pharmacies that originally agreed to participate in the scheme did so. The 'pharmacist-in-charge' at each of these community pharmacies was contacted and asked to participate in a semi-structured telephone interview. One pharmacist had moved away and was not contactable and one declined to participate, thus nine were interviewed. The pharmacists were asked what had influenced their decision to take part in the scheme, about their participation in the campaigns and the involvement of other pharmacy staff, and perceived positive and negative aspects of the scheme. The interview also asked about the practicalities of offering Level 1 and Level 2 interventions, whether pharmacists thought the scheme could be offered more widely, and any barriers they perceived to doing so.

4 Stakeholder interviews

Interviews were conducted by telephone with all members of the project board (seven in total) and these comprised: the Deputy Head of Health Promotion; the Health Authority Community Pharmacy Facilitator; National Pharmaceutical Association Regional Professional Development co-ordinator and four community pharmacists, one of whom was a participant in the scheme. The semi-structured interview schedule was intended to stimulate reflection on the design and operation of the scheme and to consider it in the context of the changing NHS.

Data analysis

Clients

Data from the questionnaires were entered onto a computerised database. The client interview forms were coded and a content analysis of clients' comments was undertaken to identify key themes.

Pharmacists

The interview responses were subjected to content analysis by two members of the evaluation team.

Stakeholders

The stakeholder interview forms were subjected to content analysis by two members of the evaluation team.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

Pharmacist interviewees were coded as HP1–9 (pharmacists participating in the health promotion scheme) and stakeholders as S1–7. One stakeholder was also a scheme participant and was coded in both groups.

Results

How the training prepared the pharmacists

The training programme for the scheme aimed to provide pharmacists with an understanding of the TTM and resources to operationalise the model in their own pharmacy. Pharmacists' responses to the training varied and as one stakeholder pointed out:

> *Pharmacists assumed they knew the model already... thought it was just common sense. (S1)*

As other stakeholders put it:

> *Pharmacists probably need to understand... to be taken through a change themselves... before the project. (S3)*
>
> *We need to recognise where people are when they come to the pharmacy. (S6)*

Pharmacists felt more comfortable with the 'information' than the 'process' aspects:

> *They preferred the 'topic' days to the 'core' days. (S1)*

Several of the pharmacists made negative comments to the trainers about the use of role-play in the core training, perceiving it as 'patronising', while some clearly found it useful, citing it as the best part of the course.

Involvement of other pharmacy staff

The original project proposal allowed the possibility that Level 1 interventions might be delivered by pharmacy staff. The project board, however, decided that all interventions were to be delivered by pharmacists:

> *A lot of discussion was held as to whether Level 1 needed trained pharmacists at all. The working group decided it should be pharmacists. (S4)*

Counter staff were thus not included in the training programme for the scheme. Nevertheless some pharmacists had integrated their staff into the scheme and in general this involvement tended to be in referring clients to the pharmacist:

> *If staff spot a Level 1 patient and can deliver the message and refer to me as necessary. (HP1)*
>
> *Referring and giving out basic information only. (HP2)*
>
> *They know about it... they can refer to me... they can take the initiative. (HP3)*
>
> *Staff have been interested... they initiated some of the advice... by passing them to me. (HP9)*

Three of the pharmacists reported that they had not involved their staff in the scheme.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

Client uptake and response to the scheme

Uptake

The smoking cessation campaign resulted in the highest number of Level 1 interventions (140) and exercise the lowest (21) (see *Table 1*).

TABLE 1 Numbers of interventions by campaign topic

Campaign topic	Number of Level 1 interventions	Number of Level 2 interventions
Exercise	21 (7%)	0
Dental health	78 (26%)	1
Smoking cessation	140 (47%)	29
Medicines & concordance	46 (15%)	–
Topic left blank	16 (5%)	–
Total	301	30

The distribution of interventions across the participating pharmacies is shown in *Table 2*.

TABLE 2 Numbers of Level 1 interventions by topic and pharmacy

Pharmacy	Exercise	Dental health	Smoking cessation	Medicines & concordance	Total
A	11	5	31	24	71
B	0	3	14	7	24
C	0	11	24	0	35
D	5	14	21	7	47
E	0	6	10	1	17
F	4	18	15	1	38
G	0	0	11	0	11
H	0	0	14	0	14
I	0	5	0	0	5
J	1	2	0	0	3
K	0	14	0	0	14
L*	–	–	–	6	6
Totals	21	78	140	46	285**

* joined for final campaign
** topic left blank in 16 cases

Pharmacies I, J and K took part in the exercise and dental health campaigns but not smoking cessation or medicines. *Table 2* shows that all participating pharmacies were active in the smoking cessation campaign, whereas for other topics between three and five pharmacies completed interventions. One pharmacy (A) was responsible for almost one third of all interventions while some made very few, with about half making less than 20 during the entire period of the scheme (over a year).

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

Almost all (29/30) Level 2 interventions were for smoking cessation, with one for dental health. Four of the pharmacists conducted Level 2 interventions and the distribution across pharmacies is shown in *Table 3*.

TABLE 3 Numbers and topics of Level 2 interventions by pharmacy

Pharmacy	Smoking cessation Level 2's	Dental health Level 2's	Total
A	1	1	2
C	19	–	19
E	2	–	2
F	7	–	7

A profile of clients by age for Level 1 and Level 2 interventions is shown in *Table 4*.

TABLE 4 Client age profile for Level 1 and 2 interventions

Age range	Number of Level 1 clients	Age range	Number of Level 2 clients
18–25	24 (8%)	16–24	2
26–40	81 (27%)	25–34	5
41–65	88 (29%)	35–44	8
Over 65	33 (11%)	45–54	6
Not recorded	47 (17%)	55–64	4
		Over 64	5

Clients of all ages used the service, with fewer from the under-25 and over-65 age groups.

The extent to which pharmacists initiated consultations or responded to clients' approaches at Level 1 was determined. Respondents were able to tick more than one option and it was not possible to identify linkages between primary and secondary initiating sources. Most clients (173, 57 per cent) reported that they had initiated the intervention with 30 per cent citing the pharmacist's suggestion, 21 per cent (63) a purchase request, 13 a friend's suggestion, 12 referred by their GP and 9 mentioning local publicity.

Clients' views

Acceptability of the service

Overall clients were very satisfied with the level of advice, 'friendliness' and customer service provided by the pharmacists.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

The medicines campaign appears to have reinforced and stimulated clients' perception of the pharmacist as the person to ask about medication queries:

The pharmacist had a better idea about it (the prescribed medicine) than the doctor.

Clients saw the pharmacist as the person they would ask about specific issues, such as interactions between medicines:

Whether they (medicines) conflict or not.

Level 2 client questionnaires

All 30 clients completed the questionnaires. About two-thirds visited the pharmacy weekly (8) or monthly (11), with the remainder visiting less often. The findings showed that:

- clients felt they were able to spend enough time with the pharmacist (maximum score 5; mean 4.94)
- most clients (64 per cent) found one Level 2 session was sufficient and 32 per cent said they would have found a further appointment helpful
- most clients felt they were able to discuss everything they wanted with the pharmacist (maximum score 5; mean 4.81)
- most clients felt the pharmacist was able to answer all their queries to their satisfaction (maximum score 5; mean 4.74)
- some clients would have liked to receive more information or advice (minimum score 1; mean 1.6)
- clients felt they were listened to by the pharmacist (maximum score 5; mean 4.81)
- most clients felt they now had enough information to make changes to their lifestyle (maximum score 5; mean 4.73)
- the topics on which clients reported receiving information were: smoking (97 per cent), diet (39 per cent), exercise (39 per cent) and dental health (6 per cent)
- while almost all of the Level 2 interventions were for smoking cessation, a considerable amount of information and advice was given on other health topics
- there was a very high level of overall satisfaction with the discussion with the pharmacist (maximum score 5; mean 4.93)

Clients' additional comments were positive and typical comments were:

Visited pharmacy for advice and got more than anticipated.

Very pleased that there was some support available to me.

Consultation useful – more chemists should be able to do this.

Client interviews

Twenty-nine interviews were conducted. Only two of the clients said they had ever asked for general health advice from the pharmacist:

No... but it's a good thing... you can go straight to the pharmacist and not to the doctor. (Exercise client)

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

It was surprising. (Dental health client)

In general clients were not aware that pharmacists offered health advice, many believing that the pharmacist was there solely to dispense medication:

The pharmacist is for prescriptions and if I'm not sure about my medicines.

I would rather receive information regarding other matters (that is not medicine-related) from the doctor.

These findings suggest that there is considerable scope to educate clients on the health promotion function of pharmacies/pharmacists.

Level 1 and Level 2 consultations

Almost all of the smoking cessation clients were offered the opportunity of a longer discussion by the pharmacist. In most cases clients said it was unnecessary. None of the medicines campaign clients took up the offer of a Level 2:

My questions had been answered. (Medicines campaign client)

It was clear from clients' comments that pharmacists offered an invitation to raise any problems or questions during future visits to the pharmacy and several clients stated that they felt a longer discussion was available should they require it in the future:

He (the pharmacist) said that they were always there for assistance.

She said if there are any problems don't hesitate to call back... it's my local pharmacist, I can always nip back if necessary.

Did clients learn anything new?

Seven of the fifteen clients asked this question said they had:

I hadn't realised that I needed to take the baby to the dentist. It was useful because I didn't need to bother the doctor.

It was educational, particularly for the children.

I got advice on what to use for bad gums... it was useful because I was still waiting for my dentist appointment.

The clients who had consulted about exercise had mixed views:

Personal contact... we talked privately about the smoking clinic as well as exercise.

I got a telephone number for a local group... haven't used it yet but may do later.

Was given information about walking... but already knew about it.

Sort of useful but was already aware of the information in the leaflet.

There was little evidence here that increased awareness had led to change.

Did clients do anything different as a result of their consultation with the pharmacist?

Evidence was sought of changes made by clients, with most of those from the smoking cessation and some from the medicines campaign reporting having made a positive change. Individual smoking cessation clients reported the following changes:

1 purchased nicotine replacement patches and gave up completely (from 60 a day)

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

2 changed brand and reduced smoking by ten cigarettes a day
3 decided to give up smoking
4 tried to give up smoking
5 started to go to a stop-smoking clinic at Staffordshire General Hospital

Of the medicines campaign clients, one changed the timing of her painkillers to night-time and another reported having made lifestyle changes. Several commented that the information received had reassured them that they were 'doing the right thing'.

Pharmacists' perspectives

Why did pharmacists take part?

Pharmacists' comments demonstrated a mix of influencing factors. Personal development was an important factor:

> *To further my knowledge, be proactive in learning. (HP2)*
> *I just like to be involved in anything new. (HP9)*

A belief that the profession should be taking an active role in health promotion was also apparent:

> *I always thought the pharmacy would be a good place to practice health promotion and I hoped this would make me more effective. (HP1)*
> *It is an area we should be involved in. (HP7)*

Financial aspects and potential business opportunities were another motivating factor:

> *I thought it was different... extra... and we would get paid. (HP6)*
> *We would be remunerated for doing something positive for patients. (HP4)*

Only one pharmacist made reference to encouragement from their employer:

> *The company encouraged it. (HP6)*

although one of the stakeholders referred to pharmacists:

> *Being pushed by employers or feeling they ought to do it. (S3)*

Pharmacists were asked whether they thought the level of payment was generous, 'OK' or not enough. Five felt the amount was 'OK', two said it was not enough, one said it was generous and one was unsure.

Perceptions of success

Smoking cessation was perceived as the most successful campaign and as part of pharmacists' existing role and expertise. Another factor was that clients who approached the pharmacist had already made the decision that they wanted to stop. In addition pharmacists had a 'treatment', nicotine replacement therapy, that they could offer:

> *We are used to this, it's easier to spot clients and make links to people. (HP1)*
> *Everyone really appreciated it, we had good outcomes. (HP8)*
> *A sort of cure (in the pharmacist's mind) plus a product. (S4)*

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

Pharmacists also felt comfortable with the final campaign topic, *medicines and concordance*:

> *Closer to pharmacy. (HP1)*
>
> *It has been useful in helping with advice... it changed my view of customers... but quite hard to do when you are busy. (HP3)*

The medicines campaign raised expectations among stakeholders of increased client uptake. However the number of interventions was low:

> *It was thought that here there would be a way of relating the patient to the Patient Medication Record. (S3)*

Few reasons for the apparent mismatch between expectation and reality were put forward. Some stakeholders speculated that one issue might have been pharmacists' concepts of how the topic related to the TTM:

> *It was difficult to put concordance into the cycle of change model. (S3)*
>
> *Pharmacists were struggling with concordance, particularly how to decide whether a patient had gone through Stage 1 or Stage 2. (S6)*

Dental health had a take-up higher than medicines/concordance and lower than smoking cessation with a mean of eight Level 1 interventions per participating pharmacy (range 0–18) over a twelve week period. Pharmacists felt the topic was important in informing people about local out of hours services and encouraging registration of children with a dentist:

> *Clearly defined opportunities to initiate... for example children registering. (HP1)*
>
> *Did encourage visits to dentists, especially children. (HP8)*
>
> *Young mothers were keen for information. (HP9)*
>
> *I had contact with a health visitor about babies seeing the dentist. (HP7)*
>
> *Gave people more confidence to ask me about dental problems... difficult to do... hard to change lifestyle in this area. (HP4)*

These comments suggest that participants saw value in the information provided in the dental health campaign although the fit with TTM was not clear to the pharmacists.

Exercise was the campaign with the lowest number of interventions. Arguably this is the topic furthest from community pharmacists' everyday work and may have been one that pharmacists were less comfortable about raising opportunistically with clients. Pharmacists' comments concentrated on low 'uptake' and there was little evidence that they had actively introduced the subject to clients themselves:

> *Good materials... but not effective... lack of uptake. (HP1)*
>
> *We had a few people take leaflets and joined the gym. (HP2)*
>
> *One or two did more exercise and felt better. (HP5)*

Pharmacists' reactivity or proactivity

The pharmacists' own efforts and methods in promoting the scheme varied. Some had taken a proactive approach:

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

I told the local practice (and practice nurse) what we were doing... used bag stuffers and leaflets. (HP2)

Window displays, bag stuffing, staff briefing. (HP9)

Leaflets in the GP surgery and we manned a stand. (HP4)

I was interviewed on local radio. (HP5)

Other pharmacists saw their role as:

Responding, primarily. (HP1)

The stakeholders recognised the importance of promotional activities organised as part of the scheme but identified that the pharmacist's own proactivity was a key aspect in raising awareness of the scheme:

Pharmacists thought clients would respond to the poster campaign more than they did... the pharmacists had to be more proactive. One pharmacy that had a good number of Level 2 clients on smoking had a good link with a local surgery that referred patients to the pharmacy. (S3)

Pharmacists' strategies for initiating Level 1 interventions and offering Level 2

Only one of the pharmacists reported using their patient medication records (PMRs) to target customers, although it had been envisaged by the scheme organisers that this resource could be an effective way to identify clients for the exercise campaign as well as the one on medicines:

I looked for people on statins... so I could talk to them. (HP6)

Some pharmacists reported that they offered a Level 2 consultation to all clients, others took a selective approach:

I assessed their level of enthusiasm/motivation. (HP2)

Smoking cessation was more appropriate for it than the other campaigns... a patient-based decision. (HP4)

It evolved, I could tell if people had had enough or weren't interested. (HP9)

Pharmacists' delivery of Level 2 interventions

When asked what words came to mind to describe their approach to Level 2 sessions:

A mixture of excitement and fear. (HP1)

Quite daunting... different expectations... patients were expecting a GP-type consultation. (HP2)

Apprehension, because it was new. (HP5)

Difficult, quite rewarding. (HP9)

Most of the pharmacists had held Level 2 sessions when they were the pharmacist on duty. Where the pharmacy was not busy with prescriptions or medicines sales this was not an issue, but only one respondent worked in such circumstances:

My business is quiet so I can fit them in. (HP1)

Others described how they had fitted in the Level 2 sessions into the daily work of the pharmacy and reported that interruptions were an issue:

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

> *I planned them in a quieter period and used a quiet end of the pharmacy... sometimes it was alright, other times I was interrupted. (HP2)*
> *A quiet time when staff are available... this is tricky... it can be quite difficult... interruptions with prescriptions and queries. (HP5)*
> *I chose a quiet time and prepared the office. (HP9)*
> *I did it because it was at a quiet time... it was spontaneous. (HP3)*
> *No problem (might have been different if 100 came!). (HP8)*

One pharmacist provided Level 2 sessions when a locum was present and two others when a second pharmacist was working. It had been suggested by the project board that clients could be asked to attend on a particular day (for example, to have a clinic each Wednesday afternoon). One pharmacist had booked appointments:

> *My mother covers me in the dispensary... we book people in and use the consulting room. (HP8)*

One stakeholder commented:

> *Pharmacists said it was difficult to organise clients for a particular day... I don't understand why this was a problem. (S3)*

It was not clear whether pharmacists had been reluctant to specify a set day to clients or whether they had tried this approach and found clients were unhappy with it. Pharmacists' descriptions indicated that some had used appointments and others went ahead with a Level 2 intervention there and then if the pharmacy was quiet at the time. The low numbers of Level 2 interventions make it difficult to assess the feasibility of a clinic-type set up.

Applicability of the Stages of Change model in the community pharmacy setting

Suitability of the Level 1/Level 2 approach

When asked whether one Level 2 session was enough some pharmacists felt that flexibility to respond to the client's needs would be helpful:

> *Depends where they are on the cycle... for some one will be enough, for others not. (HP1)*
> *I think you need to reappraise people to see where they are on the cycle of change. (HP5)*
> *We could do with further sessions for just a few. Some were ready to change but not quite. (HP8)*

Some respondents felt that while more than one session was needed this did not necessarily have to be a 'full' Level 2.

Discussion

This is the first published study of a multi-topic community pharmacy-based health promotion scheme that utilised application of theories of client behaviour change. Local

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

stakeholders held the view that uptake by clients using the scheme was low to moderate. It is difficult to interpret levels of uptake in the absence of data on the numbers of customers using the pharmacies, although only one of the participating pharmacies reported working in a shop that was not 'busy'. Given the time period covered by the scheme it is likely that a very small proportion of pharmacy customers was involved. Evaluation showed high client acceptability of the pharmacist's interventions, and importantly, that many clients had not sought advice from pharmacists in the past. The Barnet community pharmacy health promotion scheme evaluation showed that the general practitioner (GP) was seen by pharmacy customers as the main source of health advice, with only 40 per cent of consumers agreeing that it was the "usual job" of the pharmacist to give advice about general health[5]. These findings are relevant to this study, where client feedback showed that despite the 'unexpectedness' of the advice, it was welcomed.

Clients generally appeared to view the pharmacy health promotion service as an opportunity to have their questions answered or to obtain further information if they needed it. There was little evidence that clients viewed the service as a potentially extended support mechanism rather than a simple exchange of information. This may be because some of the selected topics lent themselves better to query answering and information-giving, or because the limit of one Level 1 and one Level 2 sessions did not permit continued support. These findings suggest scope to promote the broader aspects of the service to clients. They also indicate that pharmacy customers' own constructs of the boundaries of the pharmacist's role may be limited to a model of requesting and receiving information rather than shared discussion on possible options for change.

The importance of training in embedding both the philosophy and skills of TTM is highlighted in the findings of an earlier trial of smoking cessation which showed no significant difference in smoking behaviour between intervention and controls[11]. The authors postulated that part of the explanation for the lack of efficacy was the nature and length of the training provided for the participants, a one-day training programme on Stages of Change. They recommended that future training should be tailored to the needs of individual health professionals to acknowledge their own readiness to change to a new consultation style, suggesting that health professionals may have had difficulty in adopting its negotiative style of consultation[12]. The pharmacists in the South Staffordshire scheme participated in six days' training on TTM and Motivational Interviewing and their application to different health topics. Stakeholders' accounts indicate a divergence of views between the participating pharmacists and members of the project board about the value of the training. Without observing the pharmacists' interactions with clients prior to and after the training it is difficult to know the extent to which the participants engaged with TTM or adopted it as their consultation style, or whether the 'pharmacist as expert' style may still have predominated. Contact with national pharmacy health promotion experts confirmed the lack of published community studies based on TTM and identified that some Health Authority-based

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

community pharmacy programmes (Buckinghamshire, Berkshire and Ealing) had used the Stages of Change approach but had not published their findings. The role and effectiveness of training in TTM for community pharmacists need further work. Peer review of consultation style could provide valuable feedback to participating pharmacists and indicate the type of consultation styles in use.

The South Staffordshire scheme did not include an assessment of clients' readiness to change in Level 1 interventions, a feature that could be incorporated into future schemes. Unless the pharmacist offered a Level 2 session there was no mechanism for them to receive feedback following a Level 1 intervention about whether the client had made any changes. The closing of this loop could be important and training for future schemes could incorporate a 'contract' between pharmacist and client with a more formal request to return and report progress.

The selection of topics seems to have been an important factor both in the variability of uptake by clients and also in the comfort zone, and thus probably confidence levels, of participating pharmacists. Furthermore pharmacists' comments suggest they found difficulty in applying the TTM to all of the campaigns. The TTM is based on a negotiated agreement where the client decides on subsequent action. Pharmacists may have felt more comfortable reverting to query-answering mode, and some topics may not have lent themselves to TTM, for example, dental health had a large component to do with factual information-giving about the availability of services. Respondents' comments about the framework of one 'brief' and one 'extended' 20-minute intervention used in this scheme suggests that greater flexibility is needed. Modification of this approach could both increase its feasibility for greater numbers of pharmacists and potentially provide clients with tailored support based on their needs.

Previous research on pharmacy health promotion has shown that activity was two and a half times more likely to be reactive than proactive among a general population of community pharmacists, and that pharmacists felt isolated and excluded from local health promotion activity[13]. Apart from individuals' tendency to more or less proactive behaviour, possible reasons for not intervening opportunistically may be pharmacists' concerns about offering advice that might not be welcome, or that might be seen as 'interfering' in peoples' lives[14]. The positive response from clients in the South Staffordshire scheme should give pharmacists confidence and reassurance that their input is likely to be valued.

In other health promotion projects and studies, pharmacists have cited lack of remuneration as a key reason why they were not more involved[6,15]. The South Staffordshire scheme had set remuneration levels at a level agreed with the local pharmaceutical committee and thus likely to be acceptable to community pharmacists. This was confirmed in that most of the pharmacists considered the amounts reasonable and this does not seem to have been an inhibitory factor. Of course remuneration does not in itself provide a straightforward answer to internal organisational issues in the pharmacy.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

Only two of the pharmacists reported active collaboration with their local practices. This is noteworthy because the health authority had already done a considerable amount of work to encourage GP practices to employ pharmacists on a sessional basis to provide prescribing advice. Yet opportunities for collaborating through these pharmacists to gain the practice's interest and commitment to the health promotion scheme was not mentioned by any of the pharmacists, nor were practice nurses mentioned. Networking with other primary care health professionals could have provided pharmacists with peer support and a potential source of client referrals and was important in its absence from the scheme.

Conclusion

The health promotion scheme was well received by those pharmacy clients who used it, many of whom had not previously sought health advice from the pharmacist. The majority of clients received a single short intervention where query answering and information-giving appeared to be the primary models. This information was welcomed, even where it was unsolicited by the client. Information about outcomes was limited, although most Level 2 smoking cessation clients reported having made a change. For future programmes it will be important that the pharmacist participants are more actively involved in the choice of topics and in tailoring them to the community pharmacy setting. The findings of this study should give pharmacists more confidence to proactively offer health promotion advice to clients and indicate scope for extending the provision of such advice.

Acknowledgements

The evaluation was funded by the Department of Health. We would like to thank South Staffordshire Health Authority and Local Pharmaceutical Committee for their cooperation, and the stakeholders, community pharmacists and clients who agreed to be interviewed.

References

1 Royal Pharmaceutical Society of Great Britain. *Pharmacy In A New Age*. London: RPSGB, 1996.
2 Royal Pharmaceutical Society of Great Britain. *Building the Future*. London: RPSGB, 1997.
3 Royal Pharmaceutical Society of Great Britain. *Over to You*. London: RPSGB, 1998.
4 Anderson C. Community pharmacy health promotion activity in England: a survey of policy and practice. *Health Educ J*, 1996: **55**: 194–198.
5 Anderson C. Health promotion by community pharmacists: consumers' views. *Int J Pharm Pract*, 1998: **6**: 2–12.
6 Anderson C. Health promotion by community pharmacists: perceptions, realities and constraints. *J Soc Admin Pharm*, 1998: **15**: 10–22.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016

7 Velicer WF, Prochaska JO, Fava JL, Norman GJ, Redding CA. Smoking cessation and stress management: Applications of the Transtheoretical Model of behaviour change. *Homeostasis*, 1998: **38**: 216–233.

8 Ashworth P. Breakthrough or bandwagon? Are interventions tailored to Stage of Change more effective than non-staged interventions? *Health Educ J*, 1997: **56**: 166–174.

9 Bond CM, Sinclair HK, Lennox AS, Silcock J, Winfield AJ. The primary health care team and smoking cessation: an effective contribution from community pharmacy? *Pharm J*, 1997: **259**: R5.

10 Rollnick SR, Miller WR. What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 1995: **23**: 325–334.

11 Lennox AS, Bain N, Taylor RJ, McKie L, Donnan PT, Groves J. Stages of Change training for opportunistic smoking intervention by the primary health care team. Part 1: randomised controlled trial of the effect of training on patient smoking outcomes and health professional behaviour as recalled by patients. *Health Educ J*, 1998: **57**: 140–149.

12 Bain N, McKie L. Stages of Change training for opportunistic smoking intervention by the primary health care team. Part 2: qualitative evaluation of long-term impact on professionals' reported behaviour. *Health Educ J*, 1998: **57**: 140–149.

13 Moore SM, Cairns CJ, Harding G, Craft M. Health promotion in the high street: a study of community pharmacy. *Health Educ J*, 1995: **54**: 275–284.

14 Benson MA, Cribb A. In their own words: community pharmacists and their health education role. *Int J Pharm Pract*, 1995: **3**: 74–77.

15 Keene JM, Cervetto S. Health promotion in community pharmacy: a qualitative study. *Health Educ J*, 1995: **54**: 285–293.

Downloaded from hej.sagepub.com at PENNSYLVANIA STATE UNIV on March 3, 2016